The Australian Quality Assurance and Continuing Education Program as a model for the reaccreditation of general practitioners in the United Kingdom

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SUMMARY

A Quality Assurance and Continuing Education Program has been developed in Australian general practice over the past nine years. This effectively integrates audit and education within a coherent strategy for quality improvement. The programme fulfils many of the same aims as current proposals for reaccreditation in the United Kingdom (UK). This report describes the operation of the programme and an analysis of the effects of the scheme. A similar quality assurance strategy is proposed for the UK, which would address many of the criticisms of postgraduate education and may provide a realistic model for reaccreditation.

Keywords: reaccreditation; continuing education; audit; quality assurance.

Introduction

IN recent years it has been proposed that general practitioners (GPs) in the UK should participate in a process of regular reaccreditation. Arguments for this include the need to ensure that GPs remain abreast of new developments in health care, to improve and standardize the quality of care provided, and to ensure that patients can feel confident that any GP they consult will possess a minimum level of competence.[1-4] Although British GPs appear to accept the concept of reaccreditation,[5,6] they have not yet accepted the detailed proposals put forward by the General Medical Services Committee (GMSC).[7] These envisage GPs having annual meetings with an educational mentor and a five-yearly visit from a team of inspectors.[3] The proposals are set out to be educational rather than punitive, and to be based on performance in practice rather than assessment of knowledge. However, several authors have questioned both the practicality and educational value of the proposed scheme.[8,9]

The Royal Australian College of General Practitioners (RACGP) has developed a Quality Assurance and Continuing Education Program (QA&CE Program) over the past nine years, and participation is now a mandatory requirement for vocationally-registered GPs in Australia. The QA&CE Program has similar aims to those described in the GMSC proposals. What lessons can be learnt from the Australian experience, and does the QA&CE Program offer a model for the reaccreditation of GPs in the UK?

Aims

The aim of the QA&CE Program is:

> '…to provide tools and guidance to help GPs in Australia in their own efforts to maintain and improve their high standard of care to the community.'[10]

There are several other important underlying factors. As in many other countries, general practice in Australia has had to define and defend its position in the health care system as a central focus for primary care. It was felt important to justify public investment in general practice and to build public confidence.[11] It was argued that increased accountability was inevitable, and that if GPs did not regulate themselves, other authorities would introduce regulation.[12]

Philosophy

The QA&CE Program sets out clear and coherent objectives based on an underlying philosophy of quality improvement, supported by an increasing amount of evidence concerning the nature of effective strategies for postgraduate medical education.[13-15] This philosophy is based on the concept of continuously improving the standards of all doctors ('polishing all the apples'[16]) rather than setting out to detect those doctors who fall below a minimum standard ('weeding out the bad apples').[10,16,17] Experience shows that a 'bad apples' approach leads to defensive behaviour as doctors devote their energy to meeting (or appearing to meet) the minimum criteria set, whereas creating a climate of continuous improvement has a more profound influence on quality.[16]

The QA&CE Program sets out to integrate quality assurance and continuing medical education and seeks to ensure that education does lead to changes in practice.[17] This is achieved through the quality improvement cycle, described in the programme handbook[10] as setting standards, evaluation, response, and monitoring progress. Doctors choose from several options through which they can assess various aspects of their practices, and then education options enable them to improve the care they provide. Suitable educational ventures must meet four criteria. They should be preceded by an assessment of needs, have clear objectives, use appropriate methods, and be evaluated for their effectiveness.

The QA&CE Program emphasizes the importance of self-directed learning.[10] Doctors have different learning styles, different levels of experience, practice in different contexts, and should themselves determine their educational priorities. The programme claims to allow flexibility, rather than seeking to standardize the nature of general practice.

Alongside the QA&CE Program, the RACGP have been developing 'entry standards' for voluntary practice reaccreditation. The latest draft contains 15 standards, each comprising a number of specific criteria, and each criterion has indicators that determine whether the criteria are met.[18] There are over 200 indicators, and these are assessed during a practice visit lasting several hours. Research projects have been undertaken to test and develop the feasibility, reliability and validity of the standards.[19]

Process

The QA&CE Program operates in three-yearly cycles, or triennia. During the most recent triennium (1993–1995), doctors had to accumulate a minimum of 150 credit points by choosing from a range of activities in three separate categories (Table 1).

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Categories of activity

1. Practice assessment. This involves GPs looking at their performance in their own practice. Examples of accredited options include a peer-review cycle of inter-practice visits, a patient satisfaction survey, an analysis of local morbidity patterns, audits of various aspects of preventive care, and a critical incident review scheme. In many of these examples, assessment is linked to education. The practice chooses a subject area and collects data following a procedure developed by an external organization such as a university department. The data is returned to the activity provider, who analyses it and feeds back the results. The doctors describe how they plan to improve their practice as a result of the findings, and the assessment is repeated later. The results are again fed back to the practice so that they can determine if the changes they have made have led to improvements. Each accredited activity attracts higher practice assessment points if it involves completion of the entire audit cycle. It is also possible for a practitioner to carry out an audit they have planned independently and have this accredited.
2. Category A CME. This consists of accredited educational activities. The number of points awarded reflects both the time involved in taking part and the extent to which activities meet the criteria for effective education as described earlier. Many category A points come from lectures provided by local hospitals and pharmaceutical companies, as in the UK, and the standard and relevance of these activities is increasing as organizers seek higher points for their activities. Other examples of Category A activities include the CHECK programme, which is a correspondence course based on case studies followed by an assessment, individual clinical attachments, and accredited specialist 'tours', whereby a hospital specialist will visit practices (particularly in rural areas) to discuss cases.
3. Category B CME activities. These are informal learning situations, including journal reading and practice clinical meetings. GPs recorded their category B activities personally and could claim up to 40 points over the triennium using these records.

Table 1. Points requirements for 1993–1995 triennium.

Activity category and points awarded	Total required
20 points from practice assessment activities over the whole triennium	20 points
30 points from category A CME in each year of the curriculum	90 points
The balance of points from practice assessment, category A or category B CME	40 points
Total requirement for the triennium	150 points

CME = Continuing Medical Education.

Financing and administration

The QA&CE scheme is entirely financed by GPs. Individual activities are self-financing through sponsorship and application fees from doctors. Administration of the scheme is paid for by RACGP fellows and members through their college subscription, and by non-members through payment of an annual administration fee of AU$120 (approximately £60).

The QA&CE Program is led and administered by the RACGP QA&CE Committee and RACGP officers in each state. Activity providers inform the central QA&CE department of those GPs completing each activity, and every three months the department sends individual doctors a statement of credit points gained.

Practitioners failing to gain the requisite number of points during the triennium are removed from the vocational register and their fee reimbursements, under the state insurance scheme, Medicare, are paid at a lower rate.

Analysis of RACGP database

The RACGP maintains a database of information concerning the QA&CE activities of all 16 053 doctors participating in the programme, and of all approvals given to QA&CE ventures. Analysis of data from the 1993–1995 triennium was carried out for this report.

Who are the main providers of activities?

Table 2 shows the number of activities, approved by the QA&CE committee, by category of provider.[20] The main providers of postgraduate education are pharmaceutical companies and hospitals. The main providers of practice assessment activities are university departments of general practice and RACGP units.

Table 2. Number of approved activities by type of provider, 1993–1994.

Provider type	Category A activities		Practice assessment activities	
	n	%	n	%
Pharmaceutical companies	1468	28.2	2	1.3
Hospitals	898	17.3	14	9.1
Health organizations (e.g. National Heart Foundation)	506	9.8	5	3.2
Divisions of general practice (similar to local medical committees in the UK)	492	9.5	25	16.2
Informal general practitioner groups	289	5.6	23	14.9
GP associations (e.g. AMA)	276	5.3	0	0
Educational institution other than university	242	4.7	0	0
Universities	237	4.6	35	22.7
RACGP (includes faculties, research units, committees)	186	3.6	34	22.1
Government agency (e.g. Regional Health Board)	164	3.2	9	5.8
Other	441	8.5	6	3.9
Total	5199	100.0	154	100.0

One 'activity' refers to one accredited lecture or assessment protocol, irrespective of the number of doctors who take part.

Quality of applications

By approving activities for between one and three points per hour, and giving explicit criteria about the characteristics needed to gain higher points values, the QA&CE unit have been able to exert influence on the quality of activities offered. This system began in 1993 and there was an increase in the proportion of activities gaining at least two points per hour from 40% in 1993 to 54% in 1994.[21] The QA&CE officers work with providers to improve the quality of activities, and this strategy has been more successful than earlier attempts to influence the attitudes of individual GPs towards quality assurance (B Booth, personal communication).

How many doctors fail to complete the requirements?

Approximately 8% of doctors had not fulfilled the 1993–1995 requirements by February 1996; however, very few lose their vocational registration permanently. Most of the doctors who fail to complete the requirements are retiring from general practice; others lose their registration temporarily but rapidly undertake activities and are re-instated.

What is the attitude of GPs to the QA&CE Program?

Reports suggest that Australian GPs are equally divided between those holding positive and negative views towards quality assurance.[17,22,23] The concerns of GPs in one study included a fear of losing professional autonomy, the cost of undertaking activities, difficulties in obtaining locum cover and an uncertainty about whether quality in general practice could be measured.[23]

Future development of the QA&CE Programme

Several changes have been made to the QA&CE programme for the 1996–1998 triennium.[24] GPs no longer have to record informal education under category B CME. A new category of professional development has been created, which includes activities such as teaching medical students. The total points requirement has been reduced to 130 points over three years, with fewer coming from CME. It is anticipated that the relative emphasis on education will decrease and the emphasis on practice assessment will increase.

Discussion

Does the QA&CE Program fulfill its aims?

The stated aim of the QA&CE Program is to maintain and improve standards of care. The impact of education as a means of improving quality has been repeatedly questioned.[14,15] The most effective strategies would appear to be those that are participatory, those that use methods to enable and reinforce changes in behaviour, and those that use several educational formats.[15] The development of the QA&CE Program reflects this approach.

The effectiveness of the QA&CE Program on standards of general practice can be assessed by evaluating the impact of individual activities. An improvement in process measures in areas such as preventive care, chronic disease management, and patient satisfaction would indicate the success of the programme.[13] This data is being collected but none has yet been published.

If improving the quality of general practice is the aim, it may be wrong to assume that either education or quality assurance programmes are the appropriate strategy. Berwick points out that significant change is best achieved by changing the system rather than educating people to work more effectively in the current system.[25] One GP interviewed for this report claimed that Australian GPs were frustrated by having skills that they had no opportunity to use, and by competing with specialists for patients who had problems more suitable for primary care. If the way general practice is organized de-skills and demoralizes doctors, the solution is to change the working system not to re-educate the GPs.

The aim of the QA&CE Program is to improve the quality of care provided by all doctors, rather than focusing on identifying 'poor' doctors. However, the public and the government may be more concerned to ensure minimum standards of competence among GPs, and less interested in a quality improvement and continuing education strategy. If so, the QA&CE Program is not an effective mechanism for identifying and excluding incompetent practitioners.

Lessons for the United Kingdom

Education and audit

Current arrangements for the continuing medical education of British GPs, remunerated through the postgraduate education allowance, have been extensively criticized as encouraging a passive approach to learning with no demonstrable benefits to patients.[2,26,27] Doctors obtain most of their sessional credits by attending lectures of limited relevance to GPs, given by specialists. No attempts are made to assess individuals' weaknesses and educational needs, and the range of available activities is limited. There is a need for more flexible arrangements involving a wider range of educational providers.[28] Education should be based in the workplace and be appropriate to doctors with different learning styles in different situations.[8,27,29,30]

Responsibility for the continuing education of GPs is held by regional advisers and postgraduate tutors. Quite independently of this network, medical audit advisory groups (MAAGs) have been established. This separation encourages GPs to see education and audit as distinct activities, whereas they are both means to the same end, which is to encourage high standards of medical care. Although the postgraduate education allowance provides an incentive to take part in education, there are few incentives to carry out audit.

The Australian QA&CE Program provides an answer to most of these criticisms. It includes a wide range of options that integrate both education and practice assessment, but firmly in the context of quality improvement. Many of the activities are practice-based, relevant and participatory. The concept of accumulating credit points builds logically on the postgraduate education allowance with which British GPs are familiar. Most of the organizations that act as providers in Australia have equivalents in the United Kingdom (UK). A QA&CE Program in the UK could lead to an enhanced role for Royal colleges, universities and charitable health organizations, as they all work with GPs as activity providers. The QA&CE model would lead to a merging of the roles of the MAAG and the postgraduate GP tutor within one QA&CE office responsible for the GPs in one health authority area.

Reaccreditation

The Australian QA&CE Program may also provide a possible model for the reaccreditation of doctors in the UK. Several authors have argued the case for linking proposals for reaccreditation with arrangements for education and medical audit,[1,8,27] as occurs in other countries.[3,31] British doctors appear to favour a reaccreditation process that is linked to education and involves assessments of knowledge and clinical skill,[6] although the limitations of using what doctors know as a way of predicting their performance with patients are well recognized.[32]

It is essential to clarify the primary purpose of any reaccreditation programme. In a recent editorial, Richards stated that 'the aim of the process should be positive, not punitive — to encourage self-learning and help GPs to keep their knowledge and skills up to date. It must also identify those who are under-performing'.[3] It may be a mistake to attempt to devise a scheme that is both educationally positive and yet has the potential to identify doctors who are under-performing. In an earlier editorial, Pereira Gray said that 'reaccreditation is mainly for patients... It should be an assurance that competencies have been acquired and patients can consult with confidence'.[33] Patients have more to gain from a small improvement in the quality of care provided by all doctors than by identifying a few poor doctors; focusing on the latter jeopardizes the former.

I would propose that the UK adopt a quality improvement strategy for general practice based on the Australian model, and that participation in this scheme would form the basis for the reaccreditation of GPs. The scheme might also incorporate a mandatory 'screening' test of knowledge and a self-completed audit of performance in a range of consultations. This would act as a global assessment of educational priorities to help GPs avoid the tendency to study what they already know.

The problem of identifying doctors who perform unsatisfactorily would remain. Any system of identifying poor performance that has the potential to remove the doctor's right to practice would have to be highly reliable, reflecting the context and content of the individual's practice and covering a wide range of competencies.[2,34,35] Such a scheme is inevitably too expensive to apply to all GPs. There are already several ways of identifying doctors who may be failing to provide an adequate service.[9] A system for a thorough practice review could be targeted on these doctors, and suitable procedures are already being developed for the General Medical Council.[36]

The problem of doctors who provide very poor care is small, whereas the potential benefits of a quality improvement strategy are very large. This should form the basis of reaccreditation for general practice in the UK, and the Australian QA&CE Program shows it can be achieved realistically within a short time scale.

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