1984: The quiet revolution?*

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ROYAL Colleges exist to set professional standards. They have other functions, but all are subsidiary to this central purpose. The College of General Practitioners was founded to set standards of good general practice where none existed and to provide a corporate fellowship of like-minded men and women, so that the standards of individuals could be maintained in the public and professional interest. It was inevitable that Dr William Pickles of Aysgarth should be the first President of the new College because he exemplified this aim.

Here I will consider some general arguments which may help us face the reality and the urgency of improving clinical and operational standards in general practice. How reassuring it has been to discover the obvious, that personal and professional qualities, which made some of our predecessors in general practice standard setters in their time, are precisely the same qualities required of us today. A portrait of William Pickles, a setter of standards, illustrates my theme.

Dr William Pickles—setter of standards

Will Pickles was an outstanding family doctor. His daily work in general practice reflected that of his contemporaries, he had no unusual training, and his practice possessed no special features. Pickles became known to the wider world of medicine through his original contributions to epidemiology. His observations established the place of epidemiological method in general practice and earned him a respected place in medical history.

Yet these reasons are not enough to account for the high esteem and affection in which he is held in our discipline. In fact he was outstanding because of an enviable record of service to his patients and profession. Pickles took endless pains to know his patients well, to make time to listen to them, always to be kind and to be firm when the occasion demanded.

These human qualities were matched by considerable clinical knowledge and skill and that humility which enables every good doctor critically to examine his own work, so that he can know when he needs help. His records were meticulously kept, and he paid careful attention to his own continuing education. In short, he set high personal standards which were nevertheless practical because they could be applied in a real general practice. He did more than this; he *maintained* his standards, easily the sternest test of a doctor's determination and staying power.

I predict that, as time passes, the studies which brought William Pickles fame will diminish in importance. Instead, family doctors will remember him for what he really was—a country doctor who believed in doing his job well. This is fitting for, in honouring Pickles thus, we can also salute our foundation members most of whom were also outstanding because they shared similar values and tried within their own lights to uphold high personal standards in their own practices.

Clinical and operational standards in perspective

I want to try and place this highly emotive and contentious subject in the context of modern general practice. Otherwise, to practical doctors, it may be dismissed as of

*Delivered at Ninewells Hospital, Dundee on 13 April 1975.

Journal of the Royal College of General Practitioners, 1975, **25**, 399–407

interest to enthusiasts only, or seen as an unnecessary and unjustified intrusion on the right to practise.

Contemporary problems

The pattern of illness in countries like ours ideally requires a strong community-based medical service. For the remainder of this century our major health care problem will be to cope with the effects of the many diseases which cannot be cured. For example, the survival of children with major handicaps, and the sequelae of the degenerative diseases in middle age, compounded to the multiple infirmities of the elderly—all point to very local health units which can provide first contact, continuing, and terminal care, with expensive, highly specialised services available when needed.

Britain has chosen general practice as the main way of providing this care. Most other countries of comparable social and economic organisation offer patients a choice of primary care by specialists such as paediatricians and internists as well as general practitioners. Thus, general practitioners in this country have special responsibilities.

Strategic policies

Modern general practice in Britain began in the 1950s when thoughtful and enthusiastic family doctors saw that it would have to alter radically to meet the changing needs of patients—or go out of business. In the turbulent decade which followed, the elements were generated of an extraordinary era of development and renewal which is still going on today.

It is possible to identify six great strategic policies, all with their roots in the new College, which formed the framework. These policies were: to encourage group practice; to help individual practices with the means for a viable organisation; to give family doctors the diagnostic tools for their job; to redistribute some clinical work by bringing nurses into a functionally-integrated primary care team; to provide specialist training; and lastly, to set standards.

The first five of these policies are general in that they place no special responsibilities on every doctor. Individual doctors can opt out if they wish. Thus, for instance, everyone now has right of access to hospital laboratories, but not everybody uses them. We have the means, through the ancillary staff subsidy, to provide efficient practice administration, but some of us decide not to bother.

The consequence of this highly individual approach to the use of new resources is a patchiness in the quality of general practice which becomes steadily more stark, as good practices move ahead, while others do not. The public has noticed. Complaints about badly-run appointment systems and principals who are habitually unavailable for emergency care after tea-time are too common for comfort: these contrast vividly with the praise given to well-run practices. When it comes to clinical standards the few public complaints are no consolation, because lay people have difficulty in commenting objectively on technical matters. However, evidence is accumulating especially from prescribing patterns, the College's membership examination, and our clinical colleagues in hospital, of variation in the quality of the clinical practice of individual doctors which is unquestionably wide.

Let me give a few examples of the undesirable. There is the amusing but useless prescription which read " Unguentum Borax: Mitte plenty ". The MRCGP examination candidate who thought that plantar responses were to do with the heart, later taxed a few of his colleagues with the unfairness of our examination; they supported him, " general practitioners are not expected to know about complicated medicine like that ". And there is the sophisticated variant of the " please see " letter. A doctor wrote, " this patient has a pain which needs sorting out ". A physician replied " I agree. Since you and I have the same diagnostic facilities, when do you propose to start? "

This variation points inexorably to our unwillingness to pursue systematically the sixth of these great strategic policies—that is to agree minimum clinical and operational standards for all doctors, not just those who want them. We have been unable to offer the public a guarantee of minimum performance. So far we have muddled through, because we have argued that we have not had the tools for the job, and that our training has been too haphazard. Now the National Health Service has gone a long way towards providing what we said was necessary for effective primary care. The account is due. The goodwill of the Charter will stretch no further.

Can we avoid introducing standards?

The short answer is no. I believe we must face the issue honestly because:

(1) The College has shown that the work of general practice is based on a body of knowledge whose content can be described within broadly definable boundaries. General practitioners also need certain skills to be effective in their work; we have identified these skills. The body of knowledge and skills form a distinctive discipline which can be learned, but which is not taught to young doctors before full registration. Hence there is a need for specialist training for future general practitioners.

(2) It follows that we have an obligation to the public to guarantee that individual doctors wanting to practise our discipline have mastered the knowledge and skills to an acceptable minimum. All other branches of medicine do it. It is the essence of being a profession.

(3) I believe that we must preserve our clinical freedom. It is not in the self interest of the majority of general practitioners, who do their jobs well, to have the standing of their discipline discredited, their right to make clinical decisions questioned, because of the undisciplined actions or omissions of an idle or uninformed minority.

When professional groups do not regulate the standards of all their members they invite administrators to introduce controls. In our case, no one will have forgotten the humiliating regulation linking our continuing education with seniority payments. The administrators' intentions were right; the minority of doctors who refused to keep up to date had to be persuaded somehow to do so, and this was one method tried. What a reflection on the majority for whom this measure was not intended, but was nevertheless applied!

We must learn from this lesson. Clinical freedom is not a right; it has to be earned and it carries with it real responsibilities. We must be prepared to discipline ourselves, not leave it to the State to do it for us.

(4) It is important that our earnings, professional opportunities, and standing should compare favourably with other specialties to ensure that a career in general practice compares as an attractive option for the best medical graduates. We need our share of pace setters in medicine. We should thus reinforce our bargaining position by showing that we regulate our standards as throughly as other major clinical disciplines.

An old discipline with new horizons

Some may feel that my reasoning is faulty, but there are others who will say that it is simply common sense. Either way, I suggest it assumes compelling relevance when seen against the dazzling potential of general practice—if we put our house in order. We know that the chronic nature of major illness has created a need for local, personal medical care; and we are finding out that many young doctors with a well-developed sense of social awareness want to practise in a specialty which will give them more than a chance of knowing their patients well.

Are there opportunities for expansion? Of course there are. Take, for example, the crazy overlap of work between family doctors and specialists in hospital outpatient care; should hospital doctors provide so much continuing care if we could guarantee

the quality of our services? We should move on to the offensive, and take our patents back.

Another proposal is an extension of our work to include the care of our own patients in the proposed community hospitals. Many family doctors would dearly like this—we should go for it. For those interested in research there are enough studies to show that our discipline is a major growth area. And for the many more of us keen to teach, because we want to have young people about us, we must extend our horizon to embrace many more students and young doctors. If we can get the quality of clinical diagnosis, management, and operational method in our practices right, most practices will be teaching within a decade, because it will become normal for all medical students to receive a substantial part of their clinical training in general practice. Similarly, experience in general practice will, I predict, become one of the pre-registration options, and be of obvious value to many other clinical specialists in their training. This would bridge the gap between general practice and the hospital in a massive way, which can only be helpful.

I talk to young doctors every day because it is part of my job. Many want a career in general practice—but not at any price. Their professional expectations, always heightened if they have been enthusiastically and thoroughly trained, go beyond many of our contemporaries. The pace setters among them can see the new horizons and are relying on us to introduce the standards which will help them create the reality later. We must not fail them.

Standards for new principals

We have said that general practice is a discipline with its own body of knowledge and skills. This view has been accepted by the profession and by government which is why specialist training for general practice is now being introduced for all new entrants.

Yet it is clear that many of us have not understood a fundamental implication, namely, that the assessment of individuals undertaking such specialist training is an integral part of the educational process, because it is the only way of measuring attainment, or in the current jargon, outcome.

If an assessment of individuals is not made many things happen. For example, trainees will not know how or whether they benefited from their training; teachers will have no idea whether the content of their programmes is relevant or of the right quality; government cannot know whether its investment is being spent wisely or squandered; and the profession is unable to tell the public which young doctors completing training are competent general practitioners.

It is important that we clear our minds about this intimate relationship of education and assessment if we are not to make fools of ourselves. Those who raise objections can only logically argue on the grounds that they have identified a fundamentally different body of knowledge for general practice, or that there is none at all. They will have to try to persuade the public of this as well as the profession. It is not our business to help or comfort them in their task; on the contrary some of us will challenge them at every single point.

What about the failures?

It is our responsibility, however, to show what might happen to doctors who fail. I feel this can be answered reassuringly. Once the problem of overseas doctors is resolved very few graduates should fail in any specialty training-programme. Most estimates suggest a proportion of about five per cent. Some doctors who fail specialist training will still want to work in general practice and we shall have to provide appropriately sheltered conditions of work for them. But we must make it clear to other specialties

that we are no longer prepared to be the dustbin of medicine. The new hospital practitioner grade should help solve their problem. We are not obliged to.

Current methods of assessment

There are two main approaches to the assessment of training for general practice in use today. One, the membership examination of our College, provides a national standard. It is the assessment recommended by the Councils for Postgraduate Medical Education to those trainees who wish to be evaluated. The second method, a form of continuing assessment, is being developed by Professor Byrne, but is still in the experimental stage.

(a) *The MRCGP examination*

The College's examination is designed to test a doctor's ability to recall factual knowledge, to demonstrate his problem-solving skills, and to some extent to indicate attitudes. It has obvious imperfections which the College is well aware of, but in the present state of knowledge it is the best method there is. It is in a continuous process of refinement.

The College uses the examination as an indicator of the minimum standard of competence required of a principal in general practice. The pass rate, averaged over 1,010 candidacies in recent examinations, was 81 per cent for doctors who received their basic medical qualification in the United Kingdom or Republic of Ireland.

The examination has given us our most revealing insight yet into the wide variation in the level of knowledge and skills in problem solving of individual general practitioners. Moreover, it has shown us the nature of our strengths as well as our weaknesses and is thus providing the essential feedback which will influence future educational policies.

We have begun at last to work with facts rather than opinions, and we are thus moving now on to much surer ground in influencing the design and quality of our specialist training.

Today, increasing numbers of doctors are taking our examination. There are young doctors finishing training, who want to have their work assessed. In the northern region we find that applicants for training schemes nearly always have the examination in mind—and they are certainly encouraged to take it.

Then there are established principals, men and women, often in middle age, who want to test themselves against their peers for self-satisfaction. Some are already members of the College. Dr Dorward, chairman of the East of Scotland faculty, is an outstanding example of a mature doctor, who wanted to know what his College's assessment was about. He won a well-earned distinction.

There are also the doctors for whom our membership is important for their work. It is a virtual necessity for senior academic posts. In the Northern region it has become a normal requirement for our trainers whether they are already members of the College or not. The Northern Regional General Practice Advisory Committee feels that it would be irresponsible if it placed young men and women with trainers who are not themselves prepared to meet the objective standard of competence recommended for young principals, to show that they know the literature of their discipline, and understand the College's assessment methods intimately. This view is powerfully supported by the Northern trainees who look to the College to set high standards for teachers.

Rome was not built in a day, and some regions would obviously have difficulty in reaching this objective standard for all teachers. But if there is a standard there is at least an incentive to achieve it. You know then where an effort has to be made. Without minimum standards for teachers, mediocrity could prevail with unpleasant consequences for the quality of the next generation of general practitioners.

The College has learnt that national examinations are difficult to design and organise. Many dedicated, knowledgeable people are needed; and to be relevant, an examination

has to reflect the values and the experience of many more practising doctors. In short, an examination cannot be run by a committee alone—it takes the human resources and organisation of a college. People who propose specialty boards and other devices, as another way, are really saying that they do not understand the problem.

(b) Continuing assessment

We do not know when continuing assessment will be validated as a workable tool for general application. We can say that it will be unacceptable as a universal method until there are agreed minimum standards for individual teachers in general practice throughout the land, because varying standards among teachers produce varying standards of assessment and lead to unequal standards of new doctors.

I think that continuing assessment has promise and that we should support further experimental work, because ultimately a combination of continuing assessment and examination will be needed to achieve a fair and uniform appraisal of all trainees.

Overseas doctors—a special case

I cannot leave this subject without referring to overseas doctors. In 1974, 17·4 per cent of all principals were doctors born overseas; and in the same year 32·7 per cent of new principals appointed were born overseas (Owen, 1975). Recruitment is being maintained at its present level only by their decision to join us.

In the College's published evidence to the Merrison Committee (Royal College of General Practitioners, 1974) data were given from the examination which showed that doctors who received their basic medical qualification overseas did less well than those who were trained in the United Kingdom or in the Republic of Ireland. At that time the averaged pass rate was six per cent; a subsequent analysis, based on a larger number of 141 candidacies, showed an average pass rate of 21 per cent, which is more realistic.

The problem seems not to be confined to language or cultural differences, but to depend also on a lower standard of basic medical education. This is serious. One immediate consequence is that our teachers in general practice are faced in some instances with trying to remedy deficiencies in undergraduate training which our specialist training was never designed to do. This is an impossible task and I do not believe they should be asked to attempt it. They will fail, and will be blamed for failure, which will be unjust.

The quality of basic medical education is a matter for the General Medical Council. That Council is responsible for seeing that the standards required for all those who wish to receive full registration today are roughly consistent with the minimum obtaining in our own medical schools. The General Medical Council is at last promoting action. The Temporary Registration Assessment Board is arranging the first test for overseas doctors seeking full registration this year and the GMC is to revise the status of those medical schools overseas whose basic qualifications have hitherto attracted full registration in this country. As the standard-setting body for general practice, the College has presented the facts from the MRCGP examination to the General Medical Council in the public and our own professional interest.

There is one further point which must be made on this difficult and sensitive question. In the climate of controversy, which this subject always generates, we seem easily to forget our obligation to those overseas doctors who *are* giving valuable and skilled service to their patients. More of these doctors are becoming members of the College by examination and more also becoming fellows. In conversations with some of them I have learnt how uneasy and unhappy they are that they may be dragged down with the less competent through indiscriminate prejudice. We must speak up and loudly support them publicly, for we are not talking about colour, culture, or language—but about standards of professional competence.

A framework for maintaining standards

Though the training and assessment of young doctors for general practice must have first priority, it has become essential to concentrate more on continuing education. Indeed the very presence of specialist training is forcing the pace.

Trainees may criticise the clinical work of their teachers, and some who have recently completed training, and who are now principals, are dissatisfied with the often pedestrian offerings of their local postgraduate centres.

The problem has several facets. We can keep abreast of advances in various ways, but how can we be sure that we will use our knowledge in the consulting room? And how can we know that what we do will benefit our patients? We can say that methods of measuring the quality of health care, a specialist subject, are in a formative stage and this fact alone must caution against precipitate proposals for the formal re-accreditation of doctors. But in relating what we learn to what we do, within the more manageable framework of existing knowledge and experience, there is an unprecedented opportunity for progress.

Professional isolation has bedevilled continuing education for general practice, because it can make us insecure about exposing our every-day clinical work to our peers. We have no equivalent of the ward round. Postgraduate centres have provided meeting places but the quality, content, and methods of our continuing education, provided largely by specialists, have not kept pace with the best we provide ourselves for trainees.

Those training programmes which have made extensive use of small groups have shown that there is a treasure house of unrecognised knowledge, skill, and experience in ourselves. If we could unlock this treasure house for all to share, we would make progress indeed!

Maintaining standards

Teaching has made us think about our work, partly because we have to help others learn, and partly because students and young doctors will model themselves on the kind of doctors we are. I can illustrate this from our experience in the North of England. Some years ago, the old North of England Faculty of the College proposed that vocational training should be based only on teaching practices prepared to maintain agreed clinical and operational standards. This policy has been the guide ever since.

The seven teachers first appointed agreed to give 30 sessions per year to educational activities of the scheme outside their practices, these being in addition to their own postgraduate work. The sessions were committed to the half-day release courses which have run throughout the trainees' three-year programmes, so that everyone has become involved in defining and fashioning the content of general practice into a relevant curriculum.

As new teachers have applied, all have been asked, as a condition of appointment, to subscribe to the prevailing standards of the day, which are always advancing, and to give the same commitment of time to the group educational activities of the scheme. Regular participation in half-day release has made everyone think more seriously about the literature of general practice, about learning to think conceptually, how to use evidence critically, and how to give and take criticism without offence. Although it has been a long and often painful process for all, nevertheless there has been an air of excitement, because everyone felt they were breaking new ground.

Last winter our College Faculty brought together a group of 24 doctors, comprising teachers, young doctors undergoing higher training, and other interested principals, to meet regularly to set tighter clinical and operational standards for their own practices. Several methods were used. Records were sampled to show common weaknesses which might be remedied. The records of patients who died were analysed to discover whether

more could have been done or whether bad decisions had been made; in individual cases where problems were recognised they were reviewed by the group.

A consensus, a standard, for the diagnosis and management of hypertension was devised; the implementation by individual members will be checked by the group through sampling records later.

Several general conclusions are worth noting. For example, gaps in the knowledge both of individuals and the group were identified; a decision seriously to try and improve on records was made; and individuals agreed that the group would audit their own work in future. The course also bridged a growing gap between teaching and other general practitioners and showed convincingly the measure of the contribution that general-practitioner teachers can make to continuing education. Finally, the sheer interest and pleasure which a group of doctors gained from working regularly together to discuss their own patients' problems, and their own kind of medicine, startled even themselves.

The Faculty is building on this initiative because it has responsibility for setting our standards. All the regional teachers agreed last week to underpin five new standard setting groups in the North, so that this year nearly 150 doctors will become involved in a co-ordinated programme. And the Regional General-Practice Advisory Committee has even more recently introduced the principle of standard setting as a new criterion for teaching practices.

The teachers, well disciplined, self confident, and with a sureness of purpose which is infectious, are critical to this expansion—because they are the cutting edge. They are not concerned merely with education; they are on a crusade to rebuild general practice itself. Powerful reinforcements are on the way. The best of yesterday's trainees, who are becoming principals today, and will be leaders tomorrow, are steeped in the new ideas and are itching to go into action. Within a decade the Faculty hopes to reconstruct continuing education on the foundation of these standard-setting groups, so that our specialty will stand squarely on its own two feet.

The movement is alive elsewhere. A fire burns in East Anglia, in Leicester new standards are being forged for undergraduate teachers, and Thames Valley is making the pace in the South. Scotland has already achieved so much. There is quickening interest in many other areas too. What is going on? Quite simply, more and more general practitioners are discovering to their delight and surprise that their medicine is more interesting and relevant than they had ever thought, and great fun if learnt in the company of friends.

The task for the College

It would be easy to leave it at that, to expect that the new movement would spread, to hope that standards of general practice would rise everywhere as a result. But life is not so simple. We need local organisations for education, which are not strictly the College's business, and local groups for setting standards on which that education should be based, which is the College's function. The College is not an institution, it is the living sum of all of us who are associates, members, and fellows.

I believe we have to make up our minds as individuals now whether we are prepared to commit ourselves, as William Pickles did, to show that we will maintain our standards to the very best of our ability. By such a commitment we will give leadership to our profession and our badge of membership will be recognised by the public as the hallmark of a good family doctor.

We need a mechanism progressively to refine and distil the consensus of what is good general practice from the smallest groups of doctors meeting together in every city and town, to be a co-ordinating body which can express our values to government and the rest of the profession.

I passionately believe that the initiative and responsibility for maintaining continuing standards must rest with the faculties, because that is where we live and work. Diversity and competition between faculties should be encouraged to promote excellence through local pride in a job well done.

With hard work, imagination and enthusiastic participation by all our members, we have the certainty by 1984 of achieving a quiet revolution within the College which will help our patients, secure our discipline as the central pillar of our modern health care system, and acknowledge our responsibility to guarantee standards to the public. Thus we can keep faith with ourselves as professional men and women. I can think of no finer tribute to our foundation members.

Acknowledgements

I am as ever grateful to my wife for her patient forbearance and valuable criticism. My friends Drs Michael McKendrick, ' Mac ' Simpson-Brass and John Walker gave valuable comment on earlier drafts. And to Miss Margaret Burtt my secretary go my sincerest thanks for her careful work.

REFERENCES

Owen, David (1975). Reply to Parliamentary Question on 13 January.

Royal College of General Practitioners (1974). Evidence of the College to the Committee of Inquiry into the Regulation of the Medical Profession (Merrison Committee), *Journal of the Royal College of General Practitioners*, **24**, 59–74.