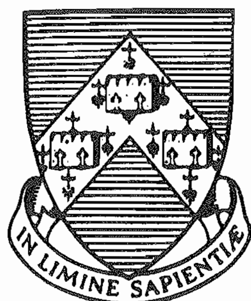


UNIVERSITY
OF YORK

CENTRE FOR HEALTH ECONOMICS
HEALTH ECONOMICS CONSORTIUM

THE ASSESSMENT OF VOCATIONAL TRAINING IN GENERAL MEDICAL PRACTICE

Jean Taylor and David Taylor

University of York
Heslington
YORK YO1 5DD

OCTOBER 1988

THE ASSESSMENT OF VOCATIONAL TRAINING IN GENERAL MEDICAL PRACTICE

Jean Taylor and David Taylor

ACKNOWLEDGEMENTS

The authors thank all those members of the medical profession working in Lambeth, Southwark and Lewisham who agreed to be interviewed during the course of this research. They also gratefully acknowledge the help and advice of Paul Bunting, Dr Sarah Divall, Richard Gorringe, Professor Peter Higgins, Dr Gwyn Howells, Dr Rob Hughes, Dr Donald Irvine, Gilbert Jessup, Dr Marshall Marinker, Christine Rivett-Carnac and Tony Ruffell.

This research was funded by the National Council for Vocational Qualifications (NCVQ) with the purpose of assisting debate on vocational education, training and assessment in professional spheres. NCVQ was established by the Government to reform and extend the national system of vocational qualifications. Full details about its role and services are available from the Press and Publicity Officer at the address below. NCVQ would welcome comments and responses relating to this report.
These should be sent to Richard Gorringe, NCVQ, 222 Euston Road, London, NW1 2BZ.

CONTENTS

	Page
INTRODUCTION	1
THE ORGANISATION OF VOCATIONAL TRAINING FOR GENERAL PRACTICE	2
Background	2
Today's Vocational Training Arrangements	2
Assessment of GP Trainees	5
Trainer Selection	7
THE ASSESSMENT DEBATE IN GP VOCATIONAL TRAINING	9
Defining General Medical Practice	10
The Competences Required in NHS General Medical Practice	11
Assessment Methods	12
Issues for Change	16
THE SURVEY RESULTS — A SUMMARY	19
DISCUSSION — OPPORTUNITIES FOR FURTHER PROGRESS	23
Options to be Examined	24

INTRODUCTION

Since 1982 all medically qualified individuals wishing to become principals in the NHS General Medical Services (that is, family doctors independently contracted to provide a full range of primary health care services) have had to undergo three years vocational training. It comprises two years in hospital posts and one as a trainee in general practice.

The establishment of these arrangements as a mandatory legal requirement for entry into general practice has been widely welcomed. They represent the culmination of several decades of largely voluntary based development, and provide an example of value not only in medicine generally but also to other professional groups seeking to achieve high standards of competence and consumer service. The processes associated with vocational training for general practice have already involved many family doctors in working out appropriate ways to define and assess their own attitudes, knowledge and skills, and to assist others to gain the necessary attributes of a good practitioner.

However, this is not, of course, to say that the system which has evolved to date is without fault or legitimate question. The UK costs of general practice vocational training may be estimated at some £30 million per annum. It is not certain that the NHS and 'the taxpayer' obtain maximum value for money for this considerable investment.

It appears, for instance, that all medical graduates wishing to find a vocational training placement are able to do so, and that virtually all receive a certificate enabling them to practise as a principal after spending the prescribed time in training. A recent (1987a) report prepared by a working party of the Joint Committee on Postgraduate Training for General Practice (the JCPTGP — is responsible for standards in this field) concluded 'the current approach to assessment (for certification) has been examined and found wanting'.

It is against this background that this report seeks to:

i) Describe the methods of assessment used by trainers in vocational training of general practitioners and the nature of the qualification and competences gained as a result of such vocational training.
ii) Examine the utility of the methods of assessment employed by trainers; to gather the views of trainees on vocational training in general practice.
iii) Describe the role of the JCPTGP and the Regional Advisers in general practice
iv) Describe and evaluate the effectiveness of the vocational training given to general practitioners in the context of "mental handicap", and to determine the place of competences (skills, knowledge, understanding and ability in application) relating to people with learning difficulties in the assessment of vocational trainees
v) Identify sources of information and support available to trainers in their assessment role

It begins with an examination of the historical development of general practice in this country, and the structures and regulations which currently exist to support and encourage GP vocational training. This is followed by a brief outline of recent thinking on the assessment of general practice vocational trainees, and the issues for change to be faced. The role of general practitioners and the competences that good medical general practice requires are examined, together with the criteria by which performance may be judged.

The report then presents the results of a qualitative survey of the views and experiences of a sample of 15 GP trainers and 14 GP trainees, drawn from an inner London Family Practitioner Committee area. (Lambeth, Southwark and Lewisham, which has a population of some 750,000 people situated in the South East Thames Region.) The interviews took place in the first three months of 1988.

Finally, conclusions and recommendations based on the above analyses are put forward, and strategies for further evolutionary change are considered. The aims of this section include identifying ways to improve methods of work-based assessment of trainee medical practitioners and deriving points of broad relevance to other higher professionals and/or personnel groups involved in health care.

This report draws on material relating to trainer and trainee responses to questions about the needs of individuals with intellectual disabilities ('mental handicap'). The significance of this last field is that 'mentally handicapped' people frequently have all the usual care needs of individuals of the same age plus varying special medical and non-medical support requirements. They typically have communication and allied difficulties common to other groups of people at risk of medical neglect in our community.

THE ORGANISATION OF VOCATIONAL TRAINING FOR GENERAL PRACTICE

Background

Medicine is a long established profession, the roots of which go back many centuries. A full understanding of the role and underlying institutional objectives and concerns of the bodies which today represent and influence its members' interests and behaviour would require a detailed and extensive historical review. It would be beyond the scope of this preliminary report on assessment in GP vocational training to attempt to provide such an analysis, although Appendix 1 offers a chronology of the key events relating to the emergence of general medical practice in the UK during the past century or so.

For the purposes of this document it is sufficient to stress just two linked, introductory, observations. The first is that in the mid 19th century the 1858 Act which established the General Medical Council also served finally to fuse together into one profession three groups which had in the past often been in conflict — the physicians, the surgeons and the apothecaries. It is from this last group (from which the predecessors of today's pharmacists split off at around the time of the Napoleonic wars) that the general medical practitioners, or family doctors, are derived.

From the 1850s onwards demarcation disputes between the general practitioners and the more specialised physicians (and surgeons) were metamorphasised into 'medical etiquette'. The GPs became both the providers of primary medical care and the keepers of the gateway through which patients were referred on to specialists. They remained, however, of relatively low status. The control of medical education stayed exclusively in the hands of the hospital based specialists even after the creation of the NHS in 1948.

Following on from this, the second introductory point on the development of general medical practice to stress is that, despite an early wave of optimistic expansion in the late 1940s and early 1950s, general practice entered a period of crisis in the late 1950s and early 1960s. This is reflected by the rise in average list size figures shown in Figure 1 (ie young doctors were not entering general practice) and the collapse in numbers of doctors taking advantage of the original NHS GP training scheme, detailed in Figure 2. The demand for practices was so low in the early 1960s that doctors wishing to become GP principals had little reason to 'waste time' training when they could find a position straight away.

This situation was reversed by changes in the NHS remuneration scheme for family doctors embodied in the so-called Doctors' Charter of 1965, followed by vigorous efforts to enhance the position of general practice as an independent specialism within medicine — see appendix 1. It was from around this time that general medical practice began to gain standing within the system of undergraduate medical education, and that postgraduate vocational training for general medical practice also started to emerge. It is with this background of relatively recent events in mind that individuals outside medicine wishing to gain a sympathetic understanding of GP vocational training should approach the topic.

Today's Vocational Training Arrangements

Figure 3 outlines the structure now underpinning the provision of vocational training for general practice in the United Kingdom. Relevant agencies and groups of personnel include:

1) The Joint Committee on Postgraduate Training for General Practice. This body was set up as a joint committee of the Royal College of General Practitioners and the General Medical Services Committee in 1975. It is responsible for (a) the certification of vocational training — see Table 1 (b) setting criteria for the selection of trainers and the identification of satisfactory hospital training posts (implemented at Regional level) (c) visiting Regions to inspect and report on training schemes and (d) producing an annual report.
2) The Royal College of General Practitioners. About a third of general practitioners now belong to the College, which was first established in 1952 and received its Royal Charter in 1967. Membership was originally conferred through referral by two other members, but an MRCGP examination system was introduced at the end of the 1960s. This examination, which has become progressively more sophisticated, has a current 'pass' rate of about 75 per cent — Table 2. Recently the RCGP has additionally concentrated on the development of peer review procedures.

Figure 1 Average list size of unrestricted principals in general practice, 1951-86

Average list size

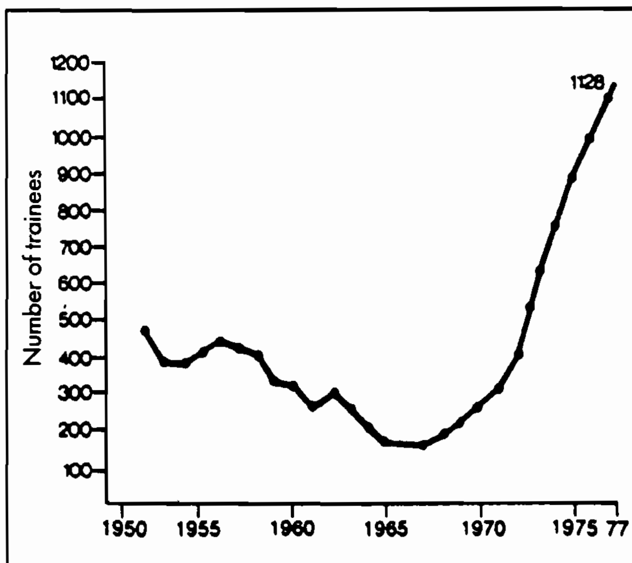
2,600
2,500
2,400
2,300
2,200
2,100
2,000
1,900
1,800
1,700
1,600
1,500

England and Wales
UK
N Ireland
Scotland

1951 1954 1957 1960 1963 1966 1969 1972 1975 1978 1981 1984 86e

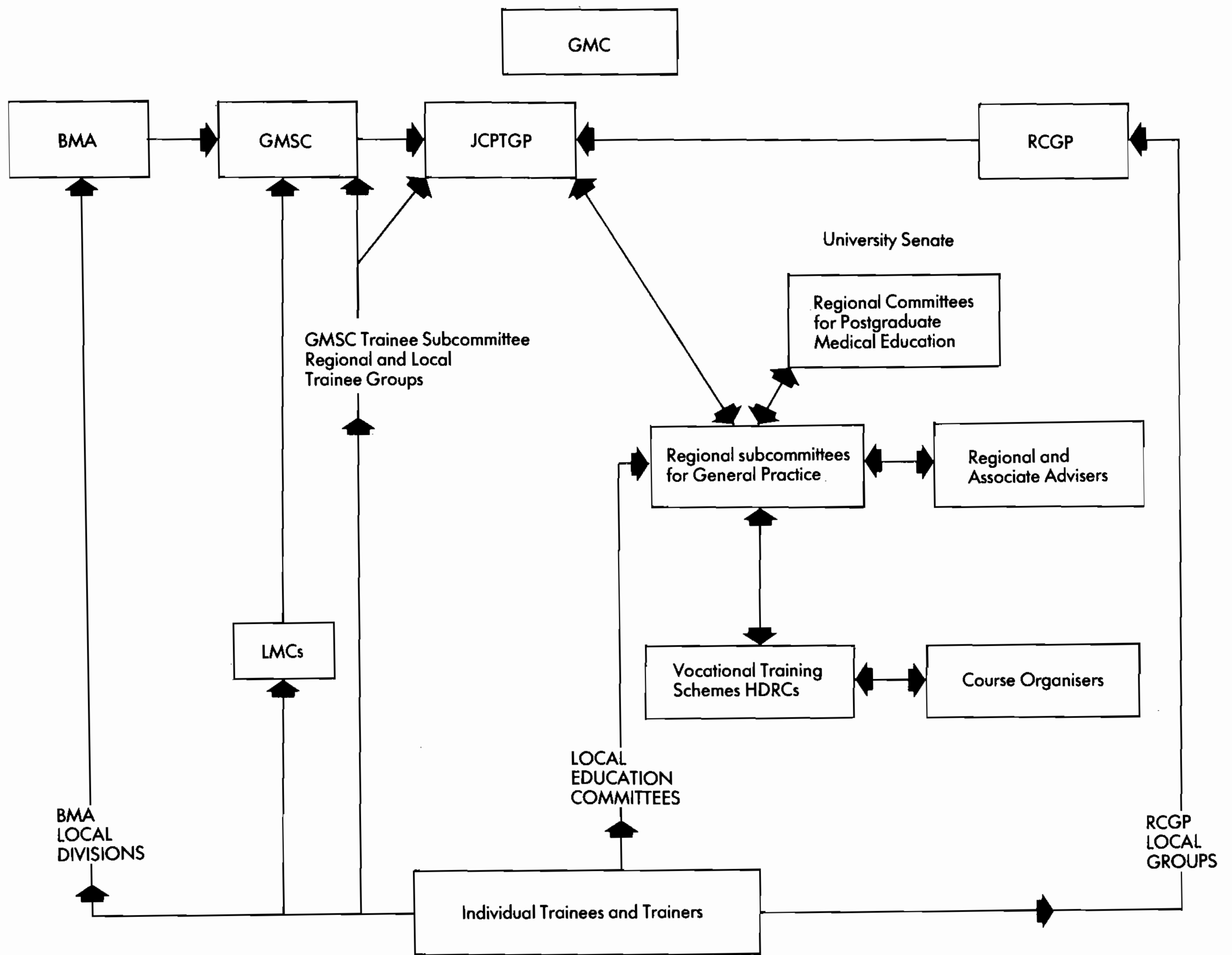
Source: OHE 1987

Figure 2 Trainees in the trainee practitioner scheme, 1952-77



Source: Horder and Swift 1979

Figure 3 The Structure of GP Vocational Training Arrangements, 1988



3) The General Medical Services Committee. Represents the interests of general practitioners within and through the BMA, and is the executive committee of the conference of Local Medical Committees which represent the local views of the profession within the NHS. It negotiates the terms and conditions of service for general practitioners with representatives of the Secretary of State for Health and Social Services.
4) The Regional Subcommittees for General Practice. Each NHS Region (there are 14 in England) has a Postgraduate Medical Education Committee, of which these are subcommittees. They advise on all matters relating to general practice education and have statutory responsibility for appointing trainers and approving training practices.
5) Regional Advisers. These are general practitioners appointed on a part time, sessional basis to promote and organise vocational training (and continuing medical education). They are assisted in this by Associate Advisers, general practitioners appointed on a similar, part time basis. (All have directly to practice medicine for two and a half or more days a week to remain active GPs.) Their activities include providing courses and workshops for prospective trainers and study days/courses for trainers and course organisers.
6) Course Organisers. At the local — effectively NHS District level — local trainers (who do not usually have trainees at the time) are selected to organise the day release course element of vocational training (see below) and to administer structured training schemes. They may also run trainer and trainee workshops, and be involved in trainer selection where this is devolved to the local level.
7) Individual Trainers. These general practitioners are selected to provide training and learning opportunities for GP trainees on a one to one basis. While they have a trainee in their practice they receive an additional fee of £3,600 per annum, paid via the local Family Practitioner Committee along with their other NHS earnings and allowances.

The regulations issued after the passing of the 1977 NHS Act, and implemented in 1981/82, lay down that a doctor can now only become a principal in the (NHS) general medical services (ie contracted to supply all normal primary medical care services to his or her patients) on having gained a certificate of prescribed or equivalent experience. This involves a three year period of post-registration training. (Registration with the GMC is permitted after graduation plus one year in junior hospital posts.) Of this time 12 months must be spent in an approved general practice. The remaining two years are spent in approved hospital or community medicine posts, with at least six months spent in two of the following areas — accident and emergency, general medicine, geriatrics, obstetrics and/or gynaecology, paediatrics or psychiatry.

It should be noted that during their hospital experience trainees are part of the normal hospital staff establishment. Only in the general practice year (during which they receive about £10,000 payment) are they supernumerary. The economic implications of this, which include the fact that the NHS hospital service gains two years relatively cheap medical labour from each future GP going through vocational training, help to explain why it is unlikely that the general practice element of the overall training period will be increased.

The regulations do not distinguish between formal, often medical school based, vocational schemes involving complete three year 'packages' and 'DIY' courses, self-constructed by trainees who apply independently to trainers and for each hospital post they take. The latter approach is flexible, and perhaps particularly useful for those doctors making career changes. Formal schemes offer advantages like a continuous half day a week release course running throughout the three year training period ('DIY' trainees usually enjoy the day release element only during their GP year) and the option to split training periods appropriately. For instance, many such courses allow trainees an initial two months with their general practitioner trainer, followed by two years in hospital and then 10 months in family practice. This may allow a greater overall sense of purpose and continuity.

Assessment of GP Trainees

At the end of each period of training a statement of satisfactory completion must be signed by the trainer or consultant concerned (JCPTGP 1987b). These are passed on to the JCPTGP which is ultimately responsible for certifying the trainee. It has the authority to issue certificates of equivalent experience for doctors it judges to have had other appropriate career backgrounds.

Table 1

Certificates of prescribed* and equivalent experience issued by JCPTGP, 1981-1986

YEAR	PRESCRIBED	EQUIVALENT
1981	2,374	180
1982	2,061	361
1983	1,422	288
1984	1,415	458
1985	1,513	518
1986	1,831	352
TOTAL	**10,616**	**2,157**

*Prescribed experience indicates the satisfactory completion of vocational training; equivalent experience is other experience judged by the JCPTGP to be sufficient to qualify an individual to become a principal in NHS general practice.

Table 2

Numbers and Pass Rates of Trainees Sitting the MRCGP Examination, 1984-1987

EXAM	TOTAL CANDIDATES	PASS RATE	TOTAL TRAINEES*	% TRAINEES	TRAINEE PASS RATE %
DEC. 1984	540	70	394	73	76
JUNE 1985	960	68	804	84	73
DEC. 1985	680	68	527	76	74
MAY 1986	1,262	71	988	78	74
DEC. 1986	738	71	573	78	73
JULY 1987	1,159	72	859	74	80

*Trainee when sitting or within one year of completing training.

Logically, this issue of assessment lies at the heart of any training process. However, the term 'satisfactory completion' has never been defined in relation to the various stages of GP vocational training. The JCPTGP regulations to date stipulate that it means 'completion in such a manner as to have acquired the medical experience which may reasonably be expected to be acquired from training of that duration in that employment'. What in practice such an approach has meant is that qualification is time/attendance based rather than criterion based. Indeed, some medical commentators have suggested that this means that the JCPTGP cannot claim to monitor standards of vocational training, since no properly defined standards or performance criteria exist. (For this and related criticisms, see Bahrami 1986.)

Regarding the Regional assessment arrangements for SE Thames (the area in which the trainers and trainees interviewed for this report work) the local guidelines are to make mandatory an originally provisional suggestion that there should be an initial appraisal of each trainee with regard to clinical knowledge and skills, and their understanding of patient care in general practice. It is required that a learning and activities programme should then be agreed between the trainer and the trainee, with assessments of progress at three and nine months. The trainees' report should include (a) a diary of work covering two weeks (b) two case reports (c) a record of tutorials (d) a record of literature read and (e) comments on the training experience. After discussion, it should be sent to the Regional Adviser.

One of the objectives of the survey described later in this report is to examine how well these arrangements work in practice. Relevant findings are presented, following an introductory outline of the current debate surrounding assessment in GP vocational training. However, before this, this section briefly examines one final topic. It is trainer selection, and the relevant local regulations applying in the SE Thames Region. The significance of this area is partly reflected in the fact that a number of medical authorities have suggested that if trainer selection is 'right', then appropriate trainee assessment will follow. That is, that if trainers are 'good enough' then there will be no need for rigorous assessment procedures in respect to trainees' attained standards of skill, knowledge and performance. And although this last view (which represents an apprenticeship approach to GP vocational training) may strongly be questioned, it is certainly the case that the influence a trainer has on his or her trainees is a critical one both in terms of providing role models and other forms of education (Freeman et al, 1982).

Trainer Selection

Along with guidelines on, for example, the standards of training, practice premises, staffing, record keeping and equipment to be expected, there are national criteria as to the qualities GP trainers require. (See Pereira Gray 1982, JCPTGP 1985). These cover areas like the individual's desire, ability and preparedness to teach, clinical competences, managerial skills, relationships with colleagues, professional values, communication skills and preparedness to be assessed by his or her colleagues.

However, there are no detailed criteria laid down at national level as to how prospective or existing trainers should be judged to have, or not to have, these required attributes. It is for the regions — through the General Practice Subcommittees and the work of Regional Advisers and their Associates — locally to interpret and implement selection criteria and processes.

In the case of SE Thames, for instance, the current local regulations stipulate that new trainers must have been in their present post for two or more years and principals for five years, and have attended a course on the theory and practice of patient care in general medical practice. (The three term, half day per week trainers' course at Guys, which 75 per cent of the Region's trainers have attended, includes elements on clinical practice, performance in relation to both set and self initiated projects, and learning and teaching skills.) The details of the current guidelines are being revised, at a time when it is felt the region now has an adequate overall number of trainers.

Appointments are made within the region by three Selection Committees, covering different geographic areas. These comprise senior trainers, course organisers and the Regional Adviser and his Associates. Applicants are interviewed, and their practices visited by the Selection Committee. Initial appointments are for two years, when the Committee additionally examines training records and trainee comments. In cases where a trainee has failed to complete a course an automatic reselection process is initiated.

Figure 4 The NVQ Model of Assessment

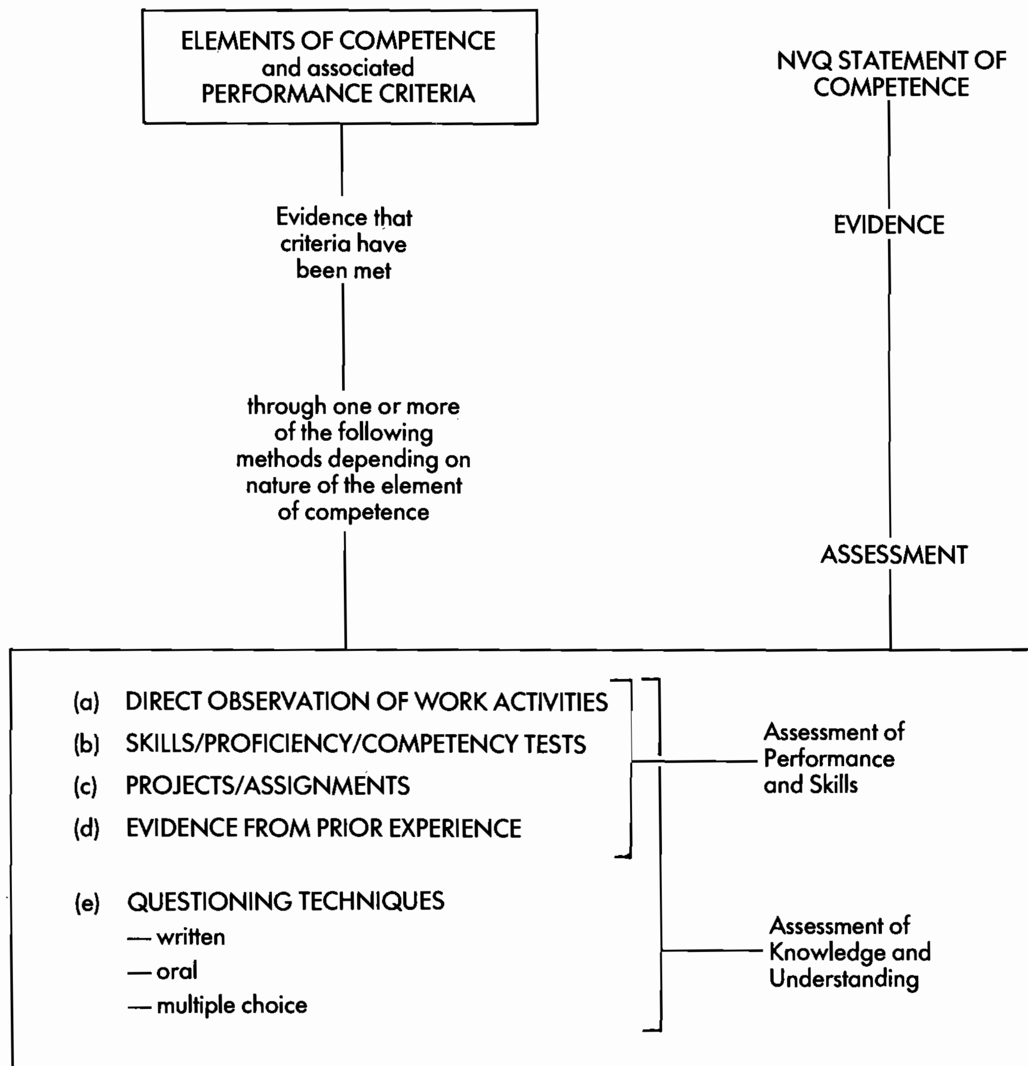


Figure 4 outlines the NVQ model of assessment. It involves defining the elements of competence needed for the successful fulfilment of a given occupational role; the identification of appropriate performance criteria in relation to each of these competences; and the establishment of assessment methods/processes through which evidence may be obtained that these criteria have been met by those seeking qualification.

Workplace based assessment, in which individuals can be observed in 'real' circumstances, is in some important respects more desirable than the other methods listed in Figure 4. But considerations such as those of cost, confidentiality or time may of course make one or other of the alternatives shown more appropriate in given instances.

This approach has been applied successfully in relation to many areas. However, its extension into 'higher level' vocational qualification contexts like general medical practice may present some difficulties. These relate potentially to both the inherent complexities of an occupational function like medicine, and the attitudes and responses of professional groups which have fought long and hard to gain or obtain control over their own educational and qualifying arrangements.

For example, one critical issue is that the identification of appropriate competences and performance criteria for a general practice vocational qualification has, until recently at least, been made extremely difficult by a lack of agreement as to what 'good' general practice comprises (Hasler 1983). And one of the reported reactions to RCGP initiatives aimed at 'devising methods of assessing established general practitioners in the setting of their own practice' was 'anxiety that the existence of a relevant and workable assessment tool might encourage outside bodies to attempt to judge the quality of general practice and then influence the direction it should take' (RCGP 1985a).

Despite such professional concerns, however, there have recently been significant moves towards a more rigorous approach to assessment relating to the vocational qualification certified by the JCPTGP. As touched on in the introduction, the 1987 report of this joint body expressed a commitment to reform (see Box 1) and subsequently it declared its intention to withdraw its approval of the NE Thames Region as from February 1st, 1989. Although the concern central to this decision (which has recently been reconsidered) was the quality of record-keeping in training practices, such unprecedented action may be taken to indicate a relatively firm overall desire to improve training standards.

Box 1

Conclusions and Recommendations of the JCPTGP Working Party on Assessment and Vocational Training for General Practice.

The current approach to assessment for certification under the NHS Vocational Training Regulations has been examined and found wanting. Furthermore, assessment both for educational and standard-setting purposes is an under-developed aspect of vocational training. Assessment should now be given a higher profile and priority by the Joint Committee and the Regional Postgraduate Organisations so that the overall effectiveness of training and the results achieved by individual trainees can be demonstrated. In particular we recommend that:

a) There should be a concentrated effort within general practice to secure broad agreement on the services which general practice should provide, on the clinical content of the discipline and on the attributes of the future general practitioner.
b) Training for general practice, including assessment, should reflect the content of the clinical services for patients more clearly.
c) The Joint Committee should be responsible, through its operation of the NHS Vocational Training Regulations, for ensuring a minimum standard of competence of doctors completing training.
d) A national system of continuous assessment, based initially on the Manchester Rating Scale, should be introduced in all regions to achieve this.
e) Statements of Satisfactory Completion of Training should therefore represent the actual performance of a trainee rather than indicate attendance at a training programme.
f) The RCGP should be invited to consider that the purpose of its membership examination, taken voluntarily, should be to indicate the standard of knowledge and skill required for good general practice.
g) Each region and scheme should be strongly encouraged to help its trainees and trainers achieve a high standard of education and training by the regular and imaginative use of assessment locally.

Source: JCPTGP 1987a

The purpose of this section is to provide an overview of the current situation regarding the assessment of GP vocational trainees, and the options for further change revealed by the current controversy within the medical profession itself. It briefly examines material relating first of all to the definition of general practice; second, the competences required by general practitioners; and third, the performance criteria and assessment methods employed by GP trainers. (Full references derived from the literature survey on which this section is based are to be found at the end of this report. Only key sources are referred to in the text.)

Box 2

The Work of the General Practitioner — the Leeuwenhorst Statement

The general practitioner is a licensed medical graduate who gives personal, primary and continuing care to individuals, families, and a practice population, irrespective of age, sex and illness. It is the synthesis of these functions which is unique. He will attend his patients in his consulting room and in their homes and sometimes in a clinic or a hospital. His aim is to make early diagnoses. He will include and integrate physical, psychological, and social factors in his considerations about health and illness. This will be expressed in the care of his patients. He will make an initial decision about every problem which is presented to him as a doctor. He will undertake the continuing management of his patients with chronic, recurrent, or terminal illnesses. Prolonged contact means that he can use repeated opportunities to gather information at a pace appropriate to each patient, and build up a relationship of trust which he can use professionally. He will know how and when to intervene, through treatment, prevention, and education, to promote the health of his patients and their families. He will recognize that he also has a professional responsibility to the community.

Educational aims

From this broad description of the general practitioner are derived the following educational aims which should be attained by the time a doctor enters independent practice. Many of them are shared with other doctors. They are arranged in three groups:

1 Knowledge 2 Skills 3 Attitudes

All three groups are equally important.

At the conclusion of the training programme, the doctor should be able to demonstrate:

1 Knowledge

a) That he has sufficient knowledge of disease processes, particularly of common diseases, chronic diseases, and those which endanger life or have serious complications or consequences.
b) That he understands the opportunities, methods and limitations of prevention, early diagnosis and management in the setting of general practice.
c) His understanding of the way in which interpersonal relationships within the family can cause health problems or alter their presentation, course and management, just as illness can influence family relationships.
d) An understanding of the social and environmental circumstances of his patients and how they may affect a relationship between health and illness.
e) His knowledge and appropriate use of the wide range of interventions available to him.
f) That he understands the ethics of his profession and their importance for the patient.
g) That he understands the basic methods of research as applied to general practice.
h) An understanding of medico-social legislation and of the impact of this on his patient.

2 Skills

a) How to form diagnoses which take account of physical, psychological, and social factors.
b) That he understands the use of epidemiology and probability in his everyday work.
c) Understanding and use of the factor (time) as a diagnostic, therapeutic, and organizational tool. (sic).
d) That he can make relevant initial decisions about every problem presented to him as a doctor.
e) The capacity to co-operate with medical and non-medical professionals.
f) Knowledge and appropriate use of the skills of practice management.

3 Attitudes

a) A capacity for empathy and for forming a specific and effective relationship with patients and for developing a degree of self-understanding.
b) How his recognition of the patient as a unique individual modifies the ways in which he elicits information and makes hypotheses about the nature of his problems and their management.
c) That he understands that helping patients to solve their own problems is a basic therapeutic activity.
d) That he recognizes that he can make a professional contribution to the wider community.
e) That he is willing and able critically to evaluate his own work.
f) That he recognises his own need for continuing education and critical reading of medical information.

Defining general medical practice

Many individual doctors, publications, working party reports and policy statements have aided the recovery of general practice from its 'identity crisis' nadir in the late 1950s/early 1960s. The most important early contributions include the work of Balint (see Balint 1964) on the relationship between GPs and their patients; the publication of 'The Future General Practitioner' (RCGP 1972), which described the wide scope of the work covered in general medical practice and indicated the range of education and learning needed; and the findings produced by a working party of the Second European Conference on the Teaching of General Practice, held at Leeuwenhorst in the Netherlands in 1974.

This last, widely known as the 'Leeuwenhorst statement' has provided the basis of virtually all subsequent attempts to define general medical practice for the purposes of vocational training. It is reproduced here as Box 2.

It would be beyond the scope of this report to attempt to add to the already substantial body of literature on this topic. However, in summary it may be noted that nearly all medical commentators agree with Pereira Gray (1982) that the key components of general practice as an independent discipline should include a combination of:

a) a focus on the primary medical care of the individual, in which the GP deals him or her self with the great majority of presenting problems but also acts as a gateway to many specialised services
b) a complementary focus on the care of families as units
c) the provision of domicilary care where needed
d) the provision of care in a manner which permits continuity over time
e) the provision of preventive care
f) holistic care, through which all the physical and psychological needs of the person in his or her social context are considered.

It may additionally be noted that two of the most significant characteristics of general medical practitioners' work as compared with that of many other professionals are or have been:

a) their relative isolation from their peers
b) the complex combination of social and medical problems daily requiring their attention, involving many ill-defined physical and mental states, intermixed with family and personal problems and the occasional life threatening or similarly serious clinical challenge.

General practitioners have frequently to rely on their own judgement as to whether or not a given patient requires further (expensive) diagonostic investigations. Good primary care involves avoiding the unnecessary use of hospital based secondary care resources. This usually requires knowledge of individual patients and their health related records and experiences over time, coupled with sensitivity to their immediate needs and sound clinical skills.

The Competences Required in NHS General Medical Practice.

It follows from the above that abilities related to self-criticism and self initiated learning are likely to be found in 'good' general medical practitioners. The ability to tolerate with reasonable, but not undue, confidence uncertainty combined with anxiety on the part of those being treated is also necessary. These characteristics may themselves be considered 'higher level' competences, although they are clearly not of the same nature as, say, the elements of clinical knowledge needed to diagnose and/or treat cases of asthma, diabetes or hypertension.

A number of individuals and groups have attempted to identify specifically the elements of knowledge, skill and attitude which are required by a good general practitioner, and hence the objectives of GP vocational training. (See Box 3 for details of alternative methodologies.) Freeman and Byrne (1973) argued that medical graduates are already fairly well equiped with clinical knowledge, and that the most important goals of training relate to the acquisition of appropriate attitudes, followed by skills and further knowledge. (This has been questioned by others — see, for instance, Williams 1984.) They developed a method of assessment, discussed below, which has been of considerable importance in the subsequent development of GP training.

Box 3

Methods of Identifying Competences required of General Practioners

A number of techniques are available for identifying competences required of general practitioners (or other professional groups). These include surveying the literature and the content of syllabuses of medical schools, and observing what doctors actually do. However, the methods which are likely to prove most useful are:

1) The Delphi Technique

A group of experts is asked (independently of one another) to describe the knowledge, skills and attitudes required in their profession and to identify competences within each area. From their responses a list of competences is compiled which is then sent back to the experts in order for them to add to, or delete from, the list. This process is repeated until a consensus is reached.

2) Critical Incident Surveys

Individuals are asked to describe events, which they will have taken part in or observed, which demonstrate either good or bad medical practice. If enough incidents are collected they fall into 'clusters' which show areas of competence.

3) Behavioural Event Interview

A survey of doctors is carried out to find those considered to be particularly good in their field. Those so identified are asked to describe both critical events within their experience and what characteristics they think a 'good' doctor should possess. Competences may then be derived from these descriptions.

These methods of identifying competences are not mutually exclusive. A combination of techniques may be used. For example, the revised Manchester ratings (see Box 6) are based on a critical incident survey of trainees supplemented by the experience of trainers and other general practitioners.

Source: Dunn, Hamilton and Harden (1985)

More recently the Oxford region produced a paper entitled 'Priority Objectives for General Practice Vocational Training' (RCGP 1985b). This detailed under five main group headings the areas where general practitioners most need to be competent — see Box 4. For the purposes of this study the combinations of understanding, skill, knowledge and ability in application described (or implied) in this reference may be considered to be probably the best available statement of necessary competences to be acquired in vocational training for general medical practice.

Assessment Methods

A wide variety of assessment methods have been suggested in relation to measuring GP trainees' competences. The literature available also examines the validity (relevance and specificity), reliability (reproduceability and consistency) and feasibility (time/cost acceptability) of the assessment options open. Overall, there is a broad consensus to the effect (a) that the use of a range of methods is necessary to assess the wide spectrum of attitudes, skills and knowledge that make up general practice competences and (b) that trainee assessment should be criterion rather than norm referenced. That is, that particular competences should be achieved to a given standard by each trainee, set independently of the performance of his or her peers.

In addition, commentators active in this field have discussed in some detail the question of the extent to which assessment processes utilised in GP vocational training should be formative as opposed to summative in nature. At present, as previously noted, the practical reality applying in this field is that certification is time rather than standard based and thus, by and large, that all trainee assessment activities are in essence formative. The only summative procedure is the examination for membership of the RCGP, which is taken voluntarily. In that the MRCGP approach may provide a model for further developments in the assessment of GP vocational trainees it is described below, along with some other assessment methods currently in use.

The MRCGP examination comprises three written papers and two oral examinations. The former consist of multiple choice questions (MCQs), traditional essay questions (TEQs) and modified essay questions (MEQs), the nature of which is indicated in Box 5. These last have been developed by the RCGP to simulate actual diagnostic and patient management problems. Information relating to the example case is presented in a phased manner, with questions to be addressed at each discrete stage.

The first oral is based on an array of 50 consecutive cases seen by the candidate, and previously submitted by him or her in the form of a brief log. The second is more open ended, but includes clinical case discussions.

Box 4

The Competences Required of General Practitioners

Patient care

1. *Problem definition*
The doctor should be able to demonstrate that he:

(a) can recognize common physical, psychological and social problems presenting in general practice and give equal consideration to them.

(b) can include in his assessment of the problem:
- the patient's beliefs, ideas and concerns about the problem
- its effects on daily living, family and friends
- its effect on the psychological state of the patient
- the patient's expectations of the doctor.

(c) understands the principles of problem definition, including:
- the consideration of appropriate possibilities
- the use of probabilities
- the use of selective history taking, physical examination and investigations.

(d) can cope with his own anxieties, particularly in relation to:
- the unstructured presentation
- the inability to reach a firm conclusion
- the lack of continual professional monitoring.

2. *Management*
The doctor should be able to demonstrate in his management of the patient's problem that he:

(a) can choose with the patient the appropriate management for each problem.

(b) understands the importance of making and reassessing a management plan which includes:
- the effective involvement of other members of the team
- the effective use of records.

(c) in his prescribing of drugs, has a knowledge of their:
- pharmacological action
- side effects
- interactions
- dosage
- cost
- regulatons, including that of scheduled drugs
- appropriate use

and that he is aware of the sources of information concerning other drugs.

(d) has the knowledge and skills necessary for the management of life events and crises. These include, for example, death, alcoholism, domestic upheavals and psychiatric illness.

(e) can provide appropriate care and support for his patients and their families.

(f) has the knowledge of available agencies and resources, and skills to make appropriate referrals.

(g) understands the importance of appropriate involvement and education of the patient.

(h) is aware of the costs of his activities, especially in the field of prescribing, and practises in the knowledge that the resources of health care are finite.

3. *Emergency care*
The doctor should be able to diagnose and initially manage in general practice all acute emergency situations and provide immediate follow-up care where appropriate. Important examples of these are acute asthma, pulmonary embolus, myocardial infarction, acute left ventricular failure, acute abdomen, acute haemorrhage, management of the unconscious patient, including diabetic coma and hypoglycaemic coma, status epilepticus, road traffic accident, obstructed airway, self-poisoning, acute depression and compulsory mental health admission.

4. *Prevention*
The doctor should be able to demonstrate that he:

(a) understands the principles involved in identifying preventable diseases in general practice, for example:
- case finding during routine consultations
- health education during routine consultations
- screening sub-groups of the population
- monitoring preventive activities, e.g. immunization and cervical screening rates; level of family planning; attendance at child health development clinics; health education for groups of patients and the community at large.

(b) has a knowledge of systems used to identify individuals and sections of the practice population.

(c) is able to provide effective preventive services to individual patients and to his registered practice population.

Communication

1. *Patients*
Communication with patients takes place largely in the consulting room but also at home, on the telephone, and in other situations. Effective communication can be defined as the ability to establish or maintain a relationship with the patient and to use appropriate strategies and skills to achieve the aims of patient care.

The tasks that can be achieved in a consultation have been incorporated in our objectives for patient care.

2. *Partners practice team and other professionals*
The doctor should be able to demonstrate:

(a) understanding and respect for the professional training and differing roles of members of the practice team and other disciplines who may be involved in the care of his/her patients. This is particularly important in relation to:
- district nursing sisters
- treatment room sisters
- health visitors
- community midwives
- social workers
- practice managers, secretaries and receptionists.

(b) his understanding of the importance of meetings and discussion wih his partners, family, practice team, and local colleagues in hospitals and general practice.

(c) the skill to discover the strengths and weaknesses of the members of these groups and their need for support.

(d) the use of his knowledge of the practice and his patients to their mutual benefit in various contacts, such as at practice meetings, team meetings, on the telephone, at interdisciplinary meetings, and within the family.

Organization

We emphasize the need to be able to monitor and manage as being more important initially than being conversant with every paragraph in the Statement of Fees and Allowances (Red Book). If the broad principles are grasped, it is likely much else will follow.

Some aspects of organization are covered in the other sections.

1. *The practice*

The doctor should be able to demonstrate:

(a) an understanding of the importance of the need to manage a practice effectively.

(b) an ability to monitor aspects of practice activity, including:

- accessibility and appointment systems
- information given to patients
- records and registers
- employment and attachment of staff
- use of time.

(c) the ability to take appropriate action when problems are identified in these fields

(d) his knowledge of the most important sections of the NHS contract and regulations, including:

- his principle obligations
- sources of income
- superannuation.

(e) his knowledge of the most important organizational aspects of practice and partnership, including:

- partnership agreements
- principles of book-keeping and accounts
- financing of premises
- income tax.

(f) his understanding of the application of new technology to general practice.

(g) his understanding of the principles of the successful introduction of change and innovation including:

- the nature of innovation
- the characteristics of the adopter
- the characteristics of the organization
- the implications for his future practice.

2. *Personal*

(a) The doctor should be able to demonstrate the ability to manage his time:

- in consultations
- in the balance between patient care, the practice, his family and other activities.

(b) The doctor should demonstrate an awareness of his own limitations, respect the skills of others, and the ability to delegate appropriately.

3. *Community*

(a) The doctor should be able to determine and to respond to the health needs of the community.

(b) He must know how and where to intervene in the community on behalf of individuals or groups of patients and have the ability to deal with and relate to a wide range of people responsible for community affairs.

Professional values

The doctor should be able to demonstrate:

(a) awareness of his own values, beliefs and attitudes, the factors that influence them, and the way that they affect his work and relationships with patients and colleagues.

(b) his recognition of the social, cultural, and organizational factors that define and affect his work as a doctor (e.g. social class, race, methods of payment).

(c) the possession and application of ethical principles in his work. These include:

- respect for the value of human life
- respect for the dignity of patients and the promotion of their autonomy
- maintenance of confidentiality
- willingness broadly to place the needs of the patients above his own convenience
- justice and fairness in allocating resources
- personal and professional integrity.

(d) tolerance, respect and flexibility in his response to the ideas of others, including those of his patients, peers and teachers.

(e) his willingness to submit his work to review by his peers and the ability to give and receive criticism.

(f) that he is able to maintain his own physical and mental health. He should be aware of the stresses of his work and of his own responses and defence mechanisms. He should be able to seek and obtain appropriate support.

(g) his awareness of the factors that influence the relationships between his personal and professional life (e.g. financial and family commitments).

(h) a willingness to accept appropriate responsibility for his patients, partners and colleagues within the practice. He should be prepared to provide appropriate support for others in the practice.

Personal and professional growth

The doctor should be able to demonstrate:

(a) that he can identify strengths and weaknesses in his performance as a doctor and his educational needs. This may be achieved by performance reviews, peer group review, and other assessment tools.

(b) that he can recognize, define and respond to changing needs in his patients, in his community, and in other professions with whom he works.

(c) that from his review of his own work and the changing pattern of needs, he can define his own educational needs and appropriate methods of meeting these needs (e.g. critical reading of the medical literature and methods of continuing medical education).

(d) the ability to adapt to change and to produce positive change both in himself and others.

(e) an awareness of the factors that limit his effectiveness, e.g. the management of time and resources, and demonstrate the ability to manage and overcome them.

The MRCGP examination can be criticised as being more of a test of theoretical knowledge and 'test passing' skill than it is of 'hands on' quality of care delivery. But it has been refined over a number of years to the point where it arguably provides evidence of the attainment of a considerable part of the competence base needed by 'good' general practitioners.

Objective structured clinical examinations have been developed specifically to test 'hands on' clinical abilities in a reliable and valid way. They involve the use of a battery of standard patients (who may be acting or genuine) in simulated clinical events, normally in conjunction with other forms of questioning. This type of approach has been used in some GP trainee half day release courses (see Reith and Taylor 1986), but its feasibility is limited by the time and resources needed to set up an OSCE.

Checklists (together with the remaining assessment methods outlined below) can more easily be used by individual trainers. They are outline lists of the skills and areas of knowledge needed in general practice which can be used by trainees and trainers to identify those competences in relation to which the trainee feels/is least confident. They are most useful as curriculum guides, but can be used as an assessment tool.

Consultation analyses are most simply conducted by trainers sitting in on a trainees' consultation with a patient. But the use of video or audio taping is now widespread, and on occasions active efforts are made to involve those individuals receiving treatment in the analytic/teaching process. One advantage of recording consultations is that recall bias can be avoided, and another is that case discussions can be easily extended to include others with relevant expertise.

Attitudinal assessments can be valuable. Even discussion of statements such as:

'the common cold should not come to the surgery'

or

'choice in prescribing should not be restricted'

or

'assessing trainees is taking things too far'

can provide a basis for improved communication and understanding between trainers and trainees.

Ratings scales overlap with the former. The most widely used GP trainee rating scales are the 'Manchester ratings' developed by Freeman and Byrne (1973). These originally consisted of eight sets of paired statements describing desirable and undesirable behavioural characteristics. The assessor's task was to place on a 12 point scale the trainees attitudes/competences/characteristics in respect to each of the criteria set down, and then to provide an overall view of his or her competence.

A new, extended version of the Manchester ratings has recently been completed — see Box 6. It is this that the JCPTGP (1987c) has recommended should in future be used as the main tool for minimum standard based assessment in general practice vocational training. However, it may be argued that this approach is still to an extent a subjective one, even though the ratings if used properly should help trainers to form more appropriately structured and considered opinions about their trainees. Aspects of this issue are discussed further in the concluding section of this paper.

Other methods of GP trainee assessment identified in the literature review conducted as part of this study include those based on trainee research projects, trainer/trainee diary and log records, analyses of patient records, referral letters and trainee prescribing patterns, and feed back from colleagues and patients.

Issues for Change

There is today a large body of work which indicates that general medical practice, and the necessary abilities of a 'good' doctor, can broadly be defined. A range of assessment methods have also been pioneered. But significant technical difficulties still exist relating to the precise specification/writing of the competences required of family doctors, and the identification and consistent measurement of valid performance criteria.

This is not least because in the complex therapeutic and social contexts in which general medical practitioners — and other higher level 'caring' professionals — often work, there may be no one 'right' approach to a given problem.

Also, elements of behaviour related to underlying personal attitudes rather than 'learnt' responses may be central elements in good general practice; their reliable assessment by any sort of formal procedure, short of lie-detection tests, is profoundly difficult. Yet without the ability to assess consistently each subject's standard of performance in practice one of the central goals of assessment for qualification (as conceived by bodies such as the NCVQ) cannot be attained.

Furthermore, the JCPTGP (1987a) has recently recognised the professional/process level problems associated with trainees being assessed by their individual trainers. It has made proposals (already referred to) as to how 'satisfactory completion' of GP vocational training may itself be satisfactorily assessed.

There can be no doubt that extended use of the revised Manchester ratings would to a degree help to improve the quality of GP trainee assessment to date achieved.

The latter is presently patchy and appears characterised by highly variable quality, subjectiveness, poor validity, and confusion related to the differing roles of summative as opposed to formative assessments. There is, for example, a clear danger of trainers 'colluding' with trainees (in part because of the 'good' reason that they treat them as patients, in part for the 'bad' one that they wish to avoid scrutiny) and allowing unsatisfactory standards to be perpetuated in future general medical practice.

Against this background it would be counter-productive to allow the pursuit of excellence in assessment to inhibit the introduction of the more adequate.

But nevertheless the longer term issues for further change confronting actors in the field of GP vocational training should not be ignored. They relate to whether or not a more satisfactorily structured approach, based in part on clearly identified performance criteria, can be introduced in a manner which allows improvements in both the process of GP vocational training (ie formative assessment) and the analysis of its end point outcome (ie summative assessment). The survey reported below was designed to generate findings relevant to the basic questions identified here. The results obtained provided the information upon which the options discussed in the final section are based.

Box 5

Examples of questions of the type set in the MRCGP Examination

Multiple Choice Questions (MCQs)

1 A patient with a DVT is taking a coumarin anticoagulant:
(a) Aspirin enhances the anticoagulant effect.
(b) Phenytoin enhances the anticoagulant effect.
(c) Oral contraceptives diminish the anticoagulant effect
(d) The anticoagulant drug will enhance the anticonvulsant effect of Phenytoin.
(e) Insulin does not alter the anticoagulant effect.

2 In child development:
(a) A child of six weeks should be able to smile at mother.
(b) A child of three months should be able to smile and laugh.
(c) A child of six months should be able to transfer a cube from one hand to the other.
(d) A child of twelve months can use two or three words with meaning.
(e) A child of eighteen months walks upstairs with one hand held.

3 In hearing testing:
(a) A Rinné negative result suggests a perceptive deafness on the affected side.
(b) A Rinné positive result indicates the absence of significant conductive deafness.
(c) A whisper should normally be heard at 20-30 feet.
(d) Holding the tuning fork prongs in line with the auditory meatus or at right angles to the line of the meatus can significantly affect the result of the test.
(e) Weber's test localizing to the left ear suggests perceptive deafness in the right ear.

4 In scabies:
(a) The head is often involved in the generalized stage of the eruption.
(b) Only those who are itching in the household should be treated.
(c) The characteristic lesion is the burrow.
(d) Itching tends to be worse at night.
(e) Irritation may persist for a week or two after treatment with benzyl benzoate.

5 In practice administration and finance:
(a) In a health centre the costs of practice stationery are paid by the DHA.
(b) Health centre rent is totally reimbursable.
(c) When a GP is paid for hospital sessions, his sessional payments are taxed under PAYE (Schedule E).
(d) A doctor may provide NH obstetric services for a patient registered with another doctor.
(e) In rented practice accommodation only 70% of the rent is reimbursable.

(each statement may be true or false).

Modified Essay Questions (MEQs)
(each part of the question should be answered independently)

● Camilla Parsons, aged 28 years, attends your surgery for the first time having just moved to your practice area. You learn that she is a consultant surgeon's daughter married to a stockbroker with a child of 18 months and that she wishes to discuss your practice with you before deciding whether to join your list.

In what different ways might a general practitioner respond? What are the advantages and disadvantages of each?

● Later she says she wishes to join your list, together with her husband and son. She produces from her handbag three containers of pills that she is currently taking. These are Dalmane (Roche) 30 mg ('one at night'), imipramine 25 mg ('one in the morning') and Microgynon 30 (Schering).

Speculate on the problems that you face.

● One week later her husband Henry Parsons, aged 32 years, comes to the surgery for the first time. He complains of reduced hearing in one ear due to wax which is cleared by syringing.

What opportunities does this visit present?

● After a further month Henry telephones the surgery. He says he has decided to have a full check-up at a private medical centre, and the doctor there has asked him to inform you of this.

What are the advantages and disadvantages to Henry of this check-up?

● The report on Henry is sent to you some time later. All the tests are normal apart from the electrocardiogram which is reported as showing Woolf Parkinson White abnormality. Henry comes to see you, as advised by the doctor at the private centre. He seems very anxious.

What problems do you face? How might you manage them?

● Some time later Henry and Camilla bring their son Tom, now two years old, to see you. They tell you that their previous doctor had been treating Tom's eczema with 1% hydrocortisone cream. They both seem very unhappy about Tom's condition although his eczema is restricted to the flexures and appears well controlled.

What reasons may there be for the parents' anxiety and how could you deal with it?

● Shortly afterward, when you are reviewing Tom's eczema, the parents ask you to tell the health visitor not to call again to see Tom. She had recommended measles vaccination to them, but Camilla's father has told them this is contraindicated.

How might you resolve this conflict?

● Six months later Camilla comes to see you on her own. She happily tells you that she is eight weeks pregnant. From previous consultations you are aware that after Tom's birth she had severe puerperal depression requiring inpatient admission and electroconvulsive therapy. You had tailed off her drugs soon after she had joined your list.

Describe the conflicting thoughts and feelings that a general practitioner might have, and how they might influence him in advising her.

Traditional Essay Questions (TEQs)

Question 1
A patient has been identified as having an alcohol problem. Discuss the general practitioner's role.

Question 2
Discuss the advantages and disadvantages of single-handed general practice.

Question 3
Write short notes to outline: (a) Your response to a married man, aged 30 years, who consults you to request a vasectomy. (b) Your management in general practice of irritable bowel syndrome.

Sources: Journal of the Royal College of General Practitioners Hall (Ed) "A GP Training Handbook" (1983).

Box 6

The Revised Manchester Ratings

These rating scales consist of sets of two sharply contrasting descriptions of observable behaviour, one of which is desired and the other to be avoided, covering all the different types of activity involved in general practice. The revised ratings, developed by the Centre for Primary Care Research of the University of Manchester with grant support from the DHSS, consist of 23 scales, all of which have sub-scales. They fall into five main groups identified by the authors (history and examination; diagnosis, problem definition; management; emergency care; and professionalism) who based their work on critical involvement reports collected by Dr J Freeman, the joint author of the original Manchester ratings.

It is intended that assessors first read each main scale, then read and mark the sub-scales, and finally mark the main scale. The example scale and sub-scales given below typify the approach embodied in the revised Manchester ratings.

VOCATIONAL TRAINING RATING SCALES

SCALE 20. **Professionalism 2: Involvement**

Main scale

The doctor sees patients as problems rather than as individuals and attempts to respond to them without being personally involved.

The doctor sees his/her patients as individuals, each in their own family and work situation, and tries to build up a relationship with them in which they are encouraged to be more self aware, questioning, and self reliant.

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1	2	3	4	5	6	7	8	9	10

Subscales The doctor	Seldom	Occasionally	Fairly frequently	Often	Usually
(a) Is non-authoritarian in manner.	☐	☐	☐	☐	☐
(b) Is clean, neat, and appropriately dressed.	☐	☐	☐	☐	☐
(c) Shows respect for patients' customs, values, ideas and attitudes.	☐	☐	☐	☐	☐
(d) Demonstrates to patients a curiosity about and a concern for, their family and work situations.	☐	☐	☐	☐	☐
(e) Makes plans which take patient's personal situation into consideration.	☐	☐	☐	☐	☐
(f) Shows tenacity in helping patients in difficult or frustrating situations.	☐	☐	☐	☐	☐
(g) Involves the patient in decision making.	☐	☐	☐	☐	☐
(h) Is prepared to teach and counsel about health when he/she has met immediate need.	☐	☐	☐	☐	☐
(i) The doctor becomes deeply concerned for, and involved with, his patients.	☐	☐	☐	☐	☐

Notes for rater

Scales a-d best assessed by direct observation.
Scales e-h assessed in case discussion.
Scale i a general assessment based on both of the above: direct observation and case discussion.

THE SURVEY RESULTS — A SUMMARY

Copies of the survey protocols used to examine the views and experiences of a sample of GP trainers and trainees working in the Lambeth, Southwark and Lewisham locality during the first quarter of 1988 may be obtained from the authors. Following pilots involving two doctors who had recently successfully completed vocational training, 14 trainees (10F/4M) were interviewed in the period January to mid-February and 15 trainers (14M/1F) were interviewed between mid-February and mid-March. Each interview took about 60 minutes. There were no refusals amongst those approached, whose names were selected at random from a list of trainees and trainers working in the FPC area.

Detailed analyses of the survey results, which by virtue of the sample sizes involved can only be considered to provide qualitative insights into the area, have been prepared. The authors intend that certain material, particularly that relating to mental handicap, shall be published elsewhere.

However for the purposes of this report the summary provided below presents the most important findings of this research. It should be noted that all individuals taking part in the survey were guaranteed complete confidentiality, and for that reason specific evidence relating to some of the possibly controversial points made below is not cited.

Personal Motivations. Amongst the trainees, the dominant reasons offered for entering medicine related to family role models and expectations (eg medically qualified parent or family friend), followed by altruistic and career/financial considerations.

Their choice of general practice was apparently mainly guided by a desire to be involved in patient centred medicine, although some female trainees mentioned possible future family considerations. Amongst the trainers the reasons most frequently given for being a trainer related to an interest in education and a desire for stimulation/updating. All were agreed that financial factors were unimportant, although some accepted that an 'extra pair of hands' was useful around the practice and several 'knew' that trainees have been/are exploited elsewhere. No trainers mentioned directly issues related to individual/group status, but at the same time training practices were generally recognised as having special — valued — characteristics.

Selection. Selection of trainees by trainers appeared mainly to be done on grounds of personal compatibility. It was widely recognised that less attractive or 'poor' trainees will be likely to end up with 'poorer' trainers. In general, however, most trainees seemed to have been able to find a place with relatively little difficulty, predominantly through informal contacts rather than advertising. There was evidence of considerable informal networking relating to the selection of trainers — for example, amongst younger trainers experience as a trainee and/or the expectations of partners in training practices appeared particularly important.

Other interviews conducted during this project indicate that there are now a sufficient number of trainers available in the Region, and that selection may thus in future become even more rigorous.

With regard to established trainers there is some reason to believe that reselection processes vary in their nature, and that the influence of JCPTGP 'visits' to the Region does not necessarily act in the direction of achieving greater equity in this context.

Competences to be gained from vocational training. There was a wide variation in both the quality and substance of responses given to questions in this area. Overall, the trainees gave more answers relating to clinical skill acquisition, whereas the trainers were more focussed on the transition from hospital to general medicine. Several of the latter mentioned 'triage', and different risk probabilities in community as opposed to specialist consultations. Others emphasised the need to build up confidence in judgement, self-knowledge, and self-teaching capabilities. Both trainers and trainees noted the need to acquire attributes relating to consultation techniques, communication abilities, counselling, 'handling' life crises experienced by patients, and working with other groups of health care professionals. Possible weaknesses in topics covered in (GP year) training appeared to relate to areas like interprofessional communication, practice management and comprehending community as opposed to individual health issues. Only a minority of trainers were able clearly to articulate a comprehensive view of what vocational training should/would offer trainees.

Teaching techniques of GP trainers. The range of teaching techniques reported was broad, and the satisfaction of both trainers and trainees as to the performance in this context was relatively strong. Only three trainees of the 14 interviewed felt that their trainers were not sufficiently available to them, and only four felt their overall workload/ learning experience ratio was unfavourably balanced. Techniques of teaching reported included regular formal discussion periods/tutorials, practice seminars, the use of video and audio taping of consultations, informal discussions, joint consultations/home visits, case note examinations, games, role playing and recommended reading. Five trainees mentioned inputs from other practice partners into their teaching.

Value of half day release courses. There was a fairly strong positive endorsement of the value of the HDRCs. They allow beneficial peer group interaction and mutual support through discussion of common problems on top of any more formal teaching role. GP trainees may gain from them experience in relating to professional colleagues and in forming supportive informal networks in ways which may have been denied earlier generations of doctors, and for those on formal courses the HDRCs serve as a way of directing their attention to GP issues during their hospital training. This is a benefit usually denied those on DIY courses, a factor which may be worth investigation by the JCPTGP.

Value of two year hospital training. There was a general consensus that this provides essential clinical experience, but it is nevertheless relatively unpopular amongst the trainees. Some trainers questioned the nature of the learning process in hospital posts, suggesting that trainees are not helped to accommodate constructively their experiences in them. Others doubted the appropriateness of the two year hospital to one year general practice experience split. The attitudes of consultants to general practice appear in the past often to have been negative, but are reportedly improving.

Assessment — trainer/trainee communication. Half the trainees were not aware whether, or how, they were being assessed by their trainers. The other half had filled in a check list of some type, and in one case the trainer had to the trainee's knowledge completed a similar assessment form. (Only one trainer appeared to be following accurately the suggested assessment procedure laid down in the SE Thames Region's guide for trainers). Trainers were on the whole vague and evasive in response to questions as to whether and to what extent they discussed assessment with their trainees.

Attitudes towards assessment. There was a considerable degree of ill-defined negative feeling towards assessment amongst both the trainers and the trainees. The latter did not clearly differentiate between summative and formative assessment procedures; on probing they rejected the former as yet another hurdle to jump in an overall process of medical education which clearly engenders substantial, if usually concealed, stress and hostility. However, they were more positive towards assessment techniques designed to help identify weaknesses and initiate appropriate further education/training. A number felt it would not be possible to assess all the desirable attributes of a 'good' general practitioner.

The trainers felt that relatively little information or support had been given to them about assessment methods, and several said that it was an area of weakness. Seven said they used checklists at given intervals; three explicitly rejected this approach. Underlying what in general seemed to be a rather confused, and defensive, picture, appeared to be the understandable view that GP vocational trainees have already undergone a long and arduous medical education and that, except in extreme circumstances, it would be an unacceptable waste to fail one at or towards the completion of the three year training period. Such action would focus attention on the trainer, as well as possibly harming the trainee's subsequent career.

Most trainers stressed that vocational trainees are adults, with postgraduate educational needs. Some said, or implied, that trainees should assess themselves, with help from the trainer. The negative side of this otherwise sensible approach appears to be that it allows some trainers to abdicate their responsibilities, and could encourage some trainees to adopt essentially isolated, insensitive attitudes similar to those allegedly found in earlier generations of GPs.

New methods of assessment? Four trainers were positive that no changes in existing GP vocational training assessment methods are needed; three responded in terms of further refining trainer selection, rather than trainee assessment. Only three trainers gave answers suggesting the direct involvement of individuals/bodies other than the trainer. Several expressed concerns regarding the production of 'clones' and/or encouraging too much concentration on the achievement of relatively simple 'measurable' attributes as

opposed to more important 'intangible' ones. However, an important minority did believe that the satisfactory measurement of GP/trainee competences is certainly possible, and there was a relatively flexible attitude base amongst both trainees and trainers in relation to the institution of more effective/objective assessment techniques aimed explicitly at contributing to trainee development, rather than making 'pass/fail' judgements.

Significance of the MRCGP examination. Ten trainees had decided to take the MRCGP at a later stage. Three said they would not, and one was uncertain. The trainers were largely in favour of their trainees taking it, essentially because of its influence on their career prospects. Although most did not see it as testing whether or not a candidate is a good GP, it was accepted (perhaps a little reluctantly) as probably indicating the potential of the candidate to become one. Even so two mentioned 'good' candidates who had failed, and others said it was mainly a test of examination skills.

Underlying many of these responses was the apparent belief that the MRCGP might in future become more significant as a regulator of entry into general practice, that was seen as potentially becoming 'too crowded'. That is, the MRCGP would become 'norm' rather than 'criterion' based, with its underlying role being to restrict professional supply as much as to maintain quality. From this viewpoint, trainees might be best advised to take it while it is still voluntary.

Knowledge of mental handicap. In general, trainees' theoretical knowledge of mental handicap was equal, or superior, to that of trainers. Certainly their attitudes towards people with intellectual disabilities appeared more positive than those of older trainers, one or two of whom made allusions to the needs of animals of various types whilst talking about those of mentally handicapped people. It would be beyond the scope of this preliminary report to enter into too much detail on this topic, but the following key points are of interest:

a) Some trainers and trainees displayed a significant understanding of severe mental handicap, but most were unable to define, and seemed unaware of, the problems of mild intellectual disability. Given the high prevalence of the latter reported in the available literature, this area would seem to be worthy of further investigation. It is possible that moderate/mild intellectual impairment is perceived only as an aspect of class or other social disadvantage, not as a discrete phenomenon. There was some confusion between mental handicap and mental illness amongst trainers, but not the trainees.

b) Most of the doctors interviewed were unaware of the WHO's impairment/disability/ handicap model relating to all forms of disability. Trainees were slightly more aware of its implications than trainers.

c) Mental handicap is generally seen as being a topic of little or no interest to the medical profession. It is seen as a problem of care (of interest to nurses or social workers) rather than of cure. Such attitudes probably mean that the medical needs of intellectually disabled people are frequently neglected (see Howells 1986). At the same time most GPs self image/confidence in relation to mental handicap appears poor, which reinforces the 'no interest' attitude.

d) The minority of doctors with a significant knowledge of mental handicap and the medical needs of intellectually disabled people had in the main obtained their information/attitudes from contact with affected members of their own families. In the sample interviewed there were both trainees and trainers with close family members affected by mental handicap.

e) In response to probing, several doctors recognised the potential value of regularly screening intellectually disabled patients for certain 'problems of neglect', through the establishment of a diagnostic register or tagged card record system. Some suggested that nurses are better at 'working through lists' than doctors. Some doctors who resisted this approach and warned against the dangers of labelling patients as mentally handicapped appeared to have particularly negative images of intellectual disability.

f) Both trainers and trainees showed a tendency to consider the needs of carers and other family members before those of individuals with intellectual disabilities. It is possible that this is because they are more able to identify with the former than the latter. And on occasions the imperatives of family practice may conflict with those of individual care.

g) When the trainers were asked about family care needs, five mentioned the problems that the siblings of mentally handicapped children may face. No trainees raised this issue.

h) Trainers and trainees seemed generally unaware of the intended role of Community Mental Handicap Teams.

i) Despite the negative aspects of the above, there was near universal agreement that general practitioners should be responsible for the primary medical care of mentally handicapped people living in the community. Building on this, future attempts to encourage greater interest in this topic amongst vocational trainers might concentrate on raising awareness of the intellectual and allied medical challenges that the needs of intellectually disabled people may present to able doctors.

DISCUSSION — OPPORTUNITIES FOR FURTHER PROGRESS

Perhaps the most important observation made during the series of 30 or so interviews reported above is one not actually mentioned so far. It relates to the intelligence, commitment and ability of all the individual doctors who were asked to take part. If, as is sometimes suggested, inner city primary care standards are not as high as in other parts of the country, then the quality of both trainers and trainees encountered in this survey augers extremely well for the nation as a whole.

The gains associated with the recent establishment of vocational training for general practice extend far beyond those direct learning advantages and personal development opportunities already enjoyed by over 10,000 young doctors in the period since 1981. The existence today of some 2,000 training practices with demonstrably desirable characteristics as compared with past norms (see, for example, Baker 1985) represents an asset to the community, while the increased interaction between family doctors involved in vocational training can only benefit general practice.

However, this awareness should not draw attention away from the fact that, to date, the utility of the methods of assessment used to measure the knowledge, skills, understanding and abilities in practical application of vocational trainees in general practice has generally been poor. Nor should the current efforts of bodies such as the JCPTGP to correct this situation be taken in some way to imply that individuals and agencies external to the medical profession do not have legitimate duties and interests in attempting to ensure that the highest attainable standards of general medical practitioner vocational training and assessment are achieved as rapidly, and cost-effectively, as possible. Relevant bodies may include the DHSS, local Family Practitioner Committees and the NCVQ, together with representatives of groups of patients.

This report has indicated the significant difficulties that general medical practitioners have encountered in establishing themselves as an appropriately respected and remunerated specialised group within the medical profession. And it also acknowledges the personal challenges facing general practitioners who, after a taxing — and still in many respects hierarchically organised — period of intensely competitive education, must as individuals be able to find sufficient self-confidence, compassion and self-understanding to cope successfully with a working environment characterised by patient need and distress, sustained uncertainty and constant technical and social change.

Against this background it is not surprising that professional autonomy and protection from potentially inadequately informed, or even hostile, interventions by other interests should feature high on the political agenda of general practitioners' representatives. To a substantial degree resistance to improved assessment procedures in GP vocational training, based on careful definition of the competences of a 'good' doctor, appears to stem from a combination of trainee and trainer insecurity combined with a desire to avoid allowing non-medical agencies an opportunity to monitor more satisfactorily the quality of primary medical care.

But understandable though this situation may be, it cannot be condoned as desirable. To the extent that it has led individuals to argue and believe that a family doctor's task is so all encompassing that the competences it requires cannot in the main be satisfactorily defined in terms of measurable sets of practice skills and items of knowledge, this has in the past impaired the provision of primary health care and exposed some general practitioners to needless isolation and stress.

It may be suggested that the way forward in general practice training and assessment should now include (a) a greater degree of interaction with, and support from, other groups with relevant competences and (b) a more defined and logically consistent approach to the balance of formative and summative assessments during and after a practitioner's vocational training and certification.

In the former context experiments in 'learning together' involving GP trainees and other groups of health care professionals have already been reported. (See, for instance, Jones 1986.) These might usefully be extended, since effective and successful nurses, social workers, psychologists, health visitors and doctors should not only be able to appreciate each others roles. They also need to recognise that they share a common core of communication and allied competences which they can usefully acquire together and be assessed on together.

Arguably, a problem still fully to be faced by the medical profession is the danger that efforts to acquire the necessary self-confidence and self-respect to practice medicine may lead some doctors to develop attitudes which devalue other professionals, and perhaps also their more disadvantaged patients. Cross professional learning and assessment procedures might, if appropriately structured, help to check any such counterproductive tendencies.

With regard to assessment per se, it may be thought that in recent years there has been a significant degree of conflict between the view sometimes expressed by senior medical commentators that the MRCGP examination guages basic standards of competence, the fact that some 25 per cent of MRCGP examinees fail, and the JCPTGP recommended policy that it should remain a voluntary qualification.

Although possible future developments (discussed below) may help to clarify this situation, the current discrepancy between the 75 per cent pass rate for the (said to be criterion referenced) MRCGP examination and the 99 per cent plus certification rate for GP vocational trainees is likely to lead some observers to question whether the profession's 'house' is in 'satisfactory order'. Such doubts may not entirely be removed by the JCPTGP's recent recommendation that the revised Manchester ratings should be used as the main trainee assessment tool of vocational trainers.

The new ratings are a substantial improvement on those previously available. But even if trainers apply them to the extent prescribed by the JCPTGP they may not provide an adequate, consistently reliable, end point measure of trainees' qualifying abilities. This is not least because of possible assessor variation. The authors of the Manchester ratings point out that they are likely to be most valuable as a formative assessment tool. They do not provide technically precise measures of competence, and their use itself requires appropriate skills and subjective judgements.

Further, it should not be assumed that they are even now entirely comprehensive. For example, in view of the limited knowledge and understanding of issues relating to mental (and other) forms of impairment, disability and handicap shown by respondents to the survey outlined in this report, it is perhaps regrettable that there is no scale and sub-scale directly relevant to this topic in the new ratings.

Options to be Examined

Assessment standards. The findings presented in this report suggest strongly that Regions should more closely monitor and inspect the application of approved assessment methods during the GP training year. It is possible that the NCVQ could assist the JCPTGP and/or individual Regions in identifying the most effective approach to achieving higher standards of assessment. The involvement of an external body could in itself serve to enhance confidence in the process(es) decided upon, which would be in the interest of both the medical profession and the public alike. In the fairly near future, for instance, it may well be desirable for the JCPTGP to introduce a regular, random sample based survey of trainees applying for certification, aimed at evaluating the extent and appropriateness in use of the revised Manchester ratings by trainers in each Region.

The balance of summative and formative assessments. During the process of training, formative assessments, conducted at appropriate intervals, are obviously of practical value to GP trainees seeking to attain acceptable levels of competence. Confusion between this type of evaluation, and that which might expose trainees to a sense of insecurity or possible fear of unfair rejection, is clearly undesirable.

However, it must also be recognised that the public's — and the overall medical profession's — interest is to ensure that all future general practitioners attain (and retain) acceptable standards of competence. This implies some form of summative assessment, as part of an overall system which is coherently organised to set acceptable standards of necessary competence and conduct valid, reliable and practically feasible assessments of those seeking full qualification to practice. The alternatives available include:

a) The universal use by trainers of the revised Manchester ratings, monitored for validity and reproduceability in use along the lines suggested above, to permit the granting of statements of satisfactory completion — and hence certification — only when a defined level of performance has been achieved. To overcome any reluctance on the part of trainers to 'fail' their trainees/apprentices, it might be appropriate to introduce provisions whereby trainees who at the end of their GP year appear not to have reached desired basic standards should have the option of (say) a six month extension

of training. During this local course organisers (and perhaps others) might have a special responsibility to work with trainer and trainee to achieve the necessary level of competence.

b) The introduction, perhaps in addition to the above, of some form of continuous trainee assessment based on, for example, project work and/or objective structured clinical examinations. These could be organised and evaluated by Regional advisors or HDRC course organisers, thus extending their role in the assessment context.

c) The modification of the MRCGP examination process, so that all GP vocational trainees might be expected to take it at a defined point after their three year training. This option is (at the time of writing — Summer 1988) under consideration.
Its advantage would be that the MRCGP examination would come to serve as a specific tool for the summative assessment of GP vocational trainees, in addition to any formative procedures employed. However, were failure to pass the MRCGP examination in future to become a firm barrier against entry into general practice, many voices would be raised in protest. It could be claimed that this would skew general practice vocational training away from the acquisition of relevant human and caring skills towards an academic, and exam passing, mode. And were a 'two tier' qualification to emerge, with only a proportion of those passing the examination being allowed to enter College membership but virtually all being judged adequate to practice, such an arrangement would be very likely to attract strong external questioning. It could, for instance, stand in direct conflict with the NCVQ approach to assessment for qualification.

What sort of doctor? Assessment of an individual's competences at the start of his or her career is no necessary guarantee of long-term performance standards in a changing world. Further, the existing cadre of doctors involved in training as established professionals represents less than 10 per cent of the overall GP workforce. Both these observations emphasise the importance of recent RCGP initiatives which might eventually establish an ongoing system of peer review, aimed at ensuring the continued competence of all general medical practitioners.

However, in the light of the 1987 White Paper 'Promoting Better Health' (Cmnd 249) it may be that in the medium to longer term a system of primary medical care standard maintenance based not only on professional mutual assessment but also on the active involvement of bodies such as FPCs will be judged appropriate. There can be no doubt that some authorities believe that established general practitioners' contracts should be redefined so that they exist between each practitioner or practitioner group and the local FPC (or even the local DHA) and are periodically renewable. The latter might be subject to some form of mutually agreed assessment of each principal. (See, for instance, The Economist, 1988.)

To many members of the medical profession such proposals may seem offensive and unnecessary, given the record of positive progress established in the field of GP vocational training in recent years. However, the most effective way to prevent the introduction of premature or counter-productive changes is probably to be found in enhanced communication about, and overall understanding of, general practice and the value for money which GP vocational training is already achieving for the community. It may thus now be timely for the medical profession to encourage a wider debate about assessment and long term evaluation in this field, involving appropriate external agencies as well as internal professional expertise.

APPENDIX 1

Key events in the evolution of General Practice and the vocational training arrangements — an outline chronology

Year	
1815	The Apothecaries Act of 1815 permitted apothecaries to charge for medical advice as well as the medicines they dispensed, and acknowledged the separate group of chemists and druggists. The latter evolved into the pharmacists, the former into general medical practitioners. The term general practice began to be widely used at around this time.
1832	The Provincial Medical and Surgical Association was founded in Worcester. This may be regarded as the progenitor of the British Medical Association, which came into being in the 1850s.
1844	An attempt to form a Royal College of General Practitioners in London failed. (The Pharmaceutical Society of Great Britain was incorporated by Royal Charter in the previous year).
1858	The Medical Requisition Act became law. The General Medical Council was formed, and medicine became established as a self regulating profession.
1882	A working party of the BMAs Metropolitan Counties Branch noted that 'no inconsiderable number of recently qualified medical men have any idea of the real duties of general practitioners until they are actually engaged in practice'.
1911	National Insurance Act passed. Basic structure of current GP services laid down, although insurance cover was at first restricted to only the working population.
1920	The 'Dawson' report advocated primary care health centres.
1929	Poor Law system ended.
1946	Legislation to establish the NHS was passed. 'Spens' Committee on GP remuneration pointed to inadequate pay of some National Insurance doctors, and examined remuneration of GP trainers.
1948	NHS established, National Insurance Act local insurance committees became Executive Councils. First trainees in NHS general medical practice.
1950	The 'Cohen' Committee report, published by the BMA, called for three years vocational training for general practice.
1952	Pioneering joint hospital and general practice GP training scheme established in Inverness. The College of General Practitioners was formed despite some opposition from other sections of the medical profession.
1961	'Christ Church' conference led to calls for more 'in service' education for GPs. First integrated vocational training scheme was started in Wessex.
1965	The 'Doctors Charter' improved GPs' pay and working conditions. The College of General Practitioners called for improved vocational training.
1966	Course for GP trainers organised in Manchester.
1968	The Royal Commission on Medical Education (the 'Todd Report') advocated five years postgraduate training for all GPs. The Health Services and Public Health Act provided 'section 63' in-service education courses for family doctors.
1972	DHSS recommended that Regional Advisers in General Practice be appointed.
1974	The NHS was reorganised, and Family Practitioner Committees assumed the functions of the Executive Councils. The Conference of Local Medical Committees accepted the principle of mandatory training for general practice.
1975	The Joint Committee on Post Graduate Training in General Practice was formed.

1976 An Act making three year vocational training for general practice by the start of the 1980s was passed by Parliament, and subsequently consolidated into other legislation.

1982 As from 1982 all new GP principals have had to have had three years vocational training, one of which involves working as a trainee in a pactice. The NHS underwent further restructuring in this year, with the elimination of the Area tier of management in England.

1985 The FPCs gain increased independence.

1986 Green paper on primary health care published. The concept of 'good practice' payments within a more competitive overall framework for general practice was put forward.

1987 The White paper 'Promoting Better Health' was published. Its proposals suggested an increasingly managerial role for FPCs, about which debate has subsequently continued.

REFERENCES

Bahrami J (1986) *British Medical Journal* 292, 29-30.

Baker R (1985) *Journal of the Royal College of General Practitioners* 35, 330-32.

Balint M (1964) The Doctor, His Patient and the Illness. Pitman Medical, London.

Brooks D (1986) *Journal of the Association of Course Organisers* 2(1), 13-17.

Cartwright A and Anderson R (1981) General Practice Revisited. Tavistock Publications, London.

Centre for Primary Care Research (1988) Rating Scales in General Practice. University of Manchester.

Charlewood J E and Airlie I (1986) *Journal of the Royal College of General Practitioners* 36, 69-71.

Cyna A M and Przyslo F R (1987) *British Medical Journal* 294, 416-18.

Dunn W R, Hamilton D D and Harden R M (1985) *Medical Teacher,* 7(1), 15-25.

The Economist (1988) 307, 7548 p15-16

Ellis P (1987) The Design and Development of assessments of Vocational Competence (unpublished).

Fleming D M (1986) *Journal of the Royal College of General Practitioners* 36, 212-16.

Freeman J and Byrne P S (1973) The Assessment of Postgraduate Training in General Practice. Society for Research into Higher Education, London.

Freeman J, Roberts J, Metcalfe D and Hillier V (1982) The influence of Trainers on Trainees in General Practice. Occasional Paper 21. RCGP, London.

Gambrill E (1986) *Journal of the Association of Course Organisers* 2(1), 7-12.

Grace J F (1986) *Journal of the Association of Course Organisers* 2(1), 65-69.

Gray D J Pereira (1982) Training for General Practice. Macdonald and Evans, Plymouth.

Hall M S (1983) (Ed) A GP Training Handbook. Blackwell Scientific Publications, Oxford.

Hasler J (1983) 57 Varieties. Second George Swift Lecture. *Journal of the Royal College of General Practitioners* 33, 329-33.

HMSO (1987) Promoting Better Health. Cmd 249.

Horder J P and Swift G (1979) *Journal of the Royal College of General Practitioners* 29, 24-32.

Howells G (1986) *Journal of the Royal College of General Practitioners* 36, 449-53.

Jefferys M and Sachs H (1983) Rethinking General Practice. Tavistock Publications, London.

JCPTGP (1985) Recommendations to Regions for the Establishment of Criteria for the Approval and Reapproval of Trainers in General Practice. JCPTGP, London.

JCPTGP (1986) The Report on the Work of the Joint Committee on Postgraduate Training for General Practice — 1986. JCPTGP, London.

JCPTGP (1987a) Assessment and Vocational Training for General Practice: Final Report of a JCPTGP Working Party (unpublished).

JCPTGP (1987b) A Guide to Certification. JCPTGP, London.

JCPTGP (1987c) The Report on the Work of the Joint Committee on Postgraduate Training for General Practice — 1987. JCPTGP, London.

Jones R V H (1986) Working Together — Learning Together. Occasional Paper 33. RCGP, London.

Leete R (1986) *Journal of the Association of Course Organisers* 2(1) 13-17.

McKendrick J (1983) *Trainee,* September 1983.

Melhuish A and Anderson P (1987) *Horizons,* July 1987.

Meyer T C, Silvertson S E, Stone H L and Hansen R C (1987). Proposal for the Development of a Peer Personalized Medical Practioner. Resident and Medical Student Assessment Center (unpublished draft).

NCVQ (1986) The National Council for Vocational Qualifications, Its Purposes and Aims. NCVQ, London.

RCGP (1972) The Future General Practioner — learning and Teaching. British Medical Association, London.

RCGP (1978) Some Aims for Training for General Practice. Occasional Paper 6, RCGP, London.

RCGP (1985a) What Sort of Doctor? Assessing Quality of Care in General Practice. Report form General Practice 23, RCGP, London.

RCGP (1985b) Priority Objectives for General Practice Vocational Training. Occasional Paper 30. RCGP, Edinburgh.

RCGP (1985c) Quality in General Practice. Policy Statement 2, RCGP, London.

Reith W and Taylor M W (1986) *Journal of the Association of Course Organisers* 2(1), 34-40.

Stanley I M, Belton A, Freeman P et al (1985) *Journal of the Royal College of General Practitioners* 35, 9-14.

Taylor J A and Taylor D G (1986) Mental Handicap — Partnership in the Community? OHE/Mencap, London.

Williams A H E (1984) *Journal of the Royal College of General Practitioners* 34, 41-44.

GLOSSARY

Associate Advisers — See page 5.

CMHTs — Community Mental Handicap Teams have now been set up in many localities to improve inter-agency service co-operation and the quality of care and support available to individuals with intellectual disabilities. They vary in structure and working arrangements, but typically comprise social workers, clinical pyschologists, community mental handicap nurses and speech and physiotherapists. Consultants in mental handicap and, in some instances, general practitioners with a particular interest in intellectual disability also contribute to the work of these teams.

Competence(s) are defined by the NCVQ (see below) as the sets of skill, knowledge, understanding and ability in application needed to perform a task, job or profession.

Course Organisers — See page 5.

DHAs — District Health Authorities are the local level managerial authorities responsible in England and Wales for the running of NHS hospitals and non FPS (see below) NHS community services like district nursing and health visiting.

FPCs — Family Practitioner Committees adminster the contracts made between the Secretary of State for Health and the independent contractors to the NHS, such as the GPs and pharmacists. Their planning and managerial role has been to a degree expanded in recent years.

FPS — the **Family Practitioner Services** include those offered by family doctors, community dentists and pharmacists and the remaining NHS services available from community opticians.

GMC — the **General Medical Council** is the main disciplinary body of the medical profession. It controls education and thus guards entry into the profession — no doctor may practice unless registered with the GMC. See page 26 and appendix 1.

GMSC — the **General Medical Services Committee.** See page 5

HDRC — Half Day Release Courses. See pages 5 and 20.

JCPTGP — The Joint Committee on Post Graduate Training for General Practice. See page 2.

LMCs — Local Medical Committees have, like other local professional bodies, an advisory function within the NHS. They also have a 'medico-political' role in representing the interests of general practitioners, and discussions of the Annual Conference of LMCs are binding on the GMSC.

MCQs — Multiple Choice Questions.

MRGCP — Member of the Royal College of General Practitioners.

Manchester Ratings — See page 15 and Box 6.

MEQs — Modified Essay Questions have been developed as a key part of the examination for Membership of the RCGP. See page 12.

Mental Handicap is often used as a general term to refer to the condition of people with limited intellectual abilities. However, a more precise terminology differentiates between brain/intellectual impairment (the fundamental lesion of the nervous system) intellectual disability (the functional deficit observed in areas like speech, walking, reading or writing) and social handicap (lack of normal social relations or roles, such as being unable to find work or a marriage partner). To some extent the latter is imposed on disabled people by their environment.

NCVQ — the **National Council for Vocational Qualifications** was established by the Government in 1986. Its remit includes:
- — securing standards of occupational competence and ensuring that vocational qualifications are based upon them
- — designing and implementing a new national framework for vocational qualifications
- — setting up effective liaison with bodies awarding vocational qualifications
- — undertaking research and development to discharge its functions.

NVQ — a **National Vocational Qualification** endorsed by the NCVQ and incorporated within its national framework, which to date covers levels up to and including Higher National awards. The question of its extension to include professional qualifications is under consideration.

OSCEs — **Objective Structured Clinical Examinations.** See page 15.

Principals in General Practice are doctors contracted with the Secretary of State to be responsible for providing a full range of primary medical care services for the patients on their lists.

Regional Advisers — See page 5.

RCGP — the **Royal College of General Practitioners.** See page 2 and appendix 1.

TEQs — **Traditional Essay Questions** may allow examinees to demonstrate complex cognitive skills such as evaluation more comprehensively than MCQs and, arguably, MEQs.

Triage is the action of sorting according to quality. In medicine it has a special meaning related to using the time and resources available as cost-effectively as possible, so treating those in most need of care and most likely to benefit from it as priority cases.