on our Internet pages, which are attracting considerable attention from North America as well as elsewhere. I hope that authors will share my enthusiasm for these new opportunities and respond by offering us not only essays, commentaries, and points of view, but more 'why' papers as well as 'how' papers in the traditional scientific mould. We will attempt to balance the new writing with scientific contributions in a reflective and reader-friendly way, cherishing philosophy and literature as well as statistics. I hope also that more readers will come to share my conviction that research questions from general practice can have their own 'fizz and pop'.[12]

The *raison d'être* of all this professional activity is to improve the quality of practice by a clearer understanding of the clinical, psychological, social, and other factors affecting the health and well-being of patients. 'The public relies on the ability of general practitioners to doubt, to question, and to reassess.'[13] We will reflect *caritas* as well as *scientia* but success will depend on feedback from readers. We hope you like our new format. Please join us at the growing edge by reading the *British Journal of General Practice* and contributing to the wider debate on primary health care.

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References

1. Wright AF. A preview of the new-look *BJGP. Br J Gen Pract* 1997; **47:** 135-136.
2. Smith BH, Taylor RJ. Medicine, a healing or dying art? *Br J Gen Pract* 1996; **46:** 249-251.
3. McCormick J. The place of judgement in medicine. *Br J Gen Pract* 1944; **44:** 50-51.
4. Britten N, Fisher B. Qualitative research and general practice. *Br J Gen Pract* 1993; **43:** 270-271.
5. Charlton BG. GP-patient, stories of sickness. *Br J Gen Pract* 1991; **41:** 222-223.
6. Macnaughton J. Anecdotes and empiricism. *Br J Gen Pract* 1995; **45:** 571-572.
7. Gray DP, Wright AF, O'Dowd T, *et al.* The discipline and literature of general practice. *Br J Gen Pract* 1997; **47:** 139-143.
8. International Committee of Journal Editors. Uniform requirements for ????????? submitted to Biomedical Journals. *BMJ* 1991; **302:** 338-341.
9. Pendleton D. Professional development in general practice: problems, puzzles and paradigms. [William Pickles Lecture 1995.] *Br J Gen Pract* 1995; **45:** 377-381.
10. Pietroni R. *Portfolio-based learning in general practice.* [Occasional Paper 63.] London: RCGP, 1993.
11. *Guardian* [editorial], 23 April 1997.
12. Wilkinson MJB, Rapley DM, Gadsby R, Wilmot J. Does the BJGP need more fizz and pop? *Br J Gen Pract* 1997; **47:** 145-149.
13. His Royal Highness the Prince of Wales. The importance of the generalist. *Br J Gen Pract* 1992; **42:** 222.

Summative assessment of vocational training: to be required by law

PARLIAMENT will soon be considering changes to the Vocational Training Regulations 1994,[1] which are likely to make vocational training for general practice necessary by law before a doctor may work in general practice in the National Health Service (NHS). Why is this necessary? Why is general practice the only branch of medicine for which Parliament has felt this to be necessary? What does it mean for the future?

The first general principle that this development reflects is a shift in thinking from competence towards performance. For most of the past century the main emphasis in medical education and in medical assessment has been on the measurement of competence: has the doctor learnt what is required? However, it has become increasingly clear that competence is not enough. Knowing how to act does not necessarily help the patient; what matters to the patient is what the doctor does. An ounce of performance is more important to patients than a ton of unimplemented knowledge.

Once the focus is on performance (defined in terms of what the patient receives), logical thinking becomes easier. It can then be seen that there are always three levels of performance at which professionals may function: the bare minimum, the average or usual, and the excellent. A doctor may function on different levels at different times, but on the whole most doctors operate at the same level for most of the time. Greatly differing proportions of the profession are involved at each of these levels of care. The definition of each level serves fundamentally different purposes: the minimum level exists to protect patients, while the usual and excellent levels have been designed to satisfy the profession collectively and to provide incentives and rewards for good work.

Good performance. Most patients receive good care from most general practitioners. In the interests of the collective reputation of the practising profession, this fact should come first in all thinking about performance in general practice. The current attention being paid to 'poorly performing doctors'[2] must not prevent proper recognition being given to the good work of the silent majority in the profession.

It is a privilege and a responsibility for the professions to determine their own standards and to regulate themselves. Indeed, self-regulation is a defining feature of any profession. In the United Kingdom this is now achieved through three 'competent authorities': the General Medical Council (GMC, established in 1858), the Joint Committee on Postgraduate Training for General Practice (JCPTGP, established in 1976), and the Specialist Training Authority (established in 1996). All three are professional bodies, with predominantly medical membership, and constituted so that the medical profession and the state (which gives all professions their independence) can both be satisfied about the standards of doctors.[3-5]

Excellent performance. There are also many general practitioners whose performance is excellent and who deserve recognition. For these practitioners the award of Fellowship by Assessment (FBA) from the Royal College of General Practitioners was introduced in 1989.[6] The aim was to encourage excellent performance and to acknowledge those who can demonstrate that they achieve it. Fellowship by Assessment made it possible, for the first time, to measure excellent performance objectively and provided professional recognition of it. Already, more than half a million patients in the NHS receive

care in practices in which one or more doctors have reached this level of excellence.

Performance below an acceptable minimum level. Unfortunately, in any profession there will be a small number of people whose performance gives cause for concern. In medicine, their work will be at a level that may prevent patients properly benefiting from all that a modern health service can offer. To identify unacceptable performance, an acceptable minimum first had to be defined. In general practice, the start came within the medical profession and can be dated to the years 1983–1985. Irvine's paper on the excess degree of variability in general practice[7] was followed by the Irvine's Assessment Working Party of the JCPTGP. Assessment remained on the agenda.[8]

By 1990, the then three chairmen of the JCPTGP, the RCGP, and the GMSC had taken legal advice and confirmed that 'satisfactory completion' of vocational training meant achieving 'a satisfactory level of competence'.[9] In 1993, after extensive formal consultation, the JCPTGP formally adopted the policy that summative (endpoint) assessment of vocational training for general practice should be required.[10] The aim was to determine the minimum standard of performance and the purpose was simply to protect the public.[11] The JCPTGP also decided that such summative assessment should have six components: adequate factual knowledge, problem solving skills, clinical competence, consulting skills, written skills, and receipt of a satisfactory trainer's report.

The next challenge was to decide on a method. An early decision by the General Medical Services Committee was to oppose the use of the MRCGP for the purposes of summative assessment. This meant that a new assessment system was needed. Under the aegis of the JCPTGP, a new system was created by the directors of postgraduate general practice education (formerly known as the regional advisers in general practice), drawing especially on research by Murray, Campbell, and Lough in the West of Scotland,[12-18] with important contributions from the Oxford region through Johnson, Hasler, Toby, and Grant,[19,20] and from the North West.[21]

Relatively quickly, a new national system was built up through John Hasler's Working Party, complete with a national office.[22] However, the principles were controversial,[23-26] and even stout hearts were wavering. So, a special meeting was organized in November 1995, known as the 'Heathrow summit', when 18 general practitioners, including 10 national general practitioner chairmen, met under the chairmanship of John Chisholm of the GMSC in a Heathrow hotel.[27] The discussions lasted until midnight!

The JCPTGP had to reconcile the tensions.[27] A meeting the next day had to be temporarily suspended to achieve reconciliation. Eventually, a unanimous decision was achieved from this big and highly representative body, which included trainee (registrar) representatives. The JCPTGP's decision was to introduce summative assessment on the basis that it would be legally voluntary but professionally expected. Assessment began in September 1996.

Only three months after this, the Secretary of State for Health responded for the Government to the professional lead. In December 1996, in the White Paper *Primary care — delivering the future,*[28] a firm statement was made that legislation would be introduced 'by September 1997'. This commitment followed a previous letter from the Minister of State for Health.[29]

Meanwhile, the issue of a few poorly performing doctors had surfaced in Parliament and in the GMC, which reported that it had inadequate powers to deal appropriately with many of them. Parliament responded with the Medical Act 1995 (Professional Performance),[2] passed in November 1995. The GMC then introduced a performance-based measure appropriate to all the different specialties. Both the competent authorities (the GMC and the JCPTGP) had to introduce a test of minimal performance because in both cases the issue is protecting patients and deciding whether or not a doctor is fit to be allowed to work. The underlying thinking is thus very similar, although it was a coincidence that plans for both happened to fall in the same month: September 1997.

General practice, as befits the largest branch of the medical profession, has now achieved another first in its educational arrangements. General practice was the first specialty to require its trainers to learn how to teach, and also the first branch of medicine to appoint its trainers on a limited term and to introduce a practice-based performance review.[31] Assessment is an integral part of the educational process[3] and one point of the 'training triangle'.[30] It is now also the first to establish measures of performance at the minimum level (summative assessment), at good practice level (MRCGP), and at the level of excellence (FBA).[6]

The future is now clearer to see. The broad legal framework for the assessment of vocational training will soon be in place for the next century, but the key responsibilities will rightly remain with the profession. The first step is likely to be a continual improvement in methodology;[25] simulated surgeries, for example, have many theoretical advantages. Secondly, there is likely to be a rationalization of the relationship between the MRCGP and summative assessment, so that registrars can take as few assessments as possible and the great majority who pass the MRCGP can be given as much exemption as possible. Thirdly, despite the advent of legally required summative assessment, it can be expected that the public as patients, the NHS, and specialist colleagues generally will increasingly respect and value assessments, in the words of the Royal Commission on the NHS,[32] of 'the relevant Royal College'.

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References

1. *Vocational Training for General Medical Practice (European Requirements) Regulations* 1994. Statutory Instrument 3130. London: HMSO, 1994.
2. Medical Act 1995 (Professional Performance). London: HMSO, 1995.
3. Merrison Committee. *Report of the Committee of Inquiry into the Regulation of the Medical Profession.* Cmnd 6018. London: HMSO, 1975.
4. Joint Committee on Postgraduate Training for General Practice. Report of the work of the JCPTGP 1995. Appendix 1. In: RCGP Members' Reference Book 1996. London: Sterling Publications, 1996.
5. European Special Medical Qualifications Order. London: HMSO, 1996.
6. Royal College of General Practitioners. *Fellowship by assessment.* [Occasional paper 50.] 2nd edition. London: RCGP, 1995.
7. Irvine D. Quality of care in general practice: our outstanding problem. *J R Coll Gen Pract* 1983; **33:** 521-523.
8. Pereira Gray D. Assessment in general practice. [Editorial.] *Br J Gen Pract* 1988; **38:** 344-345.
9. Irvine D, Pereira Gray D, Bogle I. Vocational training: the meaning of 'satisfactory completion'. [Letter.] *Br J Gen Pract* 1990; **40:** 34.
10. Joint Committee on Postgraduate Training for General Practice. *Report of the Summative Assessment Working Party.* London: JCPTGP, 1993.
11. Hayden J. Summative assessment for general practitioner registrars will protect patients from incompetent GPs. [Letter as Chairman of CRAGPIE.] *BMJ* 1995; **311:** 1300.

12. Campbell LM, Howie JGR, Murray TS. Summative assessment: a pilot project in the West of Scotland. *Br J Gen Pract* 1993; **43:** 430-434.
13. Campbell LM, Howie JGR, Murray TS. Use of videotaped consultations in summative assessment of trainees in the West of Scotland. *Br J Gen Pract* 1995; **45:** 137-141.
14. Murray TS. Summative assessment for general practitioner registrars: system as currently used in the West of Scotland. *BMJ* 1995; **311:** 1299-1300.
15. Murray TS. Summative assessment for GP registrars. [Letter as Chairman UK Conference of Regional Advisers in General Practice.] *BMJ* 1995; 1299-1300.
16. Lough JRM, McKay J, Murray TS. Audit and summative assessment: a criterion based marking schedule. *Br J Gen Pract* 1995; **45:** 607-609.
17. Campbell LM, Murray TS. Assessment of competence. *Br J Gen Pract* 1996; **46:** 619-622.
18. Lough JRM, Murray TS. Training for audit: lessons still to be learned. *Br J Gen Pract* 1997; **47:** 290-292.
19. Johnson N, Hasler J, Toby J, Grant J. Content of a trainer's report for summative assessment in general practice: views of trainers. *Br J Gen Pract* 1996; **46:** 135-139.
20. Johnson N, Hasler J, Toby J, Grant J. Consensus minimum standards for use in a trainer's report for summative assessment in general practice. *Br J Gen Pract* 1996; **46:** 140-144.
21. Bennett JJ, Hayden J. Audit as part of summative assessment. *Br J Gen Pract* 1995; **45:** 47-49.
22. Percy D. *Summative assessment for GP registrars completing vocational training after 1 September 1996.* Southampton: UK Conference of Postgraduate Advisers in General Practice, 1995.
23. Coppola W. Summative assessment in general practice proposals may damage one of the finest examples of postgraduate medical education. *BMJ* 1995; **311:** 1573.
24. Hayden J. Summative assessment – threat or opportunity? *Br J Gen Pract* 1996; **46:** 132-133.
25 Rhodes M, Wolf A. The summative assessment package: a closer look. *Education for General Practice* 1997; **8:** 1-7.
26. Pereira Gray D, Murray S, Hasler J, *et al.* The summative assessment package: an alternative view. *Education for General Practice* 1997; **8:** 8-15.
27. Joint Committee on Postgraduate Training for General Practice. Report of the work of the JCPTGP 1995. In: *RCGP Members' Reference Book* 1996. p197. London: Sterling Publications, 1996.
28. Secretary of State for Health. *Primary care - delivering the future.* Para 3.9. London: HMSO, 1996.
29. Malone G (as Minister of State for Health). Letter to chairman of JCPTGP, September 1995. In: *RCGP Members' Reference Book* 1996. London: Sterling Publications, 1996.
30. Pereira Gray DJ. *A system of training for general practice.* 2nd edition. London: RCGP, 1979.
31. Pereira Gray DJ. Selecting general practitioner trainers. *BMJ* 1984; **288:** 195-198.
32. Royal Commission on the NHS. *Report.* Para 7.29. London: HMSO, 1979.

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Refining the MRCGP

EVER since the first five candidates took the MRCGP examination in 1965, it has undergone a life of perpetual change.[1] Some of the developments introduced over the past few years include the introduction of the Critical Reading Paper (CRQ), the restructuring of the Modified Essay Question (MEQ), the refinement of the oral examinations, with greater emphasis on examiner training,[2] and the introduction of the consulting skills assessment.[3] This constant refinement of examination techniques and examiner training has inevitably resulted in the MRCGP becoming a source of advice to other medical colleges across many specialties, both in the United Kingdom (UK) and internationally.

More recently, the Examination Board has permitted candidates to take the Multiple Choice Question (MCQ) paper early, or to retake it without retaking the rest of the examination. Superficially, this was a simple change, primarily introduced to benefit candidates and associated with the introduction of mandatory summative assessment in the UK. Summative assessment was introduced as a professionally led assessment of all new entrants to general practice.[4,5] Using a number of assessment techniques, it is designed to ensure that general practitioner (GP) registrars have reached a minimum standard before being permitted to practise unsupervised. The MRCGP is set at an optimum rather than a minimum standard, and passing the MRCGP MCQ gave candidates exemption from the MCQ used in summative assessment. However, this simple change had a profound effect on the rest of the examination. We were no longer examining a single cohort of candidates at a time. The uncoupling of the MCQ from the other written papers meant that these required extra testing time to preserve their reliability as stand-alone papers. The statistical methods by which marks had been calculated required major changes. In addition, many candidates felt that the whole examination structure had become unnecessarily complex.

It became apparent to both the Examination Board and the Panel of Examiners that a radical solution was required. The intention was to simplify the structure, making it more logical, dealing with some of the organizational inconsistencies that had crept in, and making it genuinely easier to take but no easier to pass. It became clear that the solution, and the next natural development for the examination, was a modular structure.

As candidates will have been aware, over the past few examinations there has been a gradual blurring of some of the previous differences between some of the written papers. For instance, the CRQ has used MCQ techniques, and the MEQ has used extended matching questions. This blurring has made it even more essential that the examination is blueprinted — a technique of increasing importance in medical assessment worldwide.[6] Applied within the MRCGP initially by the former convenor of the panel, Professor Lesley Southgate, and more recently by her successor, Dr Roger Neighbour, blueprinting defines the examination's content and ensures that the appropriate test methods are used for each area.

So, while appearing revolutionary, the revised modular structure is actually a logical product of the MRCGP's evolution. From May 1998, the examination will consist of four separate stand-alone modules:

Paper 1. A three-hour written paper, derived from the pre-1998 Modified Essay Question and elements of the pre-1998 Critical Reading Question.
Paper 2. A three-hour machine-marked paper, including the pre-1998 Multiple Choice Question and elements of the Critical Reading Question.