National conference of postgraduate advisers in general practice

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Selection of trainees

At the eighth meeting of this Conference in June 1975, the problems of trainer selection provided the main topic of debate and discussion. Some regions are now evolving written criteria for the appointment of trainers, usually established by the region's trainers themselves and promulgated by Regional General Practice Advisory Committees for the information of intending new appointees as teachers.

In one region it has become a requirement for all trainers to pass the membership examination of the Royal College of General Practitioners on the grounds that this is the only currently accepted and validated method of training assessment, and the teachers need to be fully aware by experience of what this assessment involves. Discussion suggested that such moves might be premature in some regions and it became clear that moves towards improvements in the quality of medical care and of the teaching performance of training practices were faster in some regions than others. It was, however, agreed that firm statements by all Advisory Committees as to what is expected of their teachers were now desirable. These statements would include an expansion of the broad outlines issued by the Council for Postgraduate Medical Education for England and Wales in 1972, particularly about commitments to further learning about teaching by those appointed. It was further felt that a commitment to regular attendance at a teachers' workshop or something similar was an essential requirement for those wishing to continue teaching.

There was some discussion on the methods used for appointing teachers and the main conclusion drawn was that the maximum information to applicants before and after interview by the Committee was desirable. This would help to avoid appeals which most often were due to failure in communication by the selection organisation.

Some other technical problems were aired and the presence of representatives from the Department of Health and Social Security was much appreciated in trying to clarify some more obscure parts of the regulations.

Universal vocational training

The conference also spent some time considering the progress towards universal vocational training. The date of, and progress towards this, are the responsibility of the Department of Health and Social Security in negotiation with the General Medical Services Committee. The Advisers in general practice who are closely involved with the implementation of any decisions supported a motion before the Conference of Local Medical Committees recommending that " There should be no delay in the implementation of mandatory vocational training for general practice." The Royal College is, of course, also concerned to see full implementation as soon as possible.

Logistics

Representatives for the Department of Health and Social Security presented statistics about the development of vocational training in general practice. These showed that there are now enough trainers to provide one-year traineeships for all entrants to general practice. Evidence was presented by the Council for Postgraduate Medical Education for England and Wales to suggest that there are also enough senior house officer posts in relevant specialties to cope with the need for general-practice as well as specialist training.

Once a date for mandatory training became established it was likely that there would be a surge of (untrained) doctors seeking openings in practice. Various manoeuvres for mitigating this were were discussed, for example a " phasing " of the introduction of the full three-year

requirement between now and 1980. This would be discussed by the General Medical Services Committee with the Department of Health and Social Security if the Annual Conference of Local Medical Committees were to approve the principle (subsequently it did so on 12 June 1975).

Selection of trainees

There was also discussion on the selection of trainees. At present a trainer, once appointed, is free to appoint his trainee. In the Northern Region, however, the appointment of trainees has been taken over by the Regional Postgraduate Organisation (by the consent of all the trainers concerned) and this was helpful to trainers in that the responsibility for the assessment of applicants for schemes and traineeships is shared. This avoids the invidious position of a trainee, after appointment, being discovered to be inadequate clinically or for other reasons. At present such inadequate trainees may enter practice as principals, and for this reason there was discussion by the conference on whether such doctors should continue training if possible. This is clearly a matter to be taken up with the Postgraduate Council and with the General Medical Council. Evidence on this issue is being sought.

Other matters discussed more briefly included the representation of trainees in the consultative machinery for the organisation of education; the inclusion of general-practice training for doctors outside general practice (especially community medicine), and various other matters referred from other educational bodies. One problem of direct concern to the College was the present position of college tutors, some of whose work has now been taken over by course organisers appointed by Universities (many doctors, of course, play both roles).

The twice yearly Conference is approaching its fifth year. It continues to serve a valuable purpose in postgraduate medical education for general practice in keeping advisers in touch with each other, and with the thinking of the Department of Health and Social Security, the General Medical Services Committee, and the Council of the College.

THE TRAINING OF PHYSICIANS' ASSISTANTS

A large-scale audit of patient records was used to educate and evaluate physicians' assistants. Clinical algorithms (sets of step-by-step instructions for solving a medical problem) for 11 acute medical complaints were used in patient care by physicians' assistant trainees. Each algorithm had a corresponding checklist medical-record form, which was filled out by the physician's assistant as he saw the patient. A computer program analysed the data from each checklist to determine if the algorithm had been followed correctly. Checklist records from 3,024 patients showed that a physician's assistant could have evaluated 45 per cent of these patients accurately without direct physician involvement if he had correctly followed the algorithm logic. This clinical algorithm system provides guidance in problem solving and also measures the ability of a trainee to follow instructions.

REFERENCE

Sox, Harold C. *et al.* (1973). *New England Journal of Medicine*, **288**, 818–824 (Authors' summary)