# EDITORIALS

# Reforming Section 63

*In future regional general practice subcommittees for postgraduate medical education should (i) determine the educational policy for both vocational training and continuing education in general practice; (ii) determine the educational policy for graduate education in general practice; and (iii) together with the regional adviser in general practice control the regionally allocated Section 63 funds for general practice to carry out these educational policies.*

Conference of Local Medical Committees (1981)

THIS firm and unequivocal motion was passed by both the Conference of Local Medical Committees and the Annual Representative Meeting of the BMA. It is historically important and represents a turning point in the development of continuing education for general practitioners.

The involvement of governments in supporting education for general practitioners has long been established in the United Kingdom. Once general practice is incorporated within a National Health Service then governments inevitably acquire an interest in the continuing education of doctors, because neither politicians nor departments of health wish to be accused of providing low standards of primary health care.

When the arrangement was first made for the provision of continuing education after the introduction of the NHS it was logical for power to be placed in the hands of the universities, because at that time general practice was so badly developed it had neither an academic college of its own nor any department of general practice in a British university. The emergence of postgraduate medical deans was thus perfectly appropriate and a logical development in the university world. The then Secretary of State for Social Services became empowered to make financial provision for the continuing education of general practitioners under Section 63 of the National Health Service and Public Health Act of 1968, and postgraduate medical deans became the budget holders of quite substantial sums of money provided by successive governments for this purpose.

In 1972 the DHSS issued a circular advising regional health boards to appoint regional advisers in general practice and in 1973 regional general practice subcommittees acquired responsibility for the approval of general practitioner trainers.

Since that time general practice education, both vocational and continuing, has developed rapidly. In many regions good relationships have emerged between postgraduate medical deans, regional advisers and the general practice subcommittees. In general, progressive policies have been followed in most regions and important innovations such as small group teaching and evaluation have been introduced. The Department of Health's policy of reimbursing the travelling expenses of general practitioners has enabled the vast majority of British practitioners to attend courses under Section 63 (Wood and Byrne, 1980); there has been useful cross-fertilization of ideas and the spread of many important new developments throughout the United Kingdom. Section 63 can be seen as a major administrative reform which has oiled the wheels of the educational developments of general practice in Britain and which places British practitioners at a great advantage compared with many of their colleagues in countries overseas. The Department of Health and the postgraduate deans in most regions can look back with pride at what has been achieved during the last 13 years.

Why then was the recent motion of the Conference of Local Medical Committees necessary? Why was it passed by such an overwhelming majority? What does it mean?

## *The need for reform*

There are four reasons why reform is now necessary. They have been identified separately but simultaneously both by the Royal College of General Practitioners and by the General Medical Services Committee. Both these organizations, which represent the academic and the medico-political wings of general practice, announced during 1980 that reform was needed and would now be sought.

### *1. Independent clinical discipline*

The first and most important reason is that general practice is now generally recognized as an independent clinical discipline in its own right (McWhinney, 1966). In the past this concept was diminished by many both inside and outside general practice, who saw it as merely the practice of a variety of specialties at a superficial level. This old-fashioned approach led inevitably to the doctrine of the specialist always being the teacher of the

generalist and was seriously questioned by Balint in 1954.

The arguments for general practice as a discipline in its own right, which have recently been set out by Pereira Gray (1981), are now generally accepted within general practice itself. With this acceptance came the necessity for reform of Section 63. It would be absurd for psychiatrists to control the postgraduate education of surgeons or for surgeons to decide what is appropriate higher training for pathologists. Yet surgeons, pathologists and psychiatrists, in the roles of postgraduate medical deans or clinical tutors, are now exercising responsibility for deciding what is or is not appropriate for the continuing education of medical generalists. Sooner or later the absurdity of this arrangement was bound to become apparent.

### *2. Medical administrators*

Secondly, some postgraduate medical deans have begun to develop and change their own role. For example, several now work whole time in their capacity as dean and no longer work in clinical practice.

It is, of course, entirely appropriate for deans, like any other group of doctors, to determine for themselves their own most effective way of working. Nevertheless, both undergraduate and postgraduate deans must now realize that abandoning the care of patients has meant that, for general practice at any rate, they have forfeited their right of control over their colleagues. General practice, as the largest clinical branch of the profession, is now quite determined that decisions about its continuing medical education and particularly about medical audit can properly be taken only by those who actually do the job and bear the day-to-day burdens of clinical responsibility. The views of medical administrators will always be welcome but the final decision must belong to clinicians.

### *3. Educational approach*

The third argument is educational. General practice has adopted a formal and professional approach to teaching and learning. Trainers, unlike the teachers in other branches of the profession, are selected, and at present only about 10 per cent of general practitioners are approved. In most regions all trainers are required to attend a one-week trainers' course (BMA, 1981) and are expected to be familiar with educational aims and methods of assessment (JCPTGP, 1976). Other branches of the profession follow other paths and they are, of course, quite free to do so. Some deans and clinical tutors remain sceptical about educational theory and are fully entitled to their views; but general practitioners now believe that at a time when the vast majority of trainers, course organizers and regional advisers have systematically prepared themselves for a teaching role, they can no longer tolerate decisions about resources and approval lying in the hands of those who have not similarly prepared themselves for the task.

### *4. Democracy*

Last, but by no means least, general practitioners are independent contractors. They are suspicious of hierarchies and are accustomed to determining policy democratically. For example, every member of the Council of the Royal College of General Practitioners is elected and the majority by the faculties. Thus all Members and Associates of the College can be confident that, however small or remote their faculty, they have a colleague to represent them on the Council. Similarly, in the General Medical Services Committee and the Conference of Local Medical Committees, decisions are taken by those elected to do the job. About one in every 10 British general practitioners is now elected by his or her colleagues to a place on a local medical committee.

Given this deep tradition of democracy, it was inevitable that sooner or later the general practice branch of the profession would insist that the decisions about continuing education and medical audit should lie with committees composed not only of general practitioners, but by those elected to office by general practitioners.

General practice has now agreed that properly constituted regional general practice committees must include the skill and experience of College representatives and the political power of the representatives of the medico-political organization. History may see the regional committees as comparable to the national partnership between the College and the BMA represented by the JCPTGP.

## *Conclusion*

Each of these four arguments is powerful in itself; together they form an overwhelming case which has influenced the College, the General Medical Services Committee, the Conference and the Representative Meeting of the BMA in defining and declaring the new policy.

General practitioners are not ungrateful for the help they have had from both governments and from universities. But general practice has come of age and is determined that from now on it must control its own standards and determine its own destiny.

## References


Balint, M. (1954) *The Doctor, His Patient and the Illness.* London: Pitman.

BMA (1981). *Annual Report of the General Medical Services Committee.* London: BMA.

Conference of Local Medical Committees (1981). Report. *British Medical Journal,* **282,** 2160.

Gray, D. J. Pereira (1981). *Training for General Practice.* Plymouth: MacDonald & Evans.

The Joint Committee for Postgraduate Training for General Practice (1970). *Criteria for the Selection of Trainers.* London: JCPTGP.

McWhinney, I. R. (1966). General practice as an academic discipline. *Lancet,* **1,** 419-423.

Wood, J. & Byrne, P. S. (1980). *Section 63 Activities. Occasional Paper 11.* London: *Journal of the Royal College of General Practitioners.*