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LEADING ARTICLES

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

- *All letters must be typed with double spacing and signed by all authors.*
- *No letter should be more than 400 words.*
- *For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the BMJ.*
- *We do not routinely acknowledge letters. Please send a stamped addressed envelope if you would like an acknowledgment.*
- *Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.*

Consultant accountability

SIR,—Mr James Owen Drife's leading article (28 March, p 789) is timely and raises a number of important issues. Perhaps the most important is his assertion that it is unrealistic to expect the public to pay a consultant's salary for 30 years without checking whether he or she is giving value for money.

In the clinical context value for money relates ultimately to the individual consultant's competence. At the time of his appointment a consultant has an up to date knowledge of his specialty, which enables him to practise to a high standard. Ten, 20, 30 years on this knowledge may be far from up to date, with a consequent lowering of standards of care. Experience counts for a great deal, but at a time of rapid advance in medical science it cannot compensate for a lack of up to date knowledge.

Most consultants are anxious to keep abreast of advances but have no way of knowing how far they are succeeding, and thus an objective means of self assessment is needed. To this end the Royal College of Obstetricians and Gynaecologists last year launched a projected four year programme called LOGIC (Learning in Obstetrics and Gynaecology for In service Clinicians). Participants in the first year's programme, covering general obstetrics, received a book of 100 multiple choice questions compiled by a group of experts and covering all aspects of modern obstetrics. The questions had a strong practical clinical bias and were meant to be answered by the participant in his own time at home, using any reference material he wished. The completed answer sheet could be returned for completely confidential marking by an organisation (DRS Data and Research Services) independent of the college or be kept for self marking using the answer book. This book, sent out two months after the question book, contained the experts' preferred answers, with their reasons and up to date references.

Seven hundred and fifty fellows and members enrolled in the scheme, of whom 80 returned their answer sheet for marking. (These 80 all obtained good marks.) This year's subject is general gynaecology, and if more of the participants submit their answer sheet for marking the college, which has no idea of each participant's marks, can analyse the results to help plan its future postgraduate education programme.

Self assessment is the start of a process that could lead to specialist recertification, already mandatory in many American states and for obstetricians and gynaecologists in Australia. If individual consultants are to have to prove that their specialist knowledge is up to date they must have enough time off from their normal clinical duties to enable them to study. Regular study leave or sabbaticals would be part of a deal that would go some way towards reassuring the public that they are indeed getting value for money from their consultants. The royal colleges should take a lead in establishing planned postgraduate study for clinicians and should be examining the question of specialist recertification. If they do not there is a danger that some other statutory body will step in with the result that consultants will lose control over their own collective postgraduate destiny.

MICHAEL BRUDENELL

Royal College of Obstetricians and Gynaecologists,
London NW1 4RG

Punctuality

SIR,—I have every sympathy with Mr Pradip K Datta (11 April, p 968). Like many surgeons, he believes that an 8 30 am list should mean knife to skin at 8 30 am. So it should. Unfortunately, the only thing a surgeon can do with any certainty is to send for the patient at a particular time, say 8 00 am. After that a whole series of people may delay the hoped for start: the slowest orderly goes for the patient, the lifts are full of breakfast trolleys, the patient wants the bedpan, the anaesthetist will not start because he does not know where the surgeon is, the medical student is being taught to intubate, there is no one to lift the patient. Once the patient is in the theatre what is generally known as "anaesthetic delay" continues while the patient is positioned on the table, attached to the diathermy, prepared, and draped. Finally, the great moment arrives: the surgeon, if not on the telephone by now, puts knife to skin.

We try to teach our junior anaesthetists that