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National minimum standards

ON 25 February 1988, the Joint Committee on Postgraduate Training for General Practice withdrew its recognition of the standards applied by the regional general practice subcommittee to the training practices in the North East Thames region from 1 February 1989. In April the College followed suit and so two new and unprecedented events occurred in the world of medical education.

These decisions, affecting as they do a regional committee, about 175 trainers, about the same number of trainees, an unknown number of prospective applicants, a group of course organizers, associate advisers and the regional adviser, appear to have come as a shock to those concerned. They are bitterly resented in some quarters and a large group of general practitioners in that region are now both hurt and angry.

Many allegations are being made, in letters and in the medical press. It is suggested that the Joint Committee's decision was unexpected, and that no warnings were given, that it was taken on the basis of a visit to one or two practices, that only some of the weakest training practices had been presented to Joint Committee visitors, and that it is inappropriate to apply standards of the leafy suburbs to the tough areas of the inner cities. As for the College's decision, it is being asked if the issue of standards is constitutional or is perhaps too political for the College.

It is said that the impact on trainees is serious, that applications are collapsing and that good trainees are already choosing to train in other regions where they will be allowed to take the MRCGP examination. Many of those involved find it hard to understand how it can possibly be right for recognition to be withdrawn from a whole region, when there are obviously many good training practices there. Are the innocent being punished for the sins of the few? Finally, it is claimed that there are personality difficulties and the whole business is a problem of communication.

Before coming to any conclusions about this saga it is essential to establish not only the facts, but also the sequence and timing of events.

The facts

The Joint Committee was established in 1975 and has two parent bodies: the College and the General Medical Services Committee both of whom elect seven members each year. The Joint Committee has been recognized by the Secretary of State as the proper body to issue the certificates under the regulations of the Vocational Training Act. The Joint Committee does not appoint trainers: that is the prerogative of regional general practice subcommittees or regional general practice education committees as they are sometimes called. They alone have the statutory power to appoint and reappoint trainers and they alone are responsible for the standards in the training practices in their region. It follows that if there are any problems in the standards in any of the training practices in the North East Thames region, the responsibility lies with the regional general practice subcommittee there.

The Joint Committee visits all regions regularly to see if national standards are being applied and it reports in writing to the region concerned. When new national standards are agreed they are issued in writing to all regions, with plenty of time given for them to be introduced.

In October 1981, the Joint Committee set a national minimum standard that the medical records should be arranged in chronological order in all the records, so that

a trainee could see the patient's history and learn about continuity of care. This was communicated in writing to all regions and the date for implementation, throughout the UK, was January 1984.

As a consequence of setting this national standard, throughout the early 1980s hundreds of trainers in all parts of the country made the necessary changes in their practices. Organizing medical records in this way is not a quick or easy task and thousands of hours of doctor and staff time went into it. The work went on in Birmingham, Bristol, Glasgow, Liverpool, Manchester and Sunderland as well as in the rest of London, the suburbs, and the rural areas. In many regions trainers were either not approved or not re-approved as this new standard was applied.

In April 1983, a Joint Committee team visited three vocational training schemes in the North East Thames region. It commented on the state of the records, 33% of which it classified as 'poor' and recommended that the training practices should pay 'urgent attention' to them. The region was reminded in writing that chronological order in medical records was a requirement for training practices for implementation by the following January.

In March 1985, a different team from the Joint Committee visiting different practices in two different schemes found that this region was the only one in Britain which was not seeking to meet the national standard on medical records. It had adopted a lower standard. The team reported that national minimum standards were not present in some training practices. In the report to the Joint Committee the team was unable to recommend that the North East Thames region should be re-approved and referred the problem to the full Joint Committee. This report with its unprecedented finding went to the region in writing.

In July 1985, the Joint Committee published a booklet, *Recommendations to regions for the establishment of criteria for the approval and re-approval of trainers in general practice.*[1] This brought up to date the national criteria and described them in detail. This was sent to every region, is a public document, and can be examined by anyone interested.

The Joint Committee might have withdrawn its recognition of the North East Thames region in 1985. Instead, after careful thought it decided to see the representatives from the regional committee which was responsible for selecting trainers. On 12 December 1985, the Joint Committee officers met three representatives of the region.

The region gave assurances that 'all notes and correspondence would be filed in chronological order in all records in training practices in the region'. The Joint Committee accepted these assurances and the region's recognition was continued. The Joint Committee wrote to the region expressing its concern.

In June 1987, a different Joint Committee team visiting different practices in a different scheme in the North East Thames region reported yet again that national minimum standards were not being provided in some of the training practices in this region.

The Joint Committee concluded that it had no choice but to withdraw its recognition. The Joint Committee had either to recognize or not recognize the region as a whole. Given the history, extending over six and a half years and involving three different formal visits to six different schemes, no other decision could have been expected.

There is evidence of careful attention to proper procedures and of great patience being shown. The fact that nine different visitors from the Joint Committee were involved and that the decisions were taken by the Joint Committee under three different chairmen shows that this was an issue of principles not of personalities. A commentary on these events[2] has been sent by the Joint Committee to the College and is available to any member of the College who wishes to send for it.

The responsibility for every training practice in the North East Thames region continues to lie with the regional general practice subcommittee there. The Joint Committee has said that it is ready to receive evidence in writing that the national minimum standards are met and it will then re-consider the question of a further visit or visits.

It is not clear how long it will take for the region to supply the necessary evidence, but the responsibility lies with the regional committee.

The College

On 10 March 1988, the Chairman of the Joint Committee, Dr Dorothy Ward, formally informed the College of the decision and reminded the College of the previous agreement whereby the Joint Committee approved on behalf of the College the eligibility for trainees to take the MRCGP examination.

The College Council met the next day and strongly supported the decision taken by the Joint Committee. The College had always accepted Joint Committee approvals without question, now it had to accept a Joint Committee rejection. The College could not ignore a formal letter from the Joint Committee or condone unsatisfactory standards and in addition it had a duty to make the position about eligibility for entry to the MRCGP examination clear to its own prospective members.

The College wished to protect present trainees as far as was reasonable. In its statement, the College did protect the eligibility for entry to the examination for all the trainees already in post, even up to three years ahead. It gave no protection for prospective trainees who were thinking of going to that region.

The Joint Committee has to relate to a region as a whole under the complex legal regulations which govern vocational training; the College can be more flexible. The Joint Committee does not visit and approve individual practices: the College can.

In its statement of 12 April 1988,[3] the College was ready to receive written evidence that satisfactory standards were present. In seeking to find a way of allowing the many trainers in this region who do have satisfactory standards to receive recognition, the College is now offering to arrange individual practice visits if invited to do so.

Decisions about College recognition and eligibility to sit the College examination have now reverted from the Joint Committee back to the College itself. Once the College has received a report that the necessary standards are present in a practice, it will issue a certificate confirming College recognition and then trainees from that practice will be allowed to sit for the MRCGP examination. This will allow trainers who have implemented national standards to avoid being grouped with the minority whose standards have been found wanting.

These arrangements were described at the College's General Meeting at Cheltenham on 24 April 1988 and applications for a College visit can now be made direct to the College from individual practices whether or not the trainer is a member.

Lessons to be learnt

This six and a half year story has many lessons. It turns out to be an issue of standards, not a failure of communication. The written record is clear. The region knew exactly what it had to do, but did not do it. Repeated warnings were given and considerable time was allowed for putting matters right.

In the short term, pain and anger seem inevitable, but there is now no need for good training practices to continue to suffer. In the long term, much good may come from these unhappy events. The College is providing a new College assessment based on a practice visit and peer review which may be an example to this and to other regions. The main lesson to be learnt must be how to prevent a regional committee ever again ignoring national requirements for so long.

The College principle of the maintenance of standards in

general practice by peer review, which was published in 1987 in *The front line of the health service,*[4] has been dramatically highlighted.

History may yet show that the spring of 1988 marked a turning point in the process of the self-regulation of the largest branch of the medical profession. The issue of the implementation of minimum standards could not be avoided for ever. General practice has not waited for others to intervene but, in the educational world, has started through peer review to set its own house in order. This is medical audit in action.

Royal colleges

All Royal colleges exist to promote and at times to defend standards. The Royal College of Music defines minimum standards and assesses applicants individually. Medical royal colleges sometimes do the same. The Royal College of General Practitioners is bound to act in accordance with its royal charter and must 'encourage, foster and maintain the highest possible standards in general medical practice.'

All doctors understand the responsibility of taking decisions on national minimum standards. It is distressing to have to tell a patient who wants a licence to drive a heavy goods vehicle that they fail the national minimum standard for sight. Such patients often point out that the great majority of their bodies, perhaps all the rest of their bodies, may be fit and strong. They often say that the social consequences of the decision to them or their families may be severe. Nevertheless, failure in any one national minimum standard means that approval simply cannot be given.

This is a three word issue: 'national', 'minimum', and 'standards'. It is national because the national bodies have agreed that certain standards are expected in every training practice in the UK. It is about the minimum, because it refers to the lowest acceptable standards. Finally and most important it is about standards, because standards of care protect patients and training raises standards of care. All junior doctors in every region who choose a career in general practice are entitled to learn their craft from a trainer in a practice which has achieved the national minimum standards.

References

1. Joint Committee on Postgraduate Training for General Practice. *Recommendations to regions for the establishment of criteria for the approval and re-approval of trainers in general practice.* London: JCPTGP, 1985 (Available from the JCPTGP, 14 Princes Gate, Hyde Park, London SW7 1PU. Price £1.00).
2. Joint Committee on Postgraduate Training for General Practice. *Review of vocational training in the North East Thames region 1983-1987.* London: JCPTGP, 1988 (Unpublished, but available to any Fellow, Member or Associate of the College).
3. Royal College of General Practitioners. Statement *Entry requirements for the MRCGP examination.* London: RCGP, 1988 (Available to all Fellows, Members, and Associates with a letter of 12 April 1988 from the Chairman of Council to all members and observers of the Council and faculty officers).
4. Royal College of General Practitioners. *The front line of the health service. Report from general practice 25.* London: RCGP, 1987.

Community nursing on the planning board again?

THE review of community nursing in Wales, chaired by Noreen Edwards,[1] was published in an atmosphere of controversy generated by the Cumberledge review of community nursing in England[2] and coincided with the publication of the government's white paper on primary health care[3] towards the end of 1987. It is likely, therefore, that readers of the *Journal* will have heard little about the Welsh review, yet, like the Cumberledge report, this report is not about community nursing alone. It contains an agenda which reaches to the hub of general practice and, if adopted, will pave the way for fundamental changes in our primary health care services. Many of the premisses upon which this report is based appear to stem from the evolution of health care in the underdeveloped countries, with primary health care being viewed as the key to attaining health for all by the year 2000.

The Edwards report starts with the claim that British primary health care services appear to lack an overall sense of direction and it deplores this 'at a time when primary health care could take on a new and more active role in the promotion of good health, and thus do much to combat inequalities in health between different groups within society'. The scene is thus set for a major shift in nursing towards health promotion and a much greater coordinating role in patient care.

If the proposals of the review are adopted, a new breed of generalist nurses in primary health care will also prescribe from a limited formulary items such as dressings and appliances and perhaps certain drugs; be directly accessible to their patients; hold regular consulting sessions at the primary health care team premises; have hand-held computers to help in the collection of data and radio-pagers for two-way communication; be part of an expanded out-of-hours nursing service; have more nursing assistants working under them; have time for unsolicited visits to dependent patients and their carers; and set aside time for pro-active work with homeless and itinerant families.

Community nurses are thus bidding for much clearer front-line roles in primary health care by modifying the traditional pattern of receiving patients referred after assessment by the doctor. The new community generalist nurses will also try to achieve coverage in two areas where health visitors and general practitioners have failed: routine visiting to patients who are disabled or dependent and the care of itinerant families. The legal, ethical and scientific grounds for these major changes in a community nurse's role are not addressed in the Edwards report and this will be a source of concern to others who work in primary health care. However, the proposals reflect changes which are already occurring in our society and in other parts of the world and they question the doctor's traditional monopoly of the diagnostic process at all levels of sophistication.

A major objective of the Edwards report which most general practitioners will welcome is that all members of the primary health care team should work from the same premises and that nursing staff should be permanent members of the team. Less well defined and more controversial are recommendations for primary care teams to have annual agreed objectives and for all team members to be consulted about selection of new members. These recommendations appear to intrude on the independent contractor status of doctors but could help to build up teamwork if sensitively handled by all concerned. Unfortunately both of these recommendations represent time-consuming activities and the system could break down if more aggressive team members use them as weapons rather than as facilitators. Nevertheless, both the suggestions deserve serious consideration and