Continuing Professional Development or Compulsory Re-accreditation?

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Rodger Charlton qualified from Birmingham. During vocational training in Nottingham he completed an MPhil thesis in Medical Ethics and shortly afterwards became a GP principal in Derby and part-time lecturer in General Practice at Nottingham University. In 1991/2 he was a visiting Fellow at the Department of General Practice, University of Otago Medical School, researching into the perceived needs of undergraduates in palliative medicine education. This formed the basis of his MD thesis.

In 1994 he was appointed as a senior lecturer in primary health care at the Postgraduate School of Medicine, Keele University, and in 1995 he took over a single-handed general practice in Hampton-in-Arden, close to the Warwickshire border. In 1996 he started working as a research fellow at the NHSE GP Unit and was involved in creating a palliative care training programme for GP registrars. In 1997 he became a GP trainer and in 1998 he became editor of the RCGP Members' Reference Book (MRB) for two years. He is now acting editor of RCGP publications excluding the journal and MRB.

Research interests and published papers are in palliative care, bereavement, and meningococcal disease, but there is a strong focus on research in education and professional development in primary care. In September 2000 he was appointed as senior lecturer in continuing professional development at Warwick.

As a profession we have been internally accountable for generations. With many changes in medical practice, perhaps more appropriately referred to as health care practice, the difficult and multiple dilemmas experienced by practitioners are regularly exposed to media scrutiny. There is therefore a recognition by the profession and a call by the public (potential patients) for external accountability. This is as a result of human error, clinical negligence, those who have blatantly transgressed ethical boundaries and now in the UK the exposure of the ex-GP and serial killer, Harold Shipman.

Maintenance of Professional Standards (MOPS) and so compulsory re-accreditation in New Zealand and Accredited Professional Development (APD), which is the voluntary equivalent in the UK, are a result of rapid transition in thinking by the public, politicians and practitioners. The ultimate question is whether these processes of Continuing Professional Development (CPD) which form the basis of re-accreditation or revalidation will make us better or more competent practitioners.[1] Or are we a group of individuals who are having to jump through yet more hoops for the sake of outward appearances rather than self-improvement?[2] Many GPs are already involved in providing good practice and caution is required as these new processes have the potential to stifle their CPD which until now has been voluntary and individual to each practitioner.

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Medicine and general practice are changing dramatically in relation to the workforce, which these new processes of re-accreditation may unintentionally penalise. Medical schools have an increased intake of females, and many GPs are now involved in academic roles: undergraduate and postgraduate teaching and research. Both are important developments in practice to increase quality, but the resultant practitioners may require a reduced clinical load. As potential 'part-timers' they may have difficulty in accumulating the 'credits' necessary to ensure processes of re-accreditation. Unfortunately, their non-clinical activities, many of which increase the skills of a family physi-

cian, whether that be as a parent or a teacher, are not viewed as 'approved' or accredited activities.

Methods of 'policing' CPD include clinical governance and imposed clinician credentialing by stakeholder influence whose purpose appears to be more for the protection of health organisations against legal risks than may benefit the public. It is time for general practitioners to act to reaffirm and restore their professionalism which is presently being eroded away, and the implicit relationship of trust that should exist between the profession and the public.[3] We would all aspire to raising the overall standards of clinical performance, but some of the methods proposed, e.g. 'report cards' for surgeons, can restrict innovation.[4] Issues of performance and quality can be difficult to identify in general practice, and careful thought is required about any system introduced to reassure consumers about quality of a health care system.

However, there is a need to move away from the 'Bolam type' reasoning where groups of practitioners alone set standards of care. A balance is required to involve the public and politicians.[5] This can lead to the much desired external accountability and basis for performance management espoused by the media to set standards or clinical governance. However, a proviso has to be made in a health service where pace is gaining momentum and there is an ever increasing expectation of the public given new technologies and medications, that resources are limited. Somehow service priorities, standard setting and performance management have to be knitted together.[6]

> Practitioners should be allowed to choose a method of assessment of competence

MOPS or periodic assessment?

There is an argument for periodic assessment of clinical competence (PAC) rather than MOPS. If this were done on a five yearly basis it would be up to the individual practitioner to decide on the learning strategies used to ensure their own personal and professional development. It would, however, overcome the compulsory MOPS and allow each practitioner to organise their own CPD. This raises the question of how an assessment of competence can be made. This can be viewed in terms of basic and specialist competence.[7]

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In relation to basic competence, a 'core curriculum' and assessment therefore needs to be defined for all doctors, whether working in primary or secondary care. Anyone who acquires the necessary qualifications to obtain medical registration and so uses the honorary title 'doctor' should be expected to have certain core knowledge and skills. Many examples can be used to illustrate this, but one that immediately comes to mind is being able to attend to a person who collapses in the street. 'The good doctor' is a subjective notion, one perceived by the public, patients (participants in health care) and one that can also be defined objectively in terms of demonstrating competence theoretically. Similar examples should be defined for inclusion in specialist registers as determined and promoted by postgraduate colleges.

Unfortunately, such a tool or assessment only ensures competence theoretically and not practically in terms of performance. This is where PAC could be criticised, but in order to promote CPD built on a culture of life-long learning, PAC could provide formative feedback to guide practitioners in their learning activities. In this way a measure of external accountability is provided. Just as all practitioners have different learning methods, they should be allowed to choose a method of assessment of competence, and so a choice between MOPS and PAC and their equivalents in the UK. This is important as performance in an assessment is not necessarily determined by competence, but the method utilised. This is partly illustrated by a recent survey of GPs where not all (70%) feel that the MOPS programme is currently pitched at the right level and so a rigid system should not be adopted.[1]

There are financial issues in running a scheme to maintain professional standards and providing periodic assessments of clinical competence. Ideally, this requires a trained number of peers in the art of appraisal, perhaps a method of assessing competence, but more than this, payment of these peers and protected time for practitioners to take part. What happens about financing time out of practice to 'rehabilitate' those who 'fail'? And who assesses the assessors and how is quality assured of the assessment tools used?

Changing the focus

Perhaps the question should not be how to attain re-accreditation, but rather to identify 'poor performers' and so those who may require 'rehabilitation' by our professional bodies. Two types of poor performers should be determined. Those who are aware of deficiencies in competence in a particular defined area, so-called conscious incompetence. They can perhaps be re-accredited for one year rather than five and have their competence reassessed after a year with protected time to develop in their individual area(s) of learning need. The group of particular concern are those with unconscious incompetence. What of these doctors? What will happen to their patients and practices in times of difficulties of recruitment and retention, and what will be the effect of the pressure that im-

pacts on the surrounding practitioners who remain?

There are no obvious answers as to which way forward general practitioners should go and to a large extent the choice is not made by them as 'coal face' workers. I think it is true to say that neither New Zealand nor the UK has the ideal system for compulsory re-accreditation and thus CPD. However, they are both in a position to learn from each other and perhaps this is an opportunity for some comparative research.

A point that should be emphasised and one that is overlooked by our professional bodies, is that the need for CPD arose from industry and is promoted by political spin. This should not be viewed as the last straw, but a way forward for a profession deprived for years of time to develop through an excessive workload and minimal resources. GPs must insist on the funded, protected time off to 'develop'. There is then an incentive for CPD, rather than just re-accreditation. Morale, enthusiasm, skill development and self-esteem will increase, together with the ultimate aim of both Royal Colleges of General Practice in New Zealand and the UK. This is fulfilling the shared College motto, *Cum Scientia Caritas*, translated as "scientific skill with loving kindness" for their patients.[8]

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