General practitioners' attitudes to professional reaccreditation

Stephen H H Sylvester

Abstract

***Objective*—To determine the views of general practitioners about professional reaccreditation.**

***Design*—Postal questionnaire.**

***Subjects*—All 278 general practitioner principals working in Cleveland.**

***Main outcome measures*—General practitioner characteristics; attitudes to reaccreditation; and views on the development, conduct, content, and format of reaccreditation.**

***Results*—210 out of 278 (76%) general practitioners responded to the questionnaire. 128 (61%) agreed that general practitioners should undergo reaccreditation. 149 (72%) thought the General Medical Services Committee and local medical committees were appropriate bodies to lead its development. 120 respondents suggested that reaccreditation should be carried out by assessors appointed by the doctor's own local medical committee. The most favoured interval between reaccreditation episodes was 10 or more years. 152 doctors thought that doctors who failed reaccreditation should be advised on education and reassessed soon afterwards. Clinical knowledge (82%), clinical skill (82%), prescribing practices (67%), standards of medical record keeping (60%), and consultation behaviour (58%) were the most popular subjects for scrutiny. 138 (67%) respondents felt that reaccreditation should be part of continuing medical eduction.**

***Conclusion*—Most general practitioners support professional reaccreditation. They believe the process should be led by the profession, be educational, and take account of a range of professional activities.**

Introduction

In 1992 the General Medical Services Committee of the British Medical Association commissioned a national survey of general practitioners[1] to "provide every general practitioner in the country with an opportunity to record his/her view on the current state of general practice and what changes, if any, they would like to see in the future." The survey raised the issue of professional reaccreditation, which it defined as "a system of assessing a GP's competence to practice, at regular intervals during his or her career." Sixty five per cent of general practitioners responding to the survey disagreed with the statement that once a general practitioner had acquired a basic level of competence no further form of reappraisal was necessary during the rest of a professional life, and 42% agreed that a system of reaccreditation in general practice was long overdue.

Reaccreditation or recertification of doctors is not new. Since 1976 the American Board of Family Practice has issued time limited certificates to family physicians, demanding recertification by assessment. Since then systems of reaccreditation have developed in Australia, New Zealand, and the Netherlands. In the United Kingdom, general practices wishing to train general practitioners are accredited and reaccredited by means of a practice visit from a team of assessors. In 1989 the Royal College of General Practitioners introduced fellowship by assessment—an example of voluntary and stringent reaccreditation.[2] In 1992 the Royal College of Obstetricians and Gynaecologists recommended compulsory reaccreditation for specialists based on continuing medical education.[3]

Progress towards compulsory reaccreditation for general practitioners is inevitable, but questions remain about how doctors should be reaccredited and who should be involved in developing and applying the system. This study aimed to test the results of the General Medical Services Committee's survey and to determine general practitioners' views on the development and application of reaccreditation.

Tennant Street Surgery, Stockton on Tees TS18 2AT
Stephen H H Sylvester, *general practitioner tutor*

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Method

A postal questionnaire was sent to all 278 general practitioner principals on the medical list of the Cleveland Family Health Services Authority in January 1993. The questions were derived through a series of structured interviews with a selection of general practitioners in Cleveland. General practitioners involved in education and political representation were then invited to check that no major options had been omitted. The structure and wording of the questionnaire was examined and criticised by a researcher experienced in questionnaire design.

Statistical analysis was carried out by using the χ^2 test (with Yates's correction where appropriate) with a 95% confidence interval ($\chi^2 \geq 5{\cdot}024$).

TABLE I—*Respondents' attitudes to reaccreditation. Results are numbers (and percentages) of 210 respondents*

	Agree	Neither agree nor disagree	Disagree
GPs should undergo reaccreditation during their practising careers	128 (61)	31 (15)	51 (24)
Attendance at PGEA approved events is sufficient evidence of a GP's continuing competence to practise	76 (37)	35 (17)	97 (47)
Reaccreditation will result in better doctors	78 (37)	56 (27)	76 (36)
Reaccreditation will improve the quality of patient care	80 (38)	61 (29)	69 (33)
A reaccreditation system will help the state get better value for money from doctors (n=207)	34 (16)	60 (29)	113 (55)
Reaccreditation will be used to identify bad doctors	89 (42)	56 (27)	65 (31)
Reaccreditation is a public relations gimmick	90 (43)	41 (20)	79 (38)
A system of reaccreditation will result in the loss of the GP's independent contractor status	47 (22)	65 (31)	98 (47)
I worry that reaccreditation could result in the loss of my livelihood	61 (29)	36 (17)	113 (54)
It concerns me that reaccreditation may expose my inadequacies	65 (31)	42 (20)	103 (49)
Only GPs should be involved in reaccrediting other GPs	151 (72)	28 (13)	31 (15)

PGEA=postgraduate education allowance.

Results

Of the 278 questionnaires posted, 210 were returned completed—a response rate of 75·5%.

Doctors' attitudes to reaccreditation—The responses to the 11 attitudinal questions asked in the survey are displayed in table I. Although the questionnaire had a five point scale, categories have been combined in table

I into a three point scale. Only 19 out of 118 (16%) doctors who were members of the Royal College of General Practitioners were opposed to reaccreditation while 32 out of 92 (35%) who had never been College members opposed it ($\chi^2=5{\cdot}17$, $p=0{\cdot}0230$). Likewise, only two out of 56 (4%) doctors from training practices opposed reaccreditation compared with 49 out of 154 (32%) doctors from non-training practices ($\chi^2=11{\cdot}00$, $p=0{\cdot}0009$). The sex of the doctor, practice size, and the number of years the doctor had been in practice made no difference to the view on the need for reaccreditation. The view that attendance at courses approved for the postgraduate education allowance was sufficient evidence of continuing competence to practise was held by 53 out of 91 (58%) non-college members but only 23 out of 117 (20%) college members ($\chi^2=14{\cdot}02$, $p=0{\cdot}0002$).

Who should lead the development of reaccreditation?—Table II displays the respondents' views on which bodies should lead the development of reaccreditation. Support for the General Medical Services Committee or local medical committees was not affected by the doctor's sex, college membership, practice size, training status, or number of years in practice. Seventy five out of 117 (64%) college members favoured the college as a leader of reaccreditation compared with only 28 out of 90 (31·1%) non-college members ($\chi^2=7{\cdot}07$, $p=0{\cdot}0078$).

Who should carry out reaccreditation?—Support for assessors appointed by the doctor's own local medical committee was not affected by the doctor's sex, college membership, practice size, training status, or number of years in practice (table II).

When should reaccreditation be carried out?—Comparison of the responses of doctors who supported and opposed reaccreditation showed no significant difference as far as an interval of 10 or more years was concerned (table III). However, only two out of 45 (4%) doctors opposed to reaccreditation favoured an interval of fewer than 10 years compared with 57 out of 128 (45%) who favoured reaccreditation. Opponents of reaccreditation were significantly more likely than supporters to suggest professional misconduct (13/45 *v* 7/128) or a breach of terms of service (14/45 *v* 2/128) as appropriate triggers for reaccreditation.

What should happen to those who fail reaccreditation?—Altogether 202 respondents answered a question on what should happen to doctors who fail reaccreditation. One hundred and fifty two thought that such doctors should be advised to undertake appropriate education before being reassessed soon afterwards; 49 that they should be advised to undertake appropriate education (without reassessment), and one that they should be removed from the General Medical Council's specialist register. No one thought they should lose their licence to practice or receive lower practice allowances. The most popular choice (of education followed by reassessment) was not significantly affected by whether the responding doctor supported reaccreditation or not.

TABLE II—*Respondent's views on who should lead the development of reaccreditation and who should carry it out. Respondents could choose up to three options*

	No (%) of respondents (n=207)
Who should lead?	
General Medical Services Committee/local medical committees	149 (72)
Royal College of General Practitioners	103 (50)
British Medical Association	88 (43)
General Medical Council	87 (42)
University departments of general practice	48 (23)
Family health services authorities	38 (18)
Department of Health	8 (4)
Who should carry out accreditation?	
Assessors appointed by the local medical committee	120 (58)
Your partners or fellow GPs	83 (40)
Regional or associate advisers in general practice	72 (35)
Assessors appointed by the General Medical Council	50 (24)
General practitioner tutors	42 (20)
Assessors appointed by a different local medical committee	38 (18)
General practice trainers	35 (17)
Independent medical advisor from the family health services authority	26 (13)
Course organisers of vocational training	19 (9)
Assessors appointed by the family health services authority	16 (8)
Hospital consultants	7 (4)

TABLE III—*Respondent's views on when reaccreditation should be carried out*

	No (%) of respondents (n=203)
Every ten or more years throughout a GP's career	82 (40)
Every five to nine years throughout a GP's career	57 (28)
When a doctor is found guilty of professional misconduct by the GMC	24 (12)
When a doctor is found to be in breech of his or her terms of service by a service committee	22 (11)
When a doctor becomes eligible for the first and subsequent seniority payments	16 (8)
More frequently than every five years throughout a GP's career	2 (1)

TABLE IV—*Respondent's views on what aspects of a GP's work should be scrutinised by reaccreditation. Any number of options could be selected*

	No (%) of respondents (n=209)
Clinical knowledge	172 (82)
Clinical skill	171 (82)
Prescribing practices	139 (67)
Standard of medical record keeping	125 (60)
Consultation behaviour	121 (58)
Patient satisfaction	100 (48)
Practice management	89 (43)
Workload	86 (41)
Quality of referral letters	77 (37)
Involvement in audit	48 (23)
Referral rates to hospitals	41 (20)

What aspects of performance should be scrutinised?—Table IV lists aspects of a general practitioner's work which might be included in reaccreditation. Of 128 doctors in favour of reaccreditation 59 (46%) included the quality of referral letters compared with only seven out of 50 (14%) opponents of reaccreditation ($\chi^2=7{\cdot}27$, $p=0{\cdot}007$). Thirty eight out of 128 (30%) supporters included involvement in medical audit compared with only four out of 50 (8%) opponents ($\chi^2=5{\cdot}36$, $p=0{\cdot}0206$). Choice of the remaining criteria was not significantly affected by whether the doctor supported reaccreditation or not.

What should be the format of reaccreditation?—Two hundred and five doctors indicated what they considered the most suitable format for reaccreditation. They could select any combination of five options presented. One hundred and thirty eight opted for reaccreditation as part of continuing medical education, 113 suggested a practice visit by a small team of people, 34 chose some form of written examination, 27 chose an oral examination, and 23 favoured simulated consultations using actors as patients. Choice of a practice visit as a suitable format was not significantly affected by the training status of the responding doctor's practice.

Discussion

The 75·5% response rate achieved in this survey means that the results may be considered representative of the views of the general practitioners in Cleveland. The sample is too small to permit a confident extrapolation of these beyond Cleveland. Nevertheless, given the strong similarities between Cleveland general practitioners and general prac-

titioners in the United Kingdom as a whole,[4] I believe that these results probably do reflect wider general practice opinion. The impression from the General Medical Services Committee survey that most general practitioners favour some form of reaccreditation is borne out in this study.

DOCTORS' BELIEFS AND ATTITUDES

Differences in doctors' attitudes to reaccreditation may have more to do with their affiliation to the Royal College of General Practitioners and the training status of their practice than with their practice size or length of service. In this study, doctors near retirement or who were singlehanded were as likely to support reaccreditation as their younger or group practice colleagues. One reason for the greater willingness of college members and doctors in training practices to accept reaccreditation might be that both these groups have had experience of being assessed as general practitioners. A more systematic assessment of vocational training applied nationally might result in greater professional confidence about reaccreditation. The strong support among doctors for peer review as a vital element in reaccreditation needs to be reflected in the way it is developed and implemented. Doctors may be ambivalent about the value of reaccreditation, but their responses also suggest that they are not afraid of it.

DEVELOPING AND CARRYING OUT REACCREDITATION

Liaison between the General Medical Service Committee and the Royal College of General Practitioners in discussing reaccreditation[5] would find favour with general practitioners. Despite suggestions that the negotiation of the 1990 general practitioner contract caused the profession to lose trust in the committee and college,[6] this study shows that general practitioners are willing to entrust these two bodies with the delicate issue of reaccreditation.

Doctors in Cleveland strongly believe reaccreditation should be an education exercise. Two thirds thought it ought to be part of continuing medical education and three quarters saw "failure" as a trigger for education before reassessment. Development and implementation of a system which emphasised the educational nature of reaccreditation would certainly find professional support.

A reaccreditation interval of 10 or more years would find widest acceptance, especially among those doctors opposing or unsure of reaccreditation. If the profession is to move ahead together then this longer interval, at least initially, would be more likely to help.

HOW SHOULD DOCTORS BE REACCREDITED?

The high ratings given to prescribing practices and consultation behaviour deserve mention. At present general practices are set indicative prescribing budgets which are monitored by and discussed with the independent medical adviser of the family health services authority. With some adaptation the present system of prescribing monitoring could become part of a reaccreditation process.

Observing and analysing a representative sample of every general practitioner's consultations would be costly in time, effort, and money. Unless there are sufficient resources to ensure that conclusions from an analysis of consultations are valid and that appropriate remedial training is available, this criterion of performance may be best excluded. Also, few general practitioners have experience of simulated consultations, though they are being developed as a tool of assessment in the Netherlands.[7] Oral and written examinations have little support. Practice visits and continuing medical education are the favoured formats.

Practice implications

- Demands for professional reaccreditation of all doctors, including general practitioners, are increasing
- There is broad based support for reaccreditation among general practitioners
- Doctors who have experience of assessment feel more confident about reaccreditation
- Reaccreditation should be led by the profession, embrace peer review, and be educational rather than punitive
- An interval of ten or more years between assessments has the greatest support among general practitioners

Conclusions

This survey has confirmed the overall acceptance of professional reaccreditation by general practitioners so long as it is educational rather than punitive and covers many different areas of activity. It is now up to general practitioners' leaders to develop a system that reflects these views.

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