

General practitioner reaccréditation: use of performance indicators

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SUMMARY. *There has been increasing debate about reaccréditation of general practitioners over the last few years with contributions from the General Medical Services Committee, the Royal College of General Practitioners and the National Association of Health Authorities and Trusts. The implications of proposals in terms of cost, logistics and organization are discussed in this paper, in light of experience with the introduction of summative assessment for general practitioner registrars (trainees) and a programme of training practice visits in West Midlands Region. A model for reaccréditation for all general practitioners is proposed which is professionally led and sensitive to the needs of patients and health service managers. The basic proposition is that publicly owned family health services authority data could be used as initial performance indicators for professional competence. The model is dependent on the rebuttal of the null hypothesis: there is no link between the competence of a general practitioner and his or her achievements in the suggested performance indicators. If the performance indicators (educational commitments, prescribing data, health promotion activity and immunization targets, and service elements) can be shown to correlate with possession of the attributes for independent practice as defined by the General Medical Council, then a relatively inexpensive and simple system of reaccréditation could be envisaged. General practitioners who are recorded as achieving set performance indicator targets would be accorded automatic reaccréditation. Only substandard practitioners would be required to be assessed further by a visiting team of local general practitioner peers and, if appropriate, a remedial education strategy introduced. This method would complement the General Medical Council scheme for assessing an individual doctor's persistent poor performance, which could then be invoked as a last resort.*

Keywords: *reaccréditation; performance review; performance indicators; quality in general practice.*

Introduction

THE introduction of periodic reassessment or reaccréditation of general practitioners throughout their careers appears to be accepted in theory and is under much practical discussion.¹ Patients, health service managers and the general practice profession need to be reassured in their expectation that all general practitioners can be seen to be medically competent and fit for independent practice.

The profession has emphasized the educational aspects of reaccréditation both in a General Medical Services Committee discussion paper on reaccréditation,² with its later modifications,

and in two Royal College of General Practitioners initiatives,^{3,4} which follow Berwick's principle of continuous improvement.⁵ However, these schemes would make enormous demands on human and financial resources if they were implemented universally throughout general practice. Furthermore, they tend to ignore the issue of the persistently substandard general practitioner, being based on the hope that the overall standard of care will rise. The General Medical Services Committee and the RCGP both advocate an initial voluntary approach to reaccréditation. This approach would, of course, reduce the financial costs and manpower required. However, given the likelihood that those general practitioners who are uncertain or not interested in their quality of care will be reluctant to offer themselves for assessment, there will be no reassurance that unsatisfactory practice will be exposed and eliminated.

All family health services authorities have identified some general practitioners in their areas about whose performance they have severe reservations. For this reason the National Association of Health Authorities and Trusts expressed the desire for managers to join the profession in developing and introducing a necessary reaccréditation system.⁶ Consumer surveys show widespread patient satisfaction with their general practitioners, apart from the expression of concern about the inevitable small number of doctors who provide unacceptable, poor standards of patient care. This is why Gray has stated 'reaccréditation is mainly for patients'.⁷

A reaccréditation process should provide an assurance that education has been effective and competence has been acquired and that patients can consult with confidence. How much unacceptable practice is the result of illness, personality and relationship problems or disillusionment with career or humanity rather than a result of lack of knowledge is open to question. Donaldson has confronted this issue in his study of National Health Service consultants' 'problems', identified through reported deficiencies in services, in Northern Health Region.⁸ The substandard doctor may be unwilling or unable to use his or her knowledge rather than being incompetent solely through lack of education. Although continuous improvement, that is, a rise in the overall standard of patient care, must be encouraged, it is imperative from patients', politicians' and health service managers' viewpoints to identify unsatisfactory practitioners and safeguard patients.

Anecdotal discussions estimate the proportion of seriously substandard practitioners at around 5%, at a maximum 10%. These figures are, of course, impossible to verify without a full reaccréditation system with agreed criteria and appropriate survey. Interestingly, however, these estimates accord with the early results of a peer review programme of the College of Physicians and Surgeons of Ontario, Canada; it was reported that the performance of just four physicians out of 60 assessed (7%) was found to be unsatisfactory.⁹ A practice enhancement scheme (remedial retraining) was instituted for the four physicians identified.⁹ Given that there are about 33 000 general practitioner principals in the United Kingdom, these figures would have logistic implications if a scheme for reaccréditation were to identify about 2000 general practitioners in need of retraining.

The aim of this paper is to suggest that data held by family health services authorities on general practitioners and their general practices could be used as initial performance indicators, that

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is, as proxy indicators for professional competence. A model for reaccreditation is proposed that accepts the responsibility of identifying the substandard practitioner while taking into account managerial and patients' concerns. It is generally recognized, however, that the hallmark of a profession is that it undertakes its own regulation and defines its own competences. Therefore, a professionally-led model for reaccreditation is proposed.

Reaccreditation and summative assessment

The debate about reaccreditation of general practitioners has been sharpened by the parallel discussions on summative assessment for general practitioner registrars (trainees). Proposed changes in the rules for certification may well influence the criteria chosen for reaccreditation. The Joint Committee on Postgraduate Training for General Practice, instituted by parliament to oversee entry into independent general medical practice, has recently proposed a formal summative assessment of general practitioner registrars, to be effective by the beginning of September 1996.¹⁰ This anticipates an examination, including multiple-choice question papers, a written submission (audit project for the first year) and an observed clinical component involving externally assessed videotapes of consultations, in addition to a formal trainer's report.

The summative assessment working party for the West Midlands regional general practice education committee has estimated the minimum cost locally of summative assessment to be in excess of £200 per entrant in order to pay the assessors. This is still less than the cost of the examination for membership of the RCGP, as the examiners for this still traditionally receive only expenses for the performance of their duties. The introduction of the theory of a market economy into the NHS, with an explicit purchaser-provider split, and the government's insistence on placing a monetary value on services has meant that general practitioners are not accepting the chores of undertaking summative assessment of registrars without appropriate payment. In the same way, reaccreditation assessors will be unlikely to undertake similar tasks without remuneration and external locum costs.

In addition to the educational aspect of reaccreditation, both the RCGP proposals for fellowship by assessment⁴ and the General Medical Services Committee proposals for reaccreditation² envisage the introduction of peer review practice visits, based along the lines of the approval and reapproval of training practices, being part of the reaccreditation process. In West Midlands Region there are teams of practice visitors for the approval/reapproval of training practices but there is no payment for practice visitors at present except for the associate adviser team leaders' salaries and recompense for external locum fees if these are incurred by a team member in order to participate in a visit. Any expectation that this system can be extended to cover all training and non-training practices at no further cost is naive. There are already demands locally that there should be adequate remuneration for the time and expertise involved in assessing the education of registrars by training practices.

The detailed evaluation of clinical competence required for reaccreditation cannot be expected without sufficient financial backing. Reaccreditation clearly needs to be simpler than a regular repetition of summative assessment with or without practice visits. Practice visits to all 33 000 general practitioners every five years (as suggested in the General Medical Services Committee proposals) to find a minimum of about 300 substandard practitioners (5%) per year, and to confirm that 31 500 are satisfactory over five years, would appear to be a waste of resources: this is even before organizing all the general practitioners who would have to abandon their general practices and patients in order to undertake the peer review of 6600 doctors a year.

Proposed model for reaccreditation

Family health services authorities hold considerable data on general practitioners and general practices. As a result, they make informal judgements on their contractors and recognize practices' specific strengths and weaknesses. However, family health services authority managers are often the first to agree that they are not medical professionals and should not make decisions on medical competence of doctors. This paper suggests that publicly owned family health services authority data could be used as initial performance indicators for professional competence. The first step would be the testing of the null hypothesis: that there is no link between competence of a general practitioner and his or her achievements in the suggested performance indicators. If, however, these performance indicators can be validated through an appropriate peer study to represent attributes of competence for independent practice as defined by the General Medical Council in 1993¹¹ (that is, the null hypothesis is disproven), it would then be possible to envisage a relatively inexpensive and simple system of reaccreditation, in the following manner.

General practitioners who are recorded by their family health services authority as achieving set targets in all or many of the performance indicators would be accorded automatic reaccreditation. Practitioners who are clearly substandard would receive a practice visit by a suitably composed visiting team, based on the training practice model, including a general practitioner educationalist (such as an associate adviser) and a local medical committee representative. In a survey of attitudes towards professional reaccreditation among general practitioner principals in Cleveland, such individuals were found to be widely acceptable as the leaders of a peer review process.¹² This model for practice visits also concurs with the preferred option for reaccreditation expressed in the General Medical Services Committee survey of the profession in 1992.¹³

The substandard general practitioner would then be assessed in depth by the visiting team with a view to educational and professional counselling and remedial arrangements through adult learning and continuing medical education. The expectation is that his or her performance would improve, within a set period (for example, three years), to acceptable levels compared with other practitioners in the same family health services authority area. If the practitioner fails to achieve this, despite appropriate counselling and remedial education, the ultimate sanction would have to be the recommendation either to a new reaccrediting authority or, ultimately, to the General Medical Council as the authority responsible for medical registration.

At present, the Joint Committee on Postgraduate Training for General Practice is responsible for the initial certification of all general practitioners but has no powers to withdraw this. In November 1992 the General Medical Council decided formally to seek an amendment to the medical act 1983 that would widen its powers to allow it to investigate cases of poor professional performance of doctors. Although the then president of the General Medical Council, Sir Robert Kilpatrick, declared that it was not proposing to undertake regular review of the competence and performance of every doctor on the medical register, the new procedure could be invoked following a referral from a health authority where evidence suggested that a doctor's standard of performance might be consistently deficient.¹⁴ This amendment to the medical act 1983 is currently proceeding through parliament, and Professor Lesley Southgate is refining the details of the review procedure for general practice.

While the General Medical Council would only be investigating cases actually referred to it, the model for reaccreditation proposed in this paper would involve screening all general practitioners. It would, however, be sufficiently flexible to respond to the concerns of a health authority that requested a practice visit

to a practitioner who was found to be in repeated breach of his or her terms of service. This method would then complement the General Medical Council scheme, which could be invoked as a last resort.

The main drawback of the system proposed in this paper is that in practice partnerships, practitioners may conceal the shortcomings of an incompetent colleague and ensure that his or her performance indicators are satisfactory. Even so, this would imply that the care for patients was being monitored sufficiently so that they did not suffer. Limits to partnership loyalty might become more explicit under this sort of rigorous examination, particularly if the capabilities of the other partners came to be called into question through the inadequacies of the doctor under investigation. This would not be a problem with practices who run personal lists or for single-handed principals.

Current performance indicators

The performance indicators available at present are a combination of educational commitments, prescribing data, health promotion activity and immunization targets, and service elements. These are listed in Figure 1.

Educational commitments

The emphasis on educational attainment is likely to be the least controversial aspect of the list of performance indicators. Both Gray⁷ and Irvine¹⁵ agree that attendance at a planned educational programme, approved postgraduate education allowance, could be used to indicate reaccreditation for an individual doctor. In the west of Scotland, Murray and colleagues have endeavoured to identify the characteristics of general practitioners attending educational meetings:^{16,17} they have indicated an association between high attendance and RCGP membership and, separately, between high attendance and being a member of a training practice. They have even speculated that 'if attendance at educational meetings alters the way doctors work then it could affect the quality of care given in the practice'.¹⁶ Single-handed general practitioners have been shown to participate less in postgraduate meetings and may suffer from professional isolation.¹⁶ Gray has also taken up the theme of the relationship between postgraduate qualifications and quality of care.¹⁸

Approval as a training practice involves peer review and a commitment to explicit standards of modern medical practice,^{19,20} of course any non-training practice may deliver patient care as good as, if not better than, that of a training practice but acceptance as a vocational training scheme practice has already been appreciated as an accreditation procedure.²¹ In the same way, involvement with undergraduate medical education must be seen as a sign that a practitioner has been accepted to be a competent exponent of general practice and is a suitable role model. Forrest and colleagues have shown that there is a correlation between belonging to a teaching practice, for undergraduate or registrar training, and having more positive attitudes to continuing medical education, in doctors in all age groups.²² However, if a general practitioner belongs to a teaching or training practice this may suggest peer acceptability, but lack of teaching or training status should not prejudice against reaccreditation.

Prescribing data

Analysis of prescribing data is becoming increasingly sophisticated with initiatives such as the Audit Commission's thematic analysis of prescribing data, expanded in *A prescription for improvement*,²³ Harris and colleagues' introduction of the ASTRO-PU (age, sex, temporary resident, originated prescribing unit)²⁴ and the availability of extended comparative prescribing analyses and cost (PACT) data.²⁵ Naish and colleagues have recently described a statistically significant correlation between

Educational commitments

Level of attendance at postgraduate education allowance approved meetings
General practitioner registrar training practice^a
Undergraduate medical student teaching^a

Prescribing data

Prescribing analyses and cost data/Scottish prescribing analyses data, Audit Commission thematic analysis of prescribing data and ASTRO-PU, including:
generic prescribing rates; ingredient costs;
individual item rates^b

Health promotion activity/immunization targets

Approval for band three health promotion activity
Approval for chronic disease management programmes for diabetes
Approval for chronic disease management programmes for asthma
Immunization targets: for two-year-olds and pre-school children
Cervical cytology targets (with acceptable levels of adequacy of smears)
Paediatric surveillance acceptance^b

Service elements

Hospital referral rates
Intrauterine contraceptive device claims^b
Minor surgery acceptance^b

Figure 1. Performance indicators for general practitioners based on data currently held by family health services authorities, for use in proposed system of reaccreditation. ASTRO - PU = age, sex, temporary resident, originated prescribing unit. ^aSuggests peer acceptability but lack of training or teaching status should not prejudice against reaccreditation. ^bReflects individual practice's rather than practitioner's performance but could add weight to individual's claims.

current good prescribing patterns for asthma and three other markers of 'good practice activity' — a practice being a training practice, being approved for band three health promotion (discussed later) and achieving a high level of overall generic prescribing.²⁶

Health promotion activity and immunization targets

Health promotion activity and immunization targets are probably the performance indicators likely to arouse the greatest controversy. Some explanation is in order to demonstrate why health promotion activity could be a proxy marker for competence. Recognition for diabetes or asthma chronic disease management programmes entails an obligation to undertake clinical audit activity as well as to accept clinical protocols or guidelines. The use of audit as a marker of quality in practice has been recognized for several years and progress towards implicit standard setting in terms of consensus clinical management programmes appears inexorable.^{27,28} The collection of health promotion activity data, although bureaucratically challenging, should achieve positive health gain, for example in terms of increased detection and treatment of hypertension.

At 1 January 1994, 84% of general practices in Birmingham were approved for health promotion band three (which requires the recording of information on several coronary heart disease risk factors and provision of protocols of care), 84% for chronic disease management programmes for diabetes and 87% for chronic disease management programmes for asthma.²⁹ If these levels were repeated nationwide then this would suggest that

most general practices have been able to fulfil the requirements of the general practitioner health promotion contract. Practices that have not achieved this may lack the organizational skills or leadership necessary for change.

Jones and Moon have shown that although crude immunization uptake rates are inadequate indicators of performance, multi-level modelling with data on patients in practices can provide an appropriate unified approach for producing performance indicators in general practice.³⁰ Furthermore, in evaluating breast screening uptake, significant positive correlations have been demonstrated between practice rates for breast screening uptake and cervical screening, and for breast screening uptake and immunization.³¹

Organizational and administrative improvements in practice are possible: 85% of general practitioners in Birmingham reached the higher of the targets for immunization of two-year-olds for the three-month period January to March 1993; for the comparable period in 1994, the proportion was 92%. In fact, by March 1994, only 1% of practitioners had failed to reach the lower target.²⁹ At the same time, 78% of practitioners had attained the higher of the targets for cervical screening and only 2% had failed to reach the lower target. Again, this showed an improvement on the figures for the year before, when 69% had achieved the upper level and 5% had not even reached the lower target. Failure to achieve targets for immunization and cervical screening would warrant closer assessment at practice level.

Service elements

Hospital referral rates are collected by district health authorities. Although it has been shown in the Netherlands that using crude rates to judge referral quality is misleading,³² it would be reasonable to investigate individual instances where a general practitioner has a referral rate two standard deviations away from the mean referral rate of the district in which the practitioner's practice is located.

Conclusion

This paper proposes a model for reaccreditation of general practitioners that involves the use of performance indicators as discriminants to identify apparently substandard medical performance. This is a deliberate emphasis to reassure health service managers and patients that they will be neither paying for nor in receipt of unsafe or substandard practice. Practitioners who are found repeatedly to be in breach of their terms of service may also be referred into the reaccreditation system. Automatic reaccreditation would be offered to practitioners whose performance reflects the needs and expectations of patients and health service managers in the NHS in the 1990s. Resource implications for the scheme would be kept to a minimum, especially as the collection of the performance indicators is already being undertaken routinely by family health services authorities. Although the scheme would require managerial input, it would be professionally led. The profession would be responsible for peer assessment and remedial arrangements through adult learning and continuing medical education for those practitioners needing assistance: sick doctors may be referred to appropriate agencies. The ultimate sanction would remain recourse to the General Medical Council, leading to possible removal from the medical registrar as a last resort following the failure of remedial education.

It must be stressed, however, that this scheme would in no way remove the need for a properly financed and organized infrastructure for continuing education to allow the self development of all general practitioners throughout their careers for the benefit of their patients, themselves and society. The initiatives of the RCGP and the General Medical Services Committee in

pursuit of quality in practice and enhanced education must be developed at the same time for the continuing improvement of general practice.

The question that must be answered is whether the easily measurable indicators described can be demonstrated to confirm that a general practitioner's diagnostic, caring, counselling and management skills are at a nationally and internationally acceptable level. If this can be validated by the medical profession through appropriate scientific study, a whole system of reaccreditation could be introduced with minimal expenditure and minimal interference and disruption to everyday practice.

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