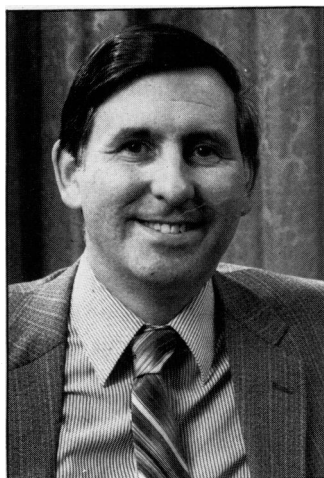

SECOND GEORGE SWIFT LECTURE

57 varieties

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MY subject is vocational training for general practice. What is it that we are trying to do for the large number of young doctors now required by law to undergo postgraduate training? I believe we are in some considerable confusion, and suggest that it is time some of this confusion is removed.

What are the aims of vocational training?

If one asks a group of general practitioner trainers what their main aims are for their trainees, each trainer responds differently. This is interesting, since much of vocational training is based on the 'Future general practitioner'¹ and the educational aims listed by a working party of European doctors at Leeuwenhorst² have been officially adopted by the Royal College of General Practitioners and the Joint Committee on Postgraduate Training for General Practice. Yet I am not aware of a training practice that bases its training on them. Nor, to my knowledge, does any day-release course cover them. Indeed how could it? The list is daunting.

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In our region we asked all the trainers and trainees to rank the European aims in order of importance.³ With the exception of agreement about the importance of clinical medicine, there was a lack of clear consensus. Practice management and teamwork scored low with many people. In truth we have more aims for training than the 57 varieties boasted of by the H. J. Heinz Company.

The normal training period is not long enough to produce a doctor who is competent in every field of general practice. Our specialist colleagues spend several years training in their own discipline, so that a trainee surgeon, for example, will have done most of the operations that he will be likely to perform as a new consultant. In our case, not only is training limited to three years, but two of the years are back in hospital. Whether we like it or not, choices have to be made in what we teach.

It is time that certain things were universal for all trainees, then at least we could say to the consumers, the profession, the Government and the taxpayer that, at the end of training, certain objectives had been achieved. I am not saying that all objectives should be the same for all trainees—only that some of them should be. An agreed list of basic objectives for different schemes could enable a trainee to be much more confident about knowing which scheme would meet his needs.

Suppose we have a trainee who is not good at communicating with health visitors and social workers and he chooses to work in a practice where this applies also to the partners, then he will learn little in this area. The doctors may all have an enjoyable time but a vital facet of training for that trainee will have been missed. A list of core objectives would help to broaden our approach. Could it be that the reason why so little assessment of trainees appears to be carried out is because we do not know what we are supposed to be assessing?

It is important not to confuse differences in style and method with basic objectives. Of course, all doctors are different. But such skills as treating acute asthma, communicating effectively and working with other professionals should be regarded as essential. How the

doctor uses his skills may be highly individual: that he needs them, I hope is not in doubt.

A set of core objectives should not be confused with a fixed curriculum for the weekly tutorials. Trainees like to learn from the patients they have seen. The objectives are merely a guide for the selection of subject matter each week for that trainee: they do not make up the selection itself but will ensure that certain items are not forgotten as the year goes by.

Difficulties for trainers

If we are logical in our thinking about educational objectives in general practice training, a clear consensus should emerge. Why has it not happened?

First, there is an inbuilt difficulty for trainers in combining clinical practice with professional education. Richard Wakeford⁴ has identified some of the difficulties in undergraduate education, which also apply to postgraduate training for general practice. Trainers' main obligations are to their patients and partners, and their involvement with training may be tenuous. Medical education is seen largely as commonsense and some doctors' love of educational jargon has been less than helpful. Equally, memories of medical student training, much of which was learning by rote, may colour trainers' perceptions of what medical education ought to be about. What is needed is the same professional approach to education as to clinical medicine.

Second, many trainers believe that general practice cannot be taught or learnt, only diffused. However, we know that much of what we do can be analysed, even though some of it is complex—the consultation is a good example.⁴⁻⁶

To summarize my arguments so far, I believe there are certain objectives that all trainees should achieve and that we should identify them. Trainees and others would then know what basic things were on offer and we could assess more easily what we were achieving. Some key objectives, if suitably chosen, would actually broaden the trainees' experience. Conversely, certain things cannot be achieved in the training period, and may have to wait until later.

Priority objectives for training

A list of core objectives is useless on its own, unless it is possible to demonstrate the reasoning behind such a choice. Our work at Oxford⁷ suggests there are a number of principles which should help us to identify priorities.

Principles of selection

1. An ability to deal effectively with life-threatening problems must have high priority. We suggest that some kind of checklist of acute emergencies be used. Illnesses which threaten life consist of more than just acute emergencies.

2. Skills and attitudes which are central to and relevant to a high proportion of the general practitioner's work for the rest of his life should receive priority. This includes the ability to switch from a value system appropriate to the hospital, where difficult diagnoses and new treatments are regarded as important activities, to one appropriate for general practice, where being committed to the person, rather than a particular body of knowledge, becomes more important. General practitioner trainers are well aware of this necessity, but do not always make it an overt part of their teaching. That they should do is essential, because undergraduate and pre-registration training are dominated by hospital experience. Equally, the teaching of communication skills is necessary in all disciplines but is particularly important in general practice. Inappropriate attitudes and inadequate communication are two of the main complaints by patients in recent surveys^{8,9} and this is confirmed by our own consumer survey at Oxford.⁷

The will to keep up to date and the knowledge and skills involved in doing so are important. Medical audit should be part of every trainee's experience.

3. Those things that are peculiar to general practice should have priority. Practice management tends to be thought of as things of concern to the doctor alone, such as the red book, partnership accounts and so on, but we would do better to spend more time on matters which concern patients and colleagues. These include working together effectively with other professionals in the team and ensuring that the appointment system runs smoothly. Both of these featured prominently in our Oxford consumers' criticisms.⁷

4. The fundamental importance of prevention should be emphasized. Recent College reports¹⁰⁻¹⁴ have shown that all trainers should be able to demonstrate and teach objectives for preventive medicine.

5. Training should provide the learner with the ability to change. Marshall Marinker, in his oration to the Reading Pathological Society,¹⁵ highlighted some of the ways that society will evolve and the problems that this change will present for medicine. Medical students (and this goes for trainees as well) should be concerned with the processes of thinking and with the strategies of adaptation rather than with the curriculum on offer today. Alvin Toffler¹⁶ has predicted that, with new information systems and automation, society will shortly face an upheaval equalled in the past only by the agricultural and industrial revolutions. The medical profession is naturally conservative; we will have to teach our trainees how to handle change, both for themselves and their patients.

Several of these principles are similar to those of family medicine described by McWhinney.¹⁷ Many of the aims of training I have mentioned are attitudinal, or in the field of behavioural skills. That is as it should be since these are the attributes that will last. Conversely, our means for acquiring knowledge change, becoming more efficient, with the advent of information systems and

microcomputers. This is the world in which today's trainees will practise, before they retire in the year 2020.

I have said little about clinical medicine for two reasons. The first reason is because, for most of the working week, the trainee is immersed in it and it is through clinical medicine that many educational objectives are achieved. The second is because the list of illnesses is so long that, with the exception of life-threatening problems, it is virtually impossible to list those that should be in a core curriculum. Rather, trainers should derive general principles from some cases and teach their application to others. For example, many of the principles of managing chronic disease can be learnt from patients with asthma and applied to diabetics, or vice versa. This transfer of training was one of the educational principles used by Paul Freeling in the design of the Nuffield courses.¹⁸

Nevertheless it is important to be aware that the clinical work experience of the trainee may be skewed or, in some cases, limited or non-existent. Research in the Oxford Region between 1976 and 1979¹⁹ demonstrated that this applies to chronic disease and acute emergencies. Trainers should be familiar with what their trainees are seeing.

I argue for an important foundation for general practice. Just as the spokes of an umbrella force out the material to provide adequate cover, so a defined number of core objectives, strategically chosen, will force out the training to cover key areas. This would be infinitely preferable to 57 or more varieties of aims, some of which are likely to be limited.

No doubt, I will be accused of attempting to force all young doctors into the same mould—'The day of the GP clone,' a Wessex doctor called it,²⁰ and suggested that many features of vocational training produce doctors of an increasingly narrow, uniform and stereotyped background. But the principles by which core objectives should be selected include the very ones that stimulate a young doctor to explore his individuality and his strengths and weaknesses. It is more likely that we shall produce variation and colour by helping our trainees to look for new skills, than to leave them to emerge by chance.

Implications for training practices

What does this mean for the trainers of the eighties? Does it mean a change in emphasis in tutorials and seminars? It means this and more.

Marshall Marinker, in his William Pickles lecture,²¹ referred to a hidden curriculum: students learn not only from what is explicitly taught, but also from the models of care that they see and the institutions in which they work. The hidden curriculum for our trainees is to be found in their training practices. The quality of partnership and teamwork, the accessibility of the doctors, the presence or absence of activities in audit and prevention play a powerful role in the learning process. No matter

what the content of tutorials or the sophistication of the day-release course, their aims will founder if our trainees work in poor practices. People argue that to work in second-rate practices is actually desirable, so that the trainee's sights are not set unrealistically high. What chance is there then for the future? No, trainees who can achieve objectives in the fields I have outlined will be far better poised to cope with a wide range of practices.

Do I ask too much? Paul Johnson, in his history of the people of England,²² describes us as a pragmatic people, working through practical expedients rather than majestic conceptions. We suspect, he says, 'the process of thought unrelated to immediate and practical decisions'.

George Swift, many years ago, faced challenges and doubt at the birth of vocational training. It was due to his determination, energy, but above all his vision, that he was able to conceive what was needed. Not for him the suspicion of matters unrelated to immediate decisions.

So today we look forward to building on those foundations and raising the standard of vocational training to new heights concerned with more than tomorrow morning's surgery, by means of a number of clear logical and key objectives.

I pay tribute to the man who introduced me to general practice, George Swift of Wessex.

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Alternative medicine

Over a five day period, 100 consultations with nine township *n'anga* (seven men and two women) were recorded. The *n'anga* divines the cause of illness either by becoming possessed by a spirit or by throwing the bones (*hakata*). Four of the nine divined with the bones and five (including the two women) through spirit possession. The ages of the 100 patients (67 males, 33 females) ranged from 0 to 60 years. C. S. M., a Zimbabwean botanist well known to the *n'anga*, was allowed to sit in on the consultations and take notes on the nature of the cause attributed to the illness of each patient, and on the remedies advocated to cure the complaints.

Only after the cause of the illness was divined was the patient asked by the *n'anga* to describe his symptoms. The necessary treatment was then advised and the patient told what measures should be taken and whether a ceremony should be held to propitiate the spirits responsible.

The patient paid the divination fee at the commencement of the consultation, then for any herbal remedy given to him. When he was free of symptoms he was charged for his cure.

In 79 per cent of cases, the complaint which brought the patient to the *n'anga* involved a specific physical symptom—and the largest proportion of physical ailments presenting were those associated with gynaecological problems and venereal disease. Seven children, all aged between 4 and 9 months old, were brought for cure or prevention of depressed fontanelle (*nhova*). In two

cases, the *n'anga* was consulted to request him to perform a specific ceremony (*gata*) to divine the cause of death of a relative. In four cases, the *n'anga* was asked to provide an aphrodisiac, and in one a protective charm; no physical ailments or symptoms were involved. The remaining patients complained of bad luck, misfortune or social problems.

There were 27 cases of illness where spirits were believed to be the causative factor. In another two cases, the patient had failed to buy *gono re-musha*—the male beast which is dedicated to the male spirit elder. Five cases involved *ngozi*, the aggrieved spirit of a person wrongly killed. Failure to perform a ceremony accounted for four cases of illness. In 11 cases, the *n'anga* divined that the illness was caused by a spirit wishing to possess the patients, either to pass on a talent or to make them become witches. Just over a quarter of patients presented with illnesses or problems which the *n'anga* said were due to witchcraft.

In all, 38 per cent of patients were considered to have illnesses arising from natural causes—and these presented most often with specific physical symptoms. The remaining cases tended to be related to forms of social control, where some social norm had been broken. For example, a 6 month old boy was suffering from convulsions because his father was committing adultery.

Only one patient had no treatment prescribed. Of the other 99 patients, 48 received multiple treatments. That is, in addition to administration of some type of herbal medicine, either for drinking or washing with, the patient had also to pay compensation, perform a ceremony, or make reparation by some similar means. In the 51 cases where a single treatment was given, it was most often a medicinal drink which was prescribed. Medicinal drinks, too, were most frequently given for illness deemed to be due to natural causes. Talismans and protective charms were also often used as part of treatment, especially where a child with depressed fontanelle was believed to be suffering because of being bewitched.

Conclusion

The review of 100 consultations showed quite clearly the difference in focus on aspects of the disease process between the *n'anga* with his traditional orientation and Western medicine with its scientific model. What remains to be seen, however, is whether the two divergent models of illnesses can be drawn together to provide an integrated health care system. And indeed, whether such an integration is desirable. What is certain, however, is that patients will continue to ask of their illness not only 'What is it?', but also 'Why is it?', and they will consult those who, they believe, can answer not one but both questions.

Source: Mavi CS, Owen FA, Gelfand M. The aetiology of illness as determined by divination and methods of treatment by Zimbabwean *N'anga*. *Central African Journal of Medicine* 1983; 29: 5-8.