REPORT

EDUCATION FOR GENERAL PRACTICE

A conference for representatives of Faculty Education Committees held at the University of Birmingham on 8–9 July, 1970

Undergraduate education

The morning session was devoted to the rôle of general practice in undergraduate medical education. DR J. P. HORDER, in the chair, pointed out the importance of identifying the objectives of teaching undergraduates in this setting before it is possible to determine the best methods of teaching.

DR D. C. MORRELL suggested that we should be asking which aspects of medicine can be taught more effectively in general practice than in the hospital setting. Illustrating diagrammatically the natural history of disease from health, through primary demand for medical care to disability and death, he pointed out that those stages leading up to primary demand and those associated with adaptation to disability are not seen within the hospital and can only be satisfactorily demonstrated in the community. These were closely concerned with human behaviour in response to illness, an area of medical care in which the general practitioner has special knowledge and skills. He then described the morbidity of patients referred to hospital from general practice and contrasted this with the morbidity of patients consulting the general practitioner. He argued that general practice is able to make a unique contribution to undergraduate education by demonstrating the prevalence and incidence of disease in the community, the social and psychological factors which determine demand for medical care and adaptation to chronic disease, and the medical and social services available in the community for providing medical care.

He described in detail the course which is organized at St Thomas's Hospital Medical School in which general practice is used for undergraduate education. He favoured integrating the teaching in general practice into the curriculum wherever it had a contribution to make and thought it was a mistake to think of teaching only in terms of short attachments of students to general practitioners.

DR D. CROMBIE then spoke of the need to maintain organized curiosity throughout the undergraduate's curriculum. This, he said, was also vitally important to the general practitioner and he described the use of the college 'E' Book, both as a morbidity register and as a basis for personal medical auditing. He then married these two concepts in project teaching in general practice for undergraduates. He described the method he had developed in Birmingham in which a student on elective for eight weeks could select a disease, e.g. 'stroke', and study it in depth. The names and addresses of the patients who had suffered from that disease during the preceding decade were then given to him from the 'E' Books, and, by reference, to the patient's notes, discussion with the general practitioner and home visits to the patients, the student was enabled to collect and analyse data which would allow him to study the impact of disease on a cohort of patients over a period of time. In this way, the student through his own initiative could obtain a deep understanding of the effects of illness on the individual and, in particular, the importance of social factors on rehabilitation.

The meeting then broke up into six discussion groups. Three considered the content and timing of teaching; the remainder, methods which may be employed in teaching undergraduates.

The importance of adjusting the content of teaching to the needs of the individual medical school was stressed. If this was done, general practice could contribute throughout the curriculum. It had an important part to play in the teaching of behavioural sciences to medical students and in the early clinical phase it could be used to foster an understanding of the development of symptoms and early signs of illness. It was an ideal setting for undergraduates to study

the impact of chronic disease on the individual and family and to learn about the resources in the community for providing medical care.

The groups discussing methods of teaching stressed the fact that general practice offers an opportunity for patient, doctor and student to relate in a unique setting, where the patient is the teacher, and that this asset should be used to form the basis for all teaching. It was important also to consider the general practitioner's rôle in integrated teaching with other disciplines, such as case conferences and multi-disciplinary seminars.

Perhaps the most important lesson we all learned was that the reports to the plenary session were shown to reflect the views of the *rapporteur* rather than those of the groups. This raised questions about the value of the discussion group or seminar as a learning situation.

Continuing education

The afternoon session on "Continuing education" was organized in a similar manner to the morning. DR M. DRURY, chairman, Education Committee, Midland Faculty, was the chairman.

DR J. D. BLAINEY, consultant physician and clinical tutor, Queen Elizabeth Hospital, Birmingham, the first speaker, voiced his worries about postgraduate courses—the number, the content, the pattern of presentation, the organization, the motive for attending and the cost. Postgraduate education was an ever expanding business and there was, in the main, no check on the effectiveness of the multiplicity of offerings. He pointed out that everyone regarded themselves as an expert in their field, but the result was often trite boring meetings and programmes constructed at the whim and prejudice of a tutor. He finished by producing the short report on "The educational needs of future general practitioners" (*The Journal of the Royal College of General Practitioners* (1969) **18,** 358) and suggesting that it was an excellent basis for planning.

DR H. W. K. ACHESON, senior lecturer in general practice, Manchester University, followed with a short account of one method of postgraduate assessment—the 'self-audit'. He emphasized the need for continual critical viewing of one's daily work, since most general practitioners were in an unsupervised environment, escaping the comments of their colleagues or the questioning of students. He pointed to the educational content of the daily work-load and how an analysis of real situations was often of more value than a classical postgraduate course. One way of learning was the retrospective examination of records. This implied the need for accurate recording.

Dr Acheson's SOAP formula was spelt out so attractively that by the end he had converted most of the audience to rethink the old formula of History, Examination, Diagnosis, Treatment —and to replace it by Subjective Information, Objective Information, Assessment (rather in the manner of a psychiatric case formulation) and Plan (to include therapy and management).

Following the two speakers, the meeting divided into six groups, three to discuss the topic "How would you construct a five-year programme for a man, who qualified aged 25, 15 and 30 years after qualification?" The other three groups were presented with: "What methods of learning and teaching are most appropriate in continuing education?"

Vocational training

On the second day of the conference the chair was taken by DR GEORGE SWIFT, chairman of council. The subject was "Vocational training", for both morning and afternoon sessions.

Two schemes

DR DONALD IRVINE described the North-east England project, occupying the three years following registration. Two years are spent in hospital with appointments in appropriate specialties and throughout this period the trainees are committed to a half-day release scheme with the intention of orienting their hospital work towards their future needs in general practice, of keeping them in touch with their trainers, and ensuring the cohesion of the group. The year in general practice is split into two six-month periods; the first period is introductory, at the start of the three-year course, and the second takes place in the last six months of the course, based on the same practice but with visits arranged to other practices in the scheme.

The selection of teaching practices is rigorous and the standards high. So far there have

been two 'intakes' of trainees and these have been men of exceptional calibre and academic attainment in their undergraduate careers. There is inadequate payment to trainees during their training and there is a need for more accommodation for married doctors. It was calculated that these trainees made a financial sacrifice amounting to some £5,000 over the three-year training period. Unless a substantial increase in the vocational training allowance were negotiated with the government, it would be difficult to sustain future programmes such as this on a wide scale.

DR JOHN STEVENS described the scheme at Ipswich. This also spans three years following registration. There are six-month hospital appointments in internal medicine and obstetrics-gynaecology, with three-month appointments in geriatrics, casualty and paediatrics. In the third (general practice) year, there is a day release scheme. A special feature is the sponsor-Exchange arrangement made between the trainee and his 'sponsor' general practitioner. For one week in every six months the general practitioner enters hospital to take on the trainee's SHO post, and the trainee acts as a locum in his sponsor's practice. Dr Stevens invited the conference to consider which of them was placed under the greater strain.

Trainees are released from their hospital posts to take part in a weekly training seminar. This is divided into two periods; a teaching seminar concerned with the behavioural sciences, psychodynamics and traditional systematic psychiatry, and a Balint seminar. The trainees, like those in Dr Irvine's scheme, are doctors who have shown the highest academic ability during their undergraduate careers. There were three basic principles to all their planning, said Dr Stevens; competent costing and administration; a non-aggressive attitude to specialist and generalist colleagues; a strict adherence to the principles of medical education.

Developments at the centre

DR JOHN HORDER reviewed the history of vocational training, starting with the trainee scheme introduced in 1948. During the first decade, the idea of vocational training was not generally accepted; during the second ten years when the idea was more acceptable, the problems had been the shortage of doctors and the disparity between incomes that were earned in the course of three years vocational training on the one hand and direct entry to general practice on the other.

There were, however, encouraging signs for the future. Both the number of trainees in the country and the number of entrants to medical schools were increasing. Although the profession had refused a mandatory specialist register they had approved an indicative register and both the British Medical Association and General Medical Services Committee had accepted a three-year period of vocational training. Dr Horder went on to describe some of the recent activities initiated by College council and its committees. An outline of the content of general practice had appeared in the College *Journal* (December 1969) in a report entitled "The educational needs of the future general practitioner". There had been two working parties, one with the Royal Medico-Psychological Association, which had produced a series of recommendations on training in psychiatry for general practitioners, and another with the Society of Medical Officers of Health, which had produced recommendations on the training of general practitioners in the work of community medicine. Both these reports were being circulated to education committees of faculty boards. The annual course for teachers, organized by DR PAUL FREELING at college headquarters, had proved stimulating and rewarding, and there were now a series of teachers' workshops in different parts of the country which were studying methods of teaching appropriate to the curriculum and were developing the expertise of its members as teachers. There was to be a conference of workshops in Manchester in April 1971. A document had been produced about the selection of teachers, and the college examination was being constantly refined by the court of examiners as an instrument for measuring the effectiveness of teaching.

The content of training

DR C. M. HARRIS followed with a description of the work of the Fourth Report Working Party. The seven members had begun by writing a definition of the general practitioner; all that follows, the division of the content into five overlapping areas (clinical medicine, human development, human behaviour, society and medicine and the practice), is a logical progression based on the assumptions of that overall definition.

The final document of the Fourth Report will contain two categories of material. First, there will be a section dealing with such matters as the reasons for vocational training, the problems of logistics and organization of training schemes. Second, there will be a section dealing with the theories and methods of teaching, a statement of the content of general practice, and suggested methods of evaluation. This second category of material, because it is regarded as more tentative than the first, will be produced as a document for comment by the members of the College. There are problems associated with integrating material from the behavioural sciences into the curriculum. In particular there are the difficulties of handling the jargon from such disciplines as psychology, ethology and sociology. Jargon was often a way of expressing a unique and complicated idea in an abbreviated form. The members of the working party had to decide how far they could go in translating jargon into plain English, without distorting or losing the ideas which the jargon described. Despite these difficulties however, they were beginning to feel that the statement of content was a 'good fit' for their original definition of the general practitioner. The membership of the College as a whole would have ample opportunity to criticize the document constructively, and help in the production of a later and more definitive statement of content.

Selection and duties of regional advisers, tutors and training practices

DR GEORGE SWIFT defined a training practice as one in which at least one of the principals had been trained to teach. The College had alreay defined criteria for the selection of teachers, based both on personal qualities and the qualities of the practice in which they worked.

College tutors would have a task in connection with vocational and continuing education, analogous to that of the tutors in surgery or psychiatry, who had been identified by their respective colleges. Their job was primarily one of liaison and planning, and they would act as advisers to the postgraduate tutor, based wherever possible at local postgraduate centres. In addition, they would advise potential entrants into general practice about career training and prospects, and they would in general represent the interests of the College.

Regional advisers were going to be *de facto* sub-deans; they would have an overall responsibility for courses in their region, would have considerable administrative responsibilities, and would probably have to work in such close proximity to the university, that they might well spend that proportion of their time devoted to practice in a teaching practice attached to their university.

The last hour of the morning was taken up in vigorous discussion from the floor of the conference. Anxiety was expressed about the preparation of teachers in the areas of 'human development', 'human behaviour' and 'society and medicine'. Both the financing and the logistics of schemes had raised many difficulties.

Developments in Canada and the U.S.A.

After lunch, PROFESSOR E. HAINES of Buffalo, New York, gave a most exciting account of developments in academic general practice, both in Canada and the United States. He spoke in some detail about the Canadian examination for specialist registration in general practice. In a recent examination, 117 candidates sat and there was an overall failure rate of 12.8 per cent; of particular interest was the fact that while 20 per cent of the candidates who had recently undergone a complete vocational programme failed, the failure rate among members of the Canadian college who were 'eligible' because of their years of experience, was only 11 per cent. He described the MCQ, which tested problem-solving in addition to information recall, the use of video-tapes, a rôle-playing oral in which the examiner takes the rôle of patient, and a programmed series of consultations, with three seasoned actors playing the rôle of patients, observed through a one-way mirror by the team of examiners.

Progress in the United States was breathtaking. There was a burgeoning number of new departments of general practice, and family medicine is now recognized as a specialty in its own right. This is the first new specialty to be recognized by the AMA in 20 years. The first certification examination was held in February 1970 and there were over 2,000 candidates. The overall pass rate was 81.5 per cent. The examination will be open to 'practice-eligible' candidates until 1978, and thereafter only to doctors who have completed an approved vocational

training programme. Certification will be regarded as valid for six years, and will thereafter have to be renewed.

Professor Haines went on to describe the residency programmes in which residents have a considerable responsibility for patients. Each resident has a 'list' of 50 to 100 families for whom he provides total care, the teacher acting as an adviser and resource man. The programmes were aimed "to produce family physicians by intent and not by default". There was, he said, a new concern, stemming from the young in America, about the quality of life. There was a rejection of the materialism which had resulted from the hard times of the 1930s, and he saw the renaissance of general practice and holistic medicine as part of a movement of renewed concern for the individual and his fulfilment as a whole man.

The conference then constituted itself into a number of seminars. Different groups discussed the selection and training of teachers for vocational training programmes, the identification of appropriate methods of teaching, a critique and development of the outline curriculum for vocational training contained in the "Educational needs of the future general practitioner" document. These seminar discussions were creative and exciting, having been inspired by a series of papers of the highest quality.

FACULTY NEWS

SOUTH LONDON FACULTY

Programme

October 20 Annual general meeting, Boardroom, King's College Hospital, London, S.E.5, commencing at 8.15 p.m., to be followed by a lecture on *Areas of deficient knowledge — their assessment and correction* by PROFESSOR PHILIP RHODES, F.R.C.O.G., Dean of St Thomas's Hospital Medical School.

December 8 Lecture on *Areas of deficient knowledge in paediatrics* by DR PATRICIA WALLIS, M.R.C.P., D.C.H., consultant paediatrician, Farnborough Hospital. 8.15 p.m. Medical Centre, Lewisham Hospital, London, S.E.13.

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January 19 Lecture, *Areas of deficient knowledge in school-age* by DR H. R. JOLLY, M.D., F.R.C.P., D.C.H., consultant paediatrician, Charing Cross Hospital. 8.15 p.m. Fulham Hospital, St Dunstan's Road, London, W.6.

March 9 Lecture, *Areas of deficient knowledge in adolescence* by DR G. F. VAUGHAN, M.P., F.R.C.P., D.P.M., consultant psychiatrist, Guy's Hospital. 8.15 p.m. Royal Army Medical College, Millbank, London, S.W.1.

April 20 Lecture, *Areas of deficient knowledge in middle-age* by DR H. B. WRIGHT, F.R.C.S., director, Institute of Directors Medical Centre. 8.15 p.m. South East London G.P. Centre, St Mary's Road, London, S.E.15.

June 8 The Pfizer lecture, *Areas of deficient knowledge in old age* by DR M. K. THOMPSON, M.B., Ch.B., M.R.C.G.P. 8.15 p.m. The Royal College of General Practitioners, 14 Princes Gate, London, S.W.7.