DISCUSSION PAPER

Making reaccreditation meaningful

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SUMMARY. Reaccreditation is a well-accepted fact for many doctors outside the United Kingdom and is likely to become a reality for British general practitioners. The author's sabbatical year in the United States of America studying reaccreditation and its relationship to continuing medical education has enabled a critical analysis of recent proposals in the UK to be carried out. The aim of reaccreditation must be understood by the profession and must be clearly stated. To be credible it will have to be mandatory and linked to continuing medical education. Current types of continuing medical education must be developed so that they are meaningful, influence doctors' behaviour and include research, audit, training, reading and medical writing. The profession must confront the need to penalize the small number of doctors who have an unacceptable standard of practice. The potential benefits of an appropriate form of reaccreditation may include improved quality of care and patient outcome, enhanced job satisfaction and reduced rates of burnout.

Keywords: reaccreditation; continuing education; general practice; United States of America; United Kingdom.

Introduction

THE idea of formal, periodic reassessment of fitness to continue in medical practice produces resentment among many British general practitioners, yet it is an accepted fact for doctors in many other countries including Canada, New Zealand, Australia and the United States of America (reaccreditation is known as recertification in the USA).[1-4] The forces behind the drive to introduce reaccreditation in the United Kingdom include the public, the media, the government and the profession.[5-8] The vast majority of family practitioners in the USA regard it as a fact of life and indeed view it as a challenge. Many are surprised at the current situation in the UK where there is no check on competence once vocational training is completed.

The impetus for reaccreditation has now built up to such an extent that its introduction has become inevitable. How may this be done in a way that restores morale and pride in the profession? The General Medical Services Committee has proposed a voluntary two-level scheme.[6] This would allow practitioner reaccreditation to be obtained by individual general practitioners completing a planned programme of approved study, and practice reaccreditation to be obtained by practices where all the partners had practitioner reaccreditation and the premises and staff achieved some unspecified standard. By deliberately opting for a voluntary scheme based on financial incentive the proposal seeks to avoid penalizing individuals and practices which fail to obtain reaccreditation.

The aim

What is the profession trying to achieve in introducing reaccreditation? This must be debated and the conclusion clearly stated. One possibility is an improvement in the outcome for patients.

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Submitted: 29 April 1994; accepted: 17 October 1994.

© *British Journal of General Practice,* 1995, **45**, 321-324.

Others have suggested a gradual improvement in the overall quality of patient care, increased accountability and a way of assuring clinical competence.[9-12] There is as yet no work linking quality of care and patient outcome.[13] More research is needed to investigate this relationship, but the principles of total quality management could be a starting point.[14]

If 'the impact on public health will be greater if the majority improve their effectiveness by 5% than if the keenest improve by 10% and the worst by 200%',[15] then the majority should be encouraged to improve gradually their quality of care.

The American way

The author's sabbatical year in the USA was spent studying reaccreditation and its relationship to continuing medical education. The American Board of Family Practice confers a diploma for seven years. It routinely administers the recertification process on a six-yearly cycle allowing a 'reserve' year for those unable to participate through sickness, maternity or sabbatical leave.[16] Applicants must be licensed (the equivalent of registration with the General Medical Council) and meet the following requirements:

- Continuing medical education. Over six years, the doctor must spend 300 hours divided between a variety of types of approved education including formal courses, teaching, reading, multi-media (for example use of videotapes and audiotapes and computers) and home study courses.
- Practice record review. Every six years the doctor must satisfactorily complete a form using several sets of randomly picked patient notes. This assesses the completeness and accuracy of data collection, and the examiners may require photocopies of some of the notes for checking.
- Cognitive examination. The doctor must pass a written test in two parts taking a full day. Part one tests knowledge over a wide variety of topics and includes multiple choice questions and modified essay questions. Part two tests deeper knowledge in three areas selected by the applicant.

All applicants receive their scores and written feedback identifying topics where their knowledge was incomplete. It is possible to practise without being recertified but doctors lose their hospital privileges and have to pay higher insurance premiums. In spite of this there had been a decrease in the numbers of doctors recertifying and the process has been made mandatory.[17,18] It remains to be seen if the financial incentives suggested by the General Medical Services Committee would work any better if implemented.[6]

Sanctions

Previous discussion about reaccreditation has avoided linking failure to achieve reaccreditation with removal from the medical list. The possibility of removing from practice the few doctors who consistently perform poorly must be debated since this area will be of particular interest to the public and government.

A voluntary system of reaccreditation would result in the doctors who are most at risk of failure avoiding the process. However, evidence from the voluntary system in Canada suggests that doctors who are most at risk of failure can be successfully targeted and offered help which improves their stand-

ards.[1,19,20] The College of Physicians and Surgeons of Ontario has identified three factors which correlate closely with serious deficiencies in proficiency: increasing age, not being a member of the college, and being in single-handed practice.[1] Support and advice enabled half of those doctors identified as having a serious deficiency to make the necessary changes when reassessed. The remainder were entered into the physician improvement programme. Ultimately it was suggested that 0.5% of doctors may require removal from the medical list. Importantly, this programme has found acceptance among the profession and the authorities in Canada.[1]

Picking out the bad apples, although unfashionable, will enhance the credibility of reaccreditation.[21] The mechanism already exists for removing from practice doctors found guilty by the General Medical Council of serious professional misconduct, and this could be extended to the few doctors who could not or would not improve their standards.

Time scale

How often should doctors be required to undergo reaccreditation? Australia has introduced a form of quality improvement with a three-year cycle but with the stated aim of making this an annual requirement.[3] The General Medical Services Committee's discussion paper suggests reaccreditation every five years.[6] In surveys of doctors, 10 years was the most popular interval for reaccreditation.[4,22] The feasibility of conducting reaccreditation must also be considered. A mandatory system which required the reaccreditation of 30 000 British general practitioners every five years would have to deal with over 100 doctors each week. Carrying out practice assessments on this scale as suggested by the General Medical Services Committee would be totally impractical.

Implementation of reaccreditation

There is no method of assessing patient outcome on the scale that would be required for a reaccreditation process, so assessments of competence (what a doctor is capable of doing) and performance (what a doctor actually does) must be considered.[23] There is no agreement as to what constitutes competence although this is the quality assumed to be assessed in undergraduates' formal final examinations. Competence is not necessarily reflected in performance.[24]

Methods of assessment

Written examinations. No one is immune to decay in their knowledge base and a feasible method of assessing knowledge would be by a multiple choice question paper.[25,26]

Performance indicators. In the UK, performance indicators are collected by many practices for the practice report and although they do not measure outcome for the patient[27] they could be used by family health services authorities and health boards to monitor general practitioners. Examples of such indicators include the number of requests for diagnostic tests and the number of referrals made to specialists.

Objective structured clinical examination. In Canada the feasibility of an objective structured clinical examination has been studied[28-30] but although this examination may play an important part in remedial medical education and assessment it cannot be recommended on the scale required for reaccreditation of general practitioners in the UK.

Peer review. Assessment of a doctor's activities in the surgery by fellow general practitioners may involve direct observation, video-recording of consultations, assessment of log diaries, and so on. It is assumed that if the process of care is found to be good, then the outcome for the patient will also be good. However, there is no evidence to support this assumption. Practice reaccreditation as suggested in the General Medical Services Committee's report[6] would attempt to assess the process of care provided by primary health care teams. While peer review is currently popular there is doubt about its reliability.[31-33] Research is needed to establish whether the team approach as currently advocated truly improves quality of care and the outcome for patients.[33]

Questionnaires. The level of input required to assess premises and teams will require a huge investment of time and money.[6] If reaccreditation is to be mandatory then the time required to assess premises and the team must be reduced from that proposed. This might be achieved by sending questionnaires to patients randomly chosen from the practice list and to members of the primary health care team. Pilot studies would be required to develop and test these questionnaires but investment in these studies now could pay great dividends in the future.

Continuing medical education

Continuing medical education is essential to ensure the quality of health care and all doctors should have a lifelong commitment to it in order to maintain and update their knowledge, attitudes and skills.[34-37] Self-directed learning where the planning, selection, implementation and evaluation of education is under the control of the learner is the most effective form of learning.[38,39] This type of learning can be undertaken in isolation or in groups and the ability to undertake it must be instilled in all doctors from the start of medical school.[40-42] Reading, audit, research, teaching and discussion with colleagues have all been shown to be capable of improving doctors' proficiency[43,44] but currently most of these areas do not count towards qualifications for the postgraduate education allowance.

Methods of continuing medical education

Lectures and small group work. Formal lectures are popular because they are an efficient way of delivering information to large groups of doctors, attendance can be easily documented and they are usually cost effective. However, they have not been shown to influence doctors' behaviour in practice.[34,40,45] Small group work is thought to be an effective way of helping doctors to improve their performance, but studies have failed to demonstrate any such changes.[34,46,47] These two activities are commonly recognized as counting towards the postgraduate education allowance.

Computers and multimedia. The personal computer has harnessed the interactive CD-ROM (compact disc read-only memory), high quality graphics, video material and accompanying soundtracks so that learners can proceed at their own pace and to the desired depth of knowledge.[48] Time spent in study can be recorded and changes in performance monitored. Systems are currently being developed by the American Board of Family Practice for use in reaccreditation. In the UK the development of software for personal use in continuing medical education is in its infancy but in the USA several programmes have been assessed.[49]

Potential problems include the time and money required for software development, and in addition the software must be made more user-friendly. Information systems should be instantly and easily accessible and frequently updated. In the future they will probably become an important part of continuing education for all doctors.

General practitioners should be helped to gain access to medical information more readily. The electronic databases available in libraries have made the collection of information considerably easier and librarians have an important role to play in continuing medical education.[50] At present many general practitioners are discouraged from using these facilities by difficulties in access and the cost of library membership. Family health services authorities and health boards should have corporate membership of a central medical library so that all general practitioners are able to use the facility.

Educational guidelines. Structured educational guidelines should be adopted by course organizers, regional advisers and by postgraduate deans.[51] This would help ensure that courses and learning methods were effective. If these were published then prospective participants could better decide which courses to attend.[52] In the Mayo Clinic, USA a 10-item document must be completed satisfactorily before a course is granted recognition as counting towards reaccreditation. The items include the target audience, how the continuing education needs of the audience were assessed, how this was used to plan the educational activity, and documented evaluation of the course.

Mentors. The need for general practitioners to become less isolated has long been apparent.[7] Recent suggestions by the Royal College of General Practitioners, that all general practitioners should have a mentor, are welcome.[53] The development of portfolio-based learning using mentors could advance continuing medical education and provide an opportunity to develop and assess it in a meaningful and relevant way.[54] Funds will have to be made available to finance the time required by the doctors who will act as mentors, their role must be expanded and formalized and, to be feasible, their introduction will have to be phased in.

Conflict of interest

Owing to the vested interests of some groups organizing medical courses, strict guidelines have been adopted in the USA to minimize potential conflicts of interest. At the Mayo Clinic a 16-item written guideline with a written declaration of any interest lecturers may have in the company sponsoring the course is displayed and helps to allay fears among participants that the speaker has a vested interest in promoting a product. Concerns have been expressed about similar problems in the UK;[55] certainly there is scope for further change in the guidelines governing company sponsorship of continuing medical education activities.[56]

Proposals

It is only a matter of time before reaccreditation is introduced in the UK, but it is vital that the grass roots of the medical profession is not alienated. The experience in the USA suggests that the system must ultimately be mandatory. Initial voluntary reaccreditation could be replaced by a mandatory system phased in over six years, the interval between episodes of reaccreditation adopted by the American Board of Family Practice. A period of one year before reaccreditation lapses should be allowed. A system based on the Canadian model should be instituted to assist doctors who fail to achieve reaccreditation[1,19] and provision should be made to remove from practice the few doctors whose standards are irremediable.

A single form of reaccreditation, combining practitioner and practice assessment, should be developed rather than the two-tier system proposed by the General Medical Services Committee.[6] This could include a test of knowledge by multiple choice questions and completion of a planned programme of continuing medical education in conjunction with a mentor. The assessment of the team and premises could be expedited by the use of questionnaires to be filled in by members of the primary health care team and patients. Videotapes of consultation should not be routinely used as part of assessment since this is too costly in terms of time and only reflects the performance of the doctor on that particular occasion, not competence. However, they may be necessary in certain cases where the doctor's suitability for reaccreditation is being questioned. It should not be possible to reaccredit doctors, however knowledgeable they may be, if they are working without an effective team or from substandard premises.

Linkage to continuing medical education is essential but not in its current form. The development of portfolio-based learning and the appointment of mentors could help to ensure that continuing medical education becomes more effective and wide ranging. More emphasis should be given to methods of learning other than formal lectures which, although easy to document, are the least effective way to modify the learner's behaviour.[46] Small group work must be regarded with scepticism until more research documents its effectiveness. The courses that are approved for reaccreditation should be more explicit in their methods of needs assessment and more open about issues of conflict of interest.

In order to expedite these developments funding will have to be found to compensate mentors. General practitioner mentors will have to find more time in their already busy schedules. Combining the use of continuing medical education in order to enhance quality of care with identifying and helping underperforming doctors and ultimately removing from practice a few doctors whose standards are unacceptable will ensure meaningful reaccreditation. This will enhance the professional standing of general practitioners. The use of mentors to encourage and develop effective portfolios of continuing medical education for individual doctors could increase the personal growth and self-awareness of all involved.

Conclusion

Reaccreditation is likely to become a reality for British general practitioners and the aims must be carefully considered and stated. Although there are many problems to be overcome, the potential benefits include increased job satisfaction and reduced risk of burnout for general practitioners and improved quality of care for patients. Research is required to ascertain which types of continuing medical education are able to influence doctors' behaviour and improve the outcome for patients. The benefits are of immense value and we should try to implement the most effective and least disruptive system as soon as possible.

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Acknowledgements

I thank the Scottish Home and Health Department for granting me prolonged study leave; Professor A Muir, Dr T R Harman, Dr C Shub and Mr A Bigbee for their advice and support; and my practice partners without whose agreement this paper would not have been possible.

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