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CONTENTS

British Medical Association

Report of Council to Special Representative Meeting

Commentary on the Report of the Royal Commission on Medical Education (Cmnd. 3569, Todd Report) and Subsequent Developments

(1) The Report of the Royal Commission on Medical Education was briefly mentioned in the Annual Report of Council for 1968-9 (paras. 4 and 18). The time has now come to present a detailed commentary upon it.

Historical Review

(2) The Royal Commission on Medical Education (of which the chairman was Lord Todd, D.Sc., F.R.S.) was appointed in 1965 at a time when (in its own words) "many factors, not least the growing shortage of doctors, made clear that practical decisions must soon be taken in medical education." The Todd Report was published in April 1968. It was a printed volume of 404 pages, containing 571 paragraphs in 12 chapters, and 19 appendices. It did not include a summary of recommendations. These details are mentioned in order to preface the statement that the Council has found this extremely important Report to be difficult and time-consuming to study and digest.

(3) The Todd Report was immediately referred to the Council's principal committees, and the Council takes this opportunity to thank the committees, including the Board of Science and Education, for the painstaking labours which they have expended on consideration of the Report.

(4) In June 1968 the Representative Body passed the resolutions on medical education which are reproduced in Appendix I. These, and further resolutions passed at the Annual Representative Meeting at Aberdeen in 1969 (Appendix II), have been considered by the Council. Some, which deal with matters of detail, are not the subject of comment here, as they are more relevant to the sectional discussions of particular aspects of the Todd Report which are likely to take place when the profession's views on the main issues have been settled.

(5) On 4 July 1968 the Chief Medical Officer of the (then) Ministry of Health invited the Association's views on seven particular points arising out of the Todd Report, especially on the number of medical school places estimated to be required. On 25 July 1968 the C.M.O. asked the Association for comments on those Todd recommendations which concerned hospital services in London. On 22 August 1968 the Council's Medical Education Committee replied to these inquiries and wrote (*inter alia*): "The Committee is in agreement in the main with the recommendations of the Royal Commission on the pattern of postgraduate training . . . . It believes, however, that any plan for postgraduate training must be flexible, and it fears that the pattern proposed, together with vocational registration . . . may lead towards undesirable rigidity . . . In its evidence to the Royal Commission, the Association firmly opposed any idea of a two-tier medical profession. At first sight this danger appears to be inherent in the proposals for vocational registers."

(6) On 31 October 1968 the C.M.O. addressed a third letter to the Association, asking for the Association's views on the finance and administration of postgraduate medical education, under the following headings: (1) the responsibility of the N.H.S. for financing postgraduate medical education; (2) the status of the proposed Central Council and Regional Committees, and the relationship of these new bodies to the bodies of whose representatives they would be composed; (3) the functions, composition, and constitution of the Central Council; and (4) the functions, composition, and constitution of the Regional Committees.

Discussions with G.M.C

(7) On 2 January 1969 the General Medical Council sent to the Association a Statement in regard to the proposals of the Royal Commission concerning vocational training and registration, which the G.M.C. had approved "as a basis for discussion with other Bodies." The Statement said: "In considering the way in which vocational registration would be carried out, the Council [that is, the G.M.C.] intends to consult with the universities, professional colleges, and professional associations, in addition to Government Departments."

(8) On 11 February 1969 representatives of the Association met the President and other members of the G.M.C. There was discussion of the G.M.C.'s proposal to establish Specialty Boards for each of the special branches of medicine (including general practice). The question of increased representation of general practitioners on the G.M.C. was raised. Lord Cohen stressed that the proposals put forward by the G.M.C. were in broad outline and there was a great deal of detail which had not yet been considered.

(9) On 24 July 1969 the Secretary of State for Social Services (Mr. R. H. S. Crossman) stated in the House of Commons that the Government intended to introduce the necessary legislation as soon as possible to enable the G.M.C. to maintain specialist registers; and intended also to make detailed proposals for the establishment of a Central Council "to co-ordinate the planning of postgraduate medical training, to consider its future and to give advice to the bodies already active in this field."

(10) On 8 September 1969 the C.M.O. to the Department of Health and Social Security wrote to the B.M.A. and confirmed that legislation was to be introduced as soon as possible to amend the Medical Acts so as to enable the G.M.C. to undertake the registration of specialists. The letter continued: "The G.M.C. has proposed that the opportunity should be taken to include in the legislation . . . certain other provisions mainly concerned with giving effect to other recommendations made by the Royal Commission on Medical Education not directly related to specialist registration. The main purpose of this letter is to refer to these additional matters and to seek your comments on them."

(11) The additional proposals (some of which were not contained in the Todd Report) were, briefly: (*a*) that the G.M.C. should be given statutory power which would enable it to give financial assistance to bodies engaged in the study or promotion of medical education; (*b*) that section 15 of the Medical Act 1956 should be amended, mainly to exclude midwifery posts from the preregistration year; (*c*) that the present definition of competence in section 10(1) of the 1956 Act should be repealed, and not replaced by any new statutory definition of the level of competence to be attained on graduation; (*d*) that any specific reference to "qualifying examinations" for the purpose of registration should be removed from the Act; (*e*) that multiple fees should be payable by applicants for specialist registration in order to meet the substantial administrative costs of specialist registration; (*f*) that the Disciplinary Committee should be enabled to cancel or suspend specialist registration in certain circumstances.

(12) It was at once apparent that these proposals went very much further than had been envisaged from a study of the Todd Report, and in some unforeseen directions. An immediate protest was therefore made to the Secretary of State, and on 8 October 1969 the C.M.O. wrote to the Secretary of the Association with certain assurances—namely (*a*) that there was not now going to be any early public announcement about the introduction of legislation; (*b*) that the legislation to establish a system of specialist registration would not in any way restrict the freedom to practise of any doctor legally entitled to do so under the existing Medical Acts; (*c*) that the profession and professional bodies should be very closely involved in shaping the requirements for specialist registration; and (*d*) that it was not intended that the legal status of provisionally or fully registered doctors should in any way be changed.

(13) On 23 October 1969 a B.M.A. deputation, consisting of the Chairman of Council and the chairmen of the principal committees, met the President and other members of the G.M.C. The C.M.O. and another senior official of the Department of Health and Social Security were also present. The Chairman of Council opened the discussion by stating that the proposals regarding specialist registration would bring about changes of such significance in the training and registration of doctors that the deputation felt that, before anything else, the meeting should discuss the functions and structure of the G.M.C. It should be so constructed that a majority of its members would be elected by the profession and be responsible to the profession. A lengthy discussion ensued, covering not only the constitution and functions of the G.M.C. but also its finances and the implications of specialist registration. The B.M.A. deputation expressed particular anxieties about the position of a fully registered doctor who did not gain admission to a specialist register. The discussions continued on 6 November 1969, when the B.M.A. deputation stated that the Association had not yet canvassed the views of its members and the (B.M.A.) Council would not feel able to commit the profession until there had been full discussions. It would be helpful if the G.M.C. could join with the B.M.A. in asking the Government to delay legislation for the time being.

(14) On 14 November 1969 the Secretary of State announced that, in view of the doubts and alarms expressed mainly by the B.M.A., he had decided to postpone the introduction of the Bill on specialist registration until the next Parliamentary session, which would open in the autumn of 1970. This welcome postponement has enabled the Council to complete its consideration of the principal issues raised by the Todd Report. On 4 March 1970 the Council received from the G.M.C. a Second Statement Concerning Specialist Registration, but decided to defer consideration of it until the Representative Body had determined its policy on the Todd Report.

Commentary

(15) It has already been remarked that the Todd Report contained no summary of recommendations. Consideration of this long and complex report would have been immeasurably facilitated if the report had included such a summary, and the Council has therefore caused such a summary to be prepared by its own staff (Appendix III). The recommendations are described below by the numbers which they bear in the Council's summary.

(16) The Council has focused its attention upon nine principal issues, which arise out of Recommendations 1, 16, 17, 25, 26, 27, 32, 38, and 41. These issues are discussed below.

Scheme of Postgraduate Professional Training (Recommendation 1)

(17) Recommendation 1 of the Todd Report sets out a pattern of postgraduate training for the future. The Council believes that an orderly scheme of well-planned postgraduate training should be available for every doctor who wants it, but that the scheme must be voluntary and must be flexible. The Council is therefore opposed to any rigid requirement that all doctors should undertake three years of "general professional training" covering a planned series of posts. It is also opposed to an arbitrary separation of this period from the following period which the Royal Commission has called "further professional training." There is a fear that the general professional training period might, in some cases, turn out to be a three-year period of "national service" in the N.H.S. Moreover, different conditions obtain in the fields of hospital practice, general practice, community medicine, and occupational health. In the hospital field, for example, there is already a well-established pattern of training, covering the post-registration grades from senior house officer to consultant. Even if it were to be decided, at some time in the future, that new grades, or a re-definition of existing grades, was necessary, this would not substantially alter the existing pattern. Such a training pattern is relatively less well developed in other fields, but the Council is concerned lest a too rigid conception of "general professional training" and "further professional training" will make it difficult or impracticable for a doctor who wants, for whatever reason, to change the course of his career, to move laterally from one branch of medicine to another, without being compelled to start again at the beginning. It is necessary to ensure in some way that comparable experience in other branches of medicine will be taken into account.

(18) The Council therefore considers that the "general professional training" element in the Todd pattern should be described as "early postgraduate training" and should be entirely voluntary. The basic curriculum for medical education should be planned so that it is legally possible for a duly qualified medical practitioner to practise medicine independently after a prescribed period of undergraduate training followed by an internship not exceeding one year. Thereafter, the extent to which he will consider himself, and be considered, fit to undertake any particular form of medical practice will be a matter of internal opinion and discipline within the profession, and not for determination by statute or regulation. Following the intern year, each specialty, and general practice, should devise and apply its own training programme. Such training programmes need to be flexible and to pay attention to the special requirements of particular groups of doctors, such as married women doctors.

Assessment (Recommendations 16 and 17)

(19) The Council agrees with Recommendation 16 of the Todd Report that the assessment of whatever early postgraduate training may be undertaken should not be solely by a single major "pass or fail" examination but should be a progressive process. As the Council seeks to demonstrate in the paragraphs which follow, all disciplines and all branches of medicine are not strictly comparable and there will be variations in the content and time taken in postgraduate training. It is logical to assume that there must be similar variations in the method of assessment. With regard to Recommendation 17, whether or not the award of a new type of certificate in any particular branch is desirable is a matter to be decided by the profession, in the light of experience.

Vocational or Specialist Registration (Recommendations 25-27 and 32)

(20) The Royal Commission wrote (para. 158 of Todd Report): "Possession of a certificate and evidence of appropriate subsequent experience will not in themselves, however, be a sufficient guarantee to the public, or to others concerned, of the competence of the doctor. . . . The time has now come, in our view, for the establishment . . . of a system of vocational registration as the necessary complement to a proper system of professional training. . . ."

(21) The adjective "vocational" has caused confusion. It is not clear whether the Royal Commission regarded "vocational registration" as synonymous with "specialist registration." Since the Todd Report was published, however, it has become clear that the concept of vocational registration in general practice (see paragraph 24 below) differs from the concept of registration after a formal programme of training in a hospital specialty (see paragraph 23 below) which is more aptly termed specialist registration. As, therefore, vocational registration for general practice and specialist registration for a branch of special practice are not strictly comparable, it follows that the terms "voca-

tional registration" and "specialist registration" are not synonymous, though they are sometimes used as if they were.

(22) At the present time the Council considers that any plan to introduce vocational and specialist registration is premature. The first necessity is to devise an agreed postgraduate training programme for each specialty and for general practice. The next requirement will be to ensure that suitable opportunities and physicial facilities are available to provide the agreed training programmes. Only when these hurdles have been successfully surmounted will it be timely to consider the desirability of vocational and specialist registration.

(23) Even if these essential preconditions were already fully met (which is far from being the case), the arguments advanced in the Todd Report for the introduction of specialist registration would not appear to the Council to carry much weight in the hospital specialties. In all of these there are well-recognized higher degrees and diplomas, and full specialist status is attained by entry to the consultant grade. The Council has taken note of the considered view of the Central Committee for Hospital Medical Services that specialist registration should not be introduced unless it can be established beyond doubt that it will serve a useful purpose, and that any advantages which it might bring could not be obtained by less expensive measures which would not place further obstacles in the long and difficult road to consultant appointment. In the opinion of the Council, the case for formal specialist registration has not been made. If a certificate of specialist accreditation is thought to be desirable, the necessary arrangements can be made by the Royal Colleges and specialist bodies. Meanwhile, the required improvement in specialist training can be achieved without recourse to a formal specialist register. The Council is aware that the registration of specialists is to be found in other countries, notably those in the European Economic Community. In these countries medical practice is differently organized and moreover a registered specialist is entitled to charge a higher fee for his services. Thus the existence of a specialist register affords to the public a measure of guidance and protection which is not required here. If the U.K. enters the E.E.C. the position may possibly (though not necessarily) have to be reconsidered, but in the meantime the Council considers that specialist registration in the hospital specialties is neither necessary nor desirable.

(24) In general practice, on the other hand, the Council has noted the view that if a doctor voluntarily undertakes and completes an agreed programme of vocational training it would be reasonable to record the fact that he has done so. If, therefore, an agreed training programme for general practice were to come into full operation, the Council would approve the principle of indicative vocational registration or certification or accreditation for general practice, which would serve only to enable the public, the profession, and the N.H.S. authorities to identify those general practitioners who had completed the training programme.

(25) With regard to community medicine and occupational health, the Council considers that indicative specialist registration at the end of the period of training appropriate to these special branches of medicine would be appropriate if also introduced for the other branches of medicine, but not otherwise.

(26) In all these cases it must be noted that the Council is firmly of the opinion that any vocational or specialist registration, or certification, or accreditation that might be introduced at any time in the future should be merely *indicative* or informative. It should indicate only that the doctor concerned has completed the agreed period of training for a specialty or for general practice. Further, the Council emphatically disagrees with Recommendation 32 of the Todd Report. The Council's view turns on a principle which the Association holds to be fundamental. This is that once a doctor is fully registered he is legally entitled to practise medicine independently in any field.* It is appreciated that modifications to the undergraduate curriculum may alter the balance of academic and clinical training and this may necessitate a reconsideration of the length of training and of the period of provisional registration before full registration is achieved, but the line which divides a doctor who has a full licence to practise medicine independently from one who has not must still be drawn at the time of full registration. Employing authorities will continue to indicate their requirements in relation to particular appointments, as they now do.

The Proposed Central Council (Recommendation 38)

(27) The Royal Commission recommended (in para. 178 of its Report) that "there should be a central body, to be known as the 'Central Council for Postgraduate Medical Education and Training in Great Britain,' for the general oversight of postgraduate medical education and training in Britain. The Central Council, which should not be large, should be composed of representatives of the universities, of the main branches of the National Health Service and of the appropriate professional colleges or similar bodies in the main fields of medical practice, and should have an independent chairman, perhaps appointed by a Minister after consultation with the Central Council." The Government's plans to implement this recommendation have given rise to considerable controversy.

(28) On 24 July 1969 the Secretary of State for Social Services announced that he (together with the Secretary of State for Education and Science, and the Secretary of State for Wales) was about to make detailed proposals for the establishment of a Central Council for England and Wales; and that the Secretary of State for Scotland would be taking similar action with a view to setting up a separate Scottish Council for Postgraduate Medical Education.

(29) On 16 October 1969 the Secretary of State for Social Services sent his proposals to the Association and other bodies, and convened a conference on 7 November 1969 to discuss them. On this occasion the Government's proposals were heavily criticized, and on 4 December 1969 revised proposals were issued. They were published in full in the *British Medical Journal* of 20 December 1969 (Supplement pp. 73, 74).

(30) The Council agrees with the Todd recommendation that a Central Council is needed, to promote postgraduate training and keep it up to a good standard. The Central Council should be independent of Government control, at least in its academic functions. Its influence should be largely advisory and be exerted by consent and co-operation. Its guidance should, however, be published, so that the profession (and the public) will know when any posts fall short of the standards which the Central Council considers appropriate for modern postgraduate training.

(31) The (B.M.A.) Council considers that it would have been preferable to adhere to the Todd recommendation of a single Central (Postgraduate) Council for Great Britain, or even for the United Kingdom, but a separate Central Council has been accepted by the profession in Scotland and is in process of being established. With regard to the proposed Central Council for England and Wales, the (B.M.A.) Council considers that its functions could be summarized in the following terms of reference which are similar to those proposed by the Secretary of State for Social Services: "To co-ordinate and stimulate the organization and development of postgraduate medical education and training in England and Wales by giving advice at a national level to professional and educational bodies and to representative regional bodies established in connexion with the organization and planning of postgraduate medical education and training regionally; and to provide a national forum for discussion of matters pertaining to postgraduate medical education and training."

(32) The (B.M.A.) Council has the following criticisms of the suggested composition. There is (*a*) too much representation of central and local government; (*b*) too little representation of hospital junior staff and regional consultants; (*c*) insufficient representation of general practitioners as a whole, and inappropriate representation of younger general practitioners; (*d*) too little, or no, representation of community medicine, occupational health, and the medical branches of the armed Forces; and (*e*) no specific provision for representation of the medical profession in Wales.

(33) The (B.M.A.) Council suggests that the Central (Postgraduate) Council should show a relationship between the universities and the Royal Colleges on the one hand and the regional consultants who will play a major rôle in postgraduate training, medical officers of health, junior staff, and other medical and dental interests on the other. Thus 22 seats could be held by the academic institutions and 22 by the others. We believe that the B.M.A. would be in the best position to organize the representation of those other medical interests, in consultation with the regional postgraduate committees, so as to give appropriate representation not only to general practitioners, regional consultants, and hospital junior staff but also to minority interests such as community medicine, occupational health, and the medical branches of the armed Forces. We see no need for an advisory professional committee of this nature to have formal representation of Government. There would, however, be medical observers from the Joint Consultants

*In this connexion it is understood that the Government is not now likely to proceed with its intention to repeal the definition of competence in section 10(1) of the Medical Act, 1956.

Committee, the University Grants Committee, the Department of Health and Social Security, and from Scotland, Wales, and Northern Ireland. The Central Council should elect its own Chairman.

Role of the G.M.C. (Recommendation 41)

(34) The Todd Commission, in paragraph 185 of the Report, proposed that the G.M.C. "should assume a function in postgraduate education and training similar in principle to that which it now efficiently discharges in the undergraduate sphere." The Special Representative Meeting held on 12 February 1970 resolved that the Representative Body should agree with the G.M.C. and the Government on the functions and composition of the G.M.C. and its committees following an immediate review conducted jointly by the G.M.C. and the B.M.A. In advance of such a review, the Council cannot accept recommendation 41 of the Todd Report.

Other Important Issues

(35) The foregoing paragraphs have dealt with the most important issues on which an early pronouncement by the Representative Body is essential. There are a number of other recommendations of only slightly lesser importance which have been considered by the various interested committees and which form the subject of the paragraphs which follow. In addition, all the other recommendations in the Todd Report (shown in Appendix III) have been, or are being, carefully studied by the appropriate committees of the Council, and any further report which seems necessary will be made in due course.

Intern Year (Recommendation 2-7)

(36) The Council does not support the proposal (para. 65) that all graduates should normally be expected to spend their intern year in the area of the medical school which provided their clinical education. This would not always be practical, for example, in Wales. It should be a responsibility of the medical school to ensure that its graduates obtain intern posts with a minimum of difficulty. It has been suggested that there should be a central register of preregistration posts, and that there should be a uniform system of relating the dates of commencement to those of the university qualifying examinations. The Council supports the proposal that overseas students at United Kingdom medical schools should normally be expected to spend their intern year in the United Kingdom.

(37) The Council is in agreement with the need to ensure that preregistration posts should be considered as a whole (para. 66), and there is some feeling among junior doctors that posts which are unsuitable either in themselves or in combination with another post are sometimes certified as having provided requisite experience. In particular, great care should be exercised in the employment of preregistration house officers in casualty departments.

(38) The Royal Commission has suggested (para. 67) that the consultant responsible for the training of a preregistered doctor in a particular post should normally spend at least six sessions a week at the hospital if that particular post is to be approved for intern purposes. This is a desirable objective and one which the Council supports, provided that it is interpreted with flexibility in particular circumstances. Where the "firm" system is in operation, it will usually be sufficient if the "firm" responsible for the post has in all at least six *consultant* sessions a week at the hospital concerned. Further, each graduate should have an identifiable clinical tutor.

Early Postgraduate Training (Todd: General Professional Training) (Recommendations 8, 10, and 14)

(39) It has already been said that the Council rejects the concept of a fixed period of "general professional training." Some of the comments of the Royal Commission in paragraphs 74—100 are of equal application, however, to those posts which, in any scheme of early training for a specialty or in general practice, will follow the intern year. The provision of a planned series of posts, according to the pattern acceptable to the colleges and other appropriate bodies in each particular specialty, is desirable, and the duration of the posts should be flexible. Special provision should be made for married women and other doctors whose commitments dictate spreading their training over a longer period. Again, there is much to be said, if only to avoid domestic upheaval, for spending these years within one region. The Royal Commission was in favour of choosing a region away from the area of the university from which the young doctor graduated. The Council feels that this is a matter of personal choice and that the important thing is to provide a rotation of posts between different hospitals (teaching and non-teaching) within a region. No doctor should be obliged to go outside the region because a sufficient variety of posts is not available locally.

Specialist Training (Todd: Further Professional Training) (Recommendations 13 and 18)

(40) The paragraphs of the Report (101-112) dealing with further professional training outline recommended changes in hospital medical staffing. These are of the utmost importance and are the subject of a separate series of discussions, which will be reported to the A.R.M. at Harrogate. They are not therefore commented upon here, except to say that the recommendations in the Todd Report of which the effect would amount to setting up a permanent subconsultant career grade are not acceptable.

Administrative Organization (Recommendations 42, 47, and 48)

(41) The Council wishes to emphasize the importance of a strong and representative regional committee in each region (or part of a large region) covering all branches of the profession (para. 186). It endorses the desirability of the further development of postgraduate medical centres.

(42) The Royal Commission recommended (para. 195) that training of a professional, rather than an academic, character should be paid for by the National Health Service, as by far the most substantial employer of doctors in this country. The Council endorses this and at the same time emphasizes that existing allocations to boards for postgraduate medical education are insufficient and that additional moneys will have to be found.

Undergraduate Medical Course (Recommendation 64)

(43) In chapter 4, the Royal Commission examines the undergraduate medical course in some detail, with the emphasis on continuous assessment rather than on a single major examination at the end of the preclinical course. While the Council is in favour of experimentation with different educational methods, it should be open to medical schools voluntarily to adopt the system preferred and there should be no hard-and-fast rule. New methods should be constantly reappraised. It is the view of the junior staff, in which Council supports them, that it would not be satisfactory to rely wholly on personal assessment, which may be subjective in character, and that some form of examination not under purely local control must be retained.

(44) The Royal Commission has expressed the view held by many that the period before qualification is primarily academic and that the intern year is the appropriate time for the commencement of apprenticeship training (paras. 197 and 63). The modifications proposed in the clinical course will mean some reduction in the clinical experience which has hitherto been obtained before graduation. The Council considers nevertheless that clinical training must continue to form part of the undergraduate curriculum and that the newly qualified doctor should have already had some practical experience.

Medical Education in London (Recommendation 89)

(45) In general the Council agrees with the proposition that close links should be established between the special hospitals and general teaching hospitals and between the postgraduate institutes and the undergraduate medical schools (paras. 449-463), subject to a caveat that in the case of those institutes of truly international repute no administrative steps should be taken which would detract from their high standing abroad.

Internal Organization and Staffing of Medical Schools and Teaching Hospitals (Recommendations 106, 107, 110, and 111)

(46) The Council endorses the view of the Commission expressed in para. 511 that "university medical teachers ought not to be worse off than doctors of comparable ability and responsibility in National Health Service appointments." A greater interchangeability of pension rights would help matters.

(47) The Council supports the provision of facilities for part-time consultants to see and treat private patients at their teaching hospital, thus enabling consultant teachers to be "geographically whole-time" (para. 515) and has indeed said to the Department of Health and Social Security that it is desirable that such provision should be made in all new district general hospitals. This should be without detriment to the right of the part-

time consultant to use private consulting-rooms if he so wishes.

6 March, 1970.

The Council recommends:

(A) That the stage at which a medical practitioner is regarded as qualified to practise his profession independently should be the date of full registration.

(B) That, while accepting the desirability of continuing medical education, this Representative Body rejects any concept of a rigid or compulsory programme of general professional training after full registration.

(C) That, until such time as postgraduate training programmes relevant to the various branches of medicine have been devised and agreed, and adequate facilities have been made available to provide such training, and the early results have been analysed, any consideration of legislation to introduce vocational or specialist registration is premature.

(D) That, subject to the foregoing general reservations,

(1) If and when an agreed training programme for general practice comes into full operation, this Representative Body will approve vocational registration (or certification or accreditation) for general practice *in principle* provided its sole purpose is to identify those general practitioners who have completed the training programme; and provided it is understood that those general practitioners who are already established as principals on the "appointed day" are automatically admitted to the Register (or certificated or accredited).

(2) Specialist registration is neither necessary nor desirable for doctors engaged in hospital practice at the present time. It should not be introduced until a case for formal specialist registration has been made and it has been established beyond doubt that it will serve a useful purpose which cannot be achieved by less expensive measures.

(3) A system of indicative specialist registration would, in the view of the Representative Body, be appropriate in community medicine, occupational health, and other special branches of medical work (such as forensic medicine, medical teaching, and military medicine), if it were introduced for the main branches of medicine, *but not otherwise.*

(E) That there should be flexibility and reciprocity between the various training schemes so that doctors are not inhibited from moving from one branch of medicine to another.

(F) That this Representative Body supports the recommendation of the Royal Commission on Medical Education that there should be a Central Council for Postgraduate Medical Education and Training. Its functions should be advisory, and it should be independent of Government control.

(G) That the money necessary for the planning and implementation of proper postgraduate medical education and training must be provided by the Government over and above the moneys allocated to the National Health Service.

Appendix I

Resolutions of the A.R.M. 1968 (Eastbourne, 24-29 June) on the Subject of Medical Education

(336) **Resolved:** That Council be instructed to offer guidance to the profession regarding the recommendations of the Royal Commission on Medical Education.

(337) **Resolved:** That this Meeting does not share the opinion of the Royal Commission on Medical Education that group practice of at least a dozen members will have such advantages, economic and professional, and to the patients as to become a widespread and desirable form of organization in general practice.

(343) **Resolved** (as a reference to Council): That this Meeting regrets that, in spite of the grave shortage of doctors and the necessity of expanding the facilities for medical teaching, the Royal Commission on Medical Education, in their report, have failed to recognize the clinical resources of the district hospitals, and the Minister is asked to rectify this without delay by having the district hospitals recognized for both undergraduate and postgraduate teaching.

(346) **Resolved:** That this Meeting strongly recommends that fresh consideration should be given to the incorporation of a short obligatory period in general practice for all medical graduates.

(347) **Resolved:** That all doctors be encouraged to attend postgraduate refresher courses regularly, that places on courses be available to all doctors and that regional postgraduate committees ensure that all doctors are informed about all courses available.

Appendix II

Resolutions of the A.R.M. 1969 (Aberdeen, 2-5 July) on the Subject of Medical Education

(96) **Resolved:** That the period of postgraduate training envisaged in the Todd Report is excessive.

(100) **Resolved:** That in order to increase the emphasis on general practice in the medical curriculum all undergraduates should have a substantial period of observation and instruction in general practice during their clinical training.

(101) **Resolved:** (*a*) That this Meeting is of the opinion that there should be more training for general practice, both undergraduate and postgraduate; (*b*) that this training should be jointly planned and carried out by general practitioners and consultants.

(102) **Resolved** (by the requisite majority): That Council appoints a representative committee to review training standards in the preregistration year and the means of accrediting preregistration posts.

(103) **Resolved:** That the B.M.A. should seek an assurance from the Secretary of State for Health and Social Security that the money necessary for the planning and implementation of proper postgraduate education will be provided over and above the present inadequate money devoted to the National Health Service.

(104) **Resolved:** That there should be a review of the comparative value of the vocational training (for specialist and general practice) offered by each junior post throughout the hospital service, with an immediate pilot study in both the teaching and regional hospitals of one Metropolitan board area.

(105) **Resolved:** That in all B.M.A. Divisions which contain a teaching hospital efforts should be made to form teaching-hospital general-practitioner liaison committees.

(106) **Resolved:** That there should be general practitioner representation on selection boards for undergraduates.

(107) **Resolved** (by the requisite majority): (*a*) That this Meeting believes that standards and methods of postgraduate education should be controlled entirely by a central committee drawn only from the profession and should be independent of Government; (*b*) that if such a committee should be set up the representative committtees of the profession—for example, including the G.M.S. and C.C.H.M.S.—should be constituent bodies of the central committtee.

(206) **Resolved:** That this Meeting considers that the Todd Report on medical education should not be implemented until its effect on the staffing of regional hospitals be fully investigated.

(207) **Resolved:** That the future career structure of doctors should be based on specialist training programmes undertaken after the preregistration house officer appointments.

Appendix III

Report of the Royal Commission on Medical Education. Summary of Main Conclusions and Recommendations*

Chapter 3. Postgraduate Education and Training

Scheme of Postgraduate Professional Training of British Doctors

(1) The most appropriate pattern for the professional training of British doctors is the following:

(*a*) Intern year.

(*b*) General professional training lasting about three years and embracing present S.H.O. and registrar grades.

(*c*) Further professional training for a period which may vary in length but which is designed to bring the doctor to the point where he might reasonably expect to be considered for a consultant appointment.

* *Note*: This summary has been prepared by the B.M.A. staff for quick reference. It does NOT form part of the Report of the Royal Commission on Medical Education and whenever necessary reference should be made to the Report itself as the authoritative document.

(*d*) Continuing education of all doctors in career posts (para. 59).

Intern Year

(2) Responsibility for approving posts should be placed firmly on those universities which have undergraduate clinical departments (para. 65).

(3) Each university should be responsible for the selection and inspection of posts in its own area, which should normally be defined as the hospital region in which the university is situated (para. 65).

(4) A graduate should normally spend his intern year in the area of the medical school which provided his clinical education (para. 65).

(5) Overseas students at British medical schools should normally be expected to spend their intern year in Britain (para. 65).

(6) The university responsible should not certify that preregistration experience has been satisfactorily completed until it is satisfied that the young graduate has held two posts which are not only suitable in themselves but together form a suitable combination; and that the Medical Acts be amended accordingly. Obstetrics is not appropriate for the intern year (para. 66).

(7) The consultant responsible for training in relation to any post should spend at least six sessions a week at the hospital if the post is to be approved for intern purposes (para. 67).

General Professional Training

(8) The three years' general professional training should be organized as a planned series of 6 or 12 months' appointments, incorporating elements common to all specialties and those specifically appropriate to the specialty chosen (paras. 74-5).

(9) During the general professional training period, young doctors who have the aptitude should be allowed to undertake worthwhile research without being penalized financially (para. 76).

(10) All the appointments in the general professional training period should usually be held within one geographical area, and graduates should be encouraged to spend it away from the area of the university at which they qualified (paras. 75 and 77).

(11) It should be vocational rather than academic in nature (para. 78).

(12) Training posts should in appropriate cases include traineeeships in general practice and posts in administration and research (para. 79).

(13) The grades of S.H.O. and registrar should be merged into a new general training grade of registrar (para. 81).

(14) Women doctors with family responsibilities should be given every opportunity to undertake part-time training over a longer period (para. 82).

(15) A certain number of approved posts should be set aside for overseas graduates (para. 83).

(16) Assessment should not rest on a single major "pass or fail" examination but should be a progressive process throughout the three years (para. 93).

(17) When a general assessment of the trainee's performance and potentiality indicates that he has satisfactorily completed his general professional training he should be given a certificate to this effect (para. 95).

Further Professional Training

(18) The medical assistant grade will be superseded by a grade of "Hospital Specialist" (para. 102), subdivided into junior specialist (before vocational registration) and specialist (post-vocational registration) (para. 103).

(19) The junior specialist and specialist grades would be open to doctors working part time in the hospital service, including those in other branches of the profession and married women (para. 104).

(20) All junior specialists would receive further training, but certain ones only would be selected for appointment to intensive training posts of limited tenure which would bring them after a relatively short period to a point where they might be considered for consultant appointments (para. 106). A certain number of intensive training posts should be set aside for overseas doctors (para. 107).

(21) Rotation posts shcuild be introduced in all Regions (para. 110).

(22) Those who are not in intensive training posts should be given appropriate supervision and further vocational training of a nature similar to but less demanding than that offered in such posts (para. 112).

Professional Training for General Practice

(23) One of the appointments in the general professional training period should be in general practice (para. 119).

(24) After the period of general professional training a further period of two years should be spent as an assistant principal in general practice (para. 121)

Vocational Registration

(25) A system of vocational registration should be established as a necessary complement to a proper system of professional training (para. 158).

(26) Vocational registration should be informative: it would signify that in the opinion of the profession the trainee had had the training and experience that would normally be expected to make a doctor sufficiently competent to exercise a substantial measure of independent clinical judgement in his chosen field (para. 158).

(27) Vocational registration should cover general practice and community medicine as well as the hospital specialties (para. 159).

(28) Vocational registration should signify a reasonable minimum of informed competence in a specified field, and should therefore be granted on the basis of general professional training and a specified period of further training and experience. The length of the latter period would be prescribed separately for each specialty in consultation with the college or other professional body concerned, and would no doubt depend on the complexity of the particular specialty, on the type of training, and whether it had been undertaken full time (para. 160).

(29) As a general rule the period ought not to be less than two years (para. 160).

(30) All doctors already holding N.H.S. appointments as hospital consultants, those medical assistants with appropriate training and experience, and also all principals in general practice should automatically be admitted to the appropriate register when vocational registration begins. Thereafter, registration should be normally regarded as a routine feature of the background of applicants for consultant and principal posts (para. 160).

(31) The definition of specialties for registration purposes would best be decided by the General Medical Council on the advice of the appropriate professional bodies, who should also be responsible for advising the Council on the length of experience that should be required after general professional training as a condition of registration in each specialty (para. 161).

(32) Doctors who fail to attain vocational registration should be appointed only to posts in which guidance and supervision are available (para. 162).

Continuing Education

(33) Every doctor should be free to choose those forms which best meet his own needs and suit his own circumstances. No doctor should suffer financial loss in making reasonable efforts to do so (para. 165).

(34) Organized continuing education should not be restricted to formal courses. There should be more opportunities for a doctor to take part in up-to-date work in his own and other specialties, and more functional contacts between doctors in different branches of medicine. General practitioners in particular should have increased opportunities for part-time hospital appointments or short-term clinical attachments (para. 166).

(35) Continuing education in pharmacology and therapeutics is particularly desirable both in the hospital service and in general practice; there is a special need for continuing education in psychiatry for doctors in many branches of medicine (para. 167).

(36) There should be a postgraduate medical centre in most district hospitals providing a base for an area organizer and/or clinical tutor (para. 168).

(37) Special educational arrangements should be made probably on a part-time basis for married women doctors (para. 170).

Administrative Organization

(38) There should be a central body, to be known as the Central Council for Postgraduate Medical Education and Training in Great Britain, for the general oversight of postgraduate medical education and training in Britain with the functions of ensuring that:

(*a*) There is a comprehensive scheme for postgraduate professional training for all specialties, including general practice and community medicine.

(*b*) Sufficient training posts are available.

(*c*) Effective professional training schemes exist in each region.

(*d*) Effective arrangements exist for the assessment of general professional training.

(*e*) Continuing education is being effectively organized both nationally and regionally.

(*f*) Proper arrangements exist for overseas doctors who come to Britain for professional training.

(*g*) Ideas are exchanged between different parts of the country, and Britain is kept abreast of developments in postgraduate education elsewhere (paras. 176 and 178).

(39) Such functions can be carried out effectively only by a body representing the universities, the National Health Service authorities, and the professional colleges or similar organizations (para. 177).

(40) Scottish interests should be represented on the Central Council with maximum delegation of Scottish affairs to a Scottish Committee (para. 184).

(41) The General Medical Council should

assume a function in postgraduate education and training similar in principle to that which it now efficiently discharges in the undergraduate sphere (para. 185).

(42) A committee responsible for seeing that postgraduate medical education and training are efficiently carried out within their areas should be established in each hospital region (or part of a large region) throughout the country (para. 186).

(43) Regional committees should be small tripartite bodies corresponding to and organically related to the central organization (para. 187).

(44) An important function of a regional postgraduate committee should be to provide a careers advisory service (para. 188).

(45) Regional committees should be responsible for seeing that junior specialists and assistant principals receive appropriate professional training (paras. 191-192).

(46) Regional committees should ensure that sufficient facilities exist for doctors wishing to engage in whole-time research (para. 192).

(47) The further development of postgraduate medical centres is desirable (para. 194).

(48) Preparation for higher degrees is a proper object for the expenditure of university funds; training of a professional, rather than an academic character, ought to be paid for by the N.H.S. (para. 195).

Chapter 4. The Undergraduate Medical Course

(49) The undergraduate course in medicine should be primarily educational (para. 197). The proper time for vocational training is in the intern year (paras. 63-64).

(50) Medical education should follow a common basic pattern, with alternative options in the later stages to satisfy the different needs of individual students (para. 198).

(51) The preclinical and clinical stages of the medical curriculum should be increasingly integrated (paras. 201-203).

(52) The undergraduate clinical course should be remodelled and reduced in length to not less than two years (para. 206).

(53) The total length of the undergraduate medical course, preclinical and clinical, should be five years, but flexible within that time (paras. 207 and 208).

Preclinical Stage

(54) The preclinical stage could well be organized on a modular system similar to that followed in the U.S.A., whereby the curriculum is divided into a number of optional and interchangeable units, each carrying a specified number of points (paras. 214-222).

(55) A degree in medical science should be awarded on successful completion of the preclinical course. (paras. 223-224).

Clinical Stage

(56) Teaching in the clinical course should be organized on an integrated basis and each medical school should have a comprehensive educational policy planned and continuously reviewed by an interdepartmental committee of teachers (para. 228). (For a sample course, see para. 235.)

(57) Group teaching at ward level (in preference to spending separate periods in different units) is to be encouraged (para. 229).

(58) Clinical clerking, in intensive short periods between periods of integrated teaching, is to be encouraged (para. 230).

(59) The clinical stage should contain a free "elective" period of about 10 weeks to be filled by the student with a topic of his own choosing (para. 231).

(60) Specific periods of time should be allocated to obstetrics, general practice, psychiatry, and emergency services (para. 232).

(61) There should be a considerable reduction in formal teaching (para. 234).

(62) Each medical school should be left free to design its own curriculum under the guidance of the General Medical Council (para. 236).

(63) Detailed proposals for course revisions in particular subjects are contained in paras. 237-282, and cover: anatomy and physiology; statistics; behavioural sciences; sex education; psychiatry; obstetrics, gynaecology, and paediatrics; general practice; and community medicine. Teaching in general practice should not be confined to intending general practitioners (para. 278) and is seen in the context of group and health centre practice (para. 279).

Examinations

(64) Assessment of the student on completion of each subject in a modular course, based on reports and minor examinations, should take the place of a single major examination at the end of the preclinical stage (para. 283). The same principle should apply to the award of a degree in medicine (para. 284).

(65) An appropriate organization on the lines of the U.S.A. National Board of Medical Examiners should be charged with the responsibility of studying and improving methods of assessment (para. 285).

(66) Some means must be provided whereby doctors from overseas can obtain a British registrable qualification without repeating the whole or large parts of the undergraduate course (para. 286). Subject to protecting for the time being the existing arrangements for dentists seeking a double qualification to do so by way of a medical diploma, medical students at British universities should *not* be allowed to enter for non-university qualifying examinations until they have completed the medical degree course (para. 286).

Patients and Teaching

(67) More time must be provided in consultants' contracts specifically for teaching (para. 289), and proper facilities must be provided. Demonstrations in open wards in the course of a ward round are largely outdated (paras. 288-9). The co-operation of the patient should be sought in advance where it is possible to do so (para. 291). No hospital should confine its services to patients who undertake to contribute to medical education (para. 292).

Chapter 5. Selection and Preparation

(68) Officers mainly responsible for selection should familiarize themselves with developments in selection procedures in industry, and medical schools should be prepared to change their methods (para. 299).

(69) There should be closer contact between secondary schools and medical faculties of universities (para. 300).

(70) Insistent complaints about unfair operation of selection methods should be investigated jointly by the bodies representing deans of medical faculties and associations of headmasters and headmistresses (para. 300).

(71) Continuous national machinery to facilitate better general understanding between medical faculties and secondary schools should be provided (para. 300).

(72) Applicants should be considered for admission to a university medical course if they offer chemistry or physical science (chemistry combined with physics) together with any two other academic subjects chosen from the range available in the G.C.E. examination at "A" level (para. 309). (See para. 310 for application to Scotland).

(73) First M.B. courses run by medical schools should be discontinued. In the few cases where such preliminary instruction is necessary, it should probably be undertaken at a technical college (para. 312).

Chapter 6. Number of Medical School Places Required

(74) This chapter describes in some detail the calculations and considerations which led the Royal Commission to the conclusion that the country faced an immediate and future serious shortage of doctors. In an interim paper, presented in June 1966, the Commission recommended that:

(*a*) Specifically designated ("earmarked") additional funds, both capital and recurrent, should be made available to enable the earliest advantage to be taken of all worthwhile possibilities of short-term expansion at established medical schools.

(*b*) With the assurance that additional funds would be available the University Grants Committee, in co-operation with the Health Departments, should accelerate to the greatest practicable extent the implementation of those schemes of short-term expansion at existing medical schools which it had found to be feasible and should conduct an urgent review of the possibilities of further quick expansion; and that

(*c*) The U.G.C. and the Health Departments should, in consultation with the Royal Commission continue to investigate the concrete possibilities of using the potentialities of additional institutions temporarily to augment the resources of medical education and to define the most promising proposals for the establishment of new permanent medical schools (para. 324).

Chapter 7. Provision of Undergraduate Medical Schools

(75) Provision should be made for an intake of 5,000 a year (para. 369).

(76) The provision of the facilities required is not justified in a medical school with an annual intake of less than 150-200 medical students. Schools which can take more than this should be encouraged to do so (para. 371).

(77) About 2,000 "acute" beds (including geriatrics and short-stay psychiatric beds)

are required to support a medical school with an annual intake of 200 students (para. 374).

(78) As medical schools become ripe for redevelopment, opportunity should be taken to replace them on a scale and pattern appropriate to an annual intake of 200 students. The new schools at Nottingham and Southampton should also be expanded to this level (para. 376).

(79) Long-distance partnerships between universities in medical education, other than those already established, will be unnecessary (para. 377).

(80) An undergraduate clinical school should be established at Cambridge (para. 379). Use should be made of facilities available at the University of Strathclyde (Glasgow), Aston (Birmingham), and Salford (Manchester) (para. 380).

(81) The establishment of at least four additional medical schools will be needed over the next 15-20 years (para. 381). Two hundred extra places should be provided in London (para. 389).

(82) A university with less than 4,000 students in all will be unlikely to be able to accommodate a medical school satisfactorily (para. 386).

(83) Suggested sites for establishing new medical schools are: Southampton (already in hand); Leicester; Swansea (with the reduction in status of the Welsh National School of Medicine to a faculty of the University of Cardiff); Keele (if the University can be sufficiently developed to take advantage of the existing hospital facilities in Stoke-on-Trent); Hull (if the available population can be effectively increased by better communication with the industrial and commercial area of Lincolnshire); Norwich (in the event of plans for providing undergraduate clinical teaching at Cambridge not maturing); Coventry (University of Warwick) by the 1980s (paras. 387-395).

(84) Provision should be made for small-group teaching, reading and study ("study-cubicles"), and residential accommodation, shared as far as possible with students in other faculties (para. 397).

Chapter 8. Cost of Medical Education

(85) Arrangements should be made by the U.G.C. and the Health Departments for formulating a co-ordinated and authoritative assessment, on a continuing basis, of the future need for medical school provision and its likely cost, and for bringing this assessment regularly to the notice of the Government (para. 415).

Chapter 9. Medical Education in London

(86) The general pattern of the London medical schools (as semi-autonomous units in a federal-type university) is no longer satisfactory, and over a period of years each medical school should aim to become an integral part of a single multi-faculty institution (para. 429).

(87) The idea that a medical student should receive all his education on one site is unrealistic where university and hospital are physically separated (i.e., the siting of preclinical departments should not necessarily be governed by their proximity to the hospital). Departments of basic medical science should be located with other science departments (para. 430).

(88) The numbers and organization of the London undergraduate medical schools need radical reorganization and a scheme of concentration to halve the present number and to associate them with multi-faculty institutions of the university is recommended (para. 433—details of proposed combinations in para. 434 and of association with multi-faculty institutions of the university in para. 438).

(89) Close links should be established as quickly as possible between the special hospitals and the general teaching hospitals and between the postgraduate institutes and the undergraduate medical schools (para. 449—details of proposed links in paras. 453 and 454). Special hospitals should not continue to be governed by separate bodies but should be administered as part of the general teaching hospital groups associated with undergraduate medical schools (para. 450). The postgraduate institutes should likewise become a part of the combined medical schools (para. 451). No more institutions should be attached to the British Postgraduate Medical Federation (para. 452). The re-siting of the special hospitals and postgraduate institutes set out in the Pickering Report (the Chelsea and Holborn "nuclei") should not be proceeded with (para. 458). Special proposals are made for broadening the basis and functions of the Institute of Basic Medical Sciences (para. 462) and attaching the London School of Hygiene and Tropical Medicine to the proposed U.C.H./Royal Free teaching hospital group (para. 463).

(90) Staffing and teaching organization in the reconstituted London medical schools should have regard to the following desiderata:

(1) An elected chairman of each division or department (main teaching subject or group of subjects), normally a university professor.

(2) A full complement of clinical professorial chairs and units of the type and number expected to be found in future in all British medical schools.

(3) No distinction between former undergraduate and postgraduate chairs.

(4) Number of university-appointed clinical teachers to be increased.

(5) Medical students who take the whole of their clinical education in London to take the internal medical degree of the University of London (i.e., those who have done preclinical studies at Oxford and Cambridge).

(paras. 464-471).

(91) In the reorganization of administrative functions, the North East and North West Metropolitan Hospital Regions should be redivided into three regions (para. 479).

(92) The University of London should not remain restricted by its statutes from widening its territorial responsibilities for medical education (para. 486).

(93) General responsibility for the implementation of all aspects of the complete plan for London should be placed in the hands of a Committee for Medical Education in London (para. 488).

Chapter 10. Organization and Administration of Medical Schools and Teaching Hospitals

Organization of Teaching Hospitals

(94) The teaching hospitals in England and Wales should be brought within the framework of the administration of the regional hospital service generally, and the constitution of the regional hospital boards throughout Great Britain should be modified in order to provide on them appropriate representation of the universities in their areas which have faculties of medicine, and these universities should be consulted when the Chairman of the Regional Board is to be appointed (para. 500).

(95) Normally, university representatives should form one-fifth of the total (para. 500).

(96) In London, university representatives should be drawn largely or entirely from the medical schools and the multi-faculty institutions with which it is hoped that the schools will become associated (para. 500).

(97) The present system of Boards of Governors of teaching hospitals in England and Wales should be discontinued (para. 500).

(98) The main hospitals associated with each medical school and other hospitals in the immediate vicinity should be grouped under a single small newly constituted governing body, subject to the general medical and financial responsibility of the Regional Board (para. 500).

(99) One-half of the members of the governing body would be nominated by the university concerned, and the hospitals would be known as "University hospitals" (para. 500).

(100) An executive committee should be appointed for each major university hospital (para. 500).

(101) Adequate financial and administrative safeguards should be provided for the maintenance and development of teaching and research (para. 500).

(102) Endowments at present vested in Boards of Governors should be placed under the effective control of the new governing bodies responsible for the hospitals concerned. Such funds should not be diverted to general purposes (para. 501).

Internal Organization and Staffing of Medical Schools and Teaching Hospitals

(103) The structure of internal boards and committees in medical schools should be overhauled so as to encourage all members of the staff to play a part (para. 505).

(104) The Dean of every medical school should appoint a senior member of the staff to organize the tutorial arrangements (para. 506).

(105) Those part-time medical staff who can give only a small part of their time to medical education should not have the same voice in the affairs of the medical school as those whose main interest lies in this field (para. 510).

(106) University medical teachers ought not to be worse off than doctors of comparable ability and responsibility in N.H.S. appointments (para. 511).

(107) Teachers and research workers in the preclinical sciences should be permitted to contribute, and be paid for, work in an advisory, consultant, or supervisory capacity outside the normal run of university duties (para. 511).

(108) The number of honorary consultant contracts need not be restricted provided (i)

the suitability of the senior lecturer for honorary consultant status is assessed by an appointments committee of the teaching hospital authority similar in composition to that which would consider applications for a paid consultant appointment in the N.H.S.; and (ii) universities should maintain a reasonable balance between the number of lecturer and senior lecturer posts and should keep the hospital authorities informed of the number of clinical lecturers employed who may become candidates for honorary or paid consultant appointments (para. 512).

(109) Part-time consultant teachers should normally be expected to hold N.H.S. contracts for not less than eight weekly sessions in the university hospital group. The number of full-time (11 sessions) clinical appointments in university hospitals should be substantially increased, particularly in London (para. 514).

(110) The hospital contract should include and specify those sessions which, with the agreement of the university, are specifically added for university teaching and research (para. 514).

(111) The offering of facilities to part-time consultants to see and treat private patients at the teaching hospital, thus enabling them to be "geographically whole-time," is to be encouraged (para. 515).

(112) The teaching in each clinical department of the medical school and its associated hospitals should be under the direction of an academic head, and the departments should be organized on a divisional basis (para. 517).

Chapter 11. Overseas Technical Assistance

Medical Education in Developing Countries

(113) Postgraduate professional training in medicine should be based on the kind of practice that the doctor will have to undertake, and developing countries should in future therefore seek to provide opportunities for postgraduate training within their own territory before creating undergraduate medical schools (para. 523).

(114) The most effective way of developing technical assistance is by creating bilateral links between medical schools in Britain and the developing countries (para. 533-5).

(115) The Ministry of Overseas Development should make a bigger contribution to the payment of fares of doctors serving overseas who return home to attend interviews; and appointing boards should place a proper value on overseas experience (para. 538).

(116) Government assistance for short-term visits by senior teachers from Britain should be increased (para. 539).

(117) Short-term overseas contracts should be encouraged (paras. 543 and 544).

(118) More overseas posts in research carrying assurance of a post in the U.K. on completion should be established (para. 546). The requirement that the developing country must pay the basic cost of the post should sometimes be waived (para. 547).

(119) A central office, independent of Government, should be set up in Britain to give advice to governments, to other organizations, and to individuals both overseas and in Britain (paras. 550 and 569).

Overseas Medical Students in Great Britain

Undergraduate Medical Students

(120) An annual entry by about 1975 of 200 undergraduate medical students from overseas to medical schools in Great Britain should be aimed at (para. 554).

(121) Medical schools should be asked to arrange for a local doctor, probably a general practitioner, to be assigned as adviser and informant to each overseas undergraduate student (para. 557).

(122) Requirements for university admission should be relaxed for sponsored overseas students (para. 558).

Postgraduate Medical Students

(123) Each overseas postgraduate student should be given on arrival a pamphlet outlining the organization and operation of the N.H.S. (para. 559).

(124) More residential accommodation for postgraduate students from overseas should be provided (para. 560).

(125) Postgraduate students from overseas should have some postgraduate experience in their own countries before coming to Britain in posts supervised by advisers from the professional colleges in this country (para. 563).

(126) Doctors from overseas who cannot be accommodated within the training arrangements recommended by the Royal Commission should be expected to find their training in their own countries (para. 564).

(127) Medical schools or their parent universities should organize instruction to improve their students' acquaintance with the spoken language of ward, classroom, and laboratory (para. 566).

Chapter 12. Epilogue

(128) A comprehensive review both of training facilities and of career structures is required (para. 568).

(129) The work of A.S.M.E. should be supported and strengthened (para. 569).

(130) Changes are urgent and should not be long delayed (para. 570).

Sub-Appendix

Some Basic Assumptions on which Certain of the Recommendations in the Report are Founded

(1) All doctors, general practitioners as well as consultants, will be specialists in particular aspects of medicine, who will be equally regarded as such and will be fully trained for the work they undertake (para. 11).

(2) Every doctor who wishes to exercise a substantial measure of independent clinical judgement will be required to have a substantial postgraduate professional training, and the aim of the undergraduate course should be to produce not a finished doctor but a broadly educated man who can become a doctor by further training (para. 12).

(3) The future pattern of medical care will be determined only partly by deliberate decisions: to a great extent it will be the result of developments in medicine itself, of movements within society, in and for which medicine is practised, and in particular of changes in the organization of medical care which themselves will be determined to a considerable extent by the other two factors mentioned (para. 21).

(4) The group practice of about a dozen members will probably become a widespread form of organization in general practice (para. 39).

(5) A natural and obvious setting for general practice in the future will be the health centre (para. 41).

(6) The main feature of the British hospital service in the foreseeable future will be the district general hospital (para. 44).

(7) The primary criterion of consultant status will remain, as at present, appointment to a consultant post (para. 160).

(8) A doctor holding an appointment at medical assistant level will be expected to take cases in his own right for the whole of their investigation and treatment, working as a member of a team and seeking guidance and advice as necessary (para. 48).

General Medical Services Committee

A meeting of the General Medical Services Committee was held on 5 March, with Dr. J. C. CAMERON in the chair.

The Committee considered some aspects of the Report of the Royal Commission on Medical Education (Todd report) which the Committee had not already dealt with, and it agreed on a report on the second Green Paper on the future structure of the National Health Service for presentation to a Special Conference of Representatives of Local Medical Committees on 5 May.

Medical Education

The CHAIRMAN said that the attitude of the profession to the Todd report would be determined at the special conference on 5 May and at a Special Representative Meeting on 6 and 7 May.

The G.M.S. Committee, he said, had been active in the field of vocational training for general practice long before the Todd commission had been set up. The Chairman of Council's Co-ordinating Committee on the Todd report had co-ordinated the views of the various standing committees in the B.M.A. in a report to the Special Representative Meeting (see page 91). It was now before the G.M.S. Committee together with a

summary of the recommendations of the Royal Commission on Medical Education, the G.M.S. Committee's statement of policy on vocational training and registration, and its report on vocational training for general practice which had been approved by the Annual Conference of Representatives of Local Medical Committees in 1968.

Dr. A. ELLIOTT said that with so much currently happening the profession unfortunately had not had time to digest all the material before it. The attitude of doctors to the Todd report was generally hostile, because of a lack of understanding. It had been aggravated by things like retention fees. He thought a short simple statement of the situation was required, which should be sent out as soon as possible. Unless this were done the Committee would "face a catastrophe" at the special conference on 5 May.

Dr. D. D. WILLIAMS was concerned that undergraduate education, which he regarded as the crux of the matter, had not been properly discussed. At a recent meeting of doctors in his area he had been horrified at the reception when he tried to persuade them to accept the B.M.A. policy. They believed it ought to be possible to produce a general practitioner capable of independent practice by the time of full registration, and any further vocational training should be voluntary. The G.M.C., it was thought, ought to be able to produce an undergraduate training capable of achieving that.

Any compulsory training, the doctors had stated, was likely to result in increased emigration and reduced recruitment. An indicative register would inevitably end up as a compulsory register. The prime object of the whole exercise, they believed, was to staff the hospital service, and in the hospital service the general practitioner could fulfil only an inferior role. General practitioners referred cases to a hospital in order to see a consultant not another general practitioner.

That, said Dr. Williams, was the basic attitude of doctors at "grass roots" level. He did not, of course, agree with it. He agreed with the Committee's policy, which ought to be pursued, but he did not believe that the documents set out the Committee's case adequately.

Lowest Rung

Undergraduate training was inadequate to produce a safe doctor. The increased breadth of training, with the behavioural sciences included, the competition of specialties, the increased number of students, making clinical training almost impossible, were all relevant factors. If things were left as they stood, and the gap widened between general practitioners and specialists, general practitioners would find their opportunities for medical responsibility gradually eroded and they would "sink to the lowest rung of the ladder."

At this time of crisis in general practice it would be tragic if the Committee failed to make the position crystal clear in its report.

Dr. R. A. KEABLE-ELLIOTT referred to the financial implications of the Todd report. A doctor's pension on retirement was dependent on the number of years he had been a principal in general practice. If a doctor had to wait two years longer before becoming a principal his pension would be adversely affected. If the Todd proposals were accepted there should be some reference to the fact that doctors must not suffer financially as a result.

Dr. W. G. A. RIDDLE said that those who had no active interest in medico-political affairs were apt to have strong views on the maintenance of the status quo. It was therefore important to produce some sort of simple document which would bring home to doctors what was the policy of the G.M.S. Committee on vocational training for general practice.

Dr. R. B. L. RIDGE said that it was nonsense to contend that on full registration a doctor was now trained and capable of independent practice. The General Medical Council's booklet, "Recommendations as to Basic Medical Education," 1967, had clearly shown that undergraduate education must be brought into line with the needs of modern medicine. The booklet's recommendations were already being implemented by the universities. The need for special training, without which general practice could not be placed on a par with the other branches of medicine or attract recruits, must be spelt out in simple terms.

The CHAIRMAN said he thought there was a danger of the profession rejecting the Todd report in whole or in part. He agreed that most busy doctors could not be expected to have mastered all the documents, and it was therefore important that the special conference should have the issues before it in simple terms.

State Doctors

Dr. G. MURRAY JONES recalled that some time ago he had said that the meaning of the Todd report was that doctors were to be produced "by the State for the State." The intention surely was to direct doctors to where they were needed most. The flow into and out of medical schools would be directed. "Whose fault is it," he asked, "that doctors are not produced as complete doctors? We have stood by and idly watched this happen."

He said he was a staunch believer in group practice up to a certain size, but he was also a staunch believer in the freedom of a man to decide how to carry on his general practice. The Todd report sought to dictate to the medical profession how it should be organized. There were a number of such warnings to be heeded, and a good, long look at the Todd report must be taken so that the full implications were realized before any final decision was made.

Dr. J. H. MARKS said that medicine had changed so greatly that no one could absorb all the information he needed in the short time of the present undergraduate course. In general, local medical committeees consisted of senior doctors who qualified when there were no antibiotics or steroids. A simple document in large print was needed for the "grass roots." If the Committee believed that vocational training was necessary its members must go to meetings of local medical committees to try to convince them the Committee was right.

Dr. A. J. ROWE asked whether the Government had accepted the general recommendations of the Todd report.

Dr. D. GULLICK, Under Secretary, said that the Government had, in July 1969, accepted some of the Royal Commission's recommendations on postgraduate education, including the establishment of a Central Council for Postgraduate Medical Education and Training.

Dr. T. K. COOKE said the Central Council for Postgraduate Education and Training was to be responsible for the administration of vocational training for general practice. Who was to set up the central council? To whom would it be responsible? What would be its powers? There was mention of regional committees to carry out the policy of the central Council. There were already regional organizations. They certainly were not carrying out the policy of the central council, because it had not yet been appointed. What powers would the central council have to ensure that the regional committees did what it wanted? Regional general practice subcommittees were being created in the Metropolitan area, yet still the central council had not been formed.

Though the administrative machine had been described, said Dr. Cooke, insufficient thought had been given to the various committees and councils. The central council was going to be a singularly powerless organization, and the regional organization now in being might differ considerably from what was envisaged. It was essential not only to consider the implications of the Todd report but also to look carefully at the administration and at the powers of its different levels.

All or in Part

Dr. R. C. R. GETHEN asked whether it was possible to accept the Todd report in respect of postgraduate education without necessarily accepting the undergraduate implications.

The CHAIRMAN said that the General Medical Council had already set in operation quite far-reaching changes in the undergraduate curriculum. What Dr. Gethen had asked would be difficult, in that the two were indivisible in the thinking of the royal commission. On the other hand, the G.M.S. Committee could state that, whatever the changes in the undergraduate curriculum, it ought to be possible to turn out a competent doctor by the time he had done his preregistration year. The Committee could agree in broad principle to the changes in postgraduate education, but it might well have to say that agreement would be dependent on some rethinking of the changes envisaged in undergraduate education.

Dr. RIDGE pointed out that the introduction of specialist registration required legislation, but the G.M.C. already had statutory powers to make changes in undergraduate training.

The CHAIRMAN said that the changes in undergraduate education recommended in the Todd report went much further than those introduced by the G.M.C.

Dr. D. L. WILLIAMS said that under the existing regulations the G.M.C. was bound to produce a doctor who at the end of his training was competent to practise medicine, surgery, and midwifery.

Dr. J. R. CALDWELL said that the purpose of undergraduate education was to produce a broadly educated man. He wondered what the educational system for the previous 18 years had been aiming at doing. "We are riddled with exams today, and compulsory education, with enormous sums of money being spent. If at the end of 18 years they do not produce a broadly educated man the teachers might just as well have remained on strike."

It had been implied that the only doctors against vocational education were the old "fuddy-duddies" who qualified before the second world war. But that was not the case. Dr. Marks had spoken of modern medicine needing much more training. "The general practitioners in my youth, and before the war," said Dr. Caldwell, "did far more and had far greater skills than any general practitioner today. They did a great deal of midwifery, a lot of surgery, and treated their patients almost unaided. Any fool can learn in a weekend course how to give a few antibiotics or steroids. Doctors do less and less and have to have more and more training to do it."

Purely Voluntary

Dr. N. S. MALIMSON asked whether the proposals would apply to students already at medical schools or only to new students.

The CHAIRMAN said that the policy of the G.M.S. Committee was that vocational training should be purely voluntary. If registration became compulsory several years' notice would have to be given before it was put into operation.

Dr. I. M. JONES said that the Committee had already accepted the corner stone of the Todd report—which was that in an undergraduate course of five to six years it was impossible to turn out a finished doctor in any branch of medicine. No responsible authority would ever put on the *Medical Register* anyone who was not competent. The Committee had stated clearly that it was prepared for something like three years' postgraduate, paid training.

The royal commission had overflowed into the sphere of what was required by the Government. Many doctors thought the recommendations would result in providing the Government with a fair amount of lower-paid medical labour. That was capable of negotiation and did not have to be accepted. Family doctors believed that in the traditional pattern they provided a service to the community and to individuals which could not be provided so advantageously in any other way. They believed in their continuance. Family doctors also believed that, if they were to survive, they must be treated financially and otherwise as the equals of those in other disciplines in medicine. "If we really believe in the continuance of our kind," said Dr. Jones, "we must accept that no independent adjudicator is going to equate us financially with other doctors unless we can show that we have undergone comparable training."

The first task was to get the realization of these facts into the minds of those who, however well meaning, had studied the proposals less deeply than had the G.M.S. Committee. He hoped that that would be the target for the forthcoming special conference.

Dr. JOAN CHAPPELL said she thought there was pretty general agreement that some sort of vocational training was needed. If the Committee did not make up its mind it would lose the chance to speak to the remainder of the profession.

Dr. G. R. OUTWIN said that, despite what had been said, there was little change in the basic undergraduate curriculum, and it was ridiculous not to be able to turn out a doctor after six years. Vocational training should be a part of postgraduate education. Otherwise, more and more time would be added to the undergraduate curriculum, and where would it end?

Learn by Doing

Dr. B. L. ALEXANDER supported Dr. Keable-Elliott's point that, should the Todd report be implemented, no doctor should get any less pension by having to start later in practice. Doctors ought to be able to look forward to retiring on a full pension at 60. By the end of undergraduate training the "basic doctor" should have been produced. "We learn by doing and not by sitting and watching," said Dr. Alexander. "Therefore if we are to have people to do general practice they have got to be able to get out into the field and stand on their own two feet and have the experience, just as they do in the hospital."

He did not think the consultants were altogether convinced of the need for vocational training. If general practitioners went it alone in having vocational training and a register where would they be? Equally, there must be a career structure and formal training for general practice, and in this the G.M.S. Committee accepted vocational registration on an indicative basis only. The Todd report was far from accepted, said Dr. Alexander. It was a series of proposals which might come about. It did not meet with everyone's approval. Finally, the implications of the report must be spelt out quite clearly.

At this point the recommendations from the report of the Council to the Special Representative Meeting on the Todd report were read out.

The CHAIRMAN, commenting on the discussion so far, said he noted a tendency to reopen certain matters on which policy had been decided at previous meetings. He was sure the G.M.S. Committee had no intention of going back on its previous decisions.

Dr. K. A. WOOD said it was absolutely necessary for general practitioners to show that their training was comparable to that of other medical disciplines. Dr. A. E. LODEN said he did not think it was possible to go on increasing the undergraduate period of training. He did not believe that after six years it was impossible to produce a competent doctor. No one would expect him to perform complicated surgical techniques, but he should be able to deal with surgical patients in his ward in the absence of his chief. Equally, he should not be expected to be able to deal with every single problem satisfactorily on his first day in general practice.

Naked Ape

Nothing was spelt out on undergraduate training in the G.M.S. Committee's recommendations, said Dr. Loden. "We should put aside," he said, "all these new subjects like social anthropology. Social anthropology produced the 'Naked Ape.' It does not produce a doctor." A doctor listened to his patient and took a history. He had to examine his patient. He was the only one who could decide. This required time, good premises, and an appointments system. Education for the undergraduate must not be increased—it must be concentrated. The G.M.S. Committee must fight strongly against such things as twelve-men group practices, which were complete nonsense, and get back to private family doctoring.

Dr. ROWE said he endorsed all that had been said about stressing to the profession the significance of the essential changes there must be in the medical curriculum. He drew particular attention to the word "sociology" in the Todd report and to the difficulties the G.M.S. Committee had been in because of the absence of training in this important discipline. It had been said that the time required for adequate training could not be increased, otherwise doctors would emigrate. That was a nonsense. The time required for adequate training abroad was longer than in this country in many cases.

The G.M.S. Committee's document approved in December was one which any general practitioner could read without difficulty, said Dr. Rowe. It was simple and concise. What was needed, however, was an introduction to explain how the basic medical course was changing and how the whole prospect was evolving. What worried him, however, was that there was no reference to the financing of general practitioner training under the regional health councils proposal in the second Green Paper and the regional postgraduate committees. There ought to be firm recommendations on this aspect.

Put Issues Clearly

The CHAIRMAN said that the feeling expressed by many members of the Committee—and he shared it—was that the documents probably did not really do justice to the work that had been done by the G.M.S. Committee. "We shall not be doing justice to those we represent," added the Chairman, "if we fail to put the issues clearly before them. I am sure the consensus of opinion is that we shall have to write an introduction to this mass of documents bringing out some of the points which have been re-emphasized today."

Dr. I. M. JONES suggested that any document for debate by the special conference should be in two parts. The first part would set out those matters on which there was general agreement in the G.M.S. Committee. The matters on which there was not agreement could be set out in the second part of the document. This procedure would be educative for the profession as a whole and assist the conference to take the right decisions.

Dr. J. G. BALL said that if the Committee favoured a mandatory training schedule it should say that the training facilities it had in mind must be provided. This point had not been made, and strategically it was important.

Hospital Doctors' Views

The CHAIRMAN then invited Mr. Walpole S. Lewin, chairman of the Central Committee for Hospital Medical Services, to state the general attitude of hospital doctors to the Todd report.

Mr. WALPOLE LEWIN, referring to the undergraduate course, said that he thought in the future it should include the preregistration year, making a period of six years. Over the next 10 to 15 years there would be much experimentation in undergraduate training. The three years' clinical experience was likely to go. Many were thinking of three years on basic sciences, perhaps including a degree in basic science, and then two years in clinical work before graduation.

Though it had been accepted that trying to cover all clinical specialties during the undergraduate period was impossible, yet, by graduation, even if he had done only two years' clinical work, a man should at least be in a position to profit from his preregistration year. There was a risk that in a purely academic training over five years a man could come to his preregistration year with little knowledge of patients and clinical procedures.

Mr. Lewin said that all undergraduate courses, whatever their length, should include a period in general practice. The third matter related to the importance of the preregistration year to general practitioners. The C.C.H.M.S. thought there should be a central register of all preregistration posts in the country, and that the universities should co-ordinate their examination times, so that it would be known when the preregistration posts could be vacant.

The C.C.H.M.S. had welcomed the opportunity to participate in postgraduate training for general practice, and it believed a suitable variety and combination of posts should be available. It was no good trying to gear up a hospital career structure and just hopefully believe that the general practitioner posts would be found. A proper training programme should be arranged. The G.M.S. Committee had already stated the kind of posts it had in mind. "It will have to be considered as a major exercise within the hospital field, and we are more than ready to take our full part in it," said Mr. Lewin.

He hoped the G.M.S. Committee would at this stage insist that vocational training should be voluntary. For years most general practitioners had done at least two years' training before going into practice, and as time went on few would wish to go into general practice, even if they could, without doing a prescribed period of training. But to keep the personal discipline independent it was right that training should be voluntary.

Rejecting Specialist Registration

Mr. Lewin said he entirely supported the Chairman's view that vocational registration should be separated from specialist registration. The only registration hospital doctors had been considering was full specialist registration at the end of the training period, which, it was hoped, would be an average of eight years. The first thing was to get the training programmes right and get the facilities and finance. Later it could be asked if the case for specialist registration had been made. If it were found to have a useful function it could be looked at, but at the moment hospital doctors were rejecting it.

Dr. RIDGE said he thought it must be stressed that education in medicine was a life-long process. This was truer today than it had been in the past, and it would be even truer in the future as the pace of advance in medicine continued to accelerate. If that were accepted the Todd report and all the suggestions about vocational training and registration could be looked at as merely the introduction of a greater measure of guidance in the first ten years of medical life.

Dr. E. TOWNSEND said that, in his view, if general practice were to survive there would have to be vocational training and its corollary vocational registration.

Second Green Paper

For the remainder of the meeting the Committee considered a draft report to the special conference on the second Green Paper.

The report, as amended after discussion, was approved by the Committee.

Young Practitioners Subcommittee

A meeting of the Young Practitioners Subcommittee of the General Medical Services Committee was held at B.M.A. House on 27 February. Dr. I. E. BLACK was in the chair.

Arising out of the minutes of the previous meeting (*Supplement*, 20 December, 1970, p.74), at which it was agreed that there should be a three-year period of vocational training for general practice after full registration, Dr. GERARD KEELE said that the Todd report should be implemented in full. Any decision now would be for a number of years ahead. If a general practitioner was to become a specialist his training should be similar to that for other specialists, otherwise general practice would become less attractive. Immediate implementation of the Todd recommendations would not affect the manpower position.

Dr. L. P. DOBSON said his colleagues were satisfied with the proposal to extend training for three years after the preregistration year. He thought any proposal to extend it further ignored the problems.

Dr. M. A. WILSON said the G.M.S. Committee had modified its policy on this matter and all were in line at the moment.

Junior Members Forum

The Subcommittee considered a proposal that the chairman and deputy chairman of the Junior Members Forum should *ex officio* be members of the committee, representing their personal professional interest as well as of the Young Practitioners Subcommittee.

Dr. WILSON said the existing practice should be continued. He objected to increasing the size of committees further. It would be enough to have the chairman of the Junior Members Forum and its representative on the Council as members of the Subcommittee. He asked whether the deputy chairman of the Junior Members Forum could not act as deputy to the chairman on the Subcommittee, to save increasing numbers.

Dr. BLACK suggested, and the Subcommittee agreed, that the chairman of the Forum and its representative on the Council should be members of the Subcommittee and that there should be a deputy for the chairman who would receive documents.

National Superannuation Scheme

The Subcommittee considered the possible effect of current Government proposals for a national superannuation scheme on the N.H.S. scheme, and Dr. BLACK suggested that Dr. R. A. KEABLE-ELLIOTT, a member of the Association's Compensation and Superannuation Committee, should be asked to address the Subcommittee on the matter.

Dr. E. MOSES said that most doctors thought the scheme would be detrimental to the medical profession, and he proposed that the Subcommittee "is opposed to any alteration to the N.H.S. Superannuation regulations without the consent of the profession."

Dr. GULLICK, Under Secretary, said a major snag was that under existing N.H.S. regulations a doctor could retire at any time after the age of 60 but the Crossman scheme would be fixed to the age of 65. Any doctor who retired at, say, 62 would get an N.H.S. pension but not get any of the Crossman pension until he was 65.

Dr. JOAN CHAPPELL said that under the Crossman scheme most doctors would wish to take out private insurance as well.

Dr. BLACK said that even with full abatements, doctors in employed branches of the N.H.S. would be paying over £100 a year for a pension of about £12 a week.

Dr. J. C. CAMERON, Chairman of the G.M.S. Committee, said that the Compensation and Superannuation Committee had been looking at the inadequacies of the N.H.S. Superannuation scheme for some time. Representations had been made to the Review Body to take the matter into account in making the next award and to express some opinion on the issue.

Dr. MOSES'S motion was adopted unanimously.

Second Green Paper

The Subcommittee considered the second Green Paper on the future structure of the N.H.S.

Dr. CAMERON outlined the discussions that had been held after the first and before the second Green Papers, and said that Mr. Crossman had tried to consult the interests concerned.

The G.M.S. Committee, continued Dr. Cameron, had agreed that he should take part in discussions on the understanding that neither the Committee nor general practitioners generally were committed. The B.M.A. had been invited to send representatives to discuss some of the points in the

new Green Paper. The Secretary of State seemed on paper to have met the criticisms levelled at the first Green Paper. The G.M.S. Committee had to prepare a report for the Special Conference of Representatives of Local Medical Committees on 5 May, and it was essential to have the views of the Young Practitioners Subcommittee.

The emphasis in the Green Paper on centralization of control, with regional offices of the Health Department and direct control of finance, must be looked at closely. The degree of centralization proposed made it necessary to be sure that the principles of democracy were preserved, and local representation must be strengthened.

Dr. BLACK said that he had tried to sort out the motives behind the proposals, and he wondered if it was not all an exercise in bureaucratic efficiency rather than an attempt to provide a better service for the patient. He could not see any comments in the Green Paper about any increase in spending on the N.H.S., nor where all the money required was to be raised from.

In reply to a question about the effect of a change in Government, Dr. CAMERON said that, in his view, even if there were a change in Government there would still be changes in the administration of Health Services.

Dr. J. ROCYN-JONES said he was worried about the fact that the general practitioners had had a very small say. Could the B.M.A. in further negotiations improve general practitioner representation? Dr. W. M. PATTERSON said that money was going to prestige projects rather than necessities. Projects of fundamental importance were being shelved.

Dr. BLACK asked Dr. Cameron if he thought that the second Green Paper helped to improve the service to the community, and Dr. ROCYN-JONES questioned how it could with no provision for increases in the money to be spent on the N.H.S.

Dr. CAMERON: "Everybody who looks at the document agrees that more money is needed for the Health Service."

"Tremendous Advance"

Dr. WILSON said he thought that the second Green Paper was a "tremendous advance." It was a much better document than the first Green Paper. General practitioners would retain their independent contractor status, and it went a long way towards what they had asked for.

It was difficult to know what would be the relationship between the chief administrative medical officer and the chief administrative officer of an area health authority. Were they going to be the two henchman of the partially salaried chairman? Who was going to be top dog of these two? The appointment of the chairmen of area health boards was going to be by the Secretary of State, along with a third of the members. The chairmen should be elected by their colleagues.

To suggest that district committees should be based on the district general hospital would be unsound, said Dr. Wilson, and he thought district committees had been very poorly dealt with in the document. They would have no budgets. Were they to be advisory committees, liaison boards, or what? The composition of the statutory committee for general medical services was not clear. It should be identical with that of executive councils. Regional health councils would deal with postgraduate education, but the proposals were woolly and would have to be looked at carefully.

Dr. BLACK said that complete medical independence must be maintained, and he thought it was not sufficiently guaranteed in the Green Paper. He asked how independent did clauses 67 and 68 of the Green Paper make members of the Subcommittee feel.

Dr. GULLICK commented that the Green Paper seemed to give with one hand and take away with the other.

Independent Contractors

Dr. KEELE asked whether independent contractor status was really so vital for general practitioners.

Dr. JOAN CHAPPELL said that the more medicine developed the more important it was for general practitioners to be able to attract to them patients needing their particular type of medical skill.

Dr. CAMERON said he strongly believed in the independent contractor status and with the fundamental freedom of the family doctor to criticize the town hall or anyone. "You will not maintain that if you become salaried employees."

Dr. KEELE: "Why should there be any difference in the salaried doctor? I don't see that the independent contractor status is terribly relevant to the future."

The Subcommittee caried *nem. con.* with one abstention, the following motion: "This Subcommittee feels that the full implementation of the Green Paper could lead to the erosion of the independent contractor status of the family doctor."

On the motion of Dr. WILSON, the Subcommittee agreed "That this Subcommittee is of the opinion that the statutory committee should have the same composition as the executive council."

It was further agreed that the statutory committee "should have obligatory liaison with the local medical committees."

Dr. CAMERON said that, apart from the local medical committees, a professional advisory committee in relation to an area health authority was needed. "This should be a very strong committee, especially if professional representation on area health authorities is not strong enough."

Dr. WILSON said it should be a standing medical advisory committee drawn from all branches of the profession in the area and it should be consulted by the area authority on certain matters.

Dr. CAMERON said general practitioners could not speak for their hospital colleagues but this was the kind of structure which seemed desirable and necessary. He believed the existing relationship between hospital medical advisory committees and the hospital authorities was not right. The relationship between local medical committees and executive councils was much better.

The Subcommittee agreed that the directly elected representation of the profession on area health authorities should be increased from a third to a half, leaving local government representation as proposed, and to include effective general practitioner representation.

The Subcommittee agreed that there should be no doubt about the continuation of local medical committees with all their functions; that at area level there should be an area medical committee with the right to be consulted, and that it should be recognized by regulation if not by statute; that the chairmen of area health authorities, after initial appointment by the Secretary of State in consultation, should be elected by the members of the area health authority.

Social Care

Commenting on paragraphs 29 to 36 of the Green Paper, Dr. JOAN CHAPPELL said she was concerned about the patients who would have to go to one authority for social care and dto another for medical. Dr. WILSON said that the moving of the family care work and social work for the sick and mentally disordered from the local health authority to the local social welfare department was to be deplored.

Dr. WILSON moved, and the Subcommittee adopted, a motion that "There should be no direction of doctors except through the present Medical Practice Committee procedure."

Dr. KEELE said area health authorities should have reasonable power to spend their money as they wished. He hoped also that area authorities might be able to raise money. There were resources that could be tapped. Area authorities should be allowed flexibility in their spending. He objected to so much central control of funds and wanted greater autonomy for area health boards.

Dr. BLACK said he wondered where the members of the proposed Central Advisory Council would come from. On paragraph 95, dealing with "better publicized procedures for the handling of complaints by hospital authorities," Dr. Black said the time could come when doctors would have in their waiting-room a form on which people could complain of treatment and pass it on to the authorities. Was the Subcommittee entirely happy at the implications of this?

The Subcommittee resolved "That there should be no further complaints procedure, other than the present medical services committee procedure."

Communications

Dr. BLACK said that the Young Practitioners Subcommittee represented young assistants and younger general practitioner principals, and he wondered whether the Subcommittee could reach such doctors more effectively than they did.

Dr. GULLICK said he thought that the *B.M.J.*, in printing in the *Supplement* reports of the meetings of the Subcommittee, had this point very much in mind.

Armed Forces Committee

A meeting of the B.M.A.'s Armed Forces Committee was held on 2 March. Mr. R. MYLES GIBSON was in the chair.

The Committee considered the third report of the National Prices and Incomes Board on armed Forces pay (*Supplement*, 7 March, p. 78) together with a report of meetings of B.M.A. representatives with the Ministry of Defence on 24 November and with the Prices and Incomes Board on 11 December.

It was reported that the B.M.A. had submitted a memorandum of evidence on behalf of medical officers in the armed Forces to the prices and incomes board in November 1969. Oral evidence had been given later and the Committee had been represented by the Chairman, Sir Richard Nelson, Sir Dick Caldwell, and Major-General J. P. Douglas. At the meeting with the Ministry of Defence specialist, consultant and diploma pay, the betterment factor, and permanent commission grants had been discussed. The Committee noted with regret that the prices and incomes board had not recommended a betterment factor for doctors in the armed Forces of at least 15% over their civilian colleagues—a proposal that had been strongly emphasized in both the written and oral evidence. The board's report referred only to a 5% "X factor" applicable to all servicemen. The Committee still firmly believed that a betterment factor of not less than 15% was essential to maintain a satisfactory level of recruitment of doctors to the services and to retain existing medical officers.

In introducing a military salary the board had recommended that no members of the armed Forces should be worse off as a result of the latest recommendations on pay than they would be under the existing conditions of service. This "no detriment clause" had been recommended in the B.M.A.'s written evidence.

The Committee decided that an early meeting should be arranged with the Ministry of Defence to discuss the prices and incomes board report.

Association Notices

Dissolution of Suffolk Branch

Notice is hereby given by the Council to all concerned of the dissolution of the Suffolk Branch and the reconstitution of its two Divisions as separate Branches to be known as the East Suffolk Branch and the West Suffolk Branch. The changes take effect from 1 March 1970.

DEREK STEVENSON,
Secretary.

Dissolution of Wiltshire Branch

Notice is hereby given by the Council to all concerned of the dissolution of the Wiltshire Branch and (a) the transfer of the Trowbridge Division to the Bath, Bristol and Somerset Branch, with consequential changes in the area of that Branch; and (b) the reconstitution of the Swindon Division as a separate Branch to be known as Swindon Branch. These changes to take effect from 1 March 1970.

DEREK STEVENSON,
Secretary.

Diary of Central Meetings

MARCH

24	Tues.	General Purposes Committee, 2 p.m.
25	Wed.	Negotiating Subcommittee (C.C.H.M.S.), 10.30 a.m.
26	Thurs.	General Medical Services Committee, 10 a.m.
26	Thurs.	Finance Committee, 2.30 p.m.

APRIL

1	Wed.	**Council,** 10 a.m.
2	Thurs.	Joint Formulary Committee—Editorial Committee, 10.30 a.m.
8	Wed.	Working Party on Euthanasia (Board of Science and Education), 4.30 p.m.
12	Sun.	L.M.C. Conference Agenda Committee, 11.30 a.m.
23	Thurs.	Annual Conference of Honorary Secretaries, 10 a.m.

MAY

5	Tues.	Special Conference of Representatives of Local Medical Committees, 10 a.m.
6	Wed.	**Special Representative Meeting,** 10 a.m.
7	Thurs.	**Special Representative Meeting,** 10 a.m.
8	Fri.	Panel on Audio Visual Communication (Board of Science and Education), 2 p.m.
14	Thurs.	Psychological Medicine Group Committee, 2 p.m.
26	Tues.	Scottish Joint Consultants Committee (at 7 Drumsheugh Gardens, Edinburgh), 10.15 a.m.
27	Wed.	Annual Conference of Representatives of Local Medical Committees, 10 a.m.
28	Thurs.	Annual Conference of Representatives of Local Medical Committees, 10 a.m.

Branch and Division Meetings to be Held

Members proposing to attend meetings marked ● are asked to notify in advance the honorary secretary concerned.

ALDERSHOT AND FARNHAM DIVISION.—At Cambridge Military Hospital, Aldershot, Wednesday, 25 March, 7 p.m., cases will be shown; 8.15 p.m., discussion. (Supper will follow.)●

BARNET DIVISION.—At Middlesex Arms, St. Alban's Road, South Mimms, 26 March, 8.30 p.m., dinner and B.M.A. lecture by Dr. Gavin Thurston: "Some Coroners Cases." Ladies are invited.●

BIRMINGHAM DIVISION.—At 36 Harborne Road, Edgbaston, Tuesday, 24 March, 8.30 p.m., two M.D.U. films followed by discussion.

BRADFORD DIVISION.—At Bradford Royal Infirmary, Wednesday, 25 March, 8.15 p.m., joint meeting with Medico-Chirurgical Society.

BRADFORD DIVISION.—At Medical Societies' Room, Bradford Royal Infirmary, Wednesday, 25 March, 8.15 p.m., B.M.A. lecture by Dr. Ronald Gibson: "The Satchel and the Shining Morning Face."

BURTON-ON-TRENT DIVISION.—At Stanhope Arms, Bretby, Tuesday, 24 March, 7 for 7.30 p.m., dinner; 8.45 p.m., M.D.U. film: "Ogden v. Bell."

FOLKESTONE AND DOVER DIVISION.—At New Metropole Hotel, Folkestone, Monday, 23 March, 8.30 p.m., meeting to discuss future of medical services and education including specialist registration and to consider resolutions for Annual Representative Meeting.

GLOUCESTERSHIRE BRANCH.—At the Abbey House, Tewkesbury, Thursday, 12 March, 6.30 p.m. B.M.A. lecture by Mr. J. Hicks: "Modern Trends with Injuries." (Followed by dinner at Gupshill Manor.●)

HALIFAX DIVISION.—At Royal Halifax Infirmary postgraduate lecture room, Thursday, 26 March, 8.30 p.m., Dr. D. Verel: "Domiciliary Management of Coronary Thrombosis."

LANARKSHIRE DIVISION.—At Stonehouse Hospital, Tuesday, 24 March, 8 for 8.30 p.m., clinical night.

LONDONDERRY DIVISION.—At Postgraduate Centre, Altnagelvin Hospital, Wednesday, 25 March, 8.15 p.m., B.M.A. lecture by Professor A. K. M. Macrae: "Crime and Sickness."

MID-HERTS DIVISION.—At St. Albans City Hospital Medical Centre, Friday, 20 March, 8.45 p.m., Mr. A. Swinson: "Writing behind the Writing." Guests are invited.

NORTH BEDFORDSHIRE DIVISION.—At Medical Institute, Bedford Hospital, Thursday, 26 March, 8.15 for 8.30 p.m. meeting to discuss the Green Paper.

WEST NORFOLK DIVISION.—At Assembly Rooms, Town Hall, King's Lynn, Thursday, 26 March, 8.30 p.m., B.M.A. lecture by Professor F. E. Camps: "Crime—How the Medical Profession can Contribute to its Control."

TOWER HAMLETS DIVISION.—At Mile End Hospital, Friday, 20 March, 3 p.m., Mr. P. England: "Surgery of Rheumatoid Arthritis."

Correction.—In the report of the Proceedings of Council (14 March, p. 84) Dr. W. R. King was reported to have said that in the Welsh Council's view "the contents of the Welsh Green Paper would not be much different from the English Green Paper." He informs us that what he said was that the contents "would be materially different".