Postgraduate Medical Education

RETROSPECT AND PROSPECT

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PREFACE

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Chairman of the Governing Trustees

Since the conference on postgraduate medical education held in Christ Church, Oxford, in 1961, the Trust has continued to make grants to assist further developments in this field. The trustees have been made increasingly aware, in the last few years particularly, by requests made to them, that money from the private sector can be most valuably employed in assisting postgraduate education in the medical field. But where and how most helpfully? At this juncture, and in the knowledge that other bodies were also examining the question, the trustees felt that they needed, for their own enlightenment, an independent study of the existing situation, with special reference to the inter-relationships and co-ordination of the many educational and service bodies concerned. Accordingly they invited Dr. John Revans, the Senior Administrative Medical Officer of the Wessex Regional Hospital Board, to review the matter and he was joined in this work by Mr. Gordon McLachlan, the Secretary of the Trust. This is their report.

The trustees have already made use of an interim version in making, *inter alia*, a grant to help establish the new central body for postgraduate medical education which has been instituted in unison by the Universities and the Royal Colleges. They believe that publication of the final Revans–McLachlan report will be of interest to the many others concerned in this field. At the same time, it gives the Trust itself the pleasant opportunity to thank both the authors themselves and those who have helped them so generously in their deliberations.

October 1967

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I · RETROSPECT

General Retrospect 1961–1967

1. The period spanned by the Trust's initial foray into the field of postgraduate medical education, the Christ Church Conference in 1961,[1] and the trustees' most recent policy decision in May 1967 which resulted in their making a substantial grant to help found the Central Committee,[2] has been specially marked by the rapid development throughout the country of a large variety of medical centres and postgraduate medical activities. These have depended mainly on local initiative, the soundest base for the improvement of continuing education. Yet the effective organization of postgraduate education generally, including specialist training, is far more than a local problem, for so many quite separate and disparate service and educational bodies are involved. The lack of a national policy designed to facilitate the co-ordination of activities of the many bodies concerned has meant there is no rational—or national—structure for postgraduate medical education in the United Kingdom. Consequently in an area of supreme importance to the development of effective services, there is an impression of confusion and frustration which is detrimental to both morale and efficiency.

2. There is also some general confusion about the several parts of the complex problem. It is not too parochial to maintain now that the fundamental questions for which answers must urgently be sought are those which have a special bearing on the medical care services in the United Kingdom. This is not to depreciate the importance of developing special arrangements for the postgraduate medical education of foreign doctors seeking educational opportunities and experience in Britain; but no one is likely to dispute that a strong framework for the specialist training and continuing education of British doctors is the prime necessity.

The Platt Report 1961

3. There have been several forces over the past few years which have shaped the present thinking about what is necessary. In 1961 the Report of the Interdepartmental Committee on the Staffing of Hospitals (the Platt Report)[3] had referred specially to the basis of the Spens

Committee's proposals in 1948[4] and the deviation in practice from this basis. The Spens Committee envisaged all the non-consultant posts in the hospital service as training grades which were related to the length of time the practitioner had been registered. The basic training grades were: (1) Junior; (2) Middle-grade; and (3) Top grade. The junior training post was envisaged as being normally obtained in less than one year after registration, and normally held for one year only; the middle-grade was to be obtained not less than two years after registration and held for two years; and the top-grade not less than four years after registration and held for three years. In practice the structure for the hospital service which was finally agreed and applied from 1948, set up 'house officer' including 'senior house officer' posts for the junior grade; 'registrar' posts for the middle-grade range, and 'senior registrar' posts for the top-grade training range. Only the registrar and senior registrar grades were regarded as training posts, and registrar posts were no longer treated as such in all cases from 1951. They increased greatly in number after that date while those of house officers and senior registrars decreased.

4. The recommendations of the Platt Committee did in effect include a recognition of the need to provide postgraduate training in *all* junior posts below consultants and senior registrars. They also provided for a new service grade to obviate the use of registrars solely to fill a service need. Presumably, because it was not within their terms of reference, the Committee did not review the adequacy of the relationships between the service and teaching authorities. Yet the particularly important recommendation regarding junior staff under training which in effect embodies a charter for vocational training, affects service responsibilities involving a major departure from existing practice. There must therefore be complete agreement now on the part of the service and educational bodies to give practical recognition to the immediate post-registration arrangements as the key phase of a doctor's postgraduate training.

The Christ Church Conference 1961

5. Those at the 1961 Christ Church Conference, which included representatives from all the main educational and health service bodies, all

concurred about what needed to be done, but did not discuss a programme in detail, apart from the first immediate steps. There was general agreement about certain hypotheses and principles for action[5]. It was known that at the time certain Regional Board hospitals had already begun to develop educational facilities. Others were in a position to start, once they had fully appreciated the need and were given sufficient incentive to do so. It was felt that hospitals should be encouraged to consider themselves as the principal base for the arrangements for the continuing education of hospital medical staff *and* the general practitioners in the area. The published report discussed financial responsibilities in a general way as between Regional Hospital Boards and Universities. While primarily it called for the stimulation of local initiative, it stressed the need for some central formulation of principles and policy but without specifying how this could be achieved.

The postgraduate medical education policy of the Nuffield Provincial Hospitals Trust 1962

6. The subsequent policy action of the Trust[6] was intended to be influential and catalytic at the local level, in that the grants offered gave the necessary incentive for hospital authorities to develop medical centres and educational programmes in conjunction with their regional universities. There was, of course, no compulsion for anybody to take any action at all. This was in accord with the permissive philosophy of the natural evolution of institutions which has been elevated to a virtue in the medical field. To judge from the response in terms of medical centres and programmes, the Conference's belief that a 'modest investment of support would yield a handsome dividend' has been amply fulfilled; none the less, there are still ominous gaps and some unevenness of action in places throughout the United Kingdom, and there are marked differences in organization and in the effectiveness of the regional arrangements.

Ministry of Health Circular 1964

7. The issue of Circular HM(64)69 in September 1964 was an important landmark in the way in which for the first time it established the principle that since improved educational facilities have a bearing on

service, the cost of postgraduate and continuing medical education is a proper charge on National Health Service Exchequer funds. It also became the major source of the ever-increasing stake of the health service authorities in postgraduate medical education.

Nuffield Provincial Hospitals Trust review of postgraduate medical education schemes 1965

8. The assessment of postgraduate medical education schemes prepared for the Trust by Mr. D. H. Patey, Dr. J. O. F. Davies, and Dr. John Ellis in 1965[7] carried forward the discussion on policy by making certain speculations and suggestions about the future of continuing and postgraduate medical education arrangements. The final comments of the survey-group indicate what they felt was needed to sharpen the focus even more:

'What is now needed is a series of experiments in methods of education and operational research studies in depth of the needs of postgraduate students, e.g.:

a. A critical study of methods of postgraduate training and education;

b. Experiments in new forms of techniques for taking education from the centre to the periphery;

c. Experiments in and a study of specialised vocational training of general practitioners;

d. A job-analysis of the work of hospital medical staff, particularly in the junior grades;

e. A study of the role of doctors in the public health services;

f. An assessment of needs, region by region, to determine the logistics of the problem;

g. The accumulation of information about the cost and adequacy of existing buildings for postgraduate medical education.

In addition a number of outstanding questions touched on in this report remain still to be explored at the highest possible policy level:

1. A realistic analysis of the aims of postgraduate medical education. It was clear from the survey that the objectives of schemes

were not always the same, particularly in their direction towards different categories of doctors.

2. Some speculation about the structure of a national and regional organisation.
3. The relations between universities and regional hospital boards; what they should embrace and where costs should lie.
4. The working relationship necessary between the various bodies in the field—e.g. medical societies, postgraduate education committees, the British Medical Association, the Royal College of Surgeons, the College of General Practitioners.
5. The designation and status of clinical tutors and/or area directors and chairmen of postgraduate committees.
6. The need for some kind of retraining organisation to attract and retain medically qualified people who have been out of medicine for some years. It is said that there are many doctors capable of taking on part-time appointments, e.g. with the schools and public health services—and even within hospitals. What is not known is their number, and their needs in terms of postgraduate training.'

Yet however admirable most of these suggestions are, many are incapable of being taken up except by some central body whose purposes embrace both policy and action on postgraduate medical education.

The Ditchley Park Conference 1966

9. In the meantime increasing attention was being paid to the principles of organization which should apply to help solve the problem of specialist training. The private Ditchley Park Conference in 1966 brought together informally a number of people influential in medical educational policy. The contrast between the training arrangements which apply in the U.S.A. and those in Britain was sharply etched and again the need in this country for the formulation of a centralized policy about specialized training was stressed.

Activity by the Colleges on vocational training in the National Health Service

10. Both the Royal College of Surgeons and the Royal College of Obstetricians and Gynaecologists have long had regulations concerning their postgraduate diplomas, which involve the virtual monitoring of training posts (including their approval) for junior doctors under training for their specialties. The Royal College of Physicians codified, and in 1964 published their recommendations for training in the specialties under their aegis[8]. These envisage approval of training posts. The published intentions of the recently established College of Pathologists perhaps sum up the general objectives to which all the Colleges seem separately to be turning,[9]

'to offer a lead on the kinds of training which it thinks would be suitable for pathologists. It is equally anxious to ensure that the facilities available for training pathologists are critically assessed before being officially recognised by the College as suitable places for the training of prospective candidates for its qualifying conditions.

The intention is to proceed now on . . . (certain lines) . . . which promulgate the ideas of the College on training, and to invite heads of laboratories to apply for recognition to their laboratories.

Obviously a realistic interval will be necessary before the College makes it a requirement for entry to its examinations that the trainee should have worked for at least a minimum period in an officially recognised laboratory; but as soon as experience has been gained of the workings of the recognition scheme Council will address itself to fixing a date after which training in a recognised laboratory will be required of all candidates seeking admission to the examinations.

The date will be realistically set to allow due notice to prospective candidates now planning their period of training and to allow of the necessary upgrading of many laboratories in terms of space, equipment, and other facilities, and the necessary senior establishment. The inadequacy of many laboratories in these important respects has long been a serious hindrance to the necessary growth of scientific content of British medicine and the College is keenly aware of its duty to take such measures as are open to it to secure, as urgently as may be possible, the necessary action to deal with a situation which has been accepted for too long.'

Scottish Postgraduate Medical Association

11. In Scotland a Postgraduate Medical Association[10] was formed in 1962 to provide a national focus on the general problems. Subsequently, with the approval of the Home and Health Department and financial support from the Nuffield Provincial Hospitals Trust, a Working Party was set up to explore what executive action was needed to improve matters and to make appropriate recommendations. This Working Party reported to the constituent bodies of the Association in March 1967[11].

The Nuffield Provincial Hospitals Trust's Working Parties on vocational training 1966

12. Working Parties were also set up by the Nuffield Provincial Hospitals Trust to further the discussions of issues concerning the training of specialists of certain categories: general practitioners, pychiatrists, and medical administrators. It was evident from the exercises mounted by these Working Parties that there are two major problems facing the young medical graduate. First, he needs counselling and advice both immediately after registration and during the years when he is preparing for his specialty. Second, there is at present no certainty that the training jobs have the right facilities and provide full opportunities for learning and for further education. There is a consistent thread running through these reports[12] which points to the inadequacy of the present facilities and arrangements for these particular specialties. The conclusions all point to the urgent need to develop speedily some better framework to reconcile the *educational* with the service needs of the National Health Service and a means to focus on the major problems as they arise.

A commissioned survey of the present position

13. Following the consideration of these reports and in continuation of their policy in this field, the trustees of the Nuffield Provincial Hospitals Trust felt there was need for a survey of the current position of postgraduate medical education in the United Kingdom. They

therefore commissioned a study to explore and sketch the several responsibilities of the various statutory educational and service bodies concerned.

Various moves 1962–1966

14. Meanwhile the idea for a national body for postgraduate medical education was gaining ground. Following the Christ Church Conference in 1961, the Chief Medical Officer of the Ministry of Health had in 1962 and 1963 convened meetings consisting of representatives of all interested parties. The attendance at these meetings was very high and indicated the large number of authorities concerned with the problem.* Indeed it was obvious the meetings were too large and this may have been the reason why they did not become a regular feature. Meanwhile a smaller advisory group has met regularly to assist the Ministry in its own developments. Early in 1966 the Committee of Vice-Chancellors and Principals prompted by the Ministry of Health, also considered the role of the Universities and decided, in association with the Colleges, to establish a Central Committee to encourage the efforts of the Regional Postgraduate Committees in the development of facilities in their areas. At the same time the general dissatisfaction among young doctors about the training and further education arrangements for junior hospital medical staff was coming to a head. The possibility of the United Kingdom joining the Common Market raised the question of the registration of specialists. Above all, the appointment of the Royal Commission on Medical Education in 1965 gave a special stimulus to the general debate.

Royal College of Physicians Conference 1966

15. Yet the growing criticism of the present position brooked no delay in continuing the debate for reform at the national level and the pressures from all directions resulted in the Conference at the Royal College of Physicians in October/November 1966[13]. The discussion at this meeting ranged over most of the ground of postgraduate medical education, but was perhaps specially notable for once more demonstrating the inadequacy of present facilities and arrangements gener-

* Appendix I lists the organizations represented.

ally, and for emphasizing the need to develop a better framework for training in the National Health Service. The lack of machinery to evolve an over-all policy and strategy was specially manifest.

16. Thus a major consequence of the Conference was the adoption of the proposal from the Vice-Chancellors' Committee for the establishment of a Central Committee on Postgraduate Medical Education. The body had certain limitations in the scope and membership proposed. Its membershp was to be drawn from the educational bodies only and it was to be mainly advisory in character. The proposal did not wholly ignore the place of the service authorities, for it assumed the existence or setting up of effective postgraduate medical education committees in each hospital region which would be mainly concerned with the arrangements necessary therein.

Nuffield Provincial Hospitals Trust grant to the Central Committee 1967

17. The Nuffield Provincial Hospitals Trust, recognizing the need for a focus on the requirements for specialist training and continuing medical education, gave a substantial grant to enable the Central Committee to establish a secretariat of the appropriate quality.[14] The trustees also agreed to make available to the Committee the report of the study commissioned by them of the current position of postgraduate medical education (paragraph 13).

18. In announcing its foundation and acknowledging the grant from the Nuffield Provincial Hospitals Trust, the Central Committee set out its terms of reference as follows:

'1. To be a clearing-house for all information bearing on the organisation of postgraduate medical education in England and Wales, including information about developments and progress in the regions, and information about the needs and facilities of the National Health Service from the Ministry of Health.

2. To arrange co-ordination of activity among the Regional Postgraduate Medical Education Committees where this is called for and to be willing to advise the Committees as appropriate.

3. To confer with
   a. the Vice-Chancellors' Committee and through it the University Grants Committee,
   b. the Colleges, and
   c. the Ministry of Health
   on matters concerning the organisation and financing of postgraduate medical education.'

Almost immediately the Committee became the Central Committee on Postgraduate Medical Education (Great Britain) and its terms of reference were widened accordingly.

II · PERSPECTIVE

Need for a new focus

19. Sir George Pickering, the Regius Professor of Medicine at Oxford, following the 1961 Christ Church Conference[15] remarked that part of its success in achieving agreement had been derived from its timing, and that it had been carried along on a flood tide of interest. He also commented shrewdly that the Conference answered a special need of the time by acting as a central focus on the steps which were then recognized as being necessary. The cause of postgraduate medical education has been advanced considerably since 1961, but all the evidence indicates that the time has now arrived for a further adjustment of focus.

Co-ordination of service and educational activities

20. One of the key questions posed at the Christ Church Conference was whether or not, having regard to the opportunities provided by the National Health Service there was then adequate co-ordination of the arrangements for the provision of postgraduate education and the medical services in the United Kingdom.

'With the experience since 1944, and especially that of a dozen or more years of the Health Service, it is possible however to be more accurate now in isolating the essential features of this issue. Although training for the practice of medicine has always depended to a high degree on demonstration in service and practice, co-ordination of attack between the educational and service authorities hardly exists except in a minor way[16].'

Still the key question in 1967

21. The time-machine has moved on but the machinery of action has not been modernized. Now nearly twenty years after 1948, there is still no real co-ordination of effort or objective. The formation of the Scottish Postgraduate Medical Association in 1962 was a promising step, but with only powers of persuasion and no money, how effective has it proved in helping to solve the major problems of the day? In 1967 the initial objectives of the Central Committee gave no hint of crisis or emergency. There may be reasonable doubt about whether or not a cautious approach is desirable, but the membership of the Com-

mittee as it is at present constituted does not provide for service representation which has a bearing on the key problem of co-ordination.

Especially for vocational training

22. Indeed, while there is great activity in various parts of the field, and in particular the desire in certain of the specialties for a more clearly rationalized and closely supervised system of training, the most notable feature now is the vast uncertainty about how best to utilize the current feeling of urgency and the almost universal will to change. The perplexity about what to do next, reflects the lack of a central policy, and consequently of purposeful direction, particularly in the vocational training part of the field. According to the General Medical Council, the aim of undergraduate medical education, complemented by the pre-registration year, is to prepare the student 'for the vocational training which is to follow [17].' The organization of the immediate post-registration years is therefore all-important as the lead-in to vocation, but this is where the organization of training and education is weakest.

No central focus

23. Many bodies are involved however, and to get a proper perspective it is essential as a preliminary to examine how all the main bodies concerned * view their responsibilities and relationships in the whole field of postgraduate medical education, both vocational and continuing. Much of the present activity probably heralds great changes; but it is difficult to determine whether or not the effective development of a sensible well-co-ordinated system of postgraduate medical education will be impeded by the lack of central direction or authoritative influence.

Inter-relationships demonstrated in Appendix II

24. Appendix II is a pictorial representation which attempts to show the relationships of all the bodies at present concerned in postgraduate medical education, and to indicate the control of finan-

* i.e. the General Medical Council, the University Grants Committee, the Universities, the Colleges, the Postgraduate Medical Federation, the Ministry of Health, the Hospital Authorities.

cial resources. In particular this highlights the stake which the service authorities have in postgraduate medical education.

The Universities

25. When the hospital services were originally regionalized, care was taken to centre each Region on a University in the hope that the Universities could use both their educational facilities and expertise to help develop postgraduate medical education in the peripheral areas. This ultimate aim has not up to now been realized (except in restricted geographical areas) because the Universities have never had the financial resources to enable them to add postgraduate to their first concern, undergraduate medical education.

The Colleges

26. While the Universities are more directly involved *academically* in training, especially since the advent of the principle of rotating senior registrarships, the *Colleges* are traditionally the bodies concerned with the specialty postgraduate diplomas which are the *professional* prerequisites of specialization. Fortunately common membership of Universities and Colleges facilitates the intermingling of these responsibilities in the task of training. However the working relationships of the Colleges with the Universities, with the Ministry of Health and the Regional Hospital Boards, with the Regional Postgraduate Committees, and with the newly formed Central Committee, are clearly fundamental to the whole problem of training. During the course of the Trust's study, answers were sought from the Colleges about their defined responsibilities to postgraduate medical education, both vocational and continuing. and what resources are being allocated to their furtherance; the timing and staging of any new proposals; the details of the examinations and training required before a medical practitioner is regarded as of consultant status in the specialties sponsored by each College; their views on their relationship to the Central Committee; their present relationships with the Regional Postgraduate Committees, and with the Ministry of Health; and finally how they would view their function if the General Medical Council assumed responsibility for establishing rolls of specialists.

1. *The role of the Colleges*

a. Perception of urgency

27. All the Colleges are currently engaged in a reconsideration of their several roles especially in relation to the full training of specialists. It is not too clear how they see such roles in relation, to say, the Universities. Indeed part of the confusion which surrounds the general problem derives from the apparently widely differing perceptions of what is regarded as necessary and how urgently action is demanded. It is also important therefore to discover how the Colleges view the timing and staging of any new proposal they have in mind, what resources they intend to allocate to further their policies, and to compare these against what is desirable from the national point of view. It is also relevant to the over-all perspective to remember that the Colleges are private foundations drawing most of their income from their members or those seeking membership.

b. Standards in relation to the General Medical Council

28. If the Colleges are indeed developing the idea of establishing standards for each of the specialties, a key question is how the definitions of their several responsibilities in relation to such standards complements those of the *General Medical Council* who, if they are going to be concerned with the keeping of specialist rolls will no doubt, on the analogy of undergraduate medical education, wish also to be assured about standards for specialties. This whole question needs a clarification of the respective functions of the General Medical Council and the Colleges. It seems necessary too that the new Central Committee will have to 'confer' with the Council as well as the other bodies named in its terms of reference.

c. Specialist training supervision

29. Yet it is evident that already the Colleges believe that their policies in this direction should not be confined to general observations about standards. Each one seems to be developing the idea that it should have some responsibility for the whole period of training for the specialties which come under its own aegis. The logistics of this operation, if it is

to include approval of posts, is therefore a matter for special study. The timing and staging of the actions necessary to implement this policy are other important issues for consideration as well as their relationship to the Universities over these factors.

2. The role of the Ministry of Health and the service authorities

30. It is important, too, to see how the *Ministry of Health* envisages its role either directly or through its agents—that is the hospital authorities who have a paramount interest as employers in those to be trained and further educated, as well as in the quality of the product. It may or may not be significant however that the Ministry's role of convenor of those interested in the field itself seems, with the Ministry's encouragement to have been taken over at a critical point by the Colleges in their convening of the conference at the Royal College of Physicians in October/November 1966. The Health Departments have clearly been at pains to avoid assuming (without however abjuring) responsibility for the definition of quality and content required in education.

a. The service authorities' major role in finance

31. It is quite clear that the major contributors to the finances of postgraduate medical education are the service bodies (those marked with solid dots in Appendix II). This is, of course, hardly surprising inasmuch as the regional service authorities employ by far the greater proportion of junior medical staff, viz. 90%. While the Universities and Colleges have key educational parts to play in postgraduate training, it is undeniable that the service authorities are finding not only the salaries of graduates under training but the large sums of money necessary to encourage the further educational activities of all doctors engaged in the health services. They are thus putting the major stake into both training and further education, and inevitably they will become increasingly interested in the kind of product being fashioned by specialist training programmes. Indeed in the United Kingdom, while the Universities and Colleges are influential as far as training is concerned, the actual *official* designation of specialist comes about from an appointment as consultant in the National Health Service.

It is perhaps a significant pointer that the Ministry has had a representative (at Deputy Chief Medical Officer level) on both the Training of Surgeons and Anaesthetists Committees of the Royal College of Surgeons of England.

b. The Minister's paramount responsibility

32. It thus seems evident that the Minister of Health at the apex of the National Health Service and ultimately responsible for standards of medical care, will feel it impossible to divest himself of some responsibility for securing the proper training of those people who are eventually going to be designated as consultants and specialists in the National Health Service, and who will have responsibilities for large numbers of patients, and for definite services in hospitals.

33. It may seem surprising therefore that the constitution of the new Central Committee does not include Ministry representatives. The service and educational elements of the trainees' existence are so closely linked that at first sight it is difficult to feel confident that what is so obviously needed, can in fact be achieved by a body of such limited direct influences. Yet the Central Committee is now in existence and it is therefore worthwhile analysing what it is likely to achieve in the present system so long as it remains an unofficial committee covering the educational bodies only.

III · ANALYSIS

The main elements of the problem

34. At the outset it is imperative to distinguish the main constituent elements in the postgraduate medical problem in the United Kingdom and settle the priorities for action. The problems of the postgraduates from overseas and of the Postgraduate Institutes of the University of London, while of great importance, ought to be considered separately. The future of the latter clearly has a bearing on postgraduate and continuing education in medicine, because they are among the foremost pacemakers for national standards. But the urgent national problem is one which is largely bound up with the immediate requirements of training in those hospitals which have only vicarious contact with the Postgraduate Institutes of London, because it concerns the arrangements for training subsequent to registration, when all but a few of the recent graduates find themselves in a series of cross-currents of specialization. All too commonly schemes for a broad-based training at an early stage are submerged in the need to staff the specialties at junior level in hospital. The fact that experience at junior level is an essential part of that training is often seen in terms of the particular specialty only and not of its possible contribution to training for other specialties, including general practice. This emphasizes the importance of a career structure for vocational training covering all the specialties (including general practice). With this as a basis the general vocational problem may be divided into specialist categories in which each College might have a pre-eminent interest. The other part of the problem is that of continuing education: in one way this is not so difficult to solve because of the increasing educational programmes, covering most of the specialties, run by the many—some of them old-established—medical and scientific societies as well as the activities of the medical centres. This is not to say that there are no problems on this front; yet there is not the same sense of urgency about it as there is concerning early vocational training.

The need for a structure

35. It is important to distinguish the gaps in the present system and set out the primary objectives. There is clearly a lack of real training

structure for vocational training based on the National Health Service. 'Structure' should not imply rigidity or too early selection of a particular specialty, but it would seem essential that there should be a clearly understood national policy which must offer flexible schemes of vocational training based on regions, in association with the appropriate University, to complement basic medical education. The essential change in the requirements of all young doctors in the last decade is that each one must now have some kind of special preparation for whatever form of medical practice he will undertake. The old—and once publicly expressed—idea that all should seek to climb a 'ladder' to consultant status by hard apprenticeship, and the majority be allowed to fall off, simply will not do. It follows that there must be provision first of all for sufficient training posts for the various groups. Currently the postgraduate diploma of the major bodies, that is the Membership of the Royal College of Physicians of London, the Fellowship of the Royal College of Surgeons of England, and the Membership of the Royal College of Obstetricians and Gynaecologists, are virtually diplomas preparatory to full specialization, which is in theory achieved when the period of Senior Registrarship is completed, after which a man is normally considered as being trained to a sufficient standard to take a consultant post in the National Health Service. Although the Universities, through the leading hospitals, work closely with the regional hospital authorities in the case of Senior Registrarships, it would be untrue to contend that hitherto there has been any effective overseeing of training posts as a whole. In this connexion, it is notable that there has been a common approach by the Colleges towards accepting responsibility for overseeing, in varying degrees, full specialty training up to consultant status.

An authoritative central body

36. In general, therefore, if undue (or at least not readily acceptable) authority is not to be vested in the Ministry of Health or some agent of it, there must be an independent authoritative central body which is in a position to demonstrate with some weight the need for such a structure and to ensure its effectiveness through a system of approval and general supervision of posts. Further, one of the centralized func-

tions must be to ensure that the quality of training available is uniformly high for all specialties. While in the present circumstances this latter function could effectively be carried out by delegating the responsibility wholly (or in part by arrangement with the Universities) to the appropriate College, the development of a satisfactory framework would best be exercised by a single central body. The Ministry of Health appears to have been holding back from the assumption of too much authority in this field in the hope that the gap will be filled in another way; but it is inevitable—and proper—that it will be forced into greater intervention if the vacuum is not filled.

The functions calling for a measure of centralized action

37. The main functions for which some measure of centralized action is necessary would seem to be:

(i) A clearing house of general information. This is indeed one of the functions intended in the terms of reference of the Central Committee;

(ii) A means of comparing the objectives of the various Colleges in relation to the requirements of vocational training for all the specialties (including, of course, general practice);

(iii) A mechanism for reconciling these as far as possible to ensure a uniform high standard for all the specialties;

(iv) A mechanism for reconciling these requirements with the very real service needs of the National Health Service because it must, for its own general staffing purposes, employ junior medical staff for apprenticeship training.

(v) A co-ordinator of inspectorate systems for approval of training posts;

(vi) An initiator of studies regarding the content and form of training to ensure a streamlining of educational function and action;

(vii) A source of pertinent information and advice to the service authorities in relation to training and education generally, and the needs of both;

(viii) A source of advice to the more broadly based regional organizations.

Executive powers needed

38. It is evident that there would be advantages in vesting these functions in a single authority. The executive powers to be wielded by such a body present, however, a great range of options; the ultimate choice will depend on the particular view held concerning the reality of the threat of an over-powerful central authority to existing institutions.

The existing interests

1. *The General Medical Council*

39. The only body which already has certain statutory functions on medical education is the *General Medical Council*, which apart from its responsibilities in relation to public health, is concerned with the medical graduate's education only up to full registration. Assuming that the Council will seek powers to keep registers of specialists—and not only do they seem willing,[18] but it is understood that they are being urged to do so by the Royal Colleges—it is clear that it would not be in character for the Council to regard their function as merely one of clerkship. They will almost certainly wish to develop standards for each of the specialties in the same way as they have done for undergraduate education, as is indeed hinted in their recently published recommendations. Their draft regulations for the one statutory responsibility they already have, on postgraduate qualification for the Diploma of Public Health, are also indicative of their potential in this sector.

40. The Council's possible responsibility for keeping and maintaining rolls of specialists needs to be looked at especially closely since it is a matter about which there is some confusion. The likely requirements of the European Economic Community as they affect specialization in medicine would seem to have little in common with the current problems of specialist training in the United Kingdom and the pressure to register doctors at the end of their specialty training. It is conceivable

that under the Treaty of Rome the General Medical Council may be called upon to establish criteria for a roll of specialists, but the qualification would appear to be no higher than the holding of specialist degrees such as the F.R.C.S., M.R.C.P., etc., or the attainment in the United Kingdom of a post of Senior Registrar status. Yet what many people seem to be calling for now in this country is the establishment of a roll of those who have carried out a prescribed period of full specialist training, i.e. to the completion of Senior Registrarships. This prescribed period of training would in effect be that which is considered necessary to fit the individual to be appointed to a consultant post in the National Health Service. It would also correspond with those periods of specialist training being suggested by practically all the Colleges, and thus be more advanced than the training likely to be accepted in the Common Market for specialist registration. If the General Medical Council is unable to keep a roll recording the attainment of advanced, in addition to basic, specialization, it might be that the Colleges should make the appropriate recognition. In any event it is desirable on all counts to have some official recognition of completed specialist training in the National Health Service.

2. The Ministry of Health

41. The Ministry of Health and its regional agents would seem in reality to have the place of paramount influence in postgraduate training. Since the trainees are paid from Exchequer funds, a policy decision to recognize the full attainment of specialist status, as in the paragraph above, would have to come from the Ministry as part of a more rational scheme than has existed hitherto. The hospital authorities, also, encouraged by the Ministry, have indicated their capacity to shoulder other financial responsibilities in further education. The quality of the end-product of the training is of the utmost importance to the Ministry as well as the service authorities. There is no evidence of an over-all plan of action so it is not, however, clear how the Ministry envisages the future. At present it seems to be content to deal only with general principles and in association with other bodies (see paragraph 30). It is currently involved in discussions with the bodies representing the 'Profession' in relation to terms and conditions of service,

and with the hospital authorities in relation to the rights of junior hospital staff for time off for further education and training. It also seems from its current negotiations with the Royal College of Surgeons to have accepted the general principle that each College should be encouraged to undertake some general *oversight* of the appropriate specialty training, and it even seems to wish as a general policy to encourage them to be responsible for *approving* suitable posts. There might sometimes be a direct clash between a College and a service authority over the consequences of not approving a post, but the purpose of such approvals is educational and this must be paramount. In any event, there would seem to be need for some provision for appeals to some national body outside the Ministry; however, if such a body is not statutory and so ill-defined in powers that its authority is uncertain, what it could do about differences of opinion is very much in doubt.

42. It is notable that the Ministry has already drawn up an outline of the regional postgraduate organization it deems necessary, and has set out its desirable functions, which seem in each region to call for a body semi-executive in character; but it is not clear what part, if any, the Universities and Colleges are to play in them. Its ready response to the suggestion from the British Postgraduate Medical Federation, endorsed by the Central Committee, for the establishment of a fellowship scheme for Senior Registrars and junior consultants for advanced clinical studies, indicates its willingness to accept the well-presented advice of suitably qualified outside organizations.

43. The Working Parties commissioned by the Trust's Medical Consultative Committee on the training of such specialties as psychiatry, general practice, and the administration of hospital and public health services, showed the urgency for there to be a clear and unequivocal career structure for those aspiring to these specialties. The Ministry would be the principal participant in any policy of relating posts in the National Health Service to schemes for the training of specialists; the main responsibility for their development, however, must lie with the educational bodies, i.e. the Universities and the Colleges. The

Boards, as the Ministry's agents, must have a clear lead as to policy and be prepared to work in postgraduate matters with the Colleges, with the Universities, and the Central Committee. It is clear that the logical mechanism for this would be a strongly constituted Regional Postgraduate Committee.

3. Regional hospital boards and their Postgraduate Committees

44. Those agents of the Minister providing the hospital service, the Regional Hospital Boards, enjoy a measure of autonomy which leaves them to decide whether a training programme for doctors is a necessary corollary to the treatment of patients and how much should be spent on implementing such programmes. As the advisory committee to the Board, the Regional Postgraduate Medical Committee has no statutory authority to determine what should be spent on postgraduate medical education, because the budget is determined by the Board in the light of its other commitments. Consequently there are marked differences in the provision of postgraduate medical schemes between the regions, which was noted by the Trust's team in its review of 1965 (see paragraph 8) and which still exist. Boards are also responsible for providing a career structure for young practitioners. There is perhaps one outstanding anomaly worthy of note. The postgraduate teaching of these young doctors, both formally through courses and informal bedside training is in the hands of consultants in contract with the Regional Hospital Board. While the right to time for education has been recognized in the case of the staff under training, in contrast with their fellows in teaching hospitals, few consultants in regional hospitals have any teaching element recognized in their contracts. To ensure that there is a satisfactory relationship between service and educational responsibilities, there is obviously a need for some *formal* relationship between the Central Committee and the Regional Postgraduate Medical Committees.

4. The Colleges

45. Hitherto there has been no general agreement among the Colleges about their several functions; but since we started (May 1967) it is possible to discern a more uniform approach to the training of special-

ists (see also the Appendix to the Wright Report[11]). It would, however, be desirable for some central body to set out in some detail, and keep under review, the implications of the perception of each College regarding their particular role, because while general objectives may be similar, the several time-tables envisaged for full and effective implementation of policies may not necessarily coincide. Questions such as the responsibilities for the counselling of junior staff under training and the role of each educational body (including the Universities) are also of the greatest importance. (See also the General Medical Council's recommendations on this matter.)

46. The Colleges cover between them all specialties. If they are to cover the whole range of postgraduate medical education this would mean that in order to meet modern requirements, their functions must go far beyond the stage of the awarding of diplomas. Indeed, it seems that they are now fully aware that they must ultimately be concerned with the training facilities and other requirements for the whole period of specialist training. They must then have the responsibility to ensure that postgraduate students should have the right facilities for their studies. Thus, to take the recent Circulars, HM (67)26, 27, and 33, which set out a centrally conceived policy for allowing junior staff time off for postgraduate studies, whose function is it to ensure that registered students actually have not only the agreed time off but adequate facilities for their studies? It would be quite wrong for this function to be left to be taken up by the professional organization. This also poses the need for individual counselling with, as well, a reasonable inspectorate system of posts to ensure both that the material is adequate and appropriate, and that the clinical opportunities are also of sufficient quality.

47. If the General Medical Council accepts the responsibility for establishing rolls of specialists, there will have to be a definition of the responsibilities between, on the one hand the General Medical Council, who seem undoubtedly to be the body to define the standards for admission to, and maintenance of, such rolls, and on the other the educational bodies concerned with training. Whether the General Medical Council's constitution and existing machinery are appropriate for this

task, requires special consideration, but is not discussed here. The Royal Colleges have of course hitherto mainly been concerned not so much with the responsibility for training schemes for specialists (although they have made general observations about basic requirements) but with the award of their own postgraduate qualifications. It may be in the future, in the absence of other arrangements, they will have to record the attainment of a satisfactory period of full specialist training.

5. The Universities including the British Postgraduate Medical Federation

48. The *Universities* play their part primarily, although without specially allocated finance, through their Postgraduate Deans who should be the pivot in the regions of the arrangements for formal courses and, on occasion, of the Regional Postgraduate Committees. The strength of the Regional Postgraduate Committee and its influence depends on the Dean's relationship with the service authorities who control the facilities and much of the money available. The chain of responsibility which runs from the Universities through the Postgraduate Dean and the Postgraduate Committee normally ends with the Clinical Tutors or Area Postgraduate Advisers who carry out local organization in postgraduate training. In some regions the Universities recognize the work of the Clinical Tutors by honorary appointments. The contracts of those regional hospital consultants rarely, if ever, recognize their actual practical teaching commitments. The Deans themselves have a national forum in the meeting convened twice a year by the Director of the British Postgraduate Medical Federation and attended by a Deputy Chief Medical Officer of the Ministry of Health, but the strength of such a congregation is perhaps more potential than real.

6. The Central Committee

49. The *Central Committee* as presently constituted is largely an unofficial confederation and clearly intended only to be advisory. Its effectiveness will ultimately depend on its ability to recognize those problems which have become acute and ripe for action and its capacity

to persuade both educational bodies—and more important, the service authorities—to useful action. The main question is whether, if it is to perform a useful function, it can continue to be only advisory and informal. Its terms of reference are vague enough to embrace the whole field, but the depth at which it can hope to operate under its constitution is open to grave doubt; belief in its ability to influence events is at present an act of faith. On the other hand its potential influence is great. Indeed, its support of the British Postgraduate Medical Federation's Scheme for Advanced Clinical Fellowships may have been a factor in the very prompt approval given by the Ministry to a substantial central allocation of the necessary funds.

50. It is conceivable that the Central Committee could, by becoming an authoritative source of information and advice, soon win a position of supreme influence for itself, but if it is to start influencing events at the crucial moment, it needs quickly to expand its aim beyond its first stated concern, that is, a review of *pre-registration posts*. Incidentally this issue seems to overlap with action currently being taken by the General Medical Council, who are statutorily responsible for approving such posts.

51. It would also be realistic to consider specifically what minimum official responsibilities the central body should have. Assuming that the General Medical Council will lay down standards for specialist registration, will the central body play any part in their implementation? They certainly would seem to need to include in their terms of reference some provision to allow for a dialogue with the General Medical Council. It may be their responsibility should be to co-ordinate the efforts of the service and educational authorities to ensure that the instruments and facilities for training are available, organized, co-ordinated, and financed. Again, it seems incontestable that the central body should be in a position to comment judicially on the effectiveness of the career structure for the specialties. Is it not to limit their responsibilities too much if the Central Committee is only 'to confer with the Ministry of Health and the Scottish Home and Health Department on matters concerning the organization and financing of postgraduate medical education'? Will they in fact be in such an in-

fluential position that they can insist on adequate organization and financing on both a national and regional scale? Do they have any sanctions available? It is obvious that if they had a special responsibility, either directly or by delegation, with the approval of posts, this itself would be a most powerful sanction *vis-à-vis* the service authorities, but should this not be spelt out?

Delegation by the Central Committee

a. To the Colleges on educational matters

52. On matters of a largely educational nature there is no reason why the central body should not, where appropriate, leave the responsibility regarding approval of posts, inspection, and the form and content of training to the Colleges, but the Central Committee ought to be in a position to compare, and be prepared to comment on, the activities of the several Colleges.

b. To regional committees on service matters

53. Equally, the Central Committee could leave the responsibility for other matters, especially those directly affecting services, to the Regional Postgraduate Medical Committees. This, of course, would be another argument for linking these committees to the central body.

c. To the regional committees on matters needing co-ordination

54. It could be objected that allotting too great responsibilities to the central body would entail the need for enormous administrative staff. This need not be the case if a major part of the operating responsibilities is delegated to the Colleges, to the Universities, and to the Regional Postgraduate Committees. The central organization could then be relatively small, but high-powered.

55. Thus it may be envisaged that part of the function of the central body will be to approve posts and inspect them at periodic intervals. It could even be that certain of the junior posts might best be approved by delegation to the Regional Postgraduate Committees on which the Colleges would be well represented. This would be sensible if the initial post-registration phase was to be for most people a period in

which they got experience in a number of posts. The Regional Postgraduate Committees themselves could then arrange for a hospital to be visited for accreditation at any one time by people concerned with the posts not only of one specialty, but with a number. In any event it is probable that there will be need for the development of common criteria against which posts can be measured for approval. This need not present great difficulty. There are already examples of joint accreditation systems in the United States; and inspection systems for other professional groups, viz. midwives, the schools of nursing, etc., exist in the United Kingdom.

Finance

56. The future *financing* of the Central Committee would require special consideration since it would need revenue finance for its central services. One view is that the Committee should eventually be partly financed from University funds and partly from service funds. It is certainly a weakness that as long as the Central Committee only consists of educational members, as at present, it could hardly look for continuing support elsewhere than to University or College sources.

IV · PROSPECT

OBSERVATIONS AND REFLECTIONS

The need for an over-all plan of action

57. It can hardly be gainsaid that the medical profession as a whole requires some form of post-registration, organized, vocational training. In Britain the whole question is bedevilled by the way in which specialist status has become co-terminous with consultant rank in the National Health Service, which occupies a special place in a species of clinical hierarchy. Particular specialties doubtless require particular qualities of mind and will, but a career structure should not imply a competition in which some succeed and are trained and some fail and drop out. Immediately following registration the object must be to have a comprehensive range of possible choices of path for all doctors for further training. To ensure this there must be some general plan in which access to entry to each path must be geared to a reasonable prospect of successful emergence eventually into suitable career positions in medicine. There is no risk that graduates will be frustrated at the end of such training by failing to find enough opportunities, provided there is also an appropriate gearing of service posts to training posts. It should not be beyond the wit of man to devise a rational scheme. Indeed in view of the loss of trained manpower by emigration, some action along such lines is imperative. It follows there must be no feeling that general practice is the residual home of other specialties' rejects; it requires special preparation as do also the vocations of medical administration, social medicine, and public health. Any general plan to make better use of manpower must be flexible and include *inter alia* a mechanism to recover and use the medical skills of women graduates who marry soon after qualification and either withdraw temporarily for family reasons, or require modified facilities for further training.

Lack of structure, finance, and means to focus

58. Three main elements are missing in the present arrangements for postgraduate medical education in the United Kingdom: a *structure* both for postgraduate and continuing education; *adequate finance*;

and any *mechanism for co-ordinating and incidentally focusing on the essentials.*

59. On a strong basic framework it should be possible to build a system in which all educational and service resources would be better deployed in training the young men and women who are preparing to specialize, as well as in the continuing education of all doctors. Equally there must be a means for making a continuous review and assessment of the structure of the system so that the necessary steps can be taken to improve matters, and if necessary to secure the requisite order of finance.

Focus through a central body

60. There is little dispute but that the focus must be provided by some central body able to speak with authority covering the needs and organization of postgraduate medical education. There are, however, differences of opinion about the role of such a body, its responsibilities and, consequently, its constitution.

Strong and comprehensive?

61. As in so many other cases the controversy has become polarized round sharply defined attitudes. The ideal is often stated by some to be a strong central body with statutory powers, it membership drawn from all the authorities concerned with education and with service—that is the Universities, the Colleges, the General Medical Council, the Ministry of Health, the service authorities at regional level, and even perhaps some outside assessors broadly representing consumer interests. The antagonists of this idea contend that the vast representation required by such a constitution would make the governing body unwieldly as an executive unit. This is, however, hardly a strong debating point and certainly the difficulties would not prove to be insoluble administratively. The more telling part of this argument is implicit condemnation of over-centralized powers; but again this is an extreme stand which can be undermined by discreet delegation. Many look for a central body with well-defined powers which conceivably could in many ways overlap the responsibilities for the supervision of specialist training currently being assumed by the Colleges.

Or weak and limited? As an act of faith

62. Against such a sharply etched idea others look expectantly to the existing Central Committee. There can be little doubt that with its membership it has a strong potential for influencing affairs. Against this, it is a fact that the Committee's present brief is vague, its constitution is extremely limited and its financial foundations are anything but secure. To believe in its ultimate effectiveness is to believe in the power of voluntary action to regulate and co-ordinate somehow or other, the several responsibilities of a vast number of bodies of differing strengths and traditions and to make them relevant to modern conditions and the needs of the National Health Service.

The potential of the Central Committee

63. Indeed, it was in some such faith that we recommended to the trustees that they make a substantial grant to the Central Committee notwithstanding the vagueness and inadequacy of the original terms of reference. From the first evidence that we had about the objectives of the Committee we were doubtful if they were in accord with what is widely believed to be urgently required. We felt, however, that it would be a major step in the right direction, and a challenge to the effectiveness of voluntary action, if the Committee was enabled to attract an effective secretariat so that it could focus attention on the problems which transcended those of the individual specialties, and to work towards a broad common policy for the whole field. We were fully aware that the third main sector, that of the service authorities, was almost the most important, if measured by finance. We felt, however, that what was required immediately was to give some substance to the somewhat shadowy form of the organization sketched originally. It seemed clear to us that they were undoubtedly launched in the right direction; and with the right momentum, the Committee would inevitably quickly approach a much sharper definition of the several responsibilities of each body concerned with postgraduate education. Almost immediately this was bound to point to the need for an effective dialogue with the service authorities. Whether this could be achieved without these authorities being substantially represented on

the Committee would soon become evident. The main objective was to enable the Committee to be launched quickly on the road to developing the means to focus centrally on the outstanding issues of postgraduate education, so that the most effective mechanism could be constructed. With the right drive some effective cohesion could be achieved well in advance of the report of the Royal Commission on Medical Education (and certainly before any action which was based on it) which might well call for a more rational system and therefore for some central statutory authority with well-defined responsibilities. The need for such a body has, of course, frequently been expressed in many quarters since the Christ Church Conference in 1961. It may well be that the Royal Commission's recommendations will seek the required modification of the objectives, or even the structure of the Committee; but in the meantime, the Committee's own action could confound the critics of its constitution.

Is there much difference?

64. The protagonists for giving the central body some well-defined authority, of course, believe with some justification that power follows finance, and finance is one of the main keys to the problem. Accordingly, unless the central body is given the means to such power by statutory authority and recourse to public funds, it will not be able to ensure adequate standards.

65. It may be that this is a debate about semantics and not about realities. The ultimate potential of the Central Committee could be distinctly influential if among its first aims it is prepared to press for a rational career structure geared to a vocational training programme which begins at registration. At the same time, if it investigates the possibility of a common approval procedure and tries a pilot scheme to see if such a procedure could be effectively carried out by delegation to the Colleges and Universities, no-one could charge it with ignoring priorities. Indeed the whole situation of postgraduate medical education is so complex that an evolutionary, albeit slow, approach, utilizing all the existing agencies which wield the undefined influence that so frequently attends tradition, may, in

the long run, be the more effective. The key question is whether the central body can develop a high degree of prestige and influence quickly. It could do so if it became the main source of knowledge concerning postgraduate medical education and was prepared to be critical of any backwardness or waywardness on the part of any of the Colleges or Universities, or the Regional Postgraduate Committees or the Health Departments themselves. Of course, so long as it is unofficial, there remains the question of how the central body should be alternatively financed for it cannot, to be effective in the long run, do without a first-class secretariat. However, the amount of money required for its long-term stability and security in relation to the whole postgraduate medical exercise is not very great, provided the vast potential of the Universities, the Colleges, and the Regional Postgraduate Committees is exploited through delegated powers. Indeed there is much to be said for utilizing as much as possible all existing influential institutions which show awareness of the problems and vigour in tackling them. What the Colleges have set themselves to do about vocational training is impressive and they should have incentives to do this as effectively as possible.

Central Committee as adviser to the Ministry

66. This leaves the criticism that the Central Committee as presently constituted is weak and likely to have little influence in service quarters because there is no service representation. Clearly, as has been shown, in paragraph 51, the Committee has to work closely with the Ministry of Health. Indeed it can really gain in authority only if it were to become in effect the key adviser to the Ministry on postgraduate medical education. It is very impressive that, at the moment, the Ministry of Health seems to wish to encourage the postgraduate activities of the existing institutions of proved authority. No doubt it will wish to utilize the experience and influence of the Central Committee when it becomes fully established; there are indeed one or two ready-made issues where systematic advice would no doubt be welcomed by the Ministry, for example, on the details of the Fellowship scheme for advanced clinical studies, in the establishment of which the Ministry acted with such promptitude.

An independent role for the Central Committee?

67. Furthermore there is an important doctrinal issue which should be underlined. It is arguable that the Ministry and the service authorities should not be represented on a body concerned primarily with educational matters. It is indeed possible to develop a theory of counter-balance: that to avoid the dangers inherent in an over-centralized bureaucracy it might be in the best interests of the nation that the Central Committee should clearly be seen to be independent and be made responsible for *monitoring* all matters concerning postgraduate medical education in the National Health Service. The hard facts must ensure that since the service authorities are going to be affected by the Committee's decisions, there will inevitably be channels for the requisite dialogue with the Ministry and its satellites.

A central body with well-defined duties is no threat to the Colleges

68. The prospect of the Central Committee growing into a body with quasi-statutory powers with regard to educational and training matters need be no threat to the Colleges. Indeed the virtue should be proclaimed of retaining existing institutions, not only for supervising training but also for developing adequate inspectorate arrangements to ensure proper standards for at least the major training posts. The Royal College of Surgeons of England has had in its regulations for many years the responsibility for ensuring that those people who are training for its Fellowships and Diplomas should be trained in suitable jobs. The Royal College of Obstetricians and Gynaecologists similarly approve posts suitable for training for its membership. More recently the Royal College of Physicians has begun a system of approving training posts for all its associated specialties. The assumption of responsibility for co-ordinating such efforts would have the effect of codifying standards and criteria of judgement. Indeed it would be an interesting exercise to test if the right results could be achieved by agreement without specific authority by statute. Official recognition could be given by allocating funds for the task of accreditation which, if done properly, is no light one, and will be costly. For obvious reasons this certainly should not be a cost borne by College members and those seeking membership of Colleges.

But a dialogue is necessary with the service authorities

69. If this, as it probably should be, is the likely pattern for the future, it is evident that on this score alone the service authorities will have to be aware of the standards adopted by the Colleges and the arrangements for accreditation. Such inspections could undoubtedly have a beneficial effect by testing the efficiency of the basic services provided by the hospital. The risk, for example, of an area or hospital pathological services failing to be recognized as a suitable training-ground for junior medical staff, would be sufficient to disturb any complacency on the part of the administrative authorities. An independent assessment of facilities, too, would constitute a protection for the public.

And with the General Medical Council

70. The Committee, which one supposes is intended eventually to pronounce about the means of achieving general standards in the specialties, must clearly also have a continuous dialogue with the General Medical Council, the statutory body which is likely to be concerned with the keeping of specialist rolls. It has sometimes been scouted that the General Medical Council could perform the double function of setting standards and taking steps to see that they are achieved. It is, however, obvious that the steps immediately necessary require a bold and exploratory outlook on medical affairs which may clash with the traditional image of an essentially judicial, regulatory body. It would thus be wise, certainly at first to have a quite distinct organization with special responsibilities, and seized with the special mission of developing a well co-ordinated general policy for postgraduate medical education and continuing education in the National Health Service.

The scale of the financial operation

71. Above all, however, it seems of the utmost importance that a main source of funds be ensured for the effective operation of the Committee in the future. The central body will need recourse to substantial funds in order to carry out the important functions set out earlier in this document and to commission such research and intelligence as is necessary for a persistent probe into the content and method of postgraduate

medical education, related to the reigning state of the art and science of medicine. In relation to the importance of the task and the total money even now being expended in the whole field, the size of these funds need not prove unduly dismaying. It would not perhaps be profitable to speculate about the source of such finance; it may be relevant that the National Health Service has already demonstrated its capacity to find money for postgraduate education on the theory that it is fundamental to good service. For this reason alone, it would seem desirable to look more optimistically in the direction of the Ministry of Health as a prime source of funds rather than the University Grants Committee or beyond it to the Department of Education and Science, where medicine will be in fierce competition with the ever-swelling demands of the arts, the general sciences, and technology. It is perhaps significant, and a precedent which could be extended to educational research in the medical field, that in relation to nurse training, the Ministry of Health is to finance a research unit at the General Nursing Council[19].

Postscripts

72. It seems important that in the face of the present urgent needs there should be neither too much scorn at the vagueness of the brief of the Committee nor alternatively should there be a false sense of complacency about the current position. There is indeed no time to lose. The Central Committee is currently the best focus that exists or is likely to exist for some little time. With the complexity of the issues, it should be given every opportunity to develop its potential unless or until its approach shows it to be unequal to the tasks which an authoritative body on postgraduate medical education must face. These tasks can and should be set out seriatim in a programme for consideration and action. A programme of research, a list of priority tasks, and the relationships to be forged, can be developed from the suggestions set out in paragraph 8, and the functions proposed in paragraph 37 above.

73. With every respect to what the Committee has already announced as its first concern, i.e. a review of pre-registration posts, its first real test will be to see how it faces up to the immediate problems, in par-

ticular to deciding what is necessary to bring some order to the relative chaos of the immediate *post*-registration phase. Its ultimate success will depend on the adequacy and smoothness of the relationships it develops in dealing with the main problems with the General Medical Council, with the Ministry of Health, and the service authorities as well as with the individual Colleges and the Universities.

74. Finally it is not too optimistic to believe that to fulfil its potential, the Committee need not depend on being granted statutory powers of direction or sanction. There is already a miscellany of bodies wielding a wide range of powers in the field of postgraduate medical education, which derive from statute or long tradition. Indeed, what is now required is possibly the influence and authority that stems from the cool considered views of an intellectual élite, suggesting the form of a Society rather than a Board of Management. Perhaps the Central Committee is indeed the start of a British Academy of Medicine.

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APPENDIX I

List of organizations represented at the Ministry of Health Conferences on Postgraduate Medical Education

British Medical Association
British Postgraduate Medical Federation
Committee of Vice-Chancellors and Principals
Department of Health for Scotland
General Medical Council
Joint Consultants Committee
Ministry of Health
Northern Ireland Hospitals Authority
Royal College of General Practitioners
Royal College of Obstetricians and Gynaecologists
Royal College of Physicians of London
Royal College of Physicians and Surgeons of Glasgow
Royal College of Physicians of Edinburgh
Royal College of Surgeons of England
Royal College of Surgeons of Edinburgh
Scottish Postgraduate Medical Association
Senior Administrative Medical Officers of Regional Hospital Boards
Society of Medical Officers of Health
University Grants Committee.

APPENDIX II

Organization of Postgraduate Medical Education

Descriptive note

Any organization set up on managerial lines follows a distinct pattern, viz.:

1. A POLICY has to be decided;
2. A PROGRAMME or programmes have to be set out to implement the policies according to the financial and personnel resources available to the organization;
3. The programmes have to be EXECUTED by the floor management (or executives).

The organization for postgraduate medical education is no exception, and the diagram below is set out on these lines.

Statutory bodies, or bodies financed from Government grants are represented by a CIRCULAR symbol.

Non-statutory bodies and Advisory Committees are represented by a RECTANGULAR symbol.

1. THE POLICY MAKERS

Monies for postgraduate medical education from H.M. Government flow from two main sources:

I. THE DEPARTMENT OF EDUCATION AND SCIENCE (open dot flow)

II. THE MINISTRY OF HEALTH (solid dot flow)

I. The *Department of Education and Science* (open dots) allocates money to the *University Grants Committee* (open dots) which in turn grants monies to the *Universities* each quinquennium. *Universities* allocate money to *Medical Schools* and to the *British Postgraduate Medical Federation* (open dots) and to *Postgraduate Teaching Hospitals* (open dots).

II. The *Ministry of Health* (solid dots), as a result of accepting that 'Training' is essential to the provision of 'Treatment' allocates monies to *Regional Hospital Boards* (solid dots) who, on the advice of their *Regional Postgraduate Committee* (solid dots) provide *Postgraduate Medical Centres* (solid dots) and schemes for the training of service practitioners and arranges a *Career Structure* for them.

OTHER BODIES WHO INFLUENCE POLICY-MAKING ARE:

a. The General Medical Council (double line flow)

A statutory body set up by Parliament in 1858 which influences postgraduate

medical education by setting out statutory requirements for the registration of medical practitioners and for certain postgraduate diplomas. The Council therefore has a powerful influence on all bodies undertaking undergraduate medical education, and on one branch of postgraduate education.

b. The Vice-Chancellors and Principals Commiteee (light dotted flow)

An advisory committee financed by the Universities which influences the University Grants Committee and the Department of Education and Science, but has hitherto had no direct influence on postgraduate medical education.

c. The Royal Colleges of England and Scotland (light broken line flow)

Who have traditionally made themselves responsible for setting the pattern and standards for the appropriate specialty training, but have in fact had widely varying influences on different specialties.

2. THE PROGRAMMERS

These are:

a. The *Universities* (open dots) and the Postgraduate Medical Federation

b. The *Regional Hospital Boards* (solid dots) and their Regional Postgraduate Medical Committees.

But the programmes have been written in widely varying detail and until recently have often done little more than specify requirements for diplomas.

3. THE EXECUTIVES

These are:

a. The *Postgraduate and Undergraduate Teaching Hospitals* (open dots)

b. The District Hospitals (solid dots) and their postgraduate medical centres.

It will be noted that the Postgraduate Teaching Hospitals and Institutes receive money for postgraduate medical training from two sources:

FIRST from the Universities (open dot flow)

SECONDLY from the Ministry of Health (solid dot flow) as part of the service element of Revenue.

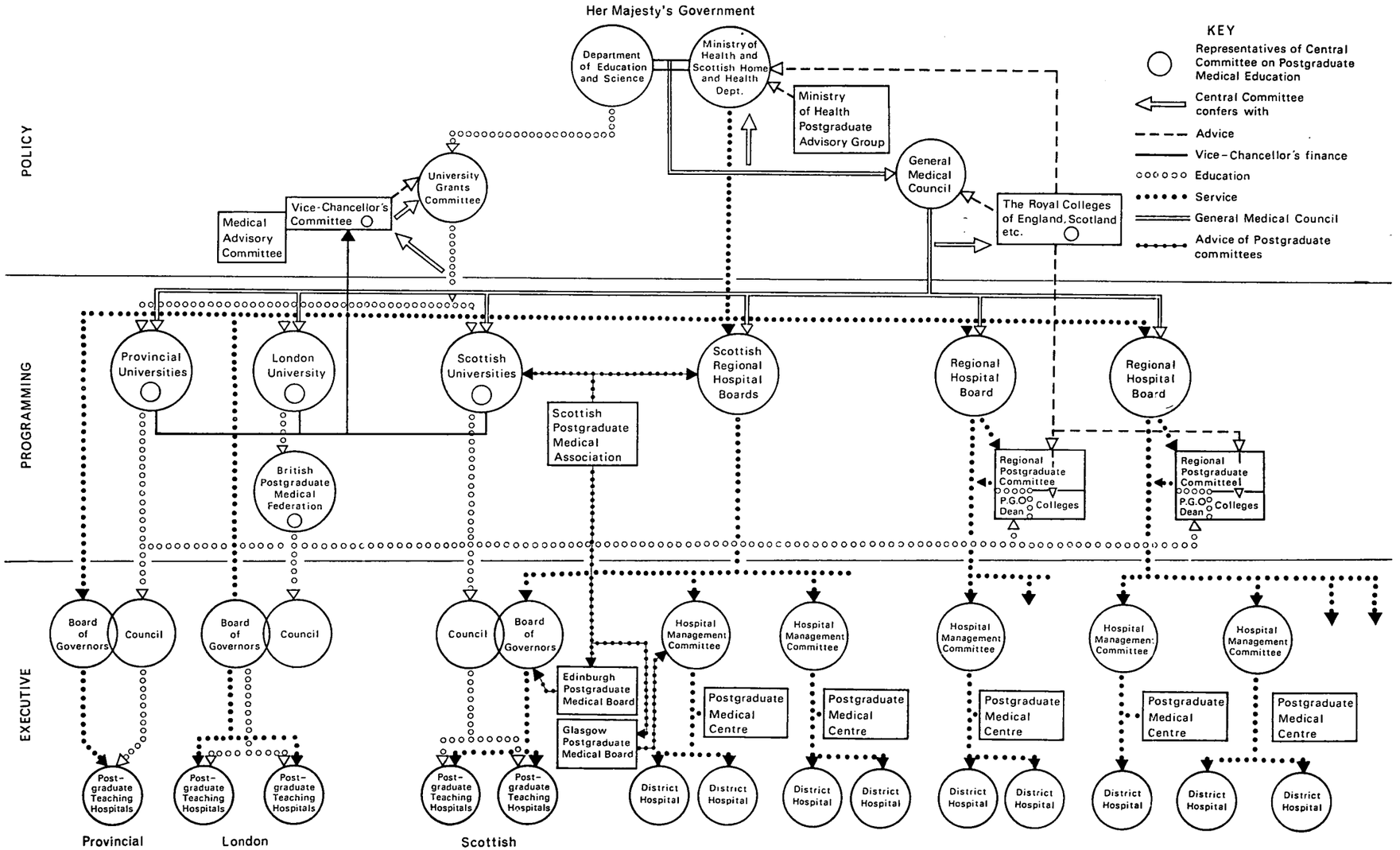
The representatives of the Central Committee on Postgraduate Medical Education (indicated by open circles) are:

a. The Vice-Chancellors and Principals Committee;
b. The Royal Colleges of England and Scotland;
c. The Universities;
d. The British Postgraduate Medical Federation and the Postgraduate Deans.

It confers with (indicated by open arrows)

a. The Ministry of Health and the Scottish Home and Health Department;
b. The Royal Colleges of England and Scotland;
c. The University Grants Committee.

ORGANIZATION OF POSTGRADUATE MEDICAL EDUCATION



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