

# Supporting physicians through standards for appraisal and revalidation

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When the Royal College of Physicians was established by Royal Charter in 1518, it was explicitly to monitor, maintain and enforce standards of physicians working within seven miles of the city of London. In those early days the College was the licensing body with the power to exclude, indeed imprison, impostors and quacks. While its *raison d'être* has remained standards of clinical care, the emphasis has been on ensuring this through the education and training of physicians. Training curricula have been established, posts inspected, examinations set and consultants appointed, but it has been hard to find explicit criteria about what the public might want to know – what is the standard expected of a competent gastroenterologist or respiratory physician. Helpful advice has been provided about developing a service, such as the equipment required, the numbers of patients that could be seen in outpatient clinics and the like,<sup>1</sup> but the College has shied away from monitoring the competence of its individual trained physicians.

This reticence is hardly surprising when you consider the difficulty in defining the competencies required to be, say, a geriatrician, never mind measuring them. But we cannot afford to evade this issue of central importance to patients and the general public, thrown into dramatic relief by the events in paediatric cardiac surgery in Bristol a decade ago. There is now wide agreement that our fitness to practise should be reaffirmed at intervals during our professional career, and that an annual appraisal at our place of work should be the cornerstone of revalidation of our licence to do so. However, a meaningful appraisal (in this sense really an assessment) has to be able to examine clinical care against defined standards, and who better to set those standards than the Royal Colleges.

What do we require of a standard in this context? Firstly, it has to be achievable by a reasonable majority of conscientious clinicians rather than aspirational (particularly as those failing to reach it may lose their livelihood); it also has to be applicable to all those working in a specialty, including locums, private practitioners and those working part time. Next, it has to be a credible standard – one that the profession itself will 'buy in to' as being important and relevant for high quality clinical care. It is no

coincidence that one dictionary definition of a standard is 'a conspicuous object or banner carried at the top of a pole and used to mark a rallying point'. Some of the targets set by the NHS in recent years, such as trolley-waits, have failed to engage clinicians. Thirdly, it should reflect as much as possible the performance of the individual clinician. This is made more difficult by multidisciplinary team working and by the impact of available resources on outcome in so many areas. Fourthly, it should be measurable, objective and based on reasonable evidence. For many conditions, there may be appropriate surrogate markers to measure, such as the percentage of patients discharged after myocardial infarction taking aspirin rather than the overall reinfarction rate in that population. Fifthly, although specific and relevant to aspects of a clinician's work, it should have general applicability and be equivalent to the standard required of those in other specialties. Finally, it should be based on data that can be collected as part of the normal delivery of care, without recourse to unachievable armies of audit staff, and should be verifiable.

We are fortunate that there is an excellent starting point for defining what physicians should do, enshrined in *Good medical practice*, published by the General Medical Council in 1995<sup>2</sup> and the watershed between the previous 'thou shalt not' proscriptive approach and the new positive assertion of what is good practice. The Federation of Royal Colleges of Physicians of the UK has taken that document and adapted it to the needs of physicians.<sup>3</sup> What is good practice is defined under seven headings:

- good clinical care
- maintaining good medical practice
- teaching and training / appraising and assessing
- relationships with patients
- working with colleagues
- probity
- health.

Next, standards are defined in each of these areas, along with the evidence that should be collected in order to support revalidation against them. Finally, in 20 appendices published on the web there are outlined specific standards and evidence for our main specialties.<sup>4</sup>

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Given the exacting requirements of an ideal standard, as outlined above, many of those to date fall short on several counts. Some lack specificity or cannot be extrapolated; others are too dependent on resources or the skills of other team members; many are impractical to monitor in daily practice or cannot be verified. But they are an important start and will be adapted as other guidelines come in, for example from the National Institute for Clinical Excellence, as data collection improves and the supporting evidence becomes clearer. The RCP can point to significant achievements already. The Clinical Effectiveness and Evaluation unit has had remarkable success in instigating the national audit of specific topics, most notably myocardial infarction (the Myocardial Infarction National Audit Project) and stroke.<sup>5</sup> All hospitals in England now collect appropriate data on outcome of myocardial infarction as part of routine clinical care, and this has led to measurable improvements. The range of national audits is being extended and close collaboration with specialist societies is vital.

In the areas of both setting standards and data collection, the Royal College of Physicians Health Informatics Unit is also making important contributions. The Unit is developing evidence-based standards for medical records, including the written case sheet. These outline the requirements for notes such as admission and follow-up entries, discharge and transfer communications and, when their current evaluation is complete, should provide a standard tool for general use across the country. The Unit is also developing core requirements for clinical information systems that will support electronic records. In an exciting initiative, the unit has opened an 'i-lab' in the University of Swansea. This information laboratory has access to data collected for all consultants in England and Wales. Clinicians supported by experts can interrogate these Hospital Episode Statistics, the bread and butter data collected in the NHS, and we are beginning to see the emergence of clinicians collecting meaningful and uniform data across the UK to support their appraisal and revalidation in the future. It is a daunting road to tread but, with its 486-year experience, the RCP is surely the appropriate professional body to take the lead for its Fellows and Members in driving up standards of care.

## References

- 1 Royal College of Physicians. *Consultant physicians working with patients: the duties, responsibilities and practice of physicians in general medicine and the specialties*, 3rd edn. London: RCP (in press).
- 2 General Medical Council. *Good medical practice*. London: GMC, 1995.
- 3 Federation of Royal Colleges of Physicians of the UK. *Good medical practice for physicians*. London: Royal College of Physicians, 2004.
- 4 [www.rcplondon.ac.uk/college/pa/prof\\_gmpfp.htm](http://www.rcplondon.ac.uk/college/pa/prof_gmpfp.htm)
- 5 Royal College of Physicians. *A multidisciplinary stroke audit package*, 2nd edn. London: RCP, 2002.