

women involved will be aged over 35 years. For this reason it is difficult to predict the background level of miscarriage. Secondly, whereas chorionic villi sampling is a first trimester procedure, amniocentesis is performed in the second trimester and simple comparisons will exclude the background rate of first trimester miscarriages which have already occurred. Finally, there are ethical difficulties in setting up two randomized cohorts of women with much wanted pregnancies who may well already have formed opinions regarding which of the two methods they prefer.

Nevertheless, it is obviously desirable that some sort of randomized comparison of the two techniques should be made and that the two cohorts of mothers and progeny should be followed up for many years. Should such a study become reality, general practitioners will be actively involved in counselling mothers who are at risk and referring patients to participating gynaecologists early in their pregnancy. They will also be asked to collaborate in the long-term follow-up of the progeny.

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## References

1. Anshan Department of Obstetrics and Gynaecology. Foetal sex prediction by sex chromatin of chorionic villi cells during early pregnancy. *Chin Med J [Engl]* 1975; 1: 117-126.
2. Zeng YT, Huang SZ. Alpha-globin gene organisation and prenatal diagnosis of alpha-thalassaemia in Chinese. *Lancet* 1985; 1: 304-306.
3. Kazy Z, Rozofsky IS, Bakharev VA. Chorion biopsy in early pregnancy: a method of early prenatal diagnosis for inherited disorders. *Prenatal Diagnosis* 1982; 2: 39-45.
4. Ward RHT, Modell B, Petrou M, *et al.* Method of sampling chorionic villi in first trimester of pregnancy under guidance of real-time ultra-sound. *Br Med J* 1983; 286: 1542-1544.
5. Goossens M, Dumez Y, Kaplan L, *et al.* Prenatal diagnosis of sickle-cell anaemia in the first trimester of pregnancy. *N Engl J Med* 1983; 309: 531-533.
6. Smit-Jensen S, Hahnemann N. Transabdominal fine-needle biopsy from chorionic villi in the first trimester. *Prenatal Diagnosis* 1984; 4: 164-169.
7. Report of a WHO/Serono Meeting. *Perspectives in fetal diagnosis of congenital diseases*. Serono Symposia, in press.
8. World Health Organization Working Group. Foetal diagnosis of hereditary diseases. *Bull WHO* 1984; 62: 345-355.
9. Medical Research Working Party. An assessment of the hazards of amniocentesis. *Br J Obstet Gynaecol* 1978; Suppl 2: 85.
10. Hislop A, Fairweather DVI. Amniocentesis and lung growth: an animal experiment with clinical implications. *Lancet* 1982; 2: 1271-1272.
11. Hislop A, Fairweather DVI, Blackwell RJ, Howard S. The effect of amniocentesis and drainage of amniotic fluid in lung development in Macaca fascicularis. *Br J Obstet Gynaecol* 1984; 91: 835-842.
12. Wald NJ, Terzian E, Viskers PA, Weatherall JAC. Congenital talipes and hip malformation in relation to amniocentesis: a case control study. *Lancet* 1983; 2: 246-249.
13. Farrant W. Stress after amniocentesis for high serum alphafetoprotein concentrations. *Br Med J* 1980; 2: 452.
14. Modell B, Ward RHT, Fairweather DVI. Effect of introducing antenatal diagnosis on reproductive behaviour of families at risk for thalassaemia major. *Br Med J* 1980; 1: 1347-1350.
15. Hahneman N. Early prenatal diagnosis: a study of biopsy technique and cell-culturing from extra-embryonic membranes. *Clin Genet* 1974; 6: 294-306.
16. Kullander S, Sandahl B. Fetal chromosome analysis after transcervical placental biopsies in early pregnancy. *Acta Obstet Gynecol Scand* 1973; 52: 355.
17. Gustavii B. Chorionic biopsy and miscarriage in the first trimester. *Lancet* 1984; 1: 562.

# What sort of doctor?

'... The Board of Censors of the Royal College of General Practitioners has set up a working party to advise on "a method of assessing the performance of established general practitioners in the setting of their own practices".'<sup>1</sup>

Once a clinical discipline defines its work, it follows that some aspects of the work come to be regarded as better or more desirable and other parts worse or less desirable. Thus it is inevitable that emphasis is placed on quality. This immediately raises the questions: How does one recognize and measure quality? How can it be assessed? Pressure to assess the quality of general practice is coming from the profession itself, the consumers (the patients) and, because British general practice is rooted in a National Health Service, from Government as well.

General practice is responding to this pressure by introducing a series of assessment methods, three of which have been developed so far.<sup>2</sup> First came the MRCGP examination, developed in the 1960s, which became the normal entry requirement for College membership in 1968. Secondly, in 1973 a new system of assessment for the selection and reselection of trainers in general practice was introduced and was based on a visit to the practice. Then, in the early 1980s, a working party of the Royal College of General Practitioners advocated a third approach to assessment.<sup>3</sup> This led to another working party and a synthesis of their two reports with accompanying documentation is published today.<sup>1</sup>

The first method of assessment, the MRCGP examination, has been continually refined since it was introduced and a huge amount of theoretical analysis and study and many examiners' meetings have led it to its current format. Its introduction helped

to underline general practice as a clinical specialty and to define the content of general practice more clearly. The examination is now taken by about 1700 doctors each year, of whom over 1000 pass. It has become the natural end-point assessment of vocational training.

The second method of assessment, that of trainer selection, is aimed by definition at principals in general practice. Normally, these principals have been in practice for at least three years and are voluntarily seeking the additional responsibility of teaching their discipline. The assessment process has been greatly influenced by the Joint Committee on Postgraduate Training for General Practice whose booklet *Criteria for the selection and reselection of trainers* has provided guidelines.<sup>4</sup> Some of the principles are also contained in the *Statement of fees and allowances*.<sup>5</sup> One essential point is that the applicant is always visited in the practice and, in the great majority of regions, revisited on subsequent applications. The historical importance of the trainer selection system was to move assessment into the practice.

The third method of assessment, popularly known as 'What sort of doctor?', also focuses on principals but it is not aimed either at achieving membership of the College or at the selection of trainers. It represents an attempt to identify the fundamental values on which good general practice rests. It does not lead to a degree or diploma, but offers applicants the opportunity to learn about their own performance and discover ways in which they can improve. The essence of this method is a visit to the applicants in their own practices by peers who, operating within an agreed framework, comment on what they find.

The first 'What sort of doctor?' working party, chaired by Dr J.A.R. Lawson, suggested four areas within which a general practitioner could be assessed. These were: clinical competence, accessibility, ability to communicate, and professional values. The working party then clarified these aspects of performance in the form of written statements which could be used as a basis for the assessment of good practice. In an assessment visit information about a practice would be sought by asking for a practice profile, by direct observation of the practice, by discussion with ancillary staff, by inspecting the practice's registers, by reviewing videotaped consultations with patients, and by interviewing the doctor. The doctor's performance in the different categories was graded on a four-point scale.

The second working party, chaired by Dr Theo Schofield, in developing this approach to assessment, modified the terminology. The original areas became areas of performance, assessment methods became sources of information and criteria were described as discrete, definable elements of agreed good practice while the level of performance noted the degree of frequency with which each element was achieved or performed. Members of the working parties tested their system on each other and several faculties of the College, notably South East Thames and Merseyside, retested the method in their own regions among several colleagues. In other parts of the country individuals used the concepts and methods in different ways and some of the ideas were incorporated in the trainer selection system adopted by the Oxford Region,<sup>6</sup> most notably the use of videotape recordings of consultations.

The significance of this development in assessment is likely to be considerable but it may take years before the full effect on general practice is known. The assessment places emphasis on accessibility and on communication skills. The work of Ann Cartwright<sup>7,8</sup> and evidence from patients and community health councils<sup>9</sup> indicates the urgent need for improvement in these areas.

Further development of the 'What sort of doctor?' method of assessment will take place as the underlying concepts become accepted. Having established the importance of communication skills in the work of general practice, the priority now is to look more closely at the assessment of clinical competence. There is a need to look at a doctor's ability to make specific diagnoses and his ability to carry out, to an agreed level of competence, certain crucial clinical skills. Clinical skills are needed increasingly in general practice, whether in carrying out an appropriate assessment of children or in detecting the early stages of diabetic retinopathy. Quite specific clinical skills are needed and will have to be included in the assessment procedures.

The special importance of this new form of assessment lies in the principles on which it is based. First, the assessment is being carried out in the right place — where patients are seen. For an operational specialty such as general practice this must be right. Secondly, the doctor participates in the assessment process, is interviewed face to face and has his own consultations with his own patients reviewed on videotape recordings. For the first time clinical performance is under the microscope and it is in this respect that the 'What sort of doctor?' assessment is an advance on the MRCGP examination or most current trainer assessment visits.

Another major principle is that the assessment is carried out by practising practitioners. Such assessment by peers is as much about progress and movement as about achieving some arbitrary standard. A practice under pressure but on the move can thus be fairly assessed. It is lack of change in practices which may be one of the most serious threats to the discipline. Finally, the focus is on performance, past and present, rather than on book knowledge and published papers.

Inevitably a new system as radical and as complex as this will throw up many new problems. Martin and Martin<sup>10</sup> and others

have already cast some doubt on the general acceptability to patients of the video camera in the consulting room and have challenged the earlier reassuring report of Elliott and colleagues.<sup>11</sup> Others have already expressed concern at the time such assessments take. From 09.00 until 17.00 hours is a considerable commitment from three doctors (the visited doctor and the two visitors) and must involve substantial costs and resources.

Finally, the numbers so far are too small to ensure that the assessment is carried out in a uniform way and there is as yet little evidence of improved performance following the assessment. The actual impact of this method on colleagues is not yet clear. It is hard to see how an assessment visit can fail to be threatening since it will be the first occasion for many doctors when their clinical performance in their own practices has been seriously examined by colleagues. The document rightly calls for the exercise of considerable tact and understanding by the assessors.

Whether or not the 'What sort of doctor?' assessment will come to be incorporated within an organizational framework remains to be seen. Most Regional General Practice Subcommittees are cautious and will want time to consider the value of this assessment. If the College used the criteria for the selection of fellows this could make the process more objective than it is at present.

All in all, the 'What sort of doctor?' assessment has emerged logically from the interests and activities of the College and the College's wish to promote quality by the continual differentiation of what is good from what is less good. For the first time in the history of British general practice a method has been devised to measure the performance of a general practitioner as a clinician. This is undoubtedly a landmark in the development of general practice and one worthy of the most careful thought by everyone in practice. The two working parties and their chairmen can be congratulated on a substantial achievement. This report deserves to be widely read and discussed.

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## References

1. Royal College of General Practitioners. *What sort of doctor? Report from general practice 23*. London: RCGP, 1985.
2. Gray DJP. *Training for general practice*. Plymouth: Macdonald and Evans, 1982.
3. Royal College of General Practitioners. What sort of doctor? *J R Coll Gen Pract* 1981; 31: 698-702.
4. Joint Committee on Postgraduate Training for General Practice. *Criteria for the selection of trainers in general practice*. London: JCPTGP, 1976.
5. Department of Health and Social Security and Welsh Office. *Statement of fees and allowances payable to general medical practitioners in England and Wales*. London: DHSS, 1985.
6. Schofield TPC, Hasler JC. Approval of trainers and training practices in the Oxford region: evaluation. *Br Med J* 1984; 288: 688-689.
7. Cartwright A. *Patients and their doctors*. London: Routledge and Kegan Paul, 1967.
8. Cartwright A, Anderson R. *General practice revisited*. London: Tavistock, 1981.
9. Oxford Region Course Organizers and Regional Advisers Group. *Priority objectives for general practice vocational training. Occasional paper 30*. London: Royal College of General Practitioners, 1985.
10. Martin E, Martin PML. The reaction of patients to a video camera in the consulting room. *J R Coll Gen Pract* 1984; 34: 607-610.
11. Elliott B, Marsh GN, Strachan D, et al. Patients' reactions to a two-way mirror. *Med Educ* 1979; 13: 439-442.