### Spring General Meeting

Dr C. Waine announced that the Spring General Meeting would be held in Bowness in the Lake District on 25, 26, and 27 April 1980.

There would be a full and varied programme for husbands, wives, and children and accommodation was being arranged at two local hotels. Dr Waine urged that people apply early for fear of shortage of accommodation.

### Chairman of Council

Dr A. G. Donald thanked Dr M. J. Linnett for his past three years as Chairman of Council and Dr Linnett received a standing ovation on his retirement.

### Annual General Meeting 1980

The Annual General Meeting in 1980 will be held on 15 November 1980 at Imperial College, London.

The meeting ended at 16.30 hours.

# Some aspects of vocational training

WITH the introduction of mandatory vocational training in general practice, the Royal College of General Practitioners will face several problems which in some respects are similar to those in Israel, where family medicine is a recognized specialty with a defined curriculum and compulsory examination. I was therefore particularly pleased to be given the opportunity of visiting the United Kingdom as Update/RCGP Traveller for 1979, in order to study trends in two important aspects of vocational training:

1. Examination and evaluation of trainees.
2. Educational courses for trainees.

The programme, planned by the Dean of Studies of the Royal College, was designed to meet both objectives.

The visit took a month, from 20 March to 22 April. The first two days consisted of orientation visits to London practices. This was followed by three days at the RCGP Examiners' Workshop in Leamington Spa and by working visits to various departments of general practice and postgraduate training programmes in England and Scotland. During this period I met, formally and informally, heads of academic departments, regional advisers in general practice, course organizers, general practitioner tutors, and trainees. I also attended several departmental meetings and teaching sessions for trainees.

It must be emphasized that I was specifically interested in the possible implications for developments in family medicine in Israel, which may account for any bias in my report.

### Examination and evaluation of competence

I was greatly impressed with the tremendous efforts which are made to improve the quality, scope, and techniques of the MRCGP examination. The refreshing candour and readiness for peer group evaluation amongst so many enthusiastic self-critical examiners reflected an attitude of honest appraisal which must inevitably lead to improvements in the standard of the examination. It is, however, not an easy task to translate good intentions into practical actions. There is no simple way to assess competence in the highly complex mass of activities which comprise the contents of the work of the general practitioner.

#### *What must be measured?*

The first question which faces our own Examining Board relates to what must be measured in terms of educational objectives and the role of the future general practitioner. If we accept that he must make his diagnosis "in physical, emotional, and social terms", then what relative weightings should our examination give to each of these components? The crucial question is: should we fail the candidate who has superb competence in the diagnosis and management of most conditions seen in general practice but who has "insufficient awareness of the emotional and social components"? Is there a consensus view of the content of good general practice? How tightly is this banner nailed to our mast? Is the approach of our examiners to be 'all or nothing', or is there room for intermediate objectives, which will permit flexible options for the future based on the objective medical needs of our society?

#### *Safety or excellence?*

The next question relates to the standard of performance required. Should we examine for 'minimal acceptable competence' or for 'excellence'? The former implies a 'safe' doctor whose 'safety' has already been assured by passing his final MB examination on completion of his undergraduate studies. Excellence, however, implies a 'closed-shop' policy with exclusive membership and with obvious implications for candidates unable to pass the examination, for foreign graduates with language problems, and for those with different standards of medical education.

The institution of a two-level examination simply begs the question and even compounds the problem.

Are we to define three levels of vocationally trained general practitioners—some who have not passed the examination, some who have passed an examination for minimal acceptable competence, and others who have passed an additional examination for excellence? What criteria will serve to define the different educational requirements, work content and medico-legal responsibilities of each group of vocationally trained doctors? This proposal does not answer the crucial question—does vocational training imply 'safety' or 'excellence'?

The uncomfortable answer is painfully obvious. It must be assumed that a general practitioner with a licence to practise (without additional postgraduate qualification) is already 'acceptably competent' or 'safe'; if not, then the criteria for licensing must be reconsidered. If this assumption is correct (and the alternative is not legally or morally tenable!), then examination after vocational training must logically imply 'excellence'. It then becomes necessary to define a set of alternative educational options which could qualify veteran general practitioners (whose 'safety' must be presumed) to approach the same examinations in order to demonstrate 'excellence', but without the need to return to hospital wards or teaching practices like newly qualified colleagues. It appears that the readiness to accept 'excellence' as our goal, and to follow the example set by other specialties in this respect, is perhaps the major challenge which faces vocational training today. The acceptance of this challenge may well determine the future of general practice as an independent discipline.

### *Duration of vocational training*

The duration of vocational training programmes should reflect the content of training, the degree of excellence required, and available facilities. It is difficult to assume that a candidate can be expected to acquire excellent clinical competence within three or even four years. Nevertheless, an 'optimal cut-off point' must arbitrarily be established for examination at the end of training. This in turn implies an implicit commitment to continuing education after completion of the training period. Whether this requires periodic re-assessment by examination is a decision which should not be taken without careful consideration of the immense implications on the health services of a social welfare state.

### *Methods of examination*

The final question relates to methods and techniques of examination and the setting in which it is performed. Our present examination includes a live patient, but the logistics may well become formidable as the number of our candidates increases. What aspects of clinical competence are best measured by multiple choice questions, traditional essays, simulated patient management problems, and oral examinations? How does each of these rate in terms of validity, reliability, objectivity, and efficiency? Audiovisual aids could perhaps be used more extensively, but these bring with them a host of problems relating to perception and interpretation.

Filling out long rating forms can become tedious and is time consuming, and there is an understandable desire among examiners to simplify these methods. There is also an inherent risk in applying oversophisticated techniques to the crude measures at present available. Nevertheless, oversimplification of rating components carries its own risk of subjective assessment and should not be undertaken lightly.

## Educational courses

The rapidly expanding number of day release courses in the regions visited was as impressive as the enthusiasm and dedication of the postgraduate departments and their tutors. The educational aims of these courses varied with the philosophy of each department and each course organizer. Some courses dealt mainly with aspects of other specialties relevant to general practice and were structured in the traditional lecture/discussion format. Others were based on the group discussion model and tried to help trainees identify their own educational needs and assess themselves objectively in a self-learning format, with the tutor serving as a resource. Other courses were planned with the declared objectives of preparing the candidates for the MRCGP examination, and were focused sharply on these aspects. There can be little doubt that postgraduate courses are an essential component of vocational training. Apart from their educational value, they also help the trainee to develop his identity as a general practitioner. Nevertheless, it may now be possible to view such courses in a wider perspective.

The advent of mandatory vocational training has for practical purposes lengthened the total medical curriculum to nine years or more. The first six years of this period are common to all medical students, and the next three or four years are specific to general practitioners. It therefore seems logical that undergraduate and postgraduate departments in each region should co-ordinate their teaching objectives so as to ensure the best use of resources and teaching time. Undergraduate objectives could then logically include those aspects relevant to all doctors which are best demonstrated in the setting of general practice. This would then enable postgraduate departments to concentrate their efforts on aspects relevant mainly to general practitioners. Such co-ordination could make a considerable contribution to vocational training.

## Conclusion

My visit seems to have evoked more questions than answers. Yet, this must surely be the hallmark of a successful educational programme and I must re-emphasize that it was an exciting, enjoyable, and thoroughly worthwhile experience. I should therefore

like to repeat my thanks to Dr E. V. Kuenssberg, President of the Royal College of General Practitioners, to Council, and to Dr A. Marcus of Update Publications Ltd for the privilege of being invited as Update/RCGP Traveller 1979. The programme was superbly organized and I am deeply indebted to Dr J. S. Norell, Dean of Studies, for his immense personal efforts in this respect. My special thanks are also due to Professor J. H. Walker for shepherding me through the Workshop at Leamington Spa, and to Mrs H. Gittins, who ensured that all arrangements went off smoothly.

I must also express my deepest appreciation to all those members of the Royal College of General Practitioners who gave so freely of their time, and extended such warm hospitality and sincere friendship during my visits to their practices, their departments, and their homes. My wife and I were both overwhelmed by the wealth of kindness which we were privileged to receive and would welcome the opportunity to reciprocate.

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# OBITUARY

## John Morton Henderson, MD, FRCP.ED, FRCGP, DPH

Dr John Morton Henderson was born in Glasgow in April 1900 and educated at Hutchesons Grammar School and the University of Glasgow. He qualified MB, CH.B with commendation in 1923 and was medallist in the classes of practical pathology and of therapeutics. On completing house officer posts he was appointed to a five-year tenure of a research post in the All-India School of Hygiene and Tropical Medicine in Calcutta. There he researched into the pathology of leprosy and had papers in the Indian *Journal of Medical Research* and in the Indian *Medical Gazette.*

He returned to the United Kingdom in 1931 and undertook a period of postgraduate study, obtaining the degree of MD from the University of Glasgow in 1932, and the Diploma in Public Health of the University of London in 1933, being awarded the Chadwick Prize of the London School of Hygiene and Tropical Medicine in that year.

He entered general practice in Birkenhead in 1933 and remained there until the outbreak of war, when as a Territorial Officer of the RAMC he joined up in September 1939. He served in the UK and in North-West Europe and was mentioned in despatches.

On demobilization he undertook a further period of postgraduate study, this time in Edinburgh, when he became by examination a Member of the Royal College of Physicians of Edinburgh in 1946. (He was subsequently admitted to Fellowship of that College in 1956.) Thereafter he entered general practice in Pitlochry in 1947 until his retirement from practice in 1969. He was wont to point out that Pitlochry is the geographical centre of Scotland.

Dr Henderson was a foundation member of the College, and when the first College Council was set up in 1952, he was invited to be one of the three Scottish representatives. Later that year an interim Scottish Council of the College was established with John Henderson as its first Chairman. He remained Chairman of the Scottish Council for the first four years of its existence and continued as a Member of the College Council while acting as the representative on Council of the South-East Scotland Faculty, of which Faculty he subsequently became Provost. He delivered the 1963 James Mackenzie Lecture.

When he retired from practice in Pitlochry in 1969, he was invited to join the Department of General Practice at the University of Edinburgh as a lecturer, where he helped considerably in setting up a bibliography service for this new department. His assistance was very much appreciated by students and staff alike. Although he had given up active practice as a general practitioner, he continued with his own researches into the place of electrocardiography in general practice and gave both encouragement and leadership to younger colleagues. Some of the material produced was published in this *Journal.*

Dr Henderson's final retirement from active practice and clinical work took place in 1976, when he settled in Meols, Cheshire.

John Henderson was a somewhat diffident, shy person who acted with great dignity in all his dealings with patients and colleagues. He was a first-rate clinician and the ideal person not only to help set up the College in Scotland but to be the first Chairman of Scottish Council. In the very early days of our College's existence, when general practice and its clinical, professional, and academic claims were by no means universally accepted, John Henderson was the perfect ambassador. Those of us who had the privilege of working closely with him have good reason to consider ourselves fortunate. At the same time the news of his death on 27 October 1979 brought with it a real sense of personal loss.

R. SCOTT