Education and training for general practice: Royal College of General Practitioners' policy statement

EDUCATION and training for general practice must relate directly to the current and future responsibilities of general practitioners, to the needs of their individual patients and to the practice populations for whom they are responsible. Despite the considerable changes that have taken place in the organization of health care in the United Kingdom in the last five years, as well as major developments in clinical practice, current arrangements for training are little different from those that evolved in the 1970s. The Royal College of General Practitioners' recently published policy statement presenting its views on training and education is therefore timely.[1] It addresses the whole question of how arrangements will need to develop if doctors are to be successful in meeting the challenges of general practice into the next century. In formulating its policies, the RCGP has responded to the criticisms of current provision that have been made by trainees and established principals.[2-5]

The length of the training programme has been debated for decades, and the current minimum three-year period required by the vocational training regulations[6] is a compromise of the five years that the RCGP first advocated almost 30 years ago.[7] The RCGP has concluded that a pragmatic way forward would be to supplement the mandatory three-year programme with an additional voluntary period of higher professional education lasting two years; for most this would be undertaken during a doctor's early years as a principal, but some might wish to postpone it until later in their careers. Securing the financial resources needed for this is an immediate priority, so that opportunities for such higher training can be readily available to all principals throughout the UK.

In considering the criticisms of vocational training programmes, the RCGP has concluded that better use could be made of the mandatory three-year period. It recommends most strongly that a greater proportion of this time should be spent in the setting of general practice itself. Although the vocational training regulations would allow for this, funding from the Department of Health has limited the period of training in general practice to a maximum of 12 months. The RCGP recommends arrangements whereby longer periods of training are spent in general practice, with as much as two thirds of the three-year programme in this setting. There is considerable scope for experimentation here, and for evaluating different ways in which the longer period of training in general practice could be utilized. As well as covering a wider curriculum, it could provide better opportunities to integrate hospital with general practice experience, for example through the development of outpatient and short-term hospital attachments from a general practice base. The RCGP has also suggested other hitherto underutilized locations that would be appropriate for training experience. These include community hospitals as well as health and commissioning authorities. In health and commissioning authorities, doctors could develop further skills in management, in the needs assessment of populations, in the application of epidemiology and in the reviewing of prescribing and other practice activities through audit.

In order to provide greater flexibility in the future, the RCGP recommends strongly that the different elements of funding for vocational training, including those for hospital posts, trainees' salaries in general practice and trainers' grants, should be brought together into a single education budget. This would be managed by regional advisers in general practice within the framework of regional postgraduate education organizations.

The RCGP believes that this would be a crucial step in freeing up a system that has constrained educational innovation and development over the last 20 years. These new arrangements would enable a regional adviser to tailor a vocational training programme to match the specific educational needs of the individual trainee, both in terms of location of training and its overall length. It could be the route to considerable improvement in educational standards.

For many years the RCGP has asserted the need for all those who complete vocational training to be able to demonstrate their competence for independent practice through an objective assessment that operates to a national standard.[8] In this way patients can be reassured about the abilities of the doctors with whom they consult. The RCGP has developed the membership of the Royal College of General Practitioners (MRCGP) examination for this purpose. In its current policy statement, the RCGP reiterates its view that upon completing vocational training all doctors should sit the MRCGP examination, and that all who are appointed as new principals in the National Health Service should hold this qualification.[9] Health authorities and health boards have been encouraged to recognize this when they are appointing new principals to their lists, and partnerships also are asked to bear this in mind when filling vacancies.

Since 1985, the RCGP has advocated the development of higher professional education for new principals as a way of supplementing their vocational training, and of providing opportunities for the pursuit of special interests.[8,10] There have been a number of important initiatives in this field.[11]

Developments in portfolio-based learning[12] and with mentors have been particularly valuable in ensuring that programmes are learner-directed and tailored to individual learning needs.[13-15] The RCGP wishes to see extended the range of educational opportunities for higher professional education, and for them to be readily available to new principals throughout the UK. Through its education network the RCGP will work with others, and in particular with regional advisers and with academic departments of general practice to develop and evaluate innovations in higher professional education.

Participation in continuing education throughout a doctor's career should be a professional responsibility, rather than the contractual obligation currently embodied in the postgraduate education allowance. The content of continuing medical education must be relevant to the needs of doctors, and to the services that they provide. The RCGP is keen to encourage participatory forms of continuing medical education, particularly those that are practice-based,[16] since they have the advantage of ensuring that educational achievements can relate directly to changes in clinical practice, as well as providing opportunities for the multiprofessional learning that the RCGP wishes to encourage.

The RCGP education network is considering how participation in continuing medical education can best be linked to the system for the recertification of its members that the RCGP wishes to

develop. The extent to which review of a doctor's performance within the setting of his or her own practice is included in this system is also being addressed.

In setting out its policies for the future direction of education and training, the RCGP is charting the way forward for at least the next decade. However, implementation will not fall to the RCGP alone. It is essential that it works closely with others if progress is to be made in the directions that it has indicated. There will be a need for continuing collaboration with regional advisers in general practice, with university departments of general practice, with the Joint Committee on Postgraduate Training for General Practice, and with the other medical royal colleges. Local medical committees and the General Medical Services Committee will be important allies in implementation.

The support of the Department of Health will be essential if the profession is to develop further the high quality educational programmes that general practitioners will need if they are to meet their extended responsibilities, and to provide high standards of patient care. Implementation of the RCGP's policies for education and training presents a considerable challenge. The imagination, energy and flair that characterized the evolution of vocational training in the 1970s should, when applied in the 1990s, ensure success.

W McN Styles

Chairman of council, Royal College of General Practitioners

References

1. Royal College of General Practitioners. *Education and training for general practice. Policy statement 3.* London: RCGP, 1994.
2. Crawley HS, Levin JB. Training for general practice; a national survey. *BMJ* 1990; **300:** 911-915.
3. Kearley K. An evaluation of the hospital component of general practice vocational training. *Br J Gen Pract* 1990; **40:** 409-414.
4. Styles W McN. General practice training in the hospital [editorial]. *Br J Gen Pract* 1990; **40:** 401-402.
5. Little P. What do Wessex GPs think about the structure of hospital vocational training? *BMJ* 1994; **308:** 1337.
6. National Health Service, England and Wales. *The National Health Service (vocational training) regulations 1979. No. 1644.* London: HMSO, 1979.
7. College of General Practitioners. *Evidence of the College of General Practitioners to the Royal Commission on Medical Education. Report from general practice 5.* London: CGP, 1966.
8. Royal College of General Practitioners. *Quality in general practice. Policy statement 2.* London: RCGP, 1985.
9. Royal College of General Practitioners. Chairman's report. *RCGP Connection* 1993; December: 1-2.
10. Royal College of General Practitioners. *An educational strategy for general practice for the 1990s. A College plan: priorities for the future. Occasional paper 49.* London: RCGP, 1990.
11. Koppel JI, Pietroni RG. *Higher professional education courses in the United Kingdom. Occasional paper 51.* London: Royal College of General Practitioners, 1991.
12. Royal College of General Practitioners. *Portfolio based learning in general practice. Occasional paper 63.* London: RCGP, 1993.
13. Savage R. Continuing education for general practice: a life long journey [editorial]. *Br J Gen Pract* 1991; **41:** 311-314.
14. Stanley I, Al-Shehri A, Thomas P. Continuing education for general practice. 1. Experience, competence and the media of self-directed learning for established general practitioners. *Br J Gen Pract* 1993; **43:** 210-214.
15. Al-Shehri A, Stanley I, Thomas P. Continuing education for general practice. 2. Systematic learning from experience. *Br J Gen Pract* 1993; **43:** 249-253.
16. Stanley I. Practice-based small group learning. *Postgrad Educ Gen Pract* 1992; **3:** 89-91.

Address for correspondence

Dr W McN Styles, Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU.

Polarities in medicine

THE constant tension between an unlimited Hippocratic commitment to the individual patient on the one hand, and awareness that resources are finite on the other, is a fact of medical life that no amount of sophistication can alleviate. It was recognized a generation ago by Rene Dubos who wrote: 'The moral responsibility of the physician in our society is to use all available resources for the succour of the sick and for the preservation of life, whatever the cost and the consequences. But the duty of the practising physician toward his individual patient is only one aspect of medicine. Another aspect is made up of knowledge, practices and points of view which bear on the welfare of the community as a whole, and on the future of mankind.'[1] We shall always be forced to resonate in a field that is polarized in many ways beyond the one just considered, a polarity that might be regarded as typical of medical practice.

Dubos' dictum, although true on one level, may not stand up to scrutiny on another. We tend to regard cost as though a choice must be made between modalities of prevention, diagnosis and cure that compete for a limited budget. We speak affectionately of the tubes of tetracycline ointment that could, for a pittance, have prevented blindness from trachoma in over six million people,[2] implicitly contrasting such potential beneficence with liver transplants that are 'only for the rich'. But what of distribution? Just as the United Nations experience in Somalia has shown that hunger is more a matter of politics than global shortage, so there is a political or human nature side to the bestowing of the fruits of medical progress. This situation cannot be remedied by making funds available from other items of the health budget such as dialysis or enzyme replacement for sufferers from Gaucher's disease.

The extent to which medicine can take credit for the quality of late 20th century life cannot be determined, although making an estimate would seem critical to health care planning. A study attempting to quantify medicine's contribution to the decline in coronary heart disease mortality during the years 1968–76 attributed 24% to a reduction in smoking prevalence, 14% to intensive coronary care, 10% to medical therapy and 4% to bypass surgery, the authors attributing the rest of the reduction in mortality to lifestyle changes.[3] Within six months, the data on which the authors based their calculations were challenged, it being suggested that mortality was declining before the above-mentioned factors came into play.[4] Thus, any attempt to lay down guidelines for health spending finds itself polarized between the view that medicine has had little impact on longevity[5] and an alternative one that the profession is responsible for half of the decrease in victims claimed by the western world's leading killer.[3] According to Illich, life expectancy has been improved by better housing, sanitation and nutrition. To some extent this is true, but it was medical science that led us to understand the connection between these improvements and better health, in a sense empowering people to demand them.

It is also useful to consider our capacity for doing good in