Accreditation in general practice

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Accreditation is becoming established within the medical profession. In this article a brief classification of the theory of accreditation is presented, with special reference to doctors, and a brief history of accreditation in medical organisations is given, with special reference to general practice and quality assurance.

Definitions

The word accreditation has different meanings in different settings. *The Concise Oxford Dictionary* defines it as "recommending by documents," or "a statement," or "officially recognised."¹ In the United Kingdom accreditation is most commonly used to mean approval or assessment in relation to a person – for example, a doctor completing a recognised programme of medical education approved by, for instance, one of the medical royal colleges. Alternatively, the term is used in relation to an approved or recognised institution such as a hospital. Approval in this latter sense carries connotations of rights to practise or the maintenance or loss of privileges.

Why accredit doctors?

This question needs to be answered in any serious discussion of accreditation. Why should doctors need to be accredited, when in most countries they are doubly selected, firstly by stringent entry criteria and, secondly, by survival of one of the longest training periods and some of the most rigorous higher qualifications?

There are at least four answers. Firstly, the special importance of medicine and its involvement with life and death; medicine is one of the oldest professions and, with law, is still often regarded as an example of what professional status means. Secondly, more than many professions, medicine has become involved with the state. Although this involvement varies among countries, as does public expenditure on medicine, the profession's use of vast sums of public money means a degree of public accountability and political concern which involves governments everywhere, all of which want both competent performance and value for money. Thirdly, change. The pace of scientific and technical advance, though affecting all professions, is more visible and dramatic in medicine than many other occupations. Updating skills in medicine is now a matter of public debate, and the issues for the generalists and the specialists have much in common. Change in medicine is so rapid that an undergraduate degree or first qualification is of lasting value more as a vehicle for acquiring intellectual and human

skills such as values, and communication, and acceptance of the need for lifelong learning rather than as a memory store of facts. Fourthly, the revolution of attitudes in education generally and medical education in particular has led to a complete reversal of the nineteenth century approach of planning to produce a "safe doctor," through a formal final examination, which would equip a practitioner for a lifetime of practice. Following the General Medical Council's view² education is seen as a continuing requirement throughout a professional lifetime. The final qualifying examination has thus become a ticket into higher professional education.

These reasons, separately and together, lead towards the need for higher education, and higher education leads to the idea of approved or "accredited" competencies³ and for the doctor completing the programme to have some recognition or "accreditation."

What is the purpose of accreditation?

The aims of accreditation are to ensure that the places in which practice and learning take place are fully satisfactory and appropriate for the purpose and that the doctor, when accredited, is fully competent for the tasks which he or she may have to undertake.

How to accredit individual doctors

There are two main approaches to accreditation: knowledge based (norm based) and performance based approaches.

KNOWLEDGE BASED APPROACH

The knowledge based approach starts with the assumption that certain knowledge is required for the job and then sets out to test it. The knowledge is derived from examiners or experts and is essentially norm based, and this approach has the advantage that lack of knowledge can reasonably be assumed to preclude its application. Tests or examinations to assess the knowledge base are cheap to administer and follow comfortably on from traditional assessment of medical students in many medical institutions.

PERFORMANCE BASED APPROACH

The performance based approach starts from the assumption that what matters to the patient is the doctor's performance. It sets out to either replicate the settings in which doctors work or to devise simulated tasks. The approach has the advantage of logic, but it is harder to construct valid and reproducible methods, and those that exist tend to be expensive in time and costs.

Performance based testing is usual in most

non-medical settings – for example the everyday driving test or the complex simulations created for airline pilots.

MIXED SYSTEMS

In practice, many methods of accreditation of doctors use some form of knowledge based and performance based approaches. Many methods which claim to be performance based in practice often test only knowledge.

Where to accredit

Where to accredit obviously depends on the method of accreditation to be used. Tests of knowledge allow assessment in various settings including the examination hall. Tests of performance can take place either in simulated surroundings – for example, an airline pilot's simulator – or, more commonly, in the field or workplace.

When to accredit

The timing of the accrediting process depends on whether or not it entails any form of assessment. Here a division occurs between accreditation systems which in effect rely on the doctor's experience obtained – that is, accreditation that consists of proof of completing a predetermined period in one or more accredited settings – and, alternatively, those that entail continuing or continual assessment throughout the learning period or terminal or summative assessment at or after its completion.

The general practitioner trainee year in the United Kingdom is a compulsory learning experience for all general practitioners who wish to practise as principals (the highest grade) in the NHS. Assessment is the responsibility of the general practitioner trainer in the practice. The medical profession's view, expressed in the so called three chairmen's letter, based on legal advice, is that it should be an assessment of competence.⁴ In practice, as only a handful of about 2000 doctors completing their trainee year ever fail to receive a statement of competence, certification amounts merely to satisfactory attendance.

The MRCGP examination, by contrast, which is taken by most trainees in the United Kingdom, is an external summative assessment and accredits a doctor with membership of the college. Predominantly testing knowledge, the examination has made a powerful attempt to test some skills and attitudes and to validate its procedures.⁵

Who accredits?

The questions of who does and who should assess are of great interest and importance. In the United Kingdom the traditional accrediting bodies for both doctors and medical institutions have for many years been the medical royal colleges. They, for example, accredit the junior hospital posts to be recognised as training posts and also the most senior of the junior specialist doctors, the senior registrars, who are individually accredited on the basis of both passing an

examination controlled by the college and completing a series of posts prescribed by it.

However, other approaches exist. Assessment need not be limited to senior practitioners of high status but might be undertaken by peers. In its formal reply to the government's paper *An Agenda for Discussion*,⁶ the Royal College of General Practitioners emphasised peer review as a major principle for assessment and thus for accreditation.⁷ At least two other groups have claimed either a right to assess or accredit or a right to participate, and these are patients and managers.

As assessment becomes more advanced and accreditation more professional, it is likely that a widening membership will become involved in the processes, but important questions need to be resolved as to what is being accredited and for what purpose. If, for example, an accrediting body decides to accredit on the basis of quality then immediately a debate begins as to the attributes and criteria of quality – what quality is and how it is to be measured. Here the profession has an advantage as many of the issues are technical, and it has done much to initiate and develop the whole business of medical audit and quality assurance in medicine. Indeed, most of the thinking and developmental work in medicine has been done by the medical royal colleges and the specialty associations which have a professional interest in quality.

However, there is more to quality than technical excellence, and in medicine, especially general practice, there is now general agreement that quality has two broad components: a scientific, knowledge based, research based component and a human, social, communicating component in which the doctor relates to another person. These have been beautifully encapsulated in the motto of the Royal College of General Practitioners "Cum Scientia Caritas."⁸ Later Donabedian reemphasised these two components in what he called the scientific/technical and the interpersonal components of quality of care.⁹ Accepting that interpersonal skills are central to the quality of the generalist's work led to the conclusion that, though there is almost overwhelming logic in having peers – that is, professionals – skilled in assessing the scientific aspects of the work, there is, however, a strong case for including patients in assessing the interpersonal skills.

The logic of management participation rests on the scale of the resources in use and on the need for managers too to be involved and to be seen to be involved with quality. However, managerial control of doctors by managers is as illogical as medical control of managers. What is needed is a partnership of skills, and it is likely that the separation of contractual audit from educational audit (Royal College of General Practitioners, unpublished) will give both managers and the professions their own territory and responsibility.

The participation of other specialties is increasing. Educationalists, especially psychometricians, can bring important skills to the

assessment process and can contribute greatly to technical issues of assessment such as reliability and validity.

Accreditation by medical organisations

General practice, or family medicine, has played an important part in the accreditation process and tradition and in developing quality assurance world wide.

In establishing higher examinations specialist medicine led the way; indeed, the development of specialties and specialisms was intimately associated with the development of further or higher examinations. The Royal College of Surgeons of England, for example, after great debate, introduced an examination for its fellowship in 1843. The generalist colleges and associations came about 100 years later, the first being formed in the United States in 1947 as the American Academy of Family Physicians. The first college for medical generalists in Europe was the Royal College of General Practitioners in 1952. The first British formal examination in general practice for membership of that college was introduced in 1965, also after great debate.

Four years after this achievement the medical generalists in the United States introduced the first compulsory reassessment in the world for the certificate of the American Board of Family Practice. All the certificates which it ever issued were time limited (seven years). An editorial in the *Journal of the Royal College of General Practitioners* commenting on this event and asking about its potential relevance to the United Kingdom attracted virtually no interest.¹⁰ Yet by 1987, 16 out of 23 American boards had followed this lead of time limited accreditation.¹¹

Meanwhile, the alternative approach of defining standards for the accreditation of settings took a big step forward in the United Kingdom when the Joint Committee on Postgraduate Training for General Practice, formed in 1975, started in 1976 to encourage regions to establish firm standards for the accreditation of training general practices.¹² Subsequent progress was made in many regions,¹³ and by 1985 Baker found significant differences in those practices selected on the basis of regional criteria and control practices from the same geographical area.¹⁴

In Australasia the Royal Australian College of Obstetricians and Gynaecologists since its inception decided that its fellowship should be a time limited qualification subject to recertification at prescribed intervals, a view later shared by the Royal New Zealand college.

An important alternative approach has come from the Dutch School of quality assurance, particularly from the departments of general practice at the universities of Nijmegen¹⁵ and Maastricht. Here the emphasis has been on process and on constructing protocols of good care in general practice and then following up the performance of the doctors afterwards, including the use of simulated patients sent to the practice.¹⁶

In the United Kingdom the question was

where and when would the first proposal for individual clinicians' accreditation come. In July 1989 the Royal College of General Practitioners introduced its fellowship by assessment system, by which members of the college of five years' standing who were in clinical practice were given the chance to obtain the college's highest grade of membership through a new system which entailed meeting stringent standards in the doctor's own practice, which were all based on the quality of care of patients. The criteria were all agreed in advance, each is essential, and they were published with the research basis for them.¹⁷ They have been updated each year since (Royal College of General Practitioners, personal communication). This is voluntary, criterion referenced, on site, objective, performance appraisal, and the fellowship of the college by this route represents formal accreditation of a clinical standard.

The question of compulsory re-accreditation in the United Kingdom came two years later, in June 1991, from the Royal College of Obstetricians and Gynaecologists, whose report on continuing education recommended that for obstetrics and gynaecology the new specialist registration system of the General Medical Council should be adapted to require compulsory re-accreditation, a process to be organised by the college under a board of continuing medical education with a full time director.¹¹ This system is to be based on attendance and on "cognate" units of education approved by the college and is thus planned to be quite different – that is, a compulsory norm-referenced, attendance based activity.

Conclusion

Accreditation is inevitable in medicine both for individual doctors and for their work settings. The issues are now "who," "how," and "when" and not "whether."

Pressure may have come from governments, but it is the medical institutions, especially the colleges, specialty boards, or university departments which have taken the lead. At the beginning of 1992 there is great uncertainty about methods but agreement about direction. Both the accrediting processes of people and places are becoming more formal and more exact. Medical generalists have been active in this work in many countries and have taken the lead in at least four – namely, the United States, the United Kingdom, Australia, and the Netherlands. In particular they have defined the content of generalist medicine and introduced a formal examination in 1965; a formal time limited accreditation in 1969; new accrediting techniques and a new in practice assessment process in 1989.

The pace is quickening, and the topic of accreditation looks certain to remain of interest throughout the 1990s.

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