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Training for general practice: meeting the challenge

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Many changes and advances have taken place in medicine from 1948, the beginning of the National Health Service, to the present time. One of the most noteworthy is in training for general practice and in particular how general practice has met this challenge.

In 1911 Sir William Osler in a letter to Ira Remsen, President of the Johns Hopkins University, said of the hospital specialist that 'he was cabined, cribbed, confined within the four walls of a hospital practising the fugitive and cloistered virtues of a clinical monk. How shall he, forsooth, train men for a race the dust and heat of which he knows nothing and — this is a possibility! — cares less? I cannot imagine anything more subversive to the highest ideal of a clinical school than to hand over young men who are to be our best practitioners to a group of teachers who, ex officio, are out of touch with the conditions under which these young men will live'.

The career preferences of house officers in Northern Ireland between 1982 and 1988 show that 40 – 50% or more had a first preference for general practice (Fig 1). This has been the case for many years during which the education of general practitioners, both as undergraduates and postgraduates, has been in the hands of colleagues who had little or no experience of general practice. In 1969 Sir Denis Hill said 'The family physician's role is a difficult one. If it is to be sustained and developed the general practitioner must become the best educated, the most comprehensively educated of all the doctors in the Health Service'.[1] It is the marriage of the views of Osler and Hill which forms the basis of this paper.

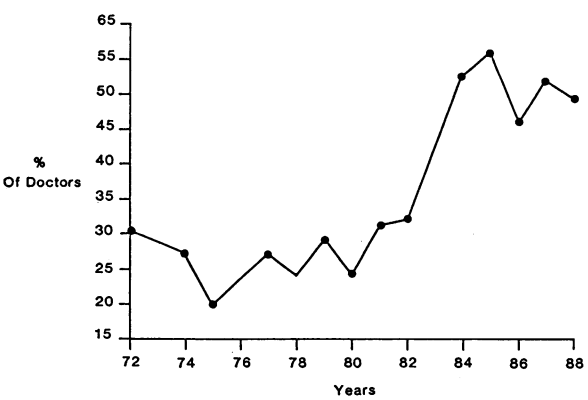

Fig 1. Career preferences of house officers in Northern Ireland 1972 – 1988, from data collected by the NI Council for Postgraduate Medical Education. The graph shows the proportion indicating general practice as first choice.

A G McKnight, MB, FRCGP, President, Ulster Medical Society, 1988 – 1989.

EARLY TRAINING ARRANGEMENTS

A history of training for general practice might begin in 1858 with the foundation of the General Medical Council. Its main purpose was to regulate the qualifications of practitioners in medicine and surgery. It was to keep a register so that persons requiring medical aid could distinguish qualified from unqualified practitioners. A Royal Commission in 1882 recommended that the qualifying examination should be in medicine, surgery and midwifery. The standard of proficiency should 'guarantee the possession of the knowledge and skill requisite for the efficient practice of medicine, surgery and midwifery' that is *a complete doctor* who could enter practice directly without further hospital experience after qualifying.

Sixty years later, the Goodenough Committee (1942 – 1944) recommended that after qualifying there should be one year of compulsory pre-registration hospital appointments in medicine and surgery.[2] This was introduced in 1953 and was the first step in the provision of postgraduate experience. It implied that undergraduate training no longer produced a fully trained doctor fit to enter general practice immediately after qualification as indeed did some of my contemporaries in 1950. (They had been preceded by many illustrious people, not least by Sir John Biggart, who was in general practice on the Shankill Road for five days between qualification at Queen's and graduation).

THE TRAINEE GENERAL PRACTITIONER SCHEME

The forerunner of vocational training for general practice was the Trainee General Practitioner Scheme which had been introduced in 1948 following the Spens Committee recommendations in 1946. The Committee recommended that the trainee should be a supernumerary member of the practice and spend one or preferably two years as an assistant after the completion of house appointments. Even those doctors who intended to become specialists would benefit from a year in general practice. Ten per cent of practitioners selected on the grounds of their success in practice and general suitability (whatever this might mean) should be encouraged to take a trainee. Trainees in the scheme were appointed by the trainers themselves and this has continued through to the present vocational training for general practice in Great Britain.

In 1957 there were 450 trainees in Great Britain in the scheme, but by 1966 the numbers had dropped to 150. The scheme became less and less attractive because of the ease in obtaining assistantships with a view to a partnership rather than because of faults in the scheme itself, though it was criticised on the grounds of exploitation of the trainee. This scheme was never introduced in Northern Ireland, which is one of the reasons for the present-day difference in the trainee entrance to vocational training in Northern Ireland compared with Great Britain. In 1950 the Cohen Committee of the British Medical Association considered the training of the general practitioner and concluded that the work of a general practitioner comprised a branch of medical practice for which an adequate period of training was necessary.[3] It suggested three years — the first as an assistant; the second in specially designated hospital posts, preferably residential; and the third year in supplementary training at the choice of the trainee. Flexibility would be required for the second and third years in order to meet the varying needs and aptitudes of the trainee. Little action appeared to follow this but the leaven of the report was working in the minds of many people including members of the College of General Practitioners which had been founded in 1953 amid opposition from the existing Royal Colleges.

That the leaven was working was shown in the College's first report on general practice in 1965 — *Special vocational training for general practice.*[4] In this, training for five years was recommended: three in hospital posts and two in general practice. The report commented specifically that trainers in the present Trainee General Practitioner Scheme, though worthy in the eyes of their fellow doctors, had no special gift for teaching.

The next advance in training was foreshadowed by the Royal Commission on Medical Education — the Todd Committee report in 1968[5] — which among other recommendations considered that after registration there should be a period of three years general professional training, followed by two years of further professional training which would be concluded by registration as a specialist or principal in general practice. The Commission stated that 'in our picture of the future pattern of medical service in Britain, all doctors — general practitioners as well as consultants — will be specialists in particular aspects of medicine who will be equally regarded as such and who will be fully trained for the work they undertake'.

The Todd Committee also stated — 'we do not think that the universal requirements for proper training will deter good doctors from entering general practice. In fact, we think that proper training will be an attraction in itself but *unless it is made compulsory* the few who put quick rewards before professional pride will have a financial advantage that will, we think, prevent any general advance in standards'.

TRAINING IN NORTHERN IRELAND

Northern Ireland was moving along a similar path. In 1962 Dr Frank Main, then Chief Medical Officer of the Ministry of Health and Social Services, convened a meeting to consider the immediate problem of continuing education for general practitioners. A steering committee chaired by the Dean of the Faculty of Medicine, Professor Sir John Biggart, recommended that the number of available refresher courses should be doubled to permit practitioners to attend a five-day course every five years. Dr Hunter, Medical Officer at the General Health Services Board — the forerunner of the Central Services Agency — was the organiser. The question of a postgraduate dean to direct the courses and appoint postgraduate tutors was also considered.

In July 1963 an important principle about the vital question of financing postgraduate education was considered. Professor Biggart was adamant that the grant for postgraduate medical education should not be merged with the block grant to the University, but that such funds should be 'earmarked' for postgraduate medical education only and that arrangements should be elastic — demand for courses would vary from year to year and therefore finance was going to change. The question of establishing a postgraduate education board was referred to the Ministry for its opinion. The steering committee met, for the last time, in 1964 to formalise representation on the Postgraduate Education Board and the decision to advertise for a postgraduate dean was taken. There is a gap from January 1964 until October 1965 when the first meeting of the Postgraduate Education Board took place. It can be surmised that those interested in general practice training were working in the background to obtain funds and set up the necessary administrative structure. Dr John McKnight was appointed Director of Postgraduate Medical Education from 1 October 1965 though he had been acting in a part-time capacity for some three months previously.

It should be remembered that these radical proposals for postgraduate education for general practitioners were taking place during the period between 1955 and 1965 when general practice was grossly underfunded and general practitioners were underpaid, overworked and very very unhappy. This was the time when general practitioners signed letters of resignation from the NHS and gave them to the BMA to hold; the time when over 100 general practitioners from Belfast wrote to the *British Medical Journal* about the pool system of payment. The unrest was halted by the 1965 Charter for General Practice which contained proposals for payment of rent and rates, ancillary staff, differential payments for elderly patients, group practice allowances, and so on. The Charter was accepted by Government in 1966 and proposals for promoting and financing postgraduate education for general practice were established.

A paper on vocational training had been considered by Professor Biggart's Committee in the spring of 1965. The relevant paragraph deals with the need for vocational training in general practice in Northern Ireland. 'The need for organised training for general practice is so self-evident that it hardly requires to be argued. Entry to practice by way of an ordinary assistantship may have sufficed as an adequate introduction to this branch of medicine before the 1939–45 war; but, more especially since the inception of the National Health Service in 1948, major changes have occurred both within general practice itself and in the context of general practice, all of which pointed to the desirability of systematic training for those who wished to take up general practice as a career. Among the internal changes in general practice were the growth of partnerships and groups, the employment of ancillary staff in large numbers, and the increasing importance of practice organisation. Among external changes were the development and increasing complexity of hospital services and the provision by local authorities of health visitors, social workers, district nurses, midwives and other domiciliary workers, which called for a greater awareness on the part of the general practitioner in the context of his branch of medicine and close collaboration with other agencies and Health Service colleagues in the interests of his patients. Furthermore, medical science itself was undergoing continual rapid change and development, and if the practitioner was to keep abreast of advances in knowledge he required more time for regular postgraduate study, for reading and for personal contact with professional colleagues. These changes all meant that the young doctor entering general practice was precipitated into a situation far more complicated, but at the same time affording far greater opportunity for the exercise of his skills, than ever before. If he was to make the fullest use of his medical knowledge in the different environment that confronted him on completion of his pre-registration year, some further period of systematic training seemed indispensable'.

In Northern Ireland it was decided to introduce a voluntary training scheme of two years' duration. One year would be spent in a training practice and one in hospital posts. The hospital posts would comprise six months obstetrics and gynaecology and the other six months in three of the following: dermatology, geriatric medicine, paediatrics or psychiatry. This was based on a scheme in Wessex. The Vocational Training Scheme which was to commence on 1 February 1966 was launched on 1 October 1965 and was given wide publicity in the news media. All senior house officers in post were informed about the scheme and a circular was sent to all general practitioners inviting them to apply to become trainers if interested.

There were about 740 general practitioners in Northern Ireland at that time. A surprising response resulted. Eighty general practitioners applied to become trainers and two senior house officers to become trainees. Of the latter both withdrew their applications — one to go into practice and the other to go back into hospital. This was a pattern to be repeated many times over the years until 1980, when mandatory vocational training for general practice came into being.

The initial criteria for appointment of the trainers were:— (1) Ten years a principal in general practice; (2) Less than 50 years old; (3) In a partnership; (4) List size was less than 2,500 in an urban and 2,000 in a rural practice; (5) Suitable practice premises and organisation; (6) Suitable geographical spread; (7) The practice had to practise midwifery.

Twelve trainers were appointed including Dr R E Hadden of Portadown, Dr N D Wright and Dr W G Irwin of Belfast. There were five in what is now the Eastern area, three in the Southern and Western areas and one in the Northern area. Twelve more were appointed in 1969 by the Trainer Selection Committee. It was decided that these, together with those appointed in 1966, should be interviewed in their practices before reappointment. This was a completely new concept and was the first example of peer review in Northern Ireland.

The criteria for the appointment of these new trainers had already advanced from the simplistic criteria used in the appointment of the first trainers. The new criteria showed the change in emphasis to teaching in the practices and were:-

(1) A desire to teach by the applicant, evidenced by past and present activities in the teaching of undergraduate or postgraduate students and paramedical staff, by interest in teaching methods, and attendance at teacher courses.

(2) The provision of time to teach or readiness to make time — at least one session per week.

(3) Attitudes towards patients, partners, colleagues, previous trainees (if any) and general practice itself.

(4) The trainer's and partners' special interests should be noted, particularly research.

(5) The ability to make available the necessary time for teaching by means of good organisation, — in particular the use of appointment systems, employment of appropriate ancillary staff and an efficient records system.

THE NORTHERN IRELAND COUNCIL FOR POSTGRADUATE MEDICAL EDUCATION

The Postgraduate Education Board was succeeded in 1970 by the Northern Ireland Council for Postgraduate Medical Education. The Council's responsibilities included the appointment of general practitioner trainers and the organisation of postgraduate education and training for doctors and dentists. Later it undertook the approval of selected hospital posts as suitable for general practice training in accordance with the Vocational Training regulations of 1979. These responsibilities were exercised through its General Practice Committee.

In Great Britain the standards of the various voluntary training schemes were being considered by the Education Committee of the College of General Practitioners. As part of the Education Committee's work in 1970–1973 it carried out studies on the accreditation of training schemes. Its main aim was to demonstrate that

visiting, preceded by written evidence, was an effective measurement of examining the quality of practices and of stimulating improvement. The recommendations following the study included (1) A national system of accreditation for training programmes should be established; (2) The views of trainees should be sought directly on a completely confidential basis; (3) Regional advisers should serve on visiting panels in regions other than their own — a very valuable exercise; (4) The visiting team should contain one member who had special knowledge of the training content, one with special knowledge of educational methods and one experienced in educational and health service administration.

An increasing administrative load was arising from recruiting trainers, training trainers, organising the day release course and giving career advice to potential trainees. More staff were required to deal with these matters. Dr Noel Wright was appointed as a course organiser in January 1971 and became Regional Adviser in December 1971. Dr Herbie Baird and I were appointed Associate Advisers in 1973 and 1974 and Dr Ben Moran in 1982.

THE JOINT COMMITTEE FOR POSTGRADUATE TRAINING IN GENERAL PRACTICE

The end of the voluntary schemes was presaged by the formation of the Joint Committee for Postgraduate Training in General Practice in 1976 which took over the central administration of vocational training in the UK. This was a national body, set up by the profession, essentially to advise on the implementation of vocational training and later to monitor the performance of regions in providing this training. It also had the statutory duty of issuing certificates of prescribed or equivalent experience. The membership of the Joint Committee was divided equally between the British Medical Association and the Royal College of General Practitioners.

The vocational training regulations came into operation in 1980. Initially, vocational training was not required before becoming a principal in general practice, from February 1981 to August 1982 a year in a training practice was required, and thereafter the full three-year training was required. This was to be one year in a training practice and two years in hospital posts which must include two of the following: medicine, geriatric medicine, paediatrics, psychiatry, accident and emergency or surgery, obstetrics, gynaecology or obstetrics/gynaecology, and the remainder in educationally approved posts.

VISITS TO APPROVED TRAINING SCHEMES

The Joint Committee adopted the methods for visiting previously used by the College for the approval of vocational training schemes in Great Britain and Northern Ireland. Visits were and still are carried out every two years. The visit is undertaken by three general practitioners led by a Regional or Associate Adviser. They are in receipt of documentation which includes the region's criteria for the approval and reapproval of trainers and training practices and they use these as a measure of the scheme. They spend three days in the region, talking first to the Adviser and Associate Advisers, then to the trainees in general practice, to the consultants in the local hospitals and to the course organisers. The team visits eight to 10 training practices. Two visitors interview the trainer, exploring his attitudes to training, his aims, his preparation and his methods of assessment of the trainee. The third visitor talks to the trainee in post and inspects the records.

Minimal educational requirements have been established for medical records — correspondence in date order (1984), long term drug therapy and monitoring prescribing (1986), library (1987) and summary problem lists (1989).

A report of the visit and its recommendations is made to the Chairman, the Secretary of Council, the Regional Adviser, the General Practice Committee and to the Joint Committee. The report is always constructive and gives a fresh perspective of the scheme being visited. Of course it may result in the withdrawal of approval from a region.

CRITERIA FOR THE APPROVAL AND REAPPROVAL OF TRAINERS

From 1980 a potential trainer applied to the Northern Ireland Council to be considered for appointment as a trainer. The applicant received the aims of the Northern Ireland Vocational Training Scheme: to produce a doctor who, on completion of training, will

(1) be able to provide personal, primary and continuing care to individuals and families in their homes and in the community
(2) be able to provide preventive care and health education
(3) have management interprofessional skills relative to general practice
(4) audit his work with a view to improving his performance
(5) understand the importance of continuing medical education and be prepared to participate
(6) be aware of personal and family needs in relation to his work
(7) be competent to pass the membership examination of the Royal College of General Practitioners
(8) hold a Certificate of Prescribed or Equivalent Experience.

He also received proformas to furnish details of his and his partners' curricula vitae, of his practice premises, records, staff, equipment etc, together with the criteria for the approval and reapproval of trainers and the priority objectives of training — these set out the educational standards Council required of its trainers. These documents had been discussed and amended at trainer meetings and courses and approved by the General Practice Committee of Council and Council itself.

In the 1986 paper the trainer's eligibility is clearly stated. He or she must have been a principal for five years and be under 50 years of age. He must demonstrate clinical competence, professional and personal values, and availability and accessibility.

He must want to teach, have time to teach (2 – 2·5 hours per week), have aims for teaching and have attended trainers' courses. He should be able to discuss his use of educational techniques, methods of assessment and involvement with the Primary Health Care Team. The practice should have adequate premises and staff with appropriate records up to the Joint Committee standards.

When the potential trainer considers he fulfils the criteria he is visited by a team consisting of the Chairman of the General Practice and Trainer Selection Committees, an established trainer and the Regional Adviser. If successful he will be appointed for two years with the proviso that he goes on a training course during this time. Subsequent appointments may be made for up to five years. The trainer is the lynchpin of the vocational training scheme. He is in contact with the

trainee daily and has the most direct influence on the trainee's education. The trainer is a very special person and Northern Ireland has been fortunate in bringing together the present cohort of 70 trainers in 62 training practices (ie 62 training places). The numbers of trainers and trainees are approaching one another. At present Council is looking for more trainers especially in the Western area (Fig 2).

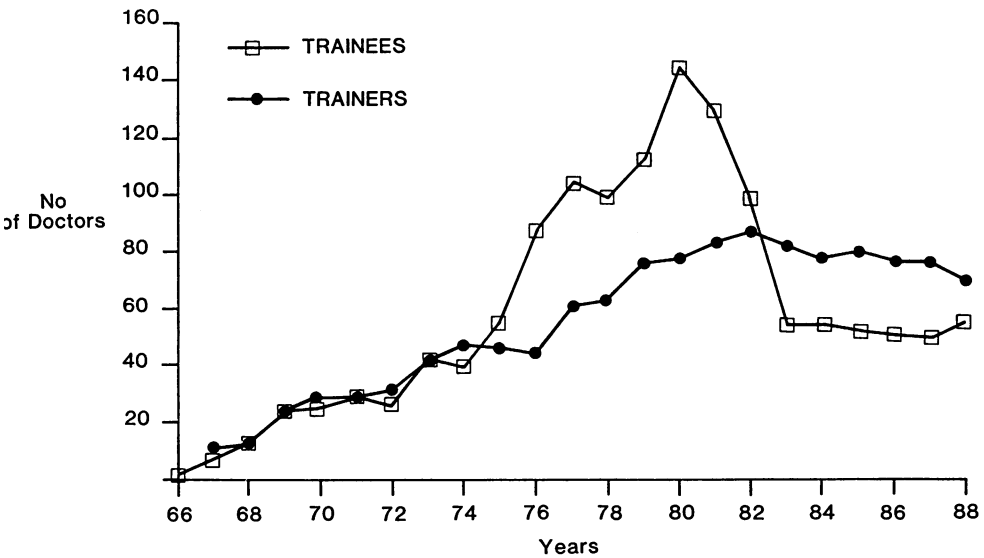

Fig 2. Numbers of trainers and of trainees in general practice in Northern Ireland 1966 – 88. Trainee numbers refer to those in both hospital and general practice posts until 1983.

TRAINER COURSES

Trainers needed instruction in teaching and educational techniques because they had little if any experience in these fields. The first courses were held in the early 1970s and have continued yearly. Trainers were introduced to the educational model which can be entered at any point but always produces a logical outcome and forms the basis of teaching in the practice and in the day release courses (Fig 3).

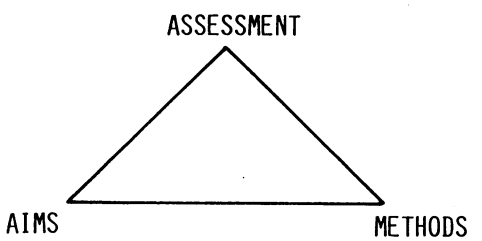

Fig 3. The educational model used in the trainer courses.

Educational techniques such as formal one-to-one tutorials with another trainer assessing the tutorial were practised at the courses. Random case analysis in which the trainer selects a particular patient for discussion, again with an assessor, proved a valuable tool. Role play in which the trainer acts out a patient's consultation was used occasionally and is coming back into vogue. Tape-recorded consultations have been used though they have drawbacks. Video-recorded consultations are really one of the best ways to assess the trainer and trainee; these have been encouraged in the practices and will be used more in the future.

Other subjects discussed over the years include assessment of the trainee, treatment protocols, prescribing and audit. Trainers were and are encouraged to go to Great Britain to attend trainer courses to obtain a different viewpoint of vocational training. These courses are not for the retiring personality as constructive criticism of a member of the course by other participants is both frank and free, and all trainers have to attend on a regular basis.

DAY RELEASE COURSES

The other main teaching activity provided for trainees are the day release courses held in Belfast, Bangor, Craigavon, Ballymena and Londonderry. These supplement the main learning process which takes place in the practice, and concentrate on group discussion and group activity rather than didactic lectures. The former is the most effective method of changing set attitudes which trainees may have absorbed already. The trainee is often deficient in problem-solving skills and in self-awareness.

The day release courses are autonomous and each reflects the ideas and expertise of the organiser and his group of trainees. The subjects discussed are wide-ranging, including an introduction to practice management, developmental screening, study of unruly adolescents and practice visits. The ideas behind the courses are considered and refined at meetings of course organisers. Professor George Irwin and his staff have an input to the courses and deal with subjects in which they have a special interest such as ethics, research, the consultation, and the dynamics of small group teaching. The present and past course organisers cannot be given enough credit for their work in the Northern Ireland Vocational Training Scheme.

Potential general practice trainees in hospital posts attend five or six evening meetings in Belfast. These concentrate on the interface between hospital and general practice under the leadership of trainers. The meetings are didactic in nature because of the numbers of young doctors attending — often 70 or 80. The meetings give the young doctors the opportunity of forming a group identity. In Londonderry potential trainees in hospital posts attend the day release course.

MANPOWER AND TRAINEE SELECTION

In 1981 and in 1986 the Medical Manpower Committee for General Practice, in considering the needs of general practice, decided that 50 trainees per year were required for Northern Ireland to replace those principals who died or retired each year. It was realised that there would be more applicants than trainee places and consequently selection would have to take place. The number of trainees completing their training from 1965 to 1988 is shown in Fig 4. Over the past six years almost all have completed and the numbers are close to 50 per year.

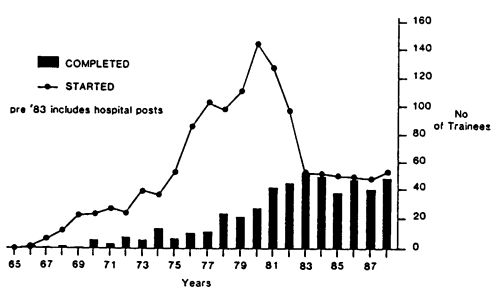

Fig 4.
Number of trainees who commenced and completed the course, 1965–1988. Before 1983 all trainees in hospital posts were counted. In 1983 and after, only those who completed a general practice year were counted.

Senior house officers who are potential general practice trainees gain their hospital experience in two ways — either by constructing their own rotations by applying for a post every six months, or by obtaining a post of two years' duration which rotates through the necessary specialties. The hospital experience obtained in Northern Ireland by trainees appears to be superior to the experience shown on the application forms submitted to the Joint Committee in the United Kingdom for Certificates of Prescribed Experience (Table).

TABLE

The distribution of Senior House Officer posts in Northern Ireland hospitals which are approved for general professional training and for vocational training for general practice compared with the Senior House Officer experience shown on the application forms submitted to the Joint Committee in the United Kingdom for Certificates of Prescribed Experience

	SHO posts shown on application forms to NIVTS August 1987 (total number of applications in brackets)	*SHO posts shown by UK Joint Committee certification 1987 (total number of certificates in brackets)*
Psychiatry	(33) 31·4%	(906) 40·5%
General medicine	(88) 83·8%	(1026) 45·8%
Geriatrics	(18) 17·4%	(878) 39·2%
Obstetrics and/or Gynaecology	(95) 90·5%	(1489) 66·5%
Paediatrics	(54) 51·4%	(1301) 58·1%
Accident and Emergency/Surgery	(75) 71·4%	(1507) 67·3%

It was decided that entry to the scheme would be for the general practice year only, both for doctors in self-constructed rotations and for those in two-year SHO rotations. The Central Services Agency is responsible for the appointments panel. Central selection has worked successfully over the years bearing in mind that the interview panel may have to spend three days in interviewing 100–110 candidates for 50 posts. Contrary to general belief, the composition of the panel does not change during the three days. The selection procedure is a great imposition on the time of the general practitioners and consultants who are on the panel.

ASSESSMENT OF THE TRAINER AND TRAINEE

Assessment of the trainer and trainee — the third apex of the educational model — has proved more difficult. The trainee assesses the trainer and training practice twice during the general practice year. The assessment is confidential to the trainee and the Adviser and cannot be used without the consent of the trainee. It is very rarely possible to obtain this. Even with this drawback the assessment gives valuable information. The trainer is also assessed by the trainer approval panels and the visitors from the Joint Committee (Fig 5).

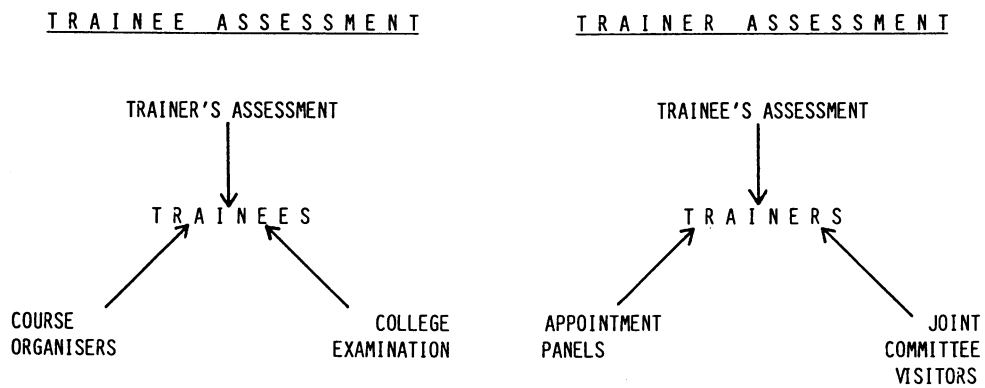

Fig 5. Models for trainee and trainer assessment.

Assessment of the trainee has been carried out over the years, but methods used in the past did not give reliable results. Recently the trainer has completed two assessments each year on the trainee, dealing with patient care; communication skills; knowledge of practice organisation, the statement of fees and allowances, and medical politics; personal values and personal and professional growth. The trainer discusses these assessments with the trainee, and this is the most valuable part of the exercise. The Course Organisers also assess the trainees at the day release course. At present the main assessment of the trainee is the membership examination of the Royal College of General Practitioners. Northern Ireland candidates have been extremely successful (Fig 6). Northern Ireland has a pass rate of about 95% for the past five years, and a very high distinction record. These excellent results are due to the teaching in the hospitals, the day release courses at the training practices, and the hard work of the trainees themselves.

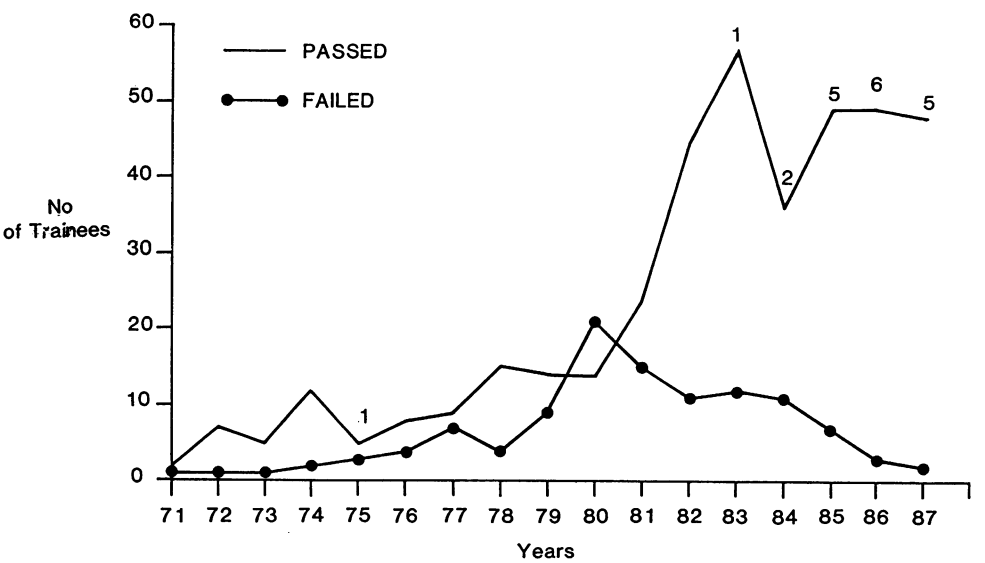

Fig 6. Number of trainees passing and failing the MRCGP examination in Northern Ireland, 1971 – 87. The numbers on the pass curve refer to those obtaining distinction.

A continuing change in education from hospital-based to general practice-based teaching of general practitioners is taking place.

WHAT OF THE FUTURE?

It is possible that the period of vocational training may be increased to four or five years with two years in hospital and two years in a training practice. The increasing number of computers in practices and their effect on audit and education has yet to be assessed but the indications are that they will make a significant impact. How will nurse/practitioners affect the role of the general practitioner, and how will day care in hospitals and the increase in community care affect the work of the health care team? The change to anticipatory care in general practice, prevention, health education, audit, and the emphasis on team work will pose new educational problems for vocational training and for general practice itself.

I would like to thank Miss Arlene Stockman, my secretary, for her work with this paper; the photographic department of the Belfast City Hospital and Mrs Gillian Stott of the Northern Ireland Council for Postgraduate Medical Education for preparing the figures.

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