

Revalidation

At its meetings in November 1998 and February 1999, the General Medical Council (GMC) decided that 'revalidation' will become a reality.¹ This follows directly from the high-profile paediatric surgery cases in Bristol, and the resulting loss of confidence by the public and the media in professional self-regulation.^{2,3}

To be effective, a system for revalidation must, first and foremost, be credible with the public. To earn that credibility, it must reliably identify doctors in hospitals and general practice who are underperforming. From our perspective, it must be a system that has the support of the profession; that is a positive experience for the vast majority of good doctors, helping them to develop their skills and services; and that is practical. If it succeeds in meeting these objectives, revalidation should be welcomed.

The introduction of such a system of revalidation into general practice will be no mean task, but I believe it is possible and that general agreement must be reached. In a survey of general practitioners (GPs) conducted by the General Medical Services Committee in 1992, 67% of GPs expressed support for a system of continuing accreditation.⁴ The two alternatives — a contractual process organized by health authorities, or no revalidation process at all — would be unacceptable to the profession and to the public respectively.

As a discipline; we have been preparing the ground,⁵⁻⁸ and we have the experience of other countries from which to learn.^{9,10} For many years, the Royal College of General Practitioners (RCGP) has been developing ways to identify quality of care in general practice.¹¹ We played a key role in creating the system for the appointment of trainers and training practices. We have developed the examination for membership, Fellowship by Assessment, and the Quality Practice Award. This spring we launch Membership by Assessment of Performance; we are actively developing ways in which GPs can demonstrate their professional development, and ways in which practices can show continuing team development.

Inevitably, the profession and the public will look to the RCGP to offer leadership in revalidation. We are ready to provide that leadership. We will work closely with all bodies — political and educational — involved in general practice, not least the General Practitioners Committee, to ensure that revalidation is relevant and effective.

If professional self-regulation had been sufficiently effective in the past, we would not now be facing revalidation. We have always taken standards for qualification from medical school seriously. Only in the past few years has summative assessment at the end of vocational training been mandatory, and even then the Joint Committee for Postgraduate Training in General Practice has accepted a standard that is lower than the examination for MRCGP.

Until now, continued fitness to practice through the next three decades has been largely taken for granted. For most of us, 'self-regulation' has not been regulation by our profession, rather it has been regulation from within ourselves as individual professionals. Despite this, the vast majority of GPs deliver a lifetime of high quality care in often stressful and demanding circumstances. The numbers of underperforming doctors are thought to be small,¹² and British general practice has much that it can be proud of. Our Achilles' heel lies in the fact that we cannot offer assurance to the public that all GPs are fit to practice.

What sort of system do I visualize? Since it will take about

two years to get revalidation up and running, it is difficult now to be too precise. However, I think that an outline is emerging. All GPs will take part in clinical governance and, through that process, will continuously collect material that shows continuing professional development. This material will show how GPs' educational needs are met and assessed, how it reflects on their quality of care through audit and case discussions, and how professional values are implemented in their practices. Most of the evidence for revalidation will be by self-assessment using material already compiled for clinical governance. In addition, each doctor may have to demonstrate acceptable communication skills. Revalidation will also have to include an element of assessment against minimum standards of clinical performance. Again, this will probably consist of providing statistics that would be known to the primary care group (or their equivalent in Wales and Scotland), the health authority, or local trusts.

The great majority of doctors should not find this process disruptive; on the contrary, they should find it a useful stimulation to good professional practice and a celebration of the quality of their care.

A peer group would examine each submission for revalidation and would identify those that gave cause for concern. These, and a proportion — perhaps one in ten — of the doctors, who did not give cause for concern, would then be visited. Where shortfalls in performance are found, local colleagues, especially those involved in education, would be called on to offer support. It is my hope that most such doctors will be helped to improve their care and become eligible for revalidation. Only if that were not the case would a referral to the GMC, and possible restriction on the right to practice, be contemplated.

The role of patients in revalidation is still under discussion. However, it is my view that patients need to be involved in all stages of revalidation if the system is to be credible.

This outline of revalidation is, of course, fluid. However, it does appear to meet the four key requirements that I set out earlier. It should command public support and it should reliably identify underperforming doctors. It should be a way to encourage professional development of individual doctors and it should be realistic.

There are many unresolved aspects in this vision, the most important of which is resources. Inevitably, there will be substantial costs in terms of time and money. It is too early to look for a solution to the resources issue; however, it must be addressed satisfactorily before a system of revalidation can be put in place.

We will need a generalist register — equivalent to the specialist register that already exists — to augment the GMC's basic register, and we will need a statutory body to oversee that new register.

These and other technical issues are important, but not essential. The essential issue is that GPs see the inevitability of revalidation, start to debate how it might be best delivered, and then work together to make it a success. The RCGP intends to work with all the other national bodies that represent general practice to ensure that revalidation operates in the interests of patients and the profession alike.

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References

1. General Medical Council's Revalidation Steering Group. *Report of the Revalidation Steering Group*. London: GMC, 1999.
2. Smith R. All changed, changed utterly. *BMJ* 1998; **316**: 1917-1918.
3. Treasure T. Lessons from the Bristol case. *BMJ* 1998; **316**: 1685-1686.
4. Electoral Reform Society. *Your choices for the future - a survey of general practitioner opinion*. London: General Medical Services Committee of the British Medical Association, 1992.
5. Richards T. Recertifying general practitioners. *BMJ* 1995; **310**: 1348-1349.
6. Houghton G. General practitioner reaccreditation: use of performance indicators. *Br J Gen Pract* 1995; **45**: 677-681.
7. Westcott R. Improving continuing medical education and addressing the challenge of instituting reaccreditation. *Br J Gen Pract* 1996; **46**: 43-46.
8. Campbell L, Murray T. Assessment of competence. *Br J Gen Pract* 1996; **46**: 619-622.
9. Nicol F. Making reaccreditation meaningful. *Br J Gen Pract* 1995; **45**: 321-324.
10. Salisbury C. The Australian Quality Assurance and Continuing Education Program as a model for the reaccreditation of general practitioners in the United Kingdom. *Br J Gen Pract* 1997; **47**: 319-322.
11. Anonymous. *Recognising quality of care in general practice*. London: RCGP, 1998.
12. Taylor G. Underperforming doctors: a postal survey of the Northern Deanery. *BMJ* 1998; **316**: 1705-1708.

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Expanding the role of the family history in primary care

HISTORICALLY, general practitioners (GPs) have asked patients about their family history to gain insight into their social background. It helps to provide a context for a patient's symptoms, both in terms of possible environmental and lifestyle causes of disease and the patient's concerns about the nature of their illness.¹ Taking a family history is a traditional part of undergraduate medical education, and questions about family history are commonly asked at patient registration in general practice. Patients already view their family history to some extent as a predictor of their personal risk of disease, linked to their beliefs about inheritance.² Recent advances in molecular medicine and its use in assessing genetic risk mean that GPs will have to share this view of the family history.³

Until now, primary care has had little involvement with genetics. A potential role for general practice in genetics has been demonstrated in screening for common recessive disorders such as cystic fibrosis^{4,5} and haemoglobinopathies.⁶ Discoveries about the genetics of common diseases are beginning to have an impact in primary care, particularly in relation to hereditary cancer. Media attention surrounding predisposing genes for breast and bowel cancer has the potential to generate anxiety among people with a family history of cancer. In the United Kingdom (UK), a GP will have an average of 40 to 50 patients aged 35 to 64 years with at least one relative with a common cancer;⁷ however, the vast majority of these patients will not be at significantly increased genetic risk of cancer. The cancer susceptibility genes for bowel and breast cancer (*APC*, *HNPCC*, and *BRCA 1* and *BRCA 2*) are dominantly inherited, and thus the family history is the best predictor of carrier status.⁸

Family history-taking in general practice is likely, therefore, to extend from exploring purely psychosocial issues to including genetic risk assessment.⁹ Furthermore, it will be useful for assessing the risk of a wide range of diseases. Family history information about thromboembolic disease is a good predictor for the factor V Leiden mutation and should be considered when prescribing combined oral contraceptives.¹⁰

As the genetics of cardiovascular disease and diabetes are further elucidated, information about these diseases in patients' relatives will help tailor preventive strategies and inform appropriate screening for these conditions.¹¹ Although the use of the apolipoprotein *e4* allele as a diagnostic test for Alzheimer's disease is not yet recommended,¹² it may become a method of predicting the response to the new range of drugs for this condi-

tion, allowing more rational decisions to be made about the purchase of such treatment.¹³ However, if such genetic advances are to be implemented in general practice, they must be accompanied by the necessary resources and appropriate educational strategies. The surrounding ethical implications of these developments have been discussed already in the *Journal*.¹⁴ Concerns have been expressed about confidentiality of genetic information within a family, and in relation to insurance companies and employers. Equally, the whole concept of autonomy is brought into question, since the decision to undergo genetic testing has implications beyond the individual.¹⁵ Despite these ethical dilemmas, however, a recent citizens' jury on genetic testing recommended proactive family history recording by the primary health care team.¹⁶

With this change in emphasis towards using the family history as a genetic tool, questions have been raised about when precisely GPs should gather this information. One school of thought is that the family history should be viewed as a screening tool¹⁷ and, as such, should adhere to the criteria defined by Wilson.¹⁸ On this basis we should only actively enquire about a patient's family history if there is good evidence that an effective intervention exists to manage a 'positive screen'. Using the example of *BRCA* genes, there is no definitive evidence for any of the current recommendations regarding management of gene mutation carriers.¹⁹ Advice to *BRCA* mutation carriers about screening and disease prophylaxis depends on expert opinion only. The logical consequence of this view is that doctors should only discuss family history of breast cancer if the patient raises the issue herself. However, this line of argument ultimately precludes doctors from proactively enquiring about a patient's family history of most diseases.

In a sense, this returns us to the issue of why doctors ask about family history. There is evidence that GPs have not yet made the shift from using the family history purely as a method of social assessment to a genetic risk predictor (Kumar, personal communication). The family history is, however, valued as an aid to decision-making for certain common symptoms.²⁰ It is unclear, though, whether this reflects an assessment of genetic risk or an exploration of shared environment and individual patient concerns. A possible way forward in the integration of both types of information is the genogram, which is being taught in some medical schools in the UK.²¹

As genetic advances slowly pervade primary care, there may

be a shift in emphasis towards using the family history to assess genetic risk, but it would be wrong to presume that it will cease to function as a psychosocial tool. We must be careful, when applying the Wilson criteria to the family history, in assuming that it acts purely for genetic risk assessment, since its psychosocial use cannot be considered in terms of screening alone. The family history in primary care should be seen as a multidimensional tool that allows us to examine patients' concerns and explore the role of both nature and nurture in the aetiology and prevention of disease.

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References

1. Brorsson A, Rastam L. The patient's family history: a key to the physician's understanding of patients' fears. *Fam Pract* 1993; **10**(2): 197-200.
2. Ponder M, Lee J, Green J, Richards M. Family history and perceived vulnerability to some common diseases: a study of young people and their parents. *J Med Gen* 1996; **33**: 485-492.
3. Kinmonth AL, Reinhard J, Bobrow M, Pauker S. The new genetics: implications for clinical services in Britain and the United States. *BMJ* 1998; **316**: 767-770.
4. Harris H, Scotcher D, Hartley N, *et al*. Cystic fibrosis carrier testing in early pregnancy by general practitioners. [Comment.] *BMJ* 1993; **306**: 1580-1583.
5. Watson EK, Mayall E, Chapple J, *et al*. Screening for carriers of cystic fibrosis through primary health care services. *BMJ* 1991; **303**: 504-507.
6. Neuenschwander H, Modell B. Audit of process of antenatal screening for sickle cell disorders at a north London hospital. *BMJ* 1997; **315**: 784-785.
7. Johnson N, Lancaster T, Fuller A, Hodgson SV. The prevalence of a family history of cancer in general practice. *Fam Pract* 1995; **12**(3): 287-289.
8. Rose PW, Suchard MA. Screening people with a family history of cancer. Taking a family history in primary care is important [Letter; comment.] *BMJ* 1997; **315**: 1306.
9. Pyeritz R. Family history and genetic risk factors. Forward to the future. *JAMA* 1997; **278**: 1284-1285.
10. Middeldorp S, Henkens C, Koopman M, *et al*. The incidence of venous thromboembolism in family members of patients with factor V Leiden mutation and venous thrombosis. *Ann Int Med* 1998; **128**: 15-20.
11. Bell J. The new genetics in clinical practice. *BMJ* 1998; **316**: 618-620.
12. American College of Medical Genetics/American Society of Human Genetics Working Group on ApoE and Alzheimer disease. Statement on the use of apolipoprotein *e* testing for Alzheimer's disease. *JAMA* 1995; **274**: 1627-1629.
13. Richard F, Helbecque N, Neuman E, *et al*. ApoE genotyping and response to drug treatment in Alzheimer's disease. *Lancet* 1997; **349**: 539.
14. Sweeney B. Genetic advances: great promise tempered with concern. *Br J Gen Pract* 1997; **47**: 544-555.
15. Wilcke JTR. Late onset genetic disease: where ignorance is bliss, is it folly to inform relatives? [In process citation.] *BMJ* 1998; **317**: 744.
16. Welsh Institute for Health and Social Care. *Report of the citizens' jury on genetic testing for common disorders*. WIHSC, 1998.
17. Wellcome Trust. *Report of the Consensus Meeting on the Management of Women with a Family History of Breast Cancer*. London: Wellcome Trust, 1998.
18. Wilson J, Junger G. *Principles and Practice of Screening for Disease*. Geneva: WHO, 1968.
19. Burke W, Daly M, Garber J, *et al*. Recommendations for follow-up care of individuals with an inherited predisposition to cancer. *JAMA* 1997; **277**: 997-1003.
20. Summerton N, Garrood PV. The family history in family practice: a questionnaire study. *Fam Pract* 1997; **14**(4): 285-288.
21. Waters I, Watson W, Wetzl W. Genograms. Practical tools for family physicians. *Can Fam Physician* 1994; **40**: 282-287.