Some aims for training for general practice

COMPILING long lists of aims for training programmes is often a tedious affair. It was certainly never done in the past; it is not very often done today, although it is likely to be done much more often in the future.

There are many problems about lists of aims. First of all, they are often lengthy; they are frequently criticized for being "obvious" or "just common sense"; and they inevitably have a somewhat depressing effect on the potential learners and indeed on the organizers. Both may be daunted at the prospects of trying to cover so much.

Nevertheless, the educational theory to which general practitioners all over the world are increasingly subscribing states that written objectives are not only desirable but essential. Put quite simply, learners have a right to know what is expected of them and if somebody does not take the trouble to write it down there is likely to be endless confusion about what precisely a training course is intended to do. Furthermore, knowing exactly what the syllabus is and what is meant to be learnt helps learners to learn more quickly and may enable them to make sense of an educational experience which may initially seem mystifying. They may also use other learning opportunities more logically and rationally. Most important of all, objective assessment can be carried out only against prestated objectives. It is simply not possible to measure whether learning has been achieved if there is not a clear written statement of what it is the learner was expected to learn in the first place.

Creating objectives for generalists is more difficult than in most of the specialties. The generalist is, by definition, in contact with a much wider number of colleagues in other branches of medicine than any one specialist. Furthermore, as medicine is constantly changing, and particularly at a time when the focus of medical care is beginning to move away from hospital towards the community, the boundaries of the medical discipline, especially those between generalists and specialists, are not rigid but flexible.

It is thus logical for the educational objectives for training medical generalists to be determined by consultation between the academic bodies representing both generalists and specialists. The Royal College of General Practitioners can therefore be congratulated on initiating a new method of determining training objectives, namely by detailed and lengthy consultations with the educational representatives of each specialty in turn.

During recent years three sets of training objectives for general practitioners have been agreed with three of the disciplines which interact with and affect general practice the most: psychiatry[1], paediatrics[2], and geriatrics[3]. Interestingly, these are exactly the same three disciplines which were suggested in 1969 as being "cousin disciplines" with general practice[4].

The Royal College of General Practitioners is most grateful to its colleagues in the three other academic organizations for spending so much time and trouble in discussing these sets of aims. All three, with the Leeuwenhorst Working Party document[5], have already been published in this *Journal* in the past, but it has become clear that there is a growing need to have them all together in one document rather than scattered in the *Journal* over several years. Publishing them together now makes it possible to give the 2,500 doctors training for general practice a large part of their curriculum in compact form.

Although this document is obviously required reading for those with a professional responsibility for providing training for general practitioners, namely the postgraduate deans, regional advisers, and course organizers, it will in practice be trainers and trainees who will use it most, and it should provide for the first time an opportunity for individuals and groups of trainees to look systematically at their day-release programme and judge its choice of topics against these aims. Furthermore, this document provides a useful guide to topics likely to be considered important in the MRCGP examination.

However, it is important to note, as Marinker states in the foreword, that educational aims and objectives such as these are not fixed and immutable laws of the Medes and Persians, but statements agreed by generalists and specialists as appropriate at the time of publication. Indeed, already there have been changes, and the dialogue between the generalists and the specialists is continuing. Objectives like these, in other words, will need to be constantly redefined and altered in the light of changing medical practice.

Some Aims for Training for General Practice is available now as *Occasional Paper Number 6* from 14 Princes Gate, Hyde Park, London SW7 1PU, price £2.75, including postage.

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Assessment of psychiatric illness severity by family physicians

Independent psychiatric illness assessments of family practice patients are compared. Of the three ratings—self-rating, evaluation by the treating physician, and a clinical interview by a research psychiatrist—patient and research psychiatrist ratings achieved the highest level of agreement (50 per cent of the variance). Of the three raters, treating physicians showed the greatest variability. There was least agreement for Practice Two, where the practice population consisted of upper middle college town people who had a relatively high incidence of interpersonal sensitivity complaints. Practice Three, consisting of ghetto inner city people with a relatively high incidence of somatic complaints, had the most agreement. The rating performance of treating physicians is attributed to both rating instrument and rating context.

Reference

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Legionnaires' disease

An explosive, common-source outbreak of pneumonia caused by a previously unrecognized bacterium affected primarily persons attending an American Legion convention in Philadelphia in July, 1976. Twenty-nine of 182 cases were fatal. Spread of the bacterium appeared to be airborne. The source of the bacterium was not found, but epidemiologic analysis suggested that exposure may have occurred in the lobby of the headquarters hotel or in the area immediately surrounding the hotel. Person to person spread seemed not to have occurred. Many of the hotel employees appeared to be immune, suggesting that the agent may have been present in the vicinity, perhaps intermittently, for two or more years.

Reference

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