What are Royal Colleges for?

R. E. Kendell

There are 13 medical Royal Colleges in Britain and another two in Ireland. They are loosely united by what used to be called the Conference and is now the Academy of Medical Royal Colleges, and they are all very similar, partly because they are self-consciously modelled on the two wealthiest and most powerful, the London College of Physicians and the English College of Surgeons. They all possess elegant premises, mainly in central London, and they all devote much time and energy to conducting examinations and accrediting postgraduate training programmes in their various specialities. Membership or fellowship of the college is restricted to those who have been through these training programmes and passed these examinations and the colleges dominate the professional and social lives of their specialities. They have undoubtedly maintained and raised the standards of postgraduate medical training, probably to a higher level than is achieved elsewhere, except in countries like Australia and New Zealand which have developed similar colleges of their own. As a result they are widely admired and copied. Doctors from the Middle East, Southern and South Eastern Asia and Africa come to Britain in droves to take the colleges' examinations because of the prestige they command and several colleges now conduct their examinations in Cairo, Kuala Lumpur and Hong Kong, as well as in London, Edinburgh and Dublin.

The problem

Until quite recently the position of the colleges was unassailable. Health ministers and other health care professions might resent their power and influence, but this power and influence was envied as well as resented, and for the past 50 years the ambitions of every emerging medical speciality and heath care profession have been focused on achieving collegiate status for itself as soon as possible. Suddenly, though, the position has changed. It has changed because it has become clear that completing a lengthy postgraduate training programme and passing a rigorous examination at the age of, say, 32 does not guarantee that a surgeon or other specialist will remain competent for the next 32 years, and that the colleges lack the power and perhaps the stomach to discipline those senior members of their fraternity who are no longer functioning competently. In the past five or six years a series of situations have come to light, and been dramatised by the media, in which the central problem was the incompetence of one or more medical specialists; and although that incompetence was often well known to or at least strongly suspected by close colleagues, nothing was done until the harsh glare of publicity made intervention unavoidable. We have had a series of cervical and breast screening scandals, revelations about a pathologist whose histology reports resulted in teenage girls having unnecessary amputations, revelations about surgeons with alcoholism who were allowed to continue operating until one of their patients died, and finally the awful saga of cardiac surgery in Bristol.

This series of well-publicised events has not merely shaken the confidence of the public in the medical profession as a whole and in the General Medical Council's (GMC's) ability to protect them from venal or incompetent doctors; it has exposed the limitations of those self proclaimed guardians of high clinical standards, the medical Royal Colleges.

So far, none of the great scandals has involved psychiatry, but this is probably simply because the nature of psychiatric practice does not lend itself to easy detection of incompetence. We do not put patients' lives at immediate risk in the way that surgeons and anaesthetists necessarily do, nor do we participate in routine procedures like breast and cervical screening which lend themselves to simple forms of audit. Luckily too, the public has the wisdom to realise that dissatisfied patients, of whom we have many, do not always have sound reasons for their dissatisfaction. Even so, the impotence of the College to insist upon or maintain high standards of clinical care has been exposed by electroconvulsive therapy (ECT). Our College has conducted three national audits of ECT in the past 20 years and each of these has revealed serious deficiencies in the supervision of ECT clinics, in the training of the junior doctors who usually administer the treatment and in the equipment used. These deficiencies were less serious and widespread at the second audit than at the first, and further reduced by the time of the third cycle in 1995–96, but even then only a third of ECT clinics were fully meeting College

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standards (Duffett & Lelliott, 1998). Although there is little evidence that patients have come to serious harm as a result of these deficiencies the College has been embarrassed by a good deal of adverse publicity, for our audits and our limited powers to correct the deficiencies they have revealed have put weapons into the hands of those who have doctrinaire objections to ECT and would like to see it banned however competently it is administered.

The fact is that at present all the medical colleges are 'toothless tigers' where consultants are concerned. They have all the powers they need to ensure that recruits to their various disciplines are properly trained. No doctor trained in the UK can get onto the Specialist Register or obtain a National Health Service (NHS) consultant post without completing a lengthy college-approved training programme and passing the College's membership or fellowship examination. And NHS trusts cannot afford to ignore the colleges' demands to bring their training programmes up to standard, because if they lose 'educational approval' they will be unable to recruit junior medical staff. However, as soon as a doctor is on the Specialist Register or has obtained a consultant post the colleges' powers are greatly reduced, and in practice restricted to exhortation. Neither consultants nor their employers need pay any attention to the colleges' statements about clinical standards or minimum staffing levels if they do not wish to. Even the ultimate and rarely used sanction of expulsion from membership or fellowship of the College is little more than a symbolic gesture. It may have social consequences but the only hard practical consequence is that the individual concerned has a few hundred pounds more to spend on other things each year. His or her ability to remain on the Specialist Register or to hold an NHS consultant post is quite unaffected.

The colleges have even less influence over those who have never passed their membership or fellowship examinations but are none the less working in the hospital service as staff grade doctors or associate specialists. They are by definition not members or fellows and often harbour feelings of resentment against the college for that reason. (The attempt by our College to overcome this problem by creating a new status of affiliate, and to encourage affiliates to enrol for Continuing Professional Development (CPD), has not yet been very successful. Only a small minority of those who were eligible have become affiliates, and most even of those who have are not participating in CPD.)

The dilemma

The colleges are therefore faced with a fairly stark choice. They either have to retreat into a restricted role as organisers and validators of postgraduate training, or they must forge an alliance either with NHS employers or with the GMC in order to obtain the powers over qualified specialists which they currently lack. Both alternatives have obvious disadvantages as well as attractions.

If the colleges chose to retreat into postgraduate training and abandon their pretensions to be the guardians of clinical standards their prestige and influence would wane rapidly. They are already widely regarded, even by some of their own members and fellows, as rather pompous, self-satisfied and inordinately wealthy organisations with arcane rituals, fancy gowns and a surfeit of elaborate dinners and ponderous speeches. This unattractive image would loom ever larger in the public consciousness with every new revelation of consultant incompetence, and although we might protest that our College is not wealthy and does not have fancy gowns and rituals that would probably not help us. More fundamentally, the gap between reality and the colleges' rhetoric would be cruelly exposed, and their genuine achievements in delivering high standards of specialist training would be overlooked or dismissed if those standards were clearly not being maintained subsequently.

If, on the other hand, the colleges chose to nail their flag to the mast of clinical standards they would be committing themselves to criticising, and indirectly imposing sanctions on, some of their own members and fellows, and in doing so would obviously risk alienating both those they criticised and any others who regarded those criticisms as unfair. In the past the colleges have been able to have it both ways: to pose as and to regard themselves as the guardians of clinical standards and simultaneously to be cozy clubs which discreetly promoted the interests of their own members and fellows. This is no longer going to be possible. The colleges have to decide, explicitly and publicly, whether when a conflict arises they exist to further the interests of patients or the interests of doctors. Hence my title.

The solution?

In reality, the choice has already been made, certainly by the College of Psychiatrists and probably by all the medical Royal Colleges. Our 1971 'Supplemental Charter' commits the college to "advance the science and practice of psychiatry and related subjects", and to this end "to encourage and promote amongst its members and others . . . the achievement and maintenance of the highest possible standards of professional competence and practice." That is why we are entitled to charitable status. We are not and

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cannot act as a trade union. That is the role of the British Medical Association, a role that it performs skilfully and usually successfully.

There are two ways in which the College could obtain the power it currently lacks to prevent its own members and fellows, and other career grade doctors too, from providing an inadequate "standard of professional competence and practice".

The first is to enter into an alliance with NHS employers. The Government has made it abundantly clear that it intends to place great emphasis on the quality of the clinical care provided by the NHS and that "clinical governance" is going to be a key concept (Department of Health, 1997). It has also said that it will shortly be introducing legislation to make trust chief executives formally responsible for the quality of the clinical services they provide as well as for balancing the books. Those chief executives and their fellow board members are going to be acutely conscious of this responsibility, and also of the fact that they will often be uncertain what clinical standards are appropriate in particular situations, what is and is not acceptable. This creates the opportunity for a partnership. Trust managers will be responsible for clinical quality and have the power to issue instructions to their staff, to increase staffing levels and to order new equipment. The colleges know better than anyone else what clinical standards should be.

At its meeting on 30 June 1998 the College Council made two crucial decisions in anticipation of this situation. The first was that the College should be prepared to respond to requests for help from a trust chief executive or medical director by mounting a visit by one or more consultants, acting not as individuals but as formal representatives of the College, in order to provide those trust managers with a well-informed opinion about the quality of whichever clinical service they were concerned about and what changes, if any, would be needed to bring it up to an acceptable standard. This would only be done after the trust's own internal procedures had failed to resolve the problem, and only with assurances that expenses would be covered and administrative assistance and indemnity provided, but it would be done promptly, if only to avoid someone being suspended from duty. The second related decision was that the College should be prepared to offer all relevant trust chief executives a formal statement about the adequacy or otherwise of their ECT services, and that these ECT services should be inspected (subject to agreement that this was feasible) in the course of the College's regular 3–4 yearly cycle of inspection of basic specialist training programmes.

The second alternative, which might be additional to or instead of the first, is for all the colleges to commit themselves in partnership with the GMC to a process of regular revalidation of every specialist's competence, and hence of his or her right to remain on the Specialist Register. Regular revalidation, which might take place every five to seven years, would have to be based on procedures which were thorough enough to carry conviction and to survive legal challenges, but also sufficiently simple and straightforward to avoid placing intolerable burdens both on those responsible for the assessments and on the thousands of individual specialists being assessed. It is by no means clear that this is feasible, particularly for a non-technological discipline like psychiatry, and if formal revalidation were to be introduced it would have to apply to all specialities. If it were feasible without creating another monstrous bureaucracy, though, regular revalidation would provide the colleges with the clout they currently lack, as well as reassuring the public that middle aged and elderly specialists were still competent and up to date.

Clearly, these are issues of the utmost importance, both for our College as an institution and for its individual members and fellows. The various possibilities and scenarios need to be understood, and debated until a consensus emerges. But time is not on our side.

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