

Reaccreditation: the why, what and how questions

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SUMMARY. *Currently, reaccreditation is the subject of debate within general practice in the United Kingdom, largely in terms of medico-political expediency. In an attempt to broaden the basis of the debate, this paper explores reaccreditation in relation to its purpose in shaping the future of general practice (the why question); the qualities it might appropriately seek to assess (what?); and, whether such qualities can be measured (how?). It is argued that reaccreditation has far-reaching educational and service implications for general practice in the UK and should only be adopted after careful consideration of the issues involved for the profession, for patients and for the National Health Service. Providing that these issues can be resolved satisfactorily, it is proposed that the ability of general practitioners to learn from experience, rather than competence or performance, represents an appropriate and feasible yardstick for reaccreditation. Both general criteria and specific characteristics of assessment methods suitable for measuring experiential learning are identified. The feasibility and acceptability of applying such methods to the reaccreditation of general practitioners are considered.*

It is concluded that once such methods have been successfully refined and field-tested the way would be open for the profession's negotiators to offer the implementation of reaccreditation in return for certain safeguards designed to protect the future role of the generalist doctor in the community.

Keywords: *reaccreditation; performance review; quality in general practice; continuing education.*

Introduction

IT is characteristic of the evolution of a distinct group within a profession that sooner or later assessment comes to be used as the ticket of entry. Thereafter, as confidence in the unique characteristics and concerns of the group grows, assessment at entry moves from informal to formal and in time is required to be renewed — membership has become time-limited.

In 1982, general practice in the United Kingdom moved beyond the stage of unrestricted entry by requiring accreditation¹ in the form of a certificate of satisfactory completion of vocational training to gain admittance.² Similarly, membership of the Royal College of General Practitioners (MRCGP) has progressed through informal assessment to rigorous examination as a test of entry;³ some have suggested that continuing membership should require periodic renewal by examination (Swanson DB, unpublished report, 1987). Fellowship of the RCGP, still largely an honour bestowed by colleagues, appears to be moving towards

becoming an award typically gained following formal assessment.⁴

At one with this theory, reaccreditation is increasingly seen as both politically irresistible and, rather more surprisingly, acceptable in principle to a significant proportion of general practitioners in the UK.⁵ However, before accepting this step as inevitable (and conscious of the risks of expedient medico-political decisions) it seems appropriate to raise two basic questions: first, do we, as general practitioners, fully understand the implications of reaccreditation for the profession and for patient care; and secondly, do we have the ability to discriminate meaningfully and justly between colleagues fitted to continue in unrestricted practice and those who are not? Assessment techniques acceptable at entry or for honours and awards may be found wanting in the more exacting process of deciding, in effect, whether or not established colleagues should retain their livelihood. While it is inconceivable that general practice would adopt a process of reaccreditation which does not anticipate and plan to cope humanely with the inevitable casualties of any such process, we believe that these issues have not been adequately debated.

This paper explores three fundamental questions: why is reaccreditation such a significant issue; what qualities might justifiably be sought; and how might they be assessed?

The why question

Case for reaccreditation

At one level the case for reaccreditation looks unassailable: the information explosion in health care;⁶ the rapidly evolving role of primary care;⁷ and growing expectations of general practitioners by patients, National Health Service managers and medical specialists, all indicate that normative standards of performance are both rising and extending to new areas of professional activity. Now that the genie of consumerism is out of the bottle, public expectations are proving to be increasingly influential both directly upon the general practitioner-patient relationship and through a variety of pressure groups at local and national levels.⁷ Moreover, consumerism is a force capable of manipulation by politicians, the media and the medical and legal professions for their respective ends.

In the UK, guardianship of standards of performance has traditionally resided within a profession: in medicine entry to and removal from the list of those licensed to practice still rests upon this principle. However, this process is concerned with minimum rather than normative standards; the latter are much more fluid as a result of influences both from within and external to a particular professional group. Thus, the Department of Health, NHS managers, and medical specialists can and do influence what is expected of a general practitioner in the UK; through 'the Bolam test'⁸ litigation applies constant upward pressure on normative standards. In the UK evidence is accumulating that patients are increasingly resorting to the legal process to seek redress for justified or imagined shortfalls in the duty of care placed upon doctors.⁹

It is important to recognize that the purpose of reaccreditation is to regulate normative standards of practice and that external demand for it arises where a professional group is perceived as unable, generally, to sustain acceptable performance throughout

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Submitted: 22 October 1992; accepted: 15 February 1993.

© *British Journal of General Practice*, 1993, 43, 524-529.

a professional lifetime. By a commitment to ongoing learning most general practitioners have acknowledged the updating of performance to be a personal responsibility.¹⁰ Belatedly, the NHS has invested substantial sums in continuing medical education for general practice;¹¹ unfortunately, it has chosen to support an arrangement which is at best patchy, at worst counter-productive.¹² Reaccreditation offers the attractive prospect of transferring responsibility for ensuring that ongoing learning is appropriate, from the individual to the professional group.¹³

Regrettably, the case for reaccreditation is strengthened where basic medical education and a large part of vocational training are ill-designed to produce a competent doctor at entry to general practice. Where these deficiencies are compounded by inadequate continuing medical education, political and public pressure for reaccreditation is, to an extent, justified. However, as an argument for reaccreditation this resembles the case for mandatory swimming lessons for passengers on the Titanic. Until basic medical education, vocational training and continuing medical education become more appropriate to the preparation and support of the community based generalist clinician it is manifestly unjust to expect uniformly high professional standards; and to impose reaccreditation without addressing more fundamental causes would be an example of victim blaming.¹⁴

Price of implementing reaccreditation

Another construction can be put upon the trends outlined above, which reflects concern about the future viability of the role of community based generalist physicians. The central question is: can a professional group embracing among its core values, uncertainty, low technology, the use of time and a relationship based on trust,¹⁵ coexist with consumerism, rampant litigation and unsupportive or manipulative NHS managers and specialist colleagues? Experience in North America would suggest that it cannot without adopting a variety of defensive attitudes and procedures¹⁶ which compromise this philosophical basis. Reaccreditation, by reinforcing core values, could help to stem the tide which is pushing UK general practice in this direction; alternatively, it could be used to undermine these values. Recent history would suggest that the latter is a real risk: for the flight from general practice has already begun;^{17,18} levels of professional stress are known to be high;¹⁹ and the practice of defensive medicine by survivors can be expected to be costly to patients and to the NHS.²⁰

When we come to examine the feasibility of reaccreditation for the 30 000 general practitioners in the UK the direct costs, too, will be seen to be considerable. It will be argued that these costs are insignificant when set against the potential gain to the NHS of higher standards of general practice. However, this argument assumes that agreement about normative standards of performance can readily be reached between general practitioners, NHS managers and specialist colleagues. On the basis of experience and published evidence^{11,21-24} we suspect that because of divergent objectives this is not the case. Thus, NHS managers may well interpret health gain in terms of population targets rather than the comprehensive, long-term care of individuals; specialists with reference to biophysical rather than biopsychosocial models. Moreover, it is implicit in the true meaning of standards²⁵ that they must attract general compliance; fundamental to professional compliance is congruence of the chosen standards with the core values of the professional group. For general practice there is evidence to suggest that even in the reformed NHS these values are not historical relics but are widely shared by patients.^{21,26}

At this point it has become clear that the why question cannot be resolved without considering what is involved in reaccreditation.

The what question

Competence and performance

At first sight, the key issue for reaccreditation is the competence of the doctor for the role of general practitioner. While performance typically subsumes competence, it is an entity difficult to assess without influencing what is being measured. Competence has been defined as 'a wide concept which embodies the ability to transfer skills and knowledge to new situations. It encompasses organization and planning of work, innovation and coping with non-routine activities. It includes those qualities of personal effectiveness that are required in the workplace to deal with co-workers, managers and customers';²⁷ it is the capacity to perform at the required level.

However, this unexceptionable general statement will take us only so far: currently there is controversy about the nature of competence for practice;²⁸ only patchy definition of the key tasks confronting general practice; and no comprehensive account of the component skills required of the competent practitioner. In part these problems stem from the central assumption (some might say, fallacy) of medical education: that teaching results in learning which gives rise to competence and in turn leads to appropriate performance. This is a reasonable assumption provided that we make three additional assumptions: first, that teachers understand the nature of competence and address its components comprehensively and effectively; secondly, that education and training have available and use valid and reliable measures of learning; and thirdly, that those who have learned are motivated to perform competently. Unfortunately, given the nature of basic medical education²⁹⁻³² and of much vocational training,^{33,34} these assumptions are unlikely to hold for general practice. What currently passes for competence is, in large part, the result of unsystematic experiential learning while acting in the role of general practitioner, as trainee or principal.

Destination or journey?

Fundamental to the controversy surrounding the nature of competence is the idea that it comprises a constellation of discrete and measurable human attributes, the competencies of a particular subgroup of the workforce.²⁷ The literature on competence is vast and much of it does not question this assumption. Nevertheless, dissenting voices have been raised against the theoretical foundations and the methods of competency-based assessment.³⁵ They remind us that once we attempt to define competence for anything more than simple tasks, the complexity and diversity of human behaviour patterns render definition next to impossible or fatuously oversimplified.

Moreover, should we ever be in a position to define, comprehensively, the competencies of a general practitioner, the reality is that such a definition would be inadequate in two important respects. First, for reasons already given, it would become outdated almost as soon as it was written down. Secondly, the practice of a profession is more than the sum of its competencies; the care of individual patients requires unique judgements in which competencies are no more than tools. Seen in this way competence in the role of general practitioner is as much a process of development as a state, journey rather than destination.

Preconditions

Given these circumstances reaccreditation cannot be justified unless two basic preconditions are met: that the qualities to be assessed are known to be of significant and enduring importance to the professional development of general practitioners in the UK; and that we possess a national medical education strategy which ensures that the chosen qualities are either present in new recruits to general practice or can be acquired within a reason-

able period by those in post, including those who 'fail' any reaccreditation procedure. Clearly, if reaccreditation is to be feasible in the immediate future, a quality other than competence/performance needs to be sought.

Self-directed learning

Kolb has made the point that judgements about performance are limited to the present and to immediate circumstances whereas judgements about learning can extend into the future and to other generically similar situations.³⁶ Elsewhere we have proposed that self-directed learning based on experience is the most appropriate educational process for established general practitioners, and suggested ways in which it can be made more systematic.^{37,38} The widespread adoption of this pattern of continuing medical education would provide two opportunities: for reaccreditation to become the natural assessment of such learning; and for the adoption of a number of 'process' options between the extremes of educational input (reliable but not valid) and output as competence (valid but not feasible). For reaccreditation to be a meaningful measure of the doctor's developing competence it must connect with this or another coherent view of learning among established general practitioners.

Justifiably, then, reaccreditation could seek to establish that a general practitioner is learning purposively; since we cannot, and perhaps should not try to, define purpose in terms of ends (competence) we might do so in terms of process, for example, the capacity of the individual to interpret experience. Since this quality is almost certainly essential to the professional development of general practitioners, this approach would meet the first of our preconditions and provide a common strategy for basic medical education, vocational training and continuing medical education — the notion of an educational continuum might then become a reality.³⁹

While this is proposed as an expedient solution to the dilemma created by political pressure to undertake reaccreditation in the absence of the theoretical and practical know-how required to assess competence, it may in fact prove to be an enduring approach. Basing reaccreditation on the ability of doctors to learn from experience has at least two important advantages: first, this quality transcends foreseeable changes in the organization of UK health care; and secondly, reaccreditation is likely to be perceived by colleagues as less of a threat, and more as a process reflecting concern for their professional well being.

Standards: individual development, normative or both?

Reaccreditation based on assessing general practitioners' capacity to learn from experience must confront another difficulty. Pursuing the analogy of professional development as a journey, not only are we unable to define the destination we cannot know exactly where for each traveller it began. In terms of effectiveness in the role of general practitioner, prior educational experience and qualifications are almost certainly unreliable measures; the basic medical qualification, the certificate of satisfactory completion and membership of the RCGP have not been shown to be predictive validity.

In these circumstances it would be theoretically unsound to propose that we can define mile-posts on the journey towards competence which have the same meaning for every general practitioner. Rather, we must also use the individual as his/her own reference standard and seek progress from assessment to assessment. At once this approach liberates us from many of the threats implicit in reaccreditation and substitutes instead an ongoing process which aims to raise the quality of primary care through the professional development of general practitioners at a rate appropriate to the needs of the individual.

One of the advantages of a large number of candidates and a

continuous process is the opportunity provided to set reference standards on statistical grounds. For example, if the chosen measure is normally distributed among candidates undergoing reaccreditation, the pass-fail level might reasonably be set at two standard deviations below the mean, and result in a failure rate of about 2%. While still an arbitrary decision, this has the merit, in a valid and reliable assessment, of indicating to failed candidates the extent of their divergence from the bulk of the profession.

However, the conclusions drawn about performance in a reaccreditation procedure designed to promote professional development must be in large part formative rather than exclusively summative. Again, using statistical criteria it should be possible to indicate and define underperformance which requires help and further assessment within a flexible one to five year programme, rather than the normal, say, 10 years. Clearly, for a particular general practitioner such a conclusion might also represent significant progress by the individual when compared with previous assessments. We assert, therefore, that both peer-defined and individual standards are relevant.

The how question

If there are problems about defining what is to be assessed these are compounded by difficulties which arise once attempts are made to measure the chosen qualities in individual doctors. The assessment techniques which we find in use can be stereotyped as either subjective, potentially collusive and of unknown reliability (for example, the certificate of satisfactory completion) or objective, reliable and of dubious validity (the multiple choice questions of the MRCGP examination). Occupying an intermediate position, there are assessment techniques which have found particular favour in general practice (the modified essay question and oral examination of the MRCGP). In the view of the RCGP, while particular techniques may be unsatisfactory, combining a number of them is felt to represent acceptable assessment practice.³ All in all this situation may be tolerable for entry to membership of a royal college but is unlikely to withstand the legal and other challenges which reaccreditation will generate.

Measuring self-directed learning

In a situation of substantial uncertainty about the central questions of competence it is easy to despair about the feasibility of reaccreditation or to fall back on highly inferential measures, for example by counting continuing medical education uptake as a surrogate for competence and performance. While the difficulty of the task should not be underestimated, we believe that methods can be devised which assess the capacity of general practitioners to learn from experience. However, the chosen assessment methods must be valid, reliable, feasible and acceptable.

Validity. Conventionally, validity is considered under the headings content, construct and criterion⁴⁰ and with reference to certain subdivisions, particularly face and predictive. All of these relate to what Ebel calls meaningfulness in an assessment.⁴¹ Optimizing validity is largely about judgements rather than measurement, although statistical correlation with external, including future, criteria can be sought.

Important judgements need to be made if an assessment procedure is to be valid for the reaccreditation of general practitioners. At one level these are easily outlined: the assessment procedure should resemble the operational challenges of general practice; a sufficient sample of the whole domain of general practice should be assessed; and the tasks required of candidates should fit a theory (or construct) of the intellectual processes and skills involved in the work of general practice.

However, as we have seen, we cannot define the whole domain of general practice or adequately describe the intellectual

processes or skills involved in effective practice. A decision to assess, instead, the capacity of general practitioners to learn from experience will lessen but not abolish these difficulties. For example, the true-false multiple choice question is a well established and reliable technique for assessing factual recall,⁴² and experiential learning is bound to include the acquisition of some new facts. However, used alone, a multiple choice question paper would sample only a small part of learning and would therefore lack content validity. Moreover, it does not resemble the operational challenges of general practice (low face validity); and, more seriously, rewards candidates for choosing 'correct' responses rather than using uncertainty, challenging accepted truths or encouraging exploration of all options (poor construct validity).

Because of its significance in terms of professional self esteem and the maturity of those being assessed there is bound to be controversy about what constitutes validity in a reaccreditation procedure. We propose that the following are minimum criteria: high face validity for the work of general practitioners; content validity which reflects the range of experience of general practitioners in clinical and organizational roles and includes learning in the domains of knowing, feeling and doing; and construct validity which reflects the increasing body of evidence that experiential learning is central to the development of professional expertise.⁴³⁻⁴⁵

Reliability. Essentially, reliability in an assessment procedure requires that the same or a similar (with defined limits) result is obtained on more than one occasion and despite the assessor being changed. Thus, the procedure should elicit similar responses from the general practitioner on each occasion and be assessed with similar results by the same examiner on more than one occasion, or by two or more assessors acting independently. Conventionally, reliability of the order of 90% is desirable^{40,41} but is rarely demonstrated in public examinations. Since without reliability an assessment method cannot be valid, we regard this as a *sine qua non* of any procedures proposed for reaccreditation.

Feasibility. Any assessment procedure which involves large numbers of candidates must recognize the limitations placed upon it by questions of feasibility. Thus, it would not be feasible to propose that reaccreditation should employ an extended assessment which disrupts the capacity of general practitioners to maintain a clinical service to their patients. Taking a figure of 30 000 full time principals and assuming that reaccreditation takes place at intervals not greater than 10 years, the procedure adopted for assessment must be able to encompass at least 3000 general practitioners per year, or about 60 per working week. The feasibility of providing assessors for this scale of continuous activity must also be taken into account: assessment material must be generated, its performance reviewed and the reliability of marking monitored. Moreover, in reaccreditation there will be appeals against adverse results; a need to counsel 'casualties'; and, as a prerequisite, remedial education programmes for those identified as in need of help.

Acceptability. While acceptability of a particular reaccreditation procedure is an issue for all those concerned with the NHS, not least its customers, the bottom line must be acceptability to general practitioners, since they will be required to cope with the burdens of assessing and being assessed (Cresswell J, *Doctor*, 4 June 1992). The concept subsumes validity, reliability and feasibility but goes beyond them to include issues of fairness, appropriateness and perceived benefit. An approach to reaccreditation which seeks broadly defined health gain for individuals in our society through the professional development of general practi-

tioners would attract widespread professional and public acceptance. The cost effectiveness of the process must be justifiable in comparison with the health gain which the money might achieve if invested otherwise. It will be important to convince politicians, NHS managers and specialists that this approach is not a soft option and is vital to preserving the role of community based generalists in the NHS.

Specific characteristics

From the above a number of characteristics can be identified which an assessment technique will need to possess in order to be suitable for reaccreditation. They represent interpretation of the general criteria in the specific context of assessment of established general practitioners, and should enable choices to be made from among the range of available methods. On this basis, a suitable assessment method must: draw upon a range of real or closely-simulated situations in the work of general practitioners; be suitable for use either in the context of practice or at least locally; employ explicit marking schedules, the content of which is open to general scrutiny; demonstrate, in operation, satisfactory levels of reliability of marking; generate findings which are useful in the professional development of individual general practitioners; and define standards against which decisions can be made about the appropriate interval between reaccreditations.

Choosing methods

Applying the list of specific characteristics to methods of assessment in current use or described in the literature leads, inescapably, to the conclusion that for reaccreditation few merit further exploration or testing. A handful of methods, some embryonic, do hold out promise; their refinement as assessment techniques would represent a significant spin-off from the reaccreditation debate even if one or more of them proved to be unsuitable for implementation.

In practical terms the list directs attention to assessment methods which employ real-world experience or closely simulate it. Basically, two types of method with high face validity are available: those which take samples of real or simulated experience and break it down into specific tasks for the candidate (for example, the objective structured clinical examination); and methods which employ 'whole', usually real, experience and require the candidate to analyse it (videotaped consultation material). A third possibility exists but has received little attention in the literature on assessment: the creation of a new synthesis, for example the construction of a vignette containing salient material from a sample of experience.

While the first of these types of assessment tends to optimize reliability, the second may well have greater construct validity for experiential learning in general practice and, at least theoretically, is closer in its philosophy to the principles of adult learning⁴⁶ in not imposing upon the candidate a construct derived from the assessors. For the first implies that we can define at least some of the component tasks of practice and assemble a sufficient sample within the assessment procedure to satisfy content validity. Thus, it can be argued that carefully designed short-answer questions or objective structured clinical examinations are capable of reliably assessing the performance of doctors in a broad range of situations using explicit tasks relevant to learning from experience. Nevertheless this may not fully satisfy construct validity for the work of general practice simply because common sense suggests that these tasks are not, in the real world, handled in isolation. This difficulty, which we might call coherence validity, is probably best addressed by using a combination of methods.

Combining real and simulated experience

Many authors have drawn attention to the paradox that as validity is increased, reliability tends to diminish, and vice versa.^{40,41} To address this, it may become necessary in reaccreditation to use a combination of assessment methods. Because of the reasonable assumption that error is cumulative, we do not support the combining of unsatisfactory techniques in the hope of optimizing reliability and validity. However, provided that each assessment technique meets minimum reliability standards, the use of two or more together can be defended where the aim is to improve validity. Thus, reaccreditation might employ methods like short-answer questions and the objective structured clinical examination alongside videotaped consultation material derived from the candidate's experience of practice which demands a more global analytical (or synthetic) approach. Provided that the performance of doctors in these different assessments is not obscured by combining the result in a meaningless total score, this approach could increase the discriminatory power of the assessment and the value of feedback to participating doctors.

Discussion

It is the express purpose of this paper to stimulate discussion of reaccreditation in terms of overall purpose, content and methods. The professional is at present some way off being able to define the key or core skills of general practice, although methods of beginning to do so have been suggested.¹⁵ We suspect that reaccreditation will become a significant medico-political imperative before this desirable first stage is reached. Above all we aim to reduce the chance of the profession sliding into reaccreditation for reasons of medico-political expediency without a thorough exploration of its implications. Whereas it may be expedient for our negotiators to discuss reaccreditation with the Department of Health this cannot imply acceptance by the profession of invalid method(s) or of exclusively summative conclusions. Moreover, we believe that in negotiation, by linking reaccreditation to social trends in consumerism and litigation, concessions might be obtained which are vital to the future of the community based generalist doctor.

General practice has been poorly-served by basic medical education and even by the vocational training process imposed on all recent recruits. In addition, continuing medical education remains ill-directed and until recently has been under-resourced. While reaccreditation can be seen as a solution to these problems (and leaving aside the justice of this view) it will fail to act in this way without general practice exerting strong influence on the purpose, content, and methods of reaccreditation through a reassertion of its core values. This leads to the conclusion that at least two preconditions need to be satisfied before technical issues are addressed: the qualities sought must be of significant and enduring importance to the professional development of general practitioners; and such qualities must in future be reflected in medical education for the generalist at all levels.

Few in the profession would seriously propose that the total points gathered by general practitioners for involvement in continuing education activities is a valid criterion for reaccreditation (Agnew T, *General Practitioner*, 31 January 1992). Moreover, it can and will be argued that continuing medical education already attracts financial rewards to general practitioners out of line with any demonstrable health gain for patients. Educational involvement alone is unlikely, then, to satisfy patients or politicians as anything more than a very temporary substitute for a valid process of reaccreditation.

In the medium and possibly the long term we suggest that a valid and acceptable criterion for reaccreditation is the capacity of the individual general practitioner to learn from experience.

Experiential learning is increasingly seen as the basis of continuing professional education; reaccreditation would become the formal assessment arm of this natural learning cycle for established general practitioners. Used in this way, reaccreditation would adopt a developmental approach, seeking to bring about demonstrable progress between assessments when measured against individual and normative standards. While few, if any, would be denied the right to continue in practice, the interval between assessments could be adjusted in a flexible way to enhance individual professional development on the basis of need.

We acknowledge the presence of major technical problems in designing and implementing an appropriate assessment procedure. Methods of assessing learning from experience will need to be valid, reliable, feasible and acceptable. Validity is a subjective issue but a crucial one in reaccreditation; reliability is a *sine qua non*; and feasibility will be a significant constraint when seen in terms of the potential of reaccreditation to distract general practitioners from their work either directly or through involvement in assessing others. Moreover, we should not forget that a developmental approach implies significant numbers of reassessments between the usual intervals and remedial 'prescriptions' or other learning therapy based on the results of formative assessment for a proportion of the 3000 general practitioners who would undergo reaccreditation annually, given a 10 year interval.

We conclude that the profession should now undertake two inter-related tasks: attempt to devise a valid, reliable, feasible and acceptable reaccreditation procedure; and secure from the Department of Health prior to implementing such a procedure, two concessions which are needed to protect general practice from otherwise inevitable damage by expedient management, consumerism, and wholesale litigation. The first concession is that, in reaccreditation, criteria are chosen and standards of performance are set by the profession and used formatively; the second, that reaccreditation of a general practitioner confers protection from managerial sanction or legal action, for example through a system of no-fault compensation for those seeking redress for his/her clinical actions.⁹

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