The College's Response to the GMC Proposals

Introduction

1 The Royal College of General Practitioners welcomes this opportunity to comment on the General Medical Council's *Proposals for Basic Specialist Training*. We applaud the Council's decision to begin its task of coordinating all stages of medical education by looking at postgraduation, pre-specialist training. In our view this is the most difficult period of medical education, because the aims of training are least clearly defined, and because there is little agreement amongst the various colleges.

2 We support the conclusion of the GMC document that some broadening of 'general professional training' is both desirable and feasible. We are particularly pleased with the emphasis which the GMC proposes for further experience of general practice in the pre-specialist training of trainees in a wide variety of specialties. The College holds that general practice has a very important part to play in the teaching of those consultation skills which are the basis of general professional training. We welcome also the emphasis which the GMC report places on the need for increasing flexibility of career choice and change. We agree with their observation that inflexibility results as much from the attitudes of appointment committees as from the policies of colleges and faculties. However, we regard the achievement of this flexibility as a desirable by-product of general professional training, and not as its *raison d'être*.

3 We had expected that these proposals would be based on the established principles of medical education. We looked for a clear statement about the goals, methods and forms of assessment appropriate to this phase of training. We were disappointed, therefore, that the proposals appear to begin with a compromise: they start from the premise that there are certain institutional priorities and policies which *de facto* limit the possibility for necessary professional educational reform.

Basic specialist training

4 Our major criticism is reserved for the concept of basic specialist training. The term itself is unhelpful because the inclusion of the word 'basic' is likely to lead to a confusion with basic medical education, and the inclusion of the word 'specialist' will give a mandate for the early teaching of specialist techniques. We prefer the term 'general professional training' because the words unambiguously convey the meaning we intend.

5 We are sympathetic with the intentions of the Council's Education Committee in wishing to emphasize areas of common ground in the early years of specialist training, and in trying to identify and enlarge those common elements. So far, however, the pressure on junior staff to become competent in the specialized functions of their departments is such that there has been a failure of general professional training. We believe that the document betrays a recognition of these facts of hospital life, and this leads to the questionable logic of the suggestion that in a number of specialties, specialist training should actually precede generalist training. We have reached the conclusion, therefore, that 'basic specialist training' is simply a term which cloaks with educational respectability many of the current policies which fail, and will continue to fail, to produce an appropriate generalist training prior to specialization.

General professional training

6 This College has consistently advocated a period of generic training beyond the present period of basic medical education for all clinicians. We formally accepted the principles of general professional training as described by Todd, and the implementation recommended by Merrison. These principles were rehearsed in an interim report from a working party on medical education of our Education Division, which is mentioned in the GMC proposals.

7 The aims of general professional training are concerned with the basic skills of the consultation. These include the skills of listening and communicating; of taking, weighing and assessing evidence; of clinical judgement; of anticipatory and preventive care; of relating the patient's problem to his home, family, work and other social settings; of sharing the health care with the patient and the patient's family. We hold that without these clinical skills, no specialist can function effectively, efficiently and humanely.

8 Our arguments for general professional training are summarized under three headings: the current performance of doctors; the current deficiencies in basic medical education and the unwanted effects of early specialization.

The current performance of doctors

9 There has been a growing critique of the performance of doctors in our health service, which comes not only from informed researchers outside medicine and from investigative journalists, but most of all from within the profession itself. These criticisms are concerned with the failure of doctors to exhibit the basic skills of the consultation listed in paragraph 7 above. The medical profession has also been charged with a failure to allocate scarce resources appropriately. There is evidence from many studies of samples of the general population, which shows gross inadequacies in the care of people suffering from (for example) high blood pressure, diabetes, epilepsy, faecal and urinary incontinence. The medical profession has been charged with a failure to allocate scarce resources on other grounds than the lobbying of specialist interest. By and large the NHS remains crisis oriented, and is not providing effective anticipatory care for the general population. Compared with the resources and energy channelled into curative medicine, there has been a relative failure to exploit the possibilities for preventive medicine, the care of patients with long term problems, the elderly, the mentally handicapped and the dying.

Deficiencies in basic medical education

10 This College accepts and endorses the General Medical Council's *Aims for Basic Medical Education* (1981). However we believe that they cannot be achieved while the curriculum continues to be subject based, and the teaching conceived in terms of departmental priorities. In the GMC proposals it is observed that 'because the undergraduate curriculum is required to include an increasing number of subjects, undergraduate teaching has in some respects become less detailed'. The document describes 'the increasing content of the undergraduate curriculum' and we believe that this will grow apace with the emergence of new medical specialties and departments. This growing specialization, most manifest in the teaching hospitals, makes it particularly difficult to present to the student or to the young postgraduate a coherent programme for the development of generalist knowledge, skills and attitudes.

11 As clinical departments in the teaching hospitals continue to become more specialized, the task of providing a generalist clinical training for the undergraduate

will become more difficult. We believe that the contribution of departments of general practice to this core content of basic medical education will eventually achieve major importance. But this contribution cannot be fully realized until a large number of general practices receive adequate resources, in order to allow them to undertake such teaching. Meanwhile medical schools will continue to be faced with a problem similar to that which is addressed but not answered in the GMC proposals: how to achieve an integrated and generic clinical education in the context of autonomous, competing and specialized subjects.

12 The pre-registration year does not provide an adequate response to these deficiencies in the medical school curriculum. Of the pre-registration year the Merrison Report (paragraph 99) stated: 'There is inadequate definition of the aims, inadequate understanding of the proper interaction of service and education, and inadequate organization and assessment of the working of the system.' This most crucial phase of general professional training has been largely ignored by the universities, and there is still no teaching programme which seeks to integrate the past acquisition of theory with the present assumption of clinical responsibility.

The effects of early specialization

13 The GMC proposals state that the principal objectives of basic specialist training will be to '. . . consolidate, while remaining under supervision but with increasing responsibility for the patient, the wide range of general and basic specialist clinical skills which constitute the consultation'. In our view this merely restates the conflict, but does nothing to resolve it. Further it is stated, 'In addition the young doctor should have further experience with increasing specialist emphasis on the range of practical skills and various clinical laboratory and radiological investigations, through having the opportunity to practice.' Far from resolving the conflict, this passage actually legitimizes the unsatisfactory *status quo*.

14 Our experience of the hospital component of vocational training for general practice is that a preoccupation with specialized clinical tasks takes precedence over the basic clinical skills which constitute the consultation, and the broader view of the tasks of medicine in society. The College recognizes that there must always be some conflict between the needs of a specialist service and the needs of the junior staff for more basic generic and generalist learning. This conflict can only be resolved in the light of a clear educational policy.

Educational strategies

15 It is our belief that general professional training requires a clear statement of the aims, a programme of learning to supplement the in-service training and apprenticeship, the training and monitoring of teachers and a programme of assessment. The GMC proposals do not deal adequately with any of these requirements.

16 We believe that it is the function of the General Medical Council to define the goals of general professional education and the strategies for achieving them. These goals may be described as the competencies to be achieved. Without such a statement of intent there will be no criteria for the assessment of the trainee, for the selection of teachers and posts or for the evaluation of programmes.

17 While we feel that a description of these competencies is beyond the scope of this response, we suggest that such competencies may resemble the General Medical Council's *Aims for Basic Medical Education,* and be derived from them. Unlike aims, competencies actually quantify the expected performance of the person to be assessed, and in this case would reflect the young doctor's increasing assumption of clinical responsibility.

18 We believe that the consultation skills of general professional training will also resemble the goals and specific objectives for vocational training in general practice, described in our own literature. Many of these were framed in order to make good the absence of a period of general professional training.

19 In good district general hospitals the junior doctor is able to supplement his self-directed and apprenticeship learning by attending joint clinical meetings and taking part in clinico-pathological conferences or so called grand rounds. Although these meetings are often no more than the exhibition of highly specialized knowledge in the form of a competitive game, they have the great advantage of allowing the junior doctor to explore the interface between different medical specialties. This allows him or her not only to integrate knowledge and skills, but also to experience the interplay of different approaches, values and attitudes.

20 Much of our day release courses for vocational trainees is currently spent in teaching about clinical problem solving, the doctor/patient relationship and the psychological, social and epidemiological aspects of diagnosis and management. Most of the work of specialists is carried out in an environment which is largely professionally controlled—the hospital ward and the outpatient department. Most of the work of the general practitioner is carried out in an environment where the patient has much more control and autonomy—the surgery and the patient's own home. Here the skills of clinical problem solving must be matched by other skills in negotiating the diagnosis and management with the patient. Such teaching should be a core component of the general professional training of all future clinicians. Indeed there would be grave dangers for the future of health care in our society if the General Medical Council were to give credence to the view that, while these generalist clinical skills might be important to future general practitioners, psychiatrists and paediatricians, they will be of little relevance to those who practice in narrower and more technical fields. Half of the medical profession may become specialists: all of their patients will remain generalists.

Teachers

21 The training and monitoring of teachers and of training posts has been a major characteristic of the growth of vocational training in general practice. In our view, such an approach will be no less important in the development of general professional training. The College was therefore disappointed with the statement in the GMC proposals' 'The consultant or the principal in general practice who is in charge must appreciate that as a trainer he has certain responsibilities in relation to the supervision of the trainee and the provision of career guidance'. The subsequent passages make no further comment on the quality of teachers but refer instead to the mechanisms which may ensure greater flexibility of choice of posts for young doctors. We hold that general professional training will demand recognized training practices of a similar standard to those which we now provide for vocational training. Although the standards of the practices will be similar, we recognize that the aims of general professional training will be different from those of vocational training, as will the levels of responsibility and supervision.

Assessment

22 The College believes that it will be essential to assess the doctor undergoing general professional training. We agree with Todd that a system of progressive assessment is the most suitable for this phase, and we believe that such assessments will require future cooperation between all the colleges, including a willingness to recognize a certificate of satisfactory completion of general professional training as a common entry requirement into all specialty (including general practice) training.

Duration of phases of medical education

23 There has been much confusion about the optimum duration of the undergraduate phase of medical education, and about the duration of the subsequent phase. The proposals state, 'The Committee has taken the view that it would be undesirable at present to consider encroaching upon the time devoted to undergraduate medical education in order to afford time for graduate clinical training as proposed by Merrison. The increasing content of the undergraduate curriculum would make this difficult and such an arrangement would pose considerable organizational problems for some medical schools. However, the Committee recognizes that the possibility of introducing such a change at some future date might need to be re-examined.'

24 Merrison had this to say on the duration of both phases: 'We believe that the arguments . . .point in the direction of making graduate clinical training last something like two years. This would be achievable were the undergraduate to be correspondingly reduced in length. Indeed we believe that such a change would allow a better balance between clinical and other teaching and facilitate greater curricular flexibility.' The GMC in its memorandum to the Robbins Committee on Higher Education (1961) felt able to 'surmise the possibility of a basic course of instruction, reduced to four and half or eventually four years instead of the present five, but followed by a carefully orientated clinical course lasting for two years or more . . . .

25 This College believes that if a curriculum is competency-based rather than subject-based, many of the arguments about duration of courses recede in importance. It is then possible to describe the likely norms of the undergraduate phase (say five years) and of general professional training (say two years) in the knowledge that with proper competency-based continuous assessment, many young doctors will achieve a much faster rate of learning. We do not believe that our recommendations should delay the earliest date at which, today, the young doctor is able to become a consultant in specialist medicine or a principal in general practice.

The role of general practice

26 This College believes that it has a major role to play in the early training of all clinicians. General practice is an independent discipline, and not simply the sum of the less specialized components of other specialist subjects. Even where this has been acknowledged (for example in most of our medical schools) general practice is still regarded as 'another subject', perhaps on a par with psychiatry or paediatrics. But numerically general practice represents half of the medical profession. This College claims that general practice is now the major generalist discipline in medicine. It alone has the task of integrating in its own teaching the developmental aspects of medicine from infancy to old age, the morbidities over the whole field of disease and the behavioural aspects of doctor and patient. It is concerned, as are all the specialties, with the care of the individual, but (because of the organization of general practice in the NHS) it is also charged with the planning and delivery of a primary health care service for a defined and manageable population. Alone among the medical disciplines, general practice allows its trainees to articulate with the entire range of medical and paramedical specialties. This College therefore declares itself as having a central role to play in the development of general professional training: in the negotiation of educational goals, the design of curricula, the training and provision of teachers and training posts and the processes of assessment.

27 Once a period of general professional training has been instituted, and as Merrison suggested, brought within the framework of registration, there will have to be a further development of our plans for vocational training for general practice. There has been wide criticism, not least from our own vocational trainees, that this College has accepted a programme of vocational training for general practice two thirds of which occurs in other subjects. The College's view is that such a three year vocational training programme is currently necessary in order to create *de facto* a period of general professional training as a pre-requisite to independent status in general practice. The GMC proposals state, 'the Committee recognizes that if a young doctor intends to pursue a career in a specialty which is neither dealt with to a great extent in the undergraduate curriculum nor included in the pre-registration year, it may be necessary for the trainee to devote a greater amount of time to that specialty during this period of training'. This underpins our argument. For the most part general practice occupies a very small part of the undergraduate curriculum, and is absent from the pre-registration year. By the Committee's own criteria, the predominant component of the three year vocational training programme for general practice should take place in general practice itself. This College has always recognized that once general professional training became a defined, assessed and mandatory component of the educational continuum, it would need to recast its recommendations for vocational training.

The continuum of medical education

28 We have been constrained, in framing this reply, by the content of the proposals and by the current shape and contents of the continuum of medical education. The fact that we have found it necessary in considering the postgraduation, pre-specialist period of training to refer to the undergraduate and vocational training phases is an indication of the difficulty we have in considering in any depth one phase of medical education in isolation. Fundamental questions now need to be asked about the intentions and nature of medical education, so that answers may be sought which are appropriate to the needs of this society, and consonant with the developments of medical care, in the closing decades of the century. This College invites the General Medical Council to undertake such a fundamental review now, and affirms its eagerness to take part.

References

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