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Incompetence in medical practice

SIR,—Professor Philip Rhodes recognises (17 May, p 1293) the difficulties of detecting the incompetent doctor before he or she becomes dangerous. Perhaps the task is made unnecessarily hard because we set about it the wrong way: by attempting to establish incompetence, when we should in fact be measuring competence.

To assess incompetence will have punitive implications; to promote competence is to pursue a positive virtue. Competent has come to be understood as implying just adequate rather than excellent, but the objective of training programmes (both undergraduate and postgraduate) should be a competent doctor—meaning one who is an expert proponent of his or her subject, in knowledge, in skills, and in attitudes. At present (as Professor Rhodes hints) this objective is only partially and unreliably met.

The components of competence can be identified[1] using objective techniques such as critical incident analysis, the Delphi method, and observational studies. Once analysed the "competencies" can be taught and appropriately assessed. In a critical incident study in child health (unpublished) the main groups of competencies identified were: interpersonal skills, problem recognition and management in primary care, and interprofessional communication. Rating scales can be developed from such a list and used to assess, for example, the progress of a vocational trainee in general practice through his or her hospital posts. Use of such scales would act as a positive inducement to the trainee to improve weak areas whether in knowledge, skills, or attitudes. At present, trainees receive little or no guidance on their strengths and weaknesses.

Professor Rhodes is right in saying that the public must be protected from the effects of incompetence in doctors: surely then, medical education has a responsibility for promoting the acquisition of competence.

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Acute epiglottitis

SIR,—Minerva draws attention to a report from Rhode Island describing eight years' experience of the potentially fatal condition of acute epiglottitis (17 May, p 1339). She advocates that all doctors should possess a laryngoscope and know how to use it. However, in dealing with patients with partial upper airway obstruction this advice may provoke complete upper airway obstruction.

Patients with acute epiglottitis are often extremely ill with a high temperature and a thready pulse. There is partial upper airway obstruction due to acute inflammatory hyperaemia and gross oedema of the epiglottis and aryepiglottic folds.[1] If acute epiglottitis is suspected then direct laryngoscopy, followed by airway intubation in proved cases, is required.[2] Successful management requires the skill and close cooperation of both anaesthetist and ear, nose, and throat surgeon. To perform direct laryngoscopy an adequate depth of anaesthesia must be attained. The skill of an experienced anaesthetist is required for this to be achieved safely in such ill patients. Attempting laryngoscopy at an inadequate depth of anaesthesia would provoke laryngeal spasm and complete upper airway obstruction.

Minerva is correct in encouraging all doctors to possess a laryngoscope and to become proficient in its use. But in upper airway obstruction the further skills of an experienced anaesthetist and ENT surgeon must be sought. If total airway obstruction is imminent then Minerva should encourage all doctors to become proficient in the simple technique of cricothyroid membrane puncture (laryngotomy), as suggested by Mr Andrew K Marsden and Mr Alastair McGowan (17 May, p 1316). This will temporarily maintain an airway until more skilled help is available.

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General practitioners' retirement plans

SIR,—I was interested to read the paper by Mr Richard Wakeford and colleagues (17 May, p 1307), but it is unfortunate that such an important article on this topical subject should be diminished by the authors' method of recruitment. By choosing only general practitioners aged 55 years and above who had remained in active general practice the sample was heavily biased towards doctors who did not wish to retire. This is confirmed by the fact that the mean age of the respondents was 61·4 years. General practitioners may retire at 60 and some recently retired doctors who might have been eligible for the study would have been missed. Similarly, the authors did not interview any doctors who had taken premature retirement and they did not make allowance for general practitioners within the same age group who had died. Doctors who know they are not fully fit are most unlikely to wish to stay at work longer than necessary.

From anecdotal evidence, it seems that the aspect of general practice that most doctors dislike is an on call commitment at night and weekends. This becomes increasingly onerous with advancing years. Several of my colleagues with a moderate degree of illness—for example, rheumatoid arthritis or angina—have had to retire from general practice even though they are quite capable of an "office hours" type job. I would be interested to learn of any correlation between general practitioners' retirement plans and the ability to contract out from night and weekend duties. A link would have important implications for those concerned with the health of doctors as well as with manpower and staffing levels.

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Foot surgery by chiropodists criticised

SIR,—I note with interest that the Central Committee on Hospital Medical Services and the Royal College of Surgeons are to discuss the increase in ambulatory surgery by chiropodists and seek the Department of Health's views (3 May, p 1217).

I would respectfully point out that it is not for the CCHMS, royal college, or the DHSS to decide what should be the scope of practice for state registered chiropodists. This decision is reached by the state board, on which there are medical representatives. The disciplinary committee of the state board has recently made the following statement: "Ambulatory foot surgery, which is becoming an established procedure in chiropodial practice, is surgery performed by chiropodists at a level sufficiently minor as to be carried out on a day case basis and which would not normally warrant inpatient admission, the patient being ambulant with or without assistance immediately after the surgery. It should be subject to the limitations of the operator's skills and training, and the facilities available."

On a historical note, a committee was set up to investigate "ambulatory podiatric surgery" by the Royal College of Surgeons some 10 years ago. I believe that this committee reported favourably to the college but that the report was vetoed by the British Orthopaedic Association members of the college. It is interesting to see, on the same page, that the Joint Consultants Committee is in favour of ambulance staff providing lifesaving treatment such as defibrillation, intubation, and infusion provided they receive adequate training and keep up to date.

Fellows of my association have had correct training to perform ambulatory surgery; all hold qualifications in local anaesthesia and are state registered. Fellows have been practising ambulatory podiatric surgery for 15 years in the United Kingdom. It is a mandatory insurance requirement that all fellows attend continuing postgraduate education courses yearly. Rather than rely on anecdotal evidence we would be more than happy to discuss podiatric surgery with both the royal college and the British Orthopaedic Association. Previous requests for such a meeting have met with a negative response.

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Government's "agenda for discussion"

SIR,—I was surprised to see how muted was the response to the government's blue paper on primary health care by the BMA and our medical hierarchy (26 April, p 1152). I know these proposals are merely for discussion, but the suggestions of a government one month are law the next.

Many of the proposals are laudable and hardly controversial, but surely the suggestion that enlargement of list sizes should be encouraged is entirely contrary to BMA policy of the past few decades.

Furthermore, the proposed abolition of the 24 hour retirement must come as a severe blow to many older doctors, who had hoped to work at a more leisurely pace on reaching 60 and who now have no time to reformulate pension plans; many of them may now work on, instead of partly stepping down and taking on a new young partner. The government must be reminded that the 24 hour scheme was not a privilege but a right—part of our pension and pay structure, negotiated over many years and recognised by the review body.

If the BMA is forced, or desires, to compromise then may I suggest that the 24 hour retirement should be phased out so that doctors over 50 (or 55) are allowed to retire under the scheme as before. In view of the growing unemployment among young doctors, perhaps it should be obligatory that those taking such retirement should take on a young partner. Finally, perhaps as a sop to the government, those taking 24 hour retirement at 60 should fully retire at 65.

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