The JCPTGP: the passing of an era

On 30 September 2005 the medical regulatory body with a famously forgettable acronym, the Joint Committee on Postgraduate Training for General Practice, was gently and sadly laid to rest.

GP educators universally referred to this UK-wide organisation, which for a generation held pole position in quality assurance of general practice, as the 'Joint Committee'. It was, however, never accorded its alphabetic or historical seniority when bracketed with its sister organisation, the Specialist Training Authority (STA); both being competent authorities for assuring medical training under the European medical directives (specialist training under Article 3, and general practice under Article 4).

The JCPTGP was a unique body that brought together not only the then divided tribes of general practice (it was a joint committee between the Royal College of General Practitioners [RCGP] and the General Practitioners Committee [GPC]), but also had representation from GP education directors, postgraduate deans, specialists, doctors in training, the Departments of Health and, latterly, the laity.

The leadership of the JCPTGP alternated between chairmen appointed by its two parents, the RCGP and GPC, and had two medical joint honorary secretaries, one from each. Its signal achievement was to unite disparate medical organisations under a single banner of excellence within general practice and it was always known for the quality of its quarterly debates.

Unlike the STA, the Joint Committee had to survive on a grant-in-aid from the Department of Health (often remitted late and well into the financial year) together with a donation from the RCGP to support its standard-setting function.

The Joint Committee, in contrast to many specialist medical royal colleges developed a respected methodology for quality assurance that was economic with the resources of the organisations it inspected. Rather than examining every individual medical post, the JCPTGP inspected deaneries and their systems for ensuring quality GP training, and only sampled the posts within them. This was held up as an exemplar by many, including successive Chief Medical Officers (England) and contributed to limiting the 'inspectionitis' that many within the NHS feel reduces time for patient care.

Over its 30 years of existence the Joint Committee achieved two other major breakthroughs.

The first was the refinement of its regulatory powers with the introduction of new Vocational Training Regulations in 1998. Until then, if the JCPTGP determined that training for embryonic GPs was deficient, and it has to be said that this was almost exclusively within the hospital training component, its only power was to de-recognise the general practice training within an entire deanery, what we used to term 'MAD' — mutually assured destruction.

The 1998 amendments allowed the JCPTGP to de-recognise individual hospitals, hospital jobs or practices within a deanery and the ultimate sanction of 'MAD' was overnight transformed into our 'stiletto powers' allowing remedial action at the correct level.

The second major breakthrough was the introduction of summative assessment of training, under the same amendments to the regulations, in the teeth of opposition from elements within the GPC. Until that date, a doctor's general practice training was entirely experiential — if the doctor had undertaken certain prescribed medical jobs, he or she gained a certificate by default, without any test of competence.

Summative assessment tested consulting skills usually by watching a video recording of the doctor at work with real patients, technical skills, and examined written evidence (usually by conducting a clinical audit). It also tested the ability to apply new knowledge learnt over time as assessed by the trainer. Variations to these criteria developed, but all were mapped to the General Medical Council's document *Good Medical Practice*.[1] For nearly the past decade, therefore, the JCPTGP has been able to say with confidence that GPs practising in the UK are at an assured standard of clinical skill, and has presided over increasing standards for both practice and hospital-based trainers.

The irony of the demise of the JCPTGP is that it has not come about because of any intrinsic deficiency in its own operations, it is more to do with perceived difficulties within the STA, where the influence of different specialist medical royal colleges was seen to have possibly compromised best regulation. The government decreed in 2000 that both the JCPTGP and the STA were to be unified under the banner of the Postgraduate Medical Training and Education Board (PMETB), which went live on 30 September. While setting up its new structures and policies during its heretofore 'shadow' existence the PMETB has shown a worrying tendency to ignore the Joint Committee's working experience developed and honed over time, but the most obvious change for GP registrars will be the imposition of certification charges as it has been decreed that unlike the Joint Committee, it must be self-financing.

I am privileged to have been the last JCPTGP chairman from the GPC stable (1997–2000) and am pleased to be able to pay tribute to those who have contributed to the proper operation of the regulation of general practice training over the past three decades. Katie Carter, our Registrar since 1997, and her small and dedicated staff have stuck to their posts over 5 turbulent years and hand on to PMETB, if it chooses to receive it, an efficient, economic and slick operation. Justin Allen and Roger Chapman (joint honorary secretaries from the RCGP and the GPC) worked tirelessly until the very day of decommissioning, and my successor, John Toby from the RCGP, has

ensured that the interests of general practice have remained high on the agenda of medical training.

We now face a new era with Modernising Medical Careers and a new unified regulator, the PMETB. What is certain, however, is that the history of achievement by the JCPTGP gives these new initiatives the very best chance of success in enhancing the training of young doctors. If they fail, they will have been profligate with the proud tradition of excellence and endeavour they have inherited from a JCPTGP that represented the very best features of cooperative working and mutual respect among doctors and lay members who worked tirelessly towards public protection and best training.

Brian Keighley

REFERENCE

1. General Medical Council. *Good Medical Practice.* http://www.gmc-uk.org/guidance/library/GMP.pdf (accessed 8 Nov 2005).

Flora medica
Richard Lehman

From the journals, October–November 2005

***New Eng J Med* Vol 353**

1555 We now know that immunity to whooping cough, whether from infection or vaccination, is not life-long, and that pertussis can cause chronic cough at all ages. A new acellular vaccine looks promising as a booster for adults.

1659 Trastuzumab (Herceptin®) really is a breakthrough in the treatment of the most aggressive form of breast cancer, the type expressing epidermal growth factor receptor 2 (HER2), which allows rapid growth and metastasis. It's nothing to do with ER, which is the oestrogen receptor. If you use the monoclonal antibody trastuzumab to bung up the HER2 receptors, you change the entire potential of the cancer. Three trials used it alongside chemotherapy in localised disease, with impressive results.

1784 But is the fall in breast cancer mortality over recent years due to better treatment or to mammographic screening? It's an area of fierce debate (see the book review in *Lancet* page 1519), and this study uses seven different mathematical models, assessing the contribution from screening at between 28 and 65%.

1810 Brain drain figures for doctors — the main exit is from India, and the NHS depends on overseas workers for 28% of its medical workforce.

1889 If the exercise ECG report reads 'unable to complete Bruce protocol due to breathlessness', the patient has a worse outlook than if it reads 'positive for ischaemia'.

1945 A useful review of bacterial infections in intravenous drug users.

***Lancet* Vol 353**

1359 All case-control studies of nonsteroidal anti-inflammatory drugs show a doubled (or worse) risk of cardiovascular events, but at least they probably reduce the risk of oral cancer.

1379 An Italian study confirming that provided your hepatitis B vaccine has made you immune, you don't need a booster.

1443 One vaccine that never guarantees protection is BCG, but a study of Turkish children in households where a parent had TB does show that it lowers the risk of infection by about 40%.

1471 A good single author review of self-harm, recommending close patient support, as well as the more general measures which feature in a meta-analysis in *JAMA* page 2064.

1538 There was a big drop in trauma deaths in the UK from 1989 and 1994, but not much progress since. For head injuries, the answer may lie in more use of neurosurgery centres.

1545 Looking at the figures of this big meta-analysis of β-blockade in hypertension, I'm struck by what good drugs they are, provided you avoid atenolol. The authors damn them all.

1607 If you find clopidogrel hard to get your tongue round, think of the thousands of Chinese doctors who took part in this trial, which proves that it should be given in addition to aspirin for all patients with acute myocardial infarction.

1640 Yet another global study showing that body mass index is less predictive of cardiovascular risk than waist measurement: waist-to-hip ratio is even better.

***JAMA* Vol 294**

1765 Most women with breast cancer die of something else, especially if they are poor and black and live in the US.

1903 The only lasting cure for obesity in most people is bariatric surgery, but at 4.6%, the 1-year mortality in real life is much higher than in the trials.

1934 Are there any safe drugs to suppress psychotic behaviour in people with advanced dementia? All the newer 'atypical' drugs have risks, with an overall odds ratio for death of 1.54%.

2188 Think of any children in your practice who have neurological problems, and vaccinate them against influenza. These are at greatest risk of death if they get severe illness.

Other Journals

A multinational cohort study of blood pressure in *Arch Intern Med* (**165:** 2142) confirms what Framingham has already been telling us — it's not the systolic or the diastolic but the difference between them that most determines outcome. Beware a pulse pressure higher than 60. If you want a thoughtful summary of the Polypill debate, go to *Ann Intern Med* (**143:** 593). The next issue contains several papers about a common contributor to mortality in the elderly — anaemia (see pages 2214, 2222 and 2237). There's a cheap, natural substance that decreases the risk of cancer death by a third, according to a meta-analysis bearing the seal of no less than Gordon Guyatt. It's melatonin, as you'll already know if you subscribe to the *J Pineal Research* (**39:** 360).

Plant of the Month: *Helleborus niger*

The Christmas Rose won't grow for a Scrooge like me, but maybe you are able enjoy its beautiful white flowers. Bah!