In a recent North American study, matching for HLA type did not reduce rejection in recipients who followed a rigorous protocol of topical steroid treatment.⁶ Interestingly, this study found that ABO blood group compatibility improved survival of the graft. In Britain the most cited work on the benefit of HLA matching in corneal grafting comes from East Grinstead.⁷ More recent reports from mainland Europe suggest benefits for matching for both class I (HLA-A,B,C)⁸ and class II (HLA-DR,DQ,DP)⁹ antigens. Data from the British corneal transplantation follow up study show that, when the fact that high risk patients often receive grafts matched for HLA type is controlled for, the risk of rejection rises with increasing mismatches for HLA-A and HLA-B specificities.¹⁰ Surprisingly, the opposite was true for HLA-DR mismatches. A true biological basis for this dichotomy of an effect for HLA class I but not class II antigens may exist as a similar observation has been reported from another study in corneal grafting¹¹ and in liver transplantation¹². Alternatively, poor definition of HLA polymorphisms, particularly for class II, would prevent accurate assessment of the matching of donor and recipient HLA types in corneal grafting.

Although considerable progress has been made in elaborating the mechanisms of rejection of corneal grafts,¹³ the confusion of data that currently faces eye surgeons¹⁴ required to manage high risk patients needs resolution now. Notwithstanding increased cost and a delay in surgery for some patients, class I matching should be defined (as, for example, no more than two mismatches) and should be made available only to carefully defined at risk patients—for example, recipients with deep corneal vascularisation or previous immunologically mediated failure. Prospective studies are still required to address the relevance of class II antigens¹⁵ by using molecular biological techniques that identify allele polymorphisms, ABO group matching, and sensitisation in patients who have received a corneal graft previously.¹⁶ The design of the studies should take into account the several studies already published or under way so that results are amenable to meta-analysis.¹⁷ A consensus on topical immunosuppression after transplantation would also be welcome.¹⁸

The network of a limited number of eye banks now underpinned by central funding has an economy of scale that will keep unit costs per cornea low compared with those in other countries. In addition, it will help to protect the service from the bureaucracy and fragmentation of the internal market. The prospects for most patients currently awaiting corneal transplantation in Britain are good, and those for high risk patients should continue to improve.

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Recertifying general practitioners

If not now, when? If not this, what?

In two weeks' time general practitioners from Britain's 117 local medical committees will have to make up their minds about reaccreditation—not whether it is a good idea, but whether the detailed scheme drawn up by the General Medical Services Committee fits the bill. It proposes that all general practitioners should have an educational performance review by a trained general practitioner "mentor" each year and should undergo assessment by a regional reaccreditation team every five years. This team would be accountable to a national reaccreditation council.

Although general practitioners generally support reaccreditation^{1,2} and both the Royal College of General Practitioners and the regional advisers in general practice have welcomed the GMSC's initiative, the proposal has already come under fire. Criticism has focused on the substantial extra workload for tutors and regional advisers, the costs, and the timing.^{3,4}

These salvoes are unsurprising, but reaccreditation, or recertification (the preferred term when the process is applied

to individuals rather than practices) is an issue that cannot be side stepped. It may lack the immediacy of the out of hours dispute, but the implications are more far reaching. The pace of change in medicine and the pressure on doctors from all sides to practise high quality, cost effective medicine throughout their professional careers are mounting. The demand for tangible evidence that they are doing so will increase. The debate has thus moved on from whether recertification is desirable to how to do it.

There is a clear consensus that the process should be professionally led, not imposed by the government. Explicit national standards need to be set and competence and performance against these standards assessed in a non-threatening way, by fair and consistent methods. Peer review of various components of practice including medical audit is regarded as far preferable to any form of knowledge based assessment.⁵ The aim of the process should be positive, not punitive—to encourage self learning and help general practitioners to keep their knowledge and skills up

to date. It must also identify those who are underperforming.

How far the GMSC's proposal meets this description will be contested at next month's meeting, but revision in response to constructive comment seems preferable to abandonment in response to howls of protest. General practitioner negotiators need to be able to convince politicians that they have grasped the nettle: agreement on a scheme will help negotiators lobby for sufficient funds to set up and service it. This will not come cheap. More regional advisers will be needed and existing departments strengthened. Mentors will have to be taught and locum cover paid for while advisers are on practice visits. General practitioners who participate in recertification must also have paid, protected time set aside for the process.

A look at the recertification programmes in general practice that are running in the United States, Australia, Canada, and Europe suggests that the ideal system has yet to be devised. It also suggests that an unstoppable movement is under way. A recent European survey showed that while only Norway, Hungary, the Netherlands, and Estonia had established programmes before 1995, Belgium, Slovenia, and Israel have introduced them this year and Denmark will in 1996.⁶

Although in most countries the medical profession is responsible for recertification, some schemes have been government led; most are funded by governments or, less desirably, by drug companies. Rigid requirements are the norm, with a large component based on hours spent in continuing medical education. The carrot and stick approach is common, with privileges being withdrawn or withheld from doctors not complying with the requirements.

The GMSC's proposals are similar to the model used in Norway, which has been running a voluntary five yearly recertification programme since 1985. Over this time doctors have to spend a minimum of one year in active general practice and complete 200 "course" hours of continuing medical education, and three months' of hospital service, or a minimum of three months' general practice based research, or a further 100 hours of courses, practice visits, lectures, or other approved activities. After the age of 60, course hours requirements are reduced by 50% and after 65 there is no further recertification. Doctors who comply can call themselves "specialist general practitioners" and be general practitioner trainers. Specialists get paid 10-15% more than doctors not granted specialist status,⁷ and, unsurprisingly, most general practitioners have opted for recertification.

The limitations of setting so much store by attendance at continuing medical education activities are well recognised.⁸ Many of the activities are of dubious quality, and little evidence exists that accumulating continuing medical

education "credits" improves performance or affects outcomes. Recognising this, the GMSC has proposed the scrapping of the postgraduate education allowance and using the money to pay general practitioners for participating in the annual review and for satisfactorily completing the five yearly review.

Although doctors will need to spend 40 hours each year in educational activities, the aim is to make these hours more productive. Mentors would help to plan a package of obligatory, self selected, and negotiated activities, geared to the experience, needs, and learning style of the individual doctor. Active participation is seen as the key component of any form of educational activity, whether in small group meetings, practice visits, portfolio learning, audit, teaching, or research. The five yearly review would be based on the well established methods used to select and reaccredit general practitioner trainers and the approach developed by the Royal College of General Practitioners for fellowship by assessment.

Those who fail either the annual or five yearly review would be reappraised after undertaking a specific programme of retraining and education. If this did not solve the problem or was not pursued the national reaccreditation body would consider "whether to advise a doctor to stop practising or refer them to the General Medical Council."

Such strictures, which are essential if recertification is to mean anything at all, are bound to cause alarm. And there is justifiable concern that, despite the soothing promise of sensitive and supportive peer review, the criteria used to define good practice and the methods used to assess them will fall well short of the ideal. The challenge for the GMSC and other proponents of recertification is to convince doctors that the merit of building on this proposal lies not so much in pre-empting the imposition of a worse one by the government but in its potential to enhance and protect their professional lives. It should not be seen as one more stick with which to beat them.

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Cooperating, not competing, to improve health care

The first European forum on quality improvement in health care will provide a way

Cooperation may become most difficult just when it is most needed. When stress is high, fear develops; and fear fragments us. Health care leaders should now be working more and more closely with each other, seeking systemic solutions for systemic problems, but the opposite is happening. As demands to cut costs increase and as governments and other groups paying for health care probe the system for evidence of safety and effectiveness, professions tend to retreat within their own walls, organisations become increasingly secretive, and individuals struggle against their interdependencies.

We have seen this in the United States as reform of health

care has gained momentum, mostly induced by large corporate purchasers of care, which provide most of the health care insurance for the American population. These purchasers have been angered by the steady growth in American health care costs—almost three times the rate of inflation for over two decades—without strong evidence either of added benefit to the population or of effective efforts by health care organisations to control their own costs. Trust has been broken, and those paying for health care are now more assertive than ever before. They are requiring organisations to provide data on their performance, including data not only