Improving continuing medical education and addressing the challenge of instituting reaccreditation

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SUMMARY. The present postgraduate education allowance structure for general practitioners is unacceptable and inadequate on a number of counts. Improvements could be made in continuing medical education by involving learners more actively, through giving them greater ownership of their continuing medical education aims and by integrating it with the current moves towards reaccreditation. Current proposals for the implementation of reaccreditation are expensive, unacceptable to many in the general practice profession, and unconnected with present continuing medical education arrangements and the existing education structure. It would be more sensitive to current attitudes, more practical, a better use of existing facilities and more logical to improve continuing medical education by linking its improvement to the evaluation of reaccreditation in as acceptable and simple a way as possible. A framework is proposed, based on an annual educational general practitioner assessment visit in which a personal learning plan is developed as a focus for an individual's continuing medical education needs.

Keywords: continuing education; reaccreditation; educational organization.

Introduction

THERE is no shortage of criticism of postgraduate education allowance-driven continuing medical education. For example:

> 'The present arrangements for PGEA [postgraduate education allowance] do little to encourage a planned programme of CME [continuing medical education] for general practitioners. Too often constraints of time, energy and finance lead to the choice of the nearest and cheapest PGEA-accredited course without any assessment of its educational relevance to the particular learning needs of the individual practitioner. Many courses are of poor quality, and learning, where it occurs at all, is often passive.'[1]

At the same time there is no doubt about the importance of continuing medical education:

> 'Maintaining the clinical competence of nearly 30 000 general practitioners of different ages, working in different places, with different experience and ability "has always represented the biggest challenge [for medical educationalists] and still does"[2].'[3]

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Submitted: 17 August 1995; accepted: 9 October 1995.

So important does the Royal College of General Practitioners consider continuing medical education that it proposes that the average amount of time devoted to continuing medical education by general practitioners should be doubled from five to 10 days per year.[4]

With continuing medical education assuming ever more importance and the present arrangements being so unsatisfactory, it is essential to think carefully about how continuing medical education is to be planned, provided, administered and regulated, and how it may be integrated with reaccreditation.

This discussion paper proposes a radical departure from the current centrally-supervised, relatively inflexible continuing medical education system. It suggests a workplace-centred, individually focused approach that can be sensitive to and that embraces the needs of all general practitioners. The arrangement does not depend on the establishment of an expensive system of mentors, elaborate (and possibly off-putting) portfolio requirements or on new bureaucracies. It could represent essential groundwork for the establishment of a professionally acceptable reaccreditation process.

Continuing medical education: suggestions for improvements, and implementation problems

That continuing medical education should be centred in the place of work has been well established[5,6] and is now generally accepted.[4] Similarly, it seems agreed that arrangements for it should take account of the factors that motivate individual doctors to learn and their preferred learning styles, as well as the content of the topics being considered.[4] It is also generally accepted that participative, self-directed methods are likely to encourage learning and to bring about changes in practice.[7]

Unfortunately, for many general practitioners such principles are not relevant. While almost all general practitioners participate in postgraduate medical education, practice-based learning was rated as second only to distance-based learning as the least preferred method of continuing medical education by a group of general practitioners who 'should be representative of doctors in other areas of the United Kingdom'.[8] As the authors of this piece of research go on to say, for learning to become active rather than passive 'it will require education of the course providers and a change of attitude of the general practitioner consumer'.[8] The sad, almost despairing, comment is made that 'it is impossible to create an educational programme to suit each individual'.[8]

Although other researchers have described a rather more encouraging picture (for example, an increase in practice-based educational sessions[9]) such findings suggest that no less than a major challenge faces all those who wish to make even modest improvements in continuing medical education.

Current proposals for reaccreditation: potential disadvantages and limitations

The General Medical Services Committee have proposed a reaccreditation scheme that will operate on two levels.[10] The first level of the scheme involves the reaccreditation of individual practitioners, to be funded from the postgraduate education

allowance; there is thus a link between changes to continuing medical education and the setting up of reaccreditation. The second level involves the reaccreditation of practices, to be funded from new resources. General practitioners would be reaccredited once every five years, with each doctor being in contact with a mentor at least once a year. Practices would be assessed once every five years.

Second level reaccreditation of a practice would involve at least three practice visitors pursuing a rigorous procedure which could extend to structured interviews with general practitioners, videorecording of consultations, interviews with other members of staff and review of audits, reports and other documents. It is acknowledged that additional funding would be required by regional advisers' departments to pay for assessors and infrastructure. The General Medical Services Committee discussion paper specifically states that 'it is essential to ensure that practice reaccreditation is not funded from the current remuneration pool by requiring GPs to earn back some element of their existing remuneration'.[10]

Such a plan for the reaccreditation of practices would be expensive — even on its own authors' admission. With current constraints on expenditure and strained relationships between the profession and the government it is unlikely that such a substantial commitment of new resources will be forthcoming: 'In an area of severe restraints on resources the high cost in terms of time will need to be addressed.'[3] The proposal could not be realized without this investment; it is feared that the expense alone of this suggested scheme renders it unachievable.

Possibly more serious, however, has been the reaction of many general practitioners to these proposals. Although nearly two thirds of general practitioners disagreed with the statement that 'Once a GP has acquired a basic level of competence no further form of appraisal is necessary during the rest of his/her active professional life',[11] there has been a vigorous rejection of the General Medical Services Committee attempts to establish a framework for reaccreditation:[12] 'The idea of formal, periodic reassessment of fitness to continue in medical practice produces resentment among many British general practitioners.'[13] Criticism has focused on the substantial extra workload for all concerned, the costs and the frequency of the assessments.[14,15]

The paradox, that while supporting the idea of reaccreditation in principle[14] many general practitioners reject it in practice (with 'howls of protest'[16]), may be explained by the inappropriateness if not the clumsiness of the present proposals. The proposals do not give the impression that the process is being sufficiently led by the general practice profession, is truly educational or is taking proper account of a range of professional activities.[14]

The secretary to the Standing Committee on Postgraduate Medical Education prefers the idea of continuing professional development to the proposed two levels of reaccreditation, advocating a formal review process undertaken with a mentor 'to identify individual educational need and give an opportunity for reflection for practitioners to assess where they've got to and where they're going'.[17] This idea follows the partnership approach of the Royal Institute of British Architects which expects its members to follow regularly updated personal development plans.

Whatever the arrangement, any system that uses a mentor, or an equivalent, is expensive. Such work is time consuming and makes heavy demands on available expertise with serious funding implications. The necessary national network of appropriately trained mentors is neither available nor in prospect.

However, the problem exists beyond the non-availability of mentors. As most general practitioners prefer a locally appointed assessor from their local medical committee for any assessment procedure[14] it seems that the profession as a whole is not yet ready for a system of mentors. Even supporters of mentors accept that 'funds will have to be made available... and, to be feasible, their introduction will have to be phased in'.[13] Is there then any framework which can help in the meantime?

Despite its inadequacies, the postgraduate education allowance is administered by a structure whose staff have educational expertise, which seems to be generally acceptable to general practitioners and has much development potential. With two thirds of general practitioners feeling that reaccreditation should be part of continuing medical education[14] the moment is right to develop the postgraduate education allowance in order to improve continuing medical education arrangements, and to suggest better solutions to the reaccreditation challenge.

A new proposal

The consensus is that reaccreditation should be led by the profession, not imposed by the government[16] — 72% of general practitioners would like there to be General Medical Services Committee or local medical committee leadership, with only 4% favouring leadership by the Department of Health.[14] Similar feelings emerged when it was asked who should perform the general practitioner assessment, most general practitioners preferring an appointee of the local medical committee and only 8% indicating an assessor from the family health services authority.[14] For reaccreditation to succeed 'it is vital that the grass roots of the medical profession is not alienated... and we should try to implement the most effective and least disruptive system as soon as possible'.[13] As the ownership of reaccreditation overlaps with that of continuing medical education,[14] any development that can help an individual general practitioner to feel more possessive about his or her own educational endeavours needs identification and encouragement.

At present the despatch of the postgraduate education allowance certificate represents the satisfactory completion of a defined unit of continuing medical education. It is ironic that this document, a personal record of achievement, is sent away by the learner to a distant office for recognition and validation. It would be hard to devise a system that was better able to demonstrate that education is separate from the workplace and colleagues and is not owned by the learner. That such a system has been tolerated, and apparently remains unquestioned, is a sad confirmation of these reflections.

The postgraduate education allowance certificates should, of course, stay with the learner. If 'the place of work is the natural setting for continuing education'[18] then it must also be the natural place for the assessment and planning of that work. The inspection and documentation of work done can readily be combined with a visit to the general practitioner in his or her practice, this visit serving both continuing medical education and reaccreditation ends. Most general practitioners have declared that they would prefer peer reviewed practice visits for this purpose and two fifths are already accustomed to such visits, for example for the assessment of training practices.[19]

An annual visit by the local general practitioner tutor to authenticate and record postgraduate education allowance certificates would represent a useful beginning for the acceptance by general practitioners of the principle of a practice-based educational assessment visit. For some general practitioners the visit would involve only the presentation of continuing medical education work done with a request for acknowledgement for postgraduate education allowance purposes. But even for these general practitioners an important step would have been taken — formally assembling and presenting their year's work as a record would create an opportunity to share achievements with practice partners as well as with the general practitioner tutor and would

enable some discussions about the following year's continuing medical education. With professionals who feel vulnerable, highly suspicious or uncertain[20] only the gentlest and most supportive of approaches is likely to be welcomed. The challenge is to have reaccreditation 'perceived... as less of a threat, and more as a process reflecting concern for their professional well being'.[21] Such an encounter would represent an important educational step for many, which could lead to deeper discussions regarding continuing medical education at the next annual visit.

For general practitioners with a greater interest in continuing medical education this meeting would enable greater growth and development. Such general practitioners in a practice would meet together before the visit to discuss and coordinate ideas and plans, and would use each other as advisers for their own continuing medical education and would begin to develop the practice into a learning organization. Soon enough, such general practitioners — and other team members[5] — would find themselves not only in effect appraising each other, but also helping evolve learning plans for the assessment of individual learning needs, for the development of personal learning styles and for the consideration of personal preferences for reassessment.

Some learners, including general practitioners already using methods of portfolio-based learning, would find themselves at a more advanced stage. These doctors would welcome the annual visit from the general practitioner tutor as they would be keen to demonstrate and share their achievements, to compare them with others' achievements and to contribute to the basket of ideas that the assessor would quickly gather. Continuing medical education based upon such an informal 'give and take' arrangement has been shown to be remarkably effective: 'The evidence... is that doctors change their practice as a result of information spread through interpersonal networks.'[22] Should there be a mentor already attached to a learner, he or she could perform this annual assessment perhaps for other members of the practice as well.

An early development from the straightforward approval of postgraduate education allowance units would be an attempt by the individual learner to assess that learning experience. The centrality of reflection in the learning process is well documented and stressed by those setting up portfolio-based methods of learning.[1] Some assessors might therefore encourage general practitioners to retain their own assessments of postgraduate education allowance activities, along with the certificates of attendance, and to reflect upon them in writing at a later stage. This reflective experience would enable general practitioners to identify ideas for further enquiry and facilitate practical changes leading to improvements in patient care.

Within a couple of years of this process of assessment some general practitioners would be ready to accept that mere certification of attendance at continuing medical education was inadequate. Assessors would look for a general practitioner's ability to use reflection and constructive criticism.

As the annual educational assessment visit became established and accepted, personal learning diaries would appear. Just as a personal learning diary could evolve from a simple gathering of postgraduate certificates, so could a personal learning plan develop from the diary. This would be a logical step, to move from a discussion of what had been achieved in the previous year to what intentions and aspirations might be considered for the following year. As the file grew there would be more to talk about at each annual visit, in terms of educational work undertaken, reflections arising from that work and ideas for the future.

As a result of the annual educational assessment visits, the learner would possess a document outlining some continuing medical education aims for the future, a record of achievement of aims previously set and an acknowledgement of work done. Such a record of achievement could form the basis of a reaccreditation file. This model represents a robust response to 'the challenge of the next decade [which] will be to develop learner directed programmes of higher professional education that will be responsive to the needs of general practitioners'.[23]

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Food for thought...

'Although knowledge obtained through scientific endeavour in medicine is being vaunted as superior to knowledge obtained in other ways, learning from anecdotes and stories and being alert to their use by patients are essential to good medicine. This kind of knowledge enables doctors to deal with patients as individuals and to respect their uniqueness as persons.'

Macnaughton J. Anecdotes and empiricism [editorial]. November *Journal,* p.571.