

PRACTICE OBSERVED

Mandatory Training

The case in favour

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Basic medical education is not sufficient to prepare a doctor to become a consultant or a principal in general practice. Thus, it has been accepted by the medical profession that to practise independently in any discipline of medicine requires a preliminary period of postgraduate training. From 15 August 1982 no doctor will be allowed to become a principal in general practice unless he or she has first completed a three-year programme of vocational training after full registration. Unlike the hospital specialties and community medicine, this period of training for general practice is required by law.

It has been agreed that standards of training should be under the control and supervision of the profession. The decision taken in general practice that a system of training, which began on a voluntary basis, should be subsequently reinforced by Statute was one of the more controversial of the decade. Many doctors thought that it set a dangerous precedent by enabling the State to extend its control over standards of medical education. This article sets out the main historical events leading to the decision to go for mandatory rather than voluntary training for general practice.

Background

General practice has always embraced many styles of medicine, reflecting different interpretations of the content of the discipline and therefore of the clinical services that practitioners should provide for their patients. These differences in content and style have resulted in wide differences in the standards of care. Standards at the lower end of the spectrum are thought by many to be unacceptable, while at their best they are a very effective way of providing primary and continuing medical care. In the early 1960s it was obvious that general practice was in decline. Morale among established practitioners and emigration was rising, and medical students were quickly losing

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interest in general practice as a career. Because there was no minimum standards of entry into general practice (too many general practitioners were prepared to welcome anyone as a new partner regardless of the person's medical competence. Similarly, the executive councils (and the family practitioner committees which followed them) and the Medical Practices Committee exercised no effective control over standards of entry since no training was required for admission to the medical list.

The Charter¹ laid the foundation for the structural rebuilding of general practice and was an essential prerequisite for recovery. Nevertheless, it did not tackle the problem of training—or rather the lack of it—and thus of widely varying standards of entry. The idea of vocational training for general practice received new impetus during the late 1960s when the Royal College of General Practitioners (RCGP) said that general practice was indeed a specialty with its own body of knowledge and skills which could be taught and learnt.² These skills were not being taught as part of basic medical education. Indeed, medical schools had for years almost totally neglected teaching about general practice, and in England (though not in Scotland or Northern Ireland) their efforts to correct this deficiency in the 1970s were, with a few notable exceptions, merely a token. The preregistration year, which is hospital-orientated, contributed nothing specific to the training of the future general practitioner, nor was it intended to. It was entirely logical, therefore, that the Royal Commission on Medical Education,³ backed by the RCGP and the General Medical Services Committee, should propose that general practitioners, like specialists, should be properly trained before being allowed to enter unsupervised practice.

The present system of vocational training for general practice began in the late 1960s as voluntary schemes in some parts of the country. The introduction of vocational training, with, and was partly responsible for, a resurgence of interest in general practice as a career, and schemes soon mushroomed as the more enthusiastic and highly motivated entrants to general practice appreciated their value.⁴ Nevertheless, despite the momentum of the new training movement, there was still

a substantial minority of young doctors who failed (or did not want) to understand the need for training. Perhaps they still saw general practice as the soft option in medicine, carrying limited responsibility and therefore requiring little effort to prepare for practice; or perhaps they simply wanted to earn a principal's income immediately after full registration, which was very easy to do at that time. Whatever the reasons, good doctors, especially volunteer vocational trainees, tended to join practices that had already attained high standards, while untrained doctors, too many of whom had a different and lower level of motivation, continued to join practices most in need of improvement, so that two quite different forms of general practice began to crystallise.

Why mandatory?

In the late 1970s the profession had to face up to this increasingly unsatisfactory situation. Given time, some said, a single standard of entry would be established. Others thought differently, since too many young doctors continued to become principals with scant or no preparation. The route followed by the hospital specialties was not acceptable, as many established general practitioners did not accept the membership examination of the RCGP as an objective test of vocational training and so would not allow the college to act as a precondition of becoming a principal. Indicative specialist registration through the General Medical Council, recommended by the Merrison Committee⁵ would have been another option. Informed people, however, recognised that in reality specialist registration was only a vague possibility over the horizon and could take years to come into effect. Given these conditions, the profession thus judged that so long as vocational training remained voluntary within the independent contractor system there would be essentially two standards of entry into general practice and that therefore the gap between good and bad general practice would widen inexorably. The Conference of Local Medical Committees and the RCGP concluded reluctantly, therefore, that vocational training would have to become mandatory for doctors who wished to become principals in general practice in the National Health Service, since the other way of controlling entry either were not available or not acceptable.

Hospital and general practice compared

In hospital specialties the responsibility for setting minimum entry standards belongs to the royal colleges and faculties and the joint higher training committees. The pattern of training required usually includes a general clinical period up to registrar level, followed by higher training in the senior registrar grade. Assessment is normally done by a combination of examination and the supervising consultant commenting on clinical performance. The royal colleges and faculties and the joint higher training committees are accepted by the profession as the bodies that set definitive standards. Training is provided and paid for by the NHS and is under the general supervision of the regional postgraduate medical committees and their specialist sub-committees. When training is concluded, appointment as a consultant in the NHS is controlled by the State through its NHS appointment committees. These appointment committees normally follow the training requirements set by the appropriate college, though they are not obliged to.

A comparable arrangement has emerged in general practice. In 1974 the council of the RCGP introduced its Postgraduate Training Committee for General Practice, which included representatives of the profession (the General Medical Services Committee) and the universities (regional advisers and postgraduate deans). It was thus analogous to the joint higher training committees in other specialties. In 1975 this

committee became fully independent and was renamed the Joint Committee on Postgraduate Training for General Practitioners (JCPTGP). The JCPTGP is no more or less independent than the joint higher training committees that supervise and, in some cases, signify the completion of training in the specialties. Housed at the Royal College of General Practitioners and serviced by the college, the JCPTGP is of the profession. Most of the members are appointed in equal numbers by the RCGP and the General Medical Services Committee. Other members represent trainees, regional advisers in general practice, the armed Forces, regional postgraduate deans, clinical tutors, and the Association of University Teachers in General Practice. The councils for postgraduate medical education and the health departments have observer status. Part of the income of the JCPTGP comes from the profession and part through grants in aid from Government, as is the case with the joint higher training committees.

The JCPTGP was charged with supervising standards of training in general practice. Later, when the decision to introduce mandatory vocational training was put into effect, the JCPTGP also became the certifying body responsible for seeing that the NHS Vocational Training Regulations were implemented as the profession and Parliament had intended. The JCPTGP's certificate is required as one condition of entry to the medical list. Training posts are provided by the NHS. In arrangements for training are the responsibility of the regional advisers in general practice acting on behalf of the general practice sub-committees of regional postgraduate committees. Entry to practice is determined, from among those eligible for inclusion on a medical list, by partners or, in the case of single-handed vacancies, by the Medical Practices Committee on the recommendation of the family practitioner committee.

Was it worth while?

Many doctors feared that the introduction of mandatory vocational training would result in the loss of independence for the profession. In fact this does not appear to have occurred. Through the JCPTGP the profession has retained control over the content of its standards for training. In addition, the membership examination of the RCGP is now well established as the definitive assessment of success in vocational training. General practitioners still have the freedom to choose their own partners, which compares very favourably with the State-controlled appointment committees that decide who shall become hospital consultants in the NHS. Specialist registration by the General Medical Council may have provided a more desirable way of controlling standards, but it is still being talked about as something the profession might do in the future. Meanwhile, mandatory vocational training for principals in the NHS became effective from 15 August this year. It has efficiently and speedily introduced the single entry standard that general practice so badly needed; it should be welcomed by the profession.

I acknowledge the advice and help of Dr D H Irvine in preparing this paper and the practice secretarial staff, particularly Miss Julie Sims.

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Research in General Practice

Problems in doing operational research

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This is an account of the problems encountered in doing a small research project that was published in the *BMJ* in 1976. It attempts to describe why, what, how, when, where, and "was it worth the effort." Some of the discouraging episodes are quoted in some detail to alert fellow travellers. The quotes are taken from a bulky file relating to the project that has been maturing in a trunk in the attic for the past six years.

Why did we start?

The stimulus that led to our partnership of three, in semi-rural Leicestershire, recording our out-of-hours calls for a year was a combination of four influences. Firstly, the practice had just been accepted as a teaching practice for vocational training and the new Leicester Medical School were warning us to prepare ourselves for teaching medical students. We felt we needed a reliable aide memoir-teaching aid for the "out-of-hours" work. Secondly, the partner who lived closest to the health centre had the impression that he was dealing with more of the out-of-hours emergency calls than the other two partners, who lived two and eight miles away. Thirdly, we had been impressed, while sitting on medical service committee cases, of the need for keeping good records of all the out-of-hours telephone calls, visits done, and actions taken. Lastly, as we were about to start recording, the summary of deputising services in Sheffield was published.¹ This article highlighted the dearth of information on "out-of-hours" activity being done by the practices that did not employ deputising services.

What did we record?

Having worked as a locum for the Leicester deputising service, I felt that we should record the same details that the deputising service recorded for accurate comparability. Inevitably, this meant noting the G.P. on duty, the patient's name and address, age, sex, and marital status; the time and date of the call; the day of the week; the message received; the action taken; the follow-up. We added the degree of urgency perceived and the mileage travelled. Later we analysed the type of call using the Royal College of General Practitioners' Classification of Morbidity (1963). We subdivided the classification down to the same 14 broad headings that the Sheffield team had used.

As it was to be a prospective study, we first tested the practicability of collecting all this information consistently by having a pilot study. We chose a small village 10 mi. S in called the Collin's Collectors. The pages were already ruled horizontally and vertically in a useful way. We detailed the way in which the

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columns were to be used in the front of the book and explained the recommended abbreviations—for example, E for emergency; go at once; U for urgent, but can probably wait for up to two hours; A for advice on the phone only.

We started recording on 1 April 1973 and found that everyone was quickly able to enter the relevant information. Occasionally part of the name or the age or the distance travelled was omitted, but these omissions were easily corrected later. When I say everyone, I mean not only the doctors on call but members of their families who might have to note down the details of the call when the doctor was already out on a call—a frequent occurrence at busy times.

In July 1973 I started to explore the different ways that we might use to analyse the data, and I wrote to the RCGP Research Unit at Birmingham. Dr Pinent sent a useful, but rather discouraging reply. The good news was that he felt "there is a real need for hard data about this," but the bad news was "people in this situation have been known to drown in their own data. If you permute and combine 15-250 items you will have some idea of the depth of water in which you are already swimming. It might be useful to go through your list of observations, to limit yourself to those which can be made by selection from a list of alternatives, and to see whether you can produce lists which are comprehensive and which contain unequivocal alternatives for at least some of the things you are recording in free hand. I think you must regard your work to date as a pilot study and if you, with your colleagues, sit down to a manual analysis of the data you already hold, you will see what I mean." I really do feel that the next stage must be one of preparation for mechanical analysis.² He also suggested that we contact Miss Hammond, the RCGP librarian, for reference lists to published work and for photocopiers of papers that we might not have access to.

Which reference?

We must have been somewhat downcast by this letter for it was not till June 1975 that the correspondence resumed with a letter from Miss Hammond enclosing the list of references. Out of the 29 titles, only seven seemed to be relevant to our study and these were obtained and summarised. Definitions varied considerably, which put a different emphasis on the results. It quickly became clear that the statement in the Sheffield study that "very little is known about how primary medical care is being delivered out-of-hours" was still true.

What finance?

We had by now collected data for two years and to produce results that could be compared with the Sheffield study we would need to use computer technology. This might prove expensive, so we sought the advice of the research expert in Trent Region, Dr B Williams. He had also been one of the authors of the Sheffield study and he was an ideal choice. Regional research funds for projects based in general practice were available on submission

to the appropriate committee. Allocations, however, were made only once a year, and we had just missed a meeting. He felt, at first, with a small project like ours, the local university department of community health should be able to contain the cost in their own research budget. He advised us to prepare a suitable protocol and apply for a permission, which is a relative term: in the first year we had nearly 1000 patient contacts.

What method?

Dr Pinent's forecast was already proving true. There were far too many data for manual or simple mechanical analysis, and we needed guidance on what computer method might be appropriate. Before submitting our protocol I went to see the head of the Leicester University computer department, Mr Fisher, and literally laid my cards on the table. He thought that the Fortran coding card system would be best and was most helpful in showing me how the data could be reduced to a numbered code with 10 variables for any one item. If more variables were necessary, then a permutation method could be used. This was converted onto the Fortran Coding Form, then his coders would type up the cards ready for electronic sorting. The ease with which a very wide range of comparisons could be made was most impressive. My permission, which I gave myself, was limited to the sort of answers we required for the project.

What protocol?

I had discussed the project informally with the newly formed Department of Community Health on several occasions, and by the time I submitted the formal protocol in May 1975 had converted all the collected data to the coding forms myself. This was to reduce observer error. I wrote: "I enclose herewith an introduction, method, and details of suggested analysis to form the protocol you asked me to produce when we last met." Professor Marinker replied promptly. "Thank you for letting me have the additional material on this study. I think this is a useful first step, and I would like to suggest..." There followed four paragraphs of detailed comment.

I suspect, with hindsight, that I must have been developing a certain paranoiac resistance to any sort of criticism, for I took me till August to reply. Impatient comments such as "... it must be more like the fifth step..." as the present draft is based on the first paragraphs of Dr B Williams' study... and his style was accepted for publication in the *BMJ*; I feel a little put out that you should be suggesting another approach..." The costs of processing the data are easily found from within the computer department budget and our practice will cover any incidental expenses.

"The method does need more explanation, but I cannot put in more detail until you have given me permission to discuss the method with the computer department." "Please help us to ask the questions I have listed and then by all means let us meet to discuss the significance of the results."

Fortunately, no offence was taken, and we were allowed to proceed with processing the data.

How were the data processed?

In the weeks before submitting the protocol I had been slowly working through the records of the first year. Missing information had to be extracted from the patient's record file when possible. Then the consistency of the entries had to be checked, such as "Advice given" when the doctor had clearly seen the patient at home and should have put U. I then had to translate all the data onto the Fortran Coding Forms. This was done at the end of the normal working day, when there was nothing worth watching on the television. The conversion became much easier with practice. Two examples may be helpful:

Column 17 dealt with age groups—Age	Code
15-14	1
15-44	2
45-64	3
65 plus	4

Columns 27 and 28 dealt with the month
January-01 June 06 December-12
Having coded all the entries, several spot checks were made, but no errors were detected.

How the computer print-out was analysed

The data were processed by the computer department on 8 October 1975. At the bottom of the concertina-like print-out there is the following information:
Number of transfers 7456
Total mill time used 113 secs
Maximum core used 61 thousand
Computing units used 19.9
Normal I/O jobs, 58 control cards were processed.
0 errors were detected."

Unless you are used to this sort of language it takes a little time to work out what the answers were. I found that I had to reconvert the tables back from figures to words so that in table 39, "variable day," value 1=00 meant Monday, 2=00 meant Tuesday, etc. The minimum number of comparisons to answer the questions that we wanted to pose required 92 pages of print-out.

How to write the article?

Even with the article on deputising services and the *BMJ*'s notes for those writing articles, I did three rough drafts of the article before it was ready for expert comment. A letter in January 1976 from Professor Marinker was most helpful, and all the suggested amendments were acted on. The tables and figures needed to be better, with clear labelling. He offered the services of the department: "We have the facility for doing a very professional job on this." He also suggested that we submit the article to the *Journal of the Royal College of General Practitioners*, but we all felt that we should try the *BMJ* first to try to reach the same readership as the Sheffield study three years earlier. We were delighted when a final draft was accepted for publication.

Was it worth the effort?

We achieved all four objectives. The record has continued, and we are now in our tenth year. It is a valuable teaching aid, and the record is still being used and we are even covered by a medical service committee. The partner living furthest from the centre was receiving only 3%, fewer calls than the partner at the centre, but he was overcompensating for distance by doing more home visits. We provided some of the missing information asked for by the Sheffield study.

We wanted to know the answers to the questions we were asking. No one else knew. I think that you need that sort of spur to overcome the frustrations along the way and somehow find the time, out of your valuable free time, to slog through the mass of data. To use Dr Pinent's analogy, it is worth learning to swim before attempting a rather ambitious project like ours.

I thank my wife, my partners, Dr R Pinent, Professor M Marinker, and Mr Fisher of the computer department, University of Leicester.

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