obstetrics and/or gynaecology; paediatrics; psychiatry); any remaining period (up to a year) may be spent in one or more of a wider range of hospital or community medicine appointments. Provided that hospital experience is in two of the listed specialties, it can be confined to those two specialties.

To count towards prescribed experience all these hospital and community medicine appointments must be held subsequent to registration with the General Medical Council. Furthermore, the posts themselves must be educationally approved, which means that (for England and Wales) they must first have been approved by the Royal College or Faculty concerned with the specialty in question, and then selected by a regional postgraduate medical education committee as suitable for general practice training. (In Scotland and Northern Ireland the approval mechanism is only slightly different.) Experience acquired on a part-time basis will count provided it is not less than half time: the duration of training must be extended proportionately, but overall the experience must be acquired within not more than seven years immediately preceding the application for the certificate. This will allow for breaks in training, which may be particularly appreciated by women doctors.

At the end of each appointment the doctor should obtain from his/her trainer or consultant a signed statement of satisfactory completion and send it, endorsed by the regional adviser, to the Joint Committee on Postgraduate Training for General Practice (JCPTGP) in support of his application for a certificate of prescribed experience. Once this certificate is issued it does not have to be used straight away: it can be retained by the doctor and used at any time in the future when applying to the Medical Practices Committee.

Other sorts of medical experience which do not fulfil the above criteria (for example, some posts overseas; appointments on a less than half-time basis; non-training assistantships in general practice) may nevertheless be deemed 'equivalent' to prescribed experience, and full details should be sent to the JCPTGP which will consider all such applications and, if satisfied, issue the appropriate certificate. (A certificate of equivalent experience will confer precisely the same status on its holder as a certificate of prescribed experience.) Application forms are available from the Joint Committee's office at 14 Princes Gate, London SW7 1PU.

If the JCPTGP declines to issue a certificate it will state its reasons, and this should prove helpful to applicants in planning their further training. On the other hand, disappointed applicants have the right to appeal to the Secretary of State against the JCPTGP's refusal to issue a certificate.

Doctors with any queries about their status under the Regulations, or who want advice on how best to complete their training to meet the requirements, should contact their regional adviser in the first instance. In addition, information is always available from the Joint Committee's office. It is important to bear in mind the implications of the phasing of the Regulations: anyone who has completed the general practice component before 16 August 1982 will have satisfied the requirement for prescribed experience and may apply for the certificate irrespective of whether or not training in hospital has been undertaken. However, application for this must be made before 16 November 1982.

Despite the complex nature of the Regulations it is expected that the great majority of future entrants in general practice will have fulfilled the criteria for prescribed experience, which after all is similar to the three-year vocational training at present undertaken voluntarily by hundreds of young doctors, whether in co-ordinated schemes or as self-constructed programmes. The true significance of this measure is that it provides the country and the profession, no less than the trainees themselves, with an assurance about standards of present-day training, and thus about the quality of general practice in the future.

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Executive Officer, JCPTGP

Joint curriculum planning in Plymouth

PLYMOUTH VOCATIONAL TRAINING SCHEME

THIS report outlines the evolution of a joint curriculum for training general practitioners between the Department of Geriatric Medicine in the Plymouth Group of hospitals and the Vocational Training Scheme for General Practice in Plymouth, Devon.

As a result of negotiations in the spring of 1979 between the vocational training scheme and the Department of Geriatric Medicine in Plymouth to establish training posts of four months' duration, concern was expressed by the geriatric department that this term of attachment might not be adequate to fulfil the training needs of each doctor. However, happily for the vocational training scheme and for the future of general practice in the South West of England, the geriatricians decided to accept the constraints placed upon their teaching resources by the time limitation, provided that the trainers within the scheme realized they also had a part to play in teaching.

On behalf of the vocational training scheme a meeting of nine trainers, the consultant geriatricians, and two trainees was convened by the course organizers to discuss co-operation in training between the vocational training scheme and the geriatric department on Tuesday, 26 June 1979. Eight further lunch-time meetings have been held.

In the early meetings thoughts centred around the need for mutual co-operation between general practice and the geriatric department over patient care. The geriatricians emphasized the need for general practitioners to be aware of the full scope and resources of their department and pleaded for early referral of patients. The general practitioners expressed the need for the geriatricians to be available to, and to be aware of, the needs of general practitioners.

Several meetings were spent discussing the need for training and the ways in which adequate training might be achieved. This led to an appreciation of the need for joint curriculum planning between the vocational training scheme and *any* hospital department involved with trainees.

Initial curricula were produced, amalgamated, and refined by discussion. A final curriculum was unanimously accepted by the working party on 6 May 1980 (Appendix 1). The working party hoped that this curriculum would offer guidelines for teaching geriatrics in the hospital, in the half-day release course, and for trainers in their practices. It was also felt that the curriculum would provide a good basis for private study by trainees.

Conclusion

The question of allocating different parts of the curriculum has not yet been resolved. Some topics are better taught in the geriatric department and others are more appropriate to general practice. This, and the problem of assessing the usefulness of the curriculum, will be tackled by the Committee in the future.

It was no accident that this venture was undertaken with the Department of Geriatric Medicine. Of all the hospital specialties geriatrics is the one closest in spirit and practice to that of general practice. We must now approach other specialties in order to plan joint curricula with them. This will allow all concerned to make the most of teaching resources for the benefit of all our trainees.

Appendix 1

Geriatric care curriculum

1. Aims

The trainee shall:

a) Appreciate that geriatrics is not 'lost cause' medicine, and that something can *always* be done to help the elderly.

b) Generate that attitude of mind which will make him receptive to the needs of the elderly.

c) Be aware of disease processes which are prone to affect the elderly, and of their early recognition and management.

d) Be aware of the effects of social class and culture on management problems in the elderly.

e) Know what services are available to the elderly and how to use them.

2. Syllabus

Health and disease

The trainee shall:

a) Be able to differentiate between natural and pathological processes in the elderly and show familiarity with the different characterizations of disease as they affect the elderly.

b) Know the nature and purpose of the hospital geriatric services.

c) Appreciate the significance of assessment in physical, psychological, and social terms, rather than only diagnosis.

d) Appreciate the ramifications of multiple pathology.

e) Be aware of the role of remedial therapy in patient management and how to provide it.

f) Appreciate the management problems of long-term care.

g) Be aware of the facilities for long-term care.

h) Justify the need for early intervention and active management in the prevention of long-stay patients.

i) Have knowledge of the problems of medication in the elderly.

j) Be able to assess adequately his patient's senses, particularly in relation to deafness and visual impairment, and know what help may be mobilized.

k) Be aware of the problems of incontinence, falls, and the development of disorders of the autonomic nervous system as they affect the elderly.

l) Appreciate the particular need for early referral to the geriatric services.

m) Demonstrate his management abilities in the optimal placement of his patients.

Human development

The trainee shall:

a) Demonstrate his knowledge of the theories of ageing and be able to describe a realistic model of the fit elderly.

b) Demonstrate his appreciation of his patient's previous state and entitlement to respect and care.

c) Be able to assess the contraction of his patient's abilities and demonstrate insight into this.

Human behaviour

The trainee shall:

a) Show an understanding of the mental disorders which affect the elderly.

b) Demonstrate understanding of the quality of his patient's life and the stage at which limited aims and easement become priority.

c) Be aware of how and when to tell a patient of the imminence of death and be able to conduct a patient's death with tact, sympathy, and understanding.

d) Be aware of the problems of the bereaved and know how and when to intervene on his patient's behalf.

Practice

The trainee shall:

a) Demonstrate the use of the extended primary care team in the care of the elderly and be able to devise and define the role of each member.

b) Be aware of the pros and cons of screening the elderly.

c) Demonstrate the use of an age/sex register to identify patients at risk.

d) Be able to construct a simple screening proforma and establish a viable screening programme within the practice.

e) Demonstrate the use of a repeat prescription card system to avoid over-medication in the elderly.

Medicine and society

The trainee shall:

a) Describe the administrative and legal aspects of care for the elderly.

b) Know what financial services, entitlements, and grants are available to the elderly, and know when and how to apply for them.

c) Be aware of the role of non-medical agencies in the care of the elderly and know when and how to use them.

d) Describe the system of progressive support provided in the home, the community, the hospital, and institutions.

e) Appreciate the right of the elderly patient to live alone and foresee the problems inherent in this.

f) Be aware of the differing religious requirements on the death of the patient.

Postgraduate medical education for general practitioners

FORTY-NINE general practitioners attended a two-day meeting organized by the Tutors of the East Anglia Faculty in March 1980, which was held in the delightful setting of Corpus Christi College, Cambridge.

Aims

The aims of the meeting were derived from two papers by East Anglia Faculty members which examined the educational needs of established general practitioners and identified the need for a district-based general practitioner tutor whose role they defined. The aims were threefold:

1. To define and examine the problems of postgraduate medical education for general practitioners, and to propose solutions.

2. To define the specific educational knowledge, skills, and attitudes required of the general practitioner who wishes to promote postgraduate educational activities among his local general practitioner colleagues.

3. To develop further the educational knowledge, skills, and attitudes of course participants and so enable them to promote more effectively postgraduate educational activities among their local general practitioner colleagues.

Method

The programme was divided into five sessions, each devoted to one of five major problem areas. Each session began with an introductory talk by an East Anglian general practitioner. This was followed by group work. Each group was set a task relevant to the particular session and led by one of the East Anglia Tutors.

The sessions

1. *Adult learning theory*

The introductory talk was given by Dr S. Oliver, General Practitioner, Bury St Edmunds. The groups were set one of three tasks:

a) You have applied for the post of general practitioner tutor, paid at two sessions a week, which is based on the local postgraduate centre where, with secretarial help, you will work in parallel with the clinical tutor.

The interviewing panel ask what, if appointed, your