

History of vocational training for general practice: the 1970s and 1980s

JOHN C. HASLER

SUMMARY. *During the 1970s and 1980s, vocational training for general practice developed from experimental beginnings to become established nationwide. Committees were set up nationally and regionally and methods devised for the approval of training practices. Important publications related to the discipline of general practice and to educational methodology appeared. The problems that remain include the absence of a compulsory assessment prior to entering general practice and the low remuneration for course organizers.*

Introduction

THE early days of general practice vocational training in the United Kingdom up to 1970 have been described by Horder and Swift.¹ By the end of the 1960s many vocational training schemes had been set up, the Royal Commission on Medical Education had published its report² and national bodies had set in motion steps that would lead to the formation of the supervisory councils and committees that we know today. This paper describes the following two decades, when experimentation was transformed into reality.

Establishment of training schemes

By 1970 experimental training schemes at Inverness and Wessex³ had proved a success and several districts had established the pattern of two years in hospital posts and one year in general practice. In 1971 the *British Medical Journal* published a series of articles describing schemes at Ipswich, Newcastle upon Tyne, Wessex, Belfast, Livingston, Bridgend, Northampton, Manchester and the Oxford region.⁴⁻¹¹

Three years' vocational training was not, in fact, recommended by the Royal Commission on Medical Education.² Prompted by evidence from the College of General Practitioners,¹² the Commission proposed a five-year programme after the intern year — three years of general professional training in junior hospital posts and two years further professional training in general practice. That these two extra years never materialized was partly due to convenience and finance — a single trainee year had been established for two decades — and partly because the full educational needs of general practitioners had not yet been established.

Hospital posts

In the original Inverness scheme, the hospital component, like its general practice counterpart, was supernumerary to service requirements. In the Wessex scheme six months was spent in an established obstetrics and gynaecology post and six months was supernumerary. As the number of schemes grew, the hospital component extended to two years, it became a sequence of service senior house officer posts in most parts of the country and supernumerary sections became uncommon.

J.C. Hasler, OBE, MD, FRCGP, regional postgraduate adviser and clinical lecturer in general practice, University of Oxford.

© *Journal of the Royal College of General Practitioners*, 1989, 39, 338-341.

Once again, financial expediency and contemporary thinking dictated this pattern. The existing senior house officer posts were already financed and it seemed an unnecessary complication to budget for more. Even in those schemes that did achieve additional finance, in most instances the extra budget gradually became lost in the general pool.

The responsibility for giving educational approval to senior house officer and registrar posts belonged to the appropriate specialist royal college. Because of the general practice interest in senior house officer posts and the belief that training immediately after full registration should be of a general rather than specialist nature, in the early 1970s the Royal College of Physicians invited representatives from the Royal College of General Practitioners to join its visiting teams. The same facility was accorded subsequently by the Royal College of Obstetricians and Gynaecologists and the Royal College of Psychiatrists.

During the 1980s the stresses and strains on the hospital service increased, the most significant being larger workloads, changes in ratios of senior to junior staff, controls on numbers of posts and a lack of properly planned educational programmes for some senior house officers. By the late 1980s there was growing anxiety, especially in relation to supervision and education, and with hindsight it would have been preferable to have had separate identifiable budgets for training which would have allowed great flexibility and control. Nevertheless, in spite of the problems, most posts are seen as important by young doctors who need to acquire a variety of clinical experience. In 1987 the General Medical Council produced recommendations¹³ which emphasized the need for general professional development in the early years after qualification and for all doctors to acquire certain basic skills: it is too early to say how far these recommendations will be adopted.

Councils for postgraduate medical education and regional postgraduate committees

The three councils for postgraduate medical education for England and Wales, Scotland, and Northern Ireland were established at the beginning of the 1970s as successors to the original central committee covering the whole of the UK. One of their aims was to provide a bridge between the National Health Service as resource provider and the academic bodies. The councils for Scotland and Northern Ireland worked well from the outset largely because they fulfilled an executive role in relation to a relatively small number of other bodies. In contrast, the council for England and Wales found itself in more difficulty. The sheer size of the council — over 60 members — made decision-making difficult and in spite of making an important contribution to the early development of postgraduate medical education, the royal colleges and other bodies continued to exercise their right of direct access to government and the Department of Health and Social Security. By the second half of the 1980s, the future of the council was in doubt and a recommendation that it be abolished was eventually adopted, although a smaller standing committee took its place in early 1989.

In the regions, comparable bodies in the form of regional postgraduate medical education committees were established with postgraduate deans as executive officers. These committees established specialty subcommittees and those for general practice were to become central to the development of vocational

training and in particular to the standards of training practices. The membership of general practice subcommittees was drawn largely from local medical committees and RCGP faculties.

Regional advisers

Those responsible for the farsighted developments in Wessex saw that individuals would be needed to supervise and expand vocational training in each region. George Swift's appointment as the first regional postgraduate adviser in general practice was a success and in 1972 the DHSS produced guidelines for regional postgraduate adviser appointments throughout the country (Circular HM (72) 25). Before long each region had made an appointment. Every adviser was employed by the university or the regional health authority on a sessional basis which varied from one region to another and all were, and still are, principals in general practice.

It was important for these doctors to communicate with each other and at the beginning of the 1970s the UK conference of postgraduate advisers in general practice was established with George Swift as its first chairman. Before long, especially in the larger regions, associate advisers were appointed, some of whom had geographically defined responsibilities while others had specific functions. The UK conference was primarily an administrative body and in order to provide an educational forum and to involve the new associate advisers, a conference of regional and associate advisers was established in England and Wales. Scotland and Northern Ireland, being smaller, had their own educational support networks.

Course organizers

As the number of vocational training schemes in each region increased, the regional advisers could not continue to supervise them. Local general practitioners were needed and at first they were unpaid. In 1972 the DHSS was persuaded that new appointments would have to be made and since the most obvious role at the time was running the local day release courses, the new appointees were known as course organizers. The DHSS made it clear, however, that new money would be difficult to obtain and that the easiest solution would be to appoint and pay course organizers as trainers but without trainees. With hindsight it is clear that this was a mistake. Throughout the 1970s and 1980s course organizers were the most important people in the system, but they were underpaid because their pay could not be raised above that of a trainer or related to their work and responsibility as described by Williams in 1986.¹⁴ By 1984 there were 267 course organizers in post: unlike regional advisers they were concerned only with vocational training.

Partly because of these pressures the course organizers formed their own association in 1984. Bahrami listed the aims of the new association which included exploring and developing the role of course organizers and providing representation on local and national bodies.¹⁵ Pressure was brought to bear on the General Medical Services Committee to negotiate better pay and arrangements but by the end of the 1980s the financial climate had changed for the worse and the matter had become submerged in much larger negotiations on the whole general practitioner contract.

Training practices

Prior to 1973 the appointment of trainers had been the responsibility of local medical committees. In October of that year, this responsibility was transferred to the regional general practice subcommittees. In England, Wales and Northern Ireland (unlike Scotland) a right of appeal against non-appointment existed and the council for postgraduate medical education took

over the administrative arrangements for this.

As general practice subcommittees developed confidence and expertise, they began to develop more detailed criteria for trainer appointments. In the Oxford region, for example, prior attendance at a trainers' course, involvement in a local trainers' group, and passing the MRCGP examination became requirements for new trainers by April 1977.¹⁶ By the early 1980s the same region had introduced whole day approval and reapproval visits involving examination of videotaped consultations and the use of all trainers as visitors.¹⁷⁻¹⁹ These arrangements had been based on the RCGP's model for peer review of practices.²⁰ While it was the individual doctor who was appointed as a trainer, as time went by increasing emphasis was placed on the whole practice as a training practice. Interest grew and by 1984 there were over 2500 trainers in England and Wales.

Training the trainers

In parallel with the organizational developments in vocational training in the 1970s, academic contributions were needed to help regional advisers, course organizers and trainers develop and shape their teaching in the most appropriate manner. The first, and in many ways the most important publication, *The future general practitioner — learning and teaching*,²¹ described the process of education and divided the content of vocational training into five areas which are still widely referred to today. At the Second European Conference on the Teaching of General Practice in Leeuwenhorst in 1974 a statement was made about the work and scope of general practice and 21 broad aims were listed. Gray adapted these aims in his paper on vocational training in 1977 which described educational theory and set out objectives, methods and assessment based on the Exeter University department of general practice.²² In 1976 Freeman and Byrne from the Manchester University department of general practice published their work on rating scales for use in the assessment of trainees.²³ Other important contributions included *Doctors talking to patients*,²⁴ *Teaching general practice*,²⁵ *The consultation — an approach to learning and teaching*,²⁶ and *Priority objectives for vocational training*.²⁷

In 1973 the RCGP, with financial support from the Nuffield Provincial Hospitals Trust set up the first of three courses designed primarily for course organizers and regional advisers. The tutor was Paul Freeling from the department of general practice at St George's Hospital medical school who combined educational theory with a small group learning approach.²⁸ Two tenets were accepted as the basic philosophy for the course — patient care in general practice and the principles of learning. Each course consisted of six weekly modules spread over one year and they had an important effect on a substantial number of key people who would subsequently shape the direction of vocational training.

The Joint Committee on Postgraduate Training for General Practice

As vocational training became established in earnest a regulatory body was needed to set national guidelines and monitor the regions' performance. While the hospital posts were the responsibility of the royal colleges there was no mechanism for dealing with the other aspects of training including the trainers and their practices. The RCGP established a committee on postgraduate training in 1975 but knew that this would need to give way to a more broadly based organization.

In 1976 the Joint Committee on Postgraduate Training for General Practice was established with John Lawson as its first chairman and with a core membership of representatives of the RCGP and GMSC. The JCPTGP set up a system of inspections of each region in the UK in alternate years conducted by three

experienced general practitioners (mainly regional and associate advisers). The visits are based on individual schemes and a large amount of time continues to be spent in visiting the training practices.

Mandatory training

Throughout the 1970s it remained possible for doctors to enter general practice without any postgraduate training. As general practitioners were self-employed independent contractors it was necessary to resort to the law to introduce mandatory training. After a great deal of medical and legal thought parliamentary legislation was introduced in 1979.²⁹ From February 1981 the practice year became compulsory for all new principals and from August 1982 the full three years was phased in. The JCPTGP became responsible for issuing certificates — mainly on the basis of signed statements from consultants and trainers — and by 1987 it was processing over 2000 a year. The statements contained the words 'satisfactory completion' and there was confusion about whether or not some appraisal of competence was involved. This dilemma was highlighted by the considerable discrepancy between the certification rate and the MRCGP examination pass rate among trainees.³⁰ In 1987 the joint committee made it clear that statements should reflect actual performance and not mere attendance; but the results of this remain to be seen.

Trainees

The number of general practitioner trainees rose steadily during the 1970s and by the mid-1980s there were over 2000 in the general practice year alone. More than one third of these were women, reflecting the entry statistics to medical school. General practice had become one of the most popular career choices in medicine.

In 1971 a national trainee conference was held in Newcastle followed by conferences in Edinburgh in 1974, Oxford in 1977 and Exeter in 1980. The Exeter conference was remarkable for its efficient organization and for the presentation of data collected by trainees from each region reflecting their experiences of training.³¹ Since then conferences have been held on a regular basis, organized largely by the local trainees.

By the end of the 1970s the number of doctors applying to join schemes was becoming a major problem for course organizers and regional advisers and it was not unusual for there to be 50–100 applicants for two to four places.³² These figures exaggerated the true demand, since many doctors made multiple applications. Trainees arranging their own programmes faced similar difficulties in gaining obstetric and paediatric posts and figures produced by the JCPTGP in 1988 showed that around two fifths of these doctors had not held posts in these specialties in the programmes they submitted.³³

During the 1980s some regions and schemes began to explore more sophisticated ways of selecting applicants since shortlisting from application forms and interviewing in large committees clearly had serious limitations.

MRCGP examination

The MRCGP examination was introduced as a requirement for RCGP membership in 1968. The number of candidates increased steadily through the 1970s reaching 2000 in 1986. It became seen as a useful diploma to acquire at the end of vocational training and by the mid-1980s 80% of candidates were trainees or within a year of completing training.

However, there was disagreement, still unresolved, about whether the examination should in effect be a test of the end of training or should revert to being primarily for membership

of the RCGP. Supporters of the former view included those who felt an end of training hurdle, albeit voluntary, was needed, and those who were anxious about the effects on recruitment to the RCGP if entry had to be delayed until after completion of training. Those in favour of the alternative suggestion, including some course organizers and trainees, argued that sitting an examination in the all too brief practice year was an unnecessary distraction; some trainees saw the exercise as merely an insurance policy to help in the quest for a partnership.

Armed forces

A number of younger doctors in the medical branches of the armed forces are on short service commissions and enter via the medical cadet scheme while at university. If the forces were to continue to attract these doctors, they too had to provide vocational training. Therefore, advisers in general practice were appointed to the three branches of the armed forces and in 1973 the Armed Services General Practice Approval Board was established with a combination of civilian and service members and Pat Byrne as its first chairman.

The board's role was to appoint trainers and to select training practices: these tasks had to be conducted separately because of the mobility of service doctors. By the end of the 1970s a substantial number of service medical centres had been approved in the UK and Germany with more outlying ones in Cyprus, Gibraltar and Hong Kong. During the 1980s the board steadily upgraded its approval processes and by 1988 standardized inspection forms were in use, visits to practices had been established on a regular basis and the use of videotaped consultations formed part of the trainer selection process.

Trainees in general practice appointments, which are usually for 18 months rather than 12 months, are part of the normal establishment and there were some problems in the early years with frequent postings elsewhere and ensuring enough time for teaching. In contrast, the hospital appointments are technically supernumerary and with the close relationship that exists between consultants and trainees in service hospitals, some of these posts offered considerable advantages over those in NHS hospitals.

European Community

The entry of the UK to the European Community had implications for the movement of doctors and the recognition of their qualifications and diplomas. In the early 1980s the UK was one of only a handful of European countries that had established mandatory postgraduate training for general practice in line with the 1975 doctors directive. If the directive were to remain in force the remainder of Europe had to be persuaded to follow suit. Given the variations in the style of general practice between the member states this was no easy matter but eventually after lengthy negotiations it was agreed that by the mid-1990s principal general practitioners must have completed a minimum period of special postgraduate training.

Conclusion

At the end of the 1980s a number of issues have emerged. The three year training period, shorter than originally envisaged, is inadequate to address all the needs of the future general practitioner. Indeed, if other branches of medicine were to adopt a more general professional training immediately after full registration (similar to the hospital component of vocational training for general practice) the single year in practice will be seen as too short to address all the facets of practice needing attention especially in the clinical, communication and management fields. The RCGP's solution has been to suggest a period of higher

training³⁴ on a day-release or part-time basis during the early years as a principal. One or two regions have set up experimental schemes (unpublished report).

While doctors can still enter general practice merely by serving time the competence of a small number of doctors will remain in doubt. The profession must address this problem.

The inappropriate title and remuneration for course organizers (and for tutors for continuing education) must be resolved with urgency if we are to continue to attract high calibre doctors to these posts.

The problems facing the hospital service are having an effect on some of the doctors in training for general practice and a close and continuing dialogue will be needed to ensure that all junior hospital doctors are able to benefit from a balance of experience and teaching. Continued efforts will be needed to bring all training practices up to the standards of the best.

Looking back over two decades, what is most striking is the immense contribution of a large group of dedicated general practitioners who have developed and moulded vocational training into what it is today. It is abundantly clear that through the successful development of postgraduate education, the whole of general practice has benefited. From the low morale of the 1950s and early 1960s, it has emerged with its role in medical care more clearly defined, its relationships with specialists and other professionals strengthened and its reputation high. Historians, looking back in years to come, will agree that this is indeed a remarkable story.

References

1. Horder JP, Swift G. The history of vocational training for general practice. *J R Coll Gen Pract* 1979; **29**: 24-32.
2. Royal Commission on Medical Education. *Todd report (Cmnd 3569)*. London: HMSO, 1968.
3. Swift G. Recollections and reflections: general practice since 1946. *J R Coll Gen Pract* 1982; **32**: 471-479.
4. Anonymous. Vocational training in general practice. I — A district hospital scheme: Ipswich. *Br Med J* 1971; **2**: 704-705.
5. Anonymous. Vocational training in general practice. II — Newcastle upon Tyne. *Br Med J* 1971; **2**: 763-765.
6. Anonymous. Vocational training in general practice. III — Wessex. *Br Med J* 1971; **3**: 41-42.
7. Anonymous. Vocational training in general practice. IV — Belfast. *Br Med J* 1971; **3**: 104-105.
8. Anonymous. Vocational training in general practice. V — Livingston. *Br Med J* 1971; **3**: 173-174.
9. Anonymous. Vocational training in general practice. V — Bridgend and Northampton. *Br Med J* 1971; **3**: 242-243.
10. Anonymous. Vocational training in general practice. VII — Manchester. *Br Med J* 1971; **3**: 299-300.
11. Anonymous. Vocational training in general practice. VIII — Oxford region. *Br Med J* 1971; **3**: 365-366.
12. College of General Practitioners. *Evidence of the College of General Practitioners to the Royal Commission on Medical Education. Reports from general practice 5*. London: CGP, 1966.
13. General Medical Council. *Recommendations on the training of specialists*. London: GMC, 1987.
14. Williams AHE. *Course organizers in general practice. Occasional paper 34*. London: Royal College General Practitioners, 1986.
15. Bahrami J. Association of Course Organizers. *J R Coll Gen Pract* 1984; **34**: 468.
16. Hasler JC. Training practices in the Oxford region. *J R Coll Gen Pract* 1978; **28**: 352-354.
17. Schofield TPC, Hasler JC. Approval of trainers and training practices in the Oxford region: criteria. *Br Med J* 1984; **288**: 538-540.
18. Schofield TPC, Hasler JC. Approval of trainers and training practices in the Oxford region: assessment. *Br Med J* 1984; **288**: 612-614.
19. Schofield TPC, Hasler JC. Approval of trainers and training practices in the Oxford region: evaluation. *Br Med J* 1984; **288**: 688-689.
20. Royal College of General Practitioners. *What sort of doctor? Reports from general practice 23*. London: RCGP, 1985.
21. Working party of the Royal College of General Practitioners. *The future general practitioner. Learning and teaching*. London: British Medical Journal, 1972.
22. Gray DJP. *A system of training for general practice. Occasional paper 4*. London: Royal College of General Practitioners, 1977.
23. Freeman J, Byrne PS. *The assessment of vocational training for general practice. Reports from general practice 17*. London: Royal College of General Practitioners, 1976.
24. Byrne PS, Long BEC. *Doctors talking to patients*. London: HMSO, 1976.
25. Cormack J, Marinker M, Morrell DC. *Teaching general practice*. London: Kluwer Medical, 1981.
26. Pendleton DA, Schofield TPC, Tate PHC, Havelock PB. *The consultation — an approach to learning and teaching*. Oxford University Press, 1984.
27. Oxford Region Course Organizers and Regional Advisers Group. *Priority objectives for general practice vocational training. Occasional paper 30*. London: Royal College General Practitioners, 1985.
28. Freeling P, Barry S. *In-service training*. Windsor: NFER - Nicholson, 1982.
29. National Health Service. *Vocational training regulations*. London: HMSO, 1979.
30. Joint Committee on Postgraduate Training for General Practice. *Assessment and vocational training for general practice. Report of a working party*. London: JCPTGP, 1987.
31. Ronalds C, Douglas A, Gray DP, Selley P. *Fourth national trainee conference. Occasional paper 18*. London: Royal College of General Practitioners, 1981.
32. Hasler JC. Overwhelmed in Oxford. *Br Med J* 1982; **285**: 1705-1706.
33. Styles WM. *Vocational training for general practice — hospital experience. A report from the Joint Committee on Postgraduate Training for General Practice*. London: JCPTGP, 1988.
34. Royal College of General Practitioners. *The front line of the health service. Reports from general practice 25*. London: RCGP, 1987: para 4.34.

Acknowledgements

My thanks are due to Mrs Hilda Gittins and Dr Paul Sackin for their help in the preparation of this paper and to Mrs Barbara Vaughan who typed the manuscript.

Address for correspondence

Dr J.C. Hasler, Oxford Regional Committee for Postgraduate Medical Education and Training, The Medical School Offices, John Radcliffe Hospital, Headington, Oxford OX3 9DU.

RCGP

Courses
and
Conferences



COMPUTER APPRECIATION COURSES

The Information Technology Centre at the RCGP offers a series of two-day Computer Appreciation Courses for general practitioners and their senior practice staff. The courses are aimed at those with little or no knowledge of computing with particular emphasis on the introduction and management of the new technology for general practice.

The cost for Members and their staff starts from £175 (inclusive of Friday night accommodation) and £150 (without accommodation). For non-members, the prices are £200 and £175 respectively. The fee includes the cost of all meals, refreshments and extensive course notes.

Courses are zero-rated under Section 63; practice staff may be eligible for 70% reimbursement under paragraph 52.9(b) of the Statement of Fees and Allowances. Staff should confirm eligibility with their local FPC.

Forthcoming courses: 29-30 September, 27-28 October and 24-25 November 1989.

Further details from: The Course Administrator, Information Technology Centre, The Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU. Telephone: 01-823 9703.