The William Pickles Lecture, 1969

Education after the Royal Commission*

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THERE must be many in this room who have known William Pickles personally and have lost a friend. I met him only twice and briefly, so that I must see him chiefly through his own writings and the writings of others about him. But it is my privilege to give this year, just after his death, the lecture which this College has created to perpetuate his memory. I am very much aware of the great honour bestowed on me and of my own inadequacy for the task.

William Pickles was born in Leeds in 1885. His father was a general practitioner and so were four of his five brothers. He was educated at Leeds Grammar School and had his medical training at Leeds General Infirmary. There he impressed Lord Moynihan who took a special interest in him. He first went to Aysgarth as a locum in 1912 when he was 27. After a short absence he returned to the same practice as second assistant with Dr Dean Dunbar, a friend from student days. He had firmly decided by now what sort of practice he wanted, after seeing many varieties as a locum. So it was in 1913 that he settled in the place and the work which he carried on for 53 years, except for his service in the Navy in the first world war. In his writings he speaks often of the happiness of his life there, "It is a hard rough life, but intensely satisfying for those cut out for it"[1]. "There is something in country practice which breeds content—I believe it is the deep bonds of friendship which exist between doctor and patient—"[2]. "A personal knowledge of one's patient and his family is of immense value in medicine and there is continuity in country practice. Most of us show little inclination to change our habitat and retire with reluctance, knowing that our real life is then ended and fearing that utter loneliness which comes with a separation from our work and from our friends".[3] Contentment in his work stands out again and again in his writings. It determines his view of the National Health Service.

> I cannot express too strongly my feelings of delight and relief when I threw aside day book and ledger. In this practice the new conditions have been established almost imperceptibly and without disturbing the doctor-patient relationship which existed before. . . . With the cost of modern treatment it was becoming increasingly difficult to obtain adequate remuneration from our patients and, under the new conditions, although the incomes earned are still too small, they are some improvement on the old. . . . My predecessors, whose patients' needs were their first concern in life, would have rejoiced could they have foreseen how much more was to be done for them with the changing times.[4]

It was not till 1928, when Pickles was already 41, that he started the work which ultimately made him famous in this country and abroad. This is in itself remarkable. So is the way he started. He read James Mackenzie's *Principles in the diagnosis and treatment of heart affections* in 1926. Two years later an epidemic of infectious hepatitis occurred in Wensleydale. Out of a population of 5,700 there were 250 suffering from jaundice and he and his partner attended 118. I wonder if any of us here have met an epidemic of this disease so large. Mackenzie's book had given Pickles the idea that a country practice could be a fruitful field for certain types of research. He had been puzzled by a smaller epidemic of jaundice since 1910, because textbooks only described Weil's disease—something much more severe. Now he seized his opportunity.

By means of the careful recording of starting dates on the charts which he and his

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wife maintained so accurately, he was able to trace the spread of infection and to establish the incubation period of this disease. But it was not simply this unusual epidemic that gave him his opportunity; it was also his setting in a rural area. Here he pays tribute to another great general practitioner, William Budd, and quotes him in the first page of his own book,

> It is obvious that the formation of just opinions on the question how diseases spread may depend less on personal ability than on the opportunities for its determination which may fall to the lot of the observer. It is equally obvious that where the question at issue is that of the propagation of disease by human intercourse, rural districts where the population is thin and the lines of intercourse few and always easily traced, offer opportunities for its settlement which are not to be met with in the crowded haunts of large towns.[5]

Between 1929 and 1939 Pickles did most of the epidemiological work which culminated in his book, *Epidemiology in country practice.*[3] This book has become a classic not only because it represents solid achievement from taking great pains, but because both in its writing and in the research method there is a quality of simplicity. He makes it all sound easy and one wonders why no one had thought of it all before. He lectured in the United States, South Africa and Australia. His lectures would often start like this: "I come to speak about very simple things, everyday happenings, and elementary deductions drawn from them, such as are within the scope of but a meagre intellectual equipment".[5]

In 1952 he was elected the first president of this College. This was the time when the College was administered from one room in Sloane Street above John Hunt's consulting rooms. Council met at the Society of Apothecaries in the City and committees at the Imperial Hotel in Russell Square, now demolished. It was a time of enthusiasm, expansion and inexperience. It has been one of my tasks in the College to see, as archivist, that the more important documents of those early days should be preserved. As president at that time, Pickles was essentially a forerunner and a figurehead, but as such he was very important to the young and unknown College.

We honour the memory of a fine man. Through this annual lecture his memory will not be allowed to fade. What is the importance of his life and work for the rest of us? We mostly work in cities or towns and only a few achieve successful individual research. It is, I think, as a doctor giving a high standard of care to people whom he knew well and loved. He loved the work he did with them, and it stemmed naturally from his training and was fed by his continuing experience. His special interest helped to keep his mind alert. He was an obviously contented man, enjoying honour in the great world of medicine as well as the respect and love of the people of Wensleydale.

This College exists to raise the standard of general practice in both town and country, to enrich the life of its members and to raise the esteem of the general practitioner in the eyes of the profession and the public. The doctor's education, research and the conditions of practice are its three main fields of activity. William Pickles has been a major figure in the early success of the College, but he had no particular concern with medical education. I have nevertheless chosen this as my subject.

There has probably never before been a time in this country when so much thought has been given to medical education as in the last five years. I have chosen it as my subject partly because of this and partly because I have always thought that education would be a major factor in deciding whether the general doctor can survive in an age of specialization.

Improvements in education raise the standard of practice. This has been demonstrated by Osler Peterson[7] and others.[8, 9] They should enrich the doctor's life and therefore breed content. There is a relation between education and esteem, that elusive thing which I make no apology for mentioning, because it matters. But in medicine as

in any other subject with a practical purpose, there must be a close relation between the education and the job to be undertaken.

The subject is appropriate in this old and beautiful city, which has meant so much to me since I was a schoolboy, although I was not educated here. But this only increases my diffidence to be speaking on it in a place where so many people are devoting their whole lives to its study and practice.

I intend to talk almost entirely about the education of general practitioners and not about medical education as a whole. I shall have much more to say about postgraduate than undergraduate education. A recurring theme will be the relating of the education to the work that has to be done.

I want to look first at the past, in order to put the Royal Commission's report[10] in a proper perspective.

We need not look back far—only to the middle of the eighteenth century—the Georgian era, the time of Dr Johnson, a period distinguished in English literature, undistinguished in medicine. From then to the present time seems, for my subject, to fall into two parts—the mid-eighteenth to the mid-nineteenth and the mid-nineteenth to the mid-twentieth centuries. The Medical Act of 1858 makes an arbitrary dividing line—this was the Act which created one portal of entry to medicine, and established the General Medical Council.

In the first of these two periods primary medical care in this country was provided by four main groups—physicians, surgeons, apothecaries and quacks. Quacks outnumbered apothecaries by nine to one, and there was little to distinguish the two groups until the Medical Act of 1815. Before that Act apothecaries objected to quacks on the ground that they were uneducated, but this was a case of the mote and beam since half of the apothecaries themselves had had no formal training. They learned by apprenticeship, which may have been short before 1815, but thereafter had to last five years. They were regarded as tradesmen because they sold medicines over the counter. Surgeons, who before 1800 also had little status, were alternative sources of primary care, but they were not numerous; like the apothecaries, their training was practical and mainly one of apprenticeship. Physicians also were few in number—one for every 20 apothecaries. They had, most of them, received a university education at Oxford or Cambridge or Edinburgh, but this was an education in literature more than even the theory of medicine. It was certainly not a practical training—this had to be picked up by trial and error in the postgraduate period. "The character of a physician", wrote Thomas Withers, "ought to be that of a gentleman, which cannot be maintained with dignity but by a man of literature". The end product was described as you will remember, "Profound, sad, discreet, groundedly learned and deeply studied in physic." The last feature seems doubtful.

This then was the time of ' the orders ' in the professions giving primary medical care. There were clearly marked differences in esteem. What distinguished each group and decided status was difference in education. Dr Charles Newman[11] in his book on medical education in the nineteenth century, stresses another important feature, that medicine and medical education was concerned before 1850 with symptoms. It was only in the next period that physical signs were recognized and taught. The feature of the earlier period was a concern with the patient, his mind and the personal details of his case; these came to be neglected in the next period. Physical signs and the study of pathology directed attention away from what the patient complained of, feared or thought about his illness, towards objective findings and common patterns of illness.

The mid-nineteenth century saw other big changes, for which the basic influence was the scientific revolution. Medicine could use science only through increased education. It was scientific understanding that came to distinguish the trained doctor from

the quack. By this time the term 'general practitioner' had crept in and gradually replaced the term 'apothecary'. The general practitioner was distinguished from the apothecary by his greater education. This raised him in esteem. Whereas Lady Chettam in *Middlemarch*, George Eliot's novel, preferred her medical attendants in 1830 to be on a footing with the servants, and Mr Gibson, in Mrs Gaskell's *Wives and daughters*, had his refreshment in the housekeeper's room when he visited Cumnor Towers, such social segregation would have been extremely rare by 1900, and is unheard of in our time —and not only because of the disappearance of servants. The term 'general practitioner' went some way to unite the 'orders'.

The century from mid-nineteenth to mid-twentieth century can for our purpose be called the era of the safe general practitioner in medical education. The development of formal undergraduate training at this time aimed to provide a complete qualification for practice. The aim was still the same by 1944 when the Goodenough Committee reported. In the last quarter of the nineteenth century this aim was reasonable. But long before the time of the Goodenough Committee,[12] the pattern was showing signs of strain. Scientific and medical specialization was causing overcrowding of the curriculum even in the early years of this century.

This was the situation when many of us here, including myself, received our medical training. We will none of us have been in practice long before we realized that there were many problems for which we had no preparation and that we had been provided with knowledge and skills some of which we could not use.

What was missing from my medical education? I did not get a balanced picture of the problems of health and disease in the population at large. I certainly learned nothing about health and little about the prevention of illness. I learned relatively little of chronic diseases or mental diseases, though I was particularly interested in the latter. There was too much emphasis on curing and too little on supporting patients whose troubles cannot be cured. I kept an interest in the patient as a person with individual problems only with difficulty. I had very little conception of the influence of social, psychological and economic factors on illness, or of how, as Querido[13] and others pointed out, these influence even the outcome of hospital treatment. I learned that the centre of interest in medicine is the hospital, and did not learn that medicine is just as interesting and important outside hospital because people are the real heart of the matter. Seeing only doctors giving hospital or secondary care in the most excellent way, I did not learn to respect those who give primary care—far from it, I scarcely knew they existed and certainly looked down on most of them.

General practice or primary medical care has to draw on too many fields of knowledge for the training to be achieved in five or six years. Some of it calls for maturity as well. To leave half of it to trial and error by throwing the young doctor in the deep end, as we have done in the past, is unfair both to him and his patients.

But the system of medical education which most of us here have known had other effects than limiting our competence. Because it had been so much shorter than that of our specialist colleagues, we lacked self-confidence and felt inferior. Because it has been inadequate to the problems we deal with, some of us have found less satisfaction and pride in our work than we might have done. Medical students in the meantime have seen that primary care is a job which seems to require less training than other jobs and is less well paid over a lifetime, though no less hard-worked. It inevitably looks a second best to most of them.

I make these criticisms even though I still feel very grateful for the training I had. It was a good introduction to a hospital career, but not to the general practice that was now segregated outside hospital.

This brings me to the start of the National Health Service. It was just after this

that the Collings Report[14] was published—a depressing and challenging document which emphasized low standards and low morale in general practice. It pointed the issue which has remained important ever since. Is the relation of general practitioners to the rest of the profession working in hospitals to be one of inferior to superior or one of different functions on the same level? Lord Moran's famous words about falling off ladders and the ejection of a certain number of practitioners from their previous hospital work pointed the same issue very clearly. This was the issue when our College was founded. Some people have seen the fault to lie chiefly in the general practitioner's rôle and circumstances, especially in cities. For them, he is not being presented with the problems nor the tools for which his training has suited him. Instead, he has to deal with social and psychiatric problems and trivial disorders, none of which deserve his attention by comparison with acute medicine, surgery and obstetrics—those being regarded as true clinical medicine. Emigration in order to find proper medicine is preferred to a career in general practice in this country.

The other school sees the fault in the training of the doctor which only fits him partially for the real problems that he inevitably meets in the community. The social and psychiatric aspects are an integral part of clinical medicine, but a part which our training leaves us unprepared for. Trivial problems often mask more serious ones and, in any case, they cannot be excluded without lessening the opportunities for diagnosing serious disorders early. If only the generalist were properly trained for his task, he could hold his own alongside his more highly trained specialist colleagues. I belong to the second school of thought. But I do not think the two are mutually exclusive.

This is the background against which I see the report of the Royal Commission on Medical Education[15]. You will have noticed several themes in this excursion into history—the arrival of the general practitioner and the moulding of undergraduate education to be a complete training for this rôle; the importance of apprenticeship as a teaching method; the concentration on pathology and objective signs of disease in the last 100 years to the relative neglect of the patient as a person; the relation between education and professional and public esteem.

The Royal Commission's Report

The first concern of the report is with the future pattern of medical care. Inevitably this governs the future pattern of education. It foresees no major or sudden change in the pattern of primary medical care. The two-tier system of generalist and specialist will continue. There will be no direct access of patients to specialists, since the unchanging needs of sick people and the foreseeable changes in morbidity alike require a general doctor. The report is completely committed to the idea of the personal doctor and predicts that the rôle will rise in esteem. These are the main assumptions about the future of medical care in so far as they affect general practitioners. I understand that they were reached only after considerable debate within the Commission.

In reading the main sections of the report about education, we cannot help noticing the central importance of general practice and education for this. There has been more wrong with education for our part of the profession than for any other and the Commission were fully alive to this. The development of a special training in the early postgraduate period is vital to the Commission's main thesis, that medical education must take place as much after qualification as before. Undergraduate curricula cannot fully discard the aim to turn out safe general practitioners until a postgraduate training for general practice exists. Until this is so, the undergraduate period cannot be devoted to what is now seen as its proper purpose—a basic education, common to all branches but by itself qualifying to practise in none. It is highly significant that the chapter on postgraduate education precedes that on undergraduate.

Postgraduate preparation for general practice requires five years after registration,

though this length of training cannot be achieved in one great leap forward. As a first stage, three years after registration is needed urgently. The incentive is to be made by introducing a vocational register. In other words there will be two registers—one as now, common to all doctors at one year after qualification, a second different for each specialty, certifying that appropriate postgraduate preparation has been achieved. Thus training for each branch, including general practice, will become mandatory and of somewhat more equal length for generalists and specialists.

The detailed proposals for the three years after ordinary registration roughly follow the sort of patterns that can already be seen in Inverness, Belfast and Winchester, spent partly in the relevant junior hospital appointments, partly in training practices and partly on courses. It will not be possible to become a principal in the National Health Service until the young doctor has completed the training and been registered on the vocational register.

Returning now to undergraduate medical education in the future, the purpose is:

> To produce at graduation a person with two essential qualifications. He should have, first, a knowledge of the biological and behavioural sciences sufficient for him to understand the scientific basis of his profession and to permit him to go forward with medicine as it develops further; and, secondly, a general introduction to clinical method and patient care in the main branches of medicine and surgery, together with an introduction to social and preventive medicine. . . . What is taught should be taught in such a way as to promote the general powers of the mind. The aim should be to produce not more specialists but rather cultivated men and women.

The main change is that there is to be an element of choice in the pre-clinical part. For instance the student must do a basic minimum of physiology, but, if he wishes, can do more physiology. Alternatively, he can do social anthropology or extra psychology in place of the extra physiology. But compared with the present situation there is more of the behavioural sciences even in the basic obligatory course before the optional subjects are chosen. All students will take a university degree in human biology—a term which covers the obligatory and optional subjects together.

In the clinical part psychiatry takes a more important place than at present and there is more chance to consider the medical needs of the community as a whole and to see the practice of medicine outside, as well as inside, hospital.

Of all the changes proposed the largest is the early postgraduate training of all doctors. In effect this means that the biggest change concerns ourselves, since the other branches of the profession have already developed and worked their postgraduate trainings. So big a change for so big a section of the profession requires determined organization. Sufficient junior hospital posts must be designated for teaching. Sufficient teaching practices—about 1,000 at first—must be picked and taught to teach. Courses must be run. To achieve these changes a regional organization is the main need. For this to be effective there must be a regional adviser for training for general practice. Below this there will need to be a local group or person who can assist the regional adviser in each part of the region. Nationally the system must be stimulated and financed through a Central Council for Postgraduate Education which will be concerned with the education of the whole profession. The General Medical Council would be responsible for vocational registration, just as it now deals with the ordinary registration for all doctors.

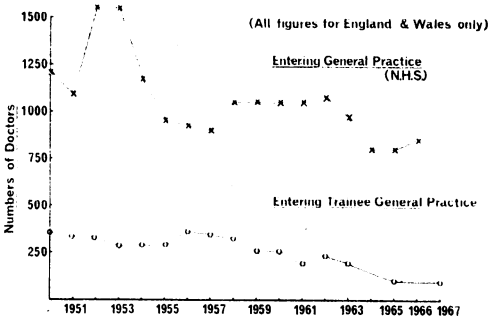
Questions of medical education are inextricably tangled with questions of recruitment both to the profession as a whole and to the various branches of it in the proportions needed by the service. The Royal Commission devoted a lot of attention to recruitment. It forecast a need for an increase by 1975 of 600 students per year—so that there would be 2,500 qualifying each year instead of the present 1,900.

There is then the question of postgraduate recruitment to the branch of general practice. There is cause for concern at present (table I and figure). Dr David Cargill[16]

of Maldon, Essex, showed in the *Lancet* that there has been a sharp rise in the percentage of Indian and Pakistani doctors filling practice vacancies in Essex and Birmingham. This may be the main reason for the upward turn of the graph.

TABLE I
NUMBER OF PRINCIPALS IN GENERAL PRACTICE
(England and Wales)

Years		
1952	(Oct.)	17,272
1962		20,325
1964		20,246
1966		19,844
1967	(Oct.)	19,849
1968	(Jan.)	19,863
	(April)	19,910
	(June)	19,935
	(Oct.)	19,970



Figure

The Royal Commission report unquestionably aims to improve education for general practice and recruitment to it. Now, one year after its publication, we have to ask two questions. Are its proposals adequate to ensure the continuance of the system of medical care that it advocates? Can its recommendations be implemented?

Are the recommendations of the Royal Commission right?

One must first consider whether the Commission was right to throw its weight behind the present system of medical care. Not many other countries now have the same two-tier arrangement of generalists and specialists. To work well the system must be acceptable to both patient and doctor. All the evidence suggests that the great majority of patients are satisfied. Admittedly they like what they know, as Dr Ann Cartwright has pointed out[17]. But there is no large demand for direct access to specialists. Patients like a doctor who is familiar and accessible and continuous. They have come to accept the important break in continuity which occurs when they go into hospital, although they would prefer their own doctor to look after them in hospital if that choice were available.

Doctors have been less content with the system than patients. Particularly important at present are the views of students and young doctors since the future depends on them. They also like what they know and therefore a majority want to work in hospital. They want to practise the medicine they have been taught and in good conditions. Till now they have continued to be taught medicine as it is in hospital. Registrars who see no hope of consultant vacancies have been emigrating rather than enter general practice.[18] Many of them would not do this if they saw a good chance of keeping a foot in hospital once they had entered general practice.[19] [20] The crucial issue here is the care of some of the doctor's own patients in hospital beds and the immediate need is for more experiments like those at East Birmingham Hospital and Welwyn or Livingstone New Town. But with this proviso the system is approved by most doctors and there is no demand from them to abolish the generalist and give direct access to specialists. I do not see how the Commission could possibly have recommended a major change in the system of medical care in these circumstances.

The Commission recommended enlarging the size of group practices. I myself work in a group of six. In three years time I shall be working in the same health centre

as 11 other doctors, but we shall still be divided into two groups of six. I think that large groups like this will be especially vulnerable to pressures to specialize. The problem of maintaining personal care, familiarity and continuity, will be particularly acute.

What of its recommendations on education? Some say that to increase medical education to ten years for all doctors will put people off this career entirely. But this length of training has never discouraged people from becoming surgeons. In any case, the last five years are in service as well as in training and the doctor is caring for patients and being paid.

A more serious objection is that to give an elaborate special training for general practice will make the young doctor discontented with the work he is actually asked to do—he will find it all too trivial and easy. This I do not believe. I think that the appropriateness of the training will increase the doctor's interest in his work. This is the verdict of young doctors who have taken the long courses at Canterbury and Winchester and of those who have attended the Tavistock Clinic Seminars in the doctor–patient relationship. Pickles saw new possibilities in his daily work when his eyes had been opened by reading Mackenzie and Budd. That is how education works. We see what we have learnt to see.

We can just as well argue that general practice is too difficult as too easy. On the day I was writing this part of my lecture, I saw in immediate succession the following three patients:

(1) A lecturer in medicine's family of six with one child incubating measles. No other member had had the disease. The mother is a cripple from disseminated sclerosis. The father has bronchiectasis and is also liable to severe depressions, since he had an encephalitis two years ago. He knows as much as I do about measles vaccine, y-globulin, and the complications of measles.

(2) A 60-year-old solicitor's secretary with vertigo due to a brain-stem ischaemia and an urinary infection. She is allergic to aspirin, paracetamol, antihistamines and most antibiotics. On this occasion, she had diarrhoea from the tetracycline which was curing the urinary infection. She has always been a frequent attender and all her illnesses last five times as long as most people's. Her marriage has never been consummated.

(3) A writer of 60 suffering from alcoholism, cerebellar ataxia, peripheral neuritis, an old ankle injury, mild diabetes and depression due to severe financial and marital problems.

I find that these multiple problems in intelligent patients tax my own intelligence to the utmost.

I am more impressed by the objection that more education will increase the doctor's perception of his responsibilities and that this is a dangerous thing to do when the number of doctors is not keeping pace with the growth in population. I do not myself think that we should allow this objection to freeze the standard of medical care at its present level. An appropriate postgraduate preparation is an absolute necessity if the people of this country are to go on having personal doctors as well as a specialist service.

So much for the extent of the training proposed. What about its content? In the undergraduate proposals there is the shift towards the behavioural sciences, the increase in psychiatry and the experience outside hospital. All this I welcome, because it seems to meet needs in patients that have too often been neglected. It should also increase the number of young doctors wanting to work in the community.

An important criticism of the postgraduate proposals is that they expect the future general practitioner to collect a little knowledge in too many subjects. Would it not be better to leave gynaecology, obstetrics, eyes and skins to specialists? One could then concentrate the general practitioner's knowledge in general medicine, paediatrics, geriatrics and psychiatry, which are the really important subjects. This criticism might be valid for the distant future in cities, if we imagine certain specialists practising in health centres alongside general practitioners—the polyclinic pattern as I saw it in Czechoslovakia. It would not fit our present system of medical care.

Can the proposals be implemented?

Let us look at the present situation in vocational training for general practitioners—first, junior posts in hospital. According to Mechanic[21] 39 per cent of general practitioners of all ages in 1966 had completed the required three years in hospital posts after qualification. Two thirds of recent new entrants to practices have been over the age of thirty. We can assume that about half the present entrants are doing sufficient hospital appointments, but not necessarily the right ones.

The trainee practitioner scheme is *not* flourishing. There are about 130 doctors entering through this route instead of the 1,000 required. The main reason is financial—much more money is being offered to ordinary assistants and junior partners in this time of shortage of doctors.

Comprehensive training schemes are so far few (table II). The schemes in Manchester, Newcastle and here in E. Anglia are ready. Money has now been made available to them on a research basis and their results are to be evaluated, along with Belfast and Winchester. This is a very encouraging major project. The E. Anglian scheme for

TABLE II
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Full schemes (Hospital posts, training practices, courses)	
Belfast	Wessex
Partial schemes (Two or more out of the three elements)	
Bedford	Lancaster
Canterbury	Livingstone
Durham	London, St Bartholomew's Hospital
Edinburgh	London, Royal College of General Practitioners
Glasgow	
Guildford	Ormskirk
Inverness	Tavistock Clinic
Proposed schemes nearly ready	
Hayward's Heath	Newcastle
Ipswich	Sheffield
Manchester	

Ipswich is very promising and has several original features. It is mainly the work of Dr John Stevens and Dr Ian Tait at Aldeburgh. But all these comprehensive schemes together could cope with no more than 200 entrants annually. As 1,000 are needed, the gap between reality and the Commission's proposals is large and time is not on our side.

I want to look now at the obstacles to bridging this gap and possible ways of overcoming them. First, the demand for training—the number of young doctors wanting to do general practice and the number who want to be properly trained for it. Despite the slight improvement in the recruitment figures in the last year, not enough men and women want to enter practice. We need about 40 per cent of the output of medical schools, but in Dr Last's 1966 survey[22] only 23 per cent of final-year students had decided to do general practice. Admittedly Last points out elsewhere that final career decisions are mostly made after qualification. Clearly, general practice does not have a sufficiently good image with students and junior hospital staff. Exposure of students to it, although on the increase, has not yet altered this fact. The chief hopes for improvement lie in improving the conditions of practice—and in the creation of training programmes. It has hitherto been an article of faith in this College that increasing the challenge through training and examination will make general practice more attractive, not less. The Royal Commission shared this faith. This view has recently had support from a

survey carried out by the British Medical Students Association last year.[23] Seventy-seven per cent of students thought that vocational training should be undertaken before entering practice, and that bringing it more nearly level with other specialties would make it more attractive. The questions were part of a questionnaire on a number of subjects; they were marred by a low response rate, but another survey gives the same impression. Seventy-five per cent of St. Thomas' Hospital students thought that a degree or diploma equivalent to the MRCP should be instituted for general practice.[24]

Despite the beliefs of this College and of medical students, in actual fact only the minority of doctors entering practice today are seeking adequate training for the job. It is no use creating training programmes if people do not want to enter them. The problem is one of incentive. Enthusiasm as an incentive only works for the few. The financial incentive of the vocational training allowance has not made any important difference after two years. Only 294 doctors received the allowance last year. There remains the proposal of a vocational register which would make adequate training mandatory for any doctor wishing to be a principal in the national health service. This now seems to be the only proper solution. The General Medical Council is prepared to accept the duty of maintaining the register. The idea is welcomed by the Council of this College and is acceptable to the General Medical Services Committee.[25]

Registration would make the provision of training programmes essential before the date when the register starts. So we must turn now from obstacles of demand to obstacles of supply. We are already at the stage where it is essential to appoint a general practice subcommittee to each regional postgraduate committee. Equally urgent is the need for a regional general practice adviser, who will be an experienced doctor working at least half-time in this new rôle. The selection of teaching practices and their training and supervision is a big task, which cannot possibly be done by devoted amateurs in time stolen from their practices and families.

Shall we find the number of teachers required? There are about 23,000 general practitioners in England, Wales, Scotland and Northern Ireland. At least 1,000 will be needed as teachers for postgraduates and undergraduates. This means about one doctor in twenty.

It has always been the experience of this College that there has been hidden talent to be drawn on. But as Dr Patrick Byrne pointed out in his magnificent Pickles lecture last year,[26] it is vital that the selection should be rigorous. Once selected they will need training in teaching methods and content. They will also need to be linked in an organization which allows for regular exchange of ideas and experience. The regional adviser seems to me to be an essential prerequisite. If he can be linked with the university department of general practice in the region, so much the better. It is encouraging that the number of university departments have now risen to six, with another three or four in an embryo stage.

What about the load on the teaching practices? Proper teaching requires time and good planning. The teacher cannot see the same number of patients and teach properly. This problem is rather easier to deal with in a group practice where the extra load can be spread, but even in a group it remains a problem. Higher payment to teachers than the present training allowance of £200 would help, but I think the solution must largely depend on the enthusiasm of those who volunteer and are selected to teach and on the support of their partners.

The introduction of a national programme for vocational training must increase the load for all existing practitioners for a short-time if all young entrants do two years of post-registration house-appointments. About half of them—possibly only one-third —would be kept back for an average of about eight months for further hospital training.

This would only be a temporary difficulty and would probably increase the work load of all of us by the equivalent of not more than 100 patients for a limited time.

If we believe, as I and many others do, that a proper postgraduate training is vital to the future of the general practitioner service and that it will prove a major factor in attracting recruits, these additional burdens must be accepted. If we do not accept them, the number and quality of recruits will fall. If we do accept them, we have the hope of relief through the number and quality rising.

I have said nothing about money. It is needed to pay general practice teachers, an increased number of trainees, and for the regional administrative structure. More married quarters are needed for the young doctors who complete a longer span of junior hospital posts. We still await a major pronouncement by the Minister of State about the overall implementation of the Royal Commission's proposals.

The challenge to this College

We could scarcely have hoped for a more encouraging report. Most of the recommendations of the College's evidence have been accepted. The chance offered both by the Royal Commission and by the General Medical Council's 1967 Recommendations[27] may not be repeated in our lifetime. For this very reason it poses a big and urgent challenge for this College at all levels—members, faculties and central headquarters.

For the individual member the challenge is to decide whether he wants to be a teacher. If so, can he find the time that this will need? Are his circumstances suitable? Will partners join in or support him? Are his premises, equipment and records going to impress a trainee favourably? Does he know what to teach and how? If not, does he know how to find out? Is he prepared to go on a course for teachers?

For faculties the challenge is to find out now the names of those who want to teach. The enquiry, in my opinion, should be to all doctors in the faculty area, not just college members and associates. But to volunteer does not necessarily mean to be selected. It is time now to identify members with a special interest in education, who might be suitable to act as general practice tutors at postgraduate medical centres. These names are needed now by the council of the College. If a faculty is not yet running a course or discussion group for teachers, it should consider the need for this now.

For the college council and headquarters the challenge is to set standards and test them by the MRCGP examination. This means reviewing again the essential content of our work, setting educational objectives, laying down criteria for selecting both junior hospital posts and teaching practices. New ideas about our work must be collected from many sources and passed on to the teachers who need them. We have to continue to be the chief stimulus in this area but to work with other bodies as we have been doing increasingly—the Department of Health, the General Medical Services Committee of the British Medical Association, the Central Committee for Postgraduate Education and many others. The establishment of vocational training through all these activities is at present the College's most important task.

But it is not the only task. We need at the same time to redouble our efforts to improve the circumstances of practice. My concern about recruitment makes me feel that the top priority in the immediate future is in the relation of the practitioner to the hospital. The crucial issue is the care of a doctor's own patients in beds in district general hospitals. Young doctors are still being trained for hospital medicine. They are indicating quite clearly that if they cannot do the work in hospital for which their training has fitted them, they prefer to emigrate. This I see as the urgent issue. It is not being attacked urgently, because there are real difficulties of organization as well

as vested interests. But if it can be solved at east Birmingham and Welwyn, it can be solved elsewhere.

But in the long term, hospital beds are not the issue. The longer aim, in my opinion, is to establish centres of excellence outside hospital, in Professor Morris's phrase.[28] This, for instance, is our hope and aim for the teaching health-centre in Kentish Town, into which my group practice will move in 1971. I myself have always been satisfied to work outside hospital—indeed I did not enjoy medicine fully until I did this. I think that people—who form the central focus of interest for general practitioners—are seen and understood much better in their own environment than in a hospital bed. No one has expressed this point of view better than Sir McFarlane Burnet,[29] the Australian virologist:

> Every development in medicine suggests that the doctor of first contact will have no responsibility for hospital treatment. One pictures him essentially as a wise counsellor, with a special quality of understanding the whole predicament of his patient and a wide range of social, psychological and medical expertise to help bring him back to full effectiveness in the community. Such a practitioner would have ample opportunity to use every faculty he possesses and will attract, I should guess, more of the respect and liking of his fellow men that the scientists and specialists in hospital.

The Royal Commission has gone a long way towards establishing the educational base for this sort of rôle. The next generation of students and young doctors should be less tightly bound to hospital, more interested in health and preventive medicine and more concerned with patients as people in their family setting. It should be more difficult for future students to reject the pleasure and pain of personal involvement and escape into the detachment of science. The contrasting characteristics of eighteenth and early twentieth century medicine, noted by Dr Charles Newman,[11] should find a more equal marriage.

I wonder what William Pickles would be thinking about all these things. I do not think he worked in hospital once he had started to practice at Aysgarth. He was content to work in his countryside and villages. I think he would have approved of the increase in education for the general practitioner. But I can imagine him saying 'Isn't this all rather complicated? Mind you don't forget the simple things that sick people need—the warmth of human kindness, understanding and continuity'. Look at the United States where these essentials are in great danger—to quote a recent article in the *New England Journal of Medicine*:[29] "Medical care is increasingly fragmented. The warmth of a longterm association with a single physician has become a luxury for a few rather than the customary setting for the delivery of medical care".[30]

You can study psychology, sociology and psychiatry, but this by no means guarantees the making of the right sort of doctor. As E. M. Foster said, 'Science explains people, but cannot understand them'. Perhaps Thomas Withers was right and the physician should be a man of literature. Maybe as much is to be learned from reading biographies and novels and watching plays and even reading the problems page in women's journals. Lord Platt[31] has pointed forcibly to the danger of too academic an approach in the teaching of behavioural sciences. Another person associated with this city of Cambridge—Lord Snow—made a moving plea at the Royal Society of Medicine[32] for the retention of the personal doctor in cities because he is one of the few bastions of stability in a fragmented and changing society. Sherlock Holmes agreed with him 'Good old Watson, you are the one fixed point in a changing age'. Like all the most important things in life, these things are not subject to measurement, can be killed by analysis, but I am sure, can be taught by good example—hence the importance of apprenticeship as a teaching method. Chekhov, who was trained as a doctor, said that if he was teaching medicine, he would spend half his time teaching what it feels like to be ill. Understanding the unique individual and caring for him and maintaining continuity are values which are not easy to weigh in the balance against

efficient organization and pressures to specialize. They frequently clash. Our College motto *Cum scientia caritas* states the contemporary problem for all doctors and all teachers of medicine with all the simplicity that William Pickles could have wished.

REFERENCES

1. Pickles, W. N. (1957). *Queen's med. Mag.* **49**, 86.
2. Pickles, W. N. (1949). *Epidemiology in country practice.* Second edition. J. Wright and Son, Bristol.
3. Pickles, W. N. (1948). *Lancet.* **1**, 201.
4. Pickles, W. N. (1951). *Practitioner.* **167**, 322.
5. Budd, W. (1873). *Typhoid fever.* London.
6. Pickles, W. N. (1955). *Practitioner,* **174**, 76.
7. Peterson, O. L., Andrews, L. P., Spain, R. S., and Greenberg, B. G. (1956). *J. med. Ed.* **31**, 1.
8. Morehead, M. A. *Quality of medical care provided by family physicians as related to their education, training and methods of practice.* Health Insurance Plan of New York (mimeographed) (undated).
9. Clute, K. F. (1963). *The general practitioner; a study of medical education and practice in Ontario and Nova Scotia.* (Toronto).
10. Royal Commission on Medical Education (1968). London. Her Majesty's Stationery Office.
11. Newman, C. (1957). *The evolution of medical education in the nineteenth century.* London. Oxford University Press.
12. Goodenough Report (1944). Report of inter-departmental committee on medical schools. London. Her Majesty's Stationery Office.
13. Querido, A. (1963). *The efficiency of medical care.* Leiden.
14. Collings, J. S. (1950). *Lancet.* **1**, 555.
15. Royal Commission on Doctors' and Dentists' Remuneration, 1958. Minutes of evidence 3–4. London. Her Majesty's Stationery Office. P.193.
16. Cargill, D. (1969). *Lancet.* 1, 669.
17. Cartwright, A. (1967). *Patients and their doctors.* London. Routledge, Kegan Paul.
18. Whitfield, A. G. W. (1969). *Lancet.* **1**, 667.
19. Last, J. M. (1967). *Lancet.* **2**, 769.
20. Stephen, W. J. (1969). *Personal cummunication* (to be published).
21. Mechanic, D. (1968). *Med. Care.* **6**, 245.
22. Last, J. M. (1968). Report of the Royal Commission on Medical Education. Appendix 19 (p. 357).
23. British Medical Students' Association (1969). Survey of Student Opinion on the Report of the Royal Commission on Medical Education.
24. Davies, R. J., and Torrens, M. J. (1968). *St Thomas' Hospital Gazette.*
25. British Medical Association (1969). Report of the General Medical Services Committee on the Royal Commission on Medical Education (to be published).
26. Byrne, P. S. (1968). *J. roy. Coll. gen. Practit.*, **15**, 409.
27. General Medical Council (1967). *Recommendations as to the medical curriculum.*
28. Morris, J. N. (1962–65). Institute of General Practice, unpublished memoranda.
29. Burnet, M. (1964). *Brit. med. J.* **2**, 1091.
30. Francis, V., Korsch, B. M., Morris, M. J. (1969). *New Eng. J. Med.* **280**, 535.
31. Platt, R. (1965). *Brit. med. J.* **2**, 551.
32. Snow, C. P. (1967). *Proc. roy. Soc. Med.* **60**, 153.