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THE HISTORY OF THE TEACHING
OF THE SPECIALITY OF GENERAL PRACTICE
IN NORTHERN IRELAND[1]

Or

THE UGLY DUCKLING—AND WHAT BECAME OF IT!

The weight of history is upon me, both physically and metaphysically. I am both very grateful and extremely humble on receipt of this magnificent chain of office, and of the responsibilities it implies. I shall make every effort to maintain the high standards set by all my predecessors.

In that regard I would particularly want to congratulate Bob Stout on a very successful year. I have a second title to my paper and it is this: 'The Ugly Duckling—and What Became of It!'

MEDICAL INDEX?

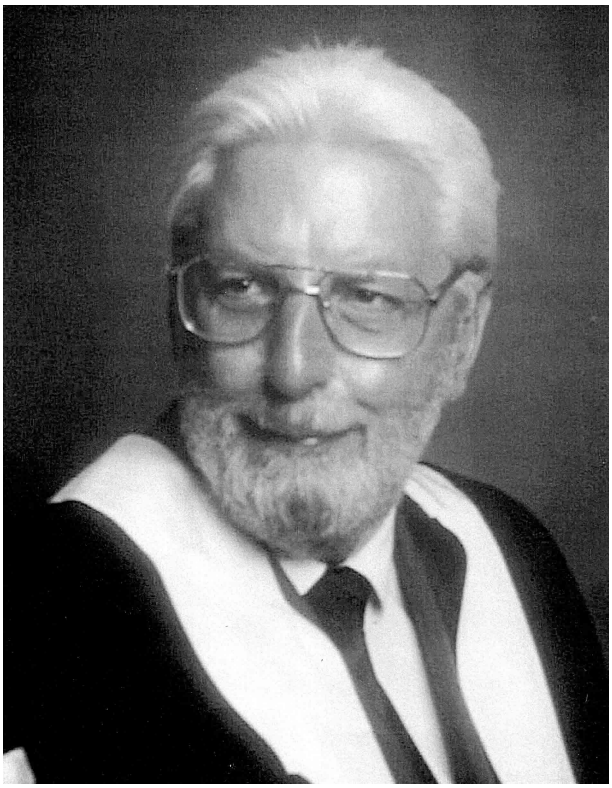
Dissection is the art of cutting up to display structure and relation to internal parts. As we come to dismember this body it will soon be only too obvious that it is a grossly obese subject. In the PowerPoint presentation we worked our way through ten cross-sections. But, in this published version I have had to use even more liposuction; and I can only proffer one big 'Excuse Me' for flying past or omitting your own favourite piece of the action in this published version.

Analysis of the Title

History

History may be regarded as being simply a record or account of past events, much as the scientist may report on what is going on in his test-tube. But, when one is actually inside that experiment, within the bubbling reaction all around, rather than at arm's length, then the chronicler and the chronicle are going to keep changing—ever changing—as time passes. I turn to T.S. Eliot's Four Quartets—The Dry Salvages.

[1] *Ulster Medical Journal*, 2001, v70(1), p5.



When the train starts, and the passengers are settled
To fruit, periodicals and business letters
(And those who saw them off have left the station)
Their faces relax from grief into relief
To the sleepy rhythm of a hundred hours.

Fair forward travellers! Not escaping from the past
Into different lives, or into any future.
You are not the same people who left that station
Or who will arrive at any terminus
While the narrowing lines slide together behind you.

Certainly, I have changed into a very different person to the one who started down his medical journey in 1943; and I am being changed again by this experience. But so are we all! History personified!

Teaching

A quarter of a century ago Professor D.A.D. Montgomery in his Presidential Address to us said "Do not let us be fooled by the technologist; the true Art of Medicine is our most prized possession". We are all agreed; but how do we teach it? The Annual Will Pick-

les Lecture is given to The Royal College of General Practitioners. In his fine 1971 lecture entitled 'The Art So Long to Learn", our own John McKnight, chose Saint Patrick's famous symbol of the Holy Trinity and gave it a secular form. He demonstrated how Continuing Education, Postgraduate Education, and Undergraduate Education were as closely linked as the leaflets of a shamrock.

What is a speciality?

In the beginning every doctor was a generalist. The words 'specialist' and 'specialism' were not used in their modern sense until 1856, but the explosion of knowledge from chloroform to vaccines made this process inevitable. It seems *de rigueur* to speak of William Osler, during each and every Presidential Address of the UMS, so I have put him in early on, because a report on a singular medical man may explain the issue more easily than general observation.

Professor William Osler, that doyen of physicians, was a Canadian who, at the age of only 25, was already the professor in charge of the medical institutes in his Alma Mater, Magill University, Montreal. He spent 20 years working in the USA—from 1884 to 1889 in Philadelphia, and then from 1889 to 1904 in Johns Hopkins in Baltimore. He only took up the Regius Chair of Medicine at Oxford in his 54th year. He was a true generalist, as a study of his publications reveals.

His articles covered such varying topics as Blood Platelets—which he was the first to describe—(Research Scientist and Haematologist); Cerebral Palsies in Children, and Chorea and Choreiform Affections (Paediatrician and Neurologist); Abdominal Tumours (Gastro-enterologist and Oncologist); Angina Pectoris (Cardiologist); and Aequanimitas (Philosopher). He was a fine example of the generalist specialist. Nowadays we all accept the concept of knowing more and more about less and less.

What is General Practice?

Although most patients seemed to have a fairly clear image of the service provided for them, the doctors in this group have had some difficulty in choosing a suitable label or marker to cover the essential qualities which distinguished them from their hospital-based colleagues. 'General Practice' and 'General Practitioner' seem to have been in common usage, while many Americans favoured 'Family Physician'. The term 'Primary Care Team' was a much later invention.

John Horder also wrote elegantly about the family doctor.

"*The personal doctor can offer care which is accessible, of broad range, relatively continuous, and above all, integrative. No one of these characteristics is easily provided by a specialist; in combination they can only be provided by a generalist. This forms a distinctive role which people value as a basis to which specialist care can be added when necessary. In this way specialists and generalists can relate to each other, not as two people doing the same job, one better than the other, but as two people doing complementary jobs of equal status within the profession and society more widely*'".

Foundations

In the early part of the nineteenth century most doctors were trained in apprenticeships, and their work in Ulster, especially amongst the poor, was governed by the Dispensary System. There were four supporting legs in this education process: the Learned Societies, the Royal Colleges, and the Universities, (often with an overlapping personnel) accepted the planning and burden of undergraduate and postgraduate medical education—both in the whole country and locally too in our Province. The fourth important leg was supplied by the Parliament and Government at Westminster.

Evolution

At the very start of my time in General Practice in February 1950 standards were at a very low ebb. An Australian visitor, Dr. J. S. Collings, wrote a definitive study that year and his report was scathing. It hit home. He particularly criticised the two-room surgery premises, "*so often ill furnished, and underequipped*".

He found these all over the kingdom. "*There did not seem to be any place for adequate record keeping, nor for any ancillary staff.*" His portrait was terribly bleak, but an accurate contemporary record, and it had a profound effect on a whole generation of doctors.

He continued, "*General Practice is unique in other ways too. For example, it is being accepted as being something specific, without anyone knowing what it really is. Neither the teacher responsible for teaching future general practitioners, nor the specialist who supposedly works in continuous association with the GP, nor for that matter the GP himself, can give an adequate definition of general practice.*" "*My observations have led me to a condemnation of general practice in its present form; but they have also led me to recognise the importance of general practice, and the dangers of continuing to pretend that it is something which it is not*".

This was a time of deep unrest in the profession. A contemporary writer described it like this: "*The position in which some doctors find themselves is more akin to slavery than to service*". The Government had been very slow to respond to the Pilkington Report which had recommended £11,000,000 extra for general practitioners and £8,000,000 for hospital staff. But it wasn't until 1962 that the Review Body which the Commission had recommended in 1960 was appointed, and their deliberations took a further year before the profession was offered a 14% increase in pay. But problems were not just related to money. Whatever the reasons some 25% of British graduates were emigrating. Junior hospital staff was in very short supply, and many posts were being filled by graduates from abroad, most noticeably from India and Pakistan. Lord Taylor had been particularly critical when he opened the debate in the House of Lords in December 1961. Unhappy comments featured weekly in the medical press under the very descriptive title he had used "This ghastly awful mess."

"*This sense of lessened status and decline in prestige has been too general for too long, to be dismissed as of little account, or as the complaints of disgruntled minority.*"

Unlike their hospital-based colleagues the general practitioners became very confrontational against the Government mainly through the leadership of the Local Medical Committees, and the General Medical Services Committee of the British Medical Association. In 1965 this almost led to a mass resignation from the NHS. Curwen wrote brilliantly as he illustrated the dichotomies. "*On the 17 January 1958, Lord Moran of Manton, who was at that time the Chairman of the Awards Committee administering awards for consultants in the National Health Service, was giving evidence before the Royal Commission on Doctors' and Dentists' Remuneration*". "*He was defending the principle of Merit Awards against a certain amount of criticism by members of the Commission, and he made the point that those selected for the awards were chosen from a group of doctors, the consultants, who had already distinguished themselves from the rest of the profession by achieving that status*". *He described the process by which they did so, and mentioned 'a ladder which people are constantly falling off'. The Chairman asked him the following question—*"*It has been put to us by a good many people that the two branches of the profession, general practice and consultancy, are not senior or junior to each other, but level. Do you agree with that?*" *To this he replied as follows* "*I say emphatically 'No'. Could anything be more absurd? I was Dean of St. Mary's Medical School for 25 years..., and all the people with outstanding merit, with few exceptions, aimed to get on the Staff. There was no other aim, and it was a ladder off which some of them fell. How can you say that the people who get to the top of the ladder are the same as the people who fell off it? It seems to me so ludicrous!*" *In reply to further questions the noble lord made evident his distaste at having to discuss such contentious matters in public, but he stuck to his guns, and maintained that 'his ladder' was real enough, although that this did not imply that general practitioners did not include amongst their number men of ability doing splendid work in their own fields*"

There was one new line-up of doctors, from 1952 onwards, which had a profound effect for the better in the education and training of general practitioners. This was the College of General Practitioners founded by a Steering Committee on 19 November 1952. Its progress was rapid, and in 1967 the royal charter was conferred by Her Majesty the Queen, allowing the name to change to the Royal College of General Practitioners. Like its precursor of over 100 years earlier this organisation too met with a great deal of initial opposition. But on this occasion the planners overcame internal dissentience, external resistance, and most of all the natural opposition of the multitude of independent minds of the many potential members. It can be no surprise that even today the policies of the Royal College of General Practitioners are not universally popular. One of its strengths was the early decentralisation of the organisation, with many regional faculties throughout the United Kingdom and Ireland. The Northern Ireland Faculty was founded on 30th April 1953, in the Whitla Institute, Belfast, under the chairmanship of Dr. J. Campbell Young. Dr. Young had been a member of the original steering committee and a founder member of the College.

The College moved very quickly on the educational issues. Curwen' s prophetic words in 1964 spell out this progress, although the precepts must have seemed outlandish to many people at that time. He wrote about general practitioner training in these words:

"*His apprenticeship must be as long and as demanding as the present-day consultant, and at the end of it he must pass an examination as least as difficult as that now required for entry into a 'minor' speciality.*"

Beginnings

As early as 1931 there are records of organised postgraduate education courses for general practitioners

in Northern Ireland. Originally this series was offered by the consultant staff of the Royal Victoria Hospital, Belfast. The proposal for such a course came from Professor Andrew Fullerton, the Professor of Surgery at Queen's University, and the Chairman of the Medical Staff at the Royal Victoria Hospital Belfast. Dr. Sydney Allison had been appointed to the visiting staff the previous year, and he was put in charge of the arrangements. In 1970 Dr. Allison was to write of his experiences to Dr. John McKnight.

"*Although a novelty in Belfast, and in many other centres in 1931, the only established postgraduate teaching centre in the United Kingdom was at the West London Hospital, Hammersmith, where a school had been in existence for many years, with a library, reading rooms, lecture theatre, and other amenities for the twenty to thirty doctors usually in attendance, and most of them drawn from the army, navy, and colonial medical service*".

I just love the style of writing from a by-gone age. The proposal for such a course was not universally popular. Allison went on to say "*However, it is interesting to recall that there were one or two dissentients who believed that the dissemination of professionalised knowledge and techniques could harm the position of the specialists, in giving implicit encouragement to practitioners to undertake work themselves which was primarily the province of the specialist. These criticisms were voiced, but not taken seriously, most of the staff recognising that nothing but good could come from the new move*". What Dr. Allison reported was that one ENT surgeon had exclaimed "*If we teach the general practitioners too much, they will take out tonsils and adenoids, and we will soon all be in the Work House*!"

This first course was attended by practitioners from as far away as Bushmills and Cookstown and Keady, as well as those from nearer at hand. It was held each Wednesday afternoon at 4 p.m. from January until June, and again in October and November of that year. 27 different members of the hospital staff gave one talk each. The fee of 2 guineas was payable in advance. 29 doctors attended the first session, including two women doctors. It is recorded that this course was given a very enthusiastic reception, and that practitioners were invited to enrol again for the following year.

By 1938 these courses were on a much more formal basis. Government officials from the Ministry of Labour were pressing the Faculty of Medicine and the staff of the Royal Victoria Hospital to provide two courses annually. There was an obvious hiatus through the Second World War 1939–1945 when many of the hospital staff and general practitioners had volunteered to serve in the RAMC. As soon as the war ended the entire energies of the medical profession were dedicated to the creation of the National Health Service on 1. July 1948.

Turbulent Times

The National Health Service was ten years old when Lord Moran talked about his ladder After this decade of NHS operation the medical profession had appointed its own Medical Services Review Committee; and this became known as the Porritt Committee—and it eventually reported in 1962. Paragraph 211 of this report is significant: "*The Royal Colleges and the Universities have an important role to play in postgraduate preparation, but the Government has an equally important part, as virtually the monopoly employer of doctors. We recommend that the Royal Colleges and the Universities, and the Ministry of Health should combine to organise postgraduate training throughout country*".

As befits such an ancient and august institution, the Faculty of Medicine of the Queen's University of Belfast counts its meetings by numbers as well as by dates. At its 420th meeting on 20 November 1962, the Faculty responded to a request from Dr. Frank Main, then Chief Medical Officer of the Ministry of Health and Social Services in Northern Ireland. It was his wish to consider the immediate problem of continuing education for general practitioners. Over the next two years the Civil Servants at Stormont pressed for an organised continual education programme for GPs. Professor John Henry Biggart, the Dean of the Faculty of Medicine at Queen's, saw a different end-point, for he wished to include the needs of the specialist registrars as well.

By the 425th meeting of Faculty on 25 June 1963 Professor Biggart was able to report that the Ministry had found adequate funds to allow the appointment by the University of clinical tutors, at an honorarium not exceeding £150 per annum each, and also of paying clinical lecturers at a rate of four guineas per half-day session.

There was now a commitment by the Ministry of Health to provide a sum of £55,000 (£11,000 for five years) for the development of postgraduate medical education in Northern Ireland. This was money which could or should have been distributed to all the GPs in Northern Ireland, as the Pool Balancing Cheque. But the GMSC(NI), under the astute chairmanship of Dr. Dan Chapman, agreed to use it instead as a fund for continuing education.

The End of the Beginning

The staff at the Ministry of Health and Local Government had prepared a draft paper on 'Training for General Medical Practice'. There was much deliberation on schemes already operating in Inverness and Wessex. An important decision was taken in principle, when it was agreed, "*That there should be a compulsory period of training prior to entry to general practice, and the Board's list*".

The Civil Servants were quite clear of the implications. There would have to be extra funding found by the Exchequer, and this would require further inter-departmental discussion. But it is quite remarkable that this Government statement was written in November 1963, and that it took nearly 17 years to implement!

By 1964 Continuing Education was well established. Vocational Training was accepted as inevitable and Undergraduate Education was already at the embryonic stage. The die was cast. Professor Biggart was able to report that a Board of Postgraduate Education had now been accepted by the Academic Council and Senate of Queen's. It was agreed that the Board would have both planning and advisory functions, and that it would cover the needs of other medical specialities, as well as general practice. On 21 April 1964 its membership was reported.

The Postgraduate Medical Education Board

The first meeting of the Postgraduate Medical Education Board was on 1 June 1964. A decision had been made to appoint a Postgraduate Dean. It has been suggested that John Henry Biggart was reluctant to share his own title of Dean with anyone else, even though this was the accepted mode of address in Britain. He favoured the more dictatorial 'Director'. But there continued to be great uncertainty as to the exact type of person who would fill this new post. Professor Biggart again stressed 'the importance of finding someone with fire in his belly'.

It was after another longish period until the Dean reported to Faculty at its 441st meeting on 29 June 1965 "*that Dr. John E. McKnight was to be appointed the Director of the Postgraduate Medical School, and would take up duties at the beginning of October*".

So with the Director in post at last, things started to move again; and Dr. John McKnight's task must have been daunting. Expansion and development were the watchwords from 1965 to 1970. Demands seemed to crowd in from all sides.

For the general practitioners he was to double the continuing education courses for established practitioners, which had to be Province wide, and not just limited to Belfast. At the same time he had to start up a 'Training for General Medical Practice Scheme' for a new breed of trainees and trainers. Again, all the other specialities were demanding his best effort on their behalf. Yet again, this was a period when great efforts were being made to attract married women doctors back into practice; and Dr. McKnight had to cater for their special needs too.

The Training for General Medical Practice Scheme

The staff in the Ministry of Health and Social Services at Stormont had been pressed further by the thinkers in the College of General Practitioners to produce a scheme for postgraduate training during the early sixties. Long before the Todd Report on Medical Education had been published in 1968, these problems had been tackled in very many different ways in various places in England, Wales, and Scotland.

In August 1959 the first trainee of the Wessex Scheme was in post. It was based in the hospitals in Southampton, Portsmouth and Winchester. In 1962 combined hospital and GP schemes were opened in Canterbury and Durham. I was the first Trainer in that scheme in Durham. By 1964 there were further similar developments in Lancaster and Birmingham.

One of John McKnight's early tasks was to organise such a training scheme in Northern Ireland, and his Board appears to have modelled its plans on the one in Wessex. He acted as quickly as he could. At the 445th meeting of Faculty on 25 January 1966 the Dean reported the appointment of 12 trainers under the General Medical Practice Trainers Scheme. They had been carefully chosen from some 80 applicants. The initial criteria for appointment look very simplistic by today's sophisticated standards. Even this task had been far from easy, and there were several disgruntled practitioners who were very aggrieved at non-selection, and did not hesitate to say so.

As it turned out, this unhappiness was misplaced, because there was a complete absence of trainees. At the outset there had been two doctors accepted; but both withdrew; one was given 'an Assistantship with a view to partnership' and the other decided to stay in hospital medicine. The first trainee started the course in August 1966. He was Dr. Myles Shortall, who had graduated from Queens in 1964, and who is now the senior partner in a group practice in Newry, Co. Down. The first trainer was the late Dr. G.W.C. ('Garry') McCartney of Lisburn. Dr. Shortall was the only trainee to complete the course in 1968, and there was not a single completion in 1969. There was a simple explanation for the acute shortage of applicants. A memorandum from the Ministry of Health

and Social Services explained the problem in this way: "*Clearly, however, the main weakness of the present scheme is its lack of financial incentives in a period of acute shortage of doctors*".

As well as offering the possibility of financial incentives, this Memorandum reaffirmed their previous decision, and recommended that consideration be given to making the vocational scheme compulsory instead of it being voluntary.

A second group of twelve practitioners was selected for trainer posts in June 1969. It is clear that there had been an upgrading of standards when one studies the new criteria, which show clear evidence of the influence of the Royal College of General Practitioners, and its Education Committee, on which John McKnight had been serving with such distinction. Even so, it is worth pointing out that those originally chosen were all interviewed again, and all were re-selected. These extended duties had to be delegated to a special General Practice Sub-Committee whose membership was first minuted by the Board on 4 February 1969. Four more 'teaching practices with a designated 'teacher-in-charge' were appointed by this new committee in May 1970.

On 29 April 1968 the sub-committee met and selected six of the applicants as trainees; and in April 1969 they appointed 18 more trainees, some of whom are now very well known in Ulster's medical services. These were boosted by six more in November 1969. The Vocational Training Scheme had become accepted at last. Between 1 February 1966 and 1 February 1970, 43 doctors were accepted on the Scheme. Of these, 3 had completed their training, 5 did not enter the scheme, 9 withdrew for various reasons between 4 weeks and 18 months; and 26 were still in training, when this data was presented to a meeting of The Board of Postgraduate Medical Education on 5 May 1970.

The Postgraduate Medical Education Board of Queen's University had fulfilled its purpose, and it was time to think afresh. Some of the recommendations of the Todd Report were to be implemented, after modification. Plans were put forward by Dr. F.D. Beddard, the new Chief Medical Officer at the Ministry of Health at Stormont, to create a new Council in Ulster. On 4 December 1970 the Northern Ireland Council for Postgraduate Medical Education was born. The following important piece of the puzzle will have to be told on another occasion.

Undergraduate GP Teaching

It was within the heady atmosphere of university expansion during the Sixties that the Department of General Practice was born. At the end of 1968 Queen's University accepted a recommendation that a Chair of General Practice be created. This was made possible by the remarkably generous decision of the general practitioners of Northern Ireland to recommend that the Practice Improvement Fund be diverted from their own pockets to this worthy purpose. This was a remarkable gift of £59,653. A decision was taken to advertise this Chair late in 1969. Dr. William George Irwin was appointed on I St October 1971. He was a Principal in the National Health Service structure in south Belfast, and became the Head of an autonomous Department in the Faculty of Medicine. The department was to be based in a newly built teaching health centre on the corner of Dunluce Avenue and Lisburn Road. Four other British Universities had already entered this new field of medical education.

It took a full nine years of effort before the Dunluce Teaching Health Centre was opened close to the Belfast City Hospital. On the ground floor there was a pharmacy and a family planning unit. The second and third floors were home to four different partnerships and one single-handed general practitioner; giving a total of over 24,000 patients catered for in twelve consulting suites. Each consulting room had a one-way mirror, so that real consultations could be observed from the viewing room next door by medical students, some two or three at a time. Informed Consent had to be obtained before any such viewing took place. In addition each consulting room was equipped with a video-camera so that everything which took place could be recorded for use in small-group discussion afterwards. In addition each consulting room was linked to the seminar rooms on the fourth floor, allowing consultations to be discussed with larger groups. The top, fourth floor, housed the University Department with a library, teaching space, and offices for clinical academic staff, non-clinical academics, research fellows, and secretarial staff.

There were two possible alternative organisational arrangements, well described in the MacKenzie report. Although on the face of it the Practice Based Department might have theoretical advantages in providing a solid research base, time showed some serious disadvantages. The full-time University lecturers were swamped by the ever-increasing demands of patient care, and academic productivity was low. Professor Irwin chose the Practice Linked Model, and was the very first in the UK to do so. With hindsight it can be seen that this was the correct decision because academic productivity in both teaching and research were of a much higher standard.

Robert Wallace Harland

Every academic has a trilogy of duties—Teaching, and Research and Administration. Sadly, only the first of these duties can be discussed in this paper. The needs of academic general practice were spelled out by George Irwin in his Inaugural Lecture. In this he pointed out that there is a considerable difference between, on the one hand, Disease with all its pathology, and on the other Illness with all "its behavioural aspects and social consequences". Professor Irwin saw academic general practice as largely an applied clinical discipline of primary care, with health promotion and preventive medicine as part of the mix. From its earliest days the department had to develop, by process, a core content of knowledge, skills, and attitudes.

Teaching and Assessment

It was clear that small-group teaching should be used whenever possible, and this meant the recruitment of many new general practitioner teachers from a variety of practices. These were loosely divided into 12 core practices, and around 100 'outer ring teachers'. Teaching took place in the seminar rooms in the department, in the consulting rooms, and during home visits. Each student entering the Department in the clinical years was given a Handbook which listed the learning objectives of general practice, and the methods of assessment in class examinations and the Final MB Examination.

Long before Dunluce Health Centre was ready for occupation Professor Irwin had to formulate a philosophy of education, defining learning objectives and methods of assessment. These objectives cannot be fully achieved in the teaching hospital where specialisms have fragmented care and where illness\disease is usually seen at quite a late stage. As a result less weight is given to social and psychological factors. From the early 1970s the Department made a substantial weekly contribution to small group teaching in the PreClinical Behavioural Science Course; but the main impact of the teaching was in the clinical phase of the curriculum.

Just at the time of Professor Irwin's appointment in 1971 the Medical Faculty had completely remodelled its teaching into an integrated teaching course. At first the departments of General Practice, Geriatrics, and Mental Health joined together, and were later joined by Community Medicine. This avoided the problems of vain repetition while combining the very different skills of the specialists involved. The topics included communication, terminal care, bereavement, alcohol problems, maternal and child care, the confused elderly patient, disability, human sexuality, coronary care and screening. The department's teaching skills have been developed over the years, and members of staff are involved in all 5 years of the undergraduate course. One interesting innovation is the introduction of first year students to individual families so that they may learn how families and individuals perceive, understand, and manage their own health.

Teaching Communication Skills

With the advent of the new Teaching Health Centre came the dawning of a whole new teaching programme exploiting the relatively new science of Closed Circuit Television (CCTV). The rising generations have come to accept the intrusion of a television camera recording every clue—verbal and non-verbal—of the consultation. Indeed the practice has become so well established that the normal way of assessment of the consulting skills module of the MRCGP examination is the submission of 15 video recordings of a variety of different types of consultation by the candidate. The students at Queen's acquired first hand knowledge of the illnesses seen in primary care and of the diagnostic and management skills needed by GPs to differentiate trivial illnesses from more serious pathology either physical or mental or both.

Involvement in Undergraduate Examinations

Having created new aims and new general practice courses for undergraduates in their penultimate and final years Professor Irwin and his team turned their attention to assessment of learning. Communication skills were evaluated by direct observation of a student consulting with a real patient in the surgery using the one-way mirror, and scoring for each attribute. Each student was given 20 minutes to take a history and perform a relevant physical examination. This method became so successful and widely acclaimed in the Faculty of Medicine that it became part of the integrated Final MB Examination in 1981. Some 16 students were randomly allocated on the day of the clinical examination to Dunluce Health Centre. There they did their major cases in General Practice, interviewing, examining and diagnosing patients with a mixture of physical and emotional disorders, and watched for 20 minutes by the examiners, who then interviewed each candidate about the diagnosis and management of their case. One External Examiner, a London Professor of Surgery, was so impressed by this system that he arranged for an ITV crew to come over from London and record similar proceedings; this was shown on National Television. It is clear that

the allocation of major cases in the Final MB Examination was a real achievement for the Department of General Practice.

In 1973 the final MB examination had been integrated (always with the exception of midwifery and gynaecology). The clinical and oral examination remained, although the examiners came from much more diverse areas, but it was in the written papers that much bigger changes occurred. Instead of separate essay papers in Medicine and Surgery the new examination had a Multiple Choice Question Paper (MCQ), an Essay Paper, and a Modified Essay Question Paper (MEQ). The Department of General Practice was chosen to assess the written work of students using the Modified Essay Question (MEQ) which had been developed by the Royal College of General Practitioners for its own entrance examination. It is reliable and valid examination tool. Each short paragraph of narrative is followed by a couple of questions, and the picture of a family or families in crisis gradually builds up. The MEQ aims to evaluate three areas of cognitive ability—recall and recognition of specific information; interpretation of data; and problem solving. It was natural that this paper should be set, invigilated, and marked by the Department of General Practice. Within a very short period of time the setting and marking of the MEQ was formalised. Some fourteen doctors would gather around a table, and each examiner would mark the same section over and over until all 150 papers had been circulated. Ideal answers were provided. This guaranteed fairness and objectivity, with an annual pass rate of between 92—95%. The whole process was reviewed with care.

MILESTONES
Steps along the way for
Postgraduate Education

We have to bypass the important story of the QUANGOs of the General Medical Council and the Northern Ireland Postgraduate Medical and Dental Education Council. But much of this part of the history of the teaching of General Practice in Northern Ireland has already been written and spoken about in the Presidential Address to the UMS by Dr. A.G. ("Lexie") McKnight 1988, and by Dr. Ben Moran.

So the dream was realised after some 30 years of toil. All trainees, now known as General Practice Registrars, have to face a three year training programme and an entry examination into the speciality. This is called the Summative Assessment, and may only be entered after completion of training. Since 1997 this goal has been made compulsory. Without reaching this minimum standard one cannot become a Principal in General Practice. The Membership examination of the Royal College of General Practitioners has different goals, but in Northern Ireland all the GP Registrars are encouraged to sit both examinations.

Much of the training is given individually and can be said to resemble the old apprenticeship system. But added to this is an intensive planned scheme provided by the Course Organiser. The very fact that a book of over three hundred pages has been written on this single topic of organised teaching for GP Registrars underlines just how highly developed the single task has become. That there is already a second edition after only five years confirms the ever-changing scene. That the author, although writing for a national and international readership, is an Ulsterman is also highly significant. Patrick McEvoy is a highly respected GP in the City of Londonderry.

The Art so Long to Learn was where we started. The Ugly Duckling has become a very fine swan indeed. But is it paddling in the right direction? For example, we all know that the modem medical students are very high-powered in the intelligence field and very well taught; but some fear that they are underpowered in the empathy stakes. Don't let this happen! Please! Let us answer that question—from now on—by focusing on the Patient!