The competent doctor: A paper for discussion

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The competent doctor: a paper for discussion

Carol Black and Alan Craft, on behalf of the Academy of Medical Royal Colleges

ABSTRACT – The clinical competence of doctors needs to be defined and assessed in relation to the circumstances of individual practice, in terms of knowledge and skills, both clinical and communicative, as well as attitudes and behaviour. The need to identify the role of the medical practitioner in the context of team working is important and this position requires the skills of diagnosis, synthesis of information and prioritisation of investigation and treatment. Completion of training and acquisition of the Certificate of Completion of Specialist Training (CCST) lead to inclusion in the Specialist Register thus defining the specialist; elevation of a specialist to consultant status in the NHS requires the potential to acquire with maturity, both of person and experience, the confidence to take responsibilities for handling difficult situations, to manage uncertainties in clinical encounters and to guide younger doctors in their careers.

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The NHS Plan and associated reforms – particularly the evolving new arrangements for postgraduate medical education and training and the policy to modernise medical careers – have intensified discussion of the qualities and competences required of doctors. This paper is chiefly concerned with doctors who work in the NHS, most of whom undertake clinical work with patients. Its purpose is to set out the views and concerns of the Academy of Medical Royal Colleges and Faculties, and of others with an interest in the evolution of healthcare and the practice of medicine, and to promote wider discussion.

Background

The modern doctor must be competent to serve effectively and efficiently in a health service that is changing – changing in the nature and scope of the clinical and care services that it can offer, in the organisation and delivery of these services, and in the ways in which healthcare professionals of different specialties and disciplines work together. Above services, the focus must be unequivocally on the needs of patients.

For a number of reasons the relationship between patients and the public and the medical profession has also changed. It will continue to do so as patients and the public become increasingly better informed, more confident and questioning, and more demanding in line with raised expectations about the care and services on offer. It goes further: the relationship between doctors and colleagues from non-medical disciplines with whom they work is changing too. Others now have clinical responsibilities that once lay exclusively with doctors, and perform clinical tasks that once only a doctor would do.

These, and other factors, have generated a number of questions such as: What constitutes the essential knowledge, skills, attitudes and behaviour that doctors should display as their clinical careers unfold? What is a competent doctor? What is meant by the terms 'specialist' and 'consultant'?'

The medical profession and medical professionalism

A balanced discussion of the issues must not lose sight of other changes that affect professionalism in the practice of medicine, and the relationship between doctors and patients. These factors are numerous and include:

- increasing pressures on the profession to meet other than professional aims
- external determination of what the profession is there to do
- increasing external accountability
- consumerist attitudes to every kind of service
- an environment where complaint is encouraged, and where punitive intolerance of normal human shortcomings exists, demeaning professional authority.

The role of the medical profession as an intellectual and cultural resource in society is omitted from most current discussion. Besides a mastery of technical knowledge and skills, medical professionalism is characterised by strong ethical principles, an aspiration to altruism, and a calling of duty and service to patients and the community that are inherent in the life and work of doctors. Doctors and their professional institutions – their collegiality – stand as independent advocates for patients and communities. Attitudes and actions that reject or do not acknowledge this wider vision are a threat to medical professionalism and its place in the life of our society.

The competent doctor

The principles and standards contained in the General Medical Council's statements *Good medical practice*[1] and *Tomorrow's doctors*,[2] and in *Good surgical practice*,[3] provide the basis for defining the competencies of doctors and a framework for acquiring them. These statements are revised and refined over time. They identify the core competencies required of every doctor. They also point to latent competencies that might be needed as doctors proceed through increasingly modernised and improved training and career paths.

Competence reflects knowledge and skills – both clinical and communication – and attitudes and behaviour. It includes the confidence needed to deal authoritatively with a range of difficult and unexpected situations, and especially in managing uncertainty – a feature of many clinical encounters. Naturally, the specific competencies possessed by a doctor should be equal to the responsibilities the doctor is asked to undertake. Compare in medicine, for example, the competencies needed in the different circumstances of acute medicine and in the outpatient clinic; or those needed by a general practitioner required to make judgements when the clinical picture is yet unformed; or by a surgeon presented with unexpected findings that call for a decision during a surgical procedure. The competencies and range of experience necessary must be defined for each circumstance of practice.

It is self-evident that from an early stage in education and training the competencies of individuals diverge. As well as knowledge of biomedical and behavioural science, a range of practical and clinical skills, and the personal qualities needed to carry them out well, there is a need for the additional skills required of teachers, researchers, managers and leaders. Only a minority of doctors will need and possess all these extra-clinical skills, but every doctor needs some. Further skills may be acquired as the need arises, by suitable placements during a trained doctor's career. At the same time, it is incumbent on every practitioner to be aware of the limitations of his or her area of skills and to know when to seek advice from others.

Given the protean changes that lay behind the deliberations of this paper, paramount among the qualities needed by doctors – more now than ever before – are the ability and willingness to foresee, initiate, respond to and participate in such changes.

The further development of those competencies, and acquisition of new ones, must equip a doctor to undertake further defined responsibilities, including clinical responsibilities carried out under the supervision of another doctor who is already experienced and competent in that particular field of practice. Similarly, doctors in training should be able to take on progressively more responsibilities as they are assessed as having acquired the necessary competencies and experience.

We recall what is required of a doctor registered with the General Medical Council. The precepts that introduce *Good medical practice*[1] are explicit and clear (Box 1).

It is obvious that not only doctors and other clinicians but also other professionals in healthcare are expected to demonstrate these or similar qualities of behaviour and attitude. Each must also possess, and be able to exercise, the body of knowledge and skill that characterise the work of their profession, and do so to an acceptable standard. For example, the *Code of conduct for NHS managers* states: 'I will make the care and safety of patients my first concern and act to protect them from risk'.

Box 1. The duties of a doctor.

Patients must be able to trust doctors with their lives and well-being. To justify that trust, we as a profession have a duty to maintain a good standard of practice and care, and to show respect for human life. In particular as a doctor you must:

- Make the care of your patient your first concern
- Treat every patient politely and considerately
- Respect patients' dignity and privacy
- Listen to patients and respect their views
- Give patients information in a way they can understand
- Respect the rights of patients to be fully involved in decisions about their care
- Keep your professional knowledge and skills up to date
- Recognise the limits of your professional competence
- Be honest and trustworthy
- Respect and protect confidential information
- Make sure that your personal beliefs do not prejudice your patients' care
- Act quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit to practise
- Avoid abusing your position as a doctor
- Work with colleagues in the ways that best serve patients' interests.

In all these matters you must never discriminate unfairly against your patients or colleagues. And you must always be prepared to justify your actions to them.

Common foundations

Whatever kind of medicine doctors come to practise, they share many competencies and much clinical experience. The specialties of medical practice build upon such common foundations. Indeed, the foundations are critical to each specialty, from general practice to the most specialised subspecialty. This commonality is very important. With lifelong learning and further training it allows flexibility in career development. Doctors who have specialised in general practice may – and many do – acquire new specialised skills; and those trained as narrower specialists may develop more general responsibilities. This kind of mutability is necessary, whether in response to changes in the needs of patients, service needs, or changing life and career plans of doctors.

The nature of medical practice

What do patients need that calls for the knowledge and skill of a doctor as distinct from that of other healthcare professionals? Elements of the doctor's knowledge and some of the doctor's

skills are possessed or can be acquired by many people. This enables some clinical work to be done by delegation, skill-mixing and task substitution. All clinical practice should focus on the individuality of patients, and be responsive to that individuality. For doctors to do it well requires strict yet sensitive observance of the precepts of *Good medical practice*.[1]

It is commonly held that skill in diagnosis is the hallmark of a medical practitioner. Without diagnosis it is really not possible to interpret problems that trouble individual patients and their families. Without a diagnosis it is not possible to describe the nature and likely course of a disorder, or the outlook of it; and decisions on intervention – whether medical or surgical intervention, or simply advice on planning for life and work – remain poorly informed.

Often complex, almost intuitive processes are needed to identify the patient's problem; to weigh, prioritise and synthesise information, some of which may be imprecise; to make a differential diagnosis (plausible and sensible hypotheses); to set about logical testing, which may range from further observation to invasive investigation; to institute necessary treatment and be ready to alter that treatment in the light of continuing observation and new information. Sometimes the best practice is to propose no intervention, and always to avoid harm.

Whatever path is taken, the effective and safe conduct of these processes requires the diverse yet integrated knowledge and skills that are only acquired through rigorous programmes of medical education and training, and refined and developed by continuing learning through practice. What distinguishes the best practice of doctors is its breadth, its 'wholeness', and a capability to recognise and sometimes foresee changing circumstances in individual patients and respond effectively to them. It is marked by the exercise of judgement in each instance. Medical practice is not action by protocol, although that may be an element of practice. Nor is it the uncritical application of guidelines.

Modern medical practice is grounded in science. The evolution of healthcare is driven largely by better understanding of causes and mechanisms of diseases, the means of prevention, advances in treatment, and the understanding of factors that determine the effectiveness of care. The greatly improved outcomes for life and health in many disorders would not have happened without the rigorous discipline of science to understanding, followed by its equally rigorous application to treatment and care. The foundations of medical practice are built up from clinical and basic sciences and parts of the behavioural and social sciences. A doctor must have sufficient knowledge and understanding to bring this science to the care of patients. Whether in the clinic, at the bedside, the treatment room or operating theatre, or in other encounters that make up practice, the patient is best served by a practitioner whose knowledge is up-to-date and whose mind is well prepared.

Lest it be thought that medicine is merely the application of science, we also expect doctors to be caring, compassionate individuals, who have a broad knowledge of human behaviour, are empathic and are able to communicate in ways that assist understanding. Many professional actions are not just responses to easily answered technical questions but rather to an anxious enquiry, an inarticulate concern, an unspoken emotion. But the action must be based on sound knowledge, practised skill and broad experience. Exercise of these attributes affirms the reality of partnership and trust between doctors and patients. Experience and learning promote invention and innovation among the kind of people who enter medicine, and these attributes They are rightly valued as desirable characteristics of good medical practice.

Role models and mentorship

The apprenticeship tradition of medical learning, in which senior figures are seen as role models, serves to reinforce the ethos of medical practice. Doctors remember with respect the senior figures from whom they learnt not only about clinical medicine but also about professional conduct, and about the attitudes and behaviour expected of doctors in their dealings with patients and with colleagues from other disciplines. Medical professionalism is learnt, and the example set by senior doctors can have an enduring effect. They have a responsibility to make it the right effect.

Most trained doctors are confident in their clinical skills but many want more experience in the wider aspects of a consultant's responsibilities, with training in teaching, clinical leadership and management. These needs have promoted interest in mentorship. Established general practitioners and consultants have long seen it as a professional duty to mentor their newly appointed colleagues, and to be available informally as sources of advice, tutorship and support. Mentoring is a relationship based on mutual respect, trust and confidentiality. Its purpose is to bring the judgement of more experienced people to help individuals achieve their fullest professional and personal potential.

It is preferable that the mentoring relationship is independent of the place of work and of professional supervision and management; and that it operates within agreed boundaries. The hope is that such arrangements may become a familiar element of a professional life. It has been suggested that the role might suit consultants who are tempted to take early retirement, and who (if adequate arrangements were made for on-call relief) might consider staying on in the capacity of mentor.

Working in teams

Although doctors are accountable for their conduct and practice individually, they do not work in isolation. Throughout the NHS they must work in teams, with mutual respect for the knowledge, skills and judgment that each member brings. This expression of team working is a prerequisite of effective modern healthcare.

Team working is necessary in many circumstances, from the direct care of individual patients to the many other activities that shape health and healthcare. The roles of doctors depend on the task to be done, and the competencies, understanding and experience needed. Sometimes a doctor will lead, sometimes another health professional, and sometimes another colleague or a lay person will lead. Naturally, the leader must be 'up to the

job', with the competencies and personal qualities needed, and able to shoulder the responsibilities and accountability that leadership must bear.

The term 'clinical team' is usually understood to mean the group of people with responsibilities for direct clinical care of individual patients in a particular setting, each member bringing clearly defined competencies to their role. Responsibility for continuity of patient care lies with the team, although one doctor must have ultimate responsibility for the plan of treatment and for the patient. An appropriate culture and behaviour are critical to the confidence and well being of each patient as they make what for most, is an unfamiliar and threatening journey.

In hospital practice, the team has long ceased to resemble the small close-knit medical firm of the past except in one crucial respect – the role of doctors in leadership where the clinical context requires it. The team is an extended body and is multi-professional and multidisciplinary. Hospital-based teams may include specialists from different medical disciplines, for example, surgery, anaesthesia, intensive care medicine, and specialist nurses, who must all work together for the best possible patient outcome. The changed conditions of work of individual members mean that its composition – including the complement of junior doctors – is ever changing. This is not a common feature of teamwork in other spheres.

Depending on the nature of the service and its environment, there are various strands of influence and responsibility. As well as routine clinical work, there may be cutting edge clinical academic work, teaching and training in service. In some teams there will be people who undertake protocol-driven rather than reflective care; and others may innovate, or design or manage.

Often there are external influences that lie beyond the team's control: for example, the changing composition that results from rotas, shifts and rotations; the impact of the European Working Time Directive; new arrangements that are necessary to service the 'hospital at night'; and the competing priorities of service and teaching. All are circumstances in which the quality of leadership is paramount. There must also be non-medical managerial input to these teams, to enable clinicians to work to best effect; but even today this is in its infancy.

We must learn what the concept of a team means in the different circumstances of medical practice, but it is clear that certain characteristics are essential. The effectiveness of a clinical team depends on strong leadership – promoting alignment of values and behaviour, firm alliances with members of other teams, and good communication within and between teams. There is a need to explore and define the functions and structures of effective clinical teams, and for well-designed studies of operational examples.

The hospital-based team is a service unit. Given the interdependence of members of a team and their combined contribution to care, assessment of outcomes and outputs of the whole team is the only feasible way of monitoring performance. An identifiable team is, therefore, key to maintaining public/patient confidence and trust. Similar relationships are found in many general practices.

Responsibility and accountability

Responsibility within a clinical team is not diffuse. Identifying the specialist doctor with responsibility for the care of and communication with the patient is a key issue. It must also be clear who is in charge, and who has ultimate responsibility and accountability for the team or unit of service. We must also bear in mind that accountability has two faces: firstly, to patients; and secondly to managers, the employer, and professional peers, professional societies and institutions, and the regulatory bodies.

Changes in service delivery

Increasing understanding of how many services – including services that have been predominantly hospital based – can be delivered in the community alongside social care, is lessening distinctions between primary and secondary care, dismantling barriers that have outlived their usefulness.

Within their own broad specialty, for example, general practitioners have developed specialised areas of interest and practice, particularly in common often chronic disorders, where approaches to diagnosis and management are increasingly evidence based and well defined. General practitioners with special interests can provide discrete clinical services or undertake specific procedures, thereby offering an additional alternative care pathway with improved patient access, and a new means of bridging and integrating primary care and hospital secondary care. Work is in progress to determine how best these doctors can acquire and maintain the desired levels of such additional specialist competencies, and develop relationships with the corresponding hospital-based specialties.

Specialist training

The role of the trainee is to learn. All the work they do should be part of a training programme. They provide service not only because it is essential to the running of the NHS, but also because this is part of the learning experience – as is taking increased service responsibility, albeit under supervision. Training is more or less time-defined, and time-limited, with doctors generally achieving a Certificate of Completed Specialist Training (CCST) in their early 30s, varying a little between specialties.

Training, refreshing and retraining are normal and necessary parts of life-long learning. The award of a CCST, like accreditation previously, signifies just one point in the process (making the term 'completed' somewhat inappropriate). In hospital-based practice the award is often thought to signify readiness for application for consultant appointment. The view outlined below is at odds with this. Should higher medical training incorporate extra-clinical competencies or should acquisition of CCST be dissociated from consultant candidature? These are contentious matters. Historical views of the pattern of training and its career goals are deeply entrenched. How should we move forward?

Similar though less contentious questions might be asked about training for the specialty of general practice.

Within any specialty the currently expected levels of training might not be necessary for the larger part of practice. For example, there is a view within the specialty of paediatrics that a general training, with more of the specialty being delivered on a community basis and fewer doctors requiring subspecialty training, is the right approach. Some of the surgical specialties are also redefining their programmes, for example in urology, where training for office-based practice will be shorter than for more invasive complex surgery. It is essential to identify what is needed for a particular job – the service requirement. The primary question is what competencies the patient needs rather than the end product of training. Should we not define the clinical tasks and the training needed to do them safely and well? A shorter period of training might be right for some posts, though it would give less experience, and in the early years of specialist appointment it would not be compatible with isolated practice. It is important that everyone who trains to specialist level should feel fulfilled in their professional aspirations, competent to take on the role to which they are appointed and confident in it. They should know their limitations and when and how to seek help.

Once there was a large hospital cadre of very experienced doctors in training. They took considerable responsibilities, making countless independent clinical decisions. Now there are fewer such doctors. How might increasing responsibilities be allocated to less experienced doctors who have not completed specialist training?

Specialists and consultants

Most people know who their family doctor is, though it is reported that the public generally, and most importantly patients, are at first unsure about the professional status of the doctors who look after them in hospital. They are quite clear that they want the opinion of a specialist (and know that a consultant is a specialist) and expect that soon after coming to an emergency department or outpatient clinic they will see a trained doctor – not only a doctor in training. Therefore, there must be a clear and known indicator of professional standing – something that declares a level of competence and identifies an individual as being sufficiently trained to undertake the role of a trained doctor in a team.

The term 'consultant' is familiar and entrenched. Patients are used to it: just as they refer to 'their family doctor' so often they refer to *'their consultant'* who they know specialises in dealing with their particular kind of problem.

Recently other professional groups in the NHS, notably nurses, have adopted the term 'consultant'. It is important that the term is qualified to denote the particular role of the individual, if we are to avoid confusion: consultant nurse, consultant physician, or consultant surgeon, for example.

Despite its common use, definition of the term 'consultant' has exercised many people (see Box 2). Consider a recent definition of a consultant:

> *A trained doctor who can be allowed to undertake a defined level of unsupervised practice but who also knows when and what to refer to others.*[1]

This is also the definition of a specialist and includes all trained doctors, whether general practitioners or consultants; and it applies to other service grades, among them Associate Specialists. The term 'specialist', so defined, provides a readily understood means of identifying a trained doctor.

Current legislation includes the condition that a person may not take up appointment to any post as a consultant in the NHS in a specialty, or any more specialised field within such a specialty, unless that person's name is included in the Specialist Register. Thus 'specialist' means a doctor whose name is included on the Specialist Register. It is for the employing authority to decide the competencies required for appointment of a doctor to a consultant post in the NHS. In addition to the possession of competencies identified by inclusion in the Specialist Register, a candidate is required to have other knowledge and skills and personal qualities necessary for that particular consultant post.

Appointment as a consultant in the NHS is considered important by doctors, whether they are already appointed or aspire to appointment. It confers status, respect and independence not otherwise achievable within the hospital medical hierarchy, and, therefore represents a kind of professional fulfilment. Moreover, NHS consultant status is normally a condition of appointment as a specialist practising independently in the private sector, and is therefore regarded as important because of the licence it confers to do practise privately.

Given the familiar, if imprecise, use of the term 'consultant' by NHS and government, and its historic and cultural significance for the public, patients and doctors, there seems little merit in seeking either to discard the term or attempting yet again to redefine it. However, it is evident to the profession, and to the Department of Health, that older views of consultant practice do not adequately describe the roles of consultants in the modern NHS. These roles are adaptations to changed circumstances and in important ways have influenced those changes. We do not attempt to describe the new roles that consultants undertake. The range is wide and the role specified for many consultant posts is special to each. Yet beyond the status of specialist a consultant must show the potential to acquire with maturity – both of person and experience – the confidence to take responsibility not only for handling difficult situations, but in particular for managing uncertainties which feature in so many clinical encounters. They should be capable of planning and auditing a service, of involvement in management and in the organisation of teaching and they need the wisdom to guide younger doctors in their professional careers.

The specialty of general practice is not encumbered with the historical legacy outlined above.

The hospital training environment in the UK

There are trainees in 90% of UK hospitals. In most other countries, at a similar stage of service development, 10-20% of

hospitals have trainees. In non-training hospitals the specialists, including very senior people, are on call. Should we be preparing for a different environment, for training and for service? For some time the competing pressures of service and training in the UK have caused difficulties. Those difficulties will increase. Changed conditions of work, with further implementation of the European Working Time Directive, and new shift patterns in which an increasing proportion junior doctors' time will be on call, mean that less time will be available for formal training. It is essential that training programmes and their delivery are not damaged, and that they are effectively 'quality assured'. This will be a responsibility of the Postgraduate Medical Education and Training Board in collaboration with those charged with implementing the policy, Modernising Medical Careers.

Continuing training

The nature of advancing knowledge is such that we cannot predict new opportunities for health and healthcare, or the needs of patients and the service. Continuing training or retraining is inevitable for many doctors, as part of the larger experience of life-long learning. It already happens. A consequence of continuing training, or modular learning, for a

Box 2. Definitions of specialists and consultants

Definition of a specialist
See the provisions of The general and specialist medical practice (education, training and qualifications), Order 2003.[5]

Definitions of a consultant
The term consultant is considered important, by doctors who have been appointed consultants and by those who aspire to appointment. Definition has exercised many people and their conclusions follow. None identifies a set of competencies. All agree that the consultant role has changed. It has adapted to changing circumstances and in important ways has influenced those changes. But this has happened in a rather accidental way, without formal examination.

The Platt Report, 1961[6]
The consultant was defined as 'a person who has been appointed by a statutory hospital authority by reason of his ability, qualifications, training and experience to undertake full personal responsibility for the investigation and/or treatment of patients... without supervision in professional matters by any other person'.

Royal Commission on Medical Education, 1965-8[7]
The Report does not attempt to define a consultant and the only reference to it is that consultant status would depend upon appointment to a consultant post.

'In our picture of the future pattern of medical services in Britain, all doctors – general practitioners as well as Consultants – will be specialists in particular aspects of medicine who will be equally regarded as such and will be fully trained for the work they undertake. This view implies a number of changes in career structure and especially in postgraduate training, which seems to us hitherto to have been haphazard and in many respects unsatisfactory.'

Report of a Working Party on the Responsibilities of the Consultant Grade, 1969
(Chairman: Sir George Godber)[8]
'A consultant is a doctor, appointed in open competition by a statutory hospital authority to permanent staff status in the hospital service after completing training in a specialty and, in future, being included in the appropriate vocational register; by reason of his training and qualifications he undertakes full responsibility for the clinical care of his patients without supervision in professional matters by any other person; and his personal qualities and other abilities are pertinent to the particular post'.

The National Health Service (Appointment of Consultants) Regulations, 1996 (extract)[9]
' "consultant" in relation to a relevant specialty, means
(a) a consultant specialising, or who has recently specialised, in the relevant specialty, or
(b) where the relevant specialty has not yet been established, a consultant specialising, or who has recently specialised, in a specialty which, in the opinion of the relevant college, is closely related to the relevant specialty…'
' "relevant specialty", in relation to a proposed appointment, means the branch of medicine or dentistry in which the appointment is to be made…'

Registration requirements
'A person may not take up appointment to any consultant post on the staff of an Authority in England unless—
(a) he is either a medical practitioner or a dental practitioner, and
(b) in the case of an appointment of a registered medical practitioner made after 31st December 1996, his name is included in the Specialist Register kept by the General Medical Council in accordance with Article 8(1) of the European Specialist Medical Qualifications Order 1995.'

Definition of a consultant
The terms and conditions of service of hospital medical and dental staff and doctors in public health medicine and the community health service give the duties of practitioners. The exact role, however, of a consultant is not defined in either the Statutory Instrument or the terms of service handbooks. A consultant will usually have independent clinical responsibility for any patient entrusted to his/her care by his/her employing body.

The general and specialist medical practice (education, training and qualifications) Order 2003: Part Four
Article 13, Para (6)
'…a person may not take up appointment to any post as a consultant in the NHS in a specialty, or any more specialised field within such a specialty, unless his name is included in the Specialist Register.'

Article 14, Para (5)
'A person is also an eligible specialist...if…and he satisfies the Board that these give him a level of knowledge and skill consistent with practise as a consultant in the NHS.'

consultant would be that for part of the time the doctor is a consultant and at other times a doctor in training. Although a departure from experience in the past, should this present any significant problems?

Career patterns and flexibility

Broader aims for personal fulfilment and family commitments have generated new kinds of career flexibility. At one time discouraged, this is now accepted and widely promoted. Moreover, for reasons that are familiar, many people in medicine do not wish to make the open-ended time commitment to their careers that doctors once did, endeavouring where possible, and consistent with their professionalism, to complete the work within the limits of contracted hours. Provided training allows them, these changes in outlook should encourage movement into new areas of practice, and shifts across traditional specialist boundaries.

Intellectual leadership

It is important that intellectual leadership is recognised. The role of the head of department, be it an academic head or an NHS '*chef de service*', might be examined more fully. This expression of leadership becomes even more significant when there is to be a realignment of delivery of services with the possibility that a smaller number of institutions will provide teaching and training.

The contractual relationship

The discontent of doctors is widely known. One reason is that they no longer feel they have sufficient control or, indeed, influence over their professional lives. There is evidence that doctors are most satisfied when they have real management responsibility along with accountability, agreeing with employers about what shall be done, how, and by whom. The Kaiser Permanente organisation in the USA is often cited as an example.

There is a view that consideration should be given to establishing a new relationship between the profession and the NHS. There is a contractual relationship between doctors and employers, which is defined in relation to the needs of patients and service delivery. An analogous relationship might be one between, say, the clinical director of a department or service or the leader of a team, and the employer. One approach might be for the department or team to decide what it could deliver, then agree it with employers? Within the team, too, each doctor would negotiate and agree a role for which they would be accountable. The system of appraisal might provide a mechanism for this. If such arrangements found widespread support, it would be best if they were made within a nationally agreed framework.

Conclusions

This paper raises issues concerning the acquisition of competence and professionalism in medical careers, in relation to new ways of working in the NHS. It emphasises the specific skills required by doctors, as distinct from other health professionals working in teams, and the importance of strong leadership together with flexibility in adapting to change.

It also discusses the requirements for hospital doctors to achieve specialist registration, as well as the additional skills required by consultants, who must of course first have established themselves as specialists. It is clear that the specialist must have acquired 'competence' – that mixture of knowledge and skill, attitudes and behaviour – that makes a practitioner capable of doing their job. Specialists who aspire to consultant status must in addition show the potential to take responsibility not only for handling difficult situations but, in particular, for managing the uncertainties which feature in so many clinical encounters; and they need the wisdom to guide younger doctors in their professional careers.

The Academy raises these issues to invite fuller discussion among other stakeholders. Among them are doctors in training, other health professional bodies, the Postgraduate Medical Education and Training Board, the Department of Health, NHS bodies, and representatives of patients and the wider public.

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