Evidence to the Inquiry into the Regulation of the Medical Profession

FROM THE COUNCIL OF THE ROYAL COLLEGE OF GENERAL PRACTITIONERS

The College

1:1 The College was founded 21 years ago by family doctors disturbed about the prevailing state of general practice, in particular its failure as a branch of medicine to have developed a modern academic organisation, to have devised relevant training, to have provided for adequate clinical standards, and to have contributed new knowledge. The College's object, embodied in the Memorandum of Association, was " to encourage, foster and maintain the highest possible standards of general practice. . . ." To achieve this object, the College has concentrated on education, standards of professional competence and research.

1:2 The College is a chartered body with 5,627 full members and fellows, and 1,974 associates. It is concerned through its Education Committee with the quality of post-graduate training for general practice, and through its Board of Censors for the standard of professional competence of its own members. It is the only body in Britain to offer a higher qualification in general practice.

1:3 The College consists of geographical faculties (mostly coterminous with the new regional health authorities), regional councils in Ireland, Scotland, Wales, and New Zealand, and a central co-ordinating Council. There are also overseas faculties in a number of countries, some of which have become or are in the process of evolving as independent Colleges such as New Zealand in 1974. All governing bodies of the College, namely the faculty boards, regional councils and the central council are composed predominantly of doctors elected by ordinary members.

Scope of the College's evidence

Medical education and the assessment of professional competence for general practice form the basis of our evidence because many shortcomings in our branch of medicine derive from inadequacies in them.

To assist the Committee of Inquiry, our evidence has appendices giving relevant background information.

The work of the general practitioner

2:1 General practice is the largest branch of medicine in the National Health Service. In Britain, in contrast to other countries, it occupies the unique position of being the main provider of primary and continuing medical care, and as such is the normal gateway for the majority of people who use the National Health Service. One reason for this is the referral system between general practice and the hospital specialties which is firmly established in the profession's ethic.

About two fifths of all medical graduates working in the National Health Service are general practitioners. Only general practitioners and consultants are deemed to have unsupervised clinical responsibility.

The training, continuing education and clinical standards of general practitioners have therefore particular relevance to the quality of medical care for the majority of people who use the National Health Service.

2:2 The Royal College of General Practitioners [1] has defined the work of the family doctor:

" The general practitioner is a doctor who provides personal, primary and continuing medical care to individuals and families. He may attend his patients in their homes, in his consulting room

or sometimes in hospital. He accepts the responsibility for making an initial decision on every problem his patient may present to him, consulting with specialists when he thinks it appropriate to do so.

He will usually work in a group with other general practitioners, from premises that are built or modified for the purpose, with the help of paramedical colleagues, adequate secretarial staff and all the equipment which is necessary. Even if he is in single-handed practice, he will work in a team and delegate when necessary. His diagnoses will be composed in physical, psychological and social terms. He will intervene educationally, preventively, and therapeutically to promote his patient's health".

2:3 General practice has changed extensively in the past ten years. Two-doctor and three-doctor practices now predominate; there has been a steady increase in the number of groups comprising four or more principals, and fewer than one fifth of all family doctors are single-handed practitioners.[2] Younger doctors, particularly those aged 35 or less, are more often to be found in groups,[3] a finding consistent with the reported career preferences of trainee general practitioners [4] for well organised and fully supported practices.

Organisational change has been a necessary preliminary to a complete re-casting of the family doctor's education, and the process has now gone far enough to enable new training to begin in a substantial way [5] (appendix 1).

Philosophy and background to regulation

3:1 Although doctors have a first duty to their patients, they also have a collective responsibility to the community and must conduct their profession for the common good. This responsibility is enhanced because the medical profession is part of society and of the welfare state. The public is better informed than ever before, and expects a safe and efficient system of medical care. Government and Parliament look for effectiveness and value for money. Doctors require clinical freedom and independence to allow them to decide what is best for their patients.

The profession wishes to be allowed to exercise discipline over its own members and to maintain its own standards in research and teaching. Thus, there must be a fair and just balance between professional freedom and a regulation that ensures high standards of care for patients.

3:2 The object of regulating the medical profession is to ensure that the public receives care of high quality from a profession:

(a) whose training and continuing education is appropriate to contemporary health problems in this country,

(b) whose members achieve and maintain acceptable standards of professional competence, and are mentally and physically fit for their work,

(c) whose members conform to standards of conduct generally acceptable to both the profession and society.

Medical education and the general practitioner

4:1 The College regards medical education as a continuum beginning at entry to medical school and ending when a doctor retires from active clinical practice. A period of formal and supervised training can be distinguished from the less structured continuing learning when a doctor has assumed full clinical responsibility. At present undergraduate education and the preregistration year are supervised by the General Medical Council while postgraduate medical education is not.

Recommendation A:

All medical education, undergraduate and postgraduate, should be regulated by a single body.

4:2 We now consider the four main components of medical education, with special reference to general practice. First, however, there is a general principle we would like to state. 'General' practice has its own body of knowledge and skills. Recently we prepared a guide for teachers of general practice [1] not only on teaching methods, but on those areas of knowledge and skill which we think competent general practitioners should

be expected to grasp. The areas are not theoretical but have been derived from many field studies delineating morbidity presenting to the primary medical care service. They are explained in detail in appendix 2.

Thus the College rejects the view that general practice is simply a collection of several specialties practised at a superficial level. That it has been so regarded has been implicit in the wider view that undergraduate education, with experience gained in the preregistration year, can produce a doctor equipped to practise competently in general practice although this has not been accepted for senior appointments in any other specialty.

4:3 It follows that postgraduate training for general practice must be made available for everyone entering this branch of medicine and that no doctor should be permitted to practise as an independent principal unless he has first completed an approved training programme. When enough training programmes are available by the target year of 1977, the opportunity for a radical revision of undergraduate curricula and the pre-registration year may also occur.

Undergraduate education

5:1 The General Medical Council in its *Recommendations on Basic Medical Education* [6] recommended that undergraduates should be taught in general practice as well as in other specialties. This view was reinforced in the Report of the Royal Commission on Medical Education [7] and has been consistently advocated by the Royal College of General Practitioners [8, 9].

5:2 The reasons for the recommendation have been better appreciated recently and are in our experience widely accepted by contemporary medical students and young doctors. There are many examples of areas in which general practice has much to offer the undergraduate such as: the early presentation of disease, its natural history and epidemiology; the demonstration of diseases or aspects of diseases not normally encountered in the hospital setting; continuing care and aftercare, and terminal care; the care of special groups such as mother and child, the aged, the incapacitated, the mentally sick, the deprived, the immigrant; the range of normality in development and behaviour.

General practice also gives the student his only chance of seeing patients in their homes and of gaining a closer understanding of the working relationship between medical and community nursing, social and voluntary services. Thus, general practice can introduce the student to the complete patient in a way that can help him to understand the interconnection between the physical, psychological and social aspects of medical care.

Finally, general practice enables medical students to see how the majority of the population get their medical care for most of the time and, arising from personal care, aspects of the doctor-patient relationship when doctor and patient know each other well.

5:3 If undergraduate teaching in general practice is to be effective the College believes

TABLE 1

CHANGES IN TEACHING OF GENERAL PRACTICE IN UNIVERSITIES IN THE UNITED KINGDOM 1965–1973

	Number of medical schools (total 29)			
	Pearson, Eimerl and Byrne 1965–66)	*Harris 1968*	*Byrne 1972*	*RCGP 1973*
Departments of general practice	1	5	11	12
Chairs of general practice	0	1	6	8
All students taught in general practice	8	12	22	23
Reports from students	3	9	12	14

In addition one university without a medical school established a department of general practice in 1973.

there must be university departments responsible for it. The Department of Health has sought the approval of the Councils for Postgraduate Medical Education for a statement on the need for undergraduate departments of general practice.[10] Moreover, the quinquennial recommendations of the University Grants Committee [11] stressed that medical schools should not cut back on resources provided for these departments.

5:4 Nevertheless, a review by Byrne [12] has shown that the situation in March 1972 was nowhere near reaching these goals. The present position is summarised in tables 1 and 2.

TABLE 2

COMPARISONS BETWEEN UNDERGRADUATE TEACHING IN GENERAL PRACTICE IN 12 LONDON MEDICAL SCHOOLS, 5 SCOTTISH AND NORTHERN IRELAND MEDICAL SCHOOLS, AND THE 12 REMAINING MEDICAL SCHOOLS IN THE UNITED KINGDOM 1973

	Medical schools (total 29)		
	London (12)	*Scotland and N. Ireland (5)*	*Remaining UK (12)*
University departments of general practice	1	4	6
Chairs in general practice	0	4	3
All students taught in general practice	8	4	10

The quality of undergraduate general-practice teaching, when present, was found in Byrne's study to be uneven, partly because of variations in curriculum time but mainly in methods of organising teaching. Organisation was most satisfactory in the very limited number of medical schools where wholetime academic general-practice staff were available in adequate numbers.

However, in 11 schools which said they were providing general-practice teaching the arrangements were in the hands of other specialists—the dean of medicine or the dean of clinical studies to give two examples; and in six schools there was no member of staff available simply to make attachment arrangements, far less to supervise and teach.

5:5 In summary, current evidence suggests that despite recommendations made by the General Medical Council on the inclusion of general practice in undergraduate training, the autonomy of medical schools has meant that many have ignored General Medical Council advice when they have seen fit to do so, or, even worse, have adopted it merely as a token gesture with practical results which can be even more damaging. The situation seems to us worst in the London medical schools.

We suggest that the supervisory role of the regulating body in undergraduate education must be strengthened.

The preregistration year

6:1 The preregistration year is regarded as a corollary to undergraduate training, and is supervised by university medical schools on behalf of the General Medical Council. There has been criticism of the year from younger doctors largely because of the casual and often unreliable way in which posts are assessed. The preregistration year, introduced with good intentions in 1951, has developed into a no-man's land between undergraduate and postgraduate training.

6:2 Nevertheless, the College sees the preregistration year continuing until postgraduate training for all postgraduates is mandatory, provided that the year is improved. This is the period when young men and women are taking substantial clinical responsibility for the first time, are really savouring the life of a doctor, and are thus developing attitudes to patient-care.

We think the main emphasis should be to encourage informal learning through clinical experience, and to explore contact with patients and their families at every possible opportunity. This means that experienced clinical teachers must be readily available to

advise, help and prevent experience becoming exploitation. Bookwork, courses, and other forms of formal learning should not be over-emphasised.

6:3 This approach implies a wider choice of appointments than is available to pre-registration doctors at present. There is scope for innovation. For example, the Medical Acts of 1951 provided for preregistration appointments " in approved health centres ", but the General Medical Council has not implemented this proposal. We suggest the Acts should be amended to read " approved teaching practices ", and should then be implemented. More young doctors, particularly those intending a career in a hospital specialty, would thus have the opportunity of gaining experience of managing patients and their problems in the community setting in practices whose standards are subject to independent scrutiny.

6:4 Looking ahead, and having regard to our view of medical education as a continuum both in content and assessment, we hope the preregistration year will be absorbed into postgraduate general professional training where logically it belongs.

6:5 Finally, there have been administrative problems with the General Medical Council in the preregistration year. The College has had complaints from trainee general practitioners that the General Medical Council is too slow in completing full registration. Delays have caused temporary unemployment for some young doctors unable to take up new appointments in general-practice schemes until fully registered.

We suggest the administrative machinery for registration should be looked into closely with a view to overcoming these and the other examples of administrative delays.

Recommendation B:

The regulating body should closely supervise the universities in their assessment of preregistration posts.

Recommendation C:

The provisions in the Medical Acts for preregistration appointments " in approved health centres " should be amended to read " in approved teaching practices " and implemented.

Recommendation D:

The regulating body should administer registration quickly and efficiently.

Postgraduate (vocational) training

7:1 The College recommended postgraduate training for general practice in its evidence to the Royal Commission on Medical Education [13]. A five-year period following full registration was proposed by the Royal Commission and agreed by the College [14] and the Councils for Postgraduate Medical Education not least because undergraduate curricula can no longer prepare the newly qualified for unsupervised clinical practice.

7:2 The British Medical Association could not accept five years of postgraduate training for general practice because there were worries about manpower shortages. The College accepted this view, and was mindful also of the enormous organisational task involved in introducing training. Thus three-year programmes are being offered now, normally comprising two years in relevant hospital specialties and one year in general practice. This is a modified form of the Royal Commission's concept of general professional training and, although it is being called vocational training for general practice, it is in reality a compromise. The College is convinced that this represents only a first stage, and that a second stage providing two more years in general practice must ultimately follow.

7:3 *Content of training*

Training programmes have three main components: practical experience in teaching practices, hospital appointments, and day-release courses. They are intended to cover the content of general practice (appendix 2).

7:4 *Implementation of programmes*

Until recently, training has been confined to some experimental schemes. Last year a recommendation was made by the College [15] and endorsed by the profession to introduce

three-year programmes of vocational training with the aim of producing enough programmes for all future general practitioners by a target date of 1977.

To achieve this it has been estimated that training places will have to be found to allow for an intake of 1,200 doctors annually, or, on the basis of three-year programmes, to find places for 3,000 to 3,600 doctors training in three-year programmes. At present there are 440 trainees doing their year in teaching practices in Great Britain.

7:5 *Further training*

Three-year programmes are now giving an indication of future needs in further training. More supervised experience in general practice is of overriding importance and appears to be the main deficiency of three-year programmes. The College is examining this problem.

Recommendation E:

All doctors wanting to become principals in general practice should complete recognised postgraduate training, with five-year programmes as the ultimate objective.

7:6 *Quality of training programmes*

Because standards of training programmes have been shown to vary [16,17] the College, with enthusiastic support from trainee general practitioners [18], is introducing a more comprehensive arrangement for the inspection of schemes and individual training programmes to be recognised as providing suitable preparation for the MRCGP examination. Questionnaires dealing with teaching practices, hospital appointments, courses and administration are being completed by regional advisers in general practice and cross-checked by similar questionnaires sent independently to trainees dealing with all aspects of their programmes. The College thinks it is important to find out what learners think about the quality of their education.

The questionnaires are being supplemented by assessment visits conducted by college visitors. Teaching appointments, courses and organisation are being assessed. Trainees in general practice are being seen in groups as well as individually so that they have an opportunity to discuss problems privately with the visitors.

Our purpose is to improve on the overall quality of training by attempting to achieve a national standard, and to try also to assist with the resolution of regional and local problems.

Recommendation F:

(a) *The assessment of training programmes for general practice independent of regional postgraduate committees and councils is necessary,*

(b) *The assessment should be conducted by the Royal College of General Practitioners for the regulating body (para. 11.2).*

Continuing education

8:1 This subject is causing concern because general practitioners find difficulty, like most others, in keeping up to date. The problem was put into sharp focus at the Christ Church Conference organised by the Nuffield Provincial Hospitals Trust in 1961 from which the proposal to introduce postgraduate centres arose. However, attendances at the postgraduate courses have improved dramatically in the past decade, especially since the link with seniority payments came in 1967. The position is summarised in table 3.

TABLE 3

NUMBER OF GENERAL PRACTITIONERS ATTENDING POSTGRADUATE COURSES (FROM D.H.S.S. ANNUAL REPORTS)

Year	*1961*	*1963*	*1965*	*1967*	*1969*	*1971*
Number of doctors attending	2,652	4,918	5,101	7,715	13,629	16,195

8:2 Most continuing postgraduate education for general practitioners has been organised

by hospital specialists and orientated accordingly. This is understandable because family doctors who are able teachers are only just being identified in adequate numbers. We urge that more continuing education should be provided by general practitioners themselves and we have evidence that this is already happening.

8:3 The College is active in continuing education. Examples of its work include:

(a) courses in the regions and in London organised through the postgraduate deans and the British Postgraduate Medical Federation,

(b) tape recordings and slides provided through the Medical Recording Service Foundation of the College, the largest of its kind in the world,

(c) *The Journal of the Royal College of General Practitioners* was the first academic journal of general practice in Europe and is published monthly,

(d) a College Tutor network throughout the country, providing advice and teaching at local postgraduate centres,

(e) the provision of self-audit packages through its research and advisory service,

(f) close liaison with university departments of general practice, particularly on the provision of special courses for general-practitioner teachers,

(g) studies to assess and develop continuing education.

Educational assessment, with special reference to general practice

9:1 The College as an educational body believes that assessment is part of the educational process. We regard the mechanism by which undergraduate assessment leads to qualification as satisfactory, but we believe that the assessments themselves should be extended to include general practice. Assessment of postgraduate training for general practice is less satisfactory because it is elective. Assessment in continuing education does not normally happen in any branch of medicine.

This section deals with the problems of our branch of the profession in postgraduate education and our recommendations on registration.

9:2 *Résumé of the present position*

Today a doctor wanting to enter general practice is not required to have had postgraduate training or to possess a higher medical qualification before appointment as a principal. The right to practise in this way, although outmoded, has been stoutly defended by many general practitioners on the misunderstanding that undergraduate training, and the assessment required for full registration, inevitably produces the ' safe ' family doctor.

9:3 To try to improve this situation, the College proposed postgraduate training. However, members of the College also came to believe in the need for a minimum standard of professional competence in general practice, which is why an examination was introduced as one requirement for membership some years ago, and more recently why the criteria were tightened by making this assessment normally the only means of entry.

Since the examination was made compulsory in June 1968, 655 candidates have passed. Since then two members have been admitted without examination. One is a member practising alone in Nepal who made a special study of leprosy; the other an associate of the College who has made a major contribution to the development of the MRCGP examination.

9:4 The College's membership examination can be taken either on completion of a training programme approved by the College, or after a minimum of four years after registration, two years of which has been spent as a principal in general practice. It is regarded by members of the College as reflecting the minimum standard of professional competence required of a principal in general practice and is recognised as such by the General Medical Council. In contrast to other membership and fellowship examinations, which identify people suitable for further training, the RCGP membership at present assesses completed training.

9:5 Doctors vary in their capacity to achieve the membership standard. In three recent examinations, whose candidates were obviously drawn only from a group of practitioners

who wanted to become members and were therefore prepared to be assessed, 188 out of 289 doctors passed, a 65 per cent pass rate. Certain trends emerged:

For example, a group of young doctors who had completed vocational training had a higher pass rate than the larger cohort of established principals who had received their undergraduate education in United Kingdom schools, but who were without vocational training. At the other end of the scale was a group of doctors who had graduated from universities overseas (excluding Eire). This group achieved a significantly lower pass rate than any other.

The results are encouraging because they suggest that the standard can be reached comfortably by the limited number of doctors who have already completed postgraduate training. Whether this will still hold true when all new entrants to general practice have postgraduate training is another matter. Reports from the training schemes suggest that the College is assessing a group of young doctors who are both able and highly motivated, and who are keen to acquire the additional knowledge and skills essential for general practice through postgraduate training.

The third group is most disturbing. Further analysis has shown that most of these principals, appointed in the National Health Service, have shortcomings so fundamental that their safety as clinicians in unsupervised general practice must be questioned.

9:6 *Methods of postgraduate assessment*

Methods used in the MRCGP examination [19] are summarised in appendix 3.

Other methods are being tested. Byrne and his colleagues [20, 21] are evaluating progressive rating on trainee general practitioners in three main centres.

The registers

10:1 Against a background of widely varying attitudes to assessment in general practice, we can now summarise our views on the registers. The General Medical Council is responsible for supervising criteria for admission to the registers and for maintaining them. We suggest that in future the regulating body should retain the former function. We refer to the second later (para. 12.3).

We do not think the regulating body should become an examining body. Instead, it should continue to function through agents which it approves to act on its behalf.

10:2 *Provisional registration*

The assessment of undergraduate medical education leading to qualification is conducted by medical schools on behalf of the General Medical Council. We see no reason for change other than the need for improved administration.

10:3 *Full registration*

The preregistration year is also the responsibility of the medical schools. We suggest the criteria and methods employed should be more strict and that the regulating body should exercise more supervision of the universities until this year is incorporated fully in postgraduate training. Administration should be improved.

If the preregistration year is incorporated in general professional training, provisional registration could lapse. Registration would coincide with qualification, but would imply limited responsibility since the doctor would then enter postgraduate training.

10:4 *Specialist registration (accreditation)*

It appears that the European directives may require specialist registration. By this we understand that those doctors who have completed an approved programme of training *satisfactorily* would be identified.

We think that such a register could be useful in general practice only if it provided the public with a qualitative indication of professional competence on completion of training. The precise criteria for specialist registration in general practice would be a matter for discussion between the regulating body, the College and the General Medical Services Committee of the British Medical Association at the appropriate time. We are

clear, however, that the criteria could not be confined to mere attendance in a training programme.

We think a specialty board in general practice would duplicate an assessment capacity already possessed and used by the College. We could not, therefore, support a proposal for such a board since it would be superfluous and incur unnecessary expense.

Recommendation G:

Specialist registration for general practice should be introduced if the European directives require it, provided the criteria include an assessment of professional competence following training.

10:5 *Specialist registration (re-accreditation)*

The suggestion that doctors should have their professional competence recertified from time to time has arisen recently, largely as a result of developments in North America where medical audits have operated for some time.

Few thoughtful doctors would disagree that assessment in continuing education, and the quality of care a doctor provides for his patients are neglected areas of British medicine. There is an increasing awareness that something needs to be done. We do not think, however, that this is the moment to introduce statutory controls.

10:6 There are several practical reasons why we hold this view. These are:

(a) There would have to be general agreement in the profession on the need for specialist registration. There is no such agreement at present.

(b) General practitioners, quite rightly, would not agree to re-accreditation unless it was to apply to the whole profession. Consultants as well as general practitioners would have to be reaccredited. It must be remembered that general practitioners are already tied to continuing education in the National Health Service through conditions for seniority payments, a situation contrasting sharply with other specialties.

(c) To be acceptable, reassessment would have to be supervised by active general practitioners. There is not at the moment the experienced manpower needed to manage both the initial assessment of training and reassessment for everyone at regular intervals. In the College's opinion the first priority is to assess effectively those entering general practice as principals.

(d) We do not think that methods of reassessment, compared with the methods of assessing the effects of postgraduate training, have been fully validated. It is important to know, for instance, that a mature doctor does not only have adequate skills and knowledge but that he also uses them. This implies the measurement of quality of care, the methods for which are as yet in a rudimentary stage of development in all specialties.

10:7 This said, it is surprising how much informal reassessment is going on in general practice. We suspect there is more in our branch of the profession than in many others. For example, those well established principals in their late thirties, forties and fifties, who now comprise the majority of candidates for the MRCGP examination are in effect having their competence recertified since they have been practising for some years. Keen general-practitioner teachers in Manchester and Newcastle regions and Ipswich have been reassessed using similar methods and have shown an excellent performance. Our own college examiners are constantly retested in the process of validating components of our membership examination. And increasingly in courses run by general practitioners themselves, self-assessment is included as an integral component.

These efforts are entirely consistent with the undertaking all members of the College are required to give to retain that status, namely, that they will *maintain* their professional standards.

Further improvements must come from general practitioners themselves. In particular the College understands the need to help individual doctors to identify their own educational and operational weaknesses through self-assessment, an approach much less threatening than a statutory review.

Recommendation H:

It would be premature to link reassessment of professional competence with statutory control.

10:8 *Registration of doctors qualifying overseas*

We suggest that the present arrangements are completely unsatisfactory and should be amended.

Recommendation I:

(a) *Doctors who have not qualified in the United Kingdom, and who want to practise in this country, should pass a test of medical knowledge and of English language,*

(b) *Distinguished visitors identified by the Royal Colleges should be exempted from the test.*

This revision is urgently needed, for the reason given earlier (para 9.5).

10:9 *Effects of assessment proposals*

The College believes that it is important to assess doctors who want to become principals in general practice. Compromises may be necessary because of manpower and other difficulties in the short term, but these should be spelt out so that they can be seen as such by the general public.

We are confident that in time most trainees, if their training programmes have been satisfactory, would achieve the equivalent of our existing membership standard without undue difficulty.

Some individuals would fail. It would be for the Health Departments and the British Medical Association to devise means of enabling these doctors to make a useful contribution until they could become fully accredited (that is ready for unsupervised practice) or to enable them to work in suitably sheltered conditions if they could not. Examples of the problem are familiar in the hospital service and we are aware that they have caused difficulties. Although we do not anticipate that the number of doctors who would not be principals would necessarily be large, the problem would be a logical outcome of our proposal and has to be faced.

The regulation of medical education

11:1 We have suggested that medical education should be supervised by the regulating body. This is particularly important in undergraduate education where an increasing number of specialties are competing for resources and curriculum time. Such conflicts are likely to be less evident in the postgraduate field; we suggest that here the regulating body would normally rely on the advice of the Colleges in association with the higher training committees.

11:2 *Supervision of the quality of training programmes*

This function should not be left to the executive training bodies. Thus the universities, executive bodies in the undergraduate field, should continue to be supervised by the regulating body itself, but more thoroughly than they are now.

In postgraduate education, executive responsibility rests with the regional postgraduate committees. Their programmes should continue to be supervised by the Colleges and joint higher training committees on behalf of the regulating body to achieve a uniform standard throughout the United Kingdom.

We assume that the postgraduate councils will continue to co-ordinate postgraduate training and see that the necessary resources are provided.

We recognise that excessive central supervision can carry with it the charge of inhibiting initiative and experiment in individual medical schools. We think the risk must be taken for we are confident that enlightened supervision will stimulate development in community orientated specialties.

Recommendation J:

The Regulating Body should be required to:

(a) *Find out to what extent its recommendations are heeded,*

(b) *Report its findings to the public and the profession in annual or special reports,*

(c) *Challenge effectively universities which continue to dissent from its recommendations,*

(d) *Challenge effectively postgraduate organisations which continue to dissent from its recommendations.*

Other functions of the regulating body

There are five functions on which we comment briefly.

12:1 *Discipline*

Several of our faculties have suggested improvements to the existing procedures. These are:

(a) that the President should not be involved in all stages of proceedings, acting as both prosecutor and judge,

(b) a small penal committee should receive complaints, and initiate proceedings against the doctor where it is shown that there is a case to do so,

(c) the outcome, rather than the full proceedings, should be reported in the Press to safeguard from unjust publicity doctors who are later acquitted.

12:2 *Doctors suffering from mental and physical illness*

The College welcomes the initiative taken by the General Medical Council and the Council of the British Medical Association. We have no further comment.

12:3 *Maintenance of the registers*

Given the assignment of the criteria for registration as a function of the regulating body, it may be desirable that the future regulating body administers the registers also, as the General Medical Council does now. On the other hand, this technical procedure might be contracted to an agency.

The College agrees with the British Medical Association that there would be considerable advantages in a single, accurate and up-to-date register which could be used by the public and a variety of professional organisations, with the potential of great savings in cost. We hope this will be explored vigorously.

12:4 *Communications*

We list this as a function to ensure that it is not overlooked. The regulating body must command the support of the public and profession if it is to function well. It is the view of many of our members that this function, or rather the neglect of it, is one of the main failings of the General Medical Council.

We would not rely over-heavily on improved reporting back to the profession by a greater number of elected representatives. Rather, we suggest that the regulating body should be required to publish regular reports of studies and enquiries in some depth, in addition to a comprehensive annual report. Complete financial statements, regularly made, could dispel other opportunities for disquiet.

The regulating body

13:1 *Criticism of the General Medical Council*

In framing our suggestions about the structure and internal functions of the regulating body, we had in mind the comments of faculties and individual members of the College on the shortcomings of the General Medical Council. The main points are:

(a) *It is undemocratic in its work.* This has been recognised by the Brynmor Jones Committee in its recommendations. We would support further development of that Committee's intentions to reform,

(b) *The office of President carries too much power,*

(c) *The Council is isolated* and has given the impression of being out of touch with important developments in education and service, and of changing attitudes in disciplinary and ethical matters.

13:2 *Internal functions*

We discussed at length whether there was a case for two regulating bodies, since modern medical education is complex, and appears at first sight to require a different approach to discipline. We concluded that a single body, properly constituted, could still discharge both functions if its specialist committees were properly formed.

Many solutions will be proposed, so we do not offer yet another. However, we think the following points are important:

(a) The regulating body should have a majority of elected members. The Brynmor Jones approach on composition is acceptable to us. We do not think that size will be critical if the constitution of the body and its executive is sound,

(b) The internal processes should be revised so that the governing body meets more regularly, is supported in its everyday work by an executive committee which is fully informed and accountable to it, and it receives advice and recommendations from standing committees.

The standing committees should also meet regularly, and with the exception of the disciplinary and general purposes committees, these should elect their own chairmen. This devolution of function should ensure that every member of the regulating body is actively involved, and diminish criticism that a large body would be unwieldy.

(c) The work of the regulating body would be enhanced further if the age of professional members ensured they still continued in active practice,

(d) The President should be elected by the regulating body. We suggest three-year terms of office open to one re-election,

(e) The regulating body should be required to publish full accounts of its activities, research and finances each year.

13:3 The composition of the main committees should reflect their particular functions. The education committee and its subcommittees (including undergraduate and postgraduate education, and professional competence), should for instance have a membership drawn mainly from bodies with a special interest in this field. By contrast the disciplinary and related committees should rely on a medical membership which reflects no particular academic interest, and should be supported by a significant lay minority.

13:4 *Finance*

This issue is critical. The functions we propose for the regulating body will be expensive if properly carried out.

Recommendation K:

The College believes that the profession must contribute to the cost of the regulating body, but suggests that some functions not immediately connected with regulation could be funded by the Government.

Examples of areas where State funding would be appropriate include the cost of compiling, maintaining and distributing the registers and expenses incurred in assessing training programmes.

Summary of the College's recommendations

A. All medical education, undergraduate and postgraduate, should be regulated by a single body.

B. The regulating body should closely supervise the universities in their assessment of pre-registration posts.

C. The provisions in the Medical Acts for preregistration appointments " in approved health centres " should be amended to read " in approved teaching practices " and implemented.

D. The regulating body should administer registration quickly and efficiently.

E. All doctors wanting to become principals in general practice should complete recognised postgraduate training, with five-year programmes as the ultimate objective.

F. (a) The assessment of training programmes for general practice independent of regional postgraduate committees and councils is necessary.

(b) The assessment should be conducted by the Royal College of General Practitioners for the regulating body.

G. Specialist registration for general practice should be introduced if the European directives require it, provided the criteria include an assessment of professional competence following training.

H. It would be premature to link re-assessment of professional competence with statutory control.

I. (a) Doctors who have not qualified in the United Kingdom, and who want to practise in this country, should pass a test of medical knowledge and of English language,

(b) Distinguished visitors identified by the Royal Colleges should be exempted from the test.

J. The regulating body should be required to:

(a) Find out to what extent its recommendations are heeded,

(b) Report its findings to the public and the profession in annual or special reports,

(c) Challenge effectively universities which continue to dissent from its recommendations,

(d) Challenge effectively postgraduate organisations which continue to dissent from its recommendations.

K. The College believes that the profession must contribute to the cost of the regulating body, but suggests that some functions not immediately connected with regulation could be funded by the Government.

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Addendum

The evidence of the College has been slightly shortened for publication and the appendices have been omitted. Enquiries about the appendices should be made to the Secretary, The Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU.

TREATMENT OF OBSTRUCTIVE RESPIRATORY DISEASE

A non-blind, within-subject, cross-over study in 25 patients only 19 of whom completed the trial, is described, the object being to compare the clinical efficacy, incidence of side-effects and patient acceptability in general practice of a sustained release tablet of theophylline (Theograd) with a sustained release tablet containing theophylline, ephedrine and phenobarbitone (Tedral S.A.).

The sustained release theophylline was seen to be marginally superior in clinical efficacy, with a comparable incidence of side-effects.

The suggestion that patient preference for the mixture tablets may not be based entirely on therapeutic efficacy found some confirmation in this trial.

It is concluded that the sustained release theophylline tablet is an effective, useful bronchodilator.

Pajwani, K. S. (1973). *Clinical Trials Journal*, **9**, 44–47.

CAUSES OF BLINDNESS UNDER THE AGE OF 65

In 1963–1968 the six leading causes of blindness were responsible for 72 per cent of all new registrations under the age of 65: diabetic retinopathy—16 per cent; congenital anomalies 14 per cent; myopic chorioretinal atrophy 14 per cent; optic atrophy (known or presumed to be acquired) 13 per cent; retinitis pigmentosa 8 per cent; and glaucoma 7 per cent.

It is noteworthy that infectious causes of blindness no longer figure prominently.

Sorsby, Arnold (1973). *Health Trends*, **5**, 7–9.