THE NEED TO STRENGTHEN EDUCATIONAL CRITERIA FOR ADMISSION TO MEMBERSHIP OF THE COLLEGE OF GENERAL PRACTITIONERS*

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The most important thing about which we have to make sure this afternoon is that we do not split our College in trying to decide on the criteria for its membership. Many of us have had further thoughts on these recently.

Nearly every college in every profession takes an intense interest and pride in maintaining educational standards for its particular field, and its value as a college is often directly proportional to the number of young people whose education it helps. Eleven years ago we started off quite well with ideas about influencing the training of young doctors for general practice, but lately we have been losing ground over this.

How many students, for instance, are really interested at present in our College and its work; and how many young men and women (house officers and trainee-assistants) do we see at our headquarters or at faculty meetings? Very few. Two years ago we had 49 applications from students for our Public Welfare Foundation prizes; this year there were only 14; only one of these was from London with its twelve teaching hospitals, and only two others from the whole of England. A dozen of our faculty undergraduate committees in the United Kingdom and Eire had little or no activity to report last year. Of our 27 home faculties only about ten have a really happy and successful working liaison with local medical schools. The other medical schools are taking little or no notice of our College or its faculties in arranging their student-attachment and other training schemes. The attitude of some of these hospital teachers was summed up only a few months ago by an officer of the undergraduate education committee of one of our largest faculties, when he wrote: "There are plenty of influential members of the medical school who are sceptical of, and even hostile to, the idea of medical students being contaminated by general practice!" After 11 years of the College's work all this is disappointing; it suggests that the main impact of our College on training for general practice itself can never be in the undergraduate phase. I believe that the influence of our College is in real danger, now, through lack of the interest of young people.

Medical schools are now aiming to give all students a balanced, basic training suitable for all branches of the profession. Student-attachment

*This speech was made by Dr Hunt in moving the South London Faculty's resolution on the tightening-up of criteria for entry to membership of the College.

schemes, general-practitioner lecturers and teaching units, and general-practitioner advisers in the medical schools are very valuable indeed for giving all these students some idea of what general practice is like—especially those who are to be specialists, it may be the only chance they will ever have of seeing this. But for the 50 per cent of students who are our particular responsibility—those who are going into general practice and require special vocational training for it—our College can have its main impact, control and influence only after the basic training is over. On that pre-practice phase our College should now concentrate; and it should take the initiative to influence training for our branch of the profession.

In Great Britain there is, so far, extraordinarily little organized pre-practice vocational training for general practice. Only 237 doctors, for instance, did trainee-assistant jobs last year. Even in those few places where there are specially-designed courses it has been found difficult sometimes to persuade young doctors to attend them; there is no adequate stimulus to encourage them to do so. Our College could quite easily, and cheaply, provide a most effective stimulus by insisting that those who wish to join one or other of our grades (I don't mind which) have been adequately trained for general practice in ways upon which we can all agree.

In all walks of life—from plumbing to the diplomatic service—better training leads almost naturally, in a perfectly fair and ordinary way, to better jobs. Why shouldn't it? There is nothing wrong in that. One of the main arguments put forward in favour of maintaining the present pay-differential between specialists and family doctors is that specialists take more trouble than we do over their training and spend longer at it. Our best chance of reducing that gap is to make our standards of education comparable with theirs.

Associates can join our College, as you know, for the asking, because we have thought it right that every qualified doctor should be welcomed, in some category, if he wants to see our work or to join in. But for our membership a ten-guinea entrance fee, two sponsor forms, an occasional interview, and a less than 1 : 500 rejection rate, seem to many now to be just not good enough, educationally. How much does our M.C.G.P. mean now educationally to students, to the public, and to the profession? Almost nothing.

The Royal College of Midwives, and the Royal Colleges of Physicians, Surgeons, Obstetricians and Gynaecologists have all, over the years, taken great pride in producing better-trained men and women in their subjects by setting educational standards for entry to their organizations; and the new College of Pathologists is doing the same. It is one of the most important things they all do. Students are impressed and stimulated by these standards and are intensely interested in the colleges which lay them down—infinitely more so than they are in our College at present.

To establish an adequate pre-practice training standard for our branch of the profession is a moral responsibility which seems now to rest with our College. It is the deep concern of many of us at this time, including

several who are opposed to formal examinations. How to set such a standard, perhaps without examination, is the problem before us. We do not need even a diploma if we think that there are too many diplomas already. A simple certificate would be better than nothing for the educational standard we have in mind.

Such a standard for us could be based on a number of educational items, assessed on a points system. The first could be time spent in hospital work (say 30 to 40 points out of 100). The second could be time spent as a trainee-assistant (30 points, or perhaps 40 for taking part in something like the Wessex scheme). The third might be a special course of lectures or practical demonstrations connected with general practice (say 10 to 20 points). Such a course, for a week or a fortnight, could be given at college headquarters or arranged by any faculty—lectures and demonstrations by all those with whom a family doctor works: medical officers of health, district nurses, health visitors, social workers, probation officers, lawyers, clergy, police, coroners, architects and so on. The fourth, fifth, and sixth could be submission of case reports with commentary, thesis, or published papers (10 to 30 points each, depending on their merit). The same would apply to the seventh—research. Eighth, voluntary service overseas in under-developed countries, or other experience in special types of general practice would deserve recognition. And so on; with or without, ninth, some sort of practical or theoretical test of knowledge of the details of clinical and social medicine of significance to the family doctor.

We must ask ourselves the question " In the art of modern general practice how important is accurate knowledge compared with intuition and the bedside manner? " We know that patients can sometimes be helped by those with no medical knowledge whatever—the quacks have shown us this—but we realize, even better, that a knowledgeable family doctor can often help his patients far more than can an ignorant one.

We should be wise, I think, not to ignore altogether, or to despise, accurate knowledge of clinical medicine and of the ancillary social services in setting our standard of excellence in training for general practice. By no means all such knowledge is gleaned from books alone; a great deal is learned in hospital and in practice work, and much of it can quite easily be tested. Many people believe that some test of knowledge would often be quite as valuable in helping to assess the results of training as would be, say, a thesis or a few case-reports from an applicant. Candidates must be allowed a choice here; some might even prefer to take such a test of knowledge to settling down, for months perhaps, writing a thesis or undertaking a piece of research. But, if we do have such a test, it must be kept in its right perspective—that is essential. As an educational criterion it is less important than hospital work or experience gained as a trainee in general practice; it cannot possibly replace either of these, and no one should ever suggest that it should. I would allot about 20-25 points for such a test of knowledge—not more than one quarter or at very most one third of the total—and it must be optional.

We can use any of these nine important training items we wish as the

basis for the educational standard we want to establish; unsuccessful candidates being deferred, perhaps, for further training rather than being failed altogether. I myself don't mind a bit which of them we use, and which we leave out, so long as we introduce some adequate standard of education soon based on a points scale upon which we can all agree. If this can be done I believe that our membership will have real stature and our influence on training will be as great or greater than that of any other medical college.

It has been suggested, quite rightly, that there are other possible ways of strengthening criteria for admission to our membership which are not educational—such as scrutiny of an applicant's practice premises, the way he examines and treats his patients, the letters he writes to hospitals, his records, case notes, etc. All these are really practical examinations of the candidate in general practice itself. It has also been suggested that an applicant's personality, ethics and morals should be examined. Our sponsor forms and faculty-board reports assess these matters to a certain extent; but to try to go deeper and strengthen criteria along any of these non-educational lines alone might lead an academic body into trouble. They sound splendid, but they would require much snooping around in a candidate's practice, among his patients, his friends, and among his specialist and general-practitioner colleagues—some of which might be difficult and embarrassing. They might lead to unpleasant and endless local ill-feeling—even to litigation—if judgments are passed on ethical and moral issues without proper judicial procedure and evidence taken on oath.

To help us all to decide which of these nine educational or other items for strenthening criteria for entry to our membership we should use now, and how many points we should allot to each, the postal enquiry which the East of Ireland Faculty has suggested in the resolution on which we have to vote next would, I think, be a most fair and democratic move for us to make. I hope very much that we agree this afternoon to arrange for that.

In conclusion and as a summary may I say that, at this critical adolescent phase in our College's development, I believe it is important that we should aim at making our College something more than a continuing education institute, a research institute, a friendly medical society, and a residential club. To fulfil our destiny, as a college, we should play a leading part in influencing training for our branch of the profession. I cannot agree with those who think that our effect on training for general practice is at present good enough for us to be content to carry on just as we are. The baby teeth of our criteria for admission to membership have served us fairly well for our first 11 years; but, from now on, for the tough competitive jobs that lie ahead of us, we really need something stronger, educationally.

If, this afternoon, you treat our pre-practice training responsibilities as seriously as does your Council and many of your faculties, and if you vote in favour of this resolution to strengthen educational criteria for admission to our membership, in whatever ways we can agree (based on the results of a postal enquiry) we shall, without splitting our College at all, begin to do one of the most important things that we set out to do in 1952—

to set an educational standard for general practice and to play a leading part in producing better-trained family doctors. Students will then take much more interest in our College's work than they do at present; the newly-qualified will be encouraged to prepare themselves specially for our branch of the profession, and we shall see more of them at our headquarters and at the meetings arranged by our faculties. Our M.C.G.P. will at last begin to indicate something positive and worthwhile, educationally. The consultant and specialist world, the universities, and the Ministry of Health, will see that, as a college, we really mean to work hard on the neglected pre-practice part of the educational field; and everyone will know that we have the determination and the courage to set and control our *own* standards, for entry to membership of our *own* College, based on what we believe to be the proper training for our *own* branch of the profession.

Abstract

Frater Virus

Duncan (1960) reported the isolation of a previously unrecognized virus associated with an outbreak of aseptic meningitis in Glasgow. This virus was provisionally named Frater after the person from whom it was first isolated. Miller (1961) gave it the designation Echo 29.

In Leicester during the period February to July 1960 viruses were isolated by Mair (1963) from 90 cases of aseptic meningitis: 72 cases yielded coxsackie B.5; 7 Echo virus type 7; 3 poliovirus type 1; in 8 cases (1 man, 6 schoolboys and a girl of nineteen) Frater virus was isolated. Dr Mair reports the clinical features as follows:

" The clinical features were typical of aseptic meningitis and could not be distinguished from those due to Coxsackie virus B.5, the virus most prevalent at the time. Onset was sudden with headache, vomiting and a low-grade pyrexia. Nuchal rigidity was moderate in seven cases and absent in one. Kernig's sign was noted in four cases. Cervical lymphadenopathy was observed in two patients, and enlargement of the axillary lymph node in another. Minute petechial haemorrhages were noted on the soft palate in two cases, and tonsils and fauces were congested and inflamed in four cases. None had a rash or diarrhoea. The patients were discharged from hospital after 12 days, having made uneventful recoveries."

Mair, Helene J. (1963). Aseptic Meningitis due to Frater Virus. *Monthly Bulletin of the Ministry of Health and the Public Health Laboratory Service*, **22**, 119.