Editorial

TWO TYPES OF TRAINING

VOCATIONAL training for general practice is now becoming the norm. After more than ten years of discussion and experiment the questions have become ' when ' and ' how ' rather than ' perhaps ' and ' if.'

Two systems

Two types of training have emerged. The first consists of a planned rotation of two years in hospital and 12 months in general practice; all linked together in time and place. This ' package deal ' has now become the commonest form of vocational training in the United Kingdom.

The other system, variously called self-constructed programmes or simply do-it-yourself training consists of the trainee choosing his or her own approved hospital posts in whatever sequence and in whatever hospitals he likes. Usually, but not always, these programmes finish with 12 months in an approved training practice, often but not always, miles from the main hospital concerned.

Trainees using these two systems now work alongside each other all over the country. Some organisers, such as Hasler (1975) report that they are planning for about 50 per cent of their trainees to be on self-planned courses. What are the pros and cons of the two methods?

(*a*) *Self-constructed programmes*

A system of self-chosen training has many advantages. First of all the trainee, as Mackie (1975) points out, is encouraged to be independent and self-reliant—two traditional qualities of good general practitioners. By contrast trainees on some three-year courses seem to need spoon feeding at times.

Secondly and particularly important is that learner participation is built in. These trainees have to weigh up for themselves the educational experience offered and compare it and assess it with other opportunities elsewhere. Educational theory underlines the importance of active participation and involvement by learners and if the trainee is responsible for the choice of post this is more easily achieved.

Thirdly, these trainees have great flexibility. They can, and do, undertake locum appointments in general practice between hospital posts and can adapt their training, as they go along, to meet their changing needs.

(*b*) *Planned three-year programmes*

Trainees on three-year rotations start with other advantages. The planned sequence of hospital posts avoids the tedium and worry of job hunting every six months. Accommodation is usually much easier as three years in one place makes it possible to buy a house and some schemes offer hospital accommodation throughout the three years. Wives and families are more settled without repeated moves and there are far more chances to integrate with local general practices and with the local community.

Educationally one big difference is the possibility of an introductory period in a training practice usually of two or three months, which only rarely occurs on self-constructed programmes.

Day-release courses

The other great educational variable is the day-release course, which the Royal College of General Practitioners and a growing number of scheme organisers increasingly see as the focal point of vocational training.

Those who choose a self-constructed programme may have access to such a course—but release from hospital posts is more difficult and sometimes is impossible. Furthermore, a price is paid for moving from area to area as attendances are correspondingly fragmented and an evolving curriculum disrupted.

A great educational question is emerging. Is it or is it not going to be possible to provide a course significantly more valuable for trainees on a planned three-year basis than can ever be achieved by those spending six months here and a year elsewhere. Can the continuity of three years be made to count?

This question is as yet unanswered. At present the advantages of self-reliance and learner participation of one method balance the social advantages of planned posts and settled homes of the other. Meanwhile it is obviously important to ensure that trainees choosing their own programmes should not, as Hasler writes, be made to feel " second class citizens ".

For the scheme organisers and the trainees themselves the educational challenge is becoming clearer. Some schemes are facing it now and are seeking to show that a planned three-year curriculum can, particularly through the release course, provide a whole that is greater than the component annual parts. Particularly through a group training together insights can occur into human behaviour and especially into the doctor/patient relationship, self-understanding, and continuity of care. Group work is particularly important for achieving changes in attitudes.

With such different systems existing side by side there is an obvious need to evaluate the two. Could the College, perhaps through its Education Committee, take on this task?

REFERENCES

Hasler, J. C. (1975). *Journal of the Royal College of General Practitioners*, **25**, 764.
Mackie, L. (1975). *Journal of the Royal College of General Practitioners*, **25**, 441.

ACCESS BY GENERAL PRACTITIONERS TO PHYSIOTHERAPY DEPARTMENT OF A DISTRICT GENERAL HOSPITAL

THERE has been much opposition, voiced most notably in the Tunbridge Report[1] to general-practitioner access to hospital rehabilitation services. Co-operation between general practitioners, physiotherapists, and the consultant with responsibility for the physiotherapy department at a general district hospital has provided an efficient open-access service. This service has been welcomed by the general practitioners because it supplies prompt treatment for their patients and by the physiotherapists because it enables them to minimise disability by treating musculoskeletal problems at an early stage.

REFERENCE

Norman, P., Clifton, H., Williams, E. & Nichols, P. J. R. (1975). *British Medical Journal* (1975), **4**, 220.