LIBRARY

Dr and Mrs C. G. W. Sykes, Chairman of the Yorkshire Faculty Board, kindly presented the College with a copy of Professor Pemberton's biography *Will Pickles of Wensleydale*, in which are recorded the signatures of members of the College who were present at Aysgarth for the ceremony of unveiling a plaque on the village Institute in memory of our first president.

In Memoriam

L. R. KIDD, Auckland 1
W. M. KNOX, Glasgow N.W.
JULIUS LOWY, Luton, Bedfordshire
SIR HENEAGE OGILVIE, London, S.W. 19
J. M. PEDEN, Paisley, Renfrewshire
D. I. ORPWOOD PRICE, London, N.2
BERNARD SPENCER, Burnley, Lancashire
W. A. H. STEVENSON, London, W.1
R. W. G. STEWART, Hamilton, Ontario

SOUTH-WEST ENGLAND FACULTY

Annual General Meeting Weekend

This year we meet at Exeter on Friday, 1 October. A course, " New Ideas in General Practice " will be held in the Postgraduate Medical Centre beginning on Friday afternoon, and continuing until tea time on Saturday.

The Gale Memorial Lecture, given by Dr John Hunt—" Meditations on Modern Medicine", will be given early on Saturday evening, to be followed by a Faculty dinner at the Royal Clarence Hotel. Early booking of hotel accommodation is necessary.

The Annual General Meeting will be held on Sunday morning, 3 October, at the Postgraduate Medical Centre.

REPORTS

CONFERENCE OF COLLEGE TUTORS
MANCHESTER UNIVERSITY, APRIL 1971

DR JOHN HORDER, chairman of Education Committee of Council, took the chair for the first session, welcomed members and outlined the two-day programme.

DR R. STEEL then described the duties of a college tutor. In the field of undergraduate education he might be required to provide advice for students on all aspects of general-practice education. He could also help in the identification of suitable practices to which undergraduate attachments could be made. To facilitate this, he should endeavour to establish professional and social contact with the medical school teaching unit and the undergraduates.

His responsibility also includes the planning and organizing of vocational training programmes. These are now extensive and varied and include day release courses, group seminars, journal clubs and the use of teaching-learning aids such as tapes, slides, films, and he needs to make himself fully conversant with these different techniques. He should stimulate involvement in college activities and encourage the trainee to become a member. He should also be concerned in interdisciplinary training for practice nurses, medical secretaries, and other paramedical personnel.

Dr Steel emphasized that to carry out this work satisfactorily, the tutor requires adequate support to allow him to delegate some of his wide-ranging duties.

DR J. LISTER then gave a clinical tutor's view of the present situation. He stressed the need for a satisfactory financial basis from which to function, and described the scope of the responsibility of the tutor. These were:

1. Organizing the training of junior hospital staff
2. Planning vocational training programmes
3. Providing for the continuing education of general practitioners
4. The organization of undergraduate attachments.

The tutor is also concerned with the administrative organization of the postgraduate medical

centre. While duties could be carried out in a dictatorial way, he believed that usually they were more successfully managed by the establishment of a committee with adequate, though not excessive hospital and general-practitioner representation.

He then went on to mention a number of important general problems. The goodwill of hospital consultants was beginning to fail and they could no longer be counted on to provide teaching at all the required levels without some further recognition or reward. Another disturbing factor was the poor attendance of general practitioners at the courses provided for them. He also mentioned the problem of providing satisfactory continuity of care in the hospital in view of the increase in 'release courses' for hospital staff, and this may be markedly increased in the case of prospective general practitioners during their hospital training. Dr Lister suggested that too many people involved in postgraduate medical education were working independently of one another with the resultant overlap of functions, and he suggested that a close liaison between the clinical and college tutors should be instituted.

DR G. SWIFT discussed how college tutors could help regional general practice advisers. He outlined the administrative structure that exists in the Wessex Region, where a postgraduate medical dean has the help of a part-time director in carrying out his duties of overall responsibility for postgraduate medical education. There are a number of postgraduate advisers in various fields such as general practice, psychiatry: in the Wessex Region there were nine different medical centres, each with a clinical tutor as well as an independent college tutor.

He stressed the danger of an overlap in activities between the many individuals involved and fully supported Dr Lister's suggestion of a general meeting between the clinical and college tutors. He felt that efforts should be made to ensure that the needs of interested individuals and groups should be represented but that these should be done by a minimum of people. Thus, efforts should be made, for example, to ensure that a college representative from the education committee should also be a local medical committee representative.

During the discussion the problem of adequate financing for postgraduate medical education was brought up and it was felt important that funds should be available to provide for satisfactory library facilities and also to reimburse speakers, be they local or visiting, general practitioner or specialist. The poor attendance at courses was mentioned and it was thought that this might be due to lack of awareness of the real needs of the course members. Closer liaison between the organizing committee and the general practitioners' representatives was needed.

DR P. S. BYRNE and PROFESSOR J. D. E. KNOX discussed various aspects of the college examination which one is now eligible to sit either after having completed a three-year vocational training programme or four years after registration of which at least two years have been spent in practice.

Dr Byrne stressed that the establishment of the examination had stimulated the setting down and identification of the content of general practice and had beneficially affected the relationship between the Royal College of General Practitioners and the other royal colleges.

It had been difficult to identify clearly the areas of knowledge, skills and attitudes which were to be examined and the methods by which this might best be done, but progress has been made. The problem had been to decide how standards could be set in view of the wide variations and individual methods of practice and place of work, but minimum requirements could be established. Factual knowledge can be examined by the multiple-choice question in which observer error is eliminated and large areas of knowledge can be rapidly tested. These questions are difficult and time-consuming to construct but once this has been done they can be used repeatedly so long as they remain secret. A considerable bank of questions is now slowly being established.

Manual skills can best be assessed by observation. The skills involved in the clinical process comprise those of communication, collection of information, diagnosis of the problem, and proposals for a solution, and little progress has as yet been made in the assessment of these. In attempting to assess attitudes, much work has been done but little agreement achieved. An attitude is dependent on knowledge, emotion and actual behaviour, and the method of assessment in the observation of overt behaviour.

DR KNOX discussed the problems and limitations of the traditional essay question, and described a modification which was now being used. A clinical problem provides the basis of the question and by gradually providing more information to the candidate one is able to structure the questioning so as to test a wide spectrum of knowledge and problem-solving

skills. He also described the use of a 'log diary'. The examinee is requested to come to the examination with a list of patients he has personally seen over a stated period of time, together with a few basic facts about them. This provides a qualitative and quantitative summary of his activities and a suitable basis for discussion during the oral assessment.

The discussion dealt with various details of the examination including the possibility of allowing college tutors access to specimen examination papers, to enable them to advise prospective candidates on the nature of the examination. It was felt that the Board of Censors were constructing an examination which was appropriate to the field of general practice.

Summing up, DR E. V. KUENNSBERG stressed the strides that had been taken by the College during the past ten years and assured all those present of the support that council was giving to these activities.

DR P. S. BYRNE, director of the department of general practice, University of Manchester, took the chair for the afternoon session, during which ten to 15 minute papers were read and discussed.

DR D. H. IRVINE began with a paper on the organization of vocational training schemes. He mentioned the essentials that those organizing such schemes must keep in mind: clear aims, methods of assessment, finding and sorting of hospital appointments, selection of teachers and practices, drawing up formal educational programmes and sound organization of framework. He urged us to look at some of the problems ahead: married women and doctors changing medical specialties will have to be incorporated into vocational training schemes; the organizers might even need to consider some involvement of trainees' wives; as schemes multiplied trainees will become more selective and demanding. One of the things they seek is a professional approach to administration. As schemes become larger it was essential to maintain lines of communication; trainees should be given their own formal committees and representation programme committees, faculty boards, even regional postgraduate boards. Trainees looked beyond their local organization and university to the College. The tutors must build on this goodwill.

DR J. G. R. CLARKE pointed out some of the difficulties in selection of hospital posts. There were over 1,000 new entrants to general practice each year, and only 543 SHO jobs. Tutors must persuade consultants not to monopolize these posts for young doctors intending to enter their specialties but to make them available for vocational training schemes.

DR J. E. MCKNIGHT described the general practice training year in Belfast. He listed what he called difficulties to watch for in any scheme:

1. The trainee is in training. The temptation to use him as an extra pair of hands must be resisted except possibly in the last three months.
2. Adequate time must be spent by the trainer teaching, especially in the first two months.
3. Trainees should do, and be seen to do, less than the partners. Their leisure time should be used for postgraduate study.
4. Trainees should have ready access to their teacher at all times.
5. The teacher must establish intellectual authority over the trainee who may be better trained, academically, than he.
6. The trainee should do no more nightwork than the teacher.
7. The trainee must get sufficient clinical experience. To see only the 'push-ins' may not give a satisfactory picture of the overall content of general practice and the care of the chronic.
8. Practices must accept that having a trainee affects the whole practice, ancillary staff, the load of work upon the teacher, the patients and so on.
9. The trainee must always obey the rules of the practice.
10. A list of teaching objectives for the year should be drawn up.

Finally, Dr McKnight posed the problem of the stage in the vocational training programme at which the trainee should come into general practice. Should the year be split?

During the discussion Dr Gilmore asked for more communication with students. Tutors should go and talk to them or write about vocational schemes for their magazines.

It was agreed that we must work slowly to expand the existing finances for vocational training schemes.

"A system that is not innovating is a system that is dying. In the long run innovators are the ones who rescue all human endeavour from death by decay. So value them. You do not have to be one yourself but you should be the friend of the innovators around you." With this quotation DR WOODALL introduced a wide-ranging review of new techniques of continuing

education. He suggested that the greatest source of this sort of education was contact with our colleagues and our patients. One of the advantages of the new medical radio and television programmes was that the doctors that contributed were themselves being monitored. This process of monitoring could be done with a tape-recorder in our surgery, or perhaps more effectively by exchange visits between colleagues, or participating in groups like the teachers workshops. We must not forget, he said, the immense increase in the written word produced for the general practitioner and the number of courses being arranged not only for postgraduate centres but from the college itself. New techniques were essential to cater for the new demand for information. Reminding us that learning often involves unlearning he quoted the late Miss Marilyn Monroe: "If I want to learn a new telephone number, I must first forget one".

DR ACHESON reported on the College continuing educational questionnaire. Education (E) was a function of time available (T) motivation (M) and opportunity (O). One way of assessing opportunities was to assess unsatisfied demand among general practitioners. Conclusions from a rapid review of 1,000 returned questionnaires show that general practitioners want more (1) subjects relevant to general practice; (2) dermatology; (3) general medicine, paediatrics, and recent advances.

The intensive course was the most popular, first for the duration of a week and then the weekend. The mid-week course was the least in demand. *The British Medical Journal*, *The Practitioner*, and *Up-Date* were the journals most frequently read, in that order: 283 doctors thought that they did all their reading in bed.

DR PIKE concluded with a paper on the role of the college tutor in continuing education Three hundred new doctors entered general practice each year through the vocational training schemes. The remaining 700 would still be in practice in the year 2,010. College tutors must begin by contacting these doctors and trying to encourage them to attend faculty meetings and postgraduate medical centres. All college tutors should attempt to join postgraduate medical committees. He listed the following methods of continuing education: contact with colleagues, reading, tapes, T.V., ward rounds, clinical attachment, seminars, courses and meetings, involvement in research, education and practice organization. He put in a plea for more general practitioner speakers on all courses. During the discussion DR M. MARINKER said that it was more important to assess the general practitioner's needs than his wants. How do we identify our deficiencies and blind spots? Somehow these must be assessed for these are the areas where continuing education is most important. Dr Andrew pointed out that there would be more general practitioner speakers with worthwhile contributions if we did more research into our practices. Dr Tate urged doctors to sit-in on other practices as a means of self-audit and practising speaking on random subjects in groups or at lunchtime meetings, as a means of producing more speakers from general practice.

The chair, for the third session, was taken by DR JOHN MCKNIGHT, chairman of the Vocational Training Subcommittee. He introduced the first part of the morning's work by saying that the Fourth Report Working Party had produced a report which would lead the way for the next ten years. A preliminary paper had already appeared in the *Journal* in December 1969, and the full report would be the most significant in the whole history of the college and finally answer the criticism that general practice could not be defined as a discipline in its own right.

DR J. HORDER then described the outline of the forthcoming book which was to be called *The Future General Practitioner: Learning and Teaching*. He described the five areas of the content of general practice, and pointed out that 'human behaviour' and 'human development' were as much a part of clinical practice as 'health and disease'. The area for which he had special responsibility was Area I 'health and disease'. He stressed the importance of the concept of health and went on to describe the following headings in relation to teaching about disease:

1. The recognition and diagnosis of life-threatening diseases
2. The early signs of disease that might be aborted
3. The dangerous complications of diseases which were not otherwise serious
4. Common diseases not serious but requiring treatment
5. Important factors in chronic disease.

DR FREELING had special responsibility for Area II 'human development'. Beginning with genetics, he admitted that for the more rare disorders nothing more might be necessary for the general practitioner than the address of the nearest genetic counselling centre. However, it was important for the future general practitioner to know the more common genetic varia-

tions which give rise to each individual's unique set of characteristics. He went on to describe the way in which the concepts of development were presented in his area under the headings of the first year; pre-school; school; adolescence; immature adult; mature adult; pre-retirement and retirement.

DR CONRAD HARRIS had particular responsibility for Area III 'human behaviour'. He described the central importance which would be placed in this report, on an understanding of the behaviour of both the doctor and the patient. The following broad headings would be used to set out the content of learning and teaching:

1. *Behaviour presenting to the general practitioner.* Examples were the changes of behaviour of the woman during pregnancy and of the patient approaching retirement.
2. *Inter-personal behaviour.* He described some of the material on verbal and non-verbal communication, self-concepts and self-esteem, and how a knowledge of these factors was essential to clinical practice.
3. *Behaviour within the family.* He described the part played by family myths; family themes; and the family tradition of illness which influenced relationships within the family, and the way in which illnesses were developed and were dealt with by the family unit.
4. *Behaviour between doctor and patient.* He described some of the special features of this relationship and gave examples of the clinical uses to which such knowledge might be put.

DR MARSHALL MARINKER had special responsibility for Area IV 'society and medicine'. He said that man, in this context, might be described as a biological system that functions within a social one. The common theme of this part of the book, was the organization of man into groups and how the characteristics of these groups related to the health of the individual in society. The content would be systematized under the following headings:

1. Culture, class, health and illness
2. Diseases of civilization
3. The uses of epidemiology
4. The organization of medical care in the UK and comparisons with other countries
5. The relationship of medical services to other institutions of society
6. Historical perspectives of general practice.

Finally, he stressed that the total work was intended to present the outline of a map of concepts which might be used by the teacher and his trainee to explore freely beyond what the working party had set down.

There were a number of questions, many of them dealing with the proposed date of publication (Dr Horder hoped that the book would appear towards the end of 1971) and with the anxieties of many doctors that one or other aspect might not have been given sufficient weight in the report. It was explained, however, that these papers which had lasted for no more than ten minutes each, had only outlined work which had been in progress for more than two years.

Professor Knox paid tribute to the working party and said that it should be made clear that they were not producing an immutable document. He also stressed that concepts and facts ought to be equally balanced and hoped that the book would emphasize the unity of medicine.

Many speakers expressed admiration for the work that had been done and felt that the book would prove of great value to both teachers and trainees.

The second part of the morning was given over to a session which had been entitled 'The London Teachers Workshop at Work' and we were given a brave and memorable display. Dr Marinker explained that there had been 25 full sessions of the workshop to date and that the conference was about to observe the twenty-sixth. The motivating forces which had led to the development of workshops were the work of the Fourth Report Working Party and a growing awareness among teachers in general practice that there was a need to develop educational skills. The London Teachers Workshop consisted of some 15 general practitioners, all of them engaged in teaching either trainees or students. The basis of their work was the analysis of actual teaching. They made no attempt to graft educational theory onto what they were doing, but tried to study what went on in a teaching–learning situation. He described three techniques which the workshop used:

1. The analysis of learning situations presented to the group by one of the teachers.

2. The analysis of a rôle-play in which a consultation was enacted by members of the group and a student or trainee was taught from that situation.
3. The analysis of a 'live tutorial' in which teacher and trainee discussed before the group, a current clinical problem.

The demonstration opened with a video-tape recording of one of the workshop's rôle plays. The patient was a girl who might have had a deep-vein thrombosis associated with the taking of an oral contraceptive: the first minute or two of this film was accompanied by gales of laughter as members of the conference acclimatized themselves to the sight of Dr Bill Styles in the role of the girl. As the interest of the clinical problem, and the problems of teaching, became more apparent, the laughter gave way to genuine interest and involvement.

This was then followed by an unrehearsed rôle-play in which a patient presented with chest pain; a tutorial between the teacher and the trainee ensued and the workshop then discussed the teaching, and the lessons that might be learned. Finally, there was a 'live' tutorial between Dr Jack Norell and his trainee Dr Keith Dunbar which was also examined by the workshop.

There was a lively discussion on the problems and perils of workshop techniques. Many doctors at the conference felt that each group of teachers should develop its own programme for learning to teach, and the members of the London Teachers Workshop constantly reiterated the importance of learning by teaching, in contrast to learning by studying the theories of educationalists. Dr Playfair described the experience of the Plymouth Workshop where teachers sat in on each other's surgeries and case histories were later discussed by the group.

The session was concluded by Dr John McKnight, who thought that the challenge presented by the papers, the demonstration and the discussion that followed, had made a fitting conclusion to a stimulating conference.

Correspondence

Episodes of Disease

Sir,

I was most interested to note that in the article "Symptoms in General Practice" by Morrell, Gage and Robinson (*Journal*, January 1971), consultations were divided into three types depending upon whether or not the symptom or disease had been presented to the doctor before. This introduction of the idea of considering episodes of disease has not been common in British studies of morbidity or work load. It has, however, been a basic consideration in morbidity studies in Australia where, without the advantage of a defined practice list, the episode of disease has often had to be the basic unit of measurement. This has advantages, as the authors of this article have pointed out. However, it also introduces the problem of not only defining disease—difficult enough as we all know—but of defining episode of disease. The authors' definition of a new symptom as one which had not been presented to any doctor in the previous 12 months is, as they state, easily interpreted and may be uniformly applied. It will inevitably include some chronic conditions, deformities and disabilities which have not needed treatment in the previous 12 months as new episodes and will underestimate new episodes of common acute conditions such as tonsillitis and gastro-enteritis which may occur in the one patient more than once in a year. In the Australian Morbidity Survey, acute conditions are counted as new episodes when they first present and chronic and recurrent conditions such as diabetes, osteoarthritis or migraine, are counted as new conditions only when the patient has never previously received treatment for them from any doctor. These examples of slightly differing approaches merely illustrate some of the problems associated with the concept of 'episode of illness'. However, because it is important in relation to behaviour of patients in seeking help for illness, I am glad to see it is being discussed.

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Royal Australian College of
General Practitioners

Traralgon,
Victoria.

Juggling with dates

Sir,

I wish to report a method of juggling with dates. Birthdays, dates of arrival and departure from the list, etc., are available to us for research, but the difficulty has been to know what to do with them to get the results. A Megaunit of time has therefore been chosen to represent 1,461