Second National Trainees' Conference

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After the success of the first national trainees' conference in Newcastle in April 1972, a second conference was held in Edinburgh on 30–31 March 1974. Its theme was *The future general practitioner and his training.*

Although the meeting was oversubscribed, 360 delegates were able to attend. Of these 210 were general-practitioner trainees (140 in organised vocational schemes) and 150 were teachers, scheme architects, or members of university departments of general practice.

Sir John Brotherston

Under the chairmanship of the trainees who had organised the conference, the opening session began with an assessment of *The future of general practice in an integrated Health Service* by Sir John Brotherston, the Chief Medical Officer of the Scottish Home and Health Department. Since the start of the Health Service in 1948 there has been a mystique of difference and separatism between general practitioners and specialists, but he saw the administrative integration of all medical services as an opportunity for communication between hospitals and practitioners with benefit to everyone involved. Although general practitioners were rejected in the early days of the Health Service they are now influential members of the profession. But, he said, they must say what they want from the administration by participating in its machinery. As for trainees, if they wanted to influence their own futures they must push for the changes they wanted. He made no promises.

Professor Marshall Marinker

Following this, Professor Marshall Marinker, in his inimitable way, discussed *The changing role of the future general practitioner.* Despite the predictions of Aneurin Bevan, when he instituted the National Health Service, people continue to be ill and only a generalist can cope with the complex presentations of the numerous problems that patients produce. Like Sir John Brotherston, he felt that one of the most important functions of the primary physician in an age of scientific medicine was to protect the patient from the secondary physician. He feared that the trend towards specialisation, emergency treatment services, and team work, would produce depersonalisation of the caring professions, so that patients might need to look elsewhere (where?) for general counselling, whole person diagnosis, continuing care, and support.

Professor Alwyn Smith

Professor Alwyn Smith, Professor of Social and Preventive Medicine at Manchester University, saw himself as the academic counterpart of Dr Snoddy and struck an even more pessimistic note. His brief was *The future of general practice and the health team* which he considered as an epidemiologist. He described the struggle between the factions of the community health team. Although all groups have a legitimate claim to certain areas of responsibility, each member whether doctor, nurse, social worker or whatever, tends to become ' imperialistic ' and none is prepared, now, to accept a subordinate role.

Conflict had developed, too, between the health team and the patient. Whereas in the old days the doctor and his patient co-operated in what tended to be acute life-threatening situations, the modern trend towards preventive care is less immediately convincing to most patients, and therefore less acceptable.

His solutions to these problems concerned the organisation and training of the team. The doctor is not necessarily the leader. He favoured a common basic education for medical and paramedical workers in a single university department, and he endorsed the development of postgraduate medical centres for general practitioners and specialists alike.

In the discussion that followed the general feeling was that there was a need to re-forge links with the hospitals, even if this was a subconsciously directed movement of the isolated general practitioner back to his clinical womb!

Dr Christopher Clayson

Saturday afternoon was devoted to the consideration of education in general practice and began with a view of general medical education by Dr Christopher Clayson, Chairman of the Scottish Council for Postgraduate Medical Education. He saw no reason why postgraduate training should be a separate entity and proposed a course of training for all potential general practitioners followed by continuing education in the form of seminars in postgraduate centres for general practitioners, hospital doctors, and perhaps paramedical personnel alike. He also predicted that the time would come when the best teaching posts in general practice would become as much sought after as the best teaching hospital posts.

Professor Henry Walton

Professor Henry Walton, psychiatrist and educationalist, followed with a discussion of teaching methods and ' teaching technology '. Education is a process by which the student is changed, he said, and teachers must define the direction of the change, and must themselves be taught the skills necessary to produce this change in their students. He looked at various teaching methods and their results in other countries, but thought that, whatever the teaching technique (lectures, television, small groups), frequent assessment during the course was important, with feedback of the results to the teachers and the opportunity to correct deficiencies. Among his proposals was the suggestion that students should be taught to perform practical skills such as lumbar puncture on a simulator before attacking and upsetting patients.

Dr John Stevens

Dr John Stevens, the provocative 1973 James Mackenzie lecturer of the Royal College of General Practitioners and one of the architects of the Ipswich training scheme, completed the afternoon trilogy on education with a talk entitled *Education for general practice: theory practice.* He did not favour a rigid curriculum for vocational training, but found that trainees left to define their own learning objectives covered the ground very adequately. This had been proved in the successful Ipswich scheme.

Among other things in the ensuing general discussion was the question of whether all training for general practice could be done in general practice. Dr Stevens thought that the practice was the most effective place for all teaching, including hard clinical medicine, and by the applause that followed, this was clearly a popular idea.

Small group discussion

Probably the most interesting and fruitful contributions to the conference were those of all the delegates in the small group discussions that were held on both days. There was no general agreement, but many topics were discussed including general-practitioner beds, emergency treatment services (generally unacceptable), the role of the health team, and medical audit. On the second day the groups had become more free and relaxed and the conference provided a unique opportunity for trainees to discuss their own training and future with those from other parts of the country. Trainees' personal experiences and aspirations varied considerably, so there was much stimulating interaction and discussion.

Also demonstrated in small groups were some teaching methods such as role play, random case analysis, and modified essay questions. These, too, were eye-opening to those not familiar with them. Particularly impressive was the intimate group from Ipswich who seemed to derive enormous benefit from the uninhibited rapport they have built up within the group.

Mr Arnold Morrison

Mr Arnold Morrison, another educationalist, started the Sunday morning session with more theoretical ideas about teaching. He discussed the aims of professional training and the problems of preparing a teaching programme for a subject so amorphous as general practice. He also pointed out, sagely, that the best clinicians are not necessarily the best teachers.

Evaluating vocational training schemes

A highlight of the meeting was the presentation of the Royal College of General Practitioners visitors' report on vocational training schemes. This was introduced by Dr John Horder who explained why the College considered that it was important to visit the schemes. Dr George Taylor, a trainee from the Newcastle scheme, then presented the results of questionnaires sent to trainees and trainers as part of the study. Although most trainees seemed to be content with their lot, there was striking variation in standards throughout the country. Dr Horder discussed the visitors' findings in more detail, describing what he imagined was the ideal training scheme, and stressing the importance of careful selection of teachers, practices, and hospital posts. Both he and Dr Taylor were keen that the College visiting should continue, in order to maintain the standards of vocational training.

Professor P. S. Byrne

Professor Pat Byrne, President of the Royal College of General Practitioners then summed up, explaining the role of the College in training and reiterating its aims.

Dr Douglas Stuart

Dr Douglas Stuart, one of the conference organisers, briefly discussed the value of the conference from a trainee's point of view. It had presented, in what was necessarily only a short weekend, enough ideas to stimulate discussion later. But perhaps it was a pity that there had not been more contribution from trainees in what had been intended as a trainees' conference. This was partly achieved on Sunday afternoon when, after a short paper from two London trainees, a diminished number of delegates in a " trainees' forum " discussed the trainee's role in helping to plan his own training and sort out any problems in course organisation. A contract of service for trainees in practice was again discussed and two draft contracts were presented.

After a lively discussion it was decided to ask the Regional Advisers in General Practice to arrange meetings of all trainees in their areas to discuss local matters. At the same time a representative of the British Medical Association said that there were moves afoot to obtain better representation for the rapidly increasing number of trainees at national level.

REFERENCE

1. *Journal of the Royal College of General Practitioners* (1972). **22,** 415–16.

ASSESSING THE NATIONAL HEALTH SERVICE

" Conclusions about the benefit of the National Health Service for the population of this country are based in the end of the knowledge that it has preserved more successfully than most of the other systems both freedom of access to medical and allied care at times of need and the availability of a personal medical attendant. Both the public and the health professions know and expect that treatment that is needed by a sick person will be available to him. It is possibly upon this assurance that public and professional confidence in the National Health Service primarily rests.

" There are of course many defects in the system and many occasions when it works less well than the individual member of the public or the professions would wish. There are grievances among many of those working in the National Health Service and some of them are justified but, however great may be the differences in quality between some of the components in the National Health Service, it is at the end of 25 years a successful service that is moving towards a unification which will make it possible to develop more rationally and, in the future, a secure a better balance."

REFERENCE

Godber, Sir George (1973). *On the State of the Public Health,* London: H.M.S.O.