Third National Trainee Conference

THE Third National Conference for Vocational Trainees in General Practice was held at Oxford from 17 to 20 July 1977.

Programme

The programme was as follows:
Introduction and welcome—Dr J. C. Hasler, Regional Organizer for General Practice Training, Oxford.

The teaching practice

Chairman: Dr J. Norell, Dean of Studies, Royal College of General Practitioners.
How adequate are teaching practices?—Dr M. J. Knightley, General Practitioner, Chinnor.
Consumer viewpoints—Dr D. Percy, General Practitioner, Southampton; Dr M. Edwards, General-Practitioner Trainee, Glamorgan.
Questions to a panel of the speakers and Dr D. Clegg, General-Practitioner Trainer, Tamworth.

Training for general practice in hospital

Chairman: Dr B. Higginson, General-Practitioner Trainee, Beaconsfield.
What is happening in hospital posts?—Dr S. J. Howe-Davies, General-Practitioner Trainee, Oxford.
Two viewpoints—Dr J. E. Staines, General-Practitioner Trainee, Newcastle upon Tyne; Mr T. I. Wagstaff, Consultant Obstetrician and Gynaecologist, Newcastle upon Tyne.
Questions and discussion with a panel of the speakers and Mr M. Rumpus, Senior Registrar, Obstetrics and Gynaecology, Reading; Dr J. C. Hasler, Regional Organizer for General-Practice Training, Oxford.

Support courses

Chairman: Dr D. Gillman, General-Practitioner Trainee, Stokenchurch.
What use are courses and when are they needed?—Dr I. Tait, Associate Adviser in General Practice, East Anglia Region; Dr J. Howie, Senior Lecturer in General Practice, University of Aberdeen.
Questions and discussion with a panel of the speakers and Dr P. Van der Veken, General-Practitioner Trainee, Nottingham.
The trainer and release courses—Dr P. McC. D. Anderson, General-Practitioner Course Organizer, Reading.

Assessment and accreditation

Chairman: Dr A. G. Donald, Regional Adviser in General Practice, South-East Scotland.
Assessment and Accreditation—Professor P. S. Byrne, CBE, Department of General Practice, University of Manchester.

Problems

Chairman: Dr S. A. Smail, General Practitioner, Oxford.
Problems of part-time trainees—Dr A. Taylor, General-Practitioner Trainee, Bicester; Dr C. Lapthorp, General-Practitioner Trainee, Aylesbury.
Questions and discussion with a panel of the speakers and Dr A. J. Tulloch, General-Practitioner Trainer, Bicester; Dr J. K. Wagstaff, Clinical Tutor, Brighton.
Vocational training. What comes next?—Dr S. Jobling, General Practitioner, Oxford; Dr B. Fletcher, General Practitioner, Guisborough.

In this way more than 200 people with an interest in vocational training spent almost three days exchanging fact, anecdote, and opinion, usefully and, at times, hilariously at this conference.

A few fundamental concepts were challenged, notably the place of hospital posts in general-practice training, but most of the discussion concerned the nuts and bolts of vocational training. What are people doing on their day-release courses? How often are they taught by consultants? How many patients do they see in their training practice? Several useful surveys were presented with background information which revealed a wide range of activities and workload. This seemed to reflect the difficulty experienced by the Conference in coping with the twin goals of flexibility and quality for training in general practice.

Particular problems which arose repeatedly were the alienation of the trainers and consultants from the day-release courses, the care of the chronic sick, the relevance of the day-release courses to trainees while working in hospital, the possibility of visits or exchanges with other schemes, and the problem of trainee boredom.

That boredom should occur at all is a damning criticism of any training programme and trainees may be their own worst enemy in not making their interests and wishes known. There seems to be a danger of trainer domination in many vocational training schemes and it seemed that this trainee conference was itself, at times, dominated by trainers.

Of course there is a danger of a 'them and us' attitude, but when we ('us') may know what we want but do not say, and they ('them') say but may not know, trainee boredom and trainer frustration become inevitable.

Some of the information provided in the background surveys was potentially disturbing. As far as workload is concerned, is it satisfactory that two thirds of trainees in general practice are seeing fewer than 100 patients a week or one in 20 over 200 per week?

Why are about a fifth of trainees reporting that they are considering emigrating after training? How much tutorial time is actually devoted to one-to-one teaching in the training practices in this country today?

Some of the figures reported were rather depressing, suggesting that in many places standards are nowhere near as high as trainees in 1977 could reasonably expect. Another cause of depression was the relative absence of stimulating new ideas which might point the way to raising the quality of training and standards of general practice in the future.

Perhaps we are in a phase of consolidation rather than experiment, and the need is now to spread the ideas of standards of the better vocational training schemes more comprehensively around the country?

However, the advantage of bringing together so many of those interested in vocational training was clear. The trainees of the Oxford region can be congratulated on arranging a most valuable conference and achieving success, both socially and intellectually.

The success of such a conference can ultimately be assessed only by what happens afterwards. If talking is a prelude to doing, the signs are encouraging.

STEPHEN HALL
Vocational Trainee

Incidence of anencephaly and other major malformations when oestriol excretion is very low

A study of 533 women with very low urinary oestriol excretion during the third trimester of pregnancy showed an incidence of major fetal malformations among their infants of 7·1 per cent, and a perinatal mortality of 14·6 per cent. Thirteen of the malformations were cases of anencephaly, and 26 of the 78 perinatal deaths were due to or associated with major fetal malformations. The incidence of these complications was higher when maternal oestriol excretion was lower. Routine screening by urinary oestriol assay, with fetal radiography when values below 20·8 μ mol/24 h (6 mg/24 h) are detected, is the most reliable method of detecting anencephaly before birth.

Reference

Dean, L., Abell, D. A. & Beischer, N. A. (1977). *British Medical Journal*, 1, 257-258.