REPORTS

National Conference of Postgraduate Advisers in General Practice in the UK

AT the twelfth conference in June 1977 the main preoccupation of regional advisers was the paper by the Department of Health and Social Security containing proposals about regulations under the Vocational Training Act, which received the Royal Assent late in 1976. Comments on these proposals had been invited from various bodies including the Conference, the College, the Joint Committee on Postgraduate Training, and the General Medical Services Committee. It was agreed that an attempt would be made to give a co-ordinated reply to the Department from these four organizations.

The NHS (Vocational Training) Act 1976 empowers the Secretary of State to make regulations which:

1. Prescribe the medical experience required of a doctor seeking to enter general practice as an unrestricted principal.
2. Designate a body to issue certificates indicating that the prescribed experience has been acquired.
3. Designate a body to assess experience not identical to that prescribed and, where appropriate, to issue certificates indicating that such experience is equivalent to that prescribed.
4. Set out circumstances in which a doctor is exempt from the need to acquire the prescribed experience.
5. Establish an appeal body.
6. Appoint a day from which the training requirement shall become operative.

The effect of the Act will be that, from the appointed day, family practitioner committees will be able to make arrangements with doctors wishing to become unrestricted principals for the first time only if those doctors have experience conforming to that required by the regulations. The vocational training requirement does *not* apply to doctors who are entering general practice as assistants, or seeking to provide a limited range of services, such as family planning only. (General practitioners providing all services to a limited group of people, such as nurses in hospital, would be subject to the requirements of the Act.)

It was proposed by the Department of Health that regulations should provide for *prescribed* experience but that doctors not conforming to this might be eligible under the regulations for *equivalent* experience.

Much debate has taken place in various formats on the lists of appropriate clinical specialties which could be acceptable for the hospital requirements for vocational training for general practice. On the one hand some have felt that virtually any previous hospital experience is necessarily useful enough to be acceptable. At the other extreme fixed lists of appropriate posts have been drawn up. The DHSS proposals contained a list similar to the list currently required for the Vocational Training Act, from which three six-month posts would need to be served out of the two hospital years. The JCPT suggested a change which would require not less than six months each in *approved* posts in two of the following specialties (the remainder to be gained in any specialty): accident and emergency, general medicine, geriatrics, medical paediatrics, obstetrics and/or gynaecology, and psychiatry.

It was suggested that the present alternative requirement of the vocational training allowance, namely a special university approved course, might be acceptable. It was pointed out, however, that there could be parliamentary objections to this course as it amounted to "delegated legislation".

In their document the JCPT, unlike the DHSS who left the matter open, insisted that all posts for training should be educationally approved. This is in line with the attitude of the deans, who would wish to see educational approval for all training posts in hospital no matter what the career aim of the occupant may be. This is a matter on which regional advisers also feel very strongly. They are anxious about the mechanisms for achieving this in their regions and somewhat daunted by the probable workload. The Conference had before it a document from the JCPT on criteria for educational approval of hospital posts for general-practice training and this was warmly welcomed as a useful approach to the problems of educational recognition.

Certificates of *equivalent* experience would enable doctors who had not completed the full three-year programme to be admitted as principals if their experience in, for example, the armed services or overseas was equivalent to the experience required under the regulations. Certificates would be issued on completion of training and the DHSS document reflected uncertainty as to whether this should be carried out by a national or regional body. All those

consulted were unanimous in agreeing that the JCPT should be designated as the body to issue certificates for both prescribed and equivalent experience. A multiplicity of bodies would:

1. Lead to multiple standards rather than a national standard of training.
2. Leave the JCPT with no effective control over the quality of training posts and programmes.
3. Confuse trainees who may undertake their prescribed experience in programmes in more than one region.

Doctors who became principals on the appointed day would be exempt from the requirement as would those who had been principals during a prescribed period before the appointed day. There is to be an appeal body.

The comments of the JCPT on the proposals were endorsed by the Conference after discussion and further written comment from the advisers; and these comments were also later endorsed by the Council of the College at its meeting in September 1977.

DOUGLAS PRICE

Practice activity analysis 2. Choice of chemotherapy

FROM THE BIRMINGHAM RESEARCH UNIT OF THE ROYAL COLLEGE OF GENERAL PRACTITIONERS

THIS report is based on an analysis of the first 140 returned proformas received, which concerned approximately 46,000 consultations. Recording took place during two consecutive weeks of July or August chosen by the recording doctors. The results are therefore not from a representative sample of family doctors, although the total of 46,000 consultations is enough to provide a reasonable cross section of patients consulting at this time of year.

Consolidated results

The consolidated results are presented in Grid C as in the retained slip of the original analysis sheet. They provide a basis for comparison between the doctors who took part. When considering the individual cell values presented in this grid, possible local biases must be taken into account. Examples include a consultation pattern biased towards a specific subgroup, such as the pupils of a residential school, or by some minor local epidemic occurring during the recording period.

Total antibiotics prescribed

In all, 4,540 new courses of chemotherapy were prescribed, equivalent to a course of antibiotics being initiated in about ten per cent of consultations. Table 1 shows the range of the frequency with which antibiotics were prescribed. As in the previous report in this series, "Punctuality of Appointments", the recording doctors are divided into five equal groups. The prescribing rates which separate the groups are shown in the table. The lowest values are seen in Group A and the highest in Group E. The minimum and maximum rates are entered. One fifth of the recorders prescribed antibiotics on fewer than 66 consultations per 1,000, and at the opposite extreme a fifth prescribed with a frequency greater than 137 per 1,000 consultations.

The significance of age is examined more closely in

Table 1. Range of rates of total antibiotic prescribing in each of five equal subgroups of recorders.

	A	B	C	D	E
Recorders	(28)	(28)	(28)	(28)	(28)

5.3	66.0	83.0	107.6	136.7	275.2
Minimum rate	Intermediate values separating subgroups				Maximum rate