The patterns of erasure and suspension in the UK (GMC) have recently been analysed. The findings are of interest to all practising doctors. It would appear that certain groups of doctors are more likely to be subject to the Council's scrutiny than others. A total of 790 doctors (0.3%) are either erased or suspended. In terms of gender, 86% are men and 14% are women; men are 4 times more likely to be affected. Hospital specialists are only half as likely to be brought before the GMC when compared with GPs. Non-UK graduates have twice the risk that of UK graduates. Another important demographic finding is the length of time since qualification, the longer the time the greater the likelihood. The proportion with suspension or erasure for those qualified before 1985 is 0.4%, for those qualified 1995-2005 it is 0.23% and for those qualified after 2005 it is 0.09%. Doctors are 4 times more likely to face disciplinary problems after being qualified over 25 years. This may reflect increased levels of responsibility, large patient workloads, less time for their own professional development and failure to keep up to date.

Since its establishment in 1858 the GMC has overseen the professional conduct of doctors. For most of its existence it has focused on misconduct. More recently clinical competence has come within its portfolio. The latter has caused confusion for practising physicians. Individuals understand misconduct as they have been taught how to behave by their parents, their teachers and during medical undergraduate ethics courses. Competence is a different matter. It is difficult to understand where it begins and where it ends. At what level has the bar been placed? If the standard is set too high how can one be deemed competent and if it is set too low it serves no purpose. Also what is the doctors' competence? One commentator has defined it as an ability equal to requirement. The judicious use of communication, knowledge, technical skills, clinical reasoning, emotional skills and reflection for the benefit of patients is another definition. While such descriptions may be valid they are unhelpful when one is striving to perform competently at a medical emergency.

At a more fundamental level, competence is about being able to relate to people in distress and make them comfortable, having appropriate knowledge and skills, and possessing listening and communication skills. Competence describes what an individual is able to do in practical practice. Performance describes what the individual actually does in practical practice. How does one learn competency? The dimensions of medical competence include scientific knowledge, clinical examination, procedural skills, doctor-patient interaction and relations with colleagues. Miller's Model of clinical competence is as follows: knows, knows how, shows how, does. Knows and knows how are knowledge based while shows how and does are performance based. Knows is about the straight facts while knows how tests how the facts can be applied to clinical situations and problem solving. Shows how is tested by assessing performance when examining patients in a pre-arranged setting. Does is the apex of the triangle and it assesses the doctors performance in active real-time interaction with patients either on the wards or in the clinic. It is the best discriminator because it is testing the doctors fitness to practice. The downside is that it is costly both in time and personnel. Supporters of the process maintain that assessment drives learning. However, it wasly accepted that in order to promote learning assessment should be educational and formative. If the exercise is simply about certification and exclusion a lot of its value will be lost.

This logical starting point for the effective assessment of the individual doctors performance is the recognition that the era of the doctor as a 'lone ranger' is over. It is about the assessment of medical knowledge, the importance of health care delivery including the crucial element of teamwork. There is a need to distinguish between the forensic assessment triggered by a patient's medico-legal complaint and that of competence examination. The latter must have an educational rather than adversarial framework.

Some of the drive for competence assurance is driven by medicine's 'global marketplace'. Migrating doctors' qualifications may be outdated, difficult to interpret, or not in line with their new country's standards. These considerations apply both to foreign doctors working in Ireland and Irish doctors working abroad. It is important that the doctors skills and competences are not compartmentalised at the expense of their overall effectiveness. Good intuitive reaction is invaluable particularly in the emergency situation where the doctor has to perform in the absence of complete facts and information. Rasmussen has proposed that one can be become competent in clinical skills before the full knowledge of the clinical skill has been acquired. Over time the practical experience increases and is augmented by increasing knowledge.

Doctors are facing serious challenges. Continual professional development has become mandatory. Falling behind, getting out of date is not acceptable. All clinicians are going to need continued support and guidance from their professional bodies such as ICPG, RCPI, RCSFI, Faculty of Radiology, on how best to achieve and maintain a competent standard.

JFA Murphy
Editor