PACman and Mrs MOPS

– a challenge to educational orthodoxy

Ian St George

Why do so many of us have a sneaking feeling we are barking up the wrong tree with these recertification activities, participating for the sake of appearances rather than really for the sake of self-improvement? For that is the feeling out there in the real world. It is easy for those of us who inhabit the inner circles of Faculty Boards, IPA boards, academic departments and College Council, peopled by supporters and devotees and converts, to be smug, to feel secure in the rightness of what we are doing.

But there is resistance to many MOPS activities and the rising cost of compliance with third party requirements. It is smothering modern general practice, and that is not what it was intended to do. Read Roger Neighbour, for instance:

People at the top of the power pyramid – politicians, managers, regulators, the devisers of guidelines and protocols – wish, for the best reasons, to make those of us at the bottom buck our ideas up in the name of raising standards. Unfortunately, because they are too busy to understand the complexity of what we do (or too besotted with innovation), the top people resort to oversimplified rules and models, whose rigidity stifles vitality, undermines common sense, and saps motivation. On every problem, so the Zeitgeist would have us believe, a solution must be imposed. But now the proliferation of solutions, each understandable in its own local context, has itself become the problem; enforcing improvement is the greatest obstacle to securing it." (BJGP 2001; 51: 514).

A recent correspondent told me, "The silly part is that I am far from the only one who finds the (College's) doctrinaire approach a bit like joining Rotary, or the Freemasons, or a religious order. It's great, if you are that way inclined." But many of us aren't.

Certainly, isolated doctors are more likely than others to deteriorate in competence. Equally certainly in the past doctors who taught, who attended CME, who did clinical audits, who undertook research (you know the list) were shown to have high clinical standards. They were also the ones who did the research on the association between participation and standards. Why not then (the MOPS argument goes) insist everyone participates, so everyone will achieve high clinical standards? Well, because that argument is logically flawed, that's why not.

Let's say we have two groups of GPs – Group A participates in CME, audits, patient satisfaction surveys etc. and shows (let's say) 80% of its members have high standards of practice. Group B doesn't do those things, and the Group A research shows only 60% of Group B members have high standards of practice.

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Clearly (if the research was truly unbiased) Group A is on average better than Group B. The inference that Group A's activities, if applied to Group B, would bring them up to 80% would rely on a cause-and-effect that may not be true. The suggestion that Group B should participate in those activities ignores the fact that 60% of Group B were already practising to a high standard *by employing different methods.*

The concept of continuous quality improvement (CQI) was borrowed after development in Japanese car factories, where people worked alongside each other, observing and overseeing each other's work. The theoretical model shows a gaussian curve of quality range shifting completely to the right as a result of CQI. But how applicable to general practice is such a model really? We practise in relative professional isolation, unobserved, overseen only at a distance. Has anyone shown our gaussian curve shifts at all? Or if it does, that the 'low quality' tail improves?

CME doesn't work very well in changing behaviour, we all know that. And anyway many find the College guidelines for approving CME doctrinaire and patronising. I like listening to lectures, I don't need 'balance' in

presentations (I am old enough to provide my own balance to counter an unbalanced presenter). The evidence for the College guidelines is slim when you look at it – yet I acknowledge we need some kind of guidelines or the fringe practitioners will claim points for colour therapy conferences.

Assessing one's own learning needs is quite inaccurate, as Jocelyn Tracey showed. Years ago this point was made and the ingenious but ingenuous 'triadic method' was mooted. But why do we continue to reward the isolated preparation of a 'professional report and plan'?

Popularity with one's patients does not signify clinical competence – we all know genial fools. So why do we require DISQ/BPPQ? What does it really measure? How was it validated, and was any correlation with clinical competence ever demonstrated?

Popularity with one's patients does not signify clinical competence.

There are those who wish to determine a minimum clinical load (three-tenths, say) required for MOPS. We will have trouble applying such a criterion to part-timers – academics, managers, mothers, retired piece-workers etc. – whose Fellowship should be associated with continuing vocational registration for their sakes and ours.

These Fellows may not be doing three-tenths clinical work, and may not be able to do realistic audits. We can't in all sincerity go on letting them count activities like bringing up children, publishing research, participating in pilot reviews of their premises and systems, lecturing, managing etc. as evidence of clinical competence; and the solution is not to 'demote' these groups to general oversight.

I learn best when I become aware of a learning need during a consultation, and I look it up on the web or in my Harrison, read it and remember it. Theoretically perfect learning: problem-oriented, temporally related to the problem stimulus arising, instant response, effective assimilation. Next best is informal consultation with colleagues in the corridor, at lunch or over a beer.

Next best is reading journals. Sure I tot up the hours of CME (most of it not 'approved') and I try to do some audits, but I gain nothing from the exercise apart from mildly obsessive satisfaction with the symmetry of the numbers.

Actually, when I ask around, there are a lot of academic GPs and College leaders in the same position.

I don't have any major argument with the College regarding participation in MOPS activities as a *good thing*, a bonding collegial activity, fun, or whatever. But there is another small issue and it's called Section 63 of the Medical Practitioners Act 1995. It requires that by 1 July this year we were all enrolled in a recertification programme that would *ensure* (my italics) that we were competent to practise general practice (and hey, listen, that means the *clinical medicine* of general practice – the Act is about protecting the public).

Such a programme (read it in S63) may require us to pass an examination, complete a period of practical training, undertake a course of instruction, permit another registered health professional to examine our clinical practice, our relations with other health professionals and our records, undergo an inspection or assessment, adopt and undertake a systematic process for ensuring our services are of an appropriate quality, or "anything else the (Medical) Council considers appropriate". No mention there of a lot of the activities of MOPS.

Are we out of kilter with the meaning of the Act? Have we misread the intentions of the lawmakers? Not really: MOPS was in place before the advent of the Act, and that may be the problem. It was set up to bolster collegiality, to transfer to a professional discipline the industrial concept of continuous quality improvement (however appropriately).

It began before, but developed along with the 1990s reforms, with the application of business principles to medicine. It was not set up to *ensure competence*. MOPS can never *ensure* that we are competent. MOPS is a range of activities, many of which used to be associated with high levels of clinical competence when only people with high levels of clinical competence participated in them.

We don't know what to do with those who 'fail' or refuse to participate in MOPS, and we are not keen to report them to the Medical Council as incompetent and needing a competence review.

The answer

The solution might be to offer two kinds of College recertification programme: a Fellow could choose either for the purposes of maintaining Vocational Registration.

1. *MOPS:*
   At least 3/10 clinical practice, PRP, DISQ/BPPQ, CME, audits, etc. in a cycle as at present.

2. *Periodic Assessment of Clinical Competence (PAC):*
   No diary keeping, no *required* interval activities – just an assessment every five years. The assessment might include the MCQs of Primex, and a practice visit that combined the current Fellowship visit with some of the activities in the Medical Council's competence reviews (case-based oral, for instance). Realistically those choosing this path would continue to keep up in the ways they always did, and that might include formal CME. But if we accept PAC is a pure assessment-based pathway, we should not defeat its purpose by *requiring* them to engage in any such activity. The assessment would of course go further, and provide a formative feedback that informed Fel-

lows of their educational needs (much more accurately than the current professional report and plan), and guided them in their interval activities.

Funding

The portion of the annual sub that goes to support MOPS would have to be made available to those choosing PAC, but otherwise participants would pay (as MOPS participants do for CME and audit tools now).

Registration

The concept of PAC is acceptable to the Medical Council's Education Committee.

Failures

1. Those who 'failed' MOPS (i.e. did not keep an adequate diary of their activities etc.) would have an avenue for proving their competence.
2. Those who 'failed' a summative PAC might have a chance to appeal or to resit after a period of focussed education and updating, but if the 'fail' were maintained (or was especially bad) they would have to accept general oversight, or referral to the Medical Council's competence section. If a Fellow were to dispute a finding of incompetence on the basis that we did not have any proven reference thresholds for competence we would have to defend our judgement; I have no doubt we could do that on the basis that the assessment tools are used elsewhere in the College processes (and thus in turn to advise the Medical Council), are used by the Medical Council for its competence reviews, and are used overseas for the same purposes.

Shortcomings

Any assessment must be valid, reliable and practical. No method is perfect, but using a range of methods reduces the likelihood of unfair failures or improper passes. PAC would have shortcomings: so does MOPS.

Established GPs wanting to join the College

This method could be used to assess the competence of new applicants for College Fellowship from established general pratitioners. Our current requirements that they participate in AVE activities could be criticised in the same way as MOPS.

Conclusion

The College should explore offering a choice of MOPS or PAC to Fellows, and offering a choice of AVE or PAC to new entrants from abroad.

A comment from Philip Barham

Dr Philip Barham, the doyen of continuing education for general practice in New Zealand, was the foundation Director of the Goodfellow Unit in the University of Auckland. He is now an elected member of the Medical Council.

Very early in the development of what has become the current MOPS programme there was a debate about the purposes of any professional development programme. The College came down heavily in favour of the continuous improvement model (CQI) as against a system of trying to identify the 'bad apples'. This was seen as having the potential to shift the whole curve to the right and even dragging the tail up with it. There is also evidence that any system which measures people against a minimum standard can actually drag down the standard of the group as a whole.

Dr St George's suggestion avoids both of the problems above, as well as giving some added bonuses.

First, what we know and *can* do is not necessarily what we *do* do. I have certainly learned new and better ways of doing things, but when the opportunity to put them into practice came along, I have reverted to my old habits and only remembered later that I had learned a better way. Second, the content of our practices varies. An assessment of our current practice will put the emphasis on the things we are doing without us having to show our expertise in areas we rarely have to deal with. So it will be entirely relevant to our particular practice.

Of course there are things which we must keep on top of even though they may be seen only rarely. In addition, there are always new developments of which we must keep abreast. For this reason I am not sure that sitting Primex is the best option for established practitioners.

I would rather see a paper which combines some questions on the rare but important emergencies in general practice, with some questions on recent developments. This would help to ensure that practitioners were:

- good at what they are doing
- able to deal with those rarer emergencies and
- keeping abreast of the recent developments.

This would be much more relevant for the purposes of the Act as well as both easier and more relevant for the practitioners.

Finally, I recently heard some surgeons mention that they had collegaues who might not do a procedure for two or three years but would then do it perfectly, while others could do it every day and still not do it well. I suspect the same is true for GPs. What we do is what is important, not how much time we spend doing it.

I am sure some very good GPs would be disadvantaged by a three-tenths minimum requirement. The above assessment proposal would detect part-timers who were not performing well without an arbitrary time factor having to be introduced.

Incidentally, I would change the name to Periodic Assessment of Performance (PAP) rather than PAC as the assessment of performance would be the main factor rather than the paper section which is the only competence component.

A comment from Lorna Martin

Lorna Martin is the Chairperson of the RNZCGP Professional Development Committee

It is very stimulating for all general practitioners to consider the implications of the Medical Council's expectations. Dr Ian St George raises some interesting concepts. He favours the format of a Competency Assessment on a regular basis (he mentions a five yearly cycle), rather than the present RNZCGP/MOPS focus on a continuing quality improvement process.

The RNZCGP endeavours to encourage collegiality, helping each other to improve our ability to practice medicine, evidence-based and acceptable when subject to peer review.

Competency is a concept that sounds simple, but proving it is a path littered with explosives. What is competency in terms of the practice of family medicine?

What parameters define a competent general practitioner, and from whose viewpoint, the doctor, his or her peers, or the general public, the consumer? Can competency be assessed using only a few methodological approaches as indicated in the PAC concept?

In a recent article Patterson, Fergusson et al (BMJ 2000; 50:188–193) reviewed the competencies deemed important for a general practitioner. They identified three areas of competency that, to the researchers, were important in practice. These were:

1. interpersonal
2. diagnostic
3. management

These areas all involve the doctor and the patient. Each views competency from a different perspective. PAC has a strongly doctor or medical perspective. But what of the patient's view? This is not assessable from an examination, or from a review of the medical notes.

Patient feedback (DISQ/BPPQ) may not always be palatable, but it does allow us, as doctors, to see ourselves as others see us. Do we listen to the patients empathically, involve them as much as possible in decision making, and encourage them to achieve 'informed' understanding of the issues surrounding their health problems? Examinations of the doctor avoid this aspect of medical care. Mrs MOPS does not.

Peer involvement and review is accepted by all medical colleges as a valid tool to measure the behaviour of one individual against the norm of a group of his/her peers. What would 'Dr Average' do in this specific situation? Involvement in peer groups on a regular basis exposes doctors to the opportunity for comparison of their practising habits.

There is evidence that contact with other doctors is the most effective way to change behaviour. At least this is so for those doctors who are open to the learning process. This is well documented (references available if requested). Small group discussion can be effective provided the doctor is open to looking at his/her practice.

Competency is a concept that most doctors aspire to achieve and maintain, however that is defined. It is, I believe, difficult for an examination to assess competency in the multifactorial occupation called 'general practice of medicine'.

Is the examination that is set to the required standard for passing Primex an adequate standard for an experienced general practitioner? Should it be more intense; should it be less? Remember that being competent is being 'properly qualified to do'. Would you, as a patient, expect more from a senior general practitioner than a registrar? And if a 15 year plus general practitioner failed the examination, is he/she incompetent or did they simply not have time to look up the relevant data, as they would have in their rooms?

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As for the actual examinations that PAC offers, are they validated for experienced doctors? Do they allow for the variety of types of practice that doctors provide.

It appears to me that if the examination is set at the level of the Primex examination it could be accused of setting a minimal standard that has not been validated or benchmarked for experienced general practitioners.

Remember that by establishing competency or its absence, one places the Medical Council in the situation of having to do something about it. At present the Medical Council has accepted the MOPS participation programme as evidence of an activity suitable to maintain vocational registration.

Dr St George may be correct in that the system may change and require more than participation. However, it may not. The College is not looking to bury its head in the sand, but it is aware that there are multiple stresses on all doctors.

Maintaining vocational registration (and obtaining it) needs to be available and as stress-free as possi-

ble. But it also has to show that the doctors are aware of all the aspects intrinsic to the consultation, after all that is what we do all day.

The College acknowledges that not all doctors have the same needs; some doctors may well prefer to sit an examination as part of the requirements for the Medical Council. MOPS would have little difficulty adjusting to this being a possible pathway to fulfil some of the requirements (once the examination has been validated to show that it is a reliable tool). To return to the main focus of the CQI based MOPS programme, participation demonstrates intent to achieve quality improvement, it sets no pass/fail, it sets no penalties. It encourages the use of a wide variety of methods to participate in quality improvement. There are few limitations to personal choices; special interests are encouraged. What is so onerous?

The College looks forward to a healthy debate of the issues. The feedback from a large number of Fellows involved in the MOPS programme is that it is easy to follow, no major stress to achieve the requirements, and that the proposed compulsory elements are all relevant to general practice. The MOPS focus is quality improvement not competency assessment. The proposed PAC potentially puts doctors' ability to maintain vocational registration directly at risk; a pass or fail could have far reaching consequences. Do we not need to be given more information before PAC can be considered more seriously? No mention has been made of the cost to individual doctors to participate in this programme. Finally, the RNZCGP promotes professional development. This is multifactorial and appropriate to the practice setting, and more appropriate to the development of general practice as a true specialty in its own right.