some patients went to great lengths to avoid seeing any doctor and probably received no after-care help at all.

There were reports from Scotland that doctors were worried about the disappearance of mental welfare officers who had been absorbed into the new social service departments. General practitioners were having to use health visitors more on mental health problems. The doctors at the meeting pointed to the value of community hospitals and health centres where psychiatrists could do sessions and follow up patients in the field. They all felt that mental welfare officers were now harder to contact in emergencies and many expressed anxiety that an all-purpose training would not lead to the development of the special skills needed in the mental health field. A general practitioner pointed out that this was hardly a valid criticism. Doctors had long ago pinned their faith on a common basic training followed by specialization and should not criticize social workers for following the same line. The availability of social workers was, in any case, a question of organization within the department rather than of training.

Summing up, Dr Kuenssberg, chairman of Council, the Royal College of General Practitioners, said that doctors had to accept Seebohm. They could not turn the clock back. Given sufficient teamwork in which professional staff treated each other as consultants rather than technical specialists, they could get beyond the problem of searching for a leader and work together. The leadership question was irrelevant; the needs of the patient would dictate the channels of consultation and the decision to be taken in consultation. Divided loyalties fell into place when all the loyalty was to the patient. Better communications and an ability for doctors and social workers to speak the same language followed inter-disciplinary discussion, training and on-going education.

A number of points had come out of the meeting which were worth discussing further. These included links between general practitioners and area social service departments rather than individual social workers, the need for health visitors and social workers to look at modern aids to communication, eg, dictating machines, the use of informal case seminars to share insights, skills and rôle-understanding and the need to include the community as part of the therapeutic resources of doctors and social workers. Above all the meeting had highlighted the need for education of and communication between doctors and social workers and for more experimentation geared to careful evaluation.

PROBLEMS AND PROGRESS IN VOCATIONAL TRAINING FOR GENERAL PRACTICE IN SCOTLAND

Vocational training for general practice is generally agreed to be essential if the needs of patients are to be met more appropriately and more fully, and if general practice is to develop its full potential to meet those needs in our system of medical care. There was almost complete unanimity on this point at a recent conference held in St Andrews under the auspices of Scottish Council of the Royal College of General Practitioners, in association with the universities of St Andrews and Dundee (3–7 April 1971).

However, there are many problems to be overcome before vocational training can be implemented on an appropriate scale in Scotland.

Hospital posts

No one should question the necessity for post-registration training in suitable hospital posts in schemes linked with appropriate training in one or more teaching practices. While the total number of junior hospital posts available is probably sufficient to meet training needs across the board, yet the distribution in the various specialties is such that the number available in specialties relevant to general practice is insufficient. The conflict between service and training needs is further expressed in resistance felt by some consultants to reducing the length of SHO posts from one year to six or even three month modules. An easy solution might be to create supernumerary posts, but such posts would not allow the trainee to be sufficiently and actively involved in patient care.

General medicine was seen to be particularly relevant to the training needs for general practice, yet many consultant physicians resisted the idea of making available 'their' posts to those who did not intend to make their future career in the specialty. This attitude was encoun-

tered among other specialties, but the problem presented most commonly in general medicine if only because of the logistics: in any one year in Scotland some 10 new consultants would be appointed in general medicine, while 160 or more new principals would be appointed in general practice.

The manner in which vocational training was developing raised problems in relation to training for many other specialties for which vocational training proper might be preceded by general professional training. To avoid forcing the young graduate into making up his mind too early, and to allow greater flexibility to all training schemes there was a need to ensure vocational training for general practice was in phase with training for other specialties. In addition to such problems of an organizational and academic nature, there were problems of assessment, of finance and of accommodation (many post-registration doctors were married).

The general-practitioner phase

In this sector, the organizational problems were marked. It was necessary to co-ordinate the interests of many different bodies with educational and political functions—local medical committees, Royal College of General Practitioners, BMA, regional hospital boards and others. The 'shop counter' had to be manned continuously and a full-time organizing secretary might be necessary.

The questionnaire of teaching practices framed by the College had had the effect of eliminating a large proportion of general practitioners who replied to advertisements for general-practitioner teachers, and the nature of the job further eliminated the least suitable practices.

Problems of matching the personalities of trainer and trainee could produce disruptions of the training programme, while the trainee might not have been suitably prepared for this phase of vocational training because of inadequate undergraduate education.

The view of one *trainee* included his sense of isolation, and lack of identity with other doctors in training for different specialties. Furthermore because many of the schemes of vocational training for general practice were new they were subject to various teething troubles—an instance was cited of a trainee's salary being discontinued while he was seconded to a course in community medicine from his hospital. The views of a *trainer* stressed the necessity of giving the trainee responsibility at an early stage, of frequent and regular seminar or tutorial sessions, of visits to other practices and organizations related to primary medical care, and of carrying through a project. There was a need for recognition by general practitioners and by the rest of the profession of the unique combination of knowledge skills and attitudes of the general practitioner. The transition from the hospital to general practice might be traumatic if anything of the Jehovah complex, sometimes generated in undergraduates, was not eradicated.

Co-operation with other bodies

A university department of general practice could help by stressing the importance of scientific thinking in training for general practice. There was no one approach characteristic of all universities, and each region had its own variations. Because of relationships already existing with clinical colleagues, the head of the department might be able to smooth some of the difficulties mentioned in relation to hospital posts. The department of general practice could foster the informal approach and encourage others to avoid introducing too much rigidity into the scheme.

Both the *Scottish Home and Health Department and the Regional* Hospital Board shared the views that they each had a responsibility in vocational training for general practice. While the rôle of Scottish Home and Health Department in medical education was associated with the rôle of paymaster, action could go far beyond the holding of purse-strings. The new schemes of vocational training had their origins in the trainee practitioner scheme: at present there was an establishment for 268 trainers, to which 109 were appointed, and in fact only some 60 trainers were in post—there was slack to be taken up. The Scottish Home and Health Department was taking action to ensure that allowances and other benefits for which the trainee in hospital was eligible were available also to the trainee in general practice.

The Royal College of General Practitioners had played a crucial rôle in promoting vocational training in general practice, not only in the UK but in Europe and in other continents. The College had accumulated facts and challenged the negative thinking prevalent in the 1950's. The appointment of tutors had been made with the object of exploiting the facilities available

in the various regions. The college library, Medical Recording Service, expertise in research and practice organization were available and must be used to further vocational training.

Achievements

The more encouraging note engendered by this consideration of the potential for co-operation was further increased by a brief review of the achievements in different parts of the UK.

In Belfast the number of places for entrants has increased from 9 to 20 per year. This has resulted in trainees being made responsible for obtaining their own hospital posts in open competition, but with a 'safety net'—help from the co-ordinator when necessary.

Other specialties relevant to general practice (medicine, pediatrics and geriatrics) are introducing their own rotating training schemes in one year modules with two six-month periods, thus facilitating the phasing of vocational training for general practice with that for these specialties.

In England, from one three-year scheme in 1968 there have developed over 100 places to-day scattered throughout the country. These schemes are attracting applicants of considerable calibre. Attention has been paid to training the teachers with courses in Manchester, Huddersfield, college headquarters, and with the 'workshop' groups, experimenting with teaching techniques.

The regional advisor in general practice is an essential appointment in the implementing of schemes of training yet only two of six appointed in England (and many more are needed) are properly paid for the hard work they do. There is emerging a movement from the trainees themselves and a national representative body has been suggested. There is a need to press for general-professional training in addition to vocational training for general practice.

In Scotland seven schemes are either in operation or in an advanced stage of planning, but we have a long way to go to meet the needs on the required scale.

That developments in vocational training for general practice are not confined to this country alone was demonstrated in a contribution from a doctor who had completed a three-year family practice residency programme in McMaster University, Hamilton, Ontario. The accent in training had been on the team approach to the delivery of medical care, on integration of hospital and general-practice experience, and on the importance of the family as a unit.

Summary

The conference considered many other aspects of vocational training—the rôle of research with attachment to a practice or unit with a research interest, and the special needs of women doctors whose family commitments might interfere with a three-year programme. Both problems underlined the need for flexibility in approach and yet organizers of schemes had to give consultants some undertaking that hospital posts would remain filled.

There remained two outstanding problems. The first was concerned with the need for publicity: it was not enough to leave this to the careers advisory services, there was a need to create awareness among undergraduates and pre-registration doctors by letters, circulars and by ensuring contact with general practitioners prepared to talk about general practice as a career. The second big problem had already been discussed—namely the obtaining of hospital posts, especially those in general medicine.

In his closing remarks, Dr Clayson, Chairman of the Scottish Council for Postgraduate Medical Education put forward the following points:

1. In his opinion there should be no difference between vocational training for the general practitioner and general professional training for the hospital doctor.
2. The regional postgraduate committees and the regional advisor in general practice were particularly important for the success of vocational training for general practice.
3. Junior hospital posts should be reviewed before the creation of more supernumerary posts.
4. Undergraduates should be encouraged to take more interest in their postgraduate career.
5. The working out of vocational training schemes for general practice could with profit follow the co-operative approach which has characterized the setting up of training schemes in the other specialties.