Education and Training for General Practice

1. INTRODUCTION

1.1 In this report, the current arrangements for postgraduate training and for continuing medical education for general practice are reviewed, and proposals are presented for their further development.

1.2 Recent developments in the organization of the National Health Service (Secretaries of State, 1989a) and changes to the general practitioner contract (Health Departments, 1989) have increased the range of responsibilities of the general practitioner. These, together with publication of the recent report of the working group on specialist medical training (Department of Health, 1993), as well as the General Medical Council's recommendations for a more modular approach to the undergraduate curriculum (GMC, 1993), indicate the need for the critical scrutiny of the training and education arrangements for general practitioners.

1.3 This report recapitulates briefly the landmarks in the development of training for general practice. It reviews current arrangements and makes proposals for improvements to the present system so that tomorrow's general practitioners can be properly prepared for their future responsibilities for patient care in the National Health Service. Also addressed is the need for the further development of higher professional education for general practice. Proposals are presented for a more relevant system of continuing medical education.

1.4 The legislative and organizational arrangements are slightly different in the various parts of the UK. This report reflects the arrangements for England and Wales but it is intended that similar principles will apply in respect of Northern Ireland and Scotland.

1.5 Each section of the report includes a series of practical action points for the College to address in the immediate future so that its policies for education and training for general practice can be implemented without delay and in a systematic way.

2. VOCATIONAL TRAINING FOR GENERAL PRACTICE

Its evolution

2.1 The case for postgraduate training for general practice was made by the College in 1965, and in the following year it defined how this should be achieved in its evidence to the Royal Commission on Medical Education (CGP, 1966). Its proposals were for a system of training that lasted for at least five years *from qualification*. It recommended that three of these years should be spent in hospital appointments directly relevant to general practice, with the remaining two years spent learning under supervision in the setting of general practice.

2.2 The report of the Royal Commission on Medical Education (1968) endorsed the College's view on the need for special training for future general practitioners. It recommended that the five-year training period should extend *from registration*, rather than from qualification, as the College had suggested. In the event, the statutory arrangements for vocational training that emerged were a compromise. A minimum period of three years' post-registration experience was stipulated and became embodied in the National Health Service (Vocational Training) Regulations (1979).

2.3 Most doctors at the end of vocational training will have completed as a minimum four hospital jobs at senior house officer (SHO) level and 12 months as a trainee in general practice (see Appendix 1). Although it is possible within the framework of the Regulations to spend up to two years in general practice with one year in hospital, normally NHS funding will only provide for a doctor to spend 12 months as a trainee. In the Defence Medical Services, which are funded separately from the NHS, normally 18 months are spent in general practice and 18 months in hospital. Less than 2% of doctors completing training spend more than one year as a trainee in general practice (Styles, 1991).

2.4 The reality of today is that vocational training for general practice equates more closely with general professional training than it does with the higher specialist training programmes of other medical disciplines. Training for general practice has yet to incorporate an element of higher specialist training. It was for this reason that the College proposed in 1985 that higher professional education for general practice should be developed, and should be available to those who wished to undertake it on a voluntary basis (RCGP, 1985). The College reiterated this view in its Educational Strategy, published five years later (RCGP, 1990a) and since that time there have been a number of important initiatives in developing the content and methods appropriate for this period of education (Koppel and Pietroni, 1991). Progress, however, has been slow. The system for implementing the College's policy for higher professional education needs to be developed with urgency and proposals are presented later in section 3 below (page 7).

2.5 Programmes of vocational training for general practice were developed throughout the United Kingdom in the late 1970s and 1980s. Undoubtedly, vocational training has been one of the great successes of general practice in the last two decades. Through it, there has developed a national framework for postgraduate education for general practice, and a series of teaching practices throughout the country. General practitioners have had opportunities to learn how to teach, and have based their teaching on the clear definition of the responsibilities of the general practitioner that the College developed in 1972 (RCGP, 1972).

2.6 The College foresaw in 1965 that the role of the gener-

al practitioner would change with time, and that the arrangements for training would need to keep pace with these, and indeed ideally would need to anticipate such changes. It recommended that "with the changing role of the general practitioner, the objectives and duration of training should be frequently reviewed" (CGP, 1965). Until now no such review has been undertaken in the last 25 years. Recent advances in clinical practice and substantial change in health service organization indicate that the time has come for such appraisal. In effect, training for general practice has reached the end of the first phase of its development. Consideration must now be given to the immediate changes that are needed to bring it up to date. Just as every patient in the United Kingdom should have available to him/her consistent and acceptable standards of patient care through general practice, so every future general practitioner should experience an adequate period of relevant postgraduate training, providing opportunities to prepare for the complex and comprehensive tasks of providing primary medical care in general practice.

The case for change

Service reasons

2.7 As a basic principle, the arrangements for training in general practice should relate directly to the service needs of individual patients who seek general practitioner care, as well as to the needs of practice populations. Recent changes in the organization of health care in the United Kingdom have had major effects on the way in which general practitioners and practice teams work, and on the range of services that they offer patients. Recent health service changes have introduced the concept of commissioning health care from providers with fundholding general practitioners doing this directly through their purchasing contracts with hospitals, rather than through health authorities or commissioning agencies (Secretaries of State, 1989a). The new general practitioner contract has encouraged more practices to develop their preventive and health promotion services (Health Departments, 1989). The implementation of proposals for care in the community (Secretaries of State, 1989b) means that general practitioners have to work much more closely with social services departments than previously. This will be even more necessary in the future because of anticipated demographic changes with doctors having a higher proportion of elderly people on their lists, and more people with long-term psychiatric illness being cared for in the community.

2.8 In the clinical field, more services have moved from secondary to primary care, and especially the management of chronic diseases such as asthma, diabetes, hypertension and ischaemic heart disease. All these changes mean that practices have to be much more multiprofessional and team orientated in their approaches to providing health care. This brings additional managerial and organizational responsibilities to general practitioners. Related to this is the need to incorporate modern information technology into practice, to support steadily increasing responsibilities and activities.

2.9 As the clinical and managerial roles of general practitioners change, then so must the training programmes that prepare them for their future responsibilities be able to adapt. They must help tomorrow's general practitioners to be able to anticipate those changes that lie ahead, and to be able to initiate and to manage change when this is needed.

Educational reasons

2.10 Although the benefits of vocational training for general practice have been considerable in the last two decades, a number of criticisms have been levelled consistently against present arrangements. These have been related to the overall length of training time, to the imbalance and lack of integration between the general practice and hospital components, and to the irrelevant and low quality of educational provision of some hospital posts. There is scope for considerable improvement if training is to meet the learning needs of doctors in general practice. A better system must be developed if recruitment to general practice is to be sustained and if doctors are to be equipped with the knowledge and skills needed for them to be able to function effectively at the heart of the National Health Service.

2.11 The hospital component has been criticized by trainees, trainers and course organizers over many years for its lack of relevance to general practice, for the limited amount of time available for learning in many hospital posts, and for the absence of an effective educational framework (Reeve and Bowman, 1989; Grant et al., 1989; Crawley and Levin, 1990; Kearley, 1990; Styles, 1990). Established general practitioners have also voiced similar criticisms (Little, 1994). Trainee assessment has been neglected and trainees have complained about the inadequacies of feedback to them about their progress. Criticisms have also been made about the lack of integration of three-year programmes, which for many have become a sequence of unrelated hospital posts terminating with time in general practice (Styles et al., 1993). Consideration must be given to the ways in which hospital experience can be related more directly to the needs of future general practitioners and this is considered further below (paragraphs 2.18-2.20).

2.12 Although the general practice component of training has not been criticized as severely as the hospital elements, nevertheless there is scope for improvement here. In particular, trainees have commented on their need for more training in practice management, and on the use of computers within the practice setting. There is a need to address more explicitly the multiprofessional aspects of training at this time, and in particular ways in which teamwork can be promoted. Opportunities for joint training should be encouraged, and in particular with professions such as nurses, health visitors and social workers. As a population-based approach to general practice is developed, training will have to address such topics as needs assessment, data collection and analysis, the application of statistics and epidemiology in general practice, as well as the processes for purchasing services from outside the practice itself. At the same time, this period must provide opportunities for developing further the communication and consulting skills that are central to general practice through supervised experience with patients. The principles of audit and their application in quality assurance should also be incorporated into the training curriculum, as well as the individual coping mechanisms for preventing personal burnout. Although there are other settings in which such learning can be undertaken, time spent as a trainee in

general practice offers the best opportunities for achieving many of these objectives.

2.13 As well as developments in practice, future developments must take into account changes elsewhere in the system of medical education. In particular, the General Medical Council's recommendations for the undergraduate curriculum (GMC, 1993) will have a substantial influence on the abilities of young doctors entering vocational training programmes. The GMC's proposals are designed to limit the knowledge overload that hitherto has been a characteristic of the undergraduate years. Its recommendations are for there to be a core component to the curriculum with additional optional elements that medical students themselves would choose. As a consequence, the undergraduate experiences of doctors entering vocational training programmes in the future are likely to differ from those of their predecessors. This will have significant implications for the postgraduate years and suggests the need for a more broadly-based programme in the early stages of vocational training.

Proposals for change

Content

2.14 The College has always recognized the need to link directly the content of training programmes for general practice with the needs of patients. Such recognition formed the basis for publication of *The Future General Practitioner: Learning and Teaching* (RCGP, 1972). This described the general practitioner's role and responsibilities and indicated ways in which these could be linked with the vocational training curriculum. Recent and substantial changes in these responsibilities indicate the need for their more up-to-date description so that today's training programmes can relate more directly to today's educational needs. The College has established a working party within its Education Network to undertake this task. The aim is to produce by the end of 1994 a comprehensive description of the general practitioner's responsibilities so that this can form the basis of training programmes. It will also represent the content of the MRCGP examination.

Place of learning

2.15 Byrne (1975) recognized the need for a more appropriate balance between the hospital and general practice components of vocational training. In the last 20 years no progress has been made in achieving this. There is now considerable urgency in developing arrangements that will provide for more training time within general practice so that better account can be taken of recent changes in the general practitioner's work. As the range of general practitioner responsibilities extends, then it is logical when preparing for a career in general practice that the greater proportion of the training period should be in this setting.

2.16 Current funding arrangements for vocational training limit the experience in general practice for most trainees to a maximum period of 12 months (DoH et al., 1990). This is illogical, and from an educational view is unacceptable. The aim should be for a trainee to spend as long in the setting of general practice as his/her educational needs require. The educational system must be freed up to allow for this. As an interim step, and in the short term, there should be sufficient funding to enable doctors who wish to spend at least 18 months of their training in the setting of general practice. This additional time in general practice would be used to address the wider curriculum outlined in paragraph 2.12. This will be presented in greater detail in the report of the working party of the Education Network that is currently preparing an up-to-date description of the general practitioner's role and responsibilities (see paragraph 2.14).

2.17 Additional time in general practice will enable doctors to develop skills in working as members of multiprofessional primary care teams, an area of vocational training that often is sacrificed given the limited time currently spent within general practice. The effective working of teams demands an understanding by each team member of his/her own role, as well as the roles of those other professional groups with whom they work. Only through such knowledge can their combined efforts be effectively integrated (*RCGP Connection*, 1993). More active measures will be needed to promote opportunities for multiprofessional learning, and trainers, course organizers and regional advisers in general practice should work with teachers in other disciplines to evaluate the different ways in which this can be achieved (Jones, 1986). There is considerable scope for developing and evaluating a range of opportunities for multiprofessional learning and the College, through the RCGP Commission on Primary Care, should become a national focus for such developments.

2.18 Urgent consideration needs to be given to the ways in which hospital experience can contribute more effectively to training for general practice. In 1993, the College published with other specialist organizations a series of booklets designed to give a clearer idea of what should be learnt from working in various hospital specialties (RCGP, 1993a). In doing this, the College recognized that there is much that a doctor in training can gain from experience as a hospital senior house officer. This can provide a concentration of clinical experience that greatly enhances a doctor's knowledge and skills, and promotes confidence in applying these. Recent criticisms of the hospital years suggest that insufficient advantage is being taken of the learning opportunities afforded by such posts (Reeve and Bowman, 1989; Grant et al., 1989; Crawley and Levin, 1990; Kearley, 1990; Styles, 1990).

2.19 Although learning does take place in a service setting by working as an SHO, it must be questioned whether all hospital-based experience for vocational training should be acquired in this way. Service-based learning may be appropriate for some specialties, but not necessarily for all. For some, attachments as an SHO for periods of less than six months may be more effective, and particularly if the training is more intense and properly focused. For vocational training, outpatient and community experience is particularly important and this could be acquired from a general practice base. There is considerable scope for experimentation with different ways in which hospital experience can meet the needs of the general practitioner trainee. The College should encourage and should evaluate such developments.

2.20 There is a need for better integration of the hospital and general practitioner years, and for better working relationships at local level between general practitioner and hospital teachers (Styles et al., 1993). Hospital experience can only be of value if it is relevant to the needs of doctors whose futures will be in general practice, and local dialogue between hospital and general practitioner teachers and education organizers should aim to achieve this. The College, through its programme of joint hospital visiting with the other Royal Colleges, should ensure that only hospital posts that fulfil its criteria for training form part of vocational training programmes (RCGP, 1993b).

2.21 Hitherto most vocational training has taken place in the setting of either general practice or hospital. The extending range of general practitioner responsibilities suggests that other locations might be appropriate. These could include community hospitals, as well as health authorities, commissioning agencies and local authorities. Such locations can provide opportunities for doctors in training to acquire skills in a broad range of activities such as the needs assessment of populations, in the application of epidemiology, and in reviewing prescribing and other practice activities. There is considerable scope to develop these other locations as options for vocational training purposes. The College should evaluate new developments to determine the contribution that such experience can make to vocational training, or to higher professional education.

Length of training

2.22 The present length of training determined by the Vocational Training Regulations is for a minimum and maximum period of three years. From an educational point of view this is unacceptable, and no other medical discipline has its training period restricted in this way. The College would wish to see the length of the training period determined by the educational needs of the individual trainee and for it to be for a minimum period of three years with no prescribed maximum term. Individual doctors, including high-flyers, should not be constrained by an unrealistic limitation on the time spent training in their chosen discipline. The College's original policy was for a training period of five years (CGP, 1965). This could be achieved by supplementing the three-year vocational training period with an additional period, say a minimum of two years, of higher professional education during the early years as a principal in general practice. This proposal is explored further in section 3 below (paragraph 3.8).

Administrative framework

2.23 The administrative framework for vocational training developed in the 1970s within the national network of regional postgraduate deans. Until now, responsibility for vocational training within each National Health Service region has rested with the regional adviser in general practice and he/she has been responsible to the regional postgraduate dean for this. Within each region there has developed a network of course organizers who have responsibility at local level for ensuring the provision of opportunities for vocational training, and particularly within the hospital setting and through half-day/day release courses for trainees. Regional advisers have also been responsible for the training and selection of general practitioner trainers, using regional criteria for this purpose. Vocational trainees have been part of the complement of junior hospital doctors when working as SHOs and have been employed individually as trainees by the trainers with whom they have worked. Family health services authorities (FHSAs) and health boards have reimbursed trainers for the salaries of trainees and have been responsible for paying trainers a nationally agreed grant for undertaking training responsibilities. Regional advisers should continue to be responsible for appointments to the networks of course organizers and general practitioner trainers in their regions. Consideration should be given to combining the posts of course organizers and general practitioner tutors so that those responsible for education at local level can work across the trainee/established practitioner interface. Regional advisers should continue to be responsible for their selection and for ensuring their continuing competence.

2.24 During the hospital years the funding for hospital training posts has come from health authorities and hospital trusts. In England and Wales half of this money is controlled by the regional postgraduate dean (NHSME, 1991; DoH, 1992); in Scotland all of it comes from this source. During the general practice component of training, trainees' salaries and trainers' grants are paid by FHSAs and health boards and come from general medical services monies.

2.25 The different sources of funding for the different elements of vocational training are obstacles to the freeing up of the system of vocational training that the College would wish to see. Shorter term SHO posts, outpatient attachments from a general practice base, and teaching in settings other than general practice or hospital will be difficult to achieve through the current funding arrangements. An appropriate way forward would be for *all* the elements of funding for vocational training to be included within the regional budget for postgraduate education, with the regional adviser in general practice, as manager of such funds, being able to purchase periods of training needed to meet individual requirements. These would be in a variety of locations and for different lengths of time and would help to ensure that the focus for a doctor in training was educational.

2.26 The regional adviser would not only be responsible for the deployment of the funds for vocational training for general practice, but would also have responsibility, in association with the regional postgraduate dean, for securing them on an annual basis from the NHS regional executive. In time, this would mean an approach to vocational training that would link it much more closely to future manpower requirements for general practice. For this, and other reasons, it would be important for the regional adviser to work closely with the NHS regional executive and to be a member of its board for postgraduate education.

Regulatory framework

2.27 The College, through the development of training standards and its responsibilities for the joint visiting of hospital posts for general professional training approval, must ensure that the hospital experience that is offered to trainees is relevant for vocational training and that educationally it is of good quality. The College has been explicit about its standards for such posts, which were published in 1993 in

the booklet *The Quality of Hospital-based Education for General Practice* (RCGP, 1993b). Only posts that achieve these standards should be approved by College visitors for incorporation into vocational training programmes. Only experience in such approved posts should be accepted by the College for admission to the MRCGP examination. The College will continue to publish widely the standards that it expects to be achieved in the hospital posts used for vocational training, and its visitors will continue to apply these as part of the approval process.

2.28 The regulatory framework for vocational training was developed in the 1970s. Before the establishment of the National Health Service (Vocational Training) Regulations (1979), the national standards of vocational training were agreed and monitored by the vocational training committee of the College. The College arranged visits to regional postgraduate organizations to ensure that its standards for training were being maintained and implemented throughout the United Kingdom. With the creation of the Joint Committee on Postgraduate Training for General Practice in 1976 to implement the Vocational Training Regulations, the College agreed that its responsibilities for standards of vocational training should be undertaken on its behalf by the Joint Committee. The Joint Committee, of which the College is a parent body, now agrees standards and monitors local implementation by visiting regions every two or three years. In approving regional standards of training, the Joint Committee also recommends their recognition to the College for the MRCGP examination. The College should review these arrangements in the near future.

2.29 Unlike other medical disciplines, experience to become an independent principal in general practice in the National Health Service is determined by government regulations (NHS Vocational Training Regulations, 1979). These prescribe the minimum experience that a doctor should acquire before obtaining a certificate from the Joint Committee on Postgraduate Training for General Practice. There is considerable evidence that these regulations are now beginning to constrain developments in vocational training. Such constraints can be overcome in either of two ways — on the one hand the regulations could be amended to take account of developments in practice; on the other they could be rescinded altogether. The disadvantage of the former is that it represents a mere modification of current arrangements and does not remove altogether the potential for rigidity that is embodied in government regulation. Within three or five years' time the modified regulations could have a similar constraining effect as they do today. Rescinding them altogether would require the establishment of an alternative system to ensure that only those who have been properly trained for general practice become independent principals and one that met the requirements of the European Directives for general practitioner training (EC, 1993). Whilst recognizing the previous benefits of the Vocational Training Regulations, the question must be addressed as to whether or not they should continue in the future, and what better arrangements could be developed.

2.30 In other medical disciplines, the appropriate Royal College determines and monitors standards of training. Each accredits training programmes and certificates those who successfully complete them. General practice, through the College, developed a similar system for regulating vocational training in the 1970s before the Vocational Training Regulations came into effect. Reversion to these previous arrangements should be explored. After appropriate consultation, the College should determine the minimum training experience needed for general practice. It should be possible for a doctor to train for general practice for as long as is appropriate for that individual. Through its visits to regions, the College, as in the 1970s, would monitor the local and individual implementation of the training standards that it has agreed. Such radical changes could not be implemented overnight. Their detailed consequences need careful consideration. The College should initiate discussions with other interested parties with the aim of rescinding the Vocational Training Regulations at an agreed date in the future.

Certification on completion of training

2.31 The methods for determining the competence of a doctor on completing vocational training were highlighted as a problem by the College in 1985. The Joint Committee on Postgraduate Training for General Practice (1993) has indicated that by 1996 each region should have developed systems for summative assessment to operate within the framework of the current Vocational Training Regulations. The College policy is that doctors on completing training should demonstrate their competence for independent practice through an objective assessment that operates to a national standard. It has developed the MRCGP for this purpose. It is the only British registrable qualification in general practice itself that is recognized by the General Medical Council.

2.32 In July 1993, the College reiterated its view on the need for an objective assessment of the competence of doctors on the completion of vocational training. This view was endorsed by the National Association of Health Authorities and Trusts (NAHAT) in March 1994. Such a system is needed in order to reassure patients, colleagues in other disciplines, health authorities and the Government that new recruits to NHS general practice have demonstrated their competence to practise independently to a national standard. The College has stated that all trainees should achieve this by sitting the MRCGP examination at the completion of vocational training (RCGP, 1994). It also recommends that all new appointees as NHS principals should have passed the examination. Family health services authorities and health boards have been encouraged to recognize this in the appointments that they are responsible for making.

2.33 The MRCGP examiners ensure the reliability and validity of the examination, which is constantly refined to take account of developments in practice (Lockie, 1990; Godlee, 1991). At present they are addressing the ways in which a more modular approach to the examination might be developed, and the extent to which some modules could be applied at regional or national level. This will include the further development of methods for the assessment of clinical competence and consulting skills which will be incorporated into the MRCGP examination by 1996.

2.34 At present, more than three quarters of trainees sit the MRCGP examination and of these, almost 90% pass within 12 months of completing vocational training (Haslam D, personal communication). It is important that those who fail should have the opportunity for further training so that they can reach the national standard of competence determined by the examination. Arrangements for funding vocational training do not readily permit such additional training periods. The College will continue to press for the resources that will permit modification of the present system to allow for additional training for those who would benefit from it. The proposals for future funding presented in paragraph 2.25 would help to achieve this.

Policy action points

Content

2.35 The working party within the Education Network should publish by the end of 1994 a comprehensive description of the general practitioner's responsibilities so that this can form a more up-to-date basis for the content of training programmes, as well as represent the content of the MRCGP examination (paragraph 2.14).

Place of training

2.36 The arrangements and funding for vocational training should permit more learning time in the setting of general practice. In the short term, funding arrangements should enable doctors in training to spend 18 months within the setting of general practice (paragraph 2.16).

2.37 Additional time in general practice should be used to help doctors to develop skills in working as members of multiprofessional primary care teams. The College, through the RCGP Commission on Primary Care, should become a national focus for developments in this area and should undertake properly evaluated experiments (paragraph 2.17).

2.38 There is scope to make better use of hospital experience in training. The College should encourage the development and evaluation of experiments that include shorter term supervised appointments, as well as outpatient attachments from a general practice base (paragraph 2.19). It should ensure that only hospital posts that fulfil its criteria for training form part of vocational training programmes (paragraphs 2.20, 2.27).

2.39 Other locations for vocational training should be used and evaluated. They include community hospitals, as well as health authorities, commissioning agencies and local authorities which could provide opportunities for doctors to acquire skills in such activities as the needs assessment of populations, the application of epidemiology, reviewing prescribing and team building. The College should evaluate new developments to determine the contribution that such experience could make to vocational training, or to higher professional education (paragraph 2.21).

Length of training

2.40 The overall length of the training period should be determined by the educational needs of an individual rather than by a prescribed time, although there should be an agreed minimum period of three years. The College should press for less restrictive arrangements for vocational training to enable this (paragraph 2.22).

Administrative framework

2.41 Regional advisers should continue to be responsible for appointments to the networks of course organizers and general practitioner trainers in their regions. Consideration should be given to combining the posts of course organizers and general practitioner tutors so that those responsible for education at local level can work across the trainee/established practitioner interface. Regional advisers should be responsible for their selection and for ensuring their continuing competence (paragraph 2.23).

2.42 Regional advisers in general practice should continue to be responsible for implementing the arrangements for vocational training at regional and local levels. Regional postgraduate medical organizations should be responsible for the total funding of vocational training in their regions. As part of these organizations, regional advisers in general practice should be responsible for managing the budgets that would include the resources for all aspects of vocational training for general practice, including its hospital and general practice elements, as well as for training in other locations (paragraphs 2.25, 2.26).

2.43 Regional advisers in general practice should work closely with regional postgraduate deans and should be members of the boards for postgraduate education of NHS regional executives (paragraph 2.26).

Regulatory framework

2.44 The arrangements whereby the Joint Committee on Postgraduate Training for General Practice monitors the implementation of vocational training standards on behalf of the College should be reviewed in the near future (paragraph 2.28).

2.45 There is evidence that the Vocational Training Regulations are beginning to constrain developments in vocational training, particularly in restricting the length of training programmes. The College should initiate discussions with other interested parties with the aim of rescinding the Vocational Training Regulations at an agreed date in the future (paragraphs 2.29, 2.30).

2.46 When the Vocational Training Regulations have been rescinded, responsibility for determining national standards for all stages of vocational training and for monitoring their implementation at regional and local levels should revert to the College (paragraphs 2.28-2.30).

Certification on completion of training

2.47 All doctors on completing vocational training should demonstrate their competence for independent practice by passing the MRCGP examination (paragraphs 2.31, 2.32).

2.48 All doctors who are appointed as new principals in the NHS should have passed the MRCGP examination (paragraph 2.32).

2.49 The MRCGP examiners will continue to ensure the reliability and validity of the examination, which will continue to be refined to take account of developments in practice. A timetable should be agreed by the end of 1994 for a more modular approach to the organization of the examination and to take account of regional and national applications. This will include the further development of methods for the assessment of clinical competence and consultation skills which will be incorporated into the examination by 1996 (paragraph 2.33).

2.50 The funding arrangements for vocational training should ensure that further training is readily available to those who are unsuccessful in the MRCGP examination (paragraph 2.34).

3. HIGHER PROFESSIONAL EDUCATION

3.1 Since 1965 the College's policy for the length of training for general practice has been for a five-year period from the date of qualification (CGP, 1965). This view was reinforced in the report of the Royal Commission on Medical Education (1968), which recommended a five-year training period from the date of registration. Present day arrangements for a three-year period of vocational training were a compromise on both the College's and the Royal Commission's recommendations. Recent developments in practice have exposed the limitations of this three-year training period. The rapidly changing and increasing responsibilities of the general practitioner indicate that preparation for this work cannot easily be compressed into a vocational training programme of only three years. Educational objectives in the clinical area, in health service and practice organization and management, in team working, in audit and quality assurance, in research and in teaching all demand a longer training period. Rather than extending the period of vocational training the College believes that a more readily achievable route for a training programme of appropriate length would be to augment vocational training with a period of higher professional education during the early years as a principal. The College first proposed this in 1985 (RCGP, 1985), and reiterated this view in its Educational Strategy of 1990 (RCGP, 1990a). Progress in developing higher professional education has been modest. The College, both nationally and locally, must become more active in implementing its policy for higher professional education by extending the range of opportunities to meet the needs of doctors in their early years in general practice.

3.2 Since 1990, higher professional education has been undertaken on a voluntary basis by a number of doctors, and there have been a number of worthwhile initiatives in the field (Koppel and Pietroni, 1991; RCGP, 1993c). The higher professional education working group of the Education Division (now Network) has encouraged many of them. These now need to be built upon so that opportunities for higher professional education are accessible to all general practitioners at appropriate stages in their careers. For many this will be in their early years as principals in general practice, but for others higher professional education may be delayed more towards the middle of their careers.

3.3 Regional advisers in general practice with their networks of associate advisers and general practitioner tutors will be key people in developing and evaluating the range of opportunities needed for higher professional education. The College will also have responsibility for contributing new ideas, monitoring standards and for ensuring that information about developments is communicated quickly and widely. Financial resources will be essential. Ultimately, such funds will come from health authorities and trusts. The College welcomes the support given by the National Association of Health Authorities and Trusts (1994) to its proposals for the development of higher professional education. Both bodies should consider jointly how funding for higher professional education can be achieved.

Content

3.4 Vocational training provides broadly based experience that is needed for all general practitioners. It equates largely with the period of general professional training that is characteristic of other medical training programmes. In its Educational Strategy the College described the purposes of higher professional education for general practice and outlined its content (RCGP, 1990a). This included:

- clinical aspects
- the development of techniques that will enable doctors to relate their continuing learning to their work within the practice setting through peer and performance review, and audit
- activities designed to promote more efficient practice management and the development of teamwork and a greater understanding of the responsibilities of individual members of the team
- preparation for undergraduate teaching and vocational training
- experience and research in general practice as a way of increasing the body of knowledge of the discipline and of enhancing the doctor's own professional development.

3.5 There are many educational activities undertaken by established principals that pass unrecognized as the higher professional education that they in fact represent. This would include the work undertaken by many young principals' groups and trainers' groups, as well as more formal activities that may lead to diplomas and degrees.

3.6 A particular need is the provision of research training fellowships to enable young general practitioners to have protected time to develop research skills on a voluntary basis. At the end of the 1980s the College advocated the provision of at least 12 places in each health service region (RCGP, 1990a). The College should continue to press this policy with NHS regional executives.

3.7 One of the main purposes of higher professional education should be to help doctors to continue to learn from their day-to-day work in general practice. The focus of most higher professional education should be on the clinical content of general practice, on the organizational issues that derive from this, and on the teaching and research that is needed to sustain it. Educational opportunities outside the practice should build upon those occurring within it. Prime amongst these must be opportunities to reflect with colleagues on work within the practice and developments in portfolio-based learning (RCGP, 1993c), and work with mentors (Savage, 1991) has emphasized the importance of such reflection. Although specific study days, seminars and courses may be developed for those undertaking higher professional education, the considerable overlap with continuing medical education means that many activities will contribute to both forms of education, depending on the doctor's career stage. The details of many such activities and the principles upon which they should be based are considered further in section 4.

Length of higher professional education

3.8 The length of the period of a doctor's higher professional education should not be fixed by any prescribed period although a minimum period of two years would seem appropriate. This period should be determined by an individual's educational needs.

Administrative framework

3.9 Opportunities for higher professional education should be readily available for doctors in their early years in practice. Their content and methodology should be broadly based, designed to match the needs and special interests of doctors in their early years of independent practice and would be approved by the College. The College should encourage the evaluation of developments in this area. Provision should be made through the regional postgraduate organizations with the regional advisers, associate advisers and general practitioner tutors taking a lead in this field. Standards of higher professional education would be agreed and monitored by the College.

Regulatory framework

3.10 The College, through its Education Network, must continue its work in developing and evaluating the range of opportunities and the standards for higher professional education. In doing this, it will work closely with academic departments of general practice as well as with regional postgraduate organizations. These are likely to be the main providers of such programmes, although other disciplines will also contribute, including social sciences, epidemiology and psychology.

3.11 The College must develop further the framework for the accreditation of activities offering higher professional education. Already it has achieved this for a handful of programmes through the Education Network. A much more comprehensive system will have to be established if programmes of College-accredited higher professional education are to be readily available throughout the country. Criteria and standards for provision must be agreed, as well as the mechanisms by which they will be applied. A parallel system should operate to that for the College approval of vocational training. Providers of higher professional education, such as regional organizations and academic departments of general practice, should be clearly informed about the College's expectations for the higher professional education of individual doctors and for the programmes designed to meet their needs. The Education Network should be developing these as a matter of high priority with the intention of Council agreeing criteria and standards for higher professional education programmes during 1995.

Recognition of completion

3.12 The College must consider the ways in which it will recognize an individual's successful completion of higher professional education. A system will have to be developed so that all who complete higher professional education can have this recognized by the College. On successful completion of higher professional education a doctor should be recognized as the equivalent to a consultant in other disciplines in medicine.

Policy action points

3.13 The College, at national and local levels, must become more active in helping education providers to develop the range of opportunities for higher professional education that will meet the needs of doctors in their early years in independent practice (paragraph 3.1).

3.14 The College should encourage the development of new ideas for higher professional education, their evaluation, and the ways in which information about developments can be communicated widely and quickly (paragraph 3.3).

3.15 The College, together with the National Association of Health Authorities and Trusts, should consider jointly how appropriate funding for higher professional education can be achieved (paragraph 3.3).

Content and length

3.16 The content of higher professional education should relate to the day-to-day work of general practice and to the special interests of individual doctors (paragraphs 3.4, 3.7).

3.17 A minimum of 200 research training fellowships should be available across the UK to enable young general practitioners to have protected time to develop their skills on a voluntary basis. The College should continue to press this policy with NHS regional executives (paragraph 3.6).

3.18 The length of higher professional education should be for a minimum of two years but otherwise should not be fixed for any prescribed period, and should be determined by the educational needs of the individual doctor (paragraph 3.8).

Administrative and regulatory frameworks

3.19 The College, through its Education Network, must

continue its work in developing and evaluating the range of opportunities for higher professional education so that a range of accessible programmes is available to doctors in their early years in independent practice (paragraphs 3.10, 3.11).

3.20 The Education Network should develop the criteria and standards by which higher professional education programmes will be accredited by the College during 1995 (paragraph 3.11).

3.21 The College must develop the framework for the accreditation of activities offering higher professional education as well as the system for determining an individual's satisfactory completion of a programme. At this stage, the doctor would be the equivalent to a consultant in the other disciplines of medicine (paragraph 3.12).

4. CONTINUING MEDICAL EDUCATION

4.1 In a rapidly developing profession such as medicine, doctors need to continue to learn about changes in the practice of their professions throughout their lives (Savage, 1991). In this way, their professional development is sustained so that they are able to provide high quality patient care at all stages in their careers. Through continuing medical education doctors must be able to incorporate validated scientific research findings into their practices, to adapt management and organizational principles for the more efficient delivery of their services, and through the audit of their practices, to become better able to ensure the effective delivery of care.

4.2 The content and arrangements for continuing medical education will overlap considerably those for higher professional education. Higher professional education is but one form of continuing medical education that is directed to those doctors in their early years as independent principals in practice. Continuing medical education must extend throughout a doctor's career and will provide opportunities for them to maintain their competence so that they can perform effectively at all stages. For this reason, continuing participation in medical education will be an essential element in the arrangements for recertification that the College is developing for its members. Through such participation members and fellows of the College will be able to maintain their educational status and through this their competence to practise. The College's Education Network is addressing the methodology and framework within which this will operate. The intention is to have a system available for members during 1995.

4.3 At present, participation in continuing medical education is encouraged through the general practitioner's contract with the NHS through the payment of the postgraduate education allowance. This was established as part of the contract of 1990 (Health Departments, 1989). The allowance is paid on completing five days of approved continuing medical education each year. Although these arrangements have resulted in high levels of participation, there have been doubts about the quality of educational activities and the degree of learning that has taken place (Agnew, 1992). The College's view is that participation in continuing education should be a professional responsibility rather than a contractual obligation, and for this reason it would wish to see such participation recognized through the peer-driven system of recertification that it wishes to establish for its members.

Content

4.4 The content of continuing medical education must be relevant to the needs of doctors and to the services that they provide (Savage, 1991). It must take account of clinical developments, changes in health service organization and changes in patients' expectations. For general practice this means maintaining a doctor's ability to provide acute and emergency care and to manage chronic disease. Through continuing medical education, management and organizational skills, including those needed for quality assurance, will have to be sustained so that they can be effectively deployed within the practice. Other essential elements will include the refinement of consulting and interpersonal skills, the development of skills in assessing the needs of practice populations, in strategic management and in the purchasing and commissioning of secondary care. Programmes will need to address the multiprofessional approach to primary care with particular emphasis on team building and team working (paragraph 2.8). Opportunities will have to be created for the development and maintenance of skills in audit and their application in quality assurance (Berwick, 1989), as well as in research and in the incorporation of research findings into daily practice.

4.5 Content should also take account of educational needs that have been reflected in complaints from patients or identified through audit activities. Wherever possible, continuing medical education should build upon the experiences of participants, and in this way will ensure that learning can relate as directly as possible to the day-to-day responsibilities that are carried by individual doctors. The benefits of continuing medical education can then directly translate into improved services for patients. Continuing developments in portfolio-based learning (RCGP, 1993c) and with mentors (Savage, 1991) should enhance this process.

Arrangements

4.6 Continuing medical education should build upon the boundless opportunities that there are for learning in everyday practice (Al-Shehri et al., 1993; Stanley et al., 1993). These occur during consultations, when dealing with reports about patients or in discussion with colleagues. Reading journals, participation in audit and research projects contribute to this process. These opportunities are of considerable worth since they relate to day-to-day practice and can bring about directly improvements in patient care. The length of time devoted to continuing medical education should be considered. The usual period of time for continuing medical education in consultant contracts is 30 days over three years. Given the growing range of responsibilities of general practice, the target for general practitioners should be no less than this and an average of 10 days per year should be the target. Partnership agreements should be encouraged to take account of this.

4.7 More formal opportunities for practice-based learning have been developed in recent years (Stanley, 1992). They are particularly valuable when all members of the multiprofessional primary care team are involved and are to be strongly encouraged. Their value needs to be acknowledged by the protection of time for such joint learning, with its opportunities for review and reflection. Work with mentors using individual self-directed plans may encourage this process, although the networks for this have yet to be developed more generally.

4.8 Hitherto, much of the focus for continuing medical education has been the local postgraduate medical centre. These will continue to be important resources for the future. They will be the locations for activities such as lectures, study days, symposia and courses. They provide opportunities for the exchange of ideas and experiences between practices and with medical colleagues who work in hospital disciplines. They will also be the major resource in supporting those learning activities that take place in other local venues such as practices. The libraries and information resource centres that are based at postgraduate centres should be accessible to all in local practice.

4.9 Academic departments of general practice are other resources that can contribute to continuing medical education and to the higher professional education of doctors in their early years of practice. There should be close co-operation between these departments and regional postgraduate organizations in developing opportunities for continuing medical education. Local primary care education centres are being developed in some localities. Their aim is to promote educational alliances between all the disciplines providing primary care and through this to encourage a more multiprofessional approach to patient services. Such arrangements should be properly evaluated and if demonstrated to be worthwhile should be extended throughout the country.

4.10 Arrangements for continuing medical education should take account of the factors that motivate doctors to learn (Al-Shehri et al., 1993; Stanley et al., 1993) and their preferred learning styles (Knowles, 1984), as well as the content of the topics being considered. More participative, self-directed methods are more likely to encourage learning and to bring about changes in practice (Stanley et al., 1993). A range of learning methods should be available in each locality and the organizers of continuing medical education should have skills in these and in recognizing when they should be deployed.

4.11 The College and regional advisers in general practice should provide opportunities for those with the responsibility for providing and commissioning continuing medical and higher professional education to acquire and to refine their educational skills.

4.12 Although formative assessment has been recognized as important during vocational training, its value for higher professional education and continuing medical education has yet to be acknowledged. Formative assessment is an essential part of any educational process and its incorporation into the later stages of medical education now needs to be progressed. Mentoring may be one way of achieving this. This provides an opportunity for a learner, under guidance, to reflect on past performance, to plan realistically for the future and to consider dispassionately progress as an individual educational plan is undertaken. Such work is time-consuming and makes heavy demands on available expertise. The financial resources for such developments will be significant and need to be identified. There may be other ways of incorporating formative assessment into continuing medical education. The College should encourage and evaluate developments through which this might be achieved.

4.13 The development of fellowship by assessment by the College (RCGP, 1990b) provides an important link between continuing medical education, assessment through peer review, and high standards of service to patients. Fellowship by this route is awarded following the assessment of candidates against operationally measurable standards of performance. These standards, kept under regular review by the College, reflect objective research evidence whereby members can demonstrate a very high level of competence in general practice itself based on the care of patients and assessed by peer review. The College is working towards the target of electing 250 fellows by assessment by November 1996.

Administrative framework

4.14 Opportunities for continuing medical education should be readily available to all general practitioners through the provision of local activities and others organized on a regional and national basis. Most general practitioners will wish to include a variety of activities within their own continuing medical education programmes. For most there will be elements that are based on learning within the practice, often in multiprofessional mode. Most will wish their continuing medical education to include activities where they meet local colleagues either in small groups, or more formally at lectures or symposia. They will wish to meet with colleagues in other primary care disciplines as well as medical colleagues within the hospital. The arrangements for continuing medical education need to be flexible enough to provide such breadth. This means that there will need to be different providers of continuing medical education ranging from practices themselves, to postgraduate centres, to primary care education centres, as well as to academic departments of general practice and to general practitioner tutors and associate advisers. College faculties should continue to contribute to local programmes as education providers. Local responsibility for ensuring the quality of continuing medical education should remain with general practitioner tutors, who should continue to be accountable to regional advisers in general practice for this.

Regulatory framework

4.15 At present, the regulatory framework for continuing medical education relates almost entirely to that for the administration of the postgraduate education allowance (PGEA). Regional advisers in general practice have responsibility for determining the criteria and standards for which activities are given approval for the postgraduate education allowance. Doctors who attend five days of PGEA-approved activities in a year qualify for the allowance from

their family health services authority or health board. The College believes that the regulation of continuing medical education should relate to the professional needs of doctors rather than to their contractual obligations and that because of this the target should be for an average of 10 days' continuing medical education per year. In other medical disciplines, responsibility for determining the criteria and standards for continuing medical education rests with the appropriate specialist Royal College. For this reason, and to ensure compatibility with the other stages of education and training for general practice, it should be the College's responsibility to determine and to monitor the implementation of national criteria and standards for continuing medical education. The College should undertake this task and should determine the ways in which participation in continuing medical education will link with the regular recertification of its members. This should be achieved in 1995. In doing this it will need to consider the extent to which continuing participation in audit should be a requirement in the framework for recertification. The Royal New Zealand College of General Practitioners has already incorporated such participation in its recertification arrangements (Turnbull, 1991, 1992).

4.16 The link between participation in continuing medical education and recertification is a common feature of developments in continuing medical education in other medical disciplines. By the end of 1994 all Royal Colleges in the UK will have set up systems for the recertification of their members through participation in continuing medical education. As well as including participation in medical audit within the requirements of recertification, the College must also decide the extent to which a review of a doctor's performance within the setting of his/her own practice forms part of the recertification process. The Education Network will determine as a high priority the criteria and standards to be achieved for the recertification of College members. In doing this it will wish to work closely with those who have an interest in this field including regional advisers in general practice and the General Medical Services Committee.

Policy action points

4.17 Participation in continuing education should be a professional responsibility rather than a contractual obligation; it should be recognized through the peer-driven system of recertification that the College wishes to establish for its members (paragraphs 4.3, 4.16). The target should be for an average of 10 days' continuing medical education per year per general practitioner (paragraphs 4.6, 4.15).

4.18 The College and regional advisers in general practice should provide opportunities for those with responsibility for providing and commissioning continuing medical and higher professional education to acquire and to refine their educational skills (paragraph 4.11).

Content

4.19 The content of continuing medical education must be relevant to the needs of doctors and the services that they provide. It must take account of clinical developments, changes in health service organization and changes in patients' expectations (paragraph 4.4).

4.20 Continuing medical education should build upon the opportunities that there are for learning in everyday practice (paragraph 4.6).

4.21 The College should encourage the development of a range of opportunities for continuing medical education, including those that are practice based and those of a more formal nature. Participatory forms of learning should be encouraged (paragraph 4.7).

4.22 Resources should be developed to support continuing medical education at local level. These will include postgraduate medical centres, academic departments of general practice and primary care education centres as well as the practice-based educational activities that the College would wish to encourage. The practice itself is the optimum site for much continuing medical education (paragraphs 4.8, 4.9).

4.23 The College should encourage the development and the evaluation of multiprofessional approaches to continuing medical education (paragraph 4.9).

4.24 The College should encourage the incorporation of formative assessment into higher professional and continuing medical education and should evaluate a range of ways through which this might be achieved (paragraph 4.12).

4.25 The College should continue to link fellowship by assessment with continuing medical education with a target of 250 fellows by assessment by November 1996 (paragraph 4.13).

Administrative and regulatory frameworks

4.26 A range of providers of continuing medical education should be developed, including practices, postgraduate centres, primary care education centres and academic departments of general practice (paragraph 4.14).

4.27 Local responsibility for ensuring the quality of continuing medical education should remain with the general practitioner tutor (associate adviser in Scotland), who would continue to be accountable to the regional adviser in general practice for this (paragraph 4.14).

4.28 The regulatory framework for continuing medical education should relate to the professional needs of doctors rather than to their contractual obligations. The College, through its Education Network, should determine the national criteria and standards of continuing medical education as well as the national framework for monitoring their implementation. This should be achieved during 1995 (paragraph 4.15).

4.29 The College should determine the ways in which participation in continuing medical education should link with the recertification of College members in established practice (paragraph 4.15).

4.30 By the end of 1995, the College, in common with other Royal Colleges, should have established a system for the recertification of its members in established practice. It must decide the extent to which review of a doctor's performance within the setting of his/her own practice forms part of this process. In doing this it will wish to work closely with others who have an interest in this field, including regional advisers in general practice and the General Medical Services Committee (paragraph 4.16).

5. EVALUATION OF MEDICAL EDUCATION

5.1 Evaluation is an important element in quality control in medical education. To date the methods for this have been limited and most have relied upon asking participants about their perceptions of specific activities, although practical methods have been developed (JCEM, 1993). More sophisticated approaches need to be developed, in particular to assess how much participants have actually learned, as well as the extent to which new learning has been incorporated into daily practice. Only through such evaluation can the worth of specific educational activities be determined, as well as the overall benefits of systems of medical education. Such knowledge is essential if programmes are to improve and to match more closely the educational needs of established doctors. Through such demonstration the future funding of the various stages of medical education can be justified and properly secured.

5.2 The College should collaborate with other organizations including academic departments of general practice, regional postgraduate organizations and educationalists to develop a range of techniques and systems that can be used to evaluate educational activities during the various stages of medical education. The value that participants ascribe to activities may be of merit for it is likely that if doctors have enjoyed an event and felt it to have been worthwhile then they will have benefited from it. Of greater significance, however, will be to demonstrate that an educational activity has brought about changes in the ways in which doctors practise and that this has improved the quality of the services that they can provide for their patients. This is the area of greater significance and the one where resources need to be concentrated, particularly in relationship to higher professional and continuing medical education. There is considerable need for funding for such initiatives and the Department of Health should make provision for this.

Policy action points

5.3 The College, in collaboration with other academic organizations, should develop a range of techniques and systems for the evaluation of educational activities at different stages in medical education (paragraph 5.2).

5.4 The College should encourage research into those evaluation methods that can relate participation in an educational activity to the quality of services offered to patients. The Department of Health should make financial provision for such initiatives (paragraph 5.2).

6. SUMMARY OF POLICY ACTION POINTS

6.1 Vocational training for general practice

Content

6.1.1 The working party within the Education Network should publish by the end of 1994 a comprehensive description of the general practitioner's responsibilities so that this can form a more up-to-date basis for the content of training programmes, as well as represent the content of the MRCGP examination (paragraph 2.14).

Place of training

6.1.2 The arrangements and funding for vocational training should permit more learning time in the setting of general practice. In the short term, funding arrangements should enable doctors in training to spend 18 months within the setting of general practice (paragraph 2.16).

6.1.3 Additional time in general practice should be used to help doctors to develop skills in working as members of multiprofessional primary care teams. The College, through the RCGP Commission on Primary Care, should become a national focus for developments in this area and should undertake properly evaluated experiments (paragraph 2.17).

6.1.4 There is scope to make better use of hospital experience in training. The College should encourage the development and evaluation of experiments that include shorter term supervised appointments, as well as outpatient attachments from a general practice base (paragraph 2.19). It should ensure that only hospital posts that fulfil its criteria for training form part of vocational training programmes (paragraphs 2.20, 2.27).

6.1.5 Other locations for vocational training should be used and evaluated. They include community hospitals, as well as health authorities, commissioning agencies and local authorities, which could provide opportunities for doctors to acquire skills in such activities as the needs assessment of populations, the application of epidemiology, reviewing prescribing and team building. The College should evaluate new developments to determine the contribution that such experience could make to vocational training, or to higher professional education (paragraph 2.21).

Length of training

6.1.6 The overall length of the training period should be determined by the educational needs of an individual rather than by a prescribed time, although there should be an agreed minimum period of three years. The College should press for less restrictive arrangements for vocational training to enable this (paragraph 2.22).

Administrative framework

6.1.7 Regional advisers should continue to be responsible for appointments to the networks of course organizers and general practitioner trainers in their regions. Consideration should be given to combining the posts of course organizers and general practitioner tutors so that those responsible for

education at local level can work across the trainee/established practitioner interface. Regional advisers should continue to be responsible for their selection and for ensuring their continuing competence (paragraph 2.23).

6.1.8 Regional advisers in general practice should continue to be responsible for implementing the arrangements for vocational training at regional and local levels. Regional postgraduate medical organizations should be responsible for the total funding of vocational training. As part of these organizations, regional advisers in general practice should be responsible for managing the budgets that would include the resources for all aspects of vocational training for general practice, including its hospital and general practice elements, as well as for training in other locations (paragraphs 2.25, 2.26).

6.1.9 Regional advisers in general practice should work closely with regional postgraduate deans and should be members of the boards for postgraduate education of NHS regional executives (paragraph 2.26).

Regulatory framework

6.1.10 The arrangements whereby the Joint Committee on Postgraduate Training for General Practice monitors the implementation of vocational training standards on behalf of the College should be reviewed in the near future (paragraph 2.28).

6.1.11 There is evidence that the Vocational Training Regulations are beginning to constrain developments in vocational training, particularly in restricting the length of training programmes. The College should initiate discussions with other interested parties with the aim of rescinding the Vocational Training Regulations at an agreed date in the future (paragraphs 2.29, 2.30).

6.1.12 When the Vocational Training Regulations have been rescinded, responsibility for determining national standards for all stages of vocational training and for monitoring their implementation at regional and local levels should revert to the College (paragraphs 2.28, 2.29, 2.30).

Certification on completion of training

6.1.13 All doctors on completing vocational training should demonstrate their competence for independent practice by passing the MRCGP examination (paragraph 2.31, 2.32).

6.1.14 All doctors who are appointed as new principals in the NHS should have passed the MRCGP examination (paragraph 2.32).

6.1.15 The MRCGP examiners will continue to ensure the reliability and validity of the examination, which will continue to be refined to take account of developments in practice. A timetable should be agreed by the end of 1994 for a more modular approach to the organization of the examination and to take account of regional and national applications. This will include the further development of methods for the assessment of clinical competence and consultation skills which will be incorporated into the MRCGP examination by 1996 (paragraph 2.33).

6.1.16 The funding arrangements for vocational training should ensure that further training is readily available to those who are unsuccessful in the MRCGP examination (paragraph 2.34).

6.2 Higher professional education

6.2.1 The College, at national and local levels, must become more active in helping education providers to develop the range of opportunities for higher professional education that will meet the needs of doctors in their early years in independent practice (paragraph 3.1).

6.2.2 The College should encourage the development of new ideas for higher professional education, their evaluation and the ways in which information about developments can be communicated widely and quickly (paragraph 3.3).

6.2.3 The College, together with the National Association of Health Authorities and Trusts, should consider jointly how appropriate funding for higher professional education can be achieved (paragraph 3.3).

Content and length

6.2.4 The content of higher professional education should relate to the day-to-day work of general practice and to the special interests of individual doctors (paragraphs 3.4, 3.7).

6.2.5 A minimum of 200 research training fellowships should be available across the United Kingdom to enable young general practitioners to have protected time to develop their skills on a voluntary basis. The College should continue to press this policy with NHS regional executives (paragraph 3.6).

6.2.6 The length of higher professional education should be for a minimum of two years but otherwise should not be fixed for any prescribed period, and should be determined by the educational needs of the individual doctor (paragraph 3.8).

Administrative and regulatory frameworks

6.2.7 The College, through its Education Network, must continue its work in developing and evaluating the range of opportunities for higher professional education so that a range of accessible programmes is available to doctors in their early years in independent practice (paragraphs 3.10, 3.11).

6.2.8 The Education Network should develop the criteria and standards by which higher professional education programmes will be accredited by the College during 1995 (paragraph 3.11).

6.2.9 The College must develop the framework for the accreditation of activities offering higher professional education as well as the system for determining an individual's satisfactory completion of a programme. At this stage, the doctor would be the equivalent to a consultant in the other disciplines of medicine (paragraph 3.12).

6.3 Continuing medical education

6.3.1 Participation in continuing education should be a professional responsibility rather than a contractual obligation; it should be recognized through the peer-driven system of recertification that the College wishes to establish for its members (paragraphs 4.3, 4.16). The target should be for an average of 10 days' continuing medical education per year per general practitioner (paragraphs 4.6, 4.15).

6.3.2 The College and regional advisers in general practice should provide opportunities for those with responsibility for providing and commissioning continuing medical and higher professional education to acquire and to refine their educational skills (paragraph 4.11).

Content

6.3.3 The content of continuing medical education must be relevant to the needs of doctors and the services that they provide. It must take account of clinical developments, changes in health service organization and changes in patients' expectations (paragraph 4.4).

6.3.4 Continuing medical education should build upon the opportunities that there are for learning in everyday practice (paragraph 4.6).

6.3.5 The College should encourage the development of a range of opportunities for continuing medical education, including those that are practice based and those of a more formal nature. Participatory forms of learning should be encouraged (paragraph 4.7).

6.3.6 Resources should be developed to support continuing medical education at local level. These will include postgraduate medical centres, academic departments of general practice and primary care education centres as well as the practice-based educational activities that the College would wish to encourage. The practice itself is the optimum site for such continuing medical education (paragraphs 4.8, 4.9).

6.3.7 The College should encourage the development and the evaluation of multiprofessional approaches to continuing medical education (paragraph 4.9).

6.3.8 The College should encourage the incorporation of formative assessment into higher professional and continuing medical education and should evaluate a range of ways through which this might be achieved (paragraph 4.12).

6.3.9 The College should continue to link fellowship by assessment with continuing medical education with a target of 250 fellows by assessment by November 1996 (paragraph 4.13).

Administrative and regulatory frameworks

6.3.10 A range of providers of continuing medical education should be developed, including practices, postgraduate centres, primary care education centres and academic departments of general practice (paragraph 4.14).

6.3.11 Local responsibility for ensuring the quality of continuing medical education should remain with the general practitioner tutor who would continue to be accountable to the regional adviser in general practice for this (paragraph 4.14).

6.3.12 The regulatory framework for continuing medical education should relate to the professional needs of doctors rather than to their contractual obligations. The College, through its Education Network, should determine the national criteria and standards of continuing medical education as well as the national framework for monitoring their implementation. This should be achieved during 1995 (paragraph 4.15).

6.3.13 The College should determine the ways in which participation in continuing medical education should link with the recertification of College members in established practice (paragraph 4.15).

6.3.14 By the end of 1995, the College, in common with other Royal Colleges, should have established a system for the recertification of its members in established practice. It must decide the extent to which review of a doctor's performance within the setting of his/her own practice forms part of this process. In doing this it will wish to work closely with others who have an interest in this field, including regional advisers in general practice and the General Medical Services Committee (paragraph 4.16).

6.4 Evaluation of medical education

6.4.1 The College, in collaboration with other academic organizations, should develop a range of techniques and systems for the evaluation of educational activities at different stages in medical education (paragraph 5.2).

6.4.2 The College should encourage research into those evaluation methods that can relate participation in an educational activity to the quality of services offered to patients. The Department of Health should make financial provision for such initiatives (paragraph 5.2).

APPENDIX 1

Short list posts

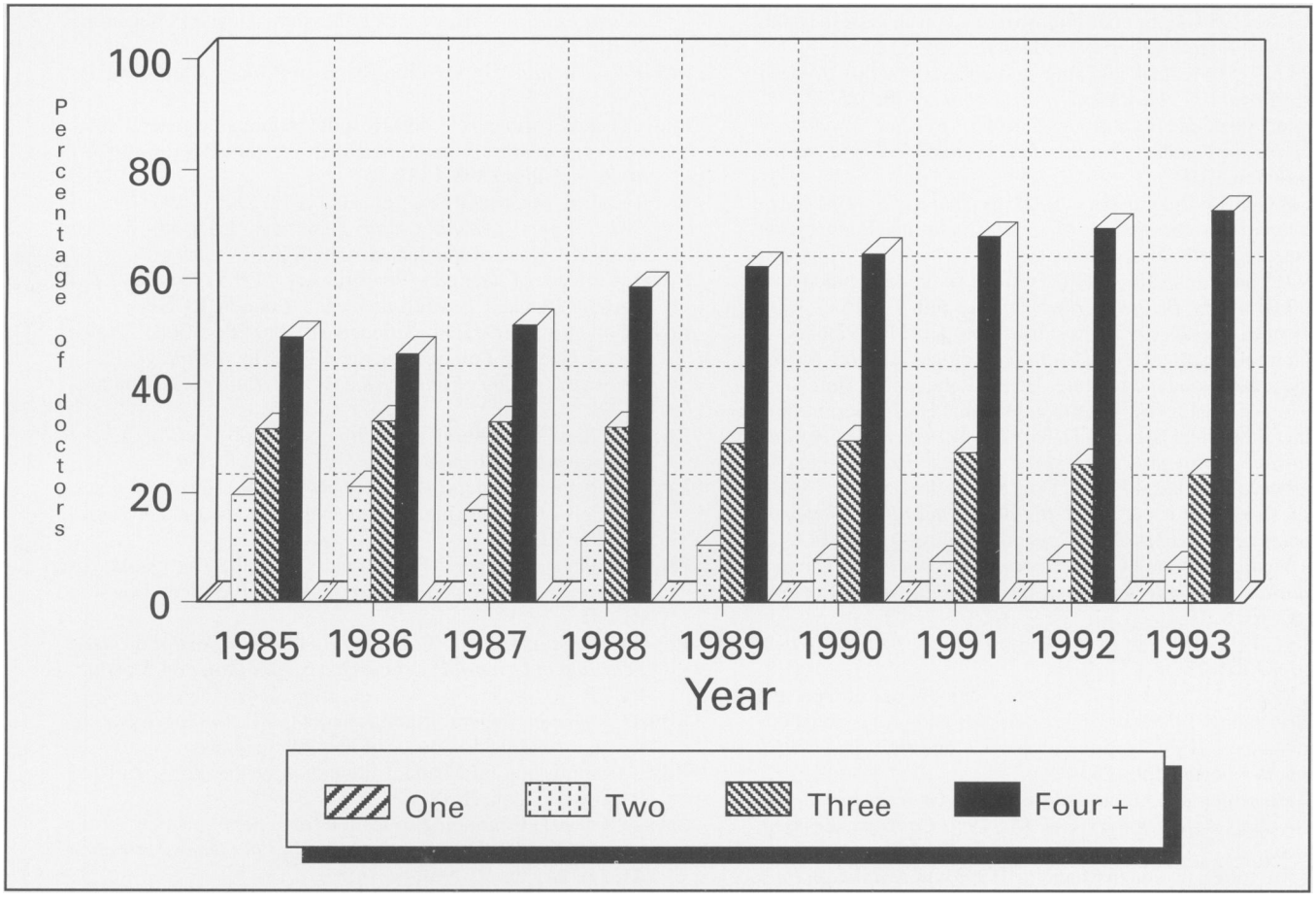

Figure 1. Completion rate of short list posts by doctors receiving JCPTGP certificates.

Table 1. Analysis of doctors receiving JCPTGP certificates 1985-1993 in relation to short list posts held.

	% of certificates issued								
Number of short list posts held by applicants	1985 (*n* = 2041)	1986 (*n* = 2196)	1987 (*n* = 2237)	1988 (*n* = 2198)	1989 (*n* = 2186)	1990 (*n* = 2112)	1991 (*n* = 2128)	1992 (*n* = 2115)	1993 (*n* = 1935)
4+	48.5	45.6	50.4	57.4	61.3	63.6	66.4	68.1	71.3
3	32.0	33.1	32.8	31.9	28.7	28.9	26.7	24.5	23.2
2	19.5	21.1	16.8	10.7	10.0	7.4	6.7	7.2	5.6
1	0.0	0.2	0.0	0.0	0.0	0.0	0.1	0.1	0.0

Source: Joint Committee on Postgraduate Training for General Practice (1994) Personal communication.

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