General professional training

GENERAL professional training is the phrase used to describe the period of postgraduate experience following the pre-registration year. There are widely differing views on its content. One view is that after full registration a doctor should choose one broad discipline and remain with it; the difficulty here is that advancement is competitive and those who fail to achieve their career ambition face a long period of retraining. Another view is that experience outside a doctor's career choice has positive advantages, not only because it increases career options but on educational grounds.

The Royal Commission on Medical Education was in no doubt that general professional training should emphasize the common basis of medical practice, not the differences which characterize each specialty.[1] Fifteen years after the Commission reported, only general practice has supported its recommendations to the extent of requiring all new entrants to the specialty to obtain a variety of clinical experience; although some other specialties encourage such training they do not insist upon it. Indeed the student who shows an aptitude for a particular hospital specialty knows that committing himself to it single-mindedly earns the approbation of his seniors and is often the shortest route to a career post. Does this matter? Are there sound grounds for believing his preparation for independent practice will be defective? Are these grounds sufficiently cogent to warrant a new restriction on the free choice of a medical graduate?

Until the middle of the nineteenth century, physicians, surgeons and general practitioners each received quite different education and training. That changed with the Medical Act of 1848; since then the basis of the undergraduate medical course in the United Kingdom has been that all doctors receive a common education. Despite the clinical experience provided by student clerkships this has long been regarded as insufficient preparation for practice; the pre-registration year was introduced[2] to give students personal experience of practice under supervision, but this experience is invariably limited to hospital work.[3] The Merrison Committee suggested that the pre-registration year should be rethought and extended into a period of graduate clinical training because it believed that 'the exercise of responsibility . . . cannot be learned without actively exercising responsibility and we believe it is necessary to encourage the development of responsibility by conferring it'.[4] The aim of graduate clinical training, the Committee held, should be, under the supervision of a university, to develop the medical graduate into a generally trained clinician—thereby implying that more than apprenticeship was needed.

Charles Newman in his elegant treatise on the university education of a doctor[5] emphasizes the need for balance between technical knowledge and the creation of a professional man. The GMC too believes that 'what matters most is not the knowledge imparted to a man but what the man himself becomes in the course of acquiring the knowledge'.[6] The characteristic of a profession is that it constantly seeks to improve itself[7] and to adapt to changing circumstances: 'The fixed person for fixed duties, who in older societies was such a godsend, in the future will be a public danger.'[8]

No doctor with experience of the medical developments of 25 or so years behind him can forecast with any confidence the changed face of medicine over even the time taken to train a doctor for independent practice. But he should be reasonably sure that whatever else changes the basis of good practice will remain an understanding of people, skill in the many facets of consultation, and a critical approach to decision-taking. Sectional interests within the profession should not be allowed to erode the time needed to establish the universality of practice in each budding recruit. The technology of medicine today demands vocational training, but that should not be confused with the need to establish the foundations of good clinical practice. It is general professional, not specialist, training that will make the graduate into a clinician.

How can this be achieved? The young graduate 'learns best by doing',[9] but he should not be so overburdened with the stresses and strains of daily work that he has neither the time nor the energy to learn from his experience. Time too is needed by his teachers to advise and guide him, yet only in general practice is the trainer rewarded for his educational responsibility. The all-embracing contract for hospital staff which purports to include time for teaching does not guarantee that time, and it is too readily assumed that excellence in clinical work is the only criterion of tutorial ability.

The Merrison Committee stressed that to give universities responsibility for graduate clinical training without resources to reward and develop the skills of tutors would lead to the educational deficiencies that have plagued the pre-registration year. General practice has amply demonstrated the value of trainer selection

and the protection of trainees from specific service responsibilities; a similar step by other specialties could be costly in money terms but priceless in the rewards it would bring in the form of unity within the profession.

K. M. PARRY
Secretary, Scottish Council for Postgraduate Medical Education, Edinburgh

References

1. Royal Commission on Medical Education (Chairman: Lord Todd) Report. Command 3569. Paragraph 74. London: HMSO, 1968.
2. Ministry of Health, Department of Health for Scotland. Report of the Interdepartmental Committee on Medical Schools (Goodenough Committee). Pp 198-203. London: HMSO, 1944.
3. Code of Good Practice in Relation to the Pre-Registration Year. General Medical Council: London, 1973.
4. Committee of Inquiry into the Regulation of the Medical Profession (Chairman: A. W. Merrison). Report. Command 6018. 1975. London: HMSO, Paragraph 124.
5. Newman, C. *The evolution of medical education in the 19th century.* Pp 252-261. OUP, 1957.
6. General Medical Council. Recommendations as to Basic Medical Education 1967. Paragraph 66.
7. Houle, CO. *Continuing education in the professions.* P 10. London: Jossey-Bass, 1980.
8. Whitehead, AN. *Science and the Modern World.* P 282. New York: Macmillan, 1926.
9. Merrison Committee. Report. Paragraph 88.

Research: The role of the general practitioner

The European General Practice Research Workshop (EGPRW)[1] has been meeting for 12 years. In it, ideas are pooled and research projects are both stimulated and if appropriate, smothered. Encouraged by the publication of statements about the role and education of the general practitioner by the Leeuwenhorst group[2-4] the EGPRW established a working group to consider the possibility of making a parallel statement concerning research in general practice. The working group had wide representation from all countries involved in the EGPRW and its deliberations were refined continuously by reporting back to the entire Workshop.

Our concern was to establish a framework in which research in primary care might be seen in relation to research in patient health and health care systems. In some countries primary care has made considerable advance and achieved academic status over recent years, but in others, the academic contribution from general practice is minimal. This document crystallizes the place of research in primary care and provides the 'raison d'être' and an organizational framework for it.

The statement is published in full. An appendix containing the full classification of research areas and a single sheet summary of the statement is available on request from the Birmingham Research Unit of the Royal College of General Practitioners, Lordswood House, 54 Lordswood Road, Harborne, Birmingham B17 9DB.

References

1. Hull FM. The European General Practice Research Workshop 1971-1981. *J R Coll Gen Pract* 1982; **32:** 106-108.
2. Working Party of the Second European Conference on the Teaching of General Practice. Statement on the work of the general practitioner. *J R Coll Gen Pract* 1977; **27:** 117.
3. Working Party of the Second European Conference on the Teaching of General Practice. Statement on the contribution of the general practitioner to undergraduate medical education. *J R Coll Gen Pract* 1978; **28:** 244-250.
4. Leeuwenhorst European Working Party. Continuing education and general practitioners. *J R Coll Gen Pract* 1980; **30:** 570-574.

Statement on general practice research: European General Practice Research Workshop, October 1982

1. Introduction

General practice is a scientific discipline within medicine and has a specific place in a comprehensive health care system. It is concerned with the provision of medical care for individuals and in a wider sense in communities. It includes clinical, administrative and educational elements. Research is determined by the problems presented which may arise from any of these elements. The fundamental object of research is to increase knowledge and to apply that knowledge to promote the health and welfare of patients by providing improvements in the quality of care.

2. What is research?

Research is systematic critical enquiry conducted in accordance with rules which facilitate reproducibility. Results are expressed objectively in terms understood by professional colleagues and members of related disciplines. The results and their interpretation are submitted to critical review and testing by others prior to their inclusion as part of the scientific basis of and teaching for general practice. In this way the scientific principles of general practice comply with the rules and canons of any specific discipline.

Detailed research techniques and methods will vary with the problems. The conventional end point of research in all the natural sciences is the elaboration of a 'cause and effect' model of reality, which symbolizes and mirrors the factors or elements interacting in the problem situation and which predicts the subsequent outcome of events involving those elements.

General practice shares with all clinical medicine a 'problem and action' orientation. The emphasis here is on clear definition of the problem and then the initiation of appropriate therapeutic action. Where the