Primary care and HIV infection in the 1990s

FOLLOWING a report by its working party in 1988, the Royal College of General Practitioners affirmed that general practitioners must be willing to treat and advise patients who are affected by the human immunodeficiency virus (HIV) or who have the acquired immune deficiency syndrome (AIDS).[1] This statement followed publicity, much of it adverse, which implied that general practitioners had not risen to the challenges presented by this new and unpredictable infection.[2]

The original working party concentrated its efforts on clarifying the potential contribution of general practice to the overall care of individuals with HIV infection and their families. The clinical and research division of the RCGP has reconstituted the working party, so that general practice can be central to the debate about the long term care of individuals with HIV infection and AIDS. The aims of the working party are:

- To maintain an optimum level of knowledge about the disease and the means of prevention in order to enable all general practitioners to recognize HIV infection and its various complications and to be aware of the risks of HIV infection in sexually active patients.
- To promote and commission research that aims to develop the care of those with HIV and AIDS with particular reference to general practice.
- To provide those general practitioners who have a special interest and an increasing expertise in HIV and AIDS with opportunities to increase their skills.
- To provide the council of the RCGP with information to enable policy statements to be formulated and promulgated in relation to the social and ethical consequences of HIV and AIDS in primary care.

One of the many factors determining the re-establishment of a working party was a need to counteract the continuing perception that general practitioners have little specific role in the care of patients with HIV infection. This concern was supported by the publication of a report by the National Audit Office which 'lamented the role played by general practitioners' in the overall care of patients with HIV infection.[3] Factors responsible for the apparent divide between primary and secondary care of patients with HIV infection have been fully documented.[4–6] It would appear that primary care is often underutilized by patients because they receive inappropriate advice or are apprehensive about care in general practice. Nevertheless, there is evidence that general practitioners are closely involved with the care of patients with HIV infection in areas of the United Kingdom where there is high prevalence.[7] In Scotland, in particular, family doctors continue to provide the bulk of care to the majority of individuals with HIV infection.[8]

General practitioners also provide a unique resource for preventive care. Attempting to predict the course of the epidemic remains problematic and trends in transmission of the virus to individuals who do not perceive themselves to be at risk provide ample proof that health promotion messages need to be repeated, reinforced and practised. The primary health care team provides care for the majority of people in the community and is ideally placed to deliver primary prevention. Clinical developments are occurring rapidly with the availability of second generation antiretroviral medications and the wider use of prophylactic antibiotic and antifungal regimens. There is now a much better prognosis for people with HIV infection.[9] Nonetheless, there remain standard treatments which are readily available in family practice. People in the early stages of the infection may remain well for many years and require a model of physical and psychological care akin to other chronic disorders. This type of care is now recognized to be the essence of general practice.[10] Regular health surveillance with a view to early diagnosis and treatment of opportunistic infections is becoming the accepted practice for individuals infected with HIV, and there is no reason why a proportion of this cannot be carried out in primary care. At the other end of the clinical spectrum, general practice may be the ideal care setting for some individuals with advanced disease, where symptom control and maintaining quality of life are the main aims of therapy. This may well result in a systematic approach to 'shared-care', including the use of joint clinical protocols by hospitals and general practice.

Other innovative models of care are being developed in cities with a high prevalence of HIV infection. For example, in London and other large cities in England new services have been established with the aim of maintaining patients in the community by bolstering and supporting traditional primary care structures.[11] Recent reports of success in managing drug abusers in general practice also have important implications for the future care of people with HIV infection.[12] The philosophy of 'harm-minimization', rather than abstinence, in the management of drug abusers is being heralded as a quiet revolution.[13]

These issues will confront the working party of the Royal College of General Practitioners. If the needs of people with HIV infection are to be most appropriately assessed and met, resources more evenly distributed and the balance of care shifted, then general practice could and should do more. The challenge for the working party is to raise awareness about the role of general practice in the management of HIV infection at a time of great change and increasing stresses for family doctors.

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Assessment of competence for entry to general practice — formative or summative?

ASSESSMENT of competence to practise family medicine is well established in Australia, Canada and the United States of America,[1] yet has been slow to receive acceptance in the United Kingdom, despite successful efforts to establish general practice as a separate discipline. The reasons for this reluctance are complex, but may well be related to the emphasis on innovative educational approaches to both vocational training and continuing medical education. Furthermore, there has been little pressure, until recently,[2] from either the government or regulatory bodies such as the General Medical Council for formal assessment. Nevertheless, some 80% of trainees take the membership examination for the Royal College of General Practitioners at the end of vocational training, 80% of these passing first time and about half of the remainder passing at their second attempt (Dastur T, RCGP examinations board, personal communication).

A sea change appears to be upon us; the General Medical Council has begun the difficult task of setting up machinery to test the allegedly incompetent general practitioner, as well as other doctors, and the mood of the profession as a whole has moved to encompass both reluctant acceptance and enthusiastic support for accrediting competence in general practice, at least upon entry. However, actual performance is notoriously hard to measure and competence (as measured effectively by the MRCGP examination, for example) has not been proven to correlate with performance.[3]

Another difficulty remains: some teachers of general practice feel that a gold standard examination at the end of vocational training may be counterproductive, leading to superficial learning aimed only at passing the assessment, with subsequent failure to integrate the information gained.[4,5] Thus, summative assessment, although recognized by some as the most powerful stimulus to learning that we have,[6] is viewed with suspicion. The word doctor means teacher and doctor-teachers, by virtue of their profession, may feel uncomfortable in making assessment decisions which might result in profound career effects for those judged incompetent. To overcome this discomfort the concept of diagnostic or formative assessment has been gladly embraced by those involved in general practice training. Entirely laudable, no judgement is made but the assessment is concerned with the improvement of performance. Thus, 'marking and grading involve summative assessment while reviewing and giving feedback involve formative assessment.'[7] The introduction to the occasional paper on Manchester rating scales describes their purpose as 'evaluating performance at regular intervals and measuring improvement.'[8]

Unfortunately the concepts of summative and formative have polarized views of assessment, whereas they really express different ends of the same spectrum. For example, regular testing of medical students in anatomy may be regarded as mini-summative as it eventually leads to a grading for the students; evaluation of general practitioner trainees by their teachers, for example using the Manchester rating scales or simulated patients, is regarded as formative, the end result being used solely for diagnostic feedback. But is this really so? Any assessment must contain an element of judgement by an outside party, either matched to a criterion formulated by experts, or to performance by the students' peers in the same testing area. The diagnostic feedback may be helpful but the profile which emerges may not remain secret. Trainers, course organizers, consultants, hospital staff and patients will all make judgements about a doctor which will leak into the general pool of consensus opinion when career references and judgements are made at the end of vocational training. This blurring of a benign formative assessment has been recognized by students and general practitioner trainees for many years and justifies the suspicions which they often express. They would argue that formative assessment is only truly formative if the assessment and assessor have no part or influence in decisions affecting career progress.

Formative assessment has two further weaknesses which need to be acknowledged. First, it may map out the trainee's strengths and weaknesses but often does not perform a diagnostic function in indicating the causes of those strengths and weaknesses.[9] Secondly, it is lacking in reliability; judgements are made by the trainer or course organizer where influences such as the halo effect and confirmation bias may play a significant part.[10] Despite attempts to define specific grading levels (as in the Manchester rating scales) no consistency between those using the scales is guaranteed. This lack of consistency in formative assessment is almost considered a benefit (or possibly a relief) by teachers. Hence the recent statement in a regional assessment package 'This means that it is not so important that the different methods used to provide a formative assessment need stand up to the strict criteria of validation or reliability.'[11]

A further caveat applies to attempts at predicting future competence. Entwistle stated 'in my view, any assessment should steer clear of prediction. What assessment can do is report achievement at a specific time, and criterion-referenced reports are much more informative than traditional measures. But they are no more clairvoyant.'[12] The reduction of insurance premiums for those who have passed the MRCGP examination may present