Editorial

The maintenance of professional competence

– Let's use the necessity to emphasise the virtues

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During the Auckland conference, Annie and I went into a florist's shop to send flowers to our daughter. As she was making up the posy, the florist asked what we were doing and the two of them discussed why the doctor was attending the conference. "I suppose you have to go to courses to keep up to date," Annie asked her. The florist bridled and declared, "I've been a florist for more than twenty years! I don't need to go to courses!"

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The theme of this issue is *Continuous Professional Development* (CPD) and the assumption behind that term is that general practitioners cannot take the attitude of the florist.

When I graduated in Glasgow in 1966 it was assumed that my medical degree was a lifetime licence to practise general practice until I retired or decided to become a specialist. That view was based on the premise that general practice is simply medicine practised on a smaller stage – an impression held by those who have either never worked in general practice or have forgotten what it is like, and still held dear by our politicians and those who manage our health system.

Yet medicine's best kept secret is just how much of its total task is carried out in the general practice consultation. As a full-time rural general practitioner, I participate in around 5 000 consultations a year with people of all ages and conditions, and deliver emergency care to a wide area. For most of that time, the only judge of what I do is the patient, and usually the patient does not have the experience or the inclination to judge whether or not I am competent.

The longer I am the doctor to the patient, the more the friendship can compensate for my incompetence. I can assure you that incompetence and poor performance is a constant feature of my day-to-day practice. Yet in 1999 I was allowed to enter a rural practice including immediate care of emergencies and trauma and intrapartum obstetrics without any recertification process.

> The bottom line is… that there has to be recertification… for the sake of our patients

The capacity for harm and danger is immense and the bottom line is therefore that there has to be re-certification, not for the sake of the Medical Council or the Government but for the sake of our patients.

So that's why we have MOPS

Of course the reason why our College has moved to a system like MOPS is not only to do with doctor competence and performance or with patient safety but also with becoming an establishment organisation.

A few years ago, the College made the key decision to transform itself from a group of enthusiastic volunteers into a modern and professional organisation. That decision changed us from counterculture into part of the establishment, and part of the deal if you join the establishment is that you play according to the rules.

Only then will you be given the responsibility by other establishment bodies such as the Medical Council or the Ministry of Health to order your own affairs.

Long ago, Gayle Stephens[1] wrote about the future of family medicine as counterculture, and in that fine exposition he explored the differences between a sect and a church.

Sects have only committed believers whereas anyone can join a church as long as you pay the dues and obey a few simple rules.

Sects have spontaneous outbursts of enthusiasm whereas churches insist that you use the prayer book and that only an ordained minister can lead your service. So now the College has ordained staff to do its bidding, and a Professional Development Unit exists within head office, charged with managing MOPS.

It is they who write to those who fought for vocational registration for general practice and inform us that, unless we complete the process including the 30 points of Practice Review Activities (PRA) in 2001, we will not have met the minimum requirements of the Programme.

These are now the rules of membership of a State Church, and the deal is that if we do not comply, we will be excommunicated. No one has yet been excommunicated but the fear of the burning retribution of the outer darkness of general oversight has already begun to trouble a few people.

The consolation may be that complying is as easy as reciting a few Hail Marys – a few turns of the quality circle and Bob's your uncle. But is this really what we all wanted?

The fires of experience

All those who have recently passed through to Fellowship of our College have had an education in general practice which is second to none in the world, thanks of course to a succession of evangelical enthusiasts such as Eric Elder as outlined in a recent book.[2] Students in the fifth year of our undergraduate medical courses now have more of the theoretical grasp of our discipline than many experienced GPs.

Audit is largely based on the concept of continuous quality improvement

We spend so much time and effort qualifying people for vocational registration in general practice but so little creativity in maintaining the same knowledge, skills and attitudes over time. CPD therefore gives us the opportunity to keep the fires of that experience burning but we have to ask the question whether the current process is fit for that purpose.

There have been a number of differing foreign and fad disciplines entering general practice. In the sixties there was psychoanalysis and Balint groups. Then modern educational theory and methods were used in the seventies in our early attempts to promote learning and teaching in general practice. In the eighties we got high on epidemiology and statistics and latterly we have listened to the siren tones of evidence-based medicine (EBM).

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Those who devised the current College system for reaccreditation unfortunately took the drastic step of making another of these foreign rituals, called audit, compulsory.

Audit is largely based on the concept of continuous quality improvement, which has been used to help such organisations as Air New Zealand, New Zealand Post, TranzRail and Crown Health Enterprises to overcome their difficulties. Presumably the techniques were so successful there that a College committee decided the same medicine should be compulsory for us all.

A major flaw in the thinking behind audit is that it fails to obey its own dictates. While the College 'Bible' on the subject of Practice Review[3] urges us only to accept the 'must do' and 'should do' of the evidence of randomised controlled trials and well designed cohort or case control studies respectively, the evidence for the effectiveness of the process is only hearsay which puts it in the 'could do' category. Why then is it compulsory?

All of these ways of looking at the world have the advantage of their own terminology which confers even on novitiates the aura of respectability.

But they are experts in these philosophies, not on the discipline of family medicine.

As has been pointed out by Schumacher,[4] they run the risk of giving us a map of our world which fails to show the many things we can see right before our very eyes. According to the experts in these world views, general practitioners, "like Johannes Kepler or Isaac Newton spend most of their time and energy on nonsensical studies of nonexisting things."

However, the discipline of family medicine "has questions of its own to answer"[5] and my belief is that, instead of blindly adopting the hearsay of others, we should use the necessity of reaccreditation to promote the virtues of our own profession.

An allergy to audit

So let me get back to my MOPS problem. The book[3] says *quality can and must be measured* but I'm not really into things like practice management, age-sex registers and the other issues mentioned there.

But I keep a daily journal, so I thought I would try to devise a study using some of the ten thousand observations I have made there.

The first of these was what I called the DEVOID study which arose directly from a real consultation with a new patient. The recruitment criteria seemed to be:

Depressed housewife
Errant husband
Vaginal discharge
One year old child with
Insulin Dependent Diabetes Mellitus
who
Doesn't know the doctor.

I've tried to be really nice to her and without antidepressants, she's not depressed now. Her husband came to see me and they've patched things up. Her vaginal discharge and his penile itch (and chlamydia) have been treated. The kid is doing really well with the help of the paediatricians and the dia-

betic clinic and she smiles now when she comes to see me.

Now for me, that is real performance. But how do I make it into an audit? I suppose if I could recruit a few more like her, I could be randomly nasty and nice, give antidepressants or placebo, and compare the results, but my problem is – why should I?

It seems that just thinking about all this has helped me to become a safer and a more compassionate doctor. I believe that this is quality care but I couldn't really assure you that the next recruit to the DEVOID study would have such a good outcome. I don't really understand what I am doing apart from telling you that it is all done by professional artistry, although specialists in quality would tell me that the evidence level is, like their own compulsory module, based on uncontrolled studies or consensus.

So why can't I do MAPS?

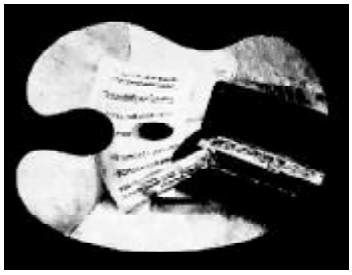
I suppose what I am trying to suggest is Mastery of Artistry by Professional Seniors or MAPS.

Donald Schon[6] defines the term professional artistry as "the kind of competence practitioners sometimes display in unique, uncertain and conflicted situations of practice." This knowing-in-action is a dynamic activity which makes general practice possible and contrasts with the static state of facts, procedures and rules.

This explains why, in the case of Mrs DEVOID, I was able to deal with so many problems by a synthesis of recognition, judgment and clinical performance. When it goes wrong, it cannot be corrected by attention to the individual facets, any more than it can be understood by that process.

For that Schon suggests "reflection-in-action" whereby the surprise that things have not turned out as expected is dealt with by naming the issues which have been at work, and framing solutions which might lead to a better outcome. Such case-based approaches to CPD have been developed.[7]

There are many more exciting things to study in our consultations such as the concept of enablement,[8] or the value of the patient-centred approach,[9] or the effectiveness of one-to-one risk communication intervention, which, incidentally, is much more when treatment choices are being addressed.[10] Portfolio-based learning[11] would also be a way to go and specifically a return to the Triadic method proposed by a previous College Education Committee, where the roles of Learner, Mentor and Assessor would be developed.



"…professional artistry [is] 'display[ed] in unique, uncertain and conflicted situations'."

Time for a debate

I started this editorial by thinking that maybe I should just go along with the incantations of compulsory audit and here I am nailing my thesis to the church door, but with very good reason. There is no evidence whatsoever that patients are safer because their doctor has an age-sex register or has engaged in some meaningless theoretical planning exercise. I have nothing against audit, I am merely against the thought of it being compulsory.

By making it so, are we not just encouraging a liturgy where GPs sing off the same hymnsheet and never think anything new about what they are doing?

We need a continuing faith in an integrating view rather than a reductionist view of performance.[12]

Reductionism is the great enemy of what we are trying to do as general practitioners and we should be very suspicious of any compulsion in our programmes because it suggests that there is only one answer.

We would do well to remember the words of Viktor Frankl, quoted by Schumaker.[4] *The present danger does not lie in the loss of universality on the part of the scientist, but rather in his pretence and claim of totality...*

What we have to deplore therefore is not so much that scientists are specialising, but rather the fact that specialists are generalising.

For my part, there is no way I can comply with 30 credits of PRA, so presumably that means general oversight next year. Since that would provide me with a mentor and an assessor perhaps hell might not be such a bad place after all.

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