developing methods of working with specialist colleagues to provide a service which is much more responsive to the individual patient and can be delivered locally. Consultants visiting surgeries to see patients can provide a much more focused opinion if they have already had the benefit of discussing the patient's history with the general practitioner and other members of the primary health care team. We can evolve structures in which students can learn across the boundaries between different disciplines to achieve a wider view of the patient, his or her illness and its impact.

Increasing general practitioner involvement in purchasing services is forcing general practitioners to look beyond their traditional preoccupation with the care of the individual and the family. They are beginning to consider and to try to define the health needs of their registered population as a whole but have little relevant expertise. We need to develop cooperative working with our public health colleagues whose central responsibility is defining public health needs.[17] Public health physicians are often isolated from their communities and a closer working relationship with general practitioners would allow them access to a mine of information about the local population. General practitioners must remain the advocates of the individual patient, public health physicians the advocates of the population, but there is much to be achieved at the boundary. At the very least, general practitioners and public health physicians can work together in the vital tasks of assessing needs, identifying gaps in provision, and amassing statistical rather than anecdotal evidence of unmet need.

The provision of low dependency beds, recommended in the Tomlinson report, gives community nurses an opportunity to extend the range of service that they provide. If low dependency beds are managed and staffed by community nursing teams with medical back up from general practitioners, the frail elderly patient being cared for at home by district nurses, for example, can be brought into a nursing bed for the treatment of an acute chest infection to be cared for by the same team. Hospital admission is avoided and discharge arrangements can be made between members of the same nursing team.

The inner city task force of the Royal College of General Practitioners is embarking on a survey of practices in deprived urban areas to identify innovative solutions to the delivery of health care in a difficult environment. The hope is that the dissemination of these solutions will empower us to seize the opportunities we have.

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Reaccreditation for general practice

RECENT changes in the National Health Service — and in general practice in particular — have been enormous. They have been so great that an issue which might have been expected to produce major headlines has come to prominence with surprisingly little controversy. The principle of reaccreditation for general practice, potential anathema to many in the profession, was implicitly accepted by nearly two thirds of those general practitioners responding to the General Medical Services Committee's 'Your choices for the future' survey early in 1992.[1] The political and managerial pressure towards reaccreditation may be great, but the United Kingdom has no strong tradition for reaccreditation of its professions, unlike other countries.[2,3] This is such a fundamental matter that, although we must recognize the external pressure, we should proceed cautiously if major difficulties are to be overcome. The establishment of reaccreditation for principals in general practice implies withdrawal of the licence to practise unsupervised for those who do not achieve the required standard. There are many organizational, ethical and legislative worms within such a can.

The case for reaccreditation is strong. Almost 40 years ago, seminal work by Peterson[4] showed that any link between levels of achievement at undergraduate and postgraduate stages of family medicine was lost after the age of 35 years, and that other factors became more important in determining the competence of the established doctor. This is easy to understand. Anyone who completed vocational training more than 10 years ago will be aware that they are practising in a wholly different world from that in which they were students. They have little or no knowledge of new technological procedures used in hospital; the pharmacopoeia has all but been replaced; and patients (and managers) have very different expectations about the provision of care. It could be argued that medicine has always been a rapidly changing field, and that the profession has invariably responded effectively to change in a voluntary way. However, such are the pressures of general practice today that reaccreditation should perhaps be seen as potential protection rather than a threat.

Furthermore, general practice has been prominent in steps towards reaccreditation of the medical profession in the UK, and we have a foundation on which to build. Selection and reselec-

tion criteria for trainers were established by the Joint Committee on Postgraduate Training for General Practice in 1976 and are the responsibility of regional advisers in general practice. Initially not much more than a series of hopeful and encouraging recommendations, they are now seen to have real power. They include a good deal of assessment of the structure and process of practice care in addition to assessment of educational provision for trainees. In the south west Thames region of England over 20% of practices are approved for training purposes,[5] and around 40% of respondents to the General Medical Services Committee's survey were in practices subject to this kind of peer assessment.[1] The Royal College of General Practitioners has also been prominent in developing performance assessment systems in addition to its own knowledge based membership examination. Initial experience with the 'what sort of doctor?' initiative[6] was followed by fellowship by assessment,[7] and more recently by proposals for membership by assessment.

This intra-professional activity is now given greater impetus by two external, government initiated factors — medical audit and contractual requirements. Medical audit, for many years the preserve of an enthusiastic but small minority, is now a prescribed activity for all doctors in the health service.[8] Money has been made available to establish audit, and the necessary support staff and systems, in both primary and secondary care. Medical audit advisory groups have the responsibility for facilitating medical audit activity in all general practices, and although these are early days, these groups will clearly have to chart a careful course of facilitation between direction and inspection. Although separate funding for medical audit is unlikely to continue indefinitely, evidence that it leads to improvements in standards of care[9–11] will ensure that it remains a prominent part of our activity for the foreseeable future.

The 1990 general practitioner contract introduced the postgraduate education allowance and a number of performance related payments which might herald the appearance of de facto reaccreditation. Admittedly the postgraduate education allowance regulations are broad and difficult to monitor,[12] and there is little evidence for their effect on improving standards. Likewise, achieving immunization and cytology targets says little about clinical competence. None of these regulations is compulsory, but they form a bridgehead for contractual reaccreditation. Competence in minor surgery and in the management of the chronic diseases asthma and diabetes are clear examples of 'reaccreditation before payment' standards which general practitioners may be obliged to meet in the near future.

Hence, the pressure for reaccreditation, from within and outside the profession is growing and may well be irresistible. However, the problems involved in adopting it should not be underestimated. We cannot, logically, have reaccreditation until accreditation is in place. At present, certification for satisfactory completion of vocational training barely counts as accreditation.[13] The MRCGP examination is a voluntary, predominantly knowledge based, summative assessment of vocational training, and there has been resistance to converting it into an accreditation standard. However, the Joint Committee on Postgraduate Training for General Practice has recently issued detailed draft proposals for just such an assessment.[14] This will form the basis of accreditation, and the joint committee is proceeding with it as a matter of priority.

Establishing accreditation would still leave the problem of devising a system for reaccreditation which combines feasibility with objectivity, reliability and validity. This is a tall order, raising the perennial question of how to judge a 'good doctor'. Performance based assessments, such as peer review visits, are complex compared with knowledge based assessments such as written examinations and multiple choice questions. However, the profession is unlikely to accept the latter as a meaningful way of assessing a general practitioner's competence.

Since it is impossible to observe everything that is going on in medical care, performance based assessment always requires some kind of sampling. Breaking down the totality of general practice into measurable tasks will always be imperfect and measurement errors are inevitable. There are, however, several principles of assessment strategy which can be defined.[15] Overall, the assessment must be valid, that is, measure what it purports to measure. To do this it must focus on the most critical aspects of the job as a whole (for example, safety in diagnosis and prescribing). Techniques which yield the most information for the least cost in time and money must be used, but they must retain content validity: that is, they should assess the range of competences for the functions and tasks demanded by the job. One of the criticisms of the selection criteria for training practices has been that they have been concentrated on easily measurable factors rather than on important ones. Validity may be heightened by multiple measurement — using more than one method to assess the most important and critical aspects of performance. For example, communication skills should be assessed broadly, perhaps by patient satisfaction questionnaires in addition to observing videotaped consultations, or simply counting service committee hearings. Deficiencies in performance identified by the assessment should also have predictive validity, that is, they should be features which are likely to cause recurrent problems in practice (for example, a repeat prescribing system without safeguards) rather than temporary aberrations which can strike anyone on a bad day.

Above all, any reaccreditation assessment must be reliable. It should have stability and internal consistency in the aspects of care that it assesses. Also, if the workload of reaccreditation is to be spread widely among peers, it must have consistency of application (inter-rater reliability).

Reaccreditation should have as its goal the improvement of care by the provision of stimuli and guides to future learning and practice. It should be seen as a package of measures comprising the whole, rather than an image of a visitation from the good and great. Much of it, particularly that part relating to contract related performance will necessarily be judged at practice rather than individual level. If reaccreditation becomes one more hoop through which hard pressed practitioners must jump we will lose sight of the goal. Furthermore, if it is not successfully introduced in some form, we may find ourselves being constantly assessed. This can be visualized as a stultifying mechanism in which performance against process protocols is assessed continuously as we enter patient data on to our desktop computers.

Rather than rush to develop an all embracing instrument in order to pre-empt imposed reaccreditation, the profession should utilize existing structures, including medical audit and contractual requirements, within an overall package. Clearly all the professional bodies involved in postgraduate education would have an important role to play. The General Medical Council has recently published draft proposals on performance procedures which suggest, encouragingly, a strongly supportive and remedial approach to helping doctors identified as 'underperformers' whether as a result of complaints, or in reappraisal procedures.[16] However, the central and coordinating role in defining and establishing reaccreditation should be that of the RCGP. The College has achieved much in the establishment of vocational training and the development of undergraduate departments of general practice. These are now self-supporting entities, and the College may be in need of a *cause célèbre* to re-establish its central role in general practice. There could not be a more important theme.

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