and two years of further professional training.
2. There should be a vocational certificate at the end of general professional training.
3. There should be a vocational register with entry at the end of five years.

It also supports the recommendation of the General Medical Council that National Specialty Boards should be created.

General professional training and further professional training are complementary parts of a total training programme. Nevertheless, the College recognizes that the full development of further professional training for general practice may take longer to achieve than that for general professional training. All teaching practices should reach a high level and this may take time. In the interim, further professional training might be based on recognized forms of in-service experience in general practice. In this case one whole year would need to be spent in a teaching practice during general professional training.

The postgraduate doctor should be assessed at the conclusion of his training, but the College supports the view of the Royal Commission on continuing assessment and is developing methods by which this may be undertaken. It also recognizes that a specialty board is likely to require objective evidence before nominating a candidate to the General Medical Council as one whose name should be included in the vocational register. The College is confident that it could provide such evidence and believes itself to be the only body which might rationally do so.

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THE EDUCATION OF THE TEAM

Family Health Care Team Committee

Working Party on Education and Training*

Summary

This document examines the educational requirements of the domiciliary health team. It surveys those educational needs which are shared by all members and those offerings from particular branches which are of value to all the others. It considers the possibility of joint education at certain stages.

Purpose of this document

As the domiciliary health team becomes a reality in more and more areas, a new educational

need appears. The different members of the team need to know what each of the other members can or cannot do and what are their special requirements and problems in their work. The team needs training to work as a team. This document brings together the educational needs of each branch providing members for the team, looking especially at those which are shared. It also brings together some of the educational offerings which each branch can make to the others. Finally, it examines the possibility of education in common. To what extent can the different members of the team be trained together?

The document is common to all branches of the health team. It could have been followed by appendices which concern the special needs, offerings and problems in education which are individual to each branch.

Background

It has, of course, always been important that the different branches of the profession should know and respect each other and understand each other's problems. The emergence of the health team only makes the need more obvious and less difficult to fulfil. There have in the past been a number of joint conferences. Members of different branches have lectured to other branches and visits of observation have been regularly arranged in some areas.

An important conference, to which the present working party owes its existence, took place in 1967—'Family Health Care—The Team'. This was supported by the Health Visitors Association, the National Association of State Enrolled Nurses, the Queen's Institute of District Nursing, the Royal College of General Practitioners, the Royal College of Midwives, the Royal College of Nursing and the Society of Medical Officers of Health. The same organizations are producing the present document.

Medical social workers were not represented at this conference and, as a consequence, have not contributed to this document. This is regretted, since there are already social workers in domiciliary health teams in a few centres who are doing excellent work.

Educational patterns

Although different branches use different words to describe the major stages of education, the pattern for each is much the same as for the others. Thus the basic nursing training for registration or enrolment corresponds in some respects with undergraduate medical education. For doctors and for those nurses who wish to work in the community, periods of special vocational training are available after registration. It is at this point that a general practitioner or medical officer of health will be differentiated from other doctors, and a district nurse, a health visitor, or the majority of midwives from other nurses. Finally, there is in every branch a need for continuing education. These broad generalizations are possible for all members of the team.

An obligation to take special vocational training and refresher courses is not common to all branches of the health team. At the time of writing there is no obligation on a general practitioner to take special vocational training, but there is for the medical officer of health. Practising midwives are obliged to take refresher courses every five years; health visitors and district nurses are recommended to do so; general practitioners are left to their own consciences.

Common educational needs

Examples follow of common needs at the three main stages of education. Each branch of the team is anxious that students in basic nursing or undergraduate medical education in hospital should know something of what goes on outside hospital, so that they start with an unbiassed picture of the community's medical needs and the rôles of those who provide them. Without

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this, both education for the domiciliary health team and recruitment to it must suffer.

In the period of special vocational training each branch needs instruction and opportunities to observe the work of the others. Discussions and visits of observation by very small groups and joint case-studies are needed; so are chances for informal contact. All can benefit from teaching by others not at present included in the team—other medical specialists, medical social workers and members of certain other social services—for instance probation officers or disablement re-settlement officers. Later in life, at regular short intervals, all branches require to know of recent advances in medicine, nursing and the field of social service. This is urgently true at present for those who are already in the field. There is already a lot of experience of co-operation scattered in different parts of the country. There is a need for interdisciplinary conferences to share existing experience, to avoid unnecessary repetitions or mistakes and to develop teaching methods.

What each branch can offer

Each branch has a fund of experience on which teachers in another branch can draw. The examples which follow, however, are likely to be of value to most of or *all* the other branches. For example, lectures or visits of observation to demonstrate the work of, say, midwives are likely to be of value to all other members of the team. Medical officers of health can offer a place in which instruction of the whole team can be given (child welfare centres). General practitioners working in groups, and even better in health centres, can offer what is probably the ideal setting since this is the base from which the health team will in future work. Integrated basic courses for hospital nurses, health visitors and district nurses are provided in a number of centres. Other experiments in integrating the work of different members of the health team are likely to be needed with the object of saving woman-power.

Education together?

Why? There is no better way of helping people to work together than by providing a common education. This is the way to ensure a common basis of thinking and a habit of communication. In so far as the different groups face common problems, joint study provides mutual support. In so far as they bring differences in approach, they stimulate each other. If there is a shortage of teachers and money, sharing is also expedient.

Is it possible?

Undergraduate medical education and basic nursing education have separate traditions and complex structures which would be very hard to mix except at certain small areas of overlap. Teaching sessions could be shared, for instance, on medical care and social services outside hospitals. There is certainly a place for joint discussion on topics of mutual interest. But any large amalgamation of basic trainings is clearly out of the question and probably not desirable.

The different groups come closer in their educational needs after registration—that is, those doctors who are training for general practice and those nurses who are training to be district nurses, health visitors or midwives. They need to learn to understand each other's backgrounds and rôles. They are likely to be sharing places of work in future—the health centre—and teaching health centres may be able to provide space and facilities for common teaching. There are many topics which are of interest to all groups (for instance, child development, nutrition, housing and health. Health education. Patient's attitudes to doctors and nurses. The management of difficult patients—the anxious, the depressed, the hostile, the lonely, those with unusually high or low intelligence. Confinement—home or hospital? Management of serious illness at home. Effects of illness on the family—and many others.) More important than any theoretical topic is the current case with which several members of the team are simultaneously involved—notably the 'problem family'.

But even at the stage of vocational training there are many subjects and skills which are not needed by all groups. Sharing of education could only be partial at best. Different educational backgrounds might still cause difficulty in mutual understanding. The traditional dominance of the medical profession might sometimes make a problem in discussion groups. Experience hitherto of joint training is extremely limited. In each area there should be a planning group of representatives from the training bodies of the several professions. There

are very few teaching health centres at present; each would contain comparatively small numbers of trainees from each group. Who would organize joint training in a teaching health centre? Clearly there should be a working group with a member from each branch; but joint training would need one organizer guided by this working group. Ideally, this should be the person best at organizing and with the greatest interest in teaching. He or she might emerge from any of the professions.

THE TEAM

A JOINT CONFERENCE SPONSORED BY the four Scottish nursing organizations, the Scottish council of the Royal College of General Practitioners and the Scottish branch of the Society of Medical Officers of Health was held at Edinburgh University on 19–20 September 1969.

The 200 delegates who attended from all over Scotland were provided with a most thought-provoking and stimulating two days in which all facets of the difficulties, advantages and disadvantages in working together as a team of doctors and nurses were thoroughly explored. The theme of the conference was set by DR BROTHERSON, chief medical officer to the Scottish Home and Health Department, who emphasized that the time for inaction in carrying into effect the concept of the Team in the community was now past. This concept had been accepted, tested and found advantageous so that there were no real excuses now for lack of progress. He welcomed also the inclusion in the programme of contributions on integration with the hospital services (notably in midwifery, psychiatry and geriatrics).

DAME ANNIS GILLIE followed this introduction and gave the opening address of the conference as overall chairman. Her basic message was the importance of developing the proper attitudes and, in this respect, one had to evaluate not only our own attitude as nurse, or doctor, but that of the public. She stressed the vital need for good communications within the team and said that if these fundamentals had been properly considered and developed, subsequent problems of provision of bricks and mortar, from which the team could operate, would become easier to solve.

The first day was devoted to papers on the general practitioner and community care. Delegates heard about the problems of a county co-ordinated general medical services team and of success in a district nurse–midwife and health visitor attachment in a small town. The difficulties of the attachment schemes in a city were also discussed and this was counterbalanced by the presentation of some achievements in attachment in Aberdeen. These two papers emphasized that the main difficulties were transport and administration but these were more than balanced by greater job satisfaction and better realization of the rôles of the different members of a team. An example of the work and impact of such a health team of nurses and doctors in a large group practice in Edinburgh was then presented in detail and the advantages and disadvantages in this setting analysed.

The following day the conference studied co-ordination of hospital and community care. First, they looked at the midwifery services and in particular the 'short stay' problem, i.e. admission of the patient for 48 hours for her confinement. The effect on midwife, patient and general practitioner of this form of obstetric care was discussed and the importance of proper communications realized.

The mental health services and their special hospital and community care problems were next on the programme. It was emphasized that in the planning of a mental health community care team, cognizance must be taken, especially in large cities, of different community areas