A national standard for entry into general practice

**Practical and symbolic benefits**

A national standard of entry into general practice—under consideration by the Joint Committee on Postgraduate Training for General Practice¹—has important implications for all of general practice but particularly for vocational training. It puts general practice on the same footing as other specialties. If the recommendations of the working party set up to advise the joint committee are accepted, then knowledge, performance during consultations, practical and management skills, and ability to audit will be taken into account together with trainers’ overall assessments. No final summative assessment (end point assessment with set standards) has yet been agreed, but, if a standard for entry is to be set and a certificate which determines competence awarded, it is hard to avoid the need for one.

Knowledge is best assessed by multiple choice or modified essay questions; why the working party thought that this should be set and applied locally is hard to fathom. The multiple choice questionnaire and written component of the examination for the MRCP is already accepted by most trainees, academic departments of general practice, and general practice partnerships as a national standard of written knowledge.² The examination’s timing and purpose as an end

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point assessment have been questioned, but as a base of factual knowledge it is accepted. Its failure rate of about 26% may be, however, too high to identify those few trainees who cannot or will not attain a certificate of competence.

Skills and attitudes are more difficult to assess. Performance during consultations, whether observed directly or by video or assessed by analysis of random cases, should be carried out by a trainer's trainer. Because no single method can provide all the information that is needed the joint committee has previously recommended a wide range of assessment methods, including the Manchester rating scales. These are regularly used nationally and internationally to assess individual trainees' knowledge and educational needs (formative assessment). If the new Manchester rating scale is applied correctly for formative assessment it needs to be used three times during a traineeship, and each time takes up a day and a half of the trainer's and trainee's time.

A summative assessment would take longer, especially if an outside assessor was involved. Setting standards for a summative assessment has so far eluded any committee or region; with the changing role of principals in general practice its content would have to change continually. One suggestion has been to use a condensed version of the Manchester rating scale: one low rating or several poor ratings would be grounds for refusing certification. Whatever standards are set, they must be valid, practicable, and acceptable to the profession and of proved reliability. Trainees in the west of Scotland have made great strides in this direction.

Trainees' assessments of their trainees are not always reliable owing to the "halo effect" and their variation from trainer to trainer. It has been suggested that, because formative assessment addresses the strengths and weaknesses of trainees throughout their training, eventually a summative assessment will not be necessary. Unfortunately, the Australian model of formative assessment was deemed insufficient to guarantee quality.

Currently two thirds of vocational training takes place in hospital posts; more thought needs to be given to its assessment, especially when in so many specialties counts as relevant experience. One solution—explaining assessment to consultants—yielded benefits in the Northern region, but more than 20 years after vocational trainee schemes were set up the time has come to question the relevance of hospital senior house officer posts.

Intensive and invasive hospital medicine differs greatly from the same subject in general practice: the care of pregnant women, children, and patients with diabetes and asthma (to name just a few) could and should be taught and assessed in general practice. The introduction of assessment could be a springboard to increase the time spent in general practice to two years—either by reversing the present division of two years in hospital posts and one year in general practice or by increasing vocational training to four or five years. Both these arrangements would provide several years of formative assessment in general practice by general practice.

A longer vocational training and a summative assessment also fit well with suggestions made by the working party of the Royal College of General Practitioners on higher education. These would result in the following career path after qualification: preregistration posts; vocational training and assessment diploma; young principal and MRCGP; higher professional education (leading to MD or MSc); and, finally, continuing medical education and FRCGP.

Whatever form of assessment is adopted, some doctors will fail, which the working party acknowledges. It suggests that additional training and counselling will remedy this, but some trainees—either through lack of knowledge or volition or through personality problems—will probably never reach such a standard. Consideration should therefore be given to a career grade post for practitioners who will never achieve the status of principals.

Trainees need not feel threatened by these suggestions. They already undergo several assessments during training. Further formative assessment can only strengthen their personal educational programme, and summative assessment, which most (70%) now seek in the MRCGP, will give them a sense of achievement.

Through the General Medical Services Committee and the Royal College of General Practitioners vocational training should be lengthened and strengthened: formative and summative assessment should become an integral part of every trainee's education.

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5 Centre for Primary Care Research, Department of General Practice, University of Manchester. Rating scales for vocational training in general practice. London: RCGP, 1988. (Occasional paper 40.)

Correction

Viral diarrohes in childhood

An author's error occurred in this editorial by Elisabeth J Elliott (7 November 1992, pp 1111-2). The last sentence in the penultimate paragraph should read, "Opium-like drugs (for example, the diphenoxylate hydrochlo ride component of Lomotil) may cause respiratory depression and even death," not "Atropine-like drugs may cause respiratory depression and even death," as published.