

**THE INFLUENCE OF THE NATIONAL HEALTH
SERVICE ON GENERAL PRACTITIONER
POSTGRADUATE EDUCATION IN THE CONTEXT OF
THE DEVELOPMENT OF GENERAL PRACTICE IN
BIRMINGHAM**

by

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ABSTRACT

This study traces the changes in the postgraduate education of General Practitioners in the city of Birmingham during the twentieth century. It begins by considering national milestones in the form of government reports and major conferences. In addition to describing the creation of national bodies, such as the General Medical Council and British Medical Association, it also provides information on local organisations including the Midland Medical Society and the Midland Faculty of the Royal College of General Practitioners and their role in developing training programmes. The increase in GP Training Practices in Birmingham after the inauguration of the National Health Service is analysed statistically. Central educational initiatives such as Half-Day Release Courses and Vocational Training Schemes are traced by means of developments in their curriculum. The contribution of the Birmingham Regional Hospital Board and West Midlands Regional Health Authority is also assessed.

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P. G. Houghton, September 2012

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LIST OF ABBREVIATIONS

A&E	Accident and Emergency
BEME	Best Evidence Medical Education
<i>BJGP</i>	<i>British Journal of General Practice</i>
BMA	British Medical Association
<i>BMJ</i>	<i>British Medical Journal</i>
CASP	Clinical Appraisal Skills Programme
CME	Continuing Medical Education
COG	Clinical Outcomes Group
CPD	Continuing Professional Development
CRAGPIE	Committee of Regional Advisors in General Practice in England
CSAG	Clinical Standards Advisory Group
DHA	District Health Authority
DHSS	Department for Health and Social Security
GMC	General Medical Council
GP	General Practitioner
FHSA	Family Health Services Authority
FPC	Family Practitioner Committee
ISU	Interactive Skills Unit
JCPTGT	Joint Committee on Postgraduate Training for General Practice
LMC	Local Medical Committee
MAAG	Medical Audit Advisory Group
MEE	Medical Education for England
MMC	Modernising Medical Careers
MRCGP	Member of the Royal College of General Practitioners
NHS	National Health Service
NICE	National Institute for Clinical Excellence
PCG	Primary Care Group
PMETB	Postgraduate Medical Education and Training Board
PMSA	Provincial Medical and Surgical Association
RAMC	Royal Army Medical Corps
RCGP	Royal College of General Practitioners
RGPEC	Regional General Practice Education Committee
RHA	Regional Health Authority
SCOPME	Standing Committee on Postgraduate Medical and Dental Education
SHA	Strategic Health Authority
SHO	Senior House Officer
TQM	Total Quality Management
VTS	Vocational Training Scheme

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INTRODUCTION

At the time of the inception of the National Health Service in 1948, there was little specific postgraduate education for general practitioners.¹ The 472 general practitioners who were listed on the Birmingham Executive as Principals in General Practice were still independent contractors who were paid for providing medical services according to the conditions of the Statement of Fees and Allowances. Although the Goodenough Report of 1944 proposed the compulsory pre-registration year in hospital prior to a doctor being allowed to enter independent practice, this was not enacted until the introduction of the Medical Act of 1956 (see Chapter 1). Prior to the Act, a doctor could open his surgery, like any other tradesman, although the introduction of the General Medical Council as a result of the Medical Act of 1858 ensured that the doctor had a genuine medical qualification. The apprentice who had undergone an apprenticeship with an apothecary in the early nineteenth century evolved into the general practitioner who attended medical school, passed a qualifying examination, and became a registered qualified doctor until retirement.²

Apart from the efforts of the medical associations and societies, such as the Provincial Medical and Surgical Society of Worcester (founded in 1832, the forerunner of the British Medical Association) and the Midland Medical Society based at the Birmingham Medical Institute, the continuing education of general practitioners after their initial medical training was not considered important (see Chapter 3).³ In 1952, a group of

¹ R. Stevens, *Medical Practice in Modern England: the Impact of Specialised Medicine and State medicine* (London: Yale UP, 1966).

² W. S. C. Copeman, *Apothecaries: A History 1617-1967* (London: Pergamon Press, 1967).

³ See Vivian Nutton and Roy Porter, eds, *The History of Medical Education in Britain* (Amsterdam: Rodopi/Clio Medical, 1995); A. Digby, *The Evolution of British General Practice*

London general practitioners met to set up a Steering Committee to found a College of General Practitioners, an idea which had originally been suggested in 1845. Both the Worshipful Society of Apothecaries of London and the British Medical Association offered encouragement and practical support. It was in the following year, 1953, when Henry Cohen presented his first Report to the General Medical Council, that the first European statement proposing specific postgraduate training for general practitioners was published.⁴

Some London teaching hospitals, such as St Bartholomew's and St Thomas',⁵ already put on refresher courses to maintain contact with their alumni in practice and, although universities in general have catered only for specific postgraduate research studies as part of higher degrees, specialists in district general hospitals developed postgraduate meetings with lunchtime or evening educational sessions dedicated to topics which they thought should be of interest to their general practitioner colleagues. Following the Christ Church Conference of 1961, the Regional Hospital Boards appointed Postgraduate Tutors and provided grants for District General Hospitals to develop Postgraduate Centres for both hospital staff and local general practitioners, who contributed covenanted subscriptions to add to the sponsorship from the Nuffield Trust (see Chapter 1).

(Oxford: Oxford UP, 1999); F. N. L. Poynter, ed., *The Evolution of Medical Practice in Britain* (London: Pitman Medical Publishing, 1961); John Cule, *A Doctor for the People: 2000 years of General Practice in Britain*. (London: Update Books, 1980).

⁴ D. J. Pereira Gray, ed., *Forty Years On: The story of the first forty years of the Royal College of General Practitioners* (London: Atalink, 1992), p. 109; Fry, John, John Henderson Hunt, and R. J. F. H. Pinsent. *A History of the Royal College of General Practitioners: The First 25 Years*. Lancaster: MTP Press., 1983, p. 7.

⁵ K. Waddington, *Medical Education at St Bartholomew's Hospital, 1123-1995* (Woodbridge: Boydell, 2003).

Only in 1974 did the Conference of Local Medical Committees (the democratically elected mouthpiece of general practitioners) vote to accept the motion that that an adequate course of vocational training “should normally be mandatory for those wishing to be principals in the NHS.”⁶ In November 1976, Parliament approved for the first time legislation which required the completion of vocational training for general practitioners, and this was finally implemented in 1982: the Department for Health and Social Security wrote to Regional Health Authorities to institute Regional Advisers in General Practice in 1973.⁷ Contracts for medical educators have enabled general practitioners to employ locums so that they can leave their practices to be involved in vocational training and postgraduate teaching. Subsequent Medical Acts have expanded and refined the rules and standards for vocational training, and changes to NHS administrative organisations, like Primary Care Trusts, have introduced continuing medical educational activities, such as clinical audit, annual appraisals and personal learning plans for their local contractors.

The Royal College of General Practitioners (RCGP) has charted its own success in developing postgraduate education for GPs and especially its members (see further Chapter 1).⁸ In addition to the vocational training, it is also important to review how established principals have accessed their so-called ‘Continuing Medical Education’ (CME) or ‘Continuing Personal Development’ (CPD) over the years, particularly as a result of the changing expectations of patients and governments. Although the RCGP has been in the forefront of the promotion of CME, it is likely that its influence has been variable across the United Kingdom on account of its geographical faculty structure.

⁶ Pereira Gray, *Forty Years On*, p. 114; D.J. Pereira Gray, *Training for General Practice*. Plymouth: MacDonald and Evans, 1982, p. 11.

⁷ W. Wintersgill, Letter to Regional Postgraduate Education Committees. 18 May, 1973. London: Department of Health and Social Security.

⁸ Pereira Gray, *Forty Years On*, pp. 109-118.

The National Health Service (NHS) has also initiated other educational activities, such as the introduction of Medical Audit in Working Paper 6 of the 1990 Government White Paper *Working for Patients* (discussed in Chapter 2).⁹ As Calman has pointed out, the introduction of a national health service has provided the opportunity to plan the teaching and learning of both undergraduate and postgraduate students, since consultants working in the National Health Service are expected to teach both junior doctors and medical students in both District General and Specialist Teaching Hospitals.

Over the last sixty years, as a result of various demographic and geographical changes, the size and population of the city of Birmingham has remained stable at around one million inhabitants. Despite several intervening reorganisations, from the inception of the National Health Service until the most recent reorganisation in 2004 the administration of primary health care remained under the supervision of a single Health Authority for the city. This provided a continuity of dialogue and understanding between NHS management and general practitioners. Practices developed over the years, their only constraints being the Statement of Fees and Allowances ('the Red Book'), and this development included increasing numbers of training practices (see the statistical analysis in Chapter 4) and increasing participation in CME activities and then practice-based learning. When Prof. Nick Bosanquet reviewed general practitioner services for Birmingham Family Health Services Authority in 1994 (see the second part of Chapter 4), he remarked that, unlike London, the standard of care in the city was typical of

⁹ Department of Health, *Working for Patients. Medical audit in the family practitioner services* HC(FP)8 (London: HMSO, 1990).

practice in the country at large, so that any evaluation of Birmingham could have national application.¹⁰

This study aims to evaluate the changes in postgraduate education in the context of a local city community and the provision of primary health care. It is necessary to study changes in both vocational training and CME, as well as other NHS initiatives such as medical audit, which was introduced as part of a city-wide educational strategy. Some developments have been suggested by government; others have been made mandatory by legislation or by contractual and financial pressures. However, the delivery of the changes has been brought about by the activities of ‘key innovators’, local individuals who have had the capacity to innovate and adopt educational strategies to achieve successful educational outcomes through their own efforts and abilities, rather than the committees of national and local organisations (see Chapter 4). In conclusion, there has been a steady increase in the number of GP Training Practices, and in the number of GP Trainers in Birmingham over the 60 years from 1948 to 2008 – even though, as we shall see in Chapter 4, this has not been mirrored in the numbers of GPs as a whole, nor in the numbers of GP practices.¹¹

¹⁰ N. Bosanquet, *Review of Birmingham General Practice* (Birmingham: Birmingham FHSA, 1994).

¹¹ D.W. Wall, “An Evaluation of the Educational Qualifications Bursary Scheme for Doctors and Dentists within the West Midlands Deanery 1996-2002” PhD Thesis, University of Birmingham, 2007, pp. 1-322.

CHAPTER 1. LITERATURE REVIEW

1.1 Postwar Developments in Medical Education

According to Sir George Pickering in *The Way Ahead in Postgraduate Medical Education*, the introduction of the Medical Act of 1956 was ‘the real beginning of postgraduate medical education in this country’.¹ The Act followed the recommendation of Sir Henry Goodenough’s 1944 Report of the Interdepartmental Committee on Medical Schools, which proposed the compulsory pre-registration year in hospital prior to a doctor being allowed to enter independent practice.²

John Horder, in his conclusion to *General Practice under the National Health Service 1948-1997*, observed that

no significant developments occurred in the organisation of general practice (and few in its clinical work) between the First and Second World Wars. ... Much had been learnt from wartime experience in the Emergency Medical Service and from clinical advances rapidly developed under the impact of war.³

These experiences had informed the recommendations of the Goodenough Report, as a result of which satisfactory completion of a pre-registration year in hospital was required by the 1956 legislation. The report also advocated refresher courses for various specialities, including general practice. In his chapter on ‘Postgraduate Training and Continuing Education’ in *General Practice under the National Health Service 1948-1997*, Denis Pereira Gray commented

¹ Sir George Pickering, in Gordon McLachlan, ed., *The Way Ahead in Postgraduate Medical Education* (Oxford: Nuffield Provincial Hospitals Trust, 1974), p. 2.

² Goodenough Committee, *Report of the Interdepartmental Committee on Medical Schools, Ministry of Health and Department of Health for Scotland* (London: HMSO, 1944).

³ In I. Loudon, J. Horder, C. Webster, *General Practice under the NHS 1948-97* (Oxford: Clarendon Press, 1978), p. 278.

When the Second World War ended in 1945, general practice had to adjust not only to a new set of attitudes and expectations in society, but to an entirely new system of organization in the form of a new NHS ... introduced on 5 July 1948.⁴

These postwar changes appear to have stimulated interest in the history of medicine and medical education in general: the new medical education policy-makers started by reviewing previous educational themes as they endeavoured to update the medical curriculum. Before the War, there were few volumes available on medical history, let alone the history of medical education. E. T. Withington's classic *Medical History from the earliest times* was originally published in 1894 and was not reprinted until 1964.⁵ Nutton and Porter, in the introduction to their *History of Medical Education in Britain*,⁶ have pointed out that the only broad survey of medical education in English published before the Second World War was Prof. Theodor Puschmann's remarkable, erudite global survey of *A History of Medical Education*, translated by Evan H. Hare.⁷ Even Cartwright's chapter on 'Medical education; the birth of a profession' in his *A Social History of Medicine* (1977) appeared to consider that the apogee of medical education was the Medical Act of 1858, and ignored any subsequent developments in either undergraduate or postgraduate training.⁸

⁴ Pereira Grey in Loudon, Horder and Webster, *General Practice Under the NHS*, 182.

⁵ E.T. Withington, *Medical History from the Earliest Times* (London: The Holland Press, 1964).

⁶ Vivian Nutton and Roy Porter, eds., *The History of Medical Education in Britain* (Amsterdam: Rodopi B V/Clio Medical, 1995).

⁷ Theodor Puschmann, and Evan H. Hart, *A History of Medical Education from The Most Remote To The Most Recent Times* (London: HK Lewis, 1891).

⁸ F.F. Cartwright, *A Social History of Medicine* (London: Longman, 1977).

1.2 The First World Conference on Medical Education

The very first World Conference on Medical Education was held in London in August 1953. The Proceedings were published in book form the following year.⁹ The Conference was organised in four sections which covered the requirements for entry into Medical Schools, the aims and content of the Medical Curriculum, Techniques and Methods of Medical Education, and Preventive and Social Medicine.

Sir Lionel Whitby, the Regius Professor of Physic at Cambridge and Vice-Chancellor of the University, was the President of the Conference; he summed up the challenge to medical education in the second half of the twentieth century by asking

Are we preparing our students at least to grasp the principles behind all this scientific work? Does the student leave the university with an understanding of the methods of science and with some knowledge of its history?¹⁰

Sir Richard Livingstone, Vice-Chancellor of Oxford University, reviewed the aims of education:

it should prepare us, either by a general or vocational training, to earn our bread; it should give us some understanding of the universe and men; and it should help us to become fully developed human beings.¹¹

The need for continuing learning is not mentioned and, although John Fulton, in his brief introduction to the history of medical education published in the Proceedings, provided a condensed insight into the principles and practice of student education over the centuries and throughout the world, he ignored any perceived need for postgraduate education.¹²

Professor A. L. Richard, albeit Professor of Obstetrics in the University of Ottawa,

⁹ Hugh Clegg (ed.), *Proceedings of the First World Conference on Medical Education: London 1953*. (London: Oxford UP, 1954).

¹⁰ Sir Lionel Whitby, "The Challenge to Medical Education in the Second Half of the Twentieth Century." *Proceedings of the First World Conference on Medical Education, London, 1953*. London: Oxford UP 1954, p. 7.

¹¹ Sir Richard Livingstone, "What is Education?" *Proceedings of the First World Conference on Medical Education, London, 1953*. London: Oxford UP 1954. p. 12.

¹² John F. Fulton, "The History of Medical Education." *Proceedings of the First World Conference on Medical Education, London, 1953*. London: Oxford UP, 1954. pp. 18-28.

demonstrated special understanding of the educational needs of his colleagues in general practice, raising more salient points in his presentation on ‘The Undergraduate and General Practice’. He recognised that

Medical Practice is necessarily dynamic and fluid, owing to the impact of increasing scientific discoveries and of the ever-changing demands of the population.¹³

His summary is as relevant today as then, as is his caveat that

Teachers should be wary of spoon-feeding the students. Instead of being primarily concerned with imparting to them so much information, we should be primarily concerned with developing in them habits of active, personal and independent learning, thinking, observation and reflection.¹⁴

Maybe he hoped that this inculcation of adult learning would stay with the students throughout their professional lives and ensure that they did not see qualifying as a doctor as the completion of their education, but would continue as lifelong learners.

In the same way, Sir Henry Cohen, Professor of Medicine at Liverpool University and then President of the British Medical Association (BMA) from 1951, observed in his presentation on the Balanced Curriculum that

since medical knowledge is ever expanding, the undergraduate curriculum must favour the acquisition of enduring habits of work and thought and of enthusiasm for study, so that the doctor shall remain a student throughout his professional life. The growth of knowledge in both medicine and in educational methods means that a curriculum can never be final.¹⁵

Cohen had previously chaired the Education Committee of the BMA, whose Report of 1948 had already stimulated debate on medical education.¹⁶ Although the report concentrated particularly on the undergraduate aspects of education, Cohen had already recognised that education did not cease with graduation –

¹³ A.L. Richard, “The Undergraduate and General Practice.” in World Medical Association, *Proceedings of the First World Conference*, p. 370.

¹⁴ Richard, “The Undergraduate and General Practice.” p. 377.

¹⁵ Sir Henry Cohen, “The Balanced Curriculum.” in World Medical Association, *Proceedings of the First World Conference*, p. 386.

¹⁶ Henry Cohen et al, *The Training of a Doctor: Report of the Medical Curriculum Committee of the BMA* (London: BMA, 1948) (The First Cohen BMA Report); id., *General Practice and the Training of the General Practitioner* (London: BMA, 1950) (The Second Cohen BMA Report).

General practice is a special form of practice which must be founded on general basic principles and appropriate postgraduate study...Sound habits and methods of study are the foundation of continued self education.¹⁷

As David Morrell, the first Professor of General Practice at St Thomas' Medical School in the University of London, observed in his 'Introduction and Overview' to *General Practice under the National Health Service 1948-1997*, this was the first time that the purpose of undergraduate medical education was "to produce not just a competent general practitioner but a 'basic doctor' who, before entering general practice, would undertake postgraduate training."¹⁸ The Committee was reconvened in 1950, again under Lord Cohen's chairmanship, to consider how to implement its earlier recommendations, which included a one-year residency programme prior to GMC registration; following this residency all potential general practitioners should undergo a further three years of vocational training. However, it was to take two decades before this latter aspiration became compulsory. Not surprisingly, nowhere in the Conference Proceedings of 1953 was there any section devoted to what knowledge that study should impart and how it should be delivered to doctors after qualification.

Charles Newman, a physician at King's College Hospital Medical School London and Sub-Dean of the new Postgraduate Medical School at Hammersmith the Dean of the Postgraduate Medical School of London, was inspired to expand his 1954 and 1955 Fitzpatrick Lectures on Medical Education at the Royal College of Physicians into his 300-page volume on *The Evolution of Medical Education in the Nineteenth Century*. He felt that

¹⁷ Henry Cohen et al, *The Training of a Doctor*; id., *General Practice and the Training of the General Practitioner*.

¹⁸ In Loudon, Horder and Webster, *General Practice Under the NHS*, p. 7.

the interest in the history of medical education in the nineteenth century lies partly in its influence on what exists today, and partly in the example it gives of the way in which reform takes place, the different processes by which change is brought about and the curious differences in the results to which they lead. The changes themselves were very great, and the contrast between the effects produced by internal spontaneous reform and by the more dramatic processes of agitation and legislation is of lasting interest. From this, and from many other details of the reform of medical education, there are valuable lessons to be learned, particularly in an era in which a new movement of change shows every sign of beginning.¹⁹

Newman's words, although newly minted at the time, showed prophetic accuracy and are still as relevant today, looking back over the half century since they were written. He goes into detail on the needs and changes involved in the development of the 'safe general practitioner' over the years and, anticipating the current concept of adult learning, suggests that

the other advantage of an under-organised curriculum is that it gives the student the opportunity of approaching his education like an adult.²⁰

Similarly, in 1961, Sir Zachary Cope, consultant surgeon at St. Mary's Hospital Medical School, London, and President of the British Medical Association, collected his writings on aspects of medical history in *Some Famous General Practitioners and other Medical History Essays*,²¹ which included a reprint of his 1955 Gideon de Laune Lecture on 'The Influence of the Society of Apothecaries on English Medical Education'; this lecture was originally published in the *British Medical Journal (BMJ)* and provides the most authoritative review of education for the forerunners of today's general practitioners.²²

¹⁹ Sir Charles Newman, *The Evolution of Medical Education in the Nineteenth Century* (London: Oxford UP, 1957), p. x.

²⁰ Newman, *The Evolution of Medical Education*, p. 223.

²¹ Sir Zachary Cope, *Some Famous General Practitioners and other Medical Historical Essays* (London: Pitman Medical Publishing, 1961).

²² Sir Zachary Cope, "Influence of the Society of Apothecaries upon Medical Education" [Gideon de Laune lecture November 1955] *British Medical Journal* 1 (1956): 1-6.

1.3 The First British Congress on the History of Medicine and Pharmacy (1960)

The first British Congress on the History of Medicine and Pharmacy was held in Apothecaries' Hall in London in September 1960. The Historical Faculty of the Worshipful Society of Apothecaries had been founded in 1958 to co-ordinate and strengthen the response to the activities of all existing bodies and individuals with an interest in the history of medicine. The theme for this first Congress was 'The Evolution of Medical Practice in Britain', and the papers were collated and edited by Noel Poynter, the Director of the Wellcome Institute of the History of Medicine, and published under this title in 1961.²³

The individual chapter headings summarise the scope of different bodies on both the practice and the teaching and learning of medicine, and provide a blueprint to assess the influences on medical practice in Britain from 1948 to the present day. Poynter himself wrote on 'The Influence of Government Legislation', and Charles Newman assessed 'The Influence of Medical Education on the Evolution of Medical Practice in Britain'. There were individual chapters on the influences of the Royal Colleges of Physicians, of Surgeons, and of Obstetricians. Both clinical research and the pharmaceutical industry were seen to have had a positive effect on medical progress, in addition to the introduction of Lloyd George's Health Insurance Scheme. The differing effects of both Scottish medical practice and English rural medical practice in the development of medical practice were considered, as well as the educational role of medical societies.

This seminal work covers all the aspects and issues influencing medical education over the centuries, in addition to the history of the practice of medicine itself; the authors were

²³ F. N. L. Poynter, ed., *The Evolution of Medical Practice in Britain* (London: Pitman Medical Publishing, 1961).

all the acknowledged authorities and leading experts of their time, and their contributions from 1960 can be seen as a benchmark against which to review the development of medical education and practice over the subsequent half century.

1.4 The Two Christ Church Conferences (1961 and 1973)

In the following year (1961), the Nuffield Provincial Hospitals Trust arranged a conference at Christ Church, Oxford.²⁴ This meeting, whilst reviewing the successes of medical education to date, also led to significant changes in the organisation and development of an infrastructure and facilities for Postgraduate Medical Education. As a result, formal requirements for postgraduate medical education were introduced, with the realisation that junior doctors were still undergoing training in addition to their service commitments, and needed a consultant in each major regional hospital to be identified as a district manager of postgraduate education (known today as the District Clinical Tutor); furthermore there should be a postgraduate medical centre established in each district hospital providing education and administrative help.

The introduction of these local postgraduate centres and the appointment of clinical tutors around the country provided both a stimulus and an embryo infrastructure for general practice postgraduate education throughout the United Kingdom. The subsequent Nuffield courses, arranged by the College of General Practitioners, also stimulated and empowered interested GPs to take a lead in vocational training in their localities.²⁵ The publication of the report of the Christ Church Conference encouraged Nuffield Provincial

²⁴ Nuffield Provincial Hospitals Trust, "Conference on Postgraduate Medical Education" ["Christ Church Conference"] *British Medical Journal* 2 (1962): 466-7.

²⁵ P. Freeling, and S. Barry, *In-service Training: Study of the Nuffield Courses of the Royal College of General Practitioners* (London: Routledge, 1982).

Hospital Trust to allocate a substantial sum of money to the implementation of the suggestions made and stimulated a great deal of progress in medical education.

A decade later, the Trust's Medical Consultative Committee reviewed the state of postgraduate medical education and, as a result, the Trustees decided to hold another meeting on the Christ Church model in 1973, under the chairmanship of Sir George Pickering, the Regius Professor of Physics at Oxford University. He opened the proceedings with the wry comment that

‘The idea that education should continue throughout life seems, oddly enough, to be novel. It certainly does not gain acceptance in the University of Oxford.’²⁶

The papers presented at this meeting were edited by Gordon McLachlan and published under the title of *The Way Ahead in Postgraduate Medical Education*. Again, the speakers and the chapter headings demonstrate the scope of the conference. Once again representatives of the various Royal Colleges of Physicians, Surgeons, Obstetricians and General Practitioners all contributed to the overall discussion as to the future direction of postgraduate education. Sir Charles Stuart-Harris, President of the Royal College of Physicians, was the son of a Birmingham General Practitioner and provided a brief synopsis of recent aspects of postgraduate activity; he was dismissive of contemporary postgraduate education for general practice:

in many ways, however, the GP still remains outside the system: a visitor rather than a contributor and one who sometimes comes in order to sign the attendance sheet rather than to learn. There are faults also in the attitude of the teachers as well as of the organization and the continued education of the GP remains an outstanding problem.²⁷

Dr R. B. Hunter, the Chancellor of Birmingham University, in his chapter on ‘The place of the Central Institutions’, considered that the General Medical Council had been

²⁶ McLachlan, *The Way Ahead*, p. 1.

²⁷ McLachlan, *The Way Ahead*, p. 44.

outstandingly successful in relation to undergraduate medical education; but he expressed concerns regarding its accreditation of specialist registration, which he suggested should be statutorily charged to the Council for Postgraduate Medical Education in England and Wales. He was critical of the Royal Colleges who, he suggested, should be allowed to award accreditation certificates but not set the standard for entry on to a specialist register.²⁸

J. O. F. Davies gave an account of the work of the Council for Postgraduate Medical Education in England and Wales since its inception in 1970 and he described the difficulties of the Council concerning inequitable distribution of senior registrars: 'Its attention has been drawn to the difficulty which universities establishing new medical schools have found in attracting consultant staff of a requisite calibre. The Council have brought these matters to the notice of the DHSS and asked that they should be considered by the Central Manpower Committee which is in the process of being formed.'²⁹ He confirmed Revens' difficulties with the provision of hospital SHO posts for GPs, but was optimistic about the future of general practice, suggesting that 'The philosophy whereby those who fail to become consultants can "fall off the ladder" and do general practice is likely not to obtain for the future.'³⁰

Davies also recommended the expanded functions of the Regional Postgraduate Education Committees to support and co-ordinate the work of postgraduate centres and of teachers in general practice; this suggestion was repeated by G. I. Watson from the College of General Practitioners, who in *The Way Ahead* recommended studies

²⁸ McLachlan, *The Way Ahead*, p. 44.

²⁹ McLachlan, *The Way Ahead*, p. 98.

³⁰ McLachlan, *The Way Ahead*, p. 76.

to judge the value of different courses and other teaching methods in continuing education and to find suitable ways whereby a doctor can from time to time assess his own needs for refresher education.³¹

The Goodenough Report had previously advocated that refresher courses should be a recognised feature of general practice (see n. 2). But, as Ann Digby reports in her *Evolution of British General Practice 1850-1948*, a previous survey amongst GP principals in 1953 published in a *British Medical Journal* supplement found that one quarter of respondents never used such facilities for continuous education, and nearly one half used them only occasionally.³² There was more of a desire to improve technical competence through informal and interactive clinical meetings with specialist consultant colleagues, rather than through formal academic meetings. Digby devotes a chapter to recruitment, education and training for general practice, but this concentrates more on the historical shortcomings of the medical school preparation, and dismisses postgraduate education in a single paragraph.³³

Although Goodenough had recommended that the Royal Colleges have control of specialist postgraduate qualifications and consultant appointments, Geiger-Kordesch and Hull in their history of the Royal Faculty of Physicians and Surgeons of Glasgow narrate how the Faculty completed its transformation into a postgraduate teaching and examining body in the early 1950s. They characterise the disorganisation of specialist training at the time:

While undergraduate education had been effectively standardised, postgraduate education, on which the whole edifice of interlinked reform of medical education and provision ultimately rested because of the centrality of the highly-trained consultant to the NHS, had been left in an archaic state of

³¹ McLachlan, *The Way Ahead*, p. 87.

³² Anne Digby, *The Evolution of British General Practice 1850-1948* (Oxford; Oxford UP, 1999), p. 62, quoting *BMJ* Supplement 26th September 1953, p. 129

³³ Digby, *The Evolution of British General Practice*, p. 63.

Laissez-faire and *Lernfreiheit*... There was no GMC control of curricula, no standard courses of instruction and no guidelines as to which qualifications were most suitable as passports to the key consultant status.³⁴

At this time, of course, potential general practitioners needed neither further qualifications nor courses of instruction in order to practice, once they had full GMC registration following two six-month house officer posts in medicine and surgery; so it is hardly surprising that, with no College of General Practitioners, there was no organised postgraduate education expected for them.

In 1966, Rosemary Stevens produced her dispassionate review of the National Health Service, *Medical Practice in Modern England*. As an interested, but uninvolved, foreign observer, she was able to see the role of the NHS as an educational structure in itself, and assessed how the status of general practice needed to be improved through the founding of the Royal College of General Practitioners, with acknowledged markers of educational and academic attainments.³⁵

1.5 The Todd Report (1968) and Other Government Reports

Probably the most significant advances in postgraduate education came as a result of the 1965-68 Royal Commission on Medical Education, under the chairmanship of Lord Todd, although its recommendations were not immediately acted upon at the time.³⁶ The Report had taken three years to complete and the Commission had held over one hundred meetings, seeking evidence from many interested parties, often based on an assessment of

³⁴ Andrew Hull and Johanna Geyer-Kordesch, *History of the Royal College of Physicians and Surgeons of Glasgow: The Shaping of the Medical Profession, 1858-1999* (London: Hambledon, 1999).

³⁵ Rosemary Stevens, *Medical Practice in Modern England: the impact of Specialised Medicine and State medicine* (London: Yale UP, 1966).

³⁶ Royal Commission on Medical Education, *Report 1965-68* (London: HMSO, 1968) ["Todd Report"].

the historical aspects of medical education. The final text covered some 400 pages, including 121 paragraphs of recommendations on General Professional Training and nineteen appendices. Although the Todd Report has to be reviewed as a primary source in the evolution of postgraduate education, the extent of its consultation process also provides an important historical perspective. Todd foresaw

a quite new kind of general practitioner...who should achieve equal professional satisfaction – and, moreover, a similar level of regard both within the profession and outside – to that of his counterpart in a major hospital.

The implementation of the Todd Report is to be considered subsequently in greater detail as a primary source of change in postgraduate education in the period under discussion, following the introduction of the NHS in 1948.

In 1951, John Hunt and Fraser Rose attended an historic meeting of the General Practice Review Committee in Committee Room A in BMA House, and after a long, animated discussion, they decided to form a steering committee of a potential College of General Practice, and wrote to the editors of the *British Medical Journal* and *The Lancet*.³⁷ The letter was published and attracted considerable notice, favourable and otherwise; however, there was sufficient private and public correspondence that the steering committee were encouraged to found the College of General Practice, which received its royal charter on 20th November 1971. Prince Philip was appointed an Honorary Fellow and eligible to be appointed President. The Royal College of General Practitioners has recounted in several publications how success in vocational and postgraduate education has developed through their efforts and investment. Even in its embryo stage, in September 1952 the newly formed Steering Committee was bold enough to comment

³⁷ Lord Hunt, John Fry, and R. J. F. H. Pinsent, *A History of the Royal College of General Practitioners: The First 25 Years* (Lancaster: MTP Press, 1983), p. 10.

It was once true that the practice of medicine did not greatly change between qualification and retirement: but nothing could be further from the truth now.³⁸

The *Journal of the Royal College of General Practitioners* evolved from a cyclostyled newsletter to a scientific medical journal for its discipline and was renamed the *British Journal of General Practice (BJGP)* to confirm its status as an academic publication. Papers and letters published in the *BJGP* continue to provide contemporary evidence for GP educational issues of the time in the same way as the *British Medical Journal* does for the wider medical readership. The accompanying *RCGP Reports from General Practice* published as stand-alone theses meant that that educational innovations, ideas and debates could be discussed both amongst practitioners and in the public domain. In 1972, the RCGP produced *The Future General Practitioner – Learning and Teaching*, as a comprehensive curriculum for general practice, which proved a seminal influence on postgraduate general practitioner education.³⁹

By 1983, the RCGP had also chronicled the history of its educational initiatives and influence in *A History of the Royal College of General Practitioners; the first 25 years*.⁴⁰ This multi-author collection of papers covers the evolution of educational issues as well as the growth of all the College's activities, including research, development of standards of practice, the refinement of examination and assessment; like the Todd Report, this history offers primary research material as well as historical evaluation.

³⁸ College of General Practitioners, "Report of the General Practice Steering Committee" *British Medical Journal* 2 (1952): 1321-1328.

³⁹ Royal College of General Practitioners, *The Future General Practitioner: Learning and Teaching* (London: British Medical Journal for the RCGP, 1972).

⁴⁰ Hunt, Fry and Pinsent, *A History of the Royal College of General Practitioners*.

The first summary of vocational training for general practice had already been published by Horder and Swift in *Journal of the Royal College of General Practitioners* in 1979.⁴¹ In 1982, Professor Denis Pereira Gray produced his handbook *Training for General Practice*, in which he presented a concise history of vocational training for general practice in addition to providing practical advice and wisdom for both GP trainers and trainees.⁴² The further achievements of the RCGP, including education for general practitioners, were then published ten years later as another volume of essays, entitled *Forty Years On*.⁴³

British General Practice: a personal guide for students (1973) was written by Dr David Barlow, GP and first vocational training scheme course organiser in Barnstaple, as a personal account principally designed to assist the new entrant into practice; it mainly covered the clinical and administrative aspects of practice, and was not intended as an educational manual. However, he stressed that

Education in medicine is a continuing process: and not only experience is involved... In order to keep in touch the general practitioner should regularly take and read one of the standard medical journals... Opportunity to attend set 'refresher' courses should be made annually and be taken up.⁴⁴

In June 1973, the Head of the Operational Research Service of the Department of Health and Social Security commissioned Donald Hicks to review the whole of Primary Health Care.⁴⁵ In this review, Hicks provided a trenchant and individual interpretation of

⁴¹ J. Horder and G. Swift, "The History of Vocational Training for General Practice" *Journal of the Royal College of GPs* 2 (1979): 24-32.

⁴² D. J. Pereira Gray, *Training for General Practice* (Plymouth: MacDonald and Evans, 1982).

⁴³ D. J. Pereira Gray, ed., *Forty Years On: the story of the first forty years of the Royal College of General Practitioners* (London: Atalink Ltd, 1992). The essays collected here include "Practice in transition" by R. J. F. H. Pinsent, "The RCGP 1968-78" by Donald Irvine, "A decade of developments in the Pharmaceutical industry" by George Teeling Smith, "Trends in Medical education" by Veronica Baker and R. M. Harden, and "A Decade of General Practice" by John Fry.

⁴⁴ D. T. C. Barlow, *British General Practice* (London: H.K. Lewis, 1973).

⁴⁵ Donald Hicks, *Primary Health Care* (London: HMSO, 1973).

morbidity statistics from general practice and from studies of sickness in the population, based on government surveys; he ignored any need for postgraduate education apart from psychiatry. He was satisfied that if psychotherapy was to have any place in general practice, it should be developed as a skill *de novo* and was not directly transferable from a hospital setting with preconceived Freudian or other theories. Given his obsession with statistics and outcomes, it is surprising that he did not offer any advocacy for medical audit, which was to stimulate a significant educational initiative in the 1990s.

The Government published three reports on the medical profession between 1975 and 1981, which will be seen to have had repercussions on medical education and may be considered as primary sources, although they offer analysis of the contemporary state of medical education. For example, the Merrison Report of 1975 was engendered by the dispute about the funding, role and functions of the General Medical Council, and, in particular, the regulation of medical education. The Merrison Committee duly reviewed the state of postgraduate education at that time and ‘found it chaotic.’⁴⁶

In October 1978, Update Publications produced a special tenth anniversary issue of *Update: The Journal of Postgraduate Medical Practice* to commemorate ten years of the journal’s existence, describing a decade of progress in continuing education for family medicine with several articles written by luminaries of general practice education.⁴⁷ This was to be followed a decade later by a further special commemorative issue to celebrate

⁴⁶ Department of Health and Social Security. *Report of the Committee of Inquiry into the Regulation of the Medical Profession*. By A.W. Merrison et al. London: H.M. Stationery Office, 1975. [“Merrison Report”].

⁴⁷ “Tenth Anniversary 1968-1978: A Special Issue Commemorating a Decade of Progress in Continuing Education for Family Medicine.” *Update: The Journal of Postgraduate Medical Practice. Special Issue* (October 1978): 7-104.

the fortieth anniversary of the National Health Service, with a broader collection of papers reviewing changes in practice since the inception of the NHS.⁴⁸

1.6 General Practitioners and Medical Education

At the same time, general practitioners and other commentators published individual books and papers on medical education. In 1979, Thomas McKeown, Professor of Social Medicine at the University of Birmingham Medical School, devoted a chapter to medical education in his thought provoking *The Role of Medicine*.⁴⁹ He promulgated his belief in an extended concept of medical care and so advocated a broader education with a less restrictive curriculum, with a greater emphasis on the need for teaching understanding of environmental and behavioural influences on disease. John Cule's history of general practice, *A Doctor for the People*, published the following year, was a general introduction to social and clinical aspects of the work of the general practitioner through the ages. However, he felt it appropriate to introduce a chapter on 'Nineteenth Century Educational Reform of General Practice' to highlight the improvements in the standards of medical education at that time as a result of the Apothecaries Act of 1815 and the subsequent extensions to the medical curriculum and increased stringency of the qualifying examination.⁵⁰

Jack Norell, in his William Pickles Lecture of 1984 'What every doctor knows', endeavoured to insert a more scientific rigour into the assessment of the success of vocational training for general practice at the same time as questioning the value of

⁴⁸ "40th Anniversary of the NHS 1948-1988." *Update: The Journal of Postgraduate Medical Practice. Special Issue.* (July 1988): 7-34.

⁴⁹ Thomas McKeown, *The Role of Medicine: Dream, Mirage or Nemesis* (Oxford: Blackwell, 1979).

⁵⁰ John Cule, *A Doctor for the People: 2000 Years of General Practice in Britain* (London: Update Books, 1980).

belonging to the Royal College of General Practitioners.⁵¹ Norell appears as an early advocate of what is now known as ‘Best Evidence Medical Education’ (BEME), a concept encouraging greater rigour in setting educational objectives and evaluating learning outcomes. Meanwhile Nigel Oswald, now Professor of General Practice at the University of Middlesbrough, took a sabbatical from general practice in Cambridge in 1986 and enrolled at the Wellcome Unit for a one year M.Phil. He subsequently concentrated his dissertation on ‘Medical Education and the General Practitioner 1948-1982’, identifying the paradox that the transformation of the ideals and delivery care introduced by the National Health Service was unmatched by any corresponding change in the medical curriculum of the medical schools.⁵²

In 1987, Robin Dowie was able to map *Postgraduate Medical Education and Training: the system in England and Wales* as a contemporary assessment of the state of postgraduate medical education at that time for the King Edward’s Hospital Fund,⁵³ explaining and illustrating the whole infrastructure of postgraduate education in the NHS, including general practice and its development. Dowie’s work complements the General Medical Council’s earlier survey of *Basic Medical Education in the British Isles* (1975-6).⁵⁴

⁵¹ J. S. Norell, “What Every Doctor Knows.” William Pickles Lecture, 1984. *Journal of the Royal College of GPs* 34 (1984): 417-24.

⁵² N. T. A. Oswald, “Medical Education and the General Practitioner in Britain 1948-82”. M.Phil dissertation, University of Cambridge 1985.

⁵³ Robin Dowie, *Postgraduate Medical Education and Training: The System in England and Wales* (London: King Edward’s Hospital Fund for London, 1987).

⁵⁴ General Medical Council. *Basic Medical Education in the British Isles: The report of the GMC Survey of Basic Medical Education in the United Kingdom and the Republic of Ireland, 1975-6* (London: Nuffield Provincial Hospitals Trust, 1977).

John Lister's Rock Carling Monograph, *Postgraduate Medical Education*, issued in 1993 under the auspices of the Nuffield Provincial Hospitals Trust, provides a further concise history of postgraduate education principally over the last century, before updating Dowie's work with the changes in political intervention and educational practice and theory over the decade succeeding his study, as well as considering some international advances. This publication from the Nuffield Provincial Hospitals Trust reviewed and assessed the pre-clinical and clinical periods of medical school studies according to each individual university and medical school. The report offered a unique record of the activities, plans and problems related to undergraduate medical education in the United Kingdom and Ireland up to 1975. Lister appears to be the first to counsel caution on education by regulation:

There also seems to be some danger of seeking to bring about change in postgraduate medical education by regulation rather than motivation. There was no doubt a need to formalise the system, but there is a surfeit of regulations, and without motivating the trainers and the trainees the desired objectives are unlikely to be achieved.⁵⁵

More apposite to this study is Nick Bosanquet's study of primary care in Birmingham, entitled *Birmingham 1993: a strategy for Primary Care*, in which he offers a short historical review before developing a strategic view for the future of primary care, which requires further assessment as a primary source. His principal recommendation regarding postgraduate education was that

the Family Health Services Authority should work with the Regional Adviser (in GP) in implementing fully the strategy for improving the quality of continuing education...and should work with family doctors to increase local

⁵⁵ John Lister, *Postgraduate Medical Education* [Rock Carling Lectures 1993] (London: Nuffield Provincial Hospitals Trust, 1993).

research and development. There should be an expansion of joint work with the Department of General Practice at the University of Birmingham.⁵⁶

Nutton and Porter arranged their eclectic collection of papers in 1995 in *The History of Medical Education in Britain* (see note 6 above). Whilst they are not concerned with recent history, the contents supply historical insights from the past on issues of medical education. The three studies most relevant to this topic are Juanita Burnby's 'An Examined and free Apothecary', Irvine Loudon's 'Medical Education and Medical Reform', and W. F. Bynum's 'Sir George Newman and the American Way' with its review of Flexner's report which was in due course to influence the Goodenough Report. The *Guide to Postgraduate Medical Education* by Glasgow GP and member of BMA council Brian Keighley and Stuart Murray, Regional Adviser in General Practice Education in the West of Scotland, offered an authoritative account of all aspects of contemporary general practitioner education throughout the United Kingdom in 1996, along with a concise introduction to the origins of postgraduate education and thoughts for the immediate future, which can now be assessed fifteen years later.⁵⁷

1.7 Government Policies and Initiatives at the Beginning of the Twenty-First Century

The election of the new Labour government in 1997 introduced new government policies concerning the National Health Services. In 1998, the Government started a ten-year modernisation programme to ensure fair access to prompt high-quality care wherever a patient is treated in the NHS. The Health Service circular *A First Class Service* proposed a new model partnership between the Government and the clinical professions, which was

⁵⁶ N. Bosanquet, *Birmingham 1995: A Strategy for Primary Care* (Birmingham: Birmingham Family Services Health Authority, 1993).

⁵⁷ Brian Keighley and Stuart Murray, *Guide to Postgraduate Medical Education* (London: BMJ Publishing Group, 1996).

designed to marry clinical judgement with clear national standards.⁵⁸ The programme included a series of National Service Frameworks, and a new National Institute for Clinical Excellence (NICE) which would assess the new and existing interventions for clinical and cost-effectiveness and produce and disseminate guidance.

Lifelong learning was defined in the 1998 circular as a process of continuing development for all individuals and teams which meets the needs of patients and delivers the health outcomes and healthcare priorities of the NHS, and which enables professionals to expand and fulfil their potential. A locally-based approach was expected, which took into account both the service development needs of the local community and the learning needs of the individual; at the same time new Primary Care Organisations were introduced to supervise primary care, and the local Health Authority would retain its administrative function and adopt a monitoring role. The application of lifelong learning for the individual professional would follow a circular pathway through an educational needs assessment, the planning of a PDP (personal development plan) – which may require facilitation and/or mentoring – and implementation with evaluation and formative appraisal.

Among other sources, histories of the Royal Colleges and of individual universities, such as E. M. McInnes' *St. Thomas' Hospital*,⁵⁹ or the University of Glasgow's *A Significant Medical History*,⁶⁰ tend to have only a tangential reflection on postgraduate general practitioner education. When Geyer-Kordesch and Hull reviewed Postgraduate Teaching

⁵⁸ Department of Health, *A First Class Service: Quality in the New NHS. Feedback on consultations. Health Service Circular 1999/033*. (London: HMSO, 1999).

⁵⁹ E. M. McInnes, *St Thomas' Hospital*. Second enlarged edition. (London: Special Trustees for St Thomas' Hospital 1990).

⁶⁰ J. Kennedy, J. Watson, P. W. MacFarlane, *A Significant Medical History* (Glasgow: University of Glasgow, 2007).

and Examining 1950-1960 in their *History of the Royal College of Physicians and Surgeons of Glasgow*, it was clear that the College saw the organisation of specialist diploma courses as its only remit towards general practitioners keen to participate in the ‘all-encompassing rubric of postgraduate education’.⁶¹ This attitude is echoed by Neil Weir in his recent MD thesis, in which he describes the introduction of an E.N.T. Diploma by British Association of Otolaryngologists for the further education of interested general practitioners.⁶²

The General Practice Jigsaw (2001), a collection of papers originally given at the annual United Kingdom Conference of Education Advisors in General Practice, held at Warwick University in June 2000, provided a comprehensive and contemporary reflection of the state of education for general practitioners at the beginning of the twenty-first century.⁶³ Concepts such as Best Evidence Medical Education,⁶⁴ Clinical Governance, and Annual Appraisals were then being accepted into the mainstream educational literature. Roger Neighbour had already reinterpreted the psychodynamics of the apprenticeship model for general practice training in *The Inner Apprentice*, published in 1992.⁶⁵ This model had previously been advocated by Lister for all medical training in his Rock Carling monograph (see above), whilst stating categorically that ‘Vocational Training for General Practice...is so clearly and securely cast in the apprenticeship mould.’⁶⁶

⁶¹ Hull and Geyer-Kordes, *History of the Royal College of Physicians and Surgeons of Glasgow*.

⁶² N. F. Weir, “The Role of the British Association of Otolaryngologists in the Development of Otolaryngology in Great Britain from 1943-1968” MD thesis. University of London, 2008.

⁶³ S. Field, R. Strachan, G. Evans, eds, *The General Practice Jigsaw* (Oxford: Radcliffe Medical Press, 2001).

⁶⁴ R. M. Harden, P. M. Lilley, “Best Evidence Medical Education: The Simple Truth” *Medical Teacher* 22.2 (2000): 117-19.

⁶⁵ Roger Neighbour, *The Inner Apprentice; An Awareness-centred Approach to Vocational Training for General Practice* (Lancaster: Kluwer Academic, 1992).

⁶⁶ John Lister, *Postgraduate Medical Education*, chapter 6.

Christopher Booth, in *A Physician Reflects* (2003), describes how the development of gastroenterology provides an example of how an individual specialty developed in Britain during the change from empirical medicine to a subject where scientific and technological advances became all-important.⁶⁷ This progress was exclusively implemented in London, partially as a result of the Fellowship of Medicine and the Postgraduate Medical Association, originally inspired in 1918 by Sir William Osler, who came from Canada to become the Regius Professor of Physic at Oxford University. The Postgraduate Committee, following the Athlone Report (1921),⁶⁸ suggested the full-time instruction of general practitioners at existing postgraduate colleges solely in Central London, but in fact tended to concentrate on medical specialties confined to hospital practice. Booth's only comment about general practice is a quotation from Tony Dornhorst, Professor of Medicine at St George's Hospital, who in his evidence to the Todd Commission 'started a storm by disagreeing with D. A. K. Black about students being given more time in general practice; he thought they would learn nothing but bad habits.'⁶⁹

The latest scholarly volume on the subject of medical education is Sir Kenneth Calman's recent, personal and thoughtful approach in *Medical Education: Past, Present and Future* (2007), in which he looks back over the centuries and then propounds the need for 'handing on learning.'⁷⁰ As Chief Medical Officer for Scotland, he had already been responsible for chairing a working party which recommended the establishment of the Scottish Council for Postgraduate Medical and Dental Education, now known as National

⁶⁷ Christopher Booth, *A Physician Reflects: Herman Boerhaave and other Essays* (London: The Wellcome Trust for the History of Medicine at UCL, 2003).

⁶⁸ Gordon C. Cook, *John MacAlister's Other Vision: A History of the Fellowship of Postgraduate Medicine* (Oxford: Radcliffe, 2005).

⁶⁹ Booth, *A Physician Reflects*, 107.

⁷⁰ Sir Kenneth Calman, *Medical Education: Past, Present and Future* (London; Churchill Livingstone, 2006), p. 8. See also M. Jackson, K. Calman, "Medical Education Past, Present and Future" *Medical Education* 40 (2006): 190-245.

Health Service Education Scotland (NES), as a special health authority in 1993; this built on the success of the Scottish Council bringing together the Royal Colleges and faculties, the NHS, and the universities as an advisory forum. The scope of Calman's book covers the period from 4000 BCE until 2007, and reviews the global history of medical education with an erudition and comprehension only rivalled by Puschmann in its unparalleled breadth of understanding of recent advances as well as historical sources.

Calman manages to include some of the government's latest medical education initiatives, including Modernising Medical Careers (MMC),⁷¹ which was a part of the Blair government's endeavour to modernise the National Health Service. The other approach to improving quality in the NHS was the concept of Clinical Governance, designed by Liam Donaldson, the Chief Medical Officer, and built on earlier efforts to audit, monitor and improve practice.⁷² MMC was launched in February 2003 by the four UK health departments after widespread consultation over the Chief Medical Officer's report *Unfinished Business*.⁷³ This latter document was seen by Calman as an important new educational development, with its emphasis on a broad curriculum underpinned by the demonstration of core competences.⁷⁴ The subsequent debacle of NHS Medical Training Application Service (MTAS) with its problems of electronic security and plagiarism on the application form, which occurred after the publication of Calman's

⁷¹ Department of Health. *Modernising Medical Careers - The New Curriculum for the Foundation Years in Postgraduate Education and Training*. <http://www.dh.gov.uk/en/Aboutus/MinistersandDepartmentLeaders/ChiefMedicalOfficer/Archive/CMOTopicsarchive/DH_4107830> accessed 17th October 2011.

⁷² G. Scally and L. Donaldson, "Clinical Governance and the Drive for Quality Improvement in the new NHS in England" *British Medical Journal* 317 (1998): 61-5.

⁷³ Sir Liam Donaldson, *Unfinished Business: Proposals for reform of the Senior House Officer Grade* (London: Department of Health, 2002).

⁷⁴ Liam Donaldson, the Chief Medical Officer, also introduced the concept of Clinical Governance, although the theory was not immediately reflected in changes to practice: the effect on practice in Birmingham is detailed in Chapter 5 which focusses on the introduction of Clinical Audit as an educational activity.

book, was to result in the setting up of an Independent Inquiry into Modernising Medical Careers under Professor Tooke.⁷⁵

In the main, the resulting report *Aspiring to Excellence* (2008) reaffirmed many of the conclusions of the Todd Report of forty years earlier. The main recommendation of the Tooke Report was the introduction of a formal structure for a continuum of education and training from medical school through postgraduate training to independent practice and beyond to continuing medical education for the whole of a professional career. Tooke proposed further that the General Medical Council should be amalgamated with the Postgraduate Medical Education and Training Board (PMETB). PMETB had only been introduced three years earlier in September 2005, as the independent regulatory body responsible for postgraduate medical education and training, with new standards and requirements, documents for training, curricula and assessment systems. A new body, Medical Education for England (MEE), would combine the General Medical Council's responsibility for standards of undergraduate education with the postgraduate remit of PMETB. MEE would then have the authority to cover the full range of medical training: from undergraduate, through pre-registration and Foundation Programme training and specialty and GP training, up to the award of the Certificate of Completion of Training and even certain aspects of Continuing Professional Development.⁷⁶ This means that there is now, finally, a nation-wide integrated approach to the whole programme of medical education for the first time in history, albeit 'advisory' rather than 'executive', since ministers retain the ultimate responsibility for the strategic management of the NHS.

⁷⁵ John Tooke et al., *Aspiring to Excellence: Findings and Final Recommendations of the Independent Inquiry into Modernising Medical Careers*. London: Aldridge Press, 2008.

⁷⁶ Department of Health. *A High Quality Workforce: NHS Next Stage Review*. 2008.

CHAPTER 2: NATIONAL REPORTS AND LEGISLATION

2.1 Medical Legislation before the Twentieth Century

Government and Parliamentary directives and legislation concerning the practice of medicine have a long history. At the start of his reign, Henry VIII was concerned about the poor medical care of his yeoman soldiers and insisted on the 1511 Act of Parliament, in which it was enacted that

No one should practise as surgeon or physician in the City of London, or within seven miles of it, unless he had been first examined, approved, and admitted by the Bishop of London or the Dean of St.Paul's.¹

Henry VIII was also responsible for the incorporation in 1518 of the College of Physicians of London, which was given the privilege of licensing practitioners; the authority of the College was extended throughout the country by a further Act of Parliament of 1523, with the result that the College became, in W. S. C. Copeman's words 'the all-powerful rulers of the profession for another three centuries.'² The College of Surgeons was similarly incorporated in 1540 to allow them some degree of independence in the treatment of external injuries and complaints.³ Henry also founded the chairs of the Regius Professor of Physic at Cambridge University in 1540 and at Oxford University in 1546.⁴ Both the various Royal Colleges and the university medical schools confined themselves for the next five centuries to undergraduate teaching and examinations.

¹ Act of Parliament 1511, quoted in C.R.B. Barrett, *The History of the Society of Apothecaries of London* London: Elliot Stock, 1905, p. xv.

² W. S. C. Copeman, *The Apothecaries 1617-1967* (Oxford: Pergamon Press, 1967), p. 16.

³ Copeman, *The Apothecaries*, p. 16.

⁴ Act of Parliament 1543, quoted in C.R.B. Barrett, *The History of the Society of Apothecaries of London* London: Elliot Stock, 1905, p. xvi.

King James I awarded the Society of Apothecaries their Royal Charter in 1617, after their separation from the Grocers' Company, when the King accepted that

Grocers are but merchants, the business of the Apothecary is a Mistery [*sic*], wherefore I think it fitting that they be a Corporation of themselves.⁵

The House of Lords ruling in the Rose case in 1703 that the Apothecary could have the authority individually to diagnose, advise and dispense medicines, albeit for a single fee, determined the evolution of the apothecary into the general practitioners of medicine in the eighteenth century and into the present day.⁶

Parliament continued to regulate the provision of medical care for the general public. The Apothecaries' Act of 1815 regulated a state of affairs that had previously been tacitly accepted.⁷ The Medical Bills of 1812 and then 1813, which had been introduced following the protests against the 1812 Glass Tax, were initially withdrawn, but the 1815 Act finally received Royal assent on 15th July 1815. This Act instituted for the first time a central body with representatives from the Royal Colleges of Physicians and Surgeons and the Worshipful Society of Apothecaries, to set up a register of practitioners who would have undergone compulsory apprenticeship and mandatory examination. Over the succeeding two decades, the Apothecaries' medical curriculum became more sophisticated and challenging, including lectures on midwifery and paediatrics.⁸

⁵ The Charter of the Worshipful Society of Apothecaries of London, signed 6th December 1617, reprinted in full in C. R. B. Barrett, *The History of the Worshipful Society of Apothecaries of London* (London: Stock Hill, 1905).

⁶ Royal College of Physicians of London vs. William Rose. Judgement on Appeal by the House of Lords 1703.

⁷ Apothecaries' Act 1815.

⁸ Sir Zachary Cope, "Influence of the Society of Apothecaries upon Medical Education" [Gideon de Laune lecture November 1955] *British Medical Journal* 1 (1956): 1-6.

2.2 The Creation of the General Medical Council

The Medical Act of 1858 created the General Medical Council (GMC) as a central governing body for the medical profession, produced a register of recognised practitioners for public perusal, ensured the right of a legally qualified practitioner to practise anywhere in the UK and insisted on basic standards of education and examination for all licensing bodies.⁹ The Act invested the new General Medical Council with the authority to demand information about the courses of study required by the universities and the licensing bodies, and to observe their examinations. The GMC was also handed the duty to ‘secure the maintenance of such standards of proficiency’, which was to be monitored by their examination inspectors. This definition encapsulated the aim of medical education to prepare the qualified doctor for a career as a safe and efficient general practitioner. This was to remain the expressed objective of medical training for the next eighty years.

The next Governmental Report concerning medical education was the Haldane Report following the Royal Commission on University Education in London in 1913.¹⁰ This was reviewed with approbation in the *British Medical Journal* by Starling, a renowned cardiac physiologist at the Royal Herbert Hospital at Greenwich who agreed with the notion of full-time university clinical teachers in the place of the part-time teachers at the London Teaching Hospitals, whose priority was tending their private practice.¹¹ Selection for the staff of teaching hospitals was based on seniority and personal connections, and appointments were entirely unrelated to teaching ability. This lack of teaching ability was

⁹ Medical Act 1858.

¹⁰ *Royal Commission on University Education in London. Final Report of the Commissioners.* By Richard Burdon Haldane, et al. (London: H.M. Stationery Office, 1913). Abstract available at: <http://www.bopcris.ac.uk/bopall/ref7575.html>

¹¹ E. H. Starling, “Medical Education in England: the overloaded curriculum and the incubus of the examination system” *British Medical Journal* 2 (1918): 258-9.

still being recognised sixty years later,¹² and was not addressed publicly and significantly until the reports from the Standing Committee on Postgraduate Medical and Dental Education (SCOPME) in the 1990s.

The Goodenough Report of the Interdepartmental Committee on Medical Schools was published in 1944 (see Chapter 1).¹³ Although principally concerned with undergraduate medical education, it also contained a section on postgraduate education setting out facilities required for the provision of refresher courses in various specialties, especially general practice. The Recommendations as to the Medical Curriculum by the General Medical Council in 1947 were a direct response to the Goodenough Report, but the GMC did not concern itself with aspects of postgraduate education at that time, nor even ten years later with its further Recommendations as to the Medical Curriculum of 1957.¹⁴

The Robbins Higher Education Report of 1963 had significant influence on medical schools with its advocacy of integrating teaching and research; it encouraged all new junior university teachers to be given formal opportunity to acquaint themselves with the techniques of lecturing and of conducting small group discussions.¹⁵

¹² G. Houghton, "Student audit of clinical teaching" *British Medical Journal* 29 (1985): 974.

¹³ Goodenough Committee. "Training of Doctors: Report of the Interdepartmental Committee on Medical Schools, Ministry of Health and Department of Health for Scotland." *British Medical Journal* 2:121 (1944).

¹⁴ General Medical Council, *Recommendations as to the Medical Curriculum* (London: Constable and Co., 1947); General Medical Council, *Recommendations as to the Medical Curriculum*. (London: The Council, 1957).

¹⁵ Committee on Higher Education, *Higher Education: Report of the Committee appointed by the Prime Minister under the Chairmanship of Lord Robbins 1961-63* ["Robbins Report"] (London: H.M. Stationery Office, 1963).

2.3 The Royal Commission on Medical Education and the Introduction of the National Health Service

In 1968, Lord Todd produced the Report of the Royal Commission on Medical Education, which was to have a profound effect on both the thinking and delivery of both undergraduate and postgraduate medical education for the next half century.¹⁶ Although its recommendations were introduced in a piecemeal fashion, most of its suggestions have been enacted over the last half century, and the latest government review of medical education, the Tooke Report of 2008,¹⁷ actually reiterates much of the wisdom of the Todd Report (see Chapter 1 above). The Todd Report suggested the formalisation of specialist registration with a Central Committee for Postgraduate Medical Education and a NHS-based Regional infrastructure to supervise arrangements for specialist education which included General Practice. This included the introduction of a Regional General Practice Education Committee and the appointment of a Regional Adviser in General Practice (a post to be subtly altered by a later government in 1996 to Regional Director of General Practice Education, with a more directive, managerial focus). The Todd Report recommended statutory specialist registration, which, in turn, necessitated a central controlling body; it stipulated that this function should be fulfilled by the General Medical Council.

Of the three reports published by the Government between 1975 and 1981 and mentioned in the preceding chapter, the Merrison Report on the Committee of Enquiry into the Regulation of the Medical Profession criticised the state of postgraduate education at the

¹⁶ Royal Commission on Medical Education, *Report 1965-68* (London: HMSO, 1968) ["Todd Report"].

¹⁷ John Tooke et al., *Aspiring to Excellence: Findings and Final Recommendations of the Independent Inquiry into Modernising Medical Careers*. London: Aldridge Press, 2008. ["Tooke Report"].

time and current problems with the General Medical Council.¹⁸ The Merrison Committee advised that there should be three stages of medical training – undergraduate, graduate clinical and specialist training. In all, there were ninety-five recommendations on education and registration. The Government of the time introduced a very short bill in the House of Lords in 1973 which omitted all these recommendations. The final result was a further bill in 1976 which accepted the need for statutory specialist registration controlled by a central body, and the General Medical Council was duly refashioned in order to undertake this function.

The following year the Alment Report considered current methods of ‘ensuring the maintenance of standards of continuing competence to practise and of clinical care of patients.’¹⁹ Interestingly, at that stage, the Report concluded that standards of clinical training should be drawn up by the joint higher training committees but stated that ‘there is as yet no evidence to justify relicensure.’ The Short Report of 1981 (Fourth Report from the Social Services Committee) was to consider medical workforce numbers and the hospital career structure.²⁰ Its recommendation was that specialist training in all fields should take the form of planned programmes to include experience in both teaching and non-teaching hospitals, with the General Medical Council as the co-ordinating point for postgraduate medical education.

¹⁸ Department of Health and Social Security. *Report of the Committee of Inquiry into the Regulation of the Medical Profession*. By A.W. Merrison et al. London: H.M. Stationery Office, 1975. [“Merrison Report”].

¹⁹ Great Britain Committee of Enquiry into Competence to Practise. *Competence to Practise: Report of Committee of Enquiry set up for the Medical Profession in the United Kingdom* [“Alment Report”]. By E.A.J. Alment, et al. (London: The Committee, 1976). [“Alment Report”].

²⁰ Social Services Committee. *Medical Education, With Special Reference to the Number of Doctors and the Career Structure in Hospitals* [“Short Report”]. By Renée Short, et al. (London: H.M. Stationery Office, 1981).

2.4 Policies and Reports in the Last Decade of the Twentieth Century

1989 saw the publication of the Government's White Paper *Working for Patients*.²¹ This had direct implications for postgraduate education for general practitioners with the introduction of the Postgraduate Education Allowance (PGEA), and the abolition of the current Section 63 funding for GP education and the Vocational Training Allowance. This allowance had been conceived initially in 1983 as an inducement to persuade future general practitioners to undertake an approved training course before becoming a GP principal. Since vocational training for general practice had become mandatory, the government decided that the allowance was no longer needed.²² Working Paper 6 of the White Paper expressed the expectation that medical audit would be universally adopted. The introduction of medical audit was the catalyst for a whole new educational initiative with Family Health Services Authorities setting up Medical Audit Advisory Groups (MAAGs) of local practitioners going to practices to teach their peers the fundamental theory of audit techniques and to facilitate audit exercises. The implementation of the White Paper warrants a special discussion in the evaluation of clinical audit as a local educational development.²³

The Postgraduate Education Allowance required general practitioners to attend a minimum of five days training per year in each quinquennium.²⁴ General Practitioners would have to attend two approved courses under the headings of health promotion and prevention of illness, disease management and service management in these five years.

²¹ Department of Health. *Working for Patients*. Cmd 555. (London: H.M. Stationery Office, 1989.)

²² D. C. MacInnes, "Vocational Training Allowance" *Journal of the Royal College of General Practitioners* 33 (1983): 317.

²³ G. Houghton, "Clinical Effectiveness, Audit and Quality Commissioning Group for Birmingham" in Nottingham 15/5/96, *Clinical Audit in Context* (London: National Centre for Clinical Audit, 1996).

²⁴ Department of Health. *Working for Patients*.

The only quality assurance was that the Regional Adviser in General Practice would have to decide on the potential educational value of each course and its relevance to general practice.²⁵ The national Committee of Regional Advisors in General Practice in England (CRAGPIE) set up a Working Party under the chairmanship of Bob Berrington, Regional Advisor of General Practice Education in Anglia Region, to report on *Future Strategies for Continuing Medical Education in General Practice*.²⁶

The Central Committee for Postgraduate Education set up in response to the Todd Report was disbanded in 1988, but was replaced in 1993 by the Standing Committee on Postgraduate Medical and Dental Education (SCOPME) with the remit

... to advise the Secretary of State (for England and Wales) on the delivery of postgraduate medical and dental education, taking into account both the standards promulgated by the professional and educational bodies and the potential difficulties of reconciling service and training needs.²⁷

As such, SCOPME was directly funded by the Department of Health, with the Chief Executive of the NHS as the accounting officer, and was expected to act in line with prevailing government policy. In 1993 SCOPME recommended the monitoring of postgraduate and continuing medical and dental education through the formal publication of the results of membership examinations of the Royal Colleges, in order to assess the quality and success of individual training programmes. This was principally directed at hospital training programmes since most Deaneries, including the West Midlands, had already started to monitor the results of the MRCGP examination as a marker of the success of general practice vocational training in their regions. This move towards monitoring had been given particular impetus by the criticism voiced by Dr Andrew

²⁵ Department of Health. *Working for Patients*.

²⁶ Regional and Associate Regional Advisors in General Practice of England and Wales. *Future Strategies for Continuing Medical Education in General Practice* (Cambridge: CRAGPIE, 1989).

²⁷ Standing Committee on Postgraduate Medical and Dental Education, *Monitoring Postgraduate and Continuing Medical and Dental Education* (London: SCOPME, 1993).

Belton, the Convener of the MRCGP examination, concerning the standard of some of the candidates.²⁸ This was to result in the introduction of a compulsory basic pass/fail Summative Assessment examination in 1995 as the end point of GP vocational training and a mandatory entry qualification for independent practice.²⁹

In 1994, under the authorship of Jolyon Oxley, SCOPME produced a working paper on the implications for postgraduate and continuing medical and dental education of the Government's White Paper *The Health of the Nation*.³⁰ This working paper contained the simple, yet obvious, statement 'Doctors and dentists need to be taught how to teach.' This emphasis on the importance of education was mirrored by the recommendation that doctors who wished to develop their role as hospital teachers should be rewarded to the same degree as those who concentrated on clinical skills, research, or management. Teachers in hospitals should be given protected time to teach and should be paid appropriately for their work, following the example of the current state of teaching in general practice. The report stressed that didactic teaching methods, which the author considered completely ignored the needs of those in training, should cease. All clinical tutors and 90% of consultants should be included in teacher training by the end of 1996.

In 1998, SCOPME produced a particularly important report for general practice education.³¹ By this time, there was an increasing realisation that there was a need for organised and relevant educational activities for GP non-principals (assistants, locums

²⁸ Andrew Belton in *Association of Course Organisers Newsletter* (1994).

²⁹ Department of Health. *General Practice (GP) Registrars and Summative Assessment: Changes to the NHS Vocational Training Regulations*. Family Health Services Letter (98)8. 1998.

³⁰ Standing Committee on Postgraduate Medical Education. *The Health of the Nation: A SCOPME Working Paper on the Implications for Postgraduate and Continuing Medical and Dental Education of the Government's White Paper*. (London: SCOPME, 1994).

³¹ The Standing Committee on Postgraduate Medical and Dental Education. *The Educational Needs of General Practitioner Non-Principals*. Ed. Jolyon Oxley and John Egan. (London: SCOPME, 1998).

and retainer scheme doctors), whom SCOPME found to be ‘an educationally disadvantaged and vulnerable group’, and could number some 4000 doctors. Following two studies of the educational needs of over 140 GP non-principals, the report highlighted the problems of this group of general practitioners: 79% of respondents had problems attending educational events. The three most common reasons given were the cost of the education, the loss of income, and family commitments. The educational needs identified most frequently by non-principals were training opportunities relating to recent advances in clinical care, including practical procedures, practice management, computer technology and business and financial skills. The report recommended that the needs identified by this study should be brought to the attention of those responsible for planning educational activities for GPs, including practice-based education; GP non-principals should be included in initiatives to help GPs to draw up personal education and development plans. SCOPME further prescribed that particular attention should be given to the needs of those who spent little time in medical work and of locums in managing chronic disorders, and that GP non-principals should be routinely notified of local educational activities in the same way as principals. It proposed that access to postgraduate centres and associated libraries should be facilitated. In addition to implementing these recommendations, the West Midlands Deanery instituted a dedicated course for non-principals whose educational outcomes were independently assessed, with 274 sessions attended by a hundred retainers.

2.5 The Introduction of Clinical Governance.

In 1999, the government introduced the concept of clinical governance in “The New NHS - modern and dependable”.³² Clinical governance is a framework for NHS Trusts and primary care for improving the standard of clinical practice, based on existing activities

³² R. Baggott, *Health and Health Care in Britain*. 3rd edition (Basingstoke: Macmillan, 2004).

such as clinical audit, education and training, lifelong learning, clinical effectiveness, research and development, and risk management. The development of clinical governance in Birmingham general practice is described in the next section.

The concept of clinical governance was intended as a part of the latest NHS reforms to emphasise the need for individual and organisational accountability for quality in the service. Along with professional self-regulation and lifelong learning, it was designed to form the basis of personal and professional development of all staff working in the NHS. Initially the white paper defined clinical governance in terms of ten elements or attributes of a quality organisation. These ten elements are listed in Table 2.1:

Table 2.1. The Elements of Clinical Governance

◆ Quality improvement (including clinical audit)
◆ Leadership
◆ Evidence-based practice
◆ Dissemination of good practice, ideas and innovation
◆ Clinical risk reduction
◆ Detection of adverse events
◆ Learning lessons from complaints
◆ Addressing poor clinical performance
◆ Professional development programmes
◆ High quality data

Although the white paper provided a conceptual framework, the actual practical implications and expectations were not spelled out until the publication in March 1999 of the Health Service Circular “Clinical Governance: Quality in the new NHS” - less than a month before the new Primary Care Groups (PCGs) took up their responsibilities.³³ As well as setting themselves up for their new central role in the NHS reorganisation with all the other tasks devolved to them, the PCG boards had to identify a clinical governance lead to undertake the responsibility for improving standards of practice and quality of

³³ G. Houghton, D. Wall and S. Field, “Primary Care Group Clinical Governance Leads: Their Educational Needs and Experiences” *Journal of Clinical Governance* 7 (1999): 190-194.

care of all practitioners in the locality with little appreciation of what would be required of them.

It was anticipated that each practice would then nominate a clinical governance lead who would reflect at practice level the quality agenda set by the PCG. This meant that these clinical governance leads - local practitioners initially elected to the PCG board by their peers and then selected by the board - would have the responsibility. There were 44 male and seven female responders. All had been qualified for at least ten years. There was a diverse range of backgrounds, with 17 qualifying from Birmingham - the local medical school - seven from Oxford or Cambridge, six from India, six from London, ten from other English universities, two from Ireland and one from Africa.

With the guidance only available three weeks before the start of the whole PCG reorganisation, there was understandable concern that the clinical governance leads might lack the knowledge, skills and understanding necessary for the task. A survey of the clinical governance leads of the PCGs in Birmingham led to the following rather unsatisfactory conclusions. There were no attributes consistently demonstrated as underpinning the selection of clinical governance leads. Free text analysis suggested personal enthusiasm ranging from evangelical desire to improve quality to pressganged “volunteers”. In terms of educational provision, the leads requested teaching on a range of teaching styles and learning experiences and opportunities were desired, with a particular need for training in change management techniques.

In consequence, Birmingham Health Authority adopted the model of a Clinical Governance Support Unit to assist PCGs, which, in its remit, included a monthly meeting

for all PCG clinical governance leads in the city to provide training in the different aspects of clinical governance. The original Birmingham MAAG (Medical Audit Advisory Group) had evolved over the years from the initial facilitation of medical - and later clinical - audit activities to offering clinical effectiveness training. The introduction of clinical governance expanded the triad of clinical audit, clinical guidelines and evidence-based practice by incorporating these into a wider process based on the themes of responsibility and accountability, comprehensive quality improvement, risk management and identification of poor performance.

Birmingham Health Authority appreciated that PCGs and their clinical governance leads needed some central direction and co-ordination and encouraged the Birmingham MAAG develop into a Clinical Governance Support Unit.³⁴ During the following year, the Support Unit provided training sessions on poorly performing practitioners from Dr Alistair Short, based on his experience with the pilot scheme in Glasgow, clinical risk reduction from the Medical Defence Union, an introduction to Personal Learning Plans from Dr Steve Field, the West Midlands Regional Director of Postgraduate General Practice Education and a presentation concerning the requirements of the Caldicott Report on issues of confidentiality in the use of data. These presentations covered four of the top six topics identified as learning needs by the clinical governance leads region-wide.

Although clinical governance appeared to become accepted as an integral part of establishing standards, Freeman and Walshe express doubts about the actual outcome of the success of clinical governance:

³⁴ G. Houghton, S. Taylor and J. Fraser, "Role of a Clinical Governance Unit in Primary Care" *Journal of Integrated Care* 4 (2000): 56-57.

“While structures and systems for clinical governance seem well established, there is more perceived progress in areas concerned with quality assurance than quality improvement.”³⁵

Evidence at the Public Inquiry into the Mid Staffordshire NHS Foundation Trust found that there was no head of clinical governance when the West Midlands Strategic Health Authority was formed in July 2006. Dr Paulette Myers, who was responsible for overseeing clinical governance in NHS organizations in Shropshire and Staffordshire, stated that

“it was clear that the clinical governance systems and teams that we’d had previously were not replicated in the same way within the new SHA. There was no one actually nominated or employed as the head of clinical governance.”³⁶

The introduction of both clinical governance and clinical audit by the National Health Service extended the scope of postgraduate education, since continuing education and training for teams are key parts of clinical governance and build on arrangements for education and training which have been established for many years. It incorporates the principle of education tailored to the needs of the individual or to the needs of the team.³⁷

³⁵ T. Freeman and K. Walshe, “Achieving Progress through Clinical Governance? A National Study of Health Care Managers’ Perceptions in the NHS in England” *Quality and Safety in Health Care* 13 (2004): 335-343

³⁶ See the online report of Mid Staffs Public Inquiry, Day 100 (16th June 2011): <<http://nhslocal.nhs.uk/story/no-head-clinical-governance-when-wmsha-was-formed-inquiry-hears>> (accessed 17th October 2011).

³⁷ See Martin Roland and Richard Baker, *Clinical Governance: A Practical Guide for Primary Care Teams* (Manchester: National Primary Care Research and Development Centre, 1999; available online at <<http://www.medicine.manchester.ac.uk/primarycare/npcrdc-archive/Publications/HANDBOOK%20CLINICAL%20GOVERNANCE.pdf>>).

CHAPTER 3: HISTORY OF LOCAL AND NATIONAL MEDICAL EDUCATIONAL INSTITUTIONS

3.1 Introduction

Several national organisations and institutions have been particularly involved with education for general practitioners in the past, and have continued to attract doctors interested in attending lectures, reading medical journals, and developing postgraduate specialties. These include the Worshipful Society of Apothecaries of London, the British Medical Association and the Royal College of General Practitioners. The National Health Service, with the introduction of the concept of individual responsibility and clinical governance, means it is no longer considered acceptable for any clinician to abstain from continuing education after qualification, since too much now of what is learned during training becomes quickly outdated. Moreover, doctors are no longer self-employed, but have contracts with NHS Trusts, which have the responsibility of ensuring the continuing professional development of clinicians.

3.2 The Worshipful Society of Apothecaries of London

In 1904, C. R. B. Barrett wrote the first history of the Society, deriving his information from the Minute Books of the Society dating from 6 December 1617.¹ Barrett provided a chronological account of the various vicissitudes of the Society from its Royal Charter in 1617 until the nineteenth century, when the Apothecaries' Act of 1815 made it the foremost controlling body in medical as opposed to surgical education. The Society was responsible for the medical reforms of the nineteenth century and concurrently developed

¹ C. R. B. Barrett, *The History of the Worshipful Society of Apothecaries of London* (London: Stock Hill, 1905), p. ix.

examinations which qualified apothecaries as practising doctors.² William Copeman subsequently brought the Society's history up to date for its 350th Anniversary celebrations in 1967.³ He devoted a whole chapter to the development of medical education and reviewed the effects of the second great Medical Act of 1858, which enabled the General Medical Council to supersede the Society in its disciplinary functions. The archives of the Clerk's letters show how in the latter half of the nineteenth century the Clerk would reply to those complaining to the Society about the conduct or capabilities of the qualified apothecary, stating such issues were now nothing to do with the Society but had to be sent directly to the General Medical Council.⁴ The Society also participated in the first abortive attempts to institute a College of General Practitioners in 1854, and the Society's archives chronicle the initiatives which were ultimately nullified through the opposition of the Royal College of Physicians.⁵ In 1908, eighty doctors practising in Birmingham still held the Licentiate in Medicine and Surgery of the Society of Apothecaries (LMSSA) as their primary medical qualification.⁶

Over the last fifty years, the Society of Apothecaries has pioneered specialist postgraduate diploma courses principally designed for general practitioners with special interests. The first course was the Diploma in Medical Jurisprudence, established in 1962 for doctors who undertook aspects of medico-legal practice, such as police surgeon work or assistant coroners. Two further courses were developed to demonstrate competence in

² Sir Zachary Cope, "Influence of the Society of Apothecaries upon Medical Education" Gideon Delaune Lecture. Society of Apothecaries, 16th November, 1955. *British Medical Journal* 1 (1956): 1-6. Reprinted in Zachary Cope, *Some Famous General Practitioners and other Medical Historical Essays* (London: Pitman, 1961).

³ W. S. C. Copeman, *The Worshipful Society of Apothecaries of London: A History 1617-1967* (Oxford: Pergamon 1967).

⁴ Worshipful Society of Apothecaries of London, Clerk's Book, August 25, 1847.

⁵ Worshipful Society of Apothecaries of London, Clerk's Book, March 31, 1848.

⁶ *Kelly's Directory of Birmingham*, 1908. Facsimile reproduction (Solihull: Midlands Historical Data, 2007).

forensic medicine for those involved in more complicated medico-legal work or court procedure. The Diploma in Forensic Medical Sciences (DFMS) was established in 1998, having been originally offered by the Medical Faculty of the University of Glasgow and transferred, after some adaptation, to the Society in 1997. The Diploma in Forensic Human Identification (DFHI) was established in 2002 but was replaced in 2009 by the Diploma in the Forensic and Clinical Aspects of Sexual Assault (DFCASA), designed to set national standards in the quality of care provided by medical professionals for victims of sexual violence and abuse, in response to a need identified by Home Office Research in 2004. The other postgraduate specialty courses were also in Sexual Medicine, with the Diploma in Genitourinary Medicine in 1973 and later the Diploma in HIV Medicine in 2002.

3.3 The British Medical Association

Charles Hastings founded the Worcester Medical and Surgical Society in 1816.⁷ Sixteen years later, at a meeting in the Board Room of Worcester Infirmary on 19 July 1832, Hastings transformed the local Worcester Society into the Provincial Medical and Surgical Association (PMSA), and essayed a national profile. Some fifty doctors were present to hear Hastings propose the inauguration of this Association to promote both social intercourse and the advancement of scientific knowledge for physicians, surgeons and general practitioners, along with the publication of a journal, *The Midland and Surgical Reporter*. The Association's objectives were to promote the medical and allied sciences and to maintain the honour and interests of the medical profession, aims which remain the same today. Birmingham had much to do with the foundation of the PMSA, and supplied its first President, Dr James Johnstone, a senior physician at Birmingham

⁷ E. M. Little, *History of the British Medical Association* [Volume 1: 1832-1932] (London: BMA, 1933).

General Hospital, who was famous for his essay on the ‘Ganglion of the Nerves’.⁸ The Birmingham and Midland Counties Branch was founded in 1854, and many of the special general meetings have been held in Birmingham, partly on account of its central geographical position, but also because of the strong corporate feeling displayed by Birmingham doctors and their participation in the activities of the Association.

In 1832 the first, and indeed the only, instrument for the advancement of medical science available to members of the PMSA was the annual meeting. Twenty-three years later, in 1855, the PMSA became known as the British Medical Association (BMA), and the Reporter became the *British Medical Journal (BMJ)*, whose aim has always been to supply members with a weekly periodical presenting a comprehensive review of progress in the science and practice of medicine. The BMA continued to hold important scientific events at both national and local levels, and the proceedings would then be summarised and selected important papers published in full in the *BMJ*. By 1932, it had become not only one of the leading medical journals in the world, and one of the most widely read, but the major source of knowledge for practitioners.⁹ Calman has described how such journals had replaced books in the nineteenth century as the way for doctors to keep up-to-date, and has concluded that they remain an important tool for doctors.¹⁰ At the Centenary Meeting, the annual scientific meeting became linked with the annual representative meeting, but took place on entirely separate days from the discussion of business and political matters. Throughout the 1950s and 1960s, representatives from the Birmingham Local Medical Committee saw their annual attendance at the scientific event

⁸ In John Thackray Bunce, *A History of the Birmingham General Hospital and the Music Festivals* (1873; facsimile repr. Kessinger; La Vergne TN, 2010).

⁹ Little, *History of the British Medical Association*.

¹⁰ Sir Kenneth Calman, *Medical Education: Past, Present and Future* (London; Churchill Livingstone, 2006).

as their principal dedicated educational activity each year, supported by weekly perusal of the *BMJ*. As Barlow commented in his introduction to general practice for students:

In order to keep in touch the GP should regularly take and read one of the standard medical journals such as the *British Medical Journal*... It is a simple and most useful practice to read the leading articles in the *British Medical Journal*. These will be found to cover most topics and advances of the day.¹¹

Although the BMA has a local office in Birmingham to assist members, the Association has had no local influence on education apart from organising the 1958 Annual Scientific Meeting, held in Birmingham. The British Medical Association has continued to pioneer educational initiatives on a national basis with innovative interactive programmes such as BMJ Masterclasses and BMJ e-learning, introduced in 2006, which provide busy GPs and hospital doctors with essential updates on the latest evidence, important advances and current issues that are relevant to their daily practice. 12,000 general practitioners have already attended the Masterclasses in the first four years of their existence, and each year 6,000 new subscribers apply to use the latest evidence and recent guidelines in practice, and meet their Continuing Professional Development / Continuing Medical Education requirements through this electronic medium.¹² This use of case studies and practical demonstrations encourages sharing of best practice and interactions with peers and experts, creating better learning outcomes for clinicians and their practice.

3.4 The Midland Medical Society / Birmingham Medical Institute

The end of the eighteenth century and the start of the nineteenth century saw the institution of medical societies around the United Kingdom. Juanita Burnby has suggested that education for surgeons and apothecaries did not cease with their setting up in practice, and pointed to the existence of the many provincial medical societies, whose

¹¹ D. T. C. Barlow, *British General Practice* (London: H.K. Lewis, 1973).

¹² Personal communication from Hilary Pinnock, Editorial Board, BMJ Masterclasses.

members met regularly in inns or their own houses.¹³ McMenemy saw the societies more as a social network than as associations of an educational nature, and concluded that, in general, they were medico-political combinations: in the early nineteenth century, practitioners were concerned with the activities of their unqualified rivals.¹⁴ Cule accepted that practitioners grouped themselves together for all sorts of medical, social and political reasons, but often also provided a forum for scientific discussions.¹⁵ The principal educational agenda related to the standardisation of medical qualifications: the country practitioner largely depended upon professional journals for his self-edification. The Liverpool Institute was founded precisely in order to provide library facilities to allow practitioners to have access to medical journals and books, which were rare and expensive.

The Midland Medical Society was founded in Birmingham on 21 October 1869. The inaugural meeting took place at the Great Western Hotel in Monmouth Street, Birmingham, with practitioners attending from as far afield as Leamington and Wolverhampton, along with some forty students from Queen's College, to hear an address from Dr B. W. Richardson, F.R.S, on the use of the lancet, the possibilities of blood transfusion, and the therapeutic uses of alcohol.

The two principal stated objects of the Society were firstly to promote the study of Medicine and Surgery amongst practitioners by the communication of clinical and

¹³ J. Burnby, "An Examined and Free Apothecary", in Vivian Nutton and Roy Porter, eds. *The History of Medical Education in Britain*. Clio Medica: Wellcome Institute Series in the History of Medicine. 30. (Amsterdam: Rodopi, 1995), pp. 16-36.

¹⁴ W. H. McMenemy, "The Influence of Medical Societies on the Development of Medical Practice in Nineteenth-Century Britain" in F. N. L. Poynter, ed., *The Evolution of Medical Practice in Britain* (London: Pitman Medical, 1961) p. 68.

¹⁵ John Cule, *A Doctor for the People: 2000 Years of General Practice in Britain*. (London: Update Books, 1980).

therapeutic facts and by the exhibition of pathological specimens and discussion thereon, and, secondly, to provide a Reading Room well supplied with professional and general periodicals, and with the latest works published in Medicine and Surgery and allied branches of science. The first objective was to be secured by fortnightly meetings between October to May, to be held alternately at 3 p.m. and 8 p.m. Thanks to a bequest of £1,000 from Dr George Fabian Evans in 1875, supplemented by a further £5,000 from the Ingleby Fund, the Birmingham Medical Institute was founded in order to provide the accommodation and library facilities desired by the Midland Medical Society. The Institute came into being in 1875 with a parallel committee structure, working in tandem with the Midland Medical Society, and set about constructing an Institute building with a library in Edmund Street, behind the City Museum and Art Gallery.

The Memorandum of Association of the Birmingham Medical Institute identified six objects for which the Association was established.¹⁶ The first two were congruent with those of the Midland Medical Society, namely ‘the establishment and maintenance of a library of the Medical and Allied Sciences at Birmingham in the county of Warwick’, and ‘the advancement of professional knowledge by the establishment and maintenance of Physiological and Pathological Laboratories and Museums, the delivery of Lectures, the establishment of prizes and rewards and other means.’ The third object was ‘the philanthropic and charitable intention to assist such poor and necessitous Members of the Medical Profession, living within 50 miles of Birmingham, as may be incapacitated for practice through bodily or mental infirmity or other inevitable calamity, and their wives and families, and the poor and necessitous widows and families of deceased Members.’ This function was later to be taken over by the Medical Benevolent Society, which was

¹⁶ Memorandum of Association of the Birmingham Medical Institute (1875).

established in Birmingham in 1821 as a benevolent society under the rules of Friendly Societies and continued to function until it was formally dissolved in 2003, as a consequence of diminishing claims on its funds in a new era of welfare; the Society's activities included provision of sickness benefits and personal life and sickness insurance policies, and at its dissolution the funds were duly transferred to the Royal Medical Benevolent Fund with its national responsibility.

The Association of the Birmingham Medical Institute had the right to acquire property, by purchase or lease, and, then, as it thought fit, resell, surrender and dispose of any such property. As a result of its memorandum, it could be granted a licence by the Board of Trade in pursuance of the Companies Act of 1867. The purpose-built Birmingham Medical Institute premises were opened officially on 17 December 1880 by Alderman Chamberlain, the Mayor of Birmingham, with an address by Dr Ridson Bennett, the President of the Royal College of Physicians of London. This building was sold in 1923 and the Institute moved to 154 Great Charles Street. The Library Hall there served as a place of meeting for the local medical societies and at that time contained some 16,000 volumes, covering all medical topics. As far as possible, all valuable books were purchased as soon as they were published, and in addition an annual subscription was paid to Lewis' Library, which enabled members to obtain any new book which was not in the library. Members were allowed to borrow twelve volumes at a time. There was a comfortable reading and writing room, with a well-furnished bookcase of standard works of reference, directories and dictionaries.

In 1939, the Great Charles Street premises were sold under a compulsory purchase order to the Birmingham City Corporation, but possession was postponed on account of the

Second World War. It was not until 1957 that the Institute was required to find an alternative home: a lease was taken until 2013 for 36 Harborne Road, Edgbaston. Plans for the reconstruction of 36 Harborne Road included a commodious Conference Hall with kitchen, foyer, cloakrooms and a Reference Library with reading rooms. In 1956, the Institute saw itself as 'a centre of scientific discussion and instruction available to all doctors and dental surgeons in the Midlands', and was home to the Midland Medical Society with its sections of Odontology, Psychiatry and Anaesthetics. It also desired close and important liaison with the Birmingham Local Medical Committee, the Birmingham Medical Benevolent Society, and the British Medical Association, which accepted the Institute's offer to house a branch office. The Institute had already been in correspondence with Dr Donald Crombie of the Midland Faculty of the new College of General Practitioners in 1954 concerning the provision of secretarial facilities, and the Midland Faculty had agreed to make a donation of £10 p.a. for four full meetings and four small meetings. Given its extensive library collection, the General Committee of the Institute was looking to establish a closer association with the Birmingham Medical School and the University's new Library development. In consequence, Dr A. G. W. Whitfield, the Director of Postgraduate Studies at Birmingham University (equivalent to the current position of Postgraduate Dean), was invited to become a co-opted member on to the General Committee of the Midland Medical Society in 1961. Following the Christ Church Conference (see Chapter 1 above), the Nuffield Provincial Hospitals Trust promised the sum of £5,000 towards the liquidation of the Highfield Road mortgage, and a donation was duly received in November 1962.

The archives of the Midland Medical Society and the minutes of the Birmingham Medical Institute provide a first-hand source for the discussions regarding the development of

postgraduate education, particularly for general practitioners in Birmingham since the advent of the National Health Service. However, the Medical Institute has developed more as a social centre than as a centre of medical education, although the library was kept up-to-date as a resource for studies. Between 1968 and 1972, there is no mention in the Committee minutes of any discussion of postgraduate education initiatives. Following the Todd Report of 1968 (see Chapters 1 and 2), the Secretary of the Midland Medical Society and the Postgraduate Dean had approached the Regional Medical Officer for financial support for improvements to the buildings and equipment, particularly the projection facilities, so that the Institute might make a more active contribution to postgraduate medical activities. Although Dr Christie Gordon (the Regional Medical Officer) seemed sympathetic to their ideas, his only contribution was to fund the appointment of two Postgraduate Tutors.

In 1976, the Birmingham General Hospital, a more convenient venue than the city centre, put on weekly lunchtime lectures for general practitioners, but attendance numbers waned after a couple of years. Meanwhile East Birmingham, Dudley Road and Selly Oak Hospitals continued to attract local practitioners on a regular basis, who could maintain contact with consultant colleagues who also used their postgraduate centres. The Institute had arranged a meeting of a Working Party on Postgraduate Activities which met on 12 May 1975, but even so, during the academic session 1977/8 just six postgraduate one-day symposia were organised by the Midland Medical Society. Following this, the Society's minutes have virtually no reports of any postgraduate education between 1977 and 1984.

The Midland Medical Society Committee hoped that the introduction of mandatory training for GPs in 1977 might allow the Institute to develop into a centre for trainers and

trainees in the Central Birmingham Vocational Training Scheme, provided some kind of financial assistance was given to the Institute itself. In the event, the Special Trustees of the Queen Elizabeth Hospital decided to donate a special grant to build a Postgraduate Centre on the Hospital site opposite the new Woman's Hospital. This centre was to be opened in 1980 and run by an independent charity, the Metchley Park Medical Society. The steering committee included the VTS course organisers for South and Central Birmingham and the Central Birmingham GP tutor, so the Centre was designed with postgraduate general practice education in mind; it was decided that the half-day Central District VTS release course would be run there and not at the Medical Institute, while the South Birmingham VTS continued at the Selly Oak Hospital Postgraduate Centre. The Midland Medical Society considered its future and on 3 February 1985 came to the almost unanimous conclusion that

The Institute should maintain its independence. And joining with QE PG Centre would be 'inadvisable'... The committee is not in favour of trying to negotiate a merger.¹⁷

The Society's schedule for 1986 did not involve any postgraduate educational activity beyond a single event, the annual Lawson Tait Lecture; rather, it concentrated on the following topics – antiques valuation evenings, wine tasting, an outing to Worcester, the Annual Dinner, and the state of the library carpets. Over the last twenty years, the Midland Medical Society and the Midland Medical Institute appear to have foregone their original function, started a century and a half ago, of the exchange and promotion of clinical and therapeutic learning, and despite their initial aims these organisations have had little effect on postgraduate medical education in the sixty years since the founding of the National Health Service.

¹⁷ Midland Medical Society Archive.

3.5 The Royal College of General Practitioners

The first attempts to set up a College of General Practitioners occurred in 1845, when a Deputation of the Society of Apothecaries and the National Association of General Practitioners presented the following petition to the Secretary of State for Health:

General Practitioners shall be incorporated under the title of THE ROYAL COLLEGE OF GENERAL PRACTITIONERS IN MEDICINE, SURGERY AND MIDWIFERY.¹⁸

The proposals included the suggestion that there should be a preliminary examination conducted by the Colleges of Physicians and Surgeons, and that the Penal Clause of the Apothecaries Act of 1815 be retained and the power of enforcement be transferred to the new College of General Practitioners. However, the opposition from the College of Physicians was overwhelming and it took another hundred years before a steering group took the initiative to found the current College of General Practitioners in 1952, with an infrastructure of geographical regional faculties. The College itself has published several accounts of its history.¹⁹

3.5.1 The Origin of the Midland Faculty

The Faculty Board for the Midlands Region first met at the Birmingham Medical Institute, the home of the Midland Medical Society, on 13 May 1953. Initially, the Midland Faculty included 223 founder members, 117 from the West Midlands and 106 from the East Midlands, and meetings alternated between Birmingham and Leicester for one year when the Faculty divided into the Midland Faculty and the North Midland

¹⁸ College of General Practitioners – petition.

¹⁹ See, for example, “The Faculty Story” in D.J. Pereira Gray, ed. *Forty Years On: The Story of the First Forty Years of the Royal College of General Practitioners*. (London: Atalink, 1992), pp. 155-162.

Faculty; the latter sought independence and assumed the title of the Trent Faculty in 1975. Only 43 (37%) of the founder members in the West Midlands actually lived and worked in Birmingham, and they represented fewer than one in ten of the 472 GP principals on the Birmingham Executive Council list at the time.²⁰

At its first meeting, the Faculty Board discussed the question of involvement in medical education, and decided there should be an office of University liaison divided into one member for postgraduate education and one for undergraduate study, as well as dialogue with the Regional Hospital Board to develop both residential and non-residential courses, along with GP attendance at consultant ward rounds and outpatient clinics. At the next meeting, in March 1955, it was resolved that the Midland Faculty should seek representation on the Dean's Committee at the Birmingham Medical School; the Dean of Postgraduate Studies was duly approached, and Professor A. P. Thomson accepted the assistance of the Faculty in the recognition of Sunday morning ward rounds at the Queen Elizabeth Hospital as a formal course of postgraduate studies. These ward rounds were not organised by the College of General Practitioners, but were the result of the initiative of individual general practitioners who had returned to practice after their experience of National Service and had become used to continuing education.

3.5.2 The Midland Faculty Education Subcommittees

The Faculty set up two education committees, one for undergraduate and another for postgraduate studies. These appear to have been discussion groups rather than concerned with actually proffering any teaching or instruction. The only educational event was an annual lecture sponsored by the pharmaceutical industry, originally underwritten by

²⁰ Birmingham Executive Council.

Geigy and later by Pfizer. The single subsequent reference in the minutes to the activities of the committees in November 1956 stated that it would be

inadvisable to give a gift or pay a fee to lecturers in the periphery of the faculty although reasonable expenses would be allowable.

Following the 1961 Christ Church conference on Postgraduate Medical Education organised by the Nuffield Provincial Hospitals Trust (see Chapter 1 above), the setting-up of local Postgraduate Centres was encouraged, as well as the appointment of clinical tutors around the country.²¹ The subsequent Nuffield courses stimulated and empowered interested GPs to take a lead in vocational training in their localities.

In 1964, the Ministry of Health accepted that the costs of postgraduate and continuing medical education constituted a proper charge on the National Health Service budget.²² Two years later, in January 1966, it was agreed to merge the UG and PG committees to discuss GP vocational training, and the Faculty decided to invite a university lecturer (Mr Edward Cope, an obstetrician) and a LMC representative (Dr A. C. Houghton) to augment the joint committee. This led to the proposal for a vocational training adviser to be appointed by the Faculty ‘with adequate time and money,’ an aspiration that was not to be substantiated until the implementation of the recommendations of the 1968 Royal Commission on Medical Education, commonly referred to as the Todd Report (see Chapter 1).

²¹ Nuffield Provincial Hospitals Trust. “Conference on Postgraduate Medical Education [“Christ Church Conference”].” *British Medical Journal* 1 (1962): 466-7.

²² W. Wintersgill, Letter to Regional Postgraduate Education Committees, 18 May, 1973. (London: Department of Health and Social Security).

The Todd Report introduced standardisation and a formal infrastructure for postgraduate education, and led to the appointment of Postgraduate Deans and Regional Advisers in General Practice in 1972. Dr David Scott from Coventry was appointed by the Regional Health Authority as the first Regional Adviser in the West Midlands. The Todd Report actually recommended five years of postgraduate training, three years of hospital 'general professional training' and two years of specialist training (in general practice.)

In 1968, following Todd's recommendation of more exposure to general practice for medical students, the Faculty sought to find practices who would consider introducing students to observe general practice. By February 1969, it had collected 200 completed questionnaires from members interested in teaching, and set up a register of GP teachers. This led to a recognised attachment scheme for senior medical students to spend their elective periods in general practice for several weeks. This culminated in an undergraduate symposium on General Practice Medicine in February 1970 organised by the students themselves with support from the Midland Faculty.

This closer relationship with the student body at Birmingham University Medical School highlighted the desire among undergraduates for further involvement with general practice and formal teaching in community medicine. The Midland Faculty hoped that this initiative would overcome some of the reluctance on the part of the Faculty of Medicine to recognise the value of postgraduate education for general practice. In consequence, the Midland Faculty proposed the desirability of setting up a small GP Advisory Committee under the aegis of the Board of Graduate Clinical Studies, but this was rejected by Professor George Whitfield; he did, however, appoint Drs Ken Dickinson

and Robin Steel to the Committee of Area Directors of Postgraduate Education and Clinical Tutors.

3.5.3 Vocational Training

The first initiative in GP vocational training in the West Midlands was the ‘Orientation towards General Practice’ course of ten afternoon sessions between 7th May and 9th July 1970, set up at the Birmingham Maternity Hospital by Dr Robin Steel with Section 63 funding from the Regional Hospital Board, and designed for trainees, assistants and young principals (see Appendices). This was a joint venture between the RCGP Midland Faculty and the Birmingham Medical School Board of Graduate Studies, and followed the pattern of the first working model of a GP Vocational Training Scheme, which had been piloted in Inverness in 1952. The first half-day release course for new GP entrants had started in Canterbury in 1964 with a two-year syllabus following the example of a much more extensive course set up by Prof. Vuletic in Zagreb in Yugoslavia.²³ The programme proved to be the template for Vocational Training Scheme half-day release courses for the next forty years, until the introduction of local cluster teaching for GP registrars.

In 1974, the DHSS authorised the appointment of GP VTS Course Organisers (Table 3.1, overleaf); the proposals anticipated that each course organiser would assume responsibility for ten trainees in general practice and oversee educational arrangements for trainees in the hospital phase of the VTS. Following this DHSS circular, and with an eye to the success of Robin Steel’s ‘Orientation Course’, the new Regional General Practice Postgraduate Education Committee decided that there should be a half-day

²³ J. P. Horder, “The General Practitioner in Yugoslavia, Czechoslovakia and Israel: Special Vocational Training” *Lancet* 2 (1965): 123-5.

release course on a Thursday afternoon available for all trainee general practitioners in the West Midlands. This involved parallel courses, one (run by Dr Robin Steel and Dr David Clegg with the help of Dr George Thorpe and Dr John Lester) for GP trainees who had been appointed to a VTS rotation of SHO posts and a trainee year, and the other (organised by Drs Tony Williams and Alistair Ross) for those trainees or assistants who had had organised their own career posts and then decided to undertake a GP trainee year. Initially, all the GP trainees in the West Midlands had to drive regularly to Birmingham to attend these courses.

Table 3.1: **Birmingham VTS Course organisers**

	Course Organisers	Course Organisers	Course Organisers	Course Organisers
<i>decades</i>	<i>1970-1980</i>	<i>1980-1990</i>	<i>1990-2000</i>	<i>2000-2010</i>
East Birmingham		Dr Geoff Tutton / Dr John Spence	Dr Martin Wilkinson / Dr Jim Storer	
West Birmingham			Dr Matthew Nye	
South Birmingham		Dr David Wall/ Dr Ken Dickinson	Dr Anne Gillies/ Dr Malcolm Laird/ Dr Andrew Ross/ Dr David Taylor/ Dr Patricia Houlston	
Central Birmingham		Dr Guy Houghton/ Dr Robert Strachan/ Dr Barbara King/ Dr Rosemary Kendall/ Dr Jim Parle Dr Sylvia Chudley	Dr David Taylor	
North Birmingham		Dr Robert Strachan/ Dr Frank Cole		
Solihull		Dr Irving Stuart	Dr Irving Stuart	

Courses open to whole of West Midlands	Dr Robin Steel Dr Tony Williams/ Dr Alistair Ross/ Dr George Thorpe/ Dr David Clegg	Dr Barbara King		
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3.5.4 Structured Assessment of GP Trainees

In 1972, the Royal College of General Practitioners published *The Future General Practitioner: Learning and Teaching*, which was designed to make a detailed statement about the knowledge, skills and attitudes essential for general practice.²⁴ Following the pioneering work of Byrne and Long on the analysis of the consultation, a chapter was devoted to discussion of the consultation as a process, related a series of separate clinical interviews, and recommended the observation of the interaction between the doctor and the patient, either by the GP trainer passively sitting in with his trainee or by use of videotaping of the consultation.²⁵ The West Midlands Regional Health Authority invested in a collection of video cameras to be loaned to practices to encourage GP trainees to record their consultations; these recordings would then be reviewed with their trainers in their regular tutorial sessions. The Vocational Training Scheme Course Organisers ensured that consultation skills were a regular theme of the Vocational half-day release courses, and trainees were encouraged to study Dr Roger Neighbour's book *The Inner Consultation*.²⁶ Videotaped consultations ultimately became an important section of the obligatory Summative Assessment endpoint examination of general practitioner training in 1997.²⁷ The GP Registrar had to demonstrate on the tape that he or she was able to

²⁴ Royal College of General Practitioners, *The Future General Practitioner: Learning and Teaching* (London: British Medical Journal, 1972).

²⁵ See also P. S. Byrne and B. E. L. Long, *Doctors Talking to Patients* (London: HMSO, 1976).

²⁶ R. H. Neighbour, *The Inner Consultation* (Lancaster: MTP, 1987).

²⁷ Joint Committee on Postgraduate Training for General Practice, *Report of Summative Assessment Working Party* (London: JCPTGP, 1993).

identify the reasons for the patient's attendance, take appropriate steps to investigate the problems presented, organise a suitable management plan, reach an agreement with the patient on diagnosis and treatment, and demonstrate the dynamic and understanding of the interaction in a log book.

The first year's experience of summative assessment highlighted a need for more intensive support in the learning and teaching of communication skills: twenty-six of the ninety-five candidates failed the video section.²⁸ Dr Sylvia Chudley was appointed as an Associate Adviser for Communication Skills and John Skelton, a Senior Lecturer at the Birmingham University Medical School, set up an Interactive Skills Unit (ISU) to support registrars who were identified as having communication problems. The ISU then became a teaching resource to improve the communication skills of undergraduates.

3.5.5 Expansion of GP Vocational Training Schemes

As numbers grew, Vocational Training Schemes budded off on a geographical basis throughout the region with their own Thursday afternoon courses. In Birmingham, there were schemes aligned to the current District Health Authorities, based on the District Hospitals with their Postgraduate Centres (see Table 3.2 below). The original Course Organisers undertook new roles as Associate Advisers for the five areas of the West Midlands, which in itself was comparable to the size and population of Scotland (Table 3.3, overleaf). They undertook responsibility for the educational standards of the training practices and monitoring educational provision for GP trainees around the region, in line with the recommendations of the new Joint Committee for Postgraduate Training for General Practice (JCPTGP), set up in 1975 with equal representation from the College of

²⁸ S. T. Field, "Newsletter of the Regional GP Unit (Spring 1997)" *West Midlands Journal of Primary Care* 1.1 (1997): 10.

General Practitioners and the General Medical Services Committee of the British Medical Association; the latter had become the recognised official trade bargaining body for the profession under the then current Trades Union legislation).²⁹

Table 3.2: **Birmingham Vocational Training Schemes**

Central Birmingham	General /Queen Elizabeth Maternity/Children's/Midland Nerve Hospitals
East Birmingham	East B'ham 'Heartlands'/Marston Green/Yardley Green Hospital
North Birmingham	Good Hope Hospital
South Birmingham	Selly Oak /Moseley Hall/John Connolly Hospitals
West Birmingham	Dudley Road 'City'/St Chad's/All Saints/ Summerfield Hospitals

Table 3.3: **RHA / Deanery Adviser Appointments**

	Birmingham Regional Health Authority Appointments		West Midlands Deanery Appointments		
	<i>decades</i>	1970-1980	1980-1990	1990-2000	2000-2010
Postgraduate Dean		Prof. George Whitfield/ Prof. John Malins	Prof. Brian Pentecost/ Prof. John Temple	Prof. Steve Field	Prof. Steve Field/ Dr Elizabeth Hughes
Deputy PG Dean		Dr Roy Cockel	Prof. David London/ Prof. David Wall	Prof. David Wall	Prof. David Wall
Regional Adviser GP		Dr David Scott	Dr George Thorpe/ Dr David Wall/ Dr Steve Field	Prof. Steve Field/ Dr Stephen Kelly/	Prof. Ruth Chambers Dr Martin Wilkinson
Deputy Regional Adviser		No appointment	No appointment	Dr Steve Field/ Dr Stephen Kelly	
Regional Director GP		No appointment	No appointment	Dr Steve Field/ Dr Stephen Kelly	
Deputy Regional Director GP		No appointment	No appointment		Dr Ian MacDonald/ Dr Mike Deighan
Area Advisers					
Birmingham & Solihull		Dr George Thorpe	Dr Robert Strachan	Dr Robert Strachan	Dr Andrew Carson

²⁹ See Elston Grey-Turner, *History of the British Medical Association. Vol 2. 1932-1981* (London: British Medical Association, 1982), p. 302.

Coventry & Warwicks	Dr David Clegg	Dr Ian MacDonald	Dr Ian MacDonald	Dr Kathi Wheatley
Hereford & Worcester	Dr Tony Williams	Dr Kevin Illsley	Dr Kevin Illsley	Dr Vic Schrieber
Black Country	Dr Derek Bloor	Dr John Lester Dr David Wall/	Dr Stephen Kelly	Dr Tony Robinson
Shropshire & Staffs	Dr Alistair Ross	Dr Mike Fisher	Dr Mike Fisher	Dr Amjad Khan
Educational Advisers				
Continuing Education	No appointment	No appointment	Dr Baron Mendes da Costa Dr Roland Spencer-Jones	
Audit/Appraisal/Assessment	No appointment	No appointment	Dr Guy Houghton	Dr Guy Houghton Dr Fiona Kameen
Consultation Skills	No appointment	No appointment	Dr Sylvia Chudley	Dr Matthew Nye
Curriculum	No appointment	No appointment	Dr Mike Deighan	Dr Steve Walter
University Medical School Representative	Prof. Brian MacGuiness (Keele Univ.)	Prof. Richard Hobbs (B'ham Univ.)	Prof. Richard Hobbs (B'ham Univ.)	Prof. Richard Hobbs (B'ham Univ.) Dr Neil Johnson (Warwick Univ.)
Recruitment	No appointment	No appointment	Dr Martin Wilkinson Dr Rob Grinsted	Dr Ryan Prince

Although the Royal College of General Practitioners continued to promote excellence in postgraduate education for general practice with occasional papers on aspects of Training Practices and Quality in Practice, which encouraged the raising of educational standards set by the JCPTGP, the Midland Faculty had much less local influence. The Faculty put on pre-examination courses to assist MRCGP candidates to prepare for the College examination. Dr David Morgan, from Liverpool, who was appointed as the first Senior Lecturer in the Department of Primary Care and General Practice at the University of Birmingham Medical School, arranged a regular annual research symposium which was very well received and attended. With the increasing numbers of Birmingham practitioners who had passed the MRCGP examination, a Birmingham sub-faculty was

set up in an endeavour to stimulate local College activity – but no lasting interest or educational initiatives persisted, and at an extraordinary general meeting in 1999 the sub-faculty took the decision to dissolve itself. With the introduction of the Membership by Performance (MAP) to assist those who had not taken the Membership examination at the end of their trainee year, sporadic groups of individuals worked together to achieve personal success.

3.5.6 General Practice Postgraduate Examinations

The Royal College of General Practitioners maintains its national influence and innovation in postgraduate education and assessment, including the revised new MRCGP examination. The new MRCGP is an integrated assessment programme that includes three components: an Applied Knowledge Test (AKT), a Clinical Skills Assessment (CSA), and Workplace-Based Assessment (WPBA).³⁰ Each of these is independent and tests different skills but together they cover the curriculum for specialty training for general practice. Evidence for the workplace-based assessment is collected in an e-portfolio completed by each GP trainee and the local examination organisation is shared by the Postgraduate Deanery and scrutinised by independent observers from other College faculties, but the Midland Faculty has only a marginal input in arranging voluntary pre-examination courses for local trainees. The National Health Service now expects all practitioners after qualification to participate in continuing medical education relevant to their patients' needs. The Department of Health advises that requirements of healthcare professionals should be identified on the basis of the needs of individuals, within the context of the needs of the organisation and of patients. This is determined through a regular appraisal process, with a personal development plan that is agreed

³⁰ See <http://www.nmrcgpexam.com/nmrcgp/>

between the individual professional and his or her manager within the commitment of time and resources. The key issue now is to ensure that healthcare professionals maintain their competency by developing CPD strategies for the revalidation/re-certification of their members through their regulatory body (the Department of Health, 2007), and postgraduate education is no longer voluntary but a universal expectation.³¹

³¹ Alfredo Pisacane, "Rethinking continuing medical education" *BMJ* 337 (2008): 973.

CHAPTER 4: GENERAL PRACTICE TRAINING AND EDUCATION IN BIRMINGHAM

This chapter first traces the development of General Practice in Birmingham through a statistical approach, by looking at lists of doctors and the numbers in training practices. In the second half, it considers the provision and organisation of postgraduate education for General Practitioners in the West Midlands region.

4.1.1 Early History

In 1854, prior to the 1859 Medical Act, the House of Commons conducted a survey of medical provision by county through the United Kingdom (Table 4.1).¹ The census was divided into specialist university-trained physicians, druggists (who just purveyed remedies over the counter), dentists, aurists and oculists, and a list of surgeon-apothecaries who would have offered their services to the general population and whose qualifications had been awarded by the Royal College of Surgeons and the Worshipful Society of Apothecaries of London. At that time, Birmingham was not a significant town in its own right and so there was no individual census for the town. The greater portion of Birmingham was considered part of Warwickshire, with a south-eastern portion in Worcestershire. The population of Birmingham had doubled from 208,190 in 1801 to 475,839 in 1851, whereas Worcester, a county town, still only had a populace of 17,000.

¹ Parliament of the United Kingdom: House of Commons Medical Census 1854, consulted in the Archives of the Worshipful Society of Apothecaries of London.

Table 4.1: **House of Commons Census, 1854**

Area	Physicians	Apothecaries/ Surgeons	Druggists
United Kingdom	2,398	15,162	11,670
West Midlands	92	1,137	1,259
Warwickshire	31	362	418
Worcestershire	18	180	200

By 1908, Kelly's *Trade Directory* published a medical list for Birmingham of some 367 doctors, but did not differentiate general practitioners from some 40 hospital doctors who also practised from private rooms.² The term 'General Practitioner' had been introduced in 1714 by John Bellers, a Quaker social reformer whose ideas were to be promoted by Karl Marx in *Das Kapital*. In his *Essay towards the Improvement of Physick*, Bellers advocated a national system of hospitals, which were to treat the poor and act as training schools for new doctors; he referred to the Apothecaries as 'General Practitioners in Physick', a term ultimately adopted by Thomas Wakley, the founding editor of *the Lancet*, in 1823.³

The history and organised development of general practice in Birmingham dates from the introduction of Lloyd George's National Insurance Act to Parliament in 1911.⁴ The Act was not primarily a Medical Act, but ensured that medical and maternity benefits were administered by state-run insurance committees who organised contracts for medical care

² Kelly's *Directory of Birmingham, 1908*. Facsimile reproduction (Solihull: Midlands Historical Data, 2007).

³ Henry Cohen, et al. *The Training of a Doctor: Report of the Medical Curriculum Committee of the BMA*. (London: British Medical Association, 1948).

⁴ Parliament of the United Kingdom: National Insurance Act 1911, consulted in the Archives of the Worshipful Society of Apothecaries of London.

with its panel of local doctors.⁵ All employees earning less than £2 per week and aged between sixteen and seventy now had access to free medical attention, including the first bottle of medicine, through a state contributory system, and were not constrained by subscriptions to friendly societies or private insurance companies. Each general practitioner accepting service under the Act received a capitation fee for each patient on his 'panel' list, but he could also supplement his state-earned income with private practice. At the start of the Second World War in 1939, Kelly's Directory listed 431 doctors in Birmingham, 83 of whom also held substantive appointments in City Hospitals or Infirmaries.⁶ The introduction of the National Health Service following the 1946 Medical Act divided the medical profession into clearly defined primary care provided by general practitioners under contract to the new Executive Councils, and specialist secondary care supervised by the Regional Hospital Board.⁷

4.1.2 The Introduction of NHS Structure in Birmingham

The first Executive Council list of GP Principals in 1948 listed 472 general practitioners.⁸ 276 (60%) were single-handed, practising from consulting rooms in their own residences, and there were 82 partnerships (Table 4.2, overleaf). Table 4.2 also shows the development of general practice over the next sixty years following the introduction of the National Health Service. There had been a tendency for the size of partnerships to increase, encouraged by the Group Practice Allowance negotiated by the BMA in the

⁵ Goodenough Committee. *Training of Doctors: Report of the Interdepartmental Committee on Medical schools, Ministry of Health and Department of Health for Scotland*. (London: HMSO, 1944).

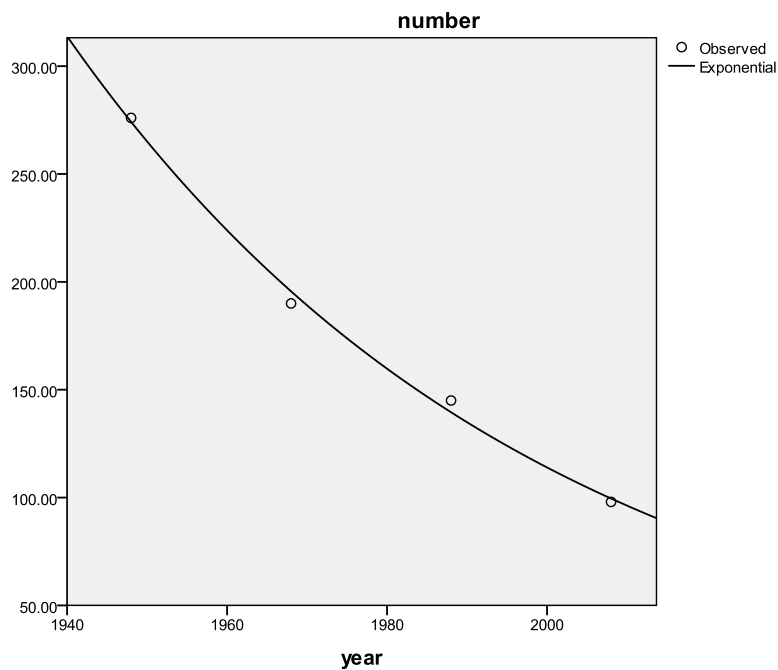
⁶ *Kelly's Directory of Birmingham, 1939*. Facsimile reproduction (Solihull: Midlands Historical Data, 2005).

⁷ John Cule, *A Doctor for the People* (London: Update Books, 1980).

⁸ Birmingham Executive Council List of GP Principals (Erdington: Sutton New Road, 1948).

‘Doctors’ Charter’ of 1965.⁹ This not only increased practice income but also stimulated practice educational meetings, often sponsored by pharmaceutical companies. At the same time, there was an acceleration in the exponential reduction in single-handed practitioners, which was being encouraged by politicians and NHS managers (Graph 4.1).

Graph 4.1: Exponential curve plot of numbers of single-handed doctors in Birmingham¹⁰



Model Summary and Parameter Estimates

Dependent Variable: number

Equation	Model Summary					Parameter Estimates	
	R Square	F	df1	df2	Sig.	Constant	b1
Exponential	.995	437.512	1	2	.002	5.261E16	-.017

The independent variable is year.

⁹ British Medical Association, *A Charter for the Family Doctor Service* (London: BMA, 1965).

¹⁰ Compiled with reference to A. Field, *Discovering Statistics Using SPSS*. Third Edition (London: Sage, 2009).

4.1.3 GP Trainee Scheme

In 1948, a new trainee scheme was introduced following the recommendation of the Goodenough Report (see Chapter 1),¹¹ and endorsed by the first Cohen Report on behalf of the British Medical Association.¹² Although Pereira Gray considered that there were no objective standards for appointment, no training in teaching methods and no real monitoring,¹³ the Birmingham Local Medical Committee (LMC) took its task seriously. Appendix 5 demonstrates the regular review of trainer applications and the frequency of rejection of practitioners considered inappropriate to employ assistants, following feedback from the trainees – particularly if there was any suggestion of exploitation of employees. In 1973, the Department of Health with the agreement of the General Medical Services Committee decided to move the responsibility of trainer selection to universities.¹⁴ The Birmingham University Board of Graduate Studies took over the newly formed Local Training Scheme Committee.

During the period of the LMC organization of trainers from the start of the National Health Service in 1949 until 1972, the numbers of trainers as the years progress, as shown in Graph 4.2. Using regression, there is a model fit of R squared = 0.937 (very high indeed) with a p value of less than 0.001.

¹¹ Goodenough Committee. *Training of Doctors*.

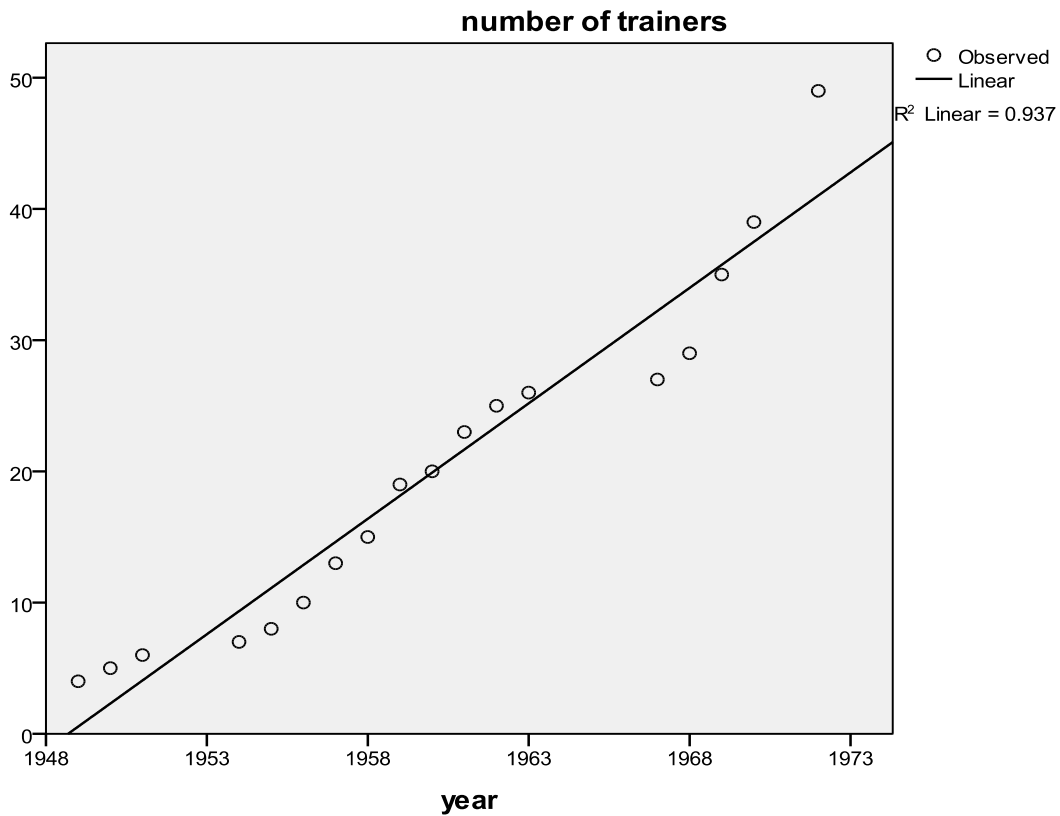
¹² Cohen, et al. *The Training of a Doctor*.

¹³ D. J. Pereira Gray, *Training for General Practice* (Plymouth: MacDonald and Evans, 1982). p. 68.

¹⁴ Department of Health and Social Security and the Welsh Office. Appointment of Regional Adviser in General Practice. Circular HM (72) 75. (London: DHSS, 1972).

Graph 4.2

Graph of numbers of trainers by year - from 1949 to 1972 - appointed by the Birmingham Local Medical Committee



4.1.4 GP Training Practices

The overall number of general practitioners in Birmingham rose steadily from 1948 to 1988, and then fell for the 1998 cohort and fell again further in 2008. This can be seen in Chart 4.1. Meanwhile, the number of GP Practices in Birmingham likewise rose steadily from 1948 to 1968, but had fallen significantly by 1988 and again by 2008; this is illustrated by Charts 4.1 and 4.2.

Chart 4.1: **Birmingham General Practitioners, 1948-2008**

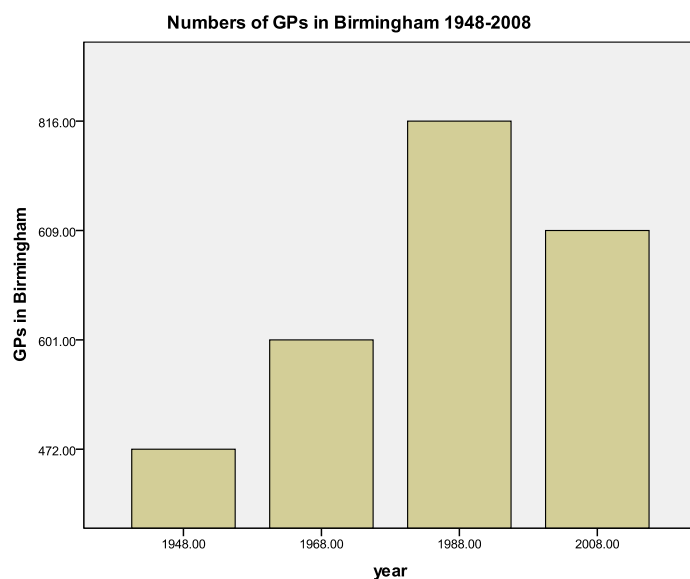
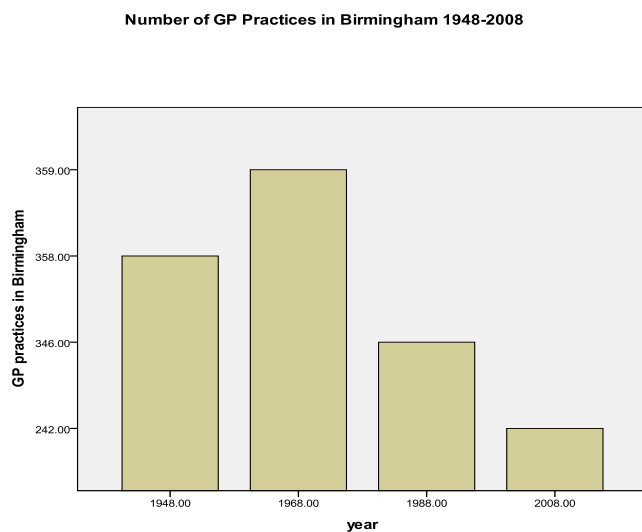


Chart 4.2: **GP Practices in Birmingham, 1948-2008**



Neither of these movements represents a linear regression (as in the case of the GP training practices and GP trainers) so no statistical tests were carried out on this set of data. The full statistical summary of the variations in numbers of the sizes of Birmingham general practices and individual general practitioners is displayed in Table 4.2.

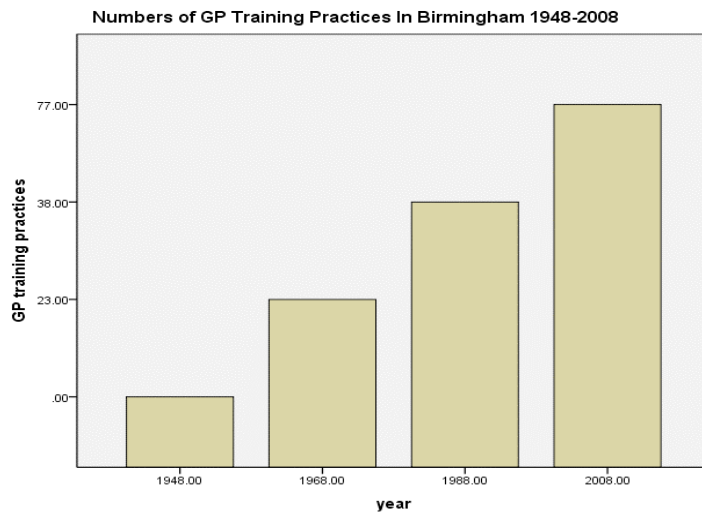
Table 4.2: **Birmingham Practices**

	1948		1968		1988		2008	
Principals		%		%		%		%
Single	276	60	190	31.5	145	18	98	16
Pairs	125	27	167	28	179	22	96	16
Three	45	10	151	25	144	18	81	13
Four	16	3	64	10.5	124	15	108	18
Five			17	3	110	13.5	100	15
Six			0		85	10	54	9
Seven			7	1	28	3	21	3.5
Eight			5	1	1	1	32	5
Nine							9	1.5
Ten							10	1.5
TOTAL	472		601		816		609	
Training practices						33		82
Trainers						46		184
Trainers	1954	23				55		
RCGP founder members								
B'ham								43
West Mids (inc. B'ham)								111
Practices								
Single	276	77	190	53	145	42	98	40
Pairs	59	16.5	89	25	80	23	48	20
Three	18	5	55	15	48	14	27	11
Four	5	1.5	19	5	31	9	27	11
Five			4	1	22	6	20	8
Six			0		15	4	9	4
Seven			1		4	1	7	3
Eight			1		1		4	1.5
Nine							1	0.5
Ten							1	0.5
TOTAL	358		359		346		242	
Training practices						35		82

The number of GP training practices in Birmingham has risen steadily from 1948 to 2008.

This is shown in Chart 4.3:

Chart 4.3: GP Training Practices in Birmingham, 1948-2008

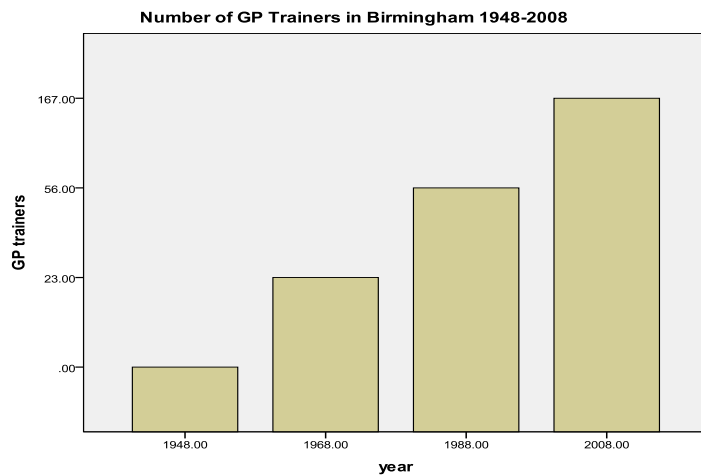


Looking at the trend statistically with the assistance of the statistical programme SPSS version 18, using regression analysis, there is a very close fit to a linear regression line for the four values. The goodness of fit has a correlation of 0.981, an extremely high value (the maximum being 1.00).

4.1.5 GP Trainers

Chart 4.4 shows that the number of GP Trainers in Birmingham has risen steadily from 1948 to 2008:

Chart 4.4: GP Trainers in Birmingham, 1948-2008



Here too regression analysis of the trend reveals a very close fit to a linear regression line for the four values. The goodness of fit has a correlation of 0.932 – once again, an extremely high value.

Summary

There is a very high correlation of GP Training Practices with the number of GP Trainers over the four cohorts. The correlation coefficient is 0.979 (extremely high) and is statistically significant with a p value of 0.021. With all GP Practices, there is a negative correlation with a value of minus 0.909, confirming that the numbers of GP Training Practices rose steadily despite fluctuation in the total number of Practices. This result was statistically significant with a p value of 0.026. With General Practitioners, the correlation was much lower, but positive, with a value of 0.401.

There is a very high correlation of the numbers of GP Trainers with those of GP Training Practices, as seen above. With GP Practices, there is a negative correlation with a value of minus 0.979, confirming that the numbers of GP Trainers rose steadily, while the number of practices as a whole fell between 1948 and 2008. This result was statistically

significant with a p value of 0.026. With General Practitioners, the correlation was again much lower, but likewise positive, with a value of 0.240.

It can therefore be concluded that there has been a steady increase in the number of GP Training Practices, and in the number of GP Trainers, in Birmingham over the 40 years from 1948 to 2008. This has not been mirrored in the numbers of GPs as a whole, nor in the numbers of GP practices. In fact it may be said that the numbers of GP Trainers and GP Training Practices rose despite the other changes to GP numbers over the four cohorts and forty years covered by this study. Taken together, these statistics would seem to indicate a growing acknowledgement of the importance of training, even as numbers of GPs and practices have fallen. The expanding ratio of Trainers and Training Practices to overall numbers of practices and practitioners suggests that opportunities for exposure to educational activities and initiatives are likely to have increased over the period in question – a conclusion borne out by experience, as well as in theory.

4.2 Postgraduate Medical Education in Birmingham

Medical Education in Birmingham centres around the University of Birmingham (and its precursors) and the provision made by the National Health Service. General Practice as a specific topic in emerged comparatively late: the department of General Practice at the University of Birmingham was set up in 1975, and specialist NHS training was first offered in 1976.

4.2.1 University of Birmingham

The history of the University of Birmingham has been detailed by Ives, Drummond and Schwarz in *The First Civic University: Birmingham, 1880-1980 - An Introductory*

History, which includes information on the Medical School.¹⁵ A fuller account of the Medical School is given in Reinarz's history of the Birmingham Teaching Hospitals.¹⁶ Both indicate that formal medical education in Birmingham started in the eighteenth century, when individual doctors such as John Ash, Thomas Tomlinson, a general surgeon, and William Sands Cox, who initiated the teaching of anatomy and medicine. Dr John Ash, a native of Coventry and an Oxford graduate, qualified with an MD (Oxon), FRCP and FRS, a distinguished physician, was responsible for the founding of the Birmingham General Hospital in 1779, which is still functioning as a teaching hospital. In 1816, the first specialist in obstetric medicine in Birmingham was appointed.¹⁷ This was Dr John Ingleby, who instituted individual lectures suitable for both a postgraduate audience and undergraduates from the other two early medical schools in Birmingham, the Sydenham College and Queen's College, which became been incorporated into the Mason Science College in 1884, originally started in 1880 by Josiah Mason from Kidderminster.¹⁸ In 1900 Mason University College became the new University of Birmingham with the fusion of the current academic staff and was granted the power to grant and validate its own medical qualifications and degrees, whereas previously Birmingham medical students were enrolled as external students of London University, like other provincial students, and had to take the examinations of London University, the Licentiate of Medicine and Surgery of the Society of Apothecaries of London, or the conjoint examinations of the Royal Colleges of Surgeons or Physicians of London. The new University then provided specialist clinical teaching at the existing Birmingham

¹⁵ Eric Ives, Diane K. Drummond and Leonard Schwarz, *The First Civic University: Birmingham, 1880-1980 - An Introductory History*. (Birmingham: University of Birmingham Press, 2009).

¹⁶ Jonathan Reinarz, *Healthcare in Birmingham: A History of the Birmingham Teaching Hospitals, 1779-1939*. (Woodbridge: Boydell & Brewer, 2009).

¹⁷ John Thackray Bunce, *A History of the Birmingham General Hospital and The Music Festivals*. (Birmingham: Cornish Bros., 1873), reprinted by Kessinger Publishing.

¹⁸ Birmingham Regional Hospital Board, *Birmingham Regional Hospital Board 1947-1966* (Birmingham, National Health Service, 1966), p. 26.

General Hospital and the Queen's Hospital. The new Regional Hospital Board introduced by the National Health Service in 1948 was concerned to obviate hospital admission where possible and to shorten hospital stays and so communications between family doctors and hospital specialists became detrimental and limited and the injurious relations needed to be improved.

4.2.2 The Start of Postgraduate Education at Queen's College

Dr John Ingleby was requested to lecture on midwifery at Sands Cox school in 1828, and began a series of postgraduate lectures in the winter of 1840.¹⁹ Ingleby died of gout in 1845 at the age of 52, and left £2000 in his will to continue the postgraduate lectures on advancement of obstetric medicine and surgery and the diseases of women and children. Samuel Berry, the Professor of Midwifery and Diseases of Women at Queen's College in Birmingham for forty years, was the founder of the Children's and Womens' Hospital, and then became the Consulting Surgeon to the Birmingham and Midland Free Hospital for Children. He gave the first Ingleby Lecture in 1877, starting with his reminiscences and eulogy of Ingleby before a historical talk on 'Some advances made in conservative surgery during the last half century'.²⁰ The new University of Birmingham continued to organise the series of Ingleby lectures, which were open to both students and doctors but were discontinued during the Second World War.²¹ Lawson Tait, a gynaecological surgeon, one of the three chief surgeons of Birmingham Womens' Hospital, gave an address in 1885. Occasionally no students attended, as was experienced by J. T. J.

¹⁹ Chris Upton, *A History of Birmingham* (Chichester: Phillimore, 1993), p. 162.

²⁰ The University of Birmingham Faculty of Medicine Archive Particulars of Postgraduate Lectures and Demonstrations, 1877-1928 (contains particulars of Ingleby Lectures, Lectureship in Psychotherapy, particulars of postgraduate courses and particulars of clinical postgraduate courses)

²¹ The University of Birmingham Faculty of Medicine Archive: Particulars of Postgraduate Lectures and Demonstrations, 1877-1928.

Morrison, the lecturer on Forensic Medicine, on 9 November 1911. Between December 1914 and January 1915, ten lectures were cancelled;²² in 1918-19, C. E. Purslow, the chair of Midwifery, gave twenty lectures, whilst John Hewetson, the assistant to chair of midwifery, gave 49 lectures. Dental surgery lectures were given on Founder's Day in 1920, and Radiology began in April 1925 (as four lectures in spring). In March 1926, the lectureship was renamed the William Withering Memorial Lectureship.

A lectureship in psychotherapy was founded in 1919 by Sir Charles Hyde, who left £2000 for a series of ten lectures in the summer session, for which the lecturer would be paid £100. Open to the medical profession and students, the first lecture was given in 1920 by William McDougall, Reader in Mental Philosophy at the University of Oxford, on 'Principles of Psychotherapy'. In 1922, the title 'lectureship in psychotherapy' changed to 'lectureship in morbid psychology', and the post was offered to Frederick Mott for three years, then extended for another year. In March 1926, this lectureship too was renamed the William Withering Memorial Lectureship.

In April 1926, Dr Hilda Lloyd (née Shufflebotham) took over as assistant to midwifery and diseases of women (renamed practical midwifery and gynaecology), and subsequently became Professor of Obstetrics at the Queen Elizabeth Hospital, before being elected the first female President of the Royal College of Obstetricians and Gynaecologists in 1949.²³ The 1926 lecture was cancelled owing to difficulties of transport caused by the General Strike. In 1927, George Still, a paediatrician from Great Ormond Street was able to give his paper on childhood diseases, and an audience of 1250 was expected. Half of those who attended were students, and the archives further reveal

²² The University of Birmingham Faculty of Medicine Archive: Professors' attendance book, Faculty of Medicine, 1909-1928.

²³ See Harold Ellis, "Dame Hilda Lloyd: First President of the Royal College of Obstetricians and Gynaecology" *Journal of Perioperative Practice* (1999).

that the students' routine lectures were cancelled at 4 p.m. on the day of the Ingleby lecture in 1929. Up to two hundred students would attend the lectures in the 1930s, with 250 attending in 1938 to hear Leonard Colebrook of Queen Charlotte's Hospital talk on puerperal and other infections caused by haemolytic streptococci.²⁴ There were no lectures in 1941 or 1942.

4.2.3 Medical Schools

Like all medical schools, Birmingham's did not concern itself with postgraduate education for general practitioners until the implementation of the recommendations of the Todd Report of 1976.²⁵ In 1971, St Thomas' Medical School set up Lambeth Towers Group Practice, whose members held teaching appointments at the Medical School and honorary appointments on the hospital staff. The establishment was designated a General Practice Teaching Unit, and part of the School's Department of Community Medicine and Dr Michael Courtenay, a general practitioner from Battersea, was appointed to set up a series of weekly informal discussion sessions at Lambeth Towers for local young general practitioners in 1970 before the formal St. Thomas' and Guys' Vocational Training Scheme was instituted in 1972; the first GP trainee appointed to the scheme was Dr Charles Zuckerman, who moved back to Birmingham as a principal in general practice in the Northfield Health Centre in 1976 and became secretary of the Birmingham Local Medical Committee in 1978. Although David Morrell was awarded the first chair in General Practice at St Thomas' in 1974, he could not persuade enough local practices to allow all the clinical students at St. Thomas' Medical School to undergo experience of general practice, and the only postgraduate educational activities were annual alumni

²⁴ The University of Birmingham Faculty of Medicine Archive: Professors' attendance book, Faculty of Medicine, 1909-1928.

²⁵ Royal Commission on Medical Education, *Report 1965-68* (London: HMSO, 1968). ["Todd Report"]

weekends to which old students were invited back to hear of the advances of medicine from distinguished specialists.²⁶ Medical students were expected to write reports on their experiences and the 1970 prize winner of “Semper Dowland: semper dolens” was Roger Neighbour, who was to become the President of the Royal College of General Practitioners.

4.2.4 The Department of General Practice at the University of Birmingham

The formal Department of General Practice at the University of Birmingham was started in 1975, following a grant from the Wolfson Foundation, in response to the recommendations of the Todd Report of 1968. The Department originally was allowed to use an old empty converted Nissen hut by the basement of the Queen Elizabeth Hospital.²⁷ Following vociferous support from Birmingham Local Medical Committee, Michael Drury was elected to a chair of General Practice by Birmingham University with an official contract in 1982.²⁸ No curriculum time had been permitted for general practice teaching at Birmingham University Medical School until 1969, when the South African Professor Raymond Hoffenberg, the William Withering Professor of Medicine, encouraged students during their final year of medicine to undertake an elective voluntary period to observe general practice, organised by the Midland Faculty of the Royal College of General Practitioners.²⁹ The students were offered a week’s attachment to local practices to observe GPs at work and then discuss their experiences with two part-time tutors, Drs Michael Drury and Robin Hull, in a special session at the conclusion,

²⁶ E. M. McInnes and J. M. T. Ford, *St. Thomas’ Hospital: A History*. (London: Special Trustees for St. Thomas’ Hospital, 1963). Reprinted with additional chapters 1990.

²⁷ Archive minutes of Birmingham Local Medical Committee.

²⁸ Robin Hull, *Just a GP: Biography of Professor Sir Michael Drury* (Oxford: Radcliffe, 1993), 83.

²⁹ Archive minutes of Birmingham Local Medical Committee.

which concentrated on the outcomes of the consultations in which the students had participated.

At this time, there was an increasing interest amongst medical educationalists in the psychodynamics of the consultation in general practice and the process of the doctor-patient relationship, which had been stimulated by a Hungarian psychologist, Michael Balint, in his *The Doctor, His Patient and The Illness*, published in 1957.³⁰ In 1966, the concept of Transactional Analysis was popularised by Eric Berne's paperback *Games People Play*,³¹ and, in the same year, Patrick Byrne and Barrie Long analysed doctors' verbal behaviour in over 2000 audio recordings of general practice consultations in *Doctors Talking to Patients*.³² In 1972, a working party of the Royal College of General Practitioners agreed on the knowledge, skills and attitudes essential for general practice, and the resulting document *The Future General Practitioner: Learning and Teaching* was accepted as a fundamental curriculum for general practice trainees and was used nationally by GP trainers as an essential study for candidates taking the MRCGP examination, and every GP trainer in Birmingham was expected to have a copy in the practice library.³³

Although Drs Drury and Hull were the first official Wolfson Tutors in General Practice, they considered themselves full-time general practitioners by profession, undertaking in their own time, with unpaid teaching, only aided by a full-time secretary and some volunteer local general practitioners, who offered some teaching sessions. The official

³⁰ M. Balint, *The Doctor, His Patient and The Illness* (London: Tavistock, 1957).

³¹ Eric Berne, *Games People Play* (London: Andre Deutsch, 1966).

³² P. S. Byrne and B. E. L. Long, *Doctors Talking to Patients* (London: HMSO, 1976).

³³ Royal College of General Practitioners, *The Future General Practitioner: Learning and Teaching* (London: British Medical Journal, 1972).

tutors introduced another early educational initiative, pioneered in 1976, in which first-year students would observe families identified by local practitioners in the city, with the idea that students early in their careers would be attached to families so that they could experience the effects of illness or pregnancy on a family and understand the role of the general practitioner. The Family Attachment Scheme was to become a major and mandatory part of the medical curriculum.³⁴

4.2.5 Regional General Practice Education Committee

The Local Training Scheme Committee, with representatives from the Postgraduate Department of the University of Birmingham Medical School, the Regional Authority and the Local Medical Committee, took over the selection and appointment of GP trainers from the General and Finance General Purposes Committee of the Birmingham Local Medical Committee. This continued until the Vocational Training Act of November 1975 gave the authority to the new Regional Postgraduate General Practice Education Committee, chaired by the new Regional Adviser in General Practice.³⁵

Even at this time, the general practitioner was viewed by many specialist colleagues as an inferior doctor who, in the words of Lord Moran, ‘had fallen off the ladder’³⁶ and acted as a small businessman providing the inevitable prescription for trivial complaints.

Continuing education was not considered of any great importance, apart from the occasional hospital meeting where practitioners’ learned consultant colleagues could inform them of the scientific advances which could be offered to their patients with ‘proper’ illnesses. As previously noted in Chapter 1, the Steering Committee of the

³⁴ Archive minutes of Birmingham Local Medical Committee.

³⁵ National Health Service England and Wales, *The National Health Service (vocational training) regulations 1979. Statutory Instrument, 1979 No 1622. (H79-683)* (London: HMSO, 1979).

³⁶ C. Moran, Evidence (Q.1323), *Royal Commission on Doctors’ and Dentists’ Remuneration 1957-1960: Report Cmnd. 939* (London: HMSO, 1960).

fledgling College of General Practitioners summed up the state of educational inertia which prevailed until 1951 as follows:

It was once true that the practice of medicine did not greatly change between qualification and retirement: but nothing could be further from the truth now.³⁷

In 1963, the Birmingham Children's Hospital instituted regular lunchtime meetings for general practitioners, and Selly Oak followed suit in 1967. In 1976, Birmingham General Hospital decided to use the facilities of the Birmingham Medical Institute (see Chapter 3) for GP meetings during the day; the Institute tended to hold evening symposia on specialist topics such as the programme of the Midland Medico-legal Society or annual lectures from celebrated speakers invited by the Midland Medical Society. Even then, the meetings arranged by Mr Norman Dorricott, a consultant general surgeon, tended to be didactic lectures given by his specialist colleagues. The Royal College of General Practitioners encouraged the appointment of Honorary GP tutors to oversee such GP meetings until the Regional GP Educational Committee found funds in 1980 to remunerate these GP tutors with an honorarium of £500 per annum, and dignify them with equal status to the VTS Course Organisers.

4.2.6 Postgraduate General Practice Teaching at Birmingham University Medical School

The first initiative between the University of Birmingham Medical School and the Regional Postgraduate GP Education Committee was the introduction in 1975 of a taught Masters Degree (MMedSci) organised jointly by Dr David Wall, then an Associate Adviser responsible for the Black Country subregion, and Dr Richard Hobbs, the first Senior Lecturer in the Department of General Practice, who was to succeed Michael

³⁷ London College of General Practitioners, "Report of the General Practice Steering Committee" *British Medical Journal* 2 (1952): 1321-1328.

Drury to the Chair of General Practice and subsequently became head of the Department of General Practice and Primary Care at Birmingham University. The MMedSci course was designed to provide higher professional training for individual GP registrars who, having completed their training, wished to advance their careers with an interest in education and research. Financial stringency has halted this as a regular course. individuals can still apply for postgraduate qualifications at the School of Medicine, which are available across a diverse range of subjects. Most of these programmes last for one year of full-time study or two years of part-time study, leading to Masters Degrees, Postgraduate Diplomas or Postgraduate Certificates.

4.2.7 Interactive Skills Unit

In 1994, Drs John Skelton, Connie Wiskin, David Fitzmaurice and Phil Hammond decided to set up an Interactive Skills Unit (ISU) to provide support for undergraduate communication skills at the Medical School; this Unit had been originally funded by a grant of £300,000 from the Siegmund Warburg Voluntary Settlement in 1991, and received a further £675,000 in 1994, which funded Dr Skelton's post.³⁸ By this time, the Medical School had accepted the value of the Unit and had paid for the cost of teaching the undergraduates. In 1998, Summative Assessment was introduced as the mandatory pass/fail entry examination into general practice, and in this year 12 out of 64 GP registrars failed the section involving videotaped consultations. As a result of this, Steve Field, the current Director of Postgraduate General Practice Education, offered a contract to the ISU to provide remedial training for Summative Assessment failures.³⁹ Despite the contract to ISU and the representation of the Professors of General Practice at

³⁸ J. R. Skelton, *Language and Clinical Communication: This Bright Babylon* (Abingdon: Radcliffe, 2008).

³⁹ S. Field, "Newsletter: the Video Component" *West Midlands Journal of Primary Care* 4 (1998): 10.

Birmingham and the Universities of Keele and Warwick on the West Midlands Regional Postgraduate GP Education Committee, the undergraduate Department has no other formal responsibility in relation to current postgraduate training for general practice.

4.2.8 NHS GP Vocational Training

During the twentieth century, the initiative to impart knowledge and skills to potential general practitioners has been the enthusiasm and personal resolve of individual practitioners in addition to their full-time medical commitments, until the 1968 Todd Report stimulated vocational training for general practice and the National Health Service provided recompense for GP teachers to take time away from their practices. Although Dr David Scott, a general practitioner from Coventry, was appointed in 1972 as the first Regional Advisor in Postgraduate Education and received a salaried contract, the appointment by the Regional Health Authority and the expectations of the post were the results of the personal efforts of Dr Robin Steel, a general practitioner from Worcester, who wrote the job description following his experiences setting up a ten-week 'Orientation towards General Practice' course first held in 1970: The original Promotional Circular for Orientation towards General Practice, 1970 (copied in Appendix 1) shows the aims and objectives of the course and the early situation of the need for postgraduate education for the potential general practitioners who had had little experience of primary care as pre-clinical students. The programme for 1970 (Appendix 2) demonstrates the need to explain and understand the administrative functions necessary for the future practitioners as well as the clinical aspects of primary care which were not covered in the medical school curriculum.

This programme, the first formal postgraduate course for new entrants into general practice in the West Midlands, was organised in conjunction with the Birmingham Medical School Board of Graduate Studies and formed the blueprint for the half-day release course for the future schemes in Birmingham, as shown by Central Birmingham Vocational Scheme programme of 1981, eleven years later (presented in Appendix 3). Dr Steel's initiative was continued the following year at the University by a small working party drawn from Local Medical Committees, the Birmingham Regional Board General Practitioner Liaison Committee, and the Midland Faculty of the Royal College of General Practitioners. This working party became the official Regional Postgraduate General Practice Education Committee, under the chairmanship of David Scott, acknowledged by the University and the Department of Health as the body responsible for organising vocational training for General Practice and appointing General Practice trainers and trainees until the NHS reorganisation of the Postgraduate Deaneries in 2008, when the new Strategic Health Authority replaced Education Committees with Postgraduate Schools of hospital specialities and of general practice (see Chapter 5).⁴⁰

4.2.9 Half-day Release Courses

Following the success of Robin Steel's Orientation Course, the Regional General Practice Education Committee decided in 1972 that there should be a regular weekly half-day release course available for all new GP trainees within the West Midlands Region. These trainees came to the new Birmingham Maternity Hospital from as far as Rugby, Hereford and Madeley in Shropshire. As a result of the numbers, two courses were organised: the first was for new GP trainees who were starting their experience in general practice immediately after their two pre-registration house posts, led by Dr Alistair Ross, a GP

⁴⁰ Hull, *Just a GP*, p.118.

based in the urban area of Stoke on Trent and Dr Tony Williams, a GP in rural Cleobury Mortimer; the second was for those who had acquired two more years' experience post registration as senior house officers, and was run by Dr Robin Steel from Worcester, Dr David Clegg from Tamworth and Dr George Thorpe, from Solihull. The growing demand for general practice training during the 1960s and 1970s meant that half-day release courses were eventually set up around the region, with local courses in Hereford and Worcester, Coventry and Warwick, Shrewsbury and Burton on Trent.

With the increase in GP training practices throughout the West Midlands Region, which covered a geographical area equivalent to the whole of Scotland, the Regional Adviser in General Practice was no longer able to supervise all the training practices and the thirty-four vocational training schemes in the region. In consequence, Dr Scott and the Regional GP Postgraduate Education Committee decided to appoint Area Advisers assisted by local Area General Practice Education Committees (AGPECs) to take on the responsibility for running local schemes. Four vocational schemes were needed to provide sufficient opportunities for general practice trainees in Birmingham itself. These were organised by the District Health Authorities, based around the district general hospitals with the opportunity for specialist experience in specialist hospitals, as detailed in Table 4.3:

Table 4.3: Birmingham Vocational Training Schemes 1978-2011

Birmingham District Health Authorities	<i>Hospitals with GP VTS posts</i>
Central Birmingham DHA/VTS	<i>Queen Elizabeth Maternity / Birmingham Women's Hospital Birmingham Childrens Hospital / Midland Nerve Hospital / Birmingham General Hospital (A&E)</i>
East Birmingham DHA/VTS	<i>East B'ham 'Heartlands' Hospital (A&E) / Marston Green Maternity Hospital / Yardley Green Geriatric Hospital / Solihull General Hospital Maternity and Children's Department</i>

North Birmingham DHA/VTS	<i>Good Hope Hospital (A&E) and Maternity and Children's Department</i>
South Birmingham DHA/ VTS	<i>Selly Oak (A&E) / Moseley Hall Geriatric Hospital / John Connolly and Hollymoor Psychiatric Hospitals</i>
West Birmingham DHA/VTS	<i>Dudley Road 'City' Hospital / St.Chad's/All Saints/Summerfield Geriatric Hospitals</i>

The curriculum of these half-day release courses tended to concentrate on learning about services which were relevant to GP consultations but which trainees would not have experienced as house officers in hospital practice. These included dentistry, physiotherapy, acupuncture and hypnotherapy; the advice and services offered by the local pharmacy; the problem solving of patient's primary presentations and symptoms (such as fits/faints, back pain, headaches, sports injuries, dizziness, venereology and sexual problems); the management of open access pathology results such as haematology and chemistry. The half-day release also enabled the trainees to visit other primary care organisations, such as the Deputising Services to understand out-of-hours care, Cadbury's at Bournville to view factory medicine, and the Family Practitioner Committee offices to learn about the National Health Service administration. The trainees were taken to different practices in various areas of the city to be shown varied types of premises and different methods of practice management. The programme for the VTS half-day release course in 1981 is given in Appendix 3.

The course organisers regularly updated the half-day release programmes to introduce sessions to cover newly identified contemporary medical issues which had become topical after the trainees had finished their training at medical school. Table 4.4 shows the emphasis on current clinical topics introduced in the Central Birmingham Vocational training scheme course between 1979 and 2000:

Table 4.4: Central Birmingham Vocational Training Scheme Course Topics

1979	Consultation (“Doctors Talking to Patients” by Byrne & Long / “Transactional Analysis” by Eric Berne) ⁴¹
1981	HIV/AIDS
1983	Hormone Replacement Therapy
1985	Evidence Based Medicine: “Clinical Epidemiology” by Sackett ⁴²
1987	Inner Consultation (Neighbour) ⁴³
1989	Helicobacter Eradication
1993	Hypertension (BHS working party guidelines) ⁴⁴
1994	Hyperlipidaemia (SSSS trial) ⁴⁵
2000	Angina (National Service Framework) ⁴⁶

The current programme of the South Birmingham Winter Session of 2011 in Appendix 4 demonstrates the emphasis on small group interrelationships and the consultation in general practice, reminiscent of Michael Courtenay’s informal sessions at St Thomas’, thirty years ago, which is surprising, since consultation skills had become a priority in the undergraduate curriculum in Birmingham, with the appointment of Dr Kevin Browne as a Senior Lecturer in Communication Skills in 1986, although Robin Hull reported that the consultation course was not well received by medical students.⁴⁷

4.2.10 Appointment of GP Trainers

The Joint Committee on Postgraduate Training for General Practice (JCPTGP) devolved to each Deanery the responsibility of inspecting and selecting training practices. Every Deanery had its Regional General Practice Education Committee (RGPEC) set up by and

⁴¹ Berne, *Games People Play*; Byrne and Long, *Doctors Talking to Patients*.

⁴² D. Sackett, R. B. Haynes, G. Guyatt, P. Tugwell, *Clinical Epidemiology: a Basic Science for Clinical Medicine* (Boston: Little, Brown, 1985).

⁴³ R. H. Neighbour, *The Inner Consultation* (Lancaster: MTP, 1987).

⁴⁴ Guidelines Subcommittee of the WHO/ISH Mild Hypertension Liaison Committee. *Hypertension* 22.3 (1993): 392-403.

⁴⁵ Randomised trial of cholesterol lowering in 444 patients with coronary heart disease; the Scandinavian Simvastatin Survival Study (4S) *Lancet* 334 (1994): 1383-9.

⁴⁶ Department of Health (March 6th 2000) *Coronary heart disease: national service framework for coronary heart disease - modern standards and service models*.

⁴⁷ Hull, *Just a GP*, p. 118

accountable to the postgraduate Dean to select trainers for general practice training and recommend to the JCPTGP that they be approved for general practice training. The RGPEC represents both service and education interests and is also responsible for selecting and recommending hospital posts for general practice training. The RGPEC could establish its own criteria for the selection of trainers to reflect local circumstances and interest, but these must be congruent with the JCPTGP recommendations for the selection and reselection of training practices and training practices must meet the JCPTGP's list of minimum criteria, which are divided into three sections:⁴⁸

1. The Trainer as Doctor (based on RCGP/GPC Good Medical Practice);
2. The Trainer as Teacher;
3. The Training Practice

The West Midlands Deanery was divided into the areas of Birmingham and Solihull, Coventry and Warwick, Hereford and Worcestershire and Staffordshire and Shropshire in 1970. These had already been developed by the West Midlands Regional Health Authority as autonomous Public Health Areas. The function of the regional committee was to ratify the area recommendations, although it could also offer an appeal process. Since 1975, the JCPTGP has visited Deaneries every three years as part of its programme of accreditation visits to training schemes to monitor the implementation of national guidelines. In addition to fulfilling the criteria established by the JCPTGP, all new trainer applicants in the West Midlands Deanery must have attended and satisfactorily completed one of its approved preparatory courses on the training structure and a foundation course on principles of education and teaching skills in use in the West Midlands. Guidance is provided as to the type and extent of evidence which trainers and practices might be expected to produce in order to satisfy a visiting team with the authority to verify their

⁴⁸ JCPTGP, *A Guide to Accreditation Visits* (London, 2001), p. 10.

performance and capabilities as both doctors and trainers. For example, the JCPTGP recommendations for the selection and reselection of training practices state that the GP trainer is expected to demonstrate:⁴⁹

- a high standard of professional and personal values in relation to patient care
- appropriate availability and accessibility to patients
- a high standard of clinical competence
- the ability to communicate effectively
- commitment to personal, professional development as a clinician
- commitment to audit and peer review
- sensitivity to the personal needs and feelings of colleagues

The aim was to ensure that potential trainers had appropriate educational ability and could demonstrate that their practice was satisfactorily organised with adequate premises and patient care services to train a trainee.

⁴⁹ JCPTGP, *A Guide to Accreditation Visits*, p. 68.

CHAPTER 5: BIRMINGHAM REGIONAL HOSPITAL BOARD AND HEALTH AUTHORITIES 1946-2010

A significant part in the promotion and regulation of medical education for general practice in the West Midlands since the inception of the NHS has been taken by the Birmingham Regional Hospital Board and its successor, the West Midlands Regional Health Authority. Along with the dedicated Postgraduate Deanery GP Unit, these organisations – or perhaps more accurately, individuals operating under the auspices of these bodies – pioneered some of the initial moves in the establishment of an active culture of training and education among general practitioners at a local level.

5.1 The Birmingham Regional Hospital Board

The Birmingham Regional Hospital Board was constituted under the National Health Service Act of 1946 by the Minister of Health to administer, on his behalf, the hospital and specialist services in the area of “the administrative counties of Hereford, Salop, Stafford, Warwick and Worcester, and the county boroughs of Birmingham, Burton-on-Trent, Coventry, Dudley, Smethwick, Stoke-on-Trent, Walsall, West Bromwich, Wolverhampton and Worcester”.¹ Excepted from the terms of this provision were a number of hospitals attached to the University of Birmingham for teaching purposes, which remained under administrative control of a separate board of governors. The Regional Hospital Board had the responsibility for funding study leave and attendance at clinical meetings, courses and conferences (expenses were normally only paid, however, when the applicant was actively participating in presenting a paper or acting as a

¹ Birmingham Regional Hospital Board, *Birmingham Regional Hospital Board 1947-1966* (Birmingham: NHS, 1966), p. 1.

chairman or convener).² In 1963, the Board introduced a special scheme whereby senior medical staff and senior registrars could apply for a special grant of £20 during a period of two years, and the number of applications rose from 91 in 1963/4 to 260 in 1965/6. Study leave for junior staff was delegated to the hospital management boards.³

The Board took the initiative to sponsor Postgraduate Centres, the first of which was built in Stoke, which required £100,000 to be raised by personal covenants and voluntary subscription.⁴ Smaller centres were then opened at Dudley Road (City), Selly Oak, and East Birmingham (Heartlands) Hospitals, and later at Good Hope Hospital in Sutton Coldfield. It was not until 1981 that the Queen Elizabeth Postgraduate Centre was built, with a grant from the Hospital's Special Trustees' Fund. An independent steering committee, composed of both Queen Elizabeth consultants and local general practitioners involved in postgraduate education (including Drs David Wall and Guy Houghton, the Vocational Training Scheme Course Organisers for Central Birmingham), was instituted with Richard Hobbs as secretary, then Senior Lecturer in General Practice at Birmingham University, to develop both the building structure and the administrative infrastructure. The previous year had seen the foundation of the Metchley Park Medical Society (see Chapter 3) as an educational charitable institution under the chairmanship of Tony Barnes FRCS.

The Board also left the responsibility for initiating and co-ordinating a continuing and active programme of postgraduate medical education to the Director of Postgraduate

² Birmingham Regional Hospital Board, *Birmingham Regional Hospital Board 1947-1966*, p. 105.

³ Birmingham Regional Hospital Board, *Birmingham Regional Hospital Board 1947-1966*, pp. 105-6.

⁴ Birmingham Regional Hospital Board, *Birmingham Regional Hospital Board 1947-1966*, p. 107.

Studies at the University of Birmingham. In 1962, however, the Board authorised some further appointments to assist the Director, providing four Directors of Postgraduate Education, nine clinical tutors in hospital groups, sixteen clinical tutors in Psychiatry, and one clinical tutor appointed by the Royal College of Surgeons. These endeavours were overseen by the University Board of Graduate Studies, which included representatives of the University, the Teaching Hospital, and the Regional Hospital Board. Although it was the policy of the Board to achieve a close working relationship with general practitioners, the Board's only commitments to GP education were to provide sessions for GPs to work as clinical assistants (which required the services of 800 or one in four of all practitioners in the region) and to encourage continuing education in those medical centres associated with district general hospitals where a general practitioner could participate in clinical demonstrations, meetings and lectures.

At this time, there was no structure for educational appointments for postgraduate activities. Although a training grant had been introduced for general practitioners authorised to train GP trainees in 1976, this was paid to practices by the Family Practitioner Committee out of the total General Practitioner Services Fund. There was no educational budget as such, and the practices of the first GP Vocational Training Course Organisers received the same sum, with the Course Organiser classified as a GP trainer without a trainee in the practice. On the appointment of the Regional GP Adviser and the Assistant Advisers, the Regional Health Authority supplied those appointed with part-time NHS Consultant contracts as Public Health Specialists, and the University of Birmingham took the initiative of recognising Course Organisers as Honorary University Tutors with Staff House privileges, which emphasised their academic role. The Regional Adviser, assisted by the Regional Postgraduate General Practice Education Committee,

was responsible for the organisation of postgraduate education for general practitioners, and was accountable to the Director of Graduate Studies at the University of Birmingham Medical School in academic matters, and to the Regional Board in the financial sphere. The Regional Postgraduate General Practice Education Committee had a tripartite structure of GP educators, representatives of the Local Medical Committees, the Midland Faculty of the Royal College of General Practitioners, and some trainees. Other Regions directed their resources towards setting up offices and courses within a local university campus, but the West Midlands objected to 40% university overheads, and so postgraduate general practice education was kept within NHS premises and secretarial services were under the control of the Regional Authority. Initially, the Regional Adviser (Dr David Scott) was provided with a part-time secretary and an office in the Regional Health Authority headquarters, but as the financial and legal aspects of GP vocational training became increasingly complex, independent office space and full-time staffing became necessary: the development of this GP Unit is described later in this chapter.

5.2 The West Midlands Regional Health Authority

The Birmingham Regional Hospital Board became the West Midlands Regional Health Authority in 1977 as a result of the NHS Act of the same year; it maintained the same headquarters for another thirty years until yet another Health Service reorganisation introduced the West Midlands Strategic Health Authority in 2006.⁵

By this time, NHS organisational and financial changes had meant that postgraduate Deaneries had taken autonomy over the organisation of medical education from the Regional Board, with the exception of financial accountability. The introduction of the

⁵ National Health Service Act 2006.

Strategic Health Authority as a purely financial management body with no educational ethos has had a negative effect on the culture and morale of Deanery activity.⁶

The Birmingham Family Practitioner Committee (FPC) was until 1990 the competent authority to administer GP services, according to the Statement of Fees and Allowances (known colloquially as ‘the Red Book’), which was updated centrally on an annual basis. As independent contractors, GPs were responsible for their own education, but the FPC sought to facilitate any reimbursement for educational activities allowed by the Red Book under the so-called Section 63 funding, and the Committee encouraged GPs to take advantage of opportunities to improve their careers and education.⁷ This situation changed with the reorganisation of the Health Service in 1990, which replaced FPCs with Family Health Service Authorities charged with the introduction of the Post Graduate Education Allowance (PGEA). The previous vocational training and postgraduate training allowances were abolished and it was enacted that GPs would lose their seniority payments if they did not attend five days of training per year for five years; this was to include courses on health promotion, disease management and service management approved by the Regional Adviser of GP Education. The introduction of the new GP Contract of 1992 removed these obligations, despite a proposal from Birmingham Local Medical Committee to the Annual Representative Meeting of the British Medical Association to maintain a section on postgraduate education in the revised contract. In order to monitor GPs’ individual experience of education and learning, in 1998 the government consultation document *A First Class Service* suggested participation for all GPs in an annual appraisal with a trained colleague Appraiser appointed by the Primary

⁶ D. Wall and G. Houghton, “From Todd to Tooke: where do Deaneries belong?” *Education for Primary Care* 19.3 (2008): 241-7.

⁷ Personal communication from T. Brown, Administrator of Birmingham FPC 1978-90.

Care Trust.⁸ The shortcomings of the initial appraisal system were highlighted by Dame Janet Smith during the course of the Shipman Inquiry.⁹

5.3 The West Midlands Postgraduate Deanery GP Education Unit

When the Regional Health Authority first appointed Dr David Scott as a Regional Adviser on Postgraduate Education for General Practice in 1972, he was issued with a part-time consultant contract and provided with a small temporary office in Arthur Thomson House, the office headquarters of Regional Health Authority, and allowed secretarial support from Mr Martin Howells, a permanent Regional Health Authority clerical officer, as required.¹⁰ As the infrastructure of postgraduate GP education developed with increasing responsibilities and supervision of training practices and considerable administration involved in the appointments of GP trainers and trainees, an autonomous GP Unit was instituted in Midland House next to Arthur Thomson House in Hagley Road. By the time that Dr Scott was appointed, there were 35 practices recognised to train GP trainees in Birmingham.¹¹ Dr George Thorpe, who succeeded Dr Scott as Regional Adviser in 1982, remained responsible to the Postgraduate Dean of the Birmingham Medical School for educational activities following the standards of the Joint Committee for Postgraduate General Practice Education (JCPTGP) and accountable to the Regional Health Authority for financial and budgetary affairs. He was assisted by the appointment of Miss Sue Beardsmore as a full-time administrator and his priority was to increase general practice training.

⁸ Department of Health. *A First Class Service: Quality in the New NHS. Consultation Document on Quality in the New NHS*. Health Service Circular 1998/113. 1998.

⁹ Janet Smith, *The Shipman Inquiry. Report 6. Shipman: The Final Report* (27 January 2005), especially Chapter 3 (available online at <<http://www.shipman-inquiry.org.uk>>).

¹⁰ Department of Health and Social Security and the Welsh Office. *Appointment of Regional Advisers in General Practice*. Circular HM(72)75. (London: DHSS, 1972).

¹¹ Birmingham Local Medical Committee. *Minutes of the General Purpose and Finance Subcommittee*. (Birmingham, 1972).

Over the next twenty years, there were increasing numbers of practices selected for training and partners in those practices were encouraged to attend regional Trainers' courses so as to become trainers in their own right, a policy which has continued to the present day. The increase over the years is shown in Table 4.2 above. The regulations for GP vocational training in England and Wales and the procedures for selecting both hospital posts and GP training practices were laid down in a statutory instrument, which gave the responsibility to the Regional GP Postgraduate Education Committees to approve training practices and to appoint GP trainers and VTS course organisers: although the Regional Adviser chaired the Committee, he was beholden to implement the decisions of the Committee.¹²

The Midland Faculty of the Royal College of General Practitioners had instituted an annual conference in the autumn at Stratford-upon-Avon to discuss the implementation of postgraduate training for general practice. Dr Thorpe formalised this activity to review the successes and problems of GP training over the previous twelve months by inviting all the appropriate stakeholders to attend the meeting, including all the Associate Advisers, representatives from all the West Midland Local Medical Committees and also representatives of the new VTS course Organisers and GP trainers, as well as the members of the Regional GP Education Committee. The results of the discussions were then presented as an oral annual report to the Postgraduate Dean on Sunday mornings. Dr Thorpe's successor as Regional Adviser, Dr David Wall, in 1992 then produced a formal report summarising the discussions and decisions, which covered both local issues and

¹² National Health Service, England and Wales. *The National Health Service (Vocational Training) Regulations 1979*. Statutory Instrument, 1979 No 1622. (H79-683) (London: HMSO, 1979); reprinted in *The Journal of the Royal College of General Practitioners Occasional Papers* 18 (1981): 36-37.

the implications of national priorities affecting the provision of education for general practice in the West Midlands.

Analysis of these annual reports from these regular Stratford Workshops of the Regional GP Education Committee demonstrates the development of postgraduate GP educational activity in Birmingham and the West Midlands Region. There is a continuing theme of improving standards of education and an emphasis on developing a coherent educational strategy for provision of education throughout the reports from 1992 to 1996. The Educational Strategy Working Party for the West Midlands was formed in October 1991, and chaired by Dr Roland Spencer-Jones, who was appointed as an Associate Adviser to lead on Continuing Professional development. It started as a means of setting objectives for education, in terms of structures, processes and outcomes and assessing the successes of implementation and setting new objectives for the future. The results included a recruitment drive for new training practices and a policy to increase the numbers of trainers in already established training practices. Over the next two decades, the number of approved training practices doubled and the number of available trainers tripled (Table 4.2) at the same time as the number of general practices in the city diminished, whilst the size of the practices increased with the increasing employment of salaried doctors as a result of the revised contractual arrangements with the introduction of a Performers' List instead of a Principals' List and associated changes in GP remuneration and financial implications of the New GMS Contract of 2003.¹³ The whole strategy was based on two main concepts: the educational cycle and the principles of adult learning. The broad areas of these strategy documents included organisational targets (1991-2), educational targets (1992-3), the promotion of individual learning (1993-4) and the further facilitation of

¹³ New GMS Contract 2003. *Investing in General Practice*. General Practitioners' Committee, British Medical Association (London: British Medical Association, 2003).

individual learning in 1994-5. The strategies involved the improvement of education for GP trainees in hospital posts, the introduction of formative and summative assessment, the provision of career posts for academic general practice with opportunities for research and masters' degrees, career guidance for general practice and the implementation of universal medical audit and the understanding of clinical effectiveness throughout all general practices. Table 4.2 of Deanery appointments demonstrates the development of specialist educational expertise and recruitment of GP educators to raise standards and resources within the GP Unit, with the individuals involved over the four decades since 1970.

In 1996, the Department of Health issued new guidance on education for the general practice. The position of Regional Adviser, originally provided with an NHS consultant contract in Public Health Medicine, was replaced by the appointment of a Regional Director with a Civil Service contract and, although the Director had to accept the deliberations and decisions of the Regional GP Education Committee, he was beholden as a civil servant to implement national priorities and accept government directives and implement budgetary strictures.¹⁴ The GP unit had expanded considerably over the previous decade which had necessitated the appointment of two managers, Mr Dean Bruton and Mrs Carol Harper, who became expert on the increasingly complicated contractual and legislative issues involving GP trainees, in addition to Mr Peter Savage who succeeded Ms Carmel O'Regan as an additional Regional Business Manager for the Board of Postgraduate Clinical Studies at the University of Birmingham.

¹⁴ The National Health Service (Vocational Training) Regulations 1979.

Combined with the introduction of the Strategic Health Authority, which no longer had the culture of education embedded in the Regional Health Authorities and insisted on redundancy of junior administrative staff, these changes have had a marked negative effect on both morale and development of general practice training.¹⁵ The Stratford weekend workshops had an important influence on the development of the whole regional strategy for postgraduate general practice education over the previous decade. They raised the standards of teaching and learning for both GP trainees and continuing education for GP principals. Even so, they were discontinued after the 1996 meeting despite a long list of aspirational commitments for the future from Dr Stephen Field, the new Director of Postgraduate General Practice Education. These have never been formally reviewed by the Regional GP Postgraduate Education Committee, whose deliberations should be available in the public domain. Although the Joint Committee for Postgraduate Training for General Practice had been responsible for the regulation of Postgraduate GP Education since 1981, the Regional GP Postgraduate Education Committee was required to work to criteria laid down by the Joint Committee which had a statutory function to fulfil its inspection of training schemes with regular triennial visits to each region: by 1994, the Joint Committee was named as the Competent Authority for general practice training under European Law.¹⁶ Since 1981, visiting processes had become more rigorous with the region expected to demonstrate its policies for vocational training were appropriate and operating satisfactorily at a local level. The Joint Committee had a duty to ensure that the Postgraduate General Practice Units of the

¹⁵ Letter of John Bacon, Department of Health, to Strategic Health Authority Chief Executives, 7th October 2005, available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4123838.pdf

¹⁶ D.W. Wall, *Annual Report of the Regional Adviser in General Practice 1994-5*. Postgraduate Medical and Dental Education, Board of Graduate Studies, University of Birmingham.

Regional Postgraduate Deaneries met European standards laid down by the Directive.¹⁷ In 2005, the JCPTGP was replaced by the Postgraduate Education and Training Board (PMETB), at the same time as the Government introduced Modernising Medical Careers, which led to a chaos in the administration of junior doctor posts by the new Medical Training Application Scheme (MTAS).¹⁸ In 2007, as a result of the MTAS debacle, Professor John Tooke from Peninsula Medical School was invited by the Department of Health to report on the state of postgraduate medical education and make appropriate recommendations.¹⁹ The recommendations of the Tooke Report reflected and reiterated much of the advice and suggestions of the Todd Report of some forty years earlier.²⁰

Although the Department of Health was responsible for funding the development of postgraduate education and issuing guidelines for an educational infrastructure, the advance and implementation of GP training has been the result of individual practitioners who were personally committed to improving both standards of medical care as well as being involved in educational activities. However, all governments, when in financial straits, appear to consider postgraduate medical education as low priority and a politically acceptable area for immediate budgetary reductions.

¹⁷ European Economic Community, *Council Directive 93/16/EEC to facilitate the free movement of doctors and the mutual recognition of their diplomas and other evidence of formal qualifications*. (5th April 1993).

¹⁸ Modernising Medical Careers - the new curriculum for the foundation years in postgraduate education and training: <http://www.dh.gov.uk/en/Aboutus/MinistersandDepartmentLeaders/ChiefMedicalOfficer/Archive/CMOTopicsarchive/DH_4107830>. See also Sir Liam Donaldson, *Unfinished Business: Proposals for reform of the Senior House Officer grade*. (London: Department of Health, 2002).

¹⁹ Department of Health and Social Security. *Aspiring to Excellence: Findings and Final Recommendations of the Independent Inquiry into Modernising Medical Careers*. [“Tooke Report”] (London: HMSO, 2008).

²⁰ David Wall and Guy Houghton, “From Todd to Tooke: Where Do Deaneries belong?” *Education for Primary Care* 19.3 (2008): 241-247.

As in the West Midlands, most deaneries in England had by 2007 combined with their Strategic Health Authorities (SHA) and the deaneries are now seen as ‘workforce’ bodies with the object of mass-production of General Practitioners, by means of training future practitioners based on the tariff or value per trainee allotted for this purpose. Other UK countries have escaped this reorganisation, being largely co-terminous with their local health authorities.²¹ The GP unit has started the process of the division of GP educators into educational ‘providers’ and ‘commissioners’ who remain as SHA employees and are expected to make efficiency savings on behalf of the Strategic Health Authority which has started to implement a recruitment freeze. The Strategic Health Authority may well be replaced by new reorganised regional offices which will oversee GP commissioning consortia, with still more negative effect on GP education, recruitment and administration.²²

²¹ <http://www.number10.gov.uk/queens-speech/2010/05/queens-speech-health-bill-50617>

²² Wall and Houghton, “From Todd to Tooke”.

CONCLUSION

Professor Sir Kenneth Calman, the former Chief Medical Officer of both England and Scotland and Chancellor of Glasgow University, asserts that ‘the creation of the NHS had a profound effect on the development of medical education’¹ – an assessment strongly supported by the evidence examined here. Calman points out that the introduction of a national health service has provided the opportunity to plan the teaching and learning of both undergraduate and postgraduate students, since consultants working in the National Health Service (NHS) are expected to teach both junior doctors and medical students in both District General and Specialist Teaching Hospitals. Despite the current government’s difficulties in funding university undergraduates, the NHS has continued to maintain a budget, albeit a fluctuating one, for postgraduate education within the context of the 1968 Health Services and Public Health Act.² However, the current priority of NHS West Midlands, according to its 2010 Annual Report, is the implementation of its West Midlands Widening Participation Strategy designed to promote access to healthcare careers and subsequent progression within the NHS, rather than quality improvement in clinical training.³

NHS West Midlands has recently appointed five Chief Executives who will head up new management cluster teams, as regional health services continue to implement the government’s reform programme with the aim of providing additional leadership and of

¹ Kenneth Calman, *Medical Education: Past, Present and Future* (Edinburgh: Churchill Livingstone, 2007).

² National Health Service, *Health Services and Public Health Act 1968*. (London: HMSO, 1968).

³ Strategic Health Authority, NHS West Midlands, *Annual Report 5* (2010), available from <<http://www.westmidlands.nhs.uk/ReportsPublications/AnnualReports.aspx>>, accessed 23 May 2011.

supporting and scrutinising future decisions affecting local NHS services. The remit of these teams is to ensure that the NHS delivers local services, and reinvests any savings, while the medical educationalists of the Deanery are entrusted with the task of maintaining the high standards of medical education and training demanded by the General Medical Council, in order to meet the needs of patients, the service and future generations of general practitioners.⁴

The influence exerted by the activities of the NHS on the educational infrastructure in Birmingham, and its effect on its funding has been described in Chapter 5, but the actual educational outcomes and the quality of postgraduate education are the direct results of the efforts and initiatives of individuals employed by the West Midlands Postgraduate Deanery and involved in programmes relating to teaching and learning, rather than of the local NHS management. Prof. David Wall, in his study of the West Midlands Bursary Scheme for Doctors and Dentists,⁵ has come to the conclusion that success in this area can be measured by the improved educational climate, inspired by the efforts of local ‘key educators’, also described by Dunn, Hamilton and Harden as ‘star performers’.⁶ It is perhaps not surprising, then, that Dr Andrew Whitehouse, the new head of the Postgraduate School of Medicine (PGSoM), the new name for the Deanery following the latest NHS reorganisation, has already pointed to the value of these individual educators, who have been responsible for the achievements of the Deanery for half a century:

The School has been richly supported by the energies of the many physicians in our region with specific educational expertise and enthusiasm.⁷

⁴ For the General Medical Council, see <<http://www.gmc-uk.org/education/index.asp>>

⁵ D. W. Wall, “An Evaluation of the Educational Qualifications Bursary Scheme for Doctors and Dentists within the West Midlands Deanery 1996-2002.” PhD Thesis: University of Birmingham, 2007.

⁶ W. R. Dunn, D. D. Hamilton and R. M. Harden, “Techniques for Identifying Competencies Needed of Doctors” *Medical Teacher* 7 (1985): 15-25.

⁷ Strategic Health Authority, NHS West Midlands, *Annual Report 5*.

Of the organisations discussed in Chapter 3, in recent decades the Midland Medical Society – although it started with educational intentions like the other medical societies throughout the country, and provided access to up-to-date scientific journals and the latest textbooks from library sources – has fulfilled a predominantly social function, offering a meeting place and occasional lectures or specialist events. The British Medical Association (BMA) has kept its provincial office in the same building, and continues to act as the professional medical association and trade union for doctors and medical students, assisting its local members with employment matters and contractual difficulties. As regards postgraduate education, the central BMA remains responsible for the publication of the *British Medical Journal* as a national publication, and organises masterclasses and web-based learning; it has no local relevance to the special needs of the West Midlands. In today’s electronic age, since 2006, 6,000 GPs subscribe annually to the BMJ Masterclasses, with a further 400 new subscribers year on year.⁸

The Midland Faculty of the Royal College of General Practitioners (RCGP) also arranges occasional study days, organised by individuals with specific interests, but the influence of the Royal College of General Practitioners has consisted principally in its contributions to government policy on general practice vocational training, and in assisting potential general practitioners to achieve their Membership qualification and thereby demonstrate a recognised standard of clinical competence.

The University of Birmingham Medical School (see Chapter 4) has concentrated on undergraduate medical education, but individual members of staff have endeavoured to offer Masters’ degrees to encourage Continuing Professional Development for general practitioners, who, thanks to the West Midlands Bursary Scheme organised by Professor

⁸ Personal communication from Hilary Pinnock, Editorial advisory board, BMJ Masterclasses, 2011.

Wall as Deputy Postgraduate Dean, have developed into a new generation of 'key educators'.⁹ Over the last forty years, the same individuals have reappeared fulfilling the different roles necessary for postgraduate general practice education. An analysis of the Deanery appointments and list of course organisers in Tables 3.1 and 3.3 in Chapter 3 reveals that the same doctors appear as VTS course organisers and as GP tutors organising lunchtime events and other equivalent educational sessions in the Hospital Postgraduate Centres. Some have supervised first-year students participating in the Medical School Family Attachment Scheme set up by Michael Drury, the first Professor of General Practice at Birmingham University, to understand the social implications of chronic illness; while others have become involved as university tutors delivering the undergraduate curriculum. The same names appear on the RCGP Midland Faculty Board or as RCGP representatives on the new School of Postgraduate Medicine. Some GP trainers and VTS Course Organisers would become Examiners for the Membership Examination of the Royal College of General Practitioners and run pre-exam courses for candidates; they then became Associate Deans, overseeing the training practices in their own locality.

One positive development stemming from a central initiative has been the National Health Service's provision of funding to allow the independent contractor GP to employ a locum to ensure patient services and continuous care whilst the practitioner can undertake educational activities and develop his or her involvement in teaching and learning. After 1970, members of the Birmingham Local Medical Committee would represent their practitioner colleagues on the Regional GP Education Committee

⁹ Robin Hull, *Just a GP: A biography of Professor Sir Michael Drury* (Oxford: Radcliffe Medical, 1993).

(RGPEC) and participate in visits to practices to monitor training standards and select training practices.

In 2006, the Strategic Health Authority closed the GP Unit offices in the Birmingham Research Park and provided the medical educator staff with 'hot desk facilities' in the SHA building, and at the same time made the entire junior clerical staff redundant. In the NHS reorganisation of the Postgraduate Deaneries in 2008, the West Midlands Strategic Health Authority replaced the GP Unit and Regional GP Education Committee Deanery with a Postgraduate School of General Practice (PGSoM: see above). The PGSoM is composed exclusively of SHA-employed medical educators, and there are no spokesmen from the Local Medical Committees to represent the views of the GP independent contractors, or to challenge the policies and decisions of the Strategic Health Authority employees. It can only be hoped that this will not have an adverse effect on efforts to maintain the educational opportunities, standards and culture of general practice training developed over the last forty years, during which the first 23 GP training practices appointed by Birmingham Local Medical Committee in 1972 have increased to 77 in 2010, and individual trainer numbers from the initial 23 to 167 (see Table 5.4 in Chapter 5 above). Local institutions like the Midland Faculty of the RCGP and the Midland Medical Society have provided an opportunity for doctors to participate in postgraduate discussion and realise their pedagogic aspirations, and these individuals have been the stalwarts of the West Midlands Postgraduate Deanery, whose GP Unit has repeatedly received laudatory reports following the triennial monitoring inspection visits of the Joint Committee on Postgraduate Training for General Practice. These activities were also praised in Professor Bosanquet's independent review for Birmingham Civic and

NHS Authorities, in which he confirmed the high standard of primary care offered to the patient population of Birmingham by well-trained general practitioners.¹⁰

This study has depended on the collection of the ephemeral papers produced by the West Midlands Regional General Practice Education Committee (RGPEC), and on its informal annual reports, which are in personal private collections; although the minutes of the Regional GP Education Committee are said to be official documents available in the public domain, they are no longer archived. The minutes of the Midland Faculty of the RCGP are stored in bound volumes, which I have been permitted to examine.¹¹

Members of the RGPEC have kept lists of GP trainers and details of the Vocational Training Scheme programmes throughout Birmingham and the West Midlands Region since Dr Robin Steel's initial 'Orientation towards General Practice' course of July 1970 (see above, Chapter 4 and the Appendices), which have provided me with sources not otherwise obtainable. I have had the opportunity to record the memories of the early GP educators, such as Dr Steel himself, who have been responsible for the development of general practice education in Birmingham, and of several Regional Advisers in General Practice, including Dr George Thorpe (a general practitioner in Solihull and Birmingham from 1954, Area Adviser for Birmingham from 1970 to 1975, and then Regional Adviser from 1975 to 1991: see Chapter 5), Dr Bob Strachan (Area Adviser for Birmingham from 1991 to 2005), and Professors David Wall and Steve Field (who have been both Regional Advisers and deputy Postgraduate Deans). Whilst these memories are becoming more distant and are subject to the standard limitations associated with the use of oral testimony, these interviews have directed me to additional primary and secondary sources and provided me with personal recollections of general practice educational

¹⁰ N. Bosanquet, *Birmingham 1995: A Strategy for Primary Care* (Birmingham: Birmingham Family Health Services Authority, 1993).

¹¹ Midland Faculty, Royal College of General Practitioners, Minute Book 1952-2009.

activity at the start of the National Health Service. Drs John Price and Llewellyn Lloyd, both retired Birmingham general practitioners, recounted how their National Service experiences as doctors in the RAMC in the 1950s encouraged them to maintain their continuing medical education and organize, on their own initiative, teaching ward rounds with consultants on a Sunday morning at the Queen Elizabeth Hospital; these were finally authorised by Prof. George Whitfield, the Head of the Board of Graduate Studies at the University of Birmingham, as a NHS-funded activity in 1964.¹²

Unfortunately, there are now few Birmingham general practitioners who were in practice before the Second World War, and they are no longer in a position to evaluate the educational changes consequent upon the introduction of the National Health Service; sources for personal historical evidence are therefore increasingly limited. That is not to say, however, that all avenues for further investigation have been exhausted – on the contrary, following this study which has reviewed the development of general practice education, the time is appropriate for continuing independent research on educational outcomes, perhaps under the auspices of the Birmingham University School of Education Centre for Research in Medical and Dental Education (CRMDE), which was established in 2000 as a partnership between the West Midlands Postgraduate Deanery and the School of Education, University of Birmingham, and has a noted track record in assessing medical education.¹³

At a time of unprecedented pressure on NHS resources, and of a genuine threat to opportunities for effective postgraduate medical education as a result of measures dictated by financial stringency, it is perhaps more than ever imperative to preserve a record of experiences which have the potential to offer a solid foundation and a salutary

¹² Minutes of Midland Medical Society, 8th April 1964.

¹³ See <<http://www.education.bham.ac.uk/research/crmde>>.

model for future developments in this field. From an early stage in the emergence and expansion of professional medical education in Britain, and especially during the second half of the twentieth century, Birmingham's medical community has taken an active part in the formulation and implementation of new initiatives, and this continuing tradition of involvement places her educators in a potentially valuable position to shape educational policy and practice in years to come.

