The vision of a poet

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Introduction

THE title should provide intrigue, and I would like to illuminate some of the themes with quotations[1] from Scotland's national bard, Robert Burns. My link with Burns is that I was born and spent my formative years in a rural Ayrshire mining village, Muirkirk.

Burns (1759-1796) was born in Alloway just outside Ayr. He was the most human of poets; he championed the rights of worthwhile causes, and as you will see his quotations are as true today as when they were written.

Pickles,[2] who in 1952 was the first President of the Royal College of General Practitioners, spent the majority of his life in Yorkshire and was the GP in a rural farming community called Aysgarth. He was to stay in and serve the district for the following 50 years, and achieved international fame for his research into epidemiology, which was based on his work in Wensleydale.

The theme of the lecture will be related to standards, and will not only give a vision for the future, but will demonstrate the reality of implementing standards in view of the gulf between what is expected and what actually happens. Often the biggest block to progress is from the profession itself.

Setting standards and quality of patient care have been themes in previous Pickles lectures.[3,4,6] Metcalfe,[3] in his 1986 Pickles Lecture, noted the consultation as the central transaction of primary care: that direct, intense, personal, and private interaction. Metcalfe's title was 'The Crucible', which he regarded in general practice as the consultation. It is a very intense interaction; the consultation is the crucible of learning. The 'holy grail' in assessment terms is to develop an instrument that assesses what happens in the consultation. The only method to date based on outcomes is the summative assessment of vocational GP registrars.

The use of video has been controversial in teaching and assessment. Burns would have been positive about the value:

O wad some Power the giftie gie us,
To see oursels as ithers see us!
It wad frae monie a blunder free us,
An' foolish notion

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Styles,[4] in his 1990 Pickles Lecture, noted that the great benefit of audit was that it encouraged and enabled us to identify errors and areas of ignorance, and to learn from these. To succeed, both audit and education depend on honesty and trust. In neither is there a place for blame and punishment.

Grol and colleagues[5] reported that peer review could change clinical practice in accordance with pre-agreed protocols, but concluded that its real value lay in promoting positive attitudes. The tapestry of general practice is complex, and peer review is essential for its development.

What would Burns have written regarding audit and peer review in general practice?

Wee sleeket, cowrin' tim'rous beastie,
O, what a panic's in they breastie!
Thou need na start awa' sae hasty,
Wi'bickerin brattle!
The best-laid schemes o' mice an' men
Gang aft agley,
An' lea'e us nought but grief an' pain,
For promis'd joy!

Stott[6] noted, in his 1993 Pickles Lecture, that from the mid-1970s words such as standard setting, priorities, audit, and quality assurance began to be heard on the lips of Pickles Lecturers. He noted that change may be exciting but it can also be extremely stressful, even for the medical profession!

The setting of standards and the improvement in the quality of patient care are two of the main aims of doctors involved in the education and training of fellow professionals. In previous Pickles lectures, the themes have dealt with setting standards but there has been no attempt to look at the practicality of putting these standards into place in everyday practice. Three areas in my work as Director of Postgraduate General Practice Education in the West of Scotland are training of general practitioner (GP) registrars, continuing education of established doctors, and setting standards within this environment.

My theme to illustrate these training aspects will be summative assessment; this has been extensively reported,[7-14] and I do not intend to dwell on any on these reports. Summative assessment has been professionally led nationally from 4 September 1996. To demonstrate competence a GP registrar has to pass all four parts:

- test of knowledge and problem solving
- test of communication and consulting skills
- written submission of practical work (audit)
- trainer's report.

There were repeated calls from the various educational bodies throughout the 1980s that the profession required a suitable entry standard to general practice – in other words, a demonstration of competence.

Video – the reality

It is generally thought that summative assessment came from the Joint Committee of Postgraduate Training for General Practice

(JCPTGP), and although they stated what was expected,[15] the JCPTGP "accepts the need for a national standard of entry into general practice, and therefore the necessity to apply a system of assessment which is credible, both to the public and the profession". It is then up to an academic group to develop the methodology and test instruments. Summative assessment succeeded against fierce opposition because it was built on sound academic foundations that were critically developed and tested.

This is a copy of a private hand-written letter that demonstrates the start of summative assessment, and is from myself to Dr Brian Keighley, dated 20 September 1991.

> Dear Brian,
>
> I realise there is urgency re: end point assessment with your meeting on Tuesday. The document enclosed is a rough sketch which resulted from discussions with Malcolm and George. I am keen to take this forward at regional level as a pilot and I would be keen to have your support and that of your medico-political colleagues. The exercise would need some funding but could be an excellent SGMSC/WOS initiative.
>
> You could perhaps test the temperature of the water and we could discuss it at a later date. If the whole exercise *is too hot* for you then we will be happy to go alone. I do understand your delicate position. I look forward to discussions with you.
>
> Yours aye, Stuart

Dr Keighley accepted this challenge and it clearly has not been a hindrance to his medical career because he is now an elected member of the General Medical Council (GMC) and Chairman of the competent authority responsible for standards of doctors entering general practice.

There was an enormous backlash from the profession in the West of Scotland, all of whom were in favour of summative assessment but were totally against videotapes leaving the practice and being assessed by doctors outside the practice. This opposition came from training groups and individual GPs. They certainly orchestrated a very effective campaign, which involved the local press, the daily press within the West of Scotland, the local Health Councils, the Scottish Association of Health Councils, the GMC, and the Scottish Office: it was very difficult to forecast where the next thunderbolt was going to appear from. Some had very reasonable points, and this feedback was helpful in the development.

There is no doubt that proper informed consent needs to be given, and that patients must be told what the tapes are being used for. Evidently, the turbulence was an enormous smoke screen designed to derail the train. Great care was taken in replying in detail to every individual letter, and in being available to talk to local Health Councils, groups of doctors, local medical committees, and so on. When the purpose of summative assessment was explained, the members of the Health Councils became extremely supportive and useful allies.

The innovative part of the process was, for the first time, being able to define and assess competence within the consultation process. This was based on professional judgement with levels of assessment that looked at sensitivity and specificity. Ultimately, any doctor who failed the process would have been assessed by six general practitioners, and the likelihood of a non-competent GP registrar passing was small, thus contributing to the development of a fair system.

Summative assessment asks one question: is this doctor competent to act as a principal in general practice?

In the West of Scotland we had one pilot year which was from 1 August 1992 to 31 July 1993; thereafter it became part of the training process. There were a number of trainers who were keen to be martyrs, and this we carefully prevented. Martyrs are always remembered for being martyrs, and not for the cause that they represented. Opposition required careful handling, and personal visits to face the wrath of training groups where a trainee had failed the process was a part of this. One enormous difficulty was in trainers' understanding that this process was for real.

The local trainers were not, however, helped by the constant flow of misinformation through the weekly medical newspapers, and this was fuelled mainly by members of the trainee General Medical Services Committee (GMSC) Sub-Committee.

These points illustrate some of the difficulties that have not previously been reported, but fortunately this did not in any way affect the timescale even by one day. It was pleasing to note that the Scottish Office publication *Health in Scotland*[16] had included summative assessment of vocational training for general practice within the text:

> Professor Murray and colleagues have devised, developed, and tested a radically new approach to assessing the competence of doctors at the end of their training for general practice. The key innovation is a use of video recordings of real consultations, an approach which has had to overcome ethical and legal, as well as logistic challenges. The willingness of patients to allow their consultations to be used for this purpose of assessment testifies to the importance people in Scotland attach to ensuring quality in the Health Service and the confidence they have in the guarantees given regarding confidentiality.

I think that paragraph is a fair summing up of the process, but the barriers to progress nearly all came from the profession. Patient groups were persuaded by the facts and, fortunately, leadership and vision were maintained by people of influence in the main professional bodies.

There is still much opposition to summative assessment, but we now have considerable data on the performance of GP registrars, and 6% nationally are currently unable to demonstrate competence. We have had a number of trainers who have walked away from training, as summative assessment has placed their own methods of training under scrutiny. Others who have failed to deliver have not been re-appointed. We also have comparative data between regions, and we can now see which Deaneries are performing effectively. As far as patients are concerned, we now have doctors going into practice who have demonstrated their competence to perform as independent GPs.

Audit – the reality

The GMC booklet *Good Medical Practice*[17] states that "doctors must work with colleagues to monitor and improve the quality of health care; in particular they should take part in regular and systematic clinical audit". Many publications have outlined the benefits of standard setting, and the practice visit within the training practice model is probably the most developed. Audit has been a criterion for training practices since August 1991. Feedback from GP registrars in the West of Scotland at the end of their training year highlighted deficiencies in audit teaching, and suggested that active practice audit was not taking place. This was confirmed at practice re-accreditation visits where the quantity, and particularly the quality, of the audits produced were poor.

In summary, this research suggests that, left to its own devices, the cultural change required to underpin systematic and rigorous audit, even within training practices that are organized to a defin-

able level, is a lengthy process. It is difficult at a personal level to recognize and admit to one's own deficiencies, and again a quote from Burns is helpful.

> The honest man, tho' e'er sae poor,
> Is king o' men for a' that.

To address these problems a defined core programme was devised for the region. The core programme was designed to meet the multi-professional needs of a training practice and was broad enough to allow trainers a range of experience and confidence in teaching audit methodology to their registrars. The whole programme was customized into a series of floppy discs using the database Visual FoxPro. The key issues in the design of the programme were:

- the setting of regional standards
- the importance of sharing comparative data with peers
- the use of a trainer group of between 12 and 15 training practices as a model
- the use of a group of audits that taught a range of audit skills
- to ensure that teamwork was part of the audits
- the importance of patient input
- to secure an infrastructure for continuous systematic audit
- to move to a more receptive culture for quality assurance

Phase one involved workload, chronic disease management, and critical event analysis. However, several professional 'smoke screens' have delayed audit.

Confidentiality

The issue of confidentiality is a professional one. It is imperative that trust among colleagues is implicit in any sharing of data, but with common sense precautions this should not be an impediment to the release of data for analysis for comparative purposes.

Ownership

It has been alleged that audits can only flourish if ownership is held by the practices, and not delivered in a top-down approach. There is no evidence for this. On the contrary, there is evidence for the counter argument. Again, this is a professional issue with ownership of audits, and the data therein should be considered in the context of trust and not used as a barrier to the evolution of the quality assurance structure.

Publication for Research

It is the primary purpose of a university department to carry out work in a rigorous manner, with a view to submitting it to wider discussion by the process of publication in peer-reviewed journals. This ensures that the work is open to scrutiny and contributes to a greater understanding of what are often highly complex areas. Again, any work submitted is done so on the basis of professional trust. It is implicit that no individual or practice will be identified.

The Health Service in Scotland currently funds audit at £6.5m per annum, and it would be very difficult for the profession to defend value for money. Talk of audit abounds, but evidence of this is scarce.

Continuing medical education (CME) – the reality

Since 1990, CME has been dominated by the postgraduate education allowance, and in reviewing what was happening within my own region I decided after discussion that we needed to relate CME more to the day to day-work-of the general practitioner, and also to review whether education could influence health care. A document containing the following points was sent to GPs within the region.

- One of the main purposes of continuing medical education is to improve patient care by the doctor improving his/her knowledge, skills, and attitudes. The crux of CME is whether attending meetings affects the way a doctor works and delivers health care.

- The reality of CME is that there is little evidence of learning gain. Doctors attend what interests them, and many accredited courses are of questionable educational quality.

- To change this situation, education should be made active and relevant to the day-to-day work of the GP. This would mean that all meetings that are longer than one hour would require a significant component of small group activity or interactive participation.

- Accreditation will now be given for practice-based education, audit, personal education plans, and portfolio learning, and any educational event thought appropriate will be considered. There will be set criteria for each activity.

This caused a storm within the GP community. The proposals were hardly radical, but opposition was nevertheless stirred by a few. This again showed how a small number of dissenters could slow down and block progress.

Forty-six letters were received, with many not written in professional terms. A comment from Burns is apt:

> Man's inhumanity to man,
> Makes countless thousands mourn!

All were answered, dealing individually with every point made, and no second letter was received.

You will be pleased to know that we did progress our plans, and education has moved forward within the region. I think that it does illustrate the difficulty that leaders have in effecting change for the benefit of patients, doctors, and the service. As professionals, we should work in a supportive environment of peer review for professional development. Burns sums it up:

> Then let us pray that come it may
> (As come it will for a' that),
> That Sense and Worth o'er a' the earth,
> Shall bear the gree an' a' that.
> For a' that, an' a' that,
> It's comin yet for a' that,
> That Man to Man, the world o'er,
> Shall brothers be for a' that.

Vocational training – the vision

We make increasing demands on trainers, both from a training and a Health Service point of view. A trainer must have a personal development plan related to training.

There is no doubt that, as the demands of both general practice and training increase, the majority of what is required for success will be delivered within the practice environment. This can only happen if the trainer and other doctors involved in training have

the necessary knowledge and skills, and this can only happen with a regional programme of trainer development. This is currently taking place in my own region, and from August 1999 all new trainers will have completed this programme before taking on their first GP registrar. The role model being provided by the trainer will be the only way of having proper adult life-long learning. The current responsibility for a trainer is considerable, and Neighbour's description of autonomy[18] in the task of a completing GP registrar is very apt, and can only happen with meaningful training.

Audit – the vision

Since the purpose of clinical audit is to improve patient care, the means will have to be found of engaging service users directly at all stages in the audit process wherever possible, thus making the object of audit relevant to their needs and concerns. Under measuring quality, the developing science should be a well focused, well founded, and centrally managed research and development programme, which will explore further the scientific aspects of quality assurance in primary health care. This should include researching and evaluating audit method, the construction, validation, implementation, and dissemination of evidence-based clinical guidelines, and the development of measures of outcome and their use.

Those concerned with the design of quality assurance systems, including clinical audit, should build in an evaluation of the system as an integral part of the activity at national, local, district, and individual practice unit levels. Under clinical audit and education, the linkage of clinical audit with training and continuing education of all health professionals is in need of major strengthening and development. This linkage may be best provided by professional bodies, by local audit groups working closely with providers of continuing education, by those supporting practice unit development, and by individual practice units. Lough[19] in the West of Scotland has developed the following model for quality assurance:

- subject for audit identified by a group
- preparation and planning discussed; criteria for care defined and standards set; method for collecting data identified
- software customized as necessary to build infrastructure; data collected at a defined time; analysis of data against standard; feedback at group meeting for peer review
- agreement on date for evaluation of change

At present, general practice does not make good use of current information technology. Long-term integrated audit will only flourish if existing technology is used to its full potential. A comprehensive teaching programme will be required to deal with this for all the professionals involved.

Recent work on quality assurance has suggested that

- it should be mandatory
- it should be multi-professional, looking at the collective contribution of all professions involved in the provision of care to particular groups of patients
- it should involve the use of explicit objective measurable standards, combined with a system of external and peer review

CME and continuing professional development – the vision

The bulk of continuing professional learning should be at practice level and also shared in meetings with other practices. Practices should have a practice educational plan with a partner taking responsibility as the lead; it must take account of clinical developments and have medium- and long-term strategy. It should build upon the opportunities that there are for learning in everyday clinical practices, and should recognize the need to encourage participatory learning, with resources being developed to support education at local level. There should be much more individual responsibility for learning tailored to specific needs and learning styles. In the current climate, widening postgraduate education allowances (PGEAs) to include personal education plans, audit, and research, would be a feasible way forward. Performance review should also be an important part of the process. I think Burns would have approved, for although he had little education he was a true adult learner.

He wrote in his first epistle to John Lapraik:

Gie me a spark of nature's fire
That's a the larning I desire.

In 1997, I had the privilege of visiting Wensleydale for the first time. I felt that I could not deliver this lecture without having done so. I talked to people in Aysgarth, including one of Will Pickles' patients, and she produced a copy of his famous book *Epidemiology in Country Practice*[20] with a handwritten message to herself.

I hope that I have, in true West of Scotland fashion, not only delivered more of the reality of standards in general practice, but also provided a vision as to how this can be taken forward. Proposals in the recent White Papers[21,22] will be helpful to the vision in, for example, clinical governance. There will always be tensions between various bodies within the general practice community. Summative assessment ultimately became a professional leadership unity issue, and I am sure that this degree of working together would take other issues forward for the benefits of patient care. I think I should finish with one of Burns' quotations about working together, and that is:

It's comin' yet for a' that
That Man to Man the world o'er
Shall brothers be for a' that

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