

The vocational training period

With an example of a training programme for general practice

J. PRICE, M.R.C.S., M.R.C.O.G., M.R.C.G.P.

Blackwater

THE objectives of any vocational training period must be to promote the establishment of priorities in thought, word and deed, according to whatever branch of medicine the vocational training period is designed to apply. In so far as general practice is concerned this could be perhaps summarized by an old French proverb: To cure sometimes, to relieve often, to comfort always. But it has not been found easy to define precisely in measureable terms exactly what is required in these objectives. The principles, however, are now evolving and details are emerging as interested parties express their points of view. Thus several publications of the Royal College of General Practitioners have summarized thoughts and ideas as they have crystallized. The Undergraduate Education Committee of the Fifth Council summarized college policy *On undergraduate education and the general practitioner* (1958) as it had evolved up to that time. Recommendations were made for the introduction of medical students into general practice. The report on *Special vocational training for general practice* (1965) studied training requirements after qualification and emphasized the importance and need for an in-service training. *The implementation of vocational training* (1967) defined for the first time some of the objectives of the programme and developed the trainee scheme further.

Educationalists have given their views on how the task should be analysed and their ideas are helpful. Professor Furneaux at the Second Course for Trainers at the College in May 1968 emphasized that training objectives are a set of exemplaries—ideals of a high standard of practice that must be maintained. They are skills to be acquired either in mental processing, in manual dexterity or in organization; they are to be achieved by certain defined activities. In order to be applied constructively, these activities should be assessable against each objective, so that the value of the activities in achieving the objective can be learned. However, the activities and assessment techniques in general practice are yet to be developed.

General practitioners, however, at trainer–trainee level are groping in their endeavour to teach their subject. What are my aims? What am I to teach, and how am I to set about it? These are questions they seek to answer. This paper (1) aims to outline the training and educational objectives of the vocational training period, and (2) gives one example of a training programme as the objectives are seen by a principal.

The objectives of an in-service vocational training programme for general practitioners are essentially a training for practice and these must be related to:

1. The individual patient.
2. The community.
3. The practice.
4. The doctor himself.

1. The individual patient

The programme for general practice must aim to inculcate a series of attitudes—

- (a) an interest in people
- (b) the importance of a symptom to the patient
- (c) the importance of the doctor's attitude to the patient and his symptom.

To this end, objectives in training will emphasize:

(a) Care of the individual as an individual

- (i) The importance of knowledge of the patient, his family and environment; getting to know his patient will be perhaps a priority on joining a practice.
- (ii) The balance between use of science and caring for a human being. The younger doctor with more recent knowledge tends to over-investigate and over-prescribe, while the older doctor, in his wisdom, may certainly under-investigate and be simple in his therapy.
- (iii) The cultivation of empathy—i.e. the capacity to put oneself in the patient's place; to give a sympathetic hearing and to be no less sincere in this hearing.
- (iv) The concept of 'womb to tomb' care of the individual—helping him to be born (or prevented), to live his life, to die (and perhaps to advise on organ transplant). This concept will emphasize the continuing nature of the professional relationship with the patient.
- (v) There is the need to help the patient educationally, healthwise, in constructive teaching.

(b) Care of the individual as a case

The general practitioner is usually the doctor of primary contact in any given health situation. The trainee general practitioner must learn:

- (i) The importance of clinical competence and clinical methods, and the correct place of special investigations in general practice—with emphasis on presymptomatic and early symptomatic management.
- (ii) The incidence of morbidity and mortality as seen in general practice—with emphasis on probabilities as determined by Crombie (1966).
- (iii) Educationally the patient must be taught as a patient the proper use of the Health Service, and he must be helped to use it wisely to the best advantage of all.

2. *The doctor and the community*

Objectives in training must emphasize that:

- (i) The place of the doctor in the community is as a professional man alongside the solicitor, the parson and the dentist and to remember that the patient may also have special relationships with each.
- (ii) Any community relationship must endanger the confidentiality of private dealings unless this is particularly guarded by high ethical standards.
- (iii) The integration of doctors' preventative activities into a team responsible for the concept of 'womb-to-tomb' welfare care.
- (iv) All doctors have some part to play in educating the community in matters relating to health and hygiene.

3. *The practice*

Training objectives must emphasize the need for good practice organization. This will involve:

- (i) The recognition of differing types of practice—new or established, rural or urban; all have a character, and a need that is different; all types are concepts continually evolving, decade by decade, as patients come and go.
- (ii) The practice team with the doctor as the leader; this must include relationships:
 - (a) with partners, assistants and colleagues
 - (b) with paramedical and ancillary staffs and their efficient use.
- (iii) The value of an efficient administrative department in the practice, with adequate organizational methods.

4. *The doctor himself*

Young doctors will need to be taught the importance of good personal discipline;

this will emphasize the value of:

- (i) Good records.
- (ii) Good prescribing habits.
- (iii) Proper utilization of the limited time available for various aspects of his work.
- (iv) The need for continuing postgraduate education—whether by do-it-yourself methods, or by research and reading, or by use of the many organized postgraduate training courses available. The doctor must develop the need for critical appraisal of all he sees and hears in order to adapt continually his skill, by knowledge and experience, and to bring to fruition the wisdom that becomes the reward of his labours.

REFERENCES

1. The College of General Practitioners. (1958). On undergraduate education and the general practitioner.
2. The College of General Practitioners. (1965). Special vocational training for general practice. Reports from general practice, No. 1.
3. The Royal College of General Practitioners. (1967). The implementation of vocational training. Reports from general practice, No. VI.
4. Crombie, D. L. (1966). The College of General Practitioners. Evidence of the College of General Practitioners to the Royal Commission on Medical Education. Reports from general practice, No. V. Appendix I.

APPENDIX

A TRAINING PROGRAMME FOR GENERAL PRACTICE

It is proposed that the trainee's year should be divided into four quarters, and that each quarter will be characterized by emphasis on different aspects of general practice.

1. Introduction to practice.
2. Clinical aspects of general practice.
3. Non-clinical aspects of general practice.
4. Responsibility.

1. *Introduction to practice*

The trainee will be introduced to general practice, and the place of the general practitioner in the community demonstrated. He will be shown:

- (i) Different types of practice—and premises:
 - (a) Urban
 - (b) Rural non-dispensing and dispensing with the problem of mileage
 - (c) Semirural.
- (ii) Forms—with special reference to all forms of statutory obligation.
- (iii) Equipment—surgery and car.
- (iv) Prescribing habits—the value of *B.P.*, *B.P.C.* and *B.N.F.*
- (v) The office:
 - (a) the value of staff
 - (b) appointment systems
 - (c) filing systems.
- (vi) Organization of the day.

During the quarter, visits will be made to neighbouring practices, who have promised to receive the trainee, in order to demonstrate specific points, *i.e.* different appointment systems, rural dispensing systems.

2. *Clinical aspects of general practice*

During the second quarter emphasis will be placed upon the clinical aspects of general

practice. Special reference will be made to:

- (i) the family unit
- (ii) the individual patient
- (iii) common disease—in all the different systems of the body
- (iv) infectious diseases
- (v) epidemics
- (vi) maternity
- (vii) paediatrics
- (viii) the elderly
- (ix) the place of the district nurse and health visitor; welfare, and mental welfare departments and organizations such as Red Cross.

Arrangements will be made for visits to be made to public health departments of the county, local authority and local clinics, during this quarter.

3. *Non-clinical aspects*

Insurance work.

Industrial aspects of practice.

Preventative medicine—immunization, and vaccination.

Immunity in practice.

Adoption work in practice.

During this quarter, arrangements will be made for the trainee to visit three or four of the local factories during the visits of the three doctors who undertake part-time industrial work in the factories concerned, and who have offered to receive the trainee.

4. *Responsibility*

During the last quarter of the year, the trainee will be given increasing responsibility if it is felt he will be able to take it. He will visit general-practitioner hospitals and be shown liaison with consultants. He will be introduced to practice finance, partnership agreements and the relationship with the legal profession, and the church.

Comment

The above quarterly programme will be used as a guide to explain the details of practice to a trainee. The details will be presented in a series of short tutorials at as frequent intervals as can be arranged or in one-hourly discussions at fortnightly intervals, at a fixed time.

The day-to-day routine for the trainee will include selected visits to specific patients in order to demonstrate specific aspects of management; he will be invited to undertake short surgery sessions in order to gain experience. At least one whole day per week and rotating each week will be spent entirely with the principal to demonstrate specific aspects and see the principal at work.

The trainee will have a half day of each week off duty. He will be on weekend duty every third weekend with the duty doctor to take calls and work as the duty doctor may request. He will have fixed Monday night on first call with the duty doctor.

Day release course. The trainee will attend the course arranged for all Wessex trainees by the Hampshire Training Committee at Winchester. The year's course is divided into three terms of about ten weeks' duration, and involves spending one whole day each week at the course during each term. This is of great advantage in that a group of trainees are able to meet and discuss mutual interests in training: Furthermore specialist lectures and visits can be arranged which are more suitably given to a group than on the individual basis of the trainer-trainee relationship.

Research. During the year the trainee will be encouraged to undertake two pieces of research work—one short and one long-term—in order to demonstrate particular aspects to the trainee.

Societies. The trainee will be encouraged to attend medical society meetings with or without

the principal and the value of such enterprise emphasized.

Individual wishes. A trainee who has specified interests will be encouraged by all possible means to utilize and develop his interests according to how this and the practice can help him.

Acknowledgement

The first part of this paper evolved during a discussion group on this subject, with the writer as recorder, held during the second Course for Trainers at the Royal College of General Practitioners on 17–21 June 1968. Credit must be given to the members of the discussion group who were responsible as a whole for the ideas generated. The second part of the paper is the programme used by the writer as his current guide to training programme; as approved by the Wessex Postgraduate Education Committee, Winchester. While this programme is based upon a period of 12 months traineeship, it would require drastic alteration if the recommendations of the Todd Report are effected and the period of in-service training reduced to six months.

Outpatient operations. 1. The surgeon's view. J. ALEXANDER WILLIAMS, Ch.M., F.R.C.S.
Brit. med. J. 1969. 1, 174.

"If we cannot have all the money we need to run a perfect health service we must make the best of the money we have."

A considerable saving in the use of hospital beds can be made by performing 'minor surgery' on outpatients. 'Minor surgery' includes 'clinic surgery'—procedures which it is possible to do at first consultations in an outpatient clinic—aspiration of breast cysts, varicose vein injections, sigmoidoscopy—and also 'theatre surgery'—procedures such as hernial repair and removal of simple breast cysts which require full operating-room facilities.

Criteria for hernia repair as an outpatient are recommendation by the general practitioner, willingness of the patient, age under 45 and absence of respiratory disease. In the past four years 159 hernial repairs were performed on inpatients and 65 on outpatients.

Outpatient operations. 2. As the general practitioner sees it. D. DEAN, M.B., M.R.C.P., D.C.H. and B. R. WILKINSON, M.B., B.S., D.Obst.R.C.O.G. *Brit. med. J.* 1969. 1, 176.

No major snags were encountered by two general practitioners over a period of two-and-a-half years. The extra work involved is easily coped with in a group practice and is compensated for by the increased stimulus and interest.

A high standard of liaison is essential between surgeon, general practitioner, nurse and patient. Advantages to the patient include reduced waiting time for operations and convalescence in familiar surroundings.

The selection of the type of patient for this scheme is the province of the general practitioner; the selection of the type of operation is the province of the surgeon.