The history of vocational training for general practice

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SUMMARY. We feel that it is worth recording the story of how vocational training for general practice was first proposed, how the earliest experiments were started, and how this prolonged exercise in teamwork developed throughout the UK. It is appropriate to do this now that Parliament has recently voted that this training should be an obligation for all doctors who wish to work as general practitioner principals in the NHS. Moreover, the first person to exert a crucial influence, Henry Cohen (Lord Cohen of Birkenhead) has recently died.

We write this account in historical sequence, not comprehensively, but selecting what in retrospect we believe to have been of chief importance. We describe initiatives at first unrelated to each other, but all contributing to one end. As the story unfolds, so does co-ordination in the common effort. The account ends at 1970.

Before 1948

THE term 'general practitioner' first appeared in the early nineteenth century. An attempt to found a College of General Practitioners was made in 1844, although it was unsuccessful. That it should among other purposes "provide for the future education of a general practitioner" is clearly suggested in letters written to the *Lancet* at the time[1,2].

In 1882 a working party of the Metropolitan Counties Branch of the British Medical Association noted that "no inconsiderable number of recently qualified medical men have no idea of the real duties of general practitioners until they are actually engaged in practice; many of them discover that their work is hardly that which they had anticipated". It recommended that "before a student receives his licence to practise he should produce a certificate of having studied for six months with a general practitioner, or a public institution, where he has personal charge of patients at their own homes"[3].

Sir James Mackenzie put the issue forcefully in 1919: "The teacher of practical matters must be one who experiences what he teaches. We all recognize that the best teacher for one who wants to be a shoemaker is the man who is in the habit of making shoes. Unfortunately this common-sense idea is rarely applied to medical education"[4].

1948

The year 1948 was of crucial importance in the story we are telling. It was of course the year in which the NHS was launched, but it also saw the publication of two reports. The first was *The Training of a Doctor: the Report of the Medical Curriculum Committee of the British Medical Association*[5]. The second was the Report of the Spens Committee[6].

Written by a committee headed by Dr Henry Cohen, then Professor of Medicine at the University of Liverpool, the first report contained this paragraph:

> "The Committee does not, therefore, accept in its full implication the often reiterated view that the end of the curriculum should be to produce a competent general practitioner. General practice is a special form of practice which must be founded on general basic principles and appropriate postgraduate study."

This report, clearly opposed to the view of the Goodenough Committee[7] about the purpose of the undergraduate curriculum, was followed in 1950 by another, *General Practice and the Training of the General Practitioner*, a Report of a committee of the

British Medical Association[8]. Here we find:

> "This study of postgraduate education of the general practitioner falls into two main divisions: first, the period of training after registration for the special work of general practice and secondly, subsequent continuous education of the general practitioner throughout his professional life. The notion of specially designed post-registration training for general practice is new, and arises from the view that general practice is a special branch of practice in the sense that, as with other special branches, it demands adequate postgraduate training and is deserving of rewards commensurate with such branches, especially if the best men are to be attracted to this field.
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> ". . . The provision of such training will necessitate certain radical changes in existing procedure and organization, including legislation to amend the Medical Acts. [The Acts stated that the practitioner, immediately after passing his final examination, is qualified to undertake independent practice throughout the whole range of medicine.]
>
> ". . . The Committee recommends that a period of three years should elapse between registration and the assumption of independent general practice and that this period should be spent in preparation directly designed for general practice, just as entrants to other special branches of practice expect to devote several years to training for it. For the first of the three years the young practitioner should act as trainee-assistant to an established general practitioner; the second year should be spent in specially designed and preferably residential hospital appointments; and the third year should provide supplementary training at the choice of trainees."

The trainee practitioner scheme

The trainee practitioner scheme was also launched in 1948. The earliest statement[6] about its purpose is interesting and not well known:

> "So far nothing has been said about practitioners under 30 years of age. Altogether, apart from the problem with which we are now concerned, we had decided to recommend that after the completion of house appointments a doctor who wished to enter general practice should spend one and preferably two years as an assistant, and receive a net salary of not less than £500 per annum. We have little doubt . . . that even those doctors who intend to become a specialist would benefit from a year spent as an assistant in general practice. We suggest that, while any practitioner should be free to engage an assistant, approximately 10 per cent of practitioners, selected on the grounds of their success in practice and general suitability, should be encouraged to do so . . . We believe that some such system would improve training, would enable the most successful practitioners to treat or supervise the treatment of considerably more patients, thus making their services more widely available, and would meet the difficulty we anticipated in securing that incomes substantially over £2,000 will continue to be obtained in general practice."

The scheme flourished at first, especially during the years when recruitment for general practice was strong. It has survived to be incorporated as the general practice year in three-year vocational training schemes, although it was nearly abolished in 1961 and its numbers dropped to their lowest by 1966 (Figure 1).

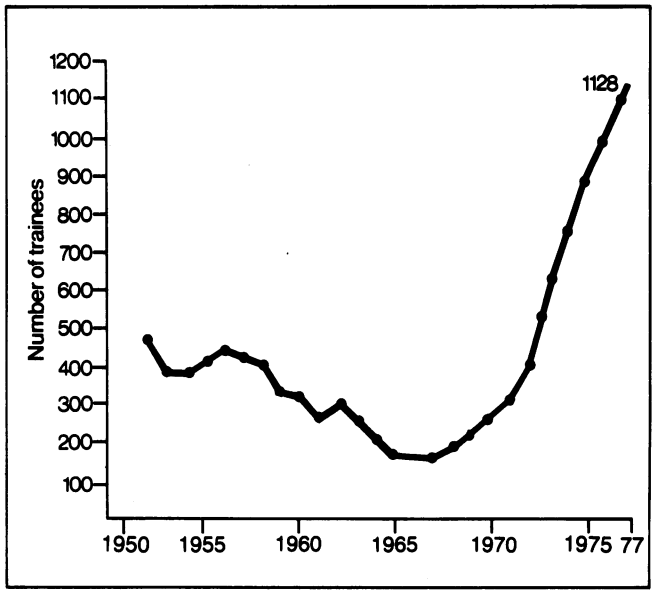

Figure 1. *Number of trainees in the trainee practitioner scheme, Great Britain, 1952 to 1977. Source: Department of Health and Social Security.*

The scheme was persistently criticized for its failure to provide adequate training and for being a means of having an assistant at the nation's expense. It suffered because of the relative shortage of general practitioners in the 1960s when there was strong pressure on young entrants to go straight into practice, especially in some areas. A particular weakness was in the method of selecting trainers, because it too often failed to identify doctors who were both able and willing to teach.

Several critical reviews of the scheme appeared, two of them based on the views of trainees[9,10,11,12,13].

1951 — The Tavistock seminars

The first seminar organized for general practitioners at the Tavistock Clinic began in 1951. It was regarded by its authors, Michael and Enid Balint, as a contribution to the special training of general practitioners. Time has justified this claim.

Although the total number of doctors spending an adequate period of training in the seminars at the Tavistock Clinic and elsewhere in this country has probably not exceeded 500, some ideas derived from this source have had a much wider influence and, after a period of rejection, become incorporated in clinical work and vocational training. These seminars urged the continuing importance of the general practitioner's role at a time when specialization in clinical medicine looked like excluding it from the scene, and when the self-confidence of doctors doing this work was at its lowest.

Concentrating on the patient's reaction to his disease, the contribution of feelings and interpersonal

relationships to the production of symptoms, the patient's behaviour towards the doctor, and the doctor's feelings about the patient, they emphasized the 'whole' patient at a time when every other powerful influence in medicine was fragmenting the patient into organ systems (or smaller parts). They thus reinstated a concern for the psychological and social aspects of medicine at a time when it was suspect and unfashionable, and helped to restore a balance which is today regarded as crucial to diagnosis and management in good general practice.

Equally important was the emphasis on the biographical uniqueness of each individual patient. Thus, although these seminars may have appeared to have been an essay in psychiatric training of a limited type, based on psychoanalytic ideas, they did in fact reintroduce principles fundamental to the training of all doctors. Moreover, seminar or small group methods of teaching have come to play an increasingly important part in medical education. A clear, brief, and early statement of aims, methods, and achievements is in Michael Balint's article "Training general practitioners in psychotherapy"[16].

1952—First integrated scheme of training

The Inverness scheme

A joint training scheme in hospital and general practice[14,15], set up at the instigation of the Northern Regional Hospital Board (Scotland) with the co-operation of the Executive Council for Inverness-shire, was launched as a pilot scheme in 1952. The trainees were expected to have had about two years' postgraduate experience and were offered at senior house officer level a contract for two years during which they would train concurrently in hospital and general practice. The primary aim of the scheme was to give these trainees, whatever their career preference, further experience of both specialist and general practice medicine such that they would have understanding of each individually and also of their interdependence.

Each trainee stayed with one general practice throughout, spending from two to four half days with the practice after an initial few weeks of full-time attachment. Since they were supernumerary in their hospital attachments, the trainees could design their programmes to their particular needs, spending periods of three to six months in different departments and possibly taking in clinics in the minor specialties at the same time. During the two years, the trainees were expected to prepare for a higher degree or diploma.

The Inverness scheme was the first by many years to combine training posts in hospital and general practice, and unique in running these concurrently. In 1965, 24 doctors who had been through the scheme reported their experience, which was highly favourable. They valued particularly its range and flexibility. Fourteen were by then in general practice, eight in specialties, one in public health, and one was a university lecturer.

Since then, the original pattern has been superseded by a three-year scheme in which the general practice and hospital elements in training are arranged in separate years.

Dr A. M. Fraser, as Senior Administrative Medical Officer for the Northern Regional Hospital Board (Scotland), conceived the scheme.

1957—Questionnaire for College Members

In 1957 the Postgraduate Education Committee of Council sent a questionnaire to all the members of the College of General Practitioners. Replies were received from 1,848 members, that is 67·4 per cent of those who received the questionnaire.

Of the 1,153 who replied to questions about their satisfaction with the trainee practitioner scheme, fewer than half were satisfied and nearly all thought the scheme open to abuse—chiefly in the form of an assistantship subsidized by the Government and involving no training. Advertisements "Trainee needed urgently" were commonplace.

The selection of trainers was strongly criticized as picking people well known locally for their committee work but not necessarily good doctors (or good teachers, though this point received less emphasis at that time).

Unlike in the 1960s, there was still a shortage of openings for young doctors in general practice; they saw the scheme as exploiting this shortage.

Suggestions from members of the College

Suggestions for improving the scheme were interesting and some, in fact, forecast the things that have actually happened, so that they might have been written 15 years later. Trainers should hold office for a limited period only, perhaps one, two, or three years. The control of the scheme should be moved into the hands of an educational body, perhaps a combination of the teaching hospitals and the College of General Practitioners. This body would appoint both trainers and trainees and draw up rules for the training. There should be a standard contract and a definite training syllabus. The duties and free time of the trainee should be stated, as should the duties of the trainer concerning supervision and the gradually increasing responsibility of the trainee. Confidential reports should be required at the end of the training from both sides. There was a need for local supervision of trainers, including visits to them, and there should be local groups of trainers and trainees. Teachers needed to attend courses which would combine instruction in the technique of teaching with a revision course on general medical work and practice organization. Trainees should see other premises as well as those in which they were trained. A considerable number of respondents favoured the trainee year being divided between more than one practice.

Thus within 10 years of starting, the trainee practitioner scheme was no longer viewed as a means of subsidizing busy, worthy doctors, as had been originally intended. This purpose was now seen as an abuse, although there was still envy of doctors "lucky enough to get a trainee" among some who had applied to be trainers but had been turned down.

1958 to 1962—Publications by the College

The booklet *Outlines of General Practice*[17] was compiled by the Midland Faculty of the College of General Practitioners in 1958. It set out, largely in note form, the content of training in so far as it concerned practice organization. It led to two further publications, both by the Council of the College: *Memorandum for the Guidance of Trainers* in 1959[18] and *Training for General Practice. A Guide to the Non-clinical Aspects* in 1962[19].

1959—The Nuffield Wessex Scheme

This scheme started in August 1959. Its official title was "an experiment in training for general practice by the University of London Committee for Postgraduate Medical Education in the Wessex Hospital Region". Two reports were published[20,21].

The aim was "to prepare recent graduates to take their places in practice with a reasonable, though still humble, degree of assurance". The experiment was conducted in two parts. The first aimed "to discover the value of the experience which could be acquired in hospital posts in an arbitrarily chosen period of one year by fully registered doctors who were free to select for themselves attachments in those specialties in which they considered their experience to be deficient". The objective in the second part was "to find out what additional value could be extracted from the general practice training year by interpreting this in a wide sense to include experience of other types of practice, of the methods of other general practitioners, of varieties of premises and administrative techniques, and of the services offered by local authorities and the voluntary organizations".

The period of training was fixed at two years, one in hospital and one in general practice. Winchester, Southampton, and Portsmouth were selected for the experiment. The Nuffield Provincial Hospitals Trust provided a grant.

Each trainee's programme was constructed by himself in consultation with the Regional Adviser in Postgraduate Education and his own consultant adviser (a precursor of the clinical tutor), but a six-month resident appointment in obstetrics and gynaecology was regarded as essential for all. (At this time forceps deliveries in the home were still commonplace; all future general practitioners needed to practise this and other skills under hospital supervision.)

The general practice year was spent in the same city as the hospital year "to allow the Nuffield practitioner, known by now to all grades of staff in all hospital departments . . . to follow his patients during any time they were in hospital, to see the interaction of medical and social services and their effect on patient care, to spend further sessions in special departments in hospital and elsewhere in order to indulge a special interest or to rectify deficiencies which had been disclosed whilst dealing with patients in practice".

The main difficulty reported was in the 'spare' six months of hospital posts where the young doctor was a 'supernumerary'. It sometimes proved difficult to obtain clinical responsibility. The purpose was seen at the time as compensating for the relative neglect by undergraduates of certain smaller clinical specialties such as eyes, skins, and ENT. Responsibility therefore seemed less essential at the time than was later realized.

Mr Donald Bowie, Postgraduate Adviser for the South-West and Wessex Regional Hospital Boards, Dr (now Sir John) Revans, Senior Administrative Medical Officer for the Wessex Region, and the Medical Officers of Health of Hampshire, Portsmouth, and Southampton all played crucial roles in starting this scheme and seeing it through.

1961—The Christchurch Conference

Although this conference[22] was not concerned directly with vocational training, it was the inspiration for the widespread development of postgraduate centres and the appointment of clinical tutors all over the country. Both have played an important part in promoting day release courses, now a feature of all vocational training schemes. For this the chief credit is due to Sir George Pickering, then Regius Professor of Medicine at Oxford, and to the Nuffield Provincial Hospitals Trust, which organized the conference.

1963—Conference of Local Medical Committees

This report[12] contains an important appendix by the General Medical Services Committee's Trainee Scheme Advisory Committee. The 1961 Conference of Local Medical Committees had nearly voted for abolishing the trainee practitioner scheme. Criticism was mainly on the same grounds as reported above from members of the College, but the background was now one of a shortage of general practitioners and falling recruitment. The number of trainees had also fallen, from 455 in 1956 to 299 in 1962.

The Advisory Committee reaffirmed the need for the trainee practitioner scheme, but opposed the suggestion that it should be compulsory. It suggested several improvements in the method of selecting trainers and made suggestions for methods of training, including various forms of attachment and a daily discussion of clinical problems between trainer and trainee.

The report included a letter from the Ministry of Health (ECL 53/60) which announced agreement about

the setting up of local training scheme committees for the selection of trainers; these included two university representatives. These committees were the precursors of the subsequent Regional General Practice Advisory Committees.

This report paved the way to a change of heart by Local Medical Committees and the General Medical Services Committee. Without it the later General Practice Advisory Committee of the Council for Postgraduate Education, the Vocational Training Act, the Joint Committee for Postgraduate Training, and the Trainee Subcommittee of the General Medical Services Committee would probably not have been acceptable to the majority of the profession.

1964 — First half-day release course

This first half-day release course[23] started in 1964 at Canterbury. Running a two-year syllabus, it was intended for general practitioners recently settled in East Kent, rather than for trainee assistants, since at that time most of the latter were unlikely to spend more than one year in the area. Dr John Lipscomb, Physician to the East Kent and Canterbury Hospital, was mainly responsible for starting and running the course.

The syllabus was designed to offer subjects which the young doctor would have been unlikely to have learned at his teaching hospital or during house appointments:

Practice organization	10 per cent
Social medicine	20 per cent
Ethical and medico-legal	10 per cent
Clinical	
(a) Psychological and psychosomatic medicine	20 per cent
(b) Special clinical subjects	40 per cent

This was the earliest day release course in the country and it owed a direct debt to the more extensive course which had been organized by Professor A. Vuletić at Zagreb, Yugoslavia since 1961[24,25].

1964 — Ministry of Health Circular

The circular HM(64)69 from the Ministry of Health[37] established the principle that, since it was accepted that educational facilities have a bearing on the delivery of medical care, the cost of postgraduate and continuing medical education is a proper charge on the NHS Exchequer funds.

Before this time only registrar and senior registrar posts had been regarded as training posts. It was the Interdepartmental Committee on the Staffing of Hospitals (the Platt Committee) which urged that *all* non-consultant posts in hospitals should be training grades[38].

The College of General Practitioners

Concerted action by the College did not begin until 1964, when, following an editorial in this *Journal*[26], a working party was set up by the College Council "to consider how it can organize and help others to organize vocational training for general practice in Great Britain and Ireland". Its first chairman was Dr William Hylton. It is curious in retrospect that the College had not acted earlier, but it had in fact been occupied in establishing itself as a national organization and in promoting research and the continuing education of established doctors.

Dr Hylton's working party produced a series of reports in quick succession, the first (1964) in *The Lancet*[27], the second (1965) as *Report from General Practice Number 1*[28], the third (1966) as part of the College's evidence to the Royal Commission on Medical Education[29], and the fourth (1967) as *The Implementation of Vocational Training*[30].

These reports made a direct contribution to the thinking of those who were beginning to plan local training schemes, but their chief importance lay in their influence on the Royal Commission on Medical Education, the report[31] of which was published in 1968.

All the College reports of this period included the pre-registration year as the first year of training for general practice and proposed a further *four* years, two in hospital, two in training practices. The final year in general practice has, in fact, never been implemented. All subsequent effort has concentrated on organizing three-year training schemes after registration.

The 1965 report used the results of a postal enquiry to 3,216 members and associates of the College (1964) to establish agreement about which hospital posts were most directly relevant to the future general practitioner's work. Regarding general medicine and general surgery as posts for the pre-registration year, it recommended paediatrics, obstetrics, and psychological medicine as most suitable for the first year after registration, and any of the following for the second: dermatology, otorhinolaryngology, ophthalmology, geriatric medicine, physical medicine, and rheumatology.

The absence of anaesthetics from this list caused a series of difficulties in the next 10 years. The original position was altered only in 1976 by the Joint Committee for Postgraduate Training in General Practice.

1967 — The General Medical Council

The General Medical Council issues 10-yearly reports on medical education and in 1967 the Council "accepted the advice which it had received that all doctors, including general practitioners, would require in the future special and extended vocational training for their chosen careers". It referred for the first time to 'basic medical education', finding it to include the pre-clinical, clinical, and pre-registration periods of study. It is

perhaps significant that at the time the President of the Council was Lord Cohen.

Nuffield Provincial Hospitals Trust

The report of the Nuffield Provincial Hospitals Trust in 1967[33] criticized the training arrangements for general practice as totally unsatisfactory, "permitting the present inadequately systematized, and too speedy progress of the medical graduate towards the legal assumption of all the responsibilities inherent in providing general medical services to the population at large". "There is a need for urgent action to be taken on a national basis to introduce a mandatory vocational training scheme." Such a scheme would consist of *two* years in a variety of junior hospital posts (one year of which would have been the pre-registration period under the existing arrangements) and one year as a trainee in selected general practices. A limited experiment should be carried out for a fourth year (a 'senior registrarship').

In retrospect the most important contribution of this short report was to state the need for a national body to set standards and make the necessary regulations (anticipating the Councils for Postgraduate Medical Education, their general practice advisory committees, and the Joint Committee for Postgraduate Education in General Practice) for regional committees based on regional hospital boards to take administrative responsibility; for a postgraduate adviser in general practice attached to each regional hospital board, with suitable links to the local university; and for part-time area organizers.

The Nuffield Provincial Hospitals Trust was responsible shortly after this for financing the first postgraduate adviser on an experimental basis in Wessex.

1967—The Committee (later Councils) for Postgraduate Medical Education

The lack of a central body, the purpose of which embraced both policy and action on postgraduate education for all types of doctors, had by now become clear.

A conference, held at the Royal College of Physicians in the autumn of 1966, adopted a proposal from the Committee of Vice-Chancellors and Principals of Universities that a Central Committee on Postgraduate Medical Education should be established. This was to be a clearing-house for information bearing on the organization of postgraduate medical education in England and Wales, to co-ordinate activity among the regional postgraduate medical education committees, and to confer with other bodies, particularly the universities, the colleges, and the Department of Health, on the organization and financing of postgraduate medical education. At first this committee covered the whole of the UK, but it was later divided into three separate Councils for England and Wales, Scotland, and Northern Ireland.

Its policy was from the start that training posts should not be designated for particular branches of the profession. This produced a conflict with the policy of three-year 'package deals' which were already being developed in the earlier vocational training schemes. The conflict has been resolved by a compromise—the co-existence of package schemes and others where the trainee continues to design his own training programme within certain guidelines[34,35,36].

1968—Royal Commission on Medical Education

The Royal Commission on Medical Education[31] reported in April 1968 and recommended as a pattern for the 'professional' training of all British doctors:

1. An intern year (that is, pre-registration year).
2. General professional training—three years (that is, the senior house officer and registrar grades).
3. Further professional training—"either the continuation of training on a less intensive basis, merging into the normal responsibilities of a professional career, or else a period of a few years' intensive advanced training . . ."
4. Continuing education.

When applied to general practice, this framework led to the recommendation that "the general professional training required for prospective general practitioners after the intern year should, like that of other specialties, be of three years' duration, and two years further professional training and experience should be required before vocational registration . . . The introduction of a training scheme on the lines we have proposed would greatly enhance the attractiveness of general practice as a career and would increase the proportion of young medical graduates who decided to seek a career in this field".

The last prophecy has proved correct in the decade after it was made, but the lines have not been exactly those which the Commission suggested. The term 'professional training' has not been used by all branches of the profession nor has the division into general and further professional training, although these are roughly equivalent to the registrar and senior registrar grades respectively. Vocational registration has not been accepted.

In supporting the need for a training after registration specifically designed for general practitioners and obligatory before appointment as a principal in the NHS, the Royal Commission had great influence. It especially helped to secure such additional government finance as has proved necessary and its advice pointed towards the Vocational Training Act of 1976.

The first local vocational training schemes

Conclusion

It was at first our intention to assess which were the most crucial contributions to the story we were telling

and which was the institution to have played the most important part. This has proved impossible, as well as invidious. The most striking feature of the story has been the way in which a ball has been passed from institution to institution, committee to committee, and person to person, eventually reaching its goal. It is impossible even to assess the relative importance of national committees versus local initiatives, because the interchange between these two elements, like that between theory and practice, has been vital. It is equally impossible to assess the relative importance of academic and political institutions in an achievement which has inevitably demanded both types of activity.

At different times the following institutions have all played essential roles: the British Medical Association and General Medical Services Committee, the College (later the Royal College) of General Practitioners and its faculties, the Nuffield Provincial Hospitals Trust, the universities and in particular the Postgraduate Medical Federation of the University of London, the General Medical Council, the Department of Health (later the Department of Health and Social Security), the Royal Commission on Medical Education, the Committee (later the Councils) for Postgraduate Medical Education, the Regional Hospital Boards, and Regional Postgraduate Medical Education Committees.

If the analogy of football is allowed, it was the British Medical Association which first took up the ball; but it dropped it. The College of General Practitioners picked it up and has remained a player in a game which has seen the British Medical Association, the Department of Health, and the Nuffield Provincial Hospitals Trust as the other most regular members of this large team during the period we have described.

It has been an essential feature that local training schemes have been organized by local initiative, usually the work of an individual volunteer or a very small group. The enthusiasm and variety which has resulted has been collectively of an importance at least as great as that of all the central committees together. It is in the local training schemes that the essential work of training takes place; without them central committees would be without purpose or result.

This complex story has been characterized above all by its general movement towards a goal. The goal was not nearly as clearly defined or widely agreed as it may now appear in retrospect, but far-sighted individuals outlined its essential features from the start. They were aware of the wider issues which surrounded the process we have described—in particular the continuing need of patients for a general doctor and the problems and limitations which go with increasing specialization, although at the time specialization appeared to be the inevitable future basis for all medical care.

As the story unfolds, an important danger looms—that of splitting doctors in training into 'us' who are going into general practice and 'them' who will work in hospitals. This danger can be minimized if it is accepted that experience at the level of senior house officer is common to all careers in medicine, and that postgraduate experience in general practice can be valuable in the training for many specialties; and if changes of career are made possible by good career advice and adequate educational control.

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