The future of the College — 2.

DONALD IRVINE, MD, FRCGP
General Practitioner, Ashington, Northumberland; Honorary Secretary of Council

The object of the College is "to encourage, foster and maintain the highest possible standards in general medical practice . . ."

The Royal Charter

OUR foundation members defined the object of the College with these carefully chosen words. Among the functions they envisaged were the setting of standards, the provision of better education, the pursuit of new knowledge, and the creation of an organization through which like-minded general practitioners could keep in touch with one another in an active fellowship to pursue mutual interests, share ideals, exchange ideas, and always to stimulate and encourage one another in good times and bad.

The balance among these functions has altered several times in the short history of the College. Thus the College has been more dynamic than institutional, about people rather than bricks and mortar, and has been capable of adapting itself fairly quickly to tasks which its members have seen as important to better care of patients.

In the evidence to the Royal Commission on the NHS (1977) the College showed why good general practice is a highly effective system of care and what resources the community must provide to make general practice better. The College also said that good care of patients requires our guarantees on competence and on the nature of our service as well as society's support for our professional needs.

Despite these statements we are now being faced with the fact that the quality and range of services given by some general practitioners in the UK is no longer proving acceptable to the community. Thus there is increasing public pressure on the profession to reduce the extremely wide variation characteristic of general practice today. The profession must get to grips with this question, in the interests of both patients and the many good general practitioners. If it does not government and people will find their own perhaps less acceptable answers through legislation designed to give more control over general practice, or by easing general practitioners out of primary health care in selected circumstances, or by a combination of both.

Can the College help find a professional solution? Should it even try? There is a view that the College should ignore the problem, to become a small, influential body for doctors who wish to pursue excellence in general practice. In my opinion the College should now give a more robust and open lead by actively encouraging and helping as many general practitioners as possible to commit themselves to reasonable standards of care for patients. I suggest that the pursuit of reasonable standards, and standards of excellence, is perfectly reconcilable within the same organization.

This essay is on the problem of quality variation and how the College might help to heal this division in general practice by redefining its functions and re-organizing its structure, to evolve as a truly federal body capable of creating maximum opportunities for all members to take part in its work, and for non-members to share in its educational activities.

The work of general practice

The College's first priority should be to work towards a better understanding of the job to be done by all general practitioners. The success of general practice will depend almost wholly on the extent to which we can hammer out a cohesive discipline which is understood and accepted by every general practitioner and most patients.

Two concepts of general practice

The divisions among general practitioners about their functions in society have become more obvious recently because two increasingly different concepts of general practice have come to exist side by side, in the same city, town, or even street.

In the simpler concept, general practitioners believe their job is to treat minor illnesses, provide sickness certificates, secure specialist services for patients with serious medical problems, and help nurses care for the chronic sick. For doctors who subscribe to this static concept, general practice is still the sum of a number of specialties practised at a fairly superficial level. These

doctors regard themselves as subordinate rather than complementary to consultants, rather like casualty officers working in the community. They look to specialists to provide the major clinical services, for they want limited clinical responsibility, and they thus expect and have lower earnings than consultants. They genuinely cannot see the need for postgraduate training because they think that it is irrelevant to the work they do and they look to consultants to help them keep up to date. They tend to be professionally isolated, even though many live in cities, and are thus normally parochial in outlook. They are not natural teachers or innovators. Some are older, but others include today's young who still see general practice as the soft option in medicine, conducive to the quiet life or to part-time work without significant responsibility.

The second, dynamic concept of general practice includes the functions of the simpler form, but there the similarity ends. Based on the practice of 'whole-person' medicine, it incorporates the rigorous application of scientific and epidemiological method, and clinical judgement, to all aspects of diagnosis and management, social and behavioural as well as physical. It has increased the range of conditions which general practitioners can handle unaided by specialists, has revealed more clearly those illnesses or aspects of illness in which the general practitioner is the doctor of first choice, and has indicated that general practice is the most important of the personal medical services for prevention. It is this comprehensive, inquisitive, self-critical approach, coupled with a highly developed sense of continuing responsibility for the health of patients which characterizes this concept of general practice as a distinctive discipline with its own unique combination of knowledge, skills, and attitudes. Doctors who try to practise in this way see that general practice provides a professional life which challenges their intellectual curiosity and satisfies their desire to know their patients well. They expect it to furnish them with an income, status, and teaching and research opportunities comparable with the other main branches of medicine. They understand the need for a life-long commitment to further learning, the logic of setting standards, and self-discipline—the essence of being a professional person. They shun professional isolation because they know that it is as incompatible with the pursuit of reasonable standards in general practice as it is in any other specialty, and is the greatest barrier to creative thinking.

A recent variant of this dynamic concept is seen in the trend among some members of academic departments of general practice and some regional advisers either to drop their clinical work altogether or to limit it severely in favour of teaching, research, and administration on the grounds that a person cannot do everything well. The College, acutely aware of the potentially damaging effects of this non-clinical variant, furnished the Royal Commission with arguments showing why all doctors engaged in education for general practice should always have the incentive to work and teach from the basis of their own professional practice with patients. It had already persuaded the Government, with help from the General Medical Services Committee (GMSC), to advise the universities and health authorities who employ regional advisers that in future these doctors must spend at least half of their time providing general medical services for their own patients. It has not so far proposed a similar clinical commitment for members of university departments of general practice, although some of us think it should.

Most of us would probably say that we come somewhere between the extremes represented by the two concepts described. What is encouraging is that there are many established doctors who are prepared to make the considerable personal effort needed to improve their mastery of the new discipline because they see a new dimension to professional life which they would now like to enjoy. Moreover, most of the young in training see it as a sensible and worthwhile objective since it is their reason for choosing general practice rather than a hospital specialty in the first place.

Our professionalism questioned

General practice has a deeply rooted entrepreneurial tradition which has had the effect that decisions about the content of work and the degree of responsibility to be accepted, as well as the standards of performance to be achieved, rest almost exclusively with the individual doctor. Hence the many variations of general practice. In one way this approach has worked to the advantage of patients because the flexibility it gives has been used by some general practitioners to introduce new services and improve existing ones. However, it has given a significant minority of general practitioners, especially in inner city areas, the opportunity to cut their availability for service to NHS patients to the bare minimum—sometimes below their contracted limits—while retaining their full NHS remuneration.

The entrepreneurial philosophy has also held our doors open to all comers—enthusiastic family doctors and refugees from other specialties, the able and the intellectually limited, the keen and the idle, the caring and the insensitive. The combination of loosely defined functions and responsibilities, interpreted and applied in widely differing ways by individual doctors, and the variety of people who have become general practitioners, has had the predictable result that patients have become confused as they try to reconcile what our representatives say we are providing with the care they actually receive from their own doctors.

Many patients, especially those living outside our cities, say they enjoy an efficient and comprehensive personal service. They like it and want it to continue. Others find it difficult to see their doctor or to be examined by him, always provided that they can find a doctor who will accept them on the NHS list in the first place. It is this second group of patients, and some of our colleagues in the health professions, who are among our sternest critics.

We say that our philosophy for setting standards in general practice is the usual one in medicine, namely, that as individuals we maintain our own standards, and as a group we agree on general criteria by consensus. This is self-discipline based on self-assessment rather than regulation by government. Yet a glance at our track record shows why the public is sceptical of our intent to apply consensus criteria to all practitioners. It was the Government, for example, which introduced the obstetric list to ensure general minimum standards of clinical performance in that field. The Government also linked postgraduate education with seniority payments until recently, against the wishes of most of us, to try and persuade some doctors to keep up to date. The Government has recently taken the initiative again by insisting on a national code of practice for deputizing services because of widespread public criticism of some of them. In these instances the Government rightly introduced regulations to protect the public interest because we general practitioners failed as a group to insist that all should observe the minimum standards willingly and voluntarily observed by most doctors. The Court Committee's proposal (1976) for a 'general practitioner paediatrician' presents the same contractual approach as adopted by government since the object is to set minimum standards in paediatrics in order to try and solve the problem of bad paediatric care given by some general practitioners.

Sometimes, the initiative for legislative controls has come from us. The NHS Act (1977) and its regulations on vocational training for general practice is the best example. The inclusion of training in the Act is regarded by our sister specialties as further evidence of our lack of self-discipline and as a precedent for State control which may threaten their professional rights as well as ours. Here the College and the GMSC together failed to persuade a sufficient number of general practitioners that postgraduate training had now become essential for safe clinical practice, so together they asked the Government to provide a standard by regulation. To be fair to the Government, it did point out the dangers very carefully, so it acted with absolute propriety.

Can we honour our obligations to patients without recourse to more government control? Inevitably there has to be a balance, because neither the profession nor the Government can succeed alone. However, what we can no longer afford to ignore is this continuing criticism of our professionalism. I suggest that if enough of us now put our backs into the task of reaching a greater agreement about the basic aspects of the job, preferably in consultation with patients, we can at least derive broad criteria for reasonable practice and thus become less divided on standards and less exposed to public hostility and government intervention.

Clarifying the job

We can still draw only wide boundaries around our subject despite the morbidity studies, studies of the consultation, and investigations into our ways of practice. The definition of a general practitioner published by the College (1972) gives only a vague indication; it is so broadly defined that it is capable of almost any interpretation. For example, some practices provide a continuing service for the chronic sick whilst others do not; some of us are careful prescribers whilst others offer symptomatic treatment regardless of cost or therapeutic effect; most of us examine our patients carefully, a few do not bother; most of us ensure that emergency care for our patients is provided by experienced principals while an increasing number of us leave it to inexperienced juniors; a few of us keep exceptionally good records and a few others keep none. I have chosen these instances at random. One could point to almost any aspect of our clinical work for more, and within each example there will be several interpretations. There is one unifying thread. Most of us regard our particular way as right!

The College's main attempt to start unravelling this confusion was *The Future General Practitioner–Learning and Teaching* (RCGP, 1972). From this, and even more from the practical experience of some doctors involved in vocational training, have come at least seven useful working conclusions.

1. Content definable. There is the basis of a discipline. The agreement on five main areas of content reached by the writers of the book has since been accepted by many other colleagues who find that the general principles make sense. This observation is vital. Agreement is possible. We do not yet know how in detail our discipline will eventually unfold; we can say that the static concept of general practice—'the sum of a number of specialties'—can be discarded in future unless we intend to have more than one grade of general practitioner.

2. Understanding concepts. There are severe limits on how far new concepts about the nature of general practice can be communicated by individuals or groups to other people through papers or memoranda. Experience with the Nuffield courses and trainers' and audit groups all point to the conclusion that if we are to gain and keep a reasonable measure of understanding, we have to work through what we do with patients, how and why and with what effect, on our own and in continuing discussion with others. There seems to be no way round this process; it involves time and effort.

3. The value of small groups. Small groups seem to be the best mechanism at present for 'working through' and thus digesting our subject. They are the most promising means we have found yet of overcoming the damaging effects of professional isolation, which is why they have opened up the field of peer group monitoring and have reached out to involve practitioners formerly untouched by peer group learning.

4. Local leaders essential. A critical factor determining the success or failure of small groups is the

quality of their leadership. The number and geographical distribution of people willing and able to run and inspire groups will be one of the most important factors determining the rate of acceptance of our discipline.

5. Standards by consensus. There is an extension of the 'working through' principle. Working standards are most often acceptable, and therefore observed, when determined by individuals collaborating informally and privately with respected and trusted colleagues. Government or university generated standards derived from the work of unknown people or from academic general practitioners who are known to be in atypical practices, or not in practice at all, tend to be resisted or ignored.

The setting of criteria for teaching practices, coupled with the system of appointing, recognizing, and reviewing trainers, is the best model we have yet devised of a dynamic, standard setting system which works on this principle.

6. Information required. Standards of performance cannot be generated by individuals or groups without recent data from individual practitioners about their own work, and the means to compare these data with the work of others. An information retrieval system must therefore be available to each practice, even if it is in a very simple form.

7. Morale. When trying to understand our job better in order to teach it, many of us have found ourselves in a new dimension of medicine. The effects on morale have been helpful, since high morale is thought to influence the quality of care for patients and is infectious, spreading to many more doctors. High morale means fewer bad doctors.

Towards a solution

If the foregoing analysis is broadly sound it follows that:

1. We must build up our discipline from its roots in individual practices.

2. Our main effort must be educational, involving doctors in a regular examination of their own clinical practice in single and multidisciplinary groups based on practice premises and postgraduate centres.

3. Our most enthusiastic and skilled people must give more time and thus more impetus to participate in local activities.

4. We must introduce better records and information retrieval systems.

5. Alongside the educational effort, we must enter the field of outcome studies guided and directed by the Research Division of the College and the universities.

6. Sensible professional incentives will be needed if all doctors are to be involved rather than the enthusiastic few. An educational allowance is one obvious possibility.

7. Sanctions, limiting or removing the right to practise, should be a last resort to deal with the sick or bad doctor. The existing machinery, through the General Medical Council, the courts, and the contracting authorities, is adequate if used properly.

What is now needed is a strategy which will enable the main body of general practitioners to maintain an effective consensus of what is 'good' general practice at any particular time through mechanisms sensitive enough to enable us to adjust reasonably quickly to changes in the needs of our patients and advances in the practice of medicine. I must stress that I am not advocating the construction of an elaborate, fixed job definition because this would be hopelessly prohibitive and quite impractical. The task will demand a commitment of a high order. There are three main components to such a strategy:

1. An educational part, local and peripheral in its main thrust, to help practitioners digest the results of their own clinical practice and improve their knowledge and skills.

2. A research programme, primarily to evaluate the effectiveness of care in general practice.

3. A synchronized political policy to ensure that general practitioners have the time, the professional and financial incentives, and other resources essential to maintain their morale and so do their work well.

Education and research would be the responsibility of the College, postgraduate organizations and universities, whilst the political aspect would rest with the British Medical Association and GMSC. The whole strategy needs to be seen within an NHS framework designed to encourage the profession to be resourceful, self-reliant and self-critical, rather than beleaguered by bureaucracy.

Why make the effort?

As we gain a clearer view of the guts of the job of every general practitioner several things should happen. For example, our understanding with patients and professional colleagues should improve since we should be able to explain more clearly the range, and also the limits, of our service. The aims of education should be clarified. We should know better what knowledge, skills, and attitudes are required for competent practice. Working out the content and the educational goals of vocational training and continuing education, and how best to teach and learn in both, should become easier.

We should also know more precisely what our discipline has to offer in the education of medical students, doctors in the pre-registration year, and those entering other specialties and other health professions. Lastly, the GMSC should be able to represent our contractual interests more effectively, for it would be better able to negotiate positively and surely on the basis of what is accepted and recognized as reasonable general practice, rather than be forced repeatedly into a

defensive posture because of our Achilles heel, the bad general practitioner.

The role of the College

If the College accepts a full commitment to education and research it will mean a major redistribution of functions and money between Council and the faculties to give the faculties new responsibilities and the freedom to show their paces. Strengthening the faculties by asking them to take such an active role should maximize participation by members and give the College the very broad foundation it needs for setting standards. The federal structure of the College, there in name more than reality today, must be reconstructed with resolution and dispatch. To achieve this it is helpful first to consider what the functions of the faculties and Council might be.

Functions of faculties

I suggest faculties should:

1. Provide an educational, professional, and social focus within easy reach of all our members.

2. Help members monitor their own clinical standards through self-audit groups and similar arrangements.

3. Work in collaboration with the postgraduate organizations and universities to determine criteria beyond the national minima for the selection of teaching practices to promote constructive competition and thus foster excellence.

4. Accredit young doctors who have demonstrated their competence on completion of vocational training and choose to have their competence recognized by the College.

5. Assist Council in the assessment of candidates for membership and conduct the main assessment of members eligible for fellowship.

6. Provide advanced courses on continuing education designed specifically for general practitioners.

7. Provide specialized courses for our membership candidates.

8. Give practical help on practice organization.

9. Run a research group.

10. Offer local advice on the work of the College.

Some characteristics of successful faculties

Among the characteristics of the more active faculties I have noted the following:

1. Pride in the values of the College. Faculties which have established our membership have done so largely because they have shown colleagues that membership symbolizes a commitment by individuals to a set of professional values, a way of practising medicine, and a respect for patients, rather than merely the acquisition of a qualification. In some faculties membership of the College is also regarded as an important safeguard to the general practitioner's future livelihood in an increasingly monopolistic State health service in which professional qualifications tend to become important.

2. Leaders. There is a critical mass of pace-setters and opinion-formers who are good doctors, and probably good teachers, organizers, and politicians as well. These doctors support the idea of an independent and healthy faculty, and identify strongly with it. They will be putting their College's views subtly and repeatedly in many local medical and lay organizations.

3. Good organization and communications. Some faculties are already subdividing and organizing themselves on local units to make access to college activities easy for members. This makes good sense. To do it well good staff work and secretarial support are vital.

4. Involvement of non-college practitioners. In successful faculties practitioners who are not members of the College are seen at many college events and are made welcome.

Functions of Council

Council should complement, co-ordinate, and facilitate rather than overshadow the work of the faculties. The main flow of ideas and policies should be in rather than out, though there is obviously a need for both. If devolution of the College to a truly federal structure is to be successful we must curtail the present unnecessary and therefore expensive proliferation of Council committees and working parties. We should beware also of spurious activity in Council committees which, even if imaginative, can create the illusion of progress through a plethora of reports and papers which few people read, far less act upon. In seeking a balance between periphery and centre, I suggest the main functions of Council should be to:

1. Conduct an effective assessment for membership based as closely as possible on the standards of performance identified in the faculties as indicative of good general practice.

2. Act as a national communications system by providing a *Journal* of high quality, by maintaining a good library, by distributing information among faculties, and by encouraging the exchange of ideas among faculty representatives.

3. Promote national and local research studies through the college research units and the Research Division.

4. Advocate college policy in other bodies concerned with general practice.

5. Provide an information service on practice organization.

6. Furnish a national forum for the discussion of important ethical matters.

7. Co-ordinate the results of the work of the faculties in education when necessary.

Money for the faculties

Successful faculties have shown what can be done with enthusiasm, working on a financial shoestring. Council, on the other hand, has a lay organization, and has recently strengthened it by the addition of paid medical time through the dean of studies. I believe that this totally unbalanced arrangement is no longer good enough. If the faculties are to be effective in the discharge of the functions I have suggested they should have in a federal college, they must also have a basic lay and medical organization which is adequately financed.

The aim should be to provide the faculties with an efficient organization which facilitates (rather than interferes with) the work of the faculties. The first priority is to provide good secretarial help. The second is to furnish some paid, medical, notional sessional time so that faculties can appoint members to see that their exclusively college functions are carried out thoroughly and consistently in all areas. These appointed doctors would stand in the same relationship to the elected chairman of the faculty board as the dean of studies does to the Chairman of Council, that is, they would be accountable to the faculty board through him. A revised and reorganized college tutor network is one model I have in mind, but there are others which faculties may prefer instead.

The key question is, can we afford it? The answer must surely be: yes, if we want to. An executive secretary with overheads will cost about £5,000. An honorarium of, say, £500 a year to college tutors for a notional two sessions would add considerably to expenditure, depending on the number of people involved. However, the medical side could be built up gradually. I believe that many college tutors would continue to work well beyond any notional sessional limit, which is why I favour an honorarium. Voluntary work for the College is still both highly desirable and indispensable.

Where can we find the money? I am talking eventually about an addition to each faculty imprest of some £5,000 to £7,000: that is, a total expenditure of between £125,000 and £175,000 in all our faculties. The money will have to come from several sources.

I suggest our aim should be to hold the absolute level of expenditure on Council activities at about or just below its present level (allowing for inflation which would be covered in the normal way by subscription review) while seeing Council expenditure diminish as a proportion of the total income of the College as our membership increases.

We should begin at Princes Gate, by exercising stricter control on the number of central working parties and on the amount of paper work of questionable value which absorbs so much secretarial time. The office at Princes Gate could provide a home and administration for the metropolitan faculties which would make more efficient use of existing resources. The UK membership of the College is just under one third of the total of all general practitioners. Increasing our UK membership by 4,000 would bring in some £100,000 more in subscriptions at the present rates, most of which must go to the faculties.

Since a capitation system would have to form the basis of the new imprest, we should give faculties an incentive to bring in new members by ensuring that each enjoys the maximum benefits possible from the additional subscriptions they attract, and that each has absolute discretion in the use of this money.

Clearly a detailed financial study will have to be made. It should begin now and should be completed within, say, six months. Then we will know more precisely what range of options is open to us.

The College and society

I am optimistic that the majority of young doctors entering general practice will become active members. In some regions over 90 per cent of doctors who have trained are joining. The College of the late 1980s should thus be more broadly representative. I believe that continuing membership of the College should always be voluntary, because I dislike the closed shop. This said, I think it is right actively to encourage doctors to join because I believe in the importance of the College to the future of the care of patients through general practice.

These remarks help explain how I see the relationship between the future College and society.

1. With patients and colleagues

Some patients are aware that the letters MRCGP or FRCGP after a doctor's name are supposed to reflect certain standards of service; more are likely to do so in future. We wear our membership or fellowship as an ambassadorial badge, and this should become a credible and easily seen guide to good general practice.

Membership means a commitment of time and effort to education and clinical monitoring. We should encourage faculties to make our membership a living symbol of good general practice by our regular participation in learning and teaching to maintain our competence.

The MRCGP examination needs reviewing now that the basis is established. I think it should be in two parts with the first part used for accreditation. Can we include an on-the-spot assessment of the doctor's work in his or her own practice using our examiners in the faculties? Should there be a clinical examination? For the established doctor wanting to become a member, can we use any of the assessment methods we have developed through the Joint Committee on Postgraduate Training for General Practice (JCPT) for the selection of new trainers instead of making older men take the multiple choice questionnaire? For younger doctors just completing training should we now incorporate information from the Manchester rating scale, since it assesses aspects of the doctor's work not covered by the examination?

Assessment for fellowship should now be reconsidered so that it reflects most positively on sustained excellence in the care of patients over a considerable period. The award of fellowship should be based on rigorous criteria which can be met by any member in active clinical practice who does his job consistently well.

Accreditation—the identification of the competent among those who have trained—assumes the use of assessment as part of a thorough programme of training. Its use must be seen in relation to the vocational training regulations which will ask only that a person who wishes to be certified as having acquired the 'prescribed' or 'equivalent' experience for general practice should first have attended a three-year training programme.

The regulations will give the public the impression, I suspect, that all so certified are also competent. To use the regulations in this way, unsupported by voluntary accreditation, will be misleading and will damage the NHS, the profession, and our College in the long run.

Voluntary accreditation based on a combination of passing our membership examination (though with no obligation to become a paid up member of the College unless a person chooses to do so) and the achievement of satisfactory scores on the Manchester rating scale has been in operation in the Northern Region for two years. I cannot see why it should not be introduced elsewhere, unless other people have better methods of assessment.

The College should establish voluntary accreditation now so that the public, through the contracting authorities, and practices choosing partners can know the credentials of the people they may be appointing as principals. It is in the interests of our patients and the profession to make this information available. It is not the business of the College to say what contracting authorities should do with it subsequently. Accreditation by the College should carry no commitment to join as a full member, and should suffice until the General Medical Council introduces specialist registration.

2. *Universities and regional postgraduate organizations*

Responsibility for the contribution of general practice to the basic medical curriculum belongs to the universities through their departments of general practice. Similarly, vocational training is the business of the regional postgraduate organizations. Continuing education has been provided mainly through the clinical tutors employed by the postgraduate organizations, but increasingly college faculties are acting as important agents. The responsibility for setting standards regionally has not yet been assigned. I believe it should now be assumed by the faculties on behalf of college members.

Ideally, I would like to see close collaboration between the universities, regional postgraduate organizations, and college faculties by agreeing that each of these bodies has a main sphere of influence while contributing fully to the work of one another.

3. *Local medical committees and the GMSC*

It has always been understood that the College and the medico-political organizations in general practice would keep their functions separate, and so would not follow the precedent set by the specialist colleges through the Joint Consultants Committee. It makes good sense to have professional standards in the hands of a corporate professional body which cannot negotiate terms and conditions of service with the NHS. Equally, it would be unwise for the medico-political organizations representing general practice to try to do both tasks.

The faculties must work closely with the local medical committees, and through Council with the GMSC. Sometimes the boundaries of our responsibilities will not be too easily or comfortably defined, particularly when questions about the quality of care arise. However, experience has shown that practical, pragmatic adjustments are in fact made when there is goodwill on both sides, and the most recent evidence of this has been the exchange of representatives between Council and the GMSC.

I can best summarize how I see the relationship, thus. In my daily professional life I have three basic needs: the support and encouragement of a body which will help me to become a better doctor; a good union to look after my income and my contract of service; and an organization to assist me when I am in trouble. The College does the first, the GMSC and my local medical committee do the second, and my defence society is the third. Each is essential, which is why I subscribe willingly to all. Each complements the work of the others and collectively they strengthen general practice.

4. *Joint Committee on Postgraduate Training for General Practice*

The JCPT inspects and recognizes vocational training programmes of the required standard, and in future it will be responsible for issuing certificates of prescribed or equivalent experience under the vocational training regulations.

The College has a close working relationship, since it is one of the two main constituent bodies. I do not see the relationship changing significantly because I do not think that the JCPT should have any additional functions.

5. *With the NHS*

The corporate College sets standards for individual doctors which the NHS can use if it so chooses.

Members of the College bring their professional knowledge and their values to the NHS through their presence on the standing committees. The role of the college member here is one of influence.

6. *Royal Colleges and faculties*

It is ironic, at a time when we are in danger of emasculating our faculties, that the other Royal Colleges and faculties are discovering that a narrow

collegiate membership is a handicap and that working standards for physicians, surgeons, psychiatrists, and others can be set and maintained better through organizations which encourage broad participation. Surely we must learn from this? The time is ripe for joint collegiate action in the pursuit of outcome studies and collaborative educational activities.

7. General Medical Council

The Bill for the reconstruction of the General Medical Council is now before Parliament. It is important that our College plays a part in the work of the new GMC in its own right, for it is surely inevitable that specialist registration will follow.

Envoy

I believe that the College has now come to a crossroads of possibly historic significance. We have a real chance to make our finest contribution yet to a charter for good care of patients in general practice if we reorganize our College to enable members and non-members alike to realize their full potential as general practitioners.

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Addendum

This is a shortened version of the paper Dr Irvine presented to Council in December.

Preventive medicine in general practice

In about 1934, Dr G. C. Sheldon introduced the first 'well-baby and mother' clinic at a Reigate surgery, an antenatal clinic, and emerging from this an immunization clinic for children. It did not conflict with the one set up by the Health Authority and was adopted on his recommendation by two other practices. It had the merit of continuing care within a practice.

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