[79] Brooks, M H, *et al*, *American Journal of Medicine*, 1967, **43**, 735.
[80] Deaton, J G, *American Journal of Tropical Medicine and Hygiene*, 1970, **19**, 196.
[81] Covell, G, *Tropical Diseases Bulletin*, 1955, **52**, 705.
[82] Howard, W A, *et al*, *Military Medicine*, 1973, **138**, 32.
[83] Stuiver, P C, *et al*, *British Medical Journal*, 1971, **1**, 426.
[84] Torrey, E F, *Journal of the American Medical Association*, 1968, **204**, 867.
[85] Geddes, T G, *British Medical Journal*, 1970, **3**, 711.
[86] Data, J L, and Nies, A S, *Annals of Internal Medicine*, 1974, **81**, 500.
[87] Covell, G, *et al*, *Chemotherapy of Malaria*. Geneva, WHO, 1955.
[88] Gilles, H M, *British Medical Journal*, 1966, **2**, 1375.
[89] Hendrickse, R G, *et al*, *Annals of Tropical Medicine and Parasitology*, 1971, **65**, 1.
[90] Ransome-Kuti, O, *Advances in Pediatrics*, 1972, **19**, 319.
[91] Barrett-Connor, E, *Annals of Internal Medicine*, 1974, **81**, 219.
[92] Pearlman, E J, and Hall, A P, *Annals of Internal Medicine*, 1975, **82**, 590.
[93] Hockwald, R S, *et al*, *Journal of the American Medical Association*, 1952, **149**, 1568.
[94] Ognibene, A J, *Annals of Internal Medicine*, 1970, **72**, 521.
[95] Thanh, P H, Huan, D H, and Tinh, T V, *Journal of Military Medicine in Vietnam*, 1971, **40**, 37.
[96] Lucas, A O, *et al*, *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 1969, **63**, 216.
[97] Laing, A B G, *Bulletin of the World Health Organisation*, 1970, **43**, 513.
[98] Pearlman, E J, *et al*, submitted for publication.
[99] O'Holohan, D R, and Hugoe-Matthews, J, *Southeast Asian Journal of Tropical Medicine and Public Health*, 1971, **2**, 164.
[100] Lewis, A N, and Ponnampalam, J T, *Annals of Tropical Medicine and Parasitology*, 1975, **69**, 1.
[101] Rieckmann, K H, *et al*, *Bulletin of the World Health Organisation*, 1974, **51**, 375.

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For Debate . . .

Specialist registration: a critical look at the proposals of the Merrison Report

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Summary

In the general euphoria over the many views in the Merrison Report that the profession welcomed too little attention has been paid to what has been said about specialist registration. The report contains several basic confusions and a serious misunderstanding of the nature of specialist medical training and practice. It makes several cardinal errors in thinking that some notorious problems related to NHS staffing are also related to a lack of an effective specialist register, and it shows how the creation of such a register would largely destroy the authority of the colleges and faculties. Nowhere in the report is there any convincing argument to show that specialist registration would confer advantages sufficient to outweigh the disadvantages. To let specialist registration in the UK slip in on the irrelevant coat tails of EEC requirements would be a grave dereliction of the long-term interests of medical practice and patient care. The General Medical Council is holding a conference in which this topic is to be discussed on 24 February 1976 and it is still not too late for the profession to think again on this topic.

Introduction

Although professional concern over the introduction of the annual retention fee was a major stimulus to the inception of the Merrison inquiry,[1] anxieties about the General Medical Council's role in specialist registration were not unknown even before that. Indeed, a determination to keep the control of specialist education in the hands of relevant professional bodies was a potent stimulus to the setting up of the Joint Committees for Higher Professional Training.

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Careful study of the Merrison Report shows that (*a*) the committee has muddled the meaning of "specialist" with that of "consultant," and has tried to equate specialist registration to accreditation and the completion of training; (*b*) the members of the committee have a very imperfect idea of the nature of specialist and consultant training; (*c*) some notorious NHS problems are assumed to flow from the lack of specialist registration when these are clearly unrelated problems; (*d*) the committee assumes that co-ordination between other phases of medical education and specialist training is desirable and that specialist registration would achieve it; (*e*) having outlined how their proposals would emasculate the influence of the Royal Colleges and Faculties, they show how a body like their proposed GMC would probably misuse its power and do a great deal of harm to the profession; (*f*) the benefits that they suggest would offset all this seem, on examination, to be illusory and ill-founded.

I have thus come to a conclusion contrary not only to that of the Merrison Committee but also to that of the editorial in the *British Medical Journal* that commended it.[2] It is difficult to believe that the author of that editorial could have been in sympathy with the BMA's evidence on this topic: "If specialist registration is *eventually* introduced, the standards of training, examination, and *accreditation should remain the responsibility* of the royal colleges' specialist faculties and specialist associations . . . ."[3] (my italics).

The Merrison proposals are likely to lead to rather different results as may be shown from the following extracts from the report (all italics are mine unless otherwise stated).

Muddles: accreditation and specialist registration

"We believe there to be three generally recognised and recognisable stages in the development of clinical responsibility: namely practice under supervision; independent practice; and practice carrying ultimate responsibility for the care of the patient, that is, at a high specialist level. These stages correspond broadly to the three stages of registration we propose: restrictive registration, general registration, and indicative specialist registration." (Para 124.)

Comment—This is the most important paragraph on this topic. Clearly, principals in general practice (eligible for the hospital

practitioner grade) and consultants are lumped together in the third stage.

"[The joint committees] establish criteria for posts and inspect them, recommend patterns of appointments, and list useful courses and higher qualifications. The endpoint is *accreditation as a specialist* by the appropriate Joint Committee. In the rest of this part we use the word "accreditation" to mean accreditation as a specialist giving *entitlement to specialist registration*." (Para 128.)

Comment—The joint committees intend their certificates to indicate the completion of higher professional training, giving entitlement to apply for a *consultant* post. There is no place in the NHS for *specialists* unless they are the part-time practitioners of a specialty in the hospital practitioner or clinical assistant grades or medical assistants. A formal specialist grade other than the consultant grade is clearly a re-introduction of a subconsultant grade.

"Completion of specialist education and accreditation by the appropriate body will mark the doctor fit to take the highest level of clinical responsibility in his chosen field." (Para 147.)

". . . We believe there to be a need for specific specialist training in general practice, and that general practice should be recognised as a specialty on the specialist register which we propose. It follows also that the standards of general practice ought to be maintained *in the same manner and to the same degree* as other specialties." (Para 129.)

Comment—This last statement may be reconciled with the others only if a full six years of "specialist" training for general practice is also envisaged. But there is no suggestion that this is envisaged; in fact, shorter periods of specialist training for some specialties are clearly suggested (see below). The report has muddled completion of training with accreditation as a specialist, which, for EEC purposes certainly, would be a much shorter period of training.

Muddle between specialist and consultant

"Many bodies are providing specialist education but there are no means by which the completion of this stage of education may be publicly recognised, [and] a reasonable equivalence of standards of specialist education brought about . . . ." (Para 38.)

". . . So far as any overall control of the standards of specialist education exists, it is by the NHS, through its appointments procedure for hospital *specialists*." (Para 43.)

"Appointment to the *consultant* grade involves a procedure . . . which seeks to ensure—particularly by the inclusion of members of the specialist college and other bodies in the committees—that every appointee has received an adequate *specialist* education." (Para 45.)

Comment—There is a clear need (made all the more urgent by the introduction of the hospital practitioner grade) for the profession to get clear what distinction should be drawn between specialist and consultant. The report certainly fails to draw one. The consultant appointment procedure ensures much more than specialist education. There is a lack of appreciation here that it is *only* by the inclusion of the college or faculty representative on consultant advisory appointments committees that the standards of consultants are preserved. The optional nature of this inclusion for hospital practitioner grade appointments gives ground for anxiety. Either procedure, however, is clearly a public recognition of a standard.

NHS problems and lack of specialist registration

". . . It is idle to pretend that the *service* as a whole is well served by there being a long waiting list for consultant status in some specialties and none at all in others; or that the interplay of supply and demand, locally and nationally, is a satisfactory means of making important and predominantly *educational decisions*, upon the sum of which the overall *quality of the service* largely depends." (Para 54.)

Comment—The only conclusion that can be drawn from this remarkable paragraph is that the committee believes that predominantly educational decisions (such as shortening the length of training) *ought* to be taken in an effort to improve the service. The apparent belief that specialist registration would facilitate such an indefensible line of reasoning is hardly a good recommendation for it.

". . . It is plain that a series of committees up and down the country appointed to deal with specific vacancies cannot be a good means of securing consistent standards even within one specialty, let alone among them all." (Para 55.)

Comment—It is equally plain to others that it is. What objective evidence there is tends to suggest that the standards of consultants are reasonably uniform over a wide range of posts. The committee quotes no evidence to the contrary.

Specialist registration and "desired" co-ordination

". . . Only by having one body overseeing all medical education will it be possible to achieve. . . the *co-ordination of all stages of medical education.* [Their italics.] This seems to us the only way of making sure of the satisfactory supervision of each part." (Para 51.)

"Suppose, for example, it were considered desirable to drop a subject from the undergraduate course on the grounds that the particular specialists needing that subject *would be instructed* in it as part of their postgraduate training. While the GMC has the power to secure the first part of such a change, the second part would at present involve persuading numerous independent bodies of the desirability of changing their practice. Even then no assurance that the specialists concerned had in fact *received the particular instruction* would exist, because the procedure for appointing NHS consultants would not bear sufficient authority to enforce such a condition." (Para 57.)

Comment—Specialists do not "receive particular instruction." For example, physiology and pharmacology are taught extensively in the undergraduate curriculum, and yet the Faculty of Anaesthetists insists on evidence of a high standard for the FFA, RCS. That practice would not change if the teaching of undergraduates in these topics greatly improved, and nor would it if this teaching were abandoned. To no significant extent are the educational needs of the future consultant geared to a consideration of what he has or has not been taught at earlier stages.

". . . There ought to be efficient co-ordination in the design of successive stages of medical education. For example, a very high level of training in some necessary background science in the undergraduate stage would reduce the amount required later on;" (Para 58.)

Comment—This is the same proposition in reverse and immediately brings into focus the danger of amateur outside meddling. Could one view with equanimity, for example, the GMC's "overall co-ordination" *removing* a requirement for training in say principles of measurement in specialist anaesthetic training *because* it was going to be taught in second MB?

". . . In the absence of overall supervision, those concerned . . . may waste effort counteracting the real *or imagined* deficiencies of other parts." (Para 59.)

Comment—Examinations show adequately whether the deficiencies are real or imagined, and the trainees devote their effort when it is found to be real. This whole argument is pitched on a plane of lofty logic which has little contact with the reality of consultant training or the nature of the colleges' role in setting standards, both of which the committee seem to have totally failed to understand.

Implicit powers of GMC over royal colleges and faculties

". . . Any registration system must ineluctably involve the registration body in the control of the standards of the education conferring a right to registration." (Para 131.)

"It follows that the GMC must have the power to refuse to accept a particular body's accreditation as providing an assurance of competence sufficient to merit registration. Such a power is an inescapable consequence of the introduction of specialist registration." (Para 136.)

". . . It would be possible for the GMC to insist, not only upon receiving full general details of the accreditation requirements for accrediting bodies, but also details relating to the accreditation of individuals." (Para 138.)

". . . Doctors from overseas will of course wish to obtain such registration on the basis of education and experience gained overseas . . . the GMC, not accrediting bodies, should grant registration direct." (Para 210.)

"If . . . it is believed—as it is by us—that every doctor ought to have received specialist education then it is logical to introduce a restrictive specialist register." (Para 154.)

" . . . An indicative specialist register . . . in the long run produces the same result as a restrictive one." (Para 149.)

Comment—Comment on these paragraphs is almost superfluous; specialist registration gives the GMC the control over the education itself and the bodies who assess it and the right to decide on individual

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cases, particularly those of doctors trained overseas. This is argued as "inevitably" flowing from the belief that every doctor should have received "specialist" training, when, in fact, "appropriate" training is what is needed. Furthermore, all these consequences flow from an apparently innocuous "indicative" register. Having elsewhere argued against the introduction of a restrictive register (for very good reasons) they frankly admit that the indicative one will have the same effect.

Opportunities for GMC to misuse its power

"The GMC must also grasp the nettle of the relative complexities of specialties. *Some specialties do not require such lengthy training as others and the arrangements for accreditation should recognize this.*" (Para 141.)

Comment—The GMC would be able to decide that a doctor specialising in general surgery needs less training than one in general medicine and that a radiologist needs less training than an anaesthetist. This opens the door to the concept that different specialists in the NHS are not equal because of their unequal training needs. Because of the confusion between specialist and consultant this could quickly lead to consultants themselves being regarded as unequal.

"We believe that the accrediting bodies must be *induced to co-operate* closely over the interchangeability of experience so that specialty programmes have as many crossover points on them as possible. This is essential for doctors at an early stage of specialist training . . . and no less important for the NHS which must have *flexibility in the use of junior specialist training posts*." (Para 141.)

Comment—It must be possible, apparently, to induce interchangeability so that the NHS can have flexibility in the use of training posts. Unless that means that geriatric registrar posts can be filled by budding paediatricians because it suddenly suits the needs of the NHS to deem the experience to be "interchangeable," it is difficult to know what it does mean. It certainly makes the interests of the NHS appear to be an important consideration and one which the GMC should feel able to consider. It goes well beyond the sense of the BMA evidence, "there would be no need for the regulatory body to set up multiple specialty boards, its function being to maintain the register, co-ordinate standards, and administer machinery for appeal against refusal of registration."[3]

There is a fundamental difference between specialist training and earlier aspects of training, a fact which the Merrison report clearly recognises. "The specialist phase of medical education, unlike the undergraduate or graduate clinical training phases, does not proceed to a roughly equivalent point for all students. The detailed aims of specialist education must, therefore, be determined in relation to each specialty." (Para 125.) The crucial significance of this has, however, been overlooked by the Merrison Committee. Because the earlier phases proceed to a roughly equivalent point it is possible to convene a representative body that can arrive at a consensus opinion against which to evaluate any variations in method or achievement of any one member organisation. The same can never be true of specialist training; a body made up of representatives of different specialties cannot generate any useful opinion about any individual specialty's level of training since only one member has sufficient relevant understanding of the situation* (the almost total ineffectiveness of the Council for Postgraduate Medical Education provides a salutary example). Not only must the aims be determined *in relation* to each specialty but they must be determined *by* the relevant specialty. Determination must also imply autonomy.

Discussion

EEC SPECIALIST CERTIFICATES

The requirement for EEC specialist certification is a separate matter from UK specialist registration, though apparently similar. Indeed, whether by accident or design, the two have been deliberately intertwined by the wording of article 5(2) of the first EEC Medical Directive (75/362/EEC), which lists the "certificate of completion of specialist training" as the "evidence of formal qualification" in specialised medicine currently awarded by the "competent authority" in the UK. Whoever was responsible for this wording has done a singular disservice to British medicine. The certificates of completion of training (or accreditation) were never designed for that purpose. There is no prospect whatever of the requirements for eligibility to receive such a certificate being harmonised with the requirements for an EEC specialist certificate in most specialties. One of the most constructive moves that could now be made would be for the joint committees, or possibly the conference of colleges and faculties, to press the Government to seek amendment of this clause. At the same time each joint committee should determine and publish the criteria on which it will be prepared to issue a certificate of specialist training which is consonant with the existing EEC requirements.

*Without restructuring the GMC would not have even one anaesthetist.

The urgent need for this can be deduced from considering the possible uses of EEC certificates.

UK graduates wanting to practise in other EEC countries—UK graduates would be at a great disadvantage because they would have to undergo much longer training for an allegedly equivalent certificate.

UK doctors wanting to practise as "specialists" in UK—If, for example, the hospital practitioner grade were to be restricted to holders of specialist certificates it would likewise be inequitable for British graduates not to be able to compete with holders of EEC certificates from abroad based on, for example, three years' training when the UK certificate required, say, six years. In both these circumstances, therefore, a UK certificate that corresponds to the EEC certificate is needed.

EEC doctors wanting to practise in UK—EEC directives require that a formal qualification in specialised medicine awarded by other member states should be given the same effect in the UK as those which the UK itself awards. A certificate of completion of training at present has no significance within the United Kingdom but the criteria so closely correspond to the criteria used by the relevant college or faculty in assessing suitability for consultant status that it is not impossible to foresee the day when the completion of certificate training will confer an entitlement to a consultant post. Clearly again, therefore, it would be unthinkable that existing EEC specialist certificates should carry that entitlement.

The problems of EEC specialist certification could be solved by an order made under the European Communities Act[4] specifying the joint committees as the competent authorities to grant EEC certificates although it would no doubt be bureaucratically more tidy for the GMC to issue the certificates on the advice of the relevant joint committee. It would be appropriate for the GMC to be empowered to register the possession of an EEC specialist certificate, but there seems to be no advantage in making it obligatory for individuals entitled to such a certificate to register the fact and such registration should be entirely voluntary.

SPECIALIST REGISTRATION IN UK

If the EEC specialist certificates would have no use or meaning in the UK what would be the position of another statutory specialist register recording the possession of a certificate of completion of training (accreditation)? The disadvantages outlined above look so overwhelming and the benefits so illusory that it is difficult to know why the profession, which was originally so against it,[5] has not reacted more vigorously. Possibly doctors thought it could be achieved without the GMC having control over the colleges and joint committees.

Such a specialist register seems to be entirely unnecessary in the field of NHS consultant advisory appointments committees. There is no evidence that doctors who are unable to obtain a certificate of completion of training are being appointed as consultants against the advice of the colleges and faculties. Replacement of an outside assessor by a certificate (issued on the basis of adequate time serving without misdemeanour in an approved scheme of training) seems unlikely to result in a general equalisation of standards, if indeed significant inequalities exist. Despite diligent inquiry, the only reason that I have been able to unearth in favour of specialist registration is that for doctors who do not have an NHS appointment it provides a means by which they can show they are fully competent to take

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clinical responsibility. It would thus be possible for organisations such as the Nuffield Nursing Homes to satisfy themselves that a doctor without a consultant NHS appointment is a suitable person to be given admitting and operating privileges. This seems a mighty small nut for the sledge-hammer which is proposed.

An entitlement to register a certificate of accreditation *voluntarily* with the GMC would furnish the necessary evidence. To those who would argue that only if the GMC has control of the bodies issuing such certificates can their registration be effective one must point out the precedent of the GMC registering higher qualifications in the past without having any form of control over the bodies concerned.

ADDENDUM—Since this paper was written the Council for Postgraduate Medical Education in England and Wales has issued a statement[6] broadly in agreement with the views I have expressed here.

References

1 Committee of Inquiry into the Regulation of the Medical Profession, *Report*, Cmnd 6018. London, HMSO, 1975. (Merrison Report.)
2 *British Medical Journal*, 1975, **2**, 155.
3 *British Medical Journal*, 1973, **3**, suppl p 29.
4 *European Communities Act 1972*. London, HMSO, 1972.
5 *British Medical Journal Supplement*, 1973, **2**, p 163.
6 *British Medical Journal*, 1976, **1**, 166.

Medical Training

General physician and specialist training in thoracic medicine

M G BRITTON, J V COLLINS

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The need for physicians with special experience in chest diseases has been the subject of constant reappraisal since 1960.[1-3] In 1968 the Central Health Services Committee[2] recommended that each district general hospital should have a department of respiratory medicine staffed by physicians who would participate in providing general medical services.

Respiratory diseases cause up to a third of surgery visits in general practice[4] and major loss of work-time,[5] yet there is little data about the demands which respiratory diseases make in hospital practice on which future plans for providing specialists may be based.

We have reviewed the work load created by patients with respiratory diseases presenting to hospital doctors in order to assess the need for specialist experience of respiratory diseases within a general medical service, and the value of these patients in educating junior hospital doctors in the specialty.

Patients and methods

St Leonard's Hospital is a small hospital in Hoxton providing adult general medical and surgical services. Acute medical admissions to the 98 medical beds are shared between three consultants acting as general physicians but holding joint academic appointments with the medical college at St Bartholomew's Hospital. The junior hospital staff consists of a medical registrar, two senior house officers, and three preregistration house physicians. The hospital has its own accident and emergency unit which is shared with the neighbouring Metropolitan Hospital, which takes two-fifths of the medical work load.

A prospective study to discover the demands which respiratory diseases make in hospital practice was conducted on patients admitted to hospital between 1 October 1973 and 30 September 1974 in whom an acute respiratory illness was considered the main reason for admission. Those patients admitted from outpatients or electively for investigations were excluded from the study.

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Results

The total number of all medical admissions during the period of the study was 1501 (HAA); of these, 1203 (80%) were acute as judged by our survey. Respiratory illnesses accounted for 15·6% of these acute admissions (table I) and the nature of these respiratory illnesses is analysed in table II. A review of the HAA statistics

TABLE I—*Causes of acute medical admission to hospital from 1 October 1973 to 30 September 1974*

	No	Percentage
Self poisoning	281	23·4
Respiratory diseases	188	15·6
Chest pain—angina or ? cause	131	10·9
Acute myocardial infarction	96	8·0
Renal diseases	90	7·5
Cerebrovascular accidents	87	7·2
Gastrointestinal diseases	86	7·2
Hypertension	49	4·1
Diabetes	35	2·9
Others	160	13·2
Total	1203	100·0

TABLE II—*Respiratory illnesses causing acute admission to hospital from 1 October 1973 to 30 September 1974*

	No	Percentage
Exacerbations of chronic bronchitis	77	41·0
Pneumonia, bronchial and lobar	36	19·1
Asthma	28	14·9
Bronchial carcinoma	26	13·8
Pneumothorax	7	3·7
Pulmonary embolism	4	2·1
Pulmonary tuberculosis	2	1·1
Others	8	4·3
Total	188	100·0

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