Scenes from Postgraduate Life

The history of postgraduate medicine education

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Although formal postgraduate medical education may be a recent phenomenon, many long-established medical societies throughout Britain have contributed to the continuing medical education of established practitioners while the specialist societies have made an immense contribution to the dissemination of new knowledge and many consultants regard these societies as the most valuable source of new knowledge in their field. The need for the medical practitioner to devote himself to a lifetime of study was stressed by Osler in a valedictory address to students at McGill University in 1905 when he said: 'The hardest conviction to get into the mind of a beginner is that the education upon which he is engaged is not a College Course, not a Medical Course but a Life Course, for which the work of a few years under teachers is but a preparation'.

Osler later became Chairman of the Postgraduate Medical Association in this country, an organization set up in 1911 to develop postgraduate medical training in the UK, although its activities were curtailed by the First World War. At the end of the war the Fellowship of Medicine was established by a group of distinguished doctors in London, again with the objective of promoting postgraduate studies, particularly for ex-service medical officers and the two organizations then combined under the presidency of Osler, eventually becoming the Fellowship of Postgraduate Medicine.

Over the years the development of postgraduate medical education has been influenced by a series of reports from influential committees, by legislation (Tables I and II) and in response to the changing needs of medical graduates in the light of the remarkable advances in medical science and technology that have taken place particularly over the last few decades, and in response to changes in the pattern of health care delivery. As Sir David Innes Williams said in the 60th anniversary issue of the Postgraduate Medical Journal, this development has been erratic, intermittent, unco-ordinated and the result of the separate endeavours of many different bodies.

In 1921 the Athlone Committee on postgraduate medical education suggested that a university medical school devoted solely to postgraduate medical education should be established in a London hospital and associated with London University; that the specialist hospitals should be linked to the new postgraduate school and that a central office should be set up to co-ordinate and develop postgraduate activities in London.

As a result the British Postgraduate Medical School was established at Hammersmith Hospital becoming a school of the university in 1934 and being officially opened by King George V in 1935.

It was not until after the Goodenough Report was published in 1944 that the British Postgraduate Medical Federation was set up in 1945 receiving its Charter as a School of London University in 1947. The federation comprised 12 institutes and their specialist hospitals together with the Postgraduate Medical School, which was granted royal status in 1966 and reverted to being an independent school of the University in 1974. The Goodenough Report was mainly concerned

<table>
<thead>
<tr>
<th>Year</th>
<th>Medical Acts</th>
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<tr>
<td>1858</td>
<td>General Council of Medical Education and Registration (GMC since 1951)</td>
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<tr>
<td>1866</td>
<td>Applicants for registration must have passed a qualifying examination 'Sufficiently to guarantee the possession of the knowledge and skill required for the efficient practice of medicine, surgery and midwifery'</td>
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<td>1950</td>
<td>Mandatory preregistration year (introduced 1953)</td>
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<tr>
<td>1978</td>
<td>GMC responsible for co-ordinating all stages of medical education. Qualifying examination no longer described as examination in medicine, surgery, obstetrics and gynaecology</td>
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This paper is based on a talk given at the 75th Anniversary celebrations of the Fellowship of Postgraduate Medicine in June 1993.
with undergraduate education but it was a remarkably perceptive report, and made important recommendations about postgraduate training. It suggested that universities with medical schools should set up boards of graduate studies and appoint postgraduate deans; that all hospitals should be incorporated in a grand educational design based on the teaching hospitals and that a preregistration year should be introduced.

Furthermore, in anticipation of the introduction of the NHS, the report stated that: ‘A nation embarking upon a comprehensive health service cannot afford to do without a comprehensive system of postgraduate medical education’.

The introduction of the National Health Service (NHS) in 1948 was a watershed in the fortunes of the medical profession. It became the monopoly employer of medical manpower and medical graduates became dependent on the service both for training and for their career opportunities. The Spens Committee in 1948 envisaged that all posts between house officer and consultant would provide appropriate training opportunities, but unfortunately the educational status of the more junior posts was soon eroded as the service demands increased and, by 1951, only senior registrar posts were recognized as being primarily for training.

One of the major achievements of the NHS was the upgrading of district hospitals, which were staffed with well-trained consultants who built up teams of junior staff on the firm pattern of their teaching hospitals. This enabled them to deliver a high standard of care and provided trainees with opportunities for obtaining a wide range of clinical experience, but teaching was largely unstructured and based on the traditional apprenticeship model of British medicine. In most district hospitals, the facilities for postgraduate study were quite inadequate. With this staffing pattern of district hospitals, the general practitioners found that they were becoming isolated from their hospital colleagues and they gradually lost any bed privileges they had previously enjoyed, and even direct access to diagnostic facilities was limited.

Against this background the Christ Church Conference was held in 1961 under the auspices of the Nuffield Provincial Hospitals Trust and under the chairmanship of Sir George Pickering, Regius Professor of Medicine at Oxford. This conference had a major catalytic affect on the development of postgraduate medical education and continuing medical education. A number of important factors contributed to its success. Firstly, the timing was right, secondly, the participants were influential and committed, and, thirdly, a number of attainable objectives were identified. The main objectives were:

1. To promote an educational atmosphere in regional and district hospitals.
2. To encourage all consultants to recognize their responsibilities for training their junior staff.
3. To restore educational status to all junior staff grades.
4. To provide appropriate teaching facilities in district general hospitals.
5. To establish a central body to co-ordinate the interests of colleges and faculties, medical schools and the NHS.

Following the conference, university postgraduate deans were appointed in those regions, where one had not already been appointed, and in each district a clinical tutor was appointed to stimulate and co-ordinate postgraduate activities.

The immediate objective was to promote an educational atmosphere in each district hospital and it was largely due to the initiative of groups of enthusiastic consultants in district hospitals that the early postgraduate centres were built. Often there would be a leading activist in the group who would emerge as the most obvious choice for clinical tutor. The Nuffield Provincial Hospitals Trust and the King’s Fund made generous contributions towards building costs. However, no exchequer funds were available initially and fund-raising was an important activity for the clinical tutors and their colleagues trying to establish centres.

This was often a remarkable collaborative effort. Consultants and general practitioners contributed
generously and such evidence of self-help encouraged donations from industry. In many districts, educational trusts were set up and local businessmen often became trustees. The cost of the early centres was modest and often no more than £10,000–£20,000, as they were planned and built on the basis of providing the minimum facilities to provide immediate needs. Later centres were more ambitious, although the majority of those being planned in 1968 were estimated to cost between £20,000 and £40,000. During the years 1962–1972, 228 medical centres were opened and, by 1978, there were more than 300 centres in England and Wales.89

The opening of a postgraduate centre in a district hospital brought immediate benefits. The centre provided a meeting place where hospital staff, senior and junior, could meet on common ground with their general practitioner colleagues. Building the centres was the first challenge, but structuring a suitable academic programme for hospital trainees and providing continuing education for general practitioners was perhaps a greater challenge for clinical tutors. The needs of the two groups are quite different and the difficulty of planning structured training programmes for small groups of residents soon became apparent, while general practitioners tended to complain that programmes arranged for them by hospital consultants were often not relevant to their practice. Thus the report of the Royal Commission (Todd Report) in 196810 noted its concern about the inadequacies or uncoordinated provision of training for junior hospital doctors.

To establish a more structured form of postgraduate training, it suggested that, following full registration there should be a period of general professional training embracing the Senior House Officer (SHO) and registrar grades and lasting about 3 years. This should be followed by a period of further training in a specialist field, which would be of variable duration according to the specialty concerned. The Royal Colleges and their faculties became responsible for approving posts for general professional training and the health departments agreed that only posts approved for training should be advertised. This provided the colleges with a powerful sanction against unsatisfactory posts but much of the training, particularly in SHO posts, remained unstructured with service demands taking precedence over training.

Higher specialist training in senior registrar and more recently in registrar posts become more structured and co-ordinated following the establishment of joint higher training committees or equivalent college committees. These joint committees were set up by the Royal Colleges, including the Irish colleges, the university associations of professorial heads of departments and the specialist societies with representatives from the Health Departments, the Medical Research Council (MRC), the Association of Medical Research Charities (AMRC), the General Medical Council (GMC), postgraduate deans and doctors in training. Their main function is to lay down criteria for training in the individual specialties and to approve posts and training programmes. Hitherto these committees, except in the specialties of pathology and psychiatry, have granted certificates of accreditation to trainees on the satisfactory completion of their training. In future, in order to comply with European Community (EC) directives, certificates of satisfactory completion of training will be granted by the GMC on the recommendation of the relevant college or joint committee.

One of the major achievements in the field of postgraduate medical education has been the introduction of mandatory vocational training for general practice. There were doubts about the wisdom of allowing the specific training requirements for any speciality to be governed by legislation, but this has caused no serious problems and much credit must go to the group of general practitioners who dedicated themselves with enthusiasm to the task of establishing general practice as a specialty in its own right, with a well-defined training programme comprising 2 years in rotating hospital posts and 1 year in an approved training practice.

The Medical Act of 1978 conferred important new responsibilities on the GMC. Previously responsible for the undergraduate curriculum, the standard of the qualifying examinations and the pre-registration year, this new act required the GMC to set up an Education Committee 'having the general function of promoting high standards of medical education and co-ordinating all stages of medical education'. This act also required the Education Committee to determine the extent of the knowledge and skill to be required for the granting of United Kingdom medical qualifications, but no longer defined the qualifying examination as being an examination in medicine, surgery and midwifery, thus finally eliminating the concept of graduating omni-competent doctors and recognizing the need for postgraduate training.

In 1987, the Education Committee published recommendations on the training of specialists11 and indicated that the GMC hoped to establish relationships with the Colleges and faculties in respect of specialist training on lines similar to the long-standing relationships it had established with the medical schools in respect of undergraduate medical education. In its recommendations the Education Committee stressed the need for structured training with a core curriculum, nominated educational supervisors for each trainee and protected teaching time. These are all worthy objec-
tives but difficult to achieve within the present staffing structure of many hospitals.

Apart from the frustrations of long hours of work, the dominance of service requirements over training needs and the uncertain career prospects, one of the most confusing issues for trainees must be the multiplicity of agencies and individuals now involved in the training scene.

The colleges retain their traditional role of maintaining standards by inspecting posts and by conducting higher examinations to ensure a high standard of entrant to specialist training. The need to pass these examinations had led to much early postgraduate training being examination driven and the colleges are sometimes seen by juniors as remote, threatening institutions. The appointment of college regional advisers and district college tutors has helped to improve the image of the colleges but unfortunately the role and even the identity of tutors is not always clear to trainees and the relationship between college tutors and clinical tutors is often confusing. The postgraduate dean is also often a remote figure and few juniors have much idea of his or her role.

The 1990 reforms of the NHS created great concern about the future status of postgraduate training, especially in Trust hospitals, but Mr Kenneth Clarke, the then Secretary of State for Health, stated in a speech on 10 July 1989 that: "The quality of care which the NHS can deliver rests entirely on the high standards and excellence of the training, education and teaching which is provided. We therefore need a framework for postgraduate education and for the continuing education of our doctors, and that includes general practitioners, which will maintain and indeed improve our educational standards."12

This was encouraging and the following year it was announced that there would be protected budgets for postgraduate and continuing medical education, which would be held by regional postgraduate deans who would make allocations to clinical tutors for funding educational activities in their district. Since then, postgraduate deans have become budget holders for the educational component of the salaries of trainees, which gives them powers to withhold funding from unsatisfactory posts.

Apart from the need to provide more structured training at all stages of postgraduate medical education, there is a need to co-ordinate the activities of all the agencies and institutions involved. It was unfortunate that the Council for Postgraduate Medical Education for England and Wales set up in 1970 was not entirely successful in fulfilling this function and eventually foundered, although the Councils for Scotland and Ireland have continued. The Standing Committee on Postgraduate Medical Education for England set up in 1988 is not an entirely satisfactory replacement as its remit is restricted to advising the Secretary of State on specific issues and does not extend to co-ordinating the activities of the many institutions and individuals concerned with postgraduate medical education. Leadership in this field is essential and there is a clear need for closer collaboration between the colleges, postgraduate deans and the GMC. The recent departmental report on specialist training indicates that the Chief Medical Officer will be taking the initiative in arranging meetings between postgraduate deans and the colleges.13 This is an important step and the Royal College of Physicians is already planning to collaborate more closely with postgraduate deans.

It is perhaps relevant to recall that it was the colleges that took the initiative in setting up the Central Committee for Postgraduate Medical Education, which preceded the three Councils, and the time seems opportune for them to take active steps to regain the initiative in this field, perhaps through the Conference of Royal Medical Colleges and their faculties, which could become a most influential body, in the co-ordination of many aspects of postgraduate medical education.

References

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