The tenure of senior house officer posts should depend on training needs and not on service requirements; no doctor should spend more than three years at this grade. Those who have been in post for longer than this should be interviewed by the regional postgraduate dean to determine why such a block in career has arisen and how it might be circumvented. The working party supports a more active approach to teaching senior house officers and endorses the GMC's recommendation that every senior house officer should have a named person as educational supervisor to provide the continuous assessment of progress and help when necessary. The report recommended that colleges and faculties should explore possible methods for training senior registrars and consultants as teachers, in the same way that general practitioners are expected to prepare for their responsibilities as trainers.

Experience in general practice for hospital doctors

There has been widespread support for the council's suggestion[2] that experience in general practice would be worthwhile for doctors who intend making their careers in a hospital specialty. Support has come particularly from those working in disciplines with a large psychosocial component such as psychiatry, geriatrics and paediatrics. However, concern has been expressed that such an arrangement might lengthen even further a doctor's training for a hospital specialty and there is agreement that attachment should not be mandatory.

Experience in general practice would be best acquired as part of basic specialist training, ideally after at least one year as senior house officer, rather than during higher training. It would fit best as part of a multi-specialty rotation and should last for between four and six months. The practices chosen for such attachments should be recognized for teaching purposes and the most convenient arrangement would be to use doctors who have already been appointed by regional general practice subcommittees as trainers for vocational training.

The greatest obstacle to the development of such a scheme is finance. Hospital authorities may be reluctant to pay for the secondment of hospital doctors to general practice. Although there is no legal bar to any registered doctor working as a general practitioner trainee, the funds used to support the trainee scheme come from the general medical services pool and it could be regarded as improper to use them in the training of doctors who would not eventually become National Health Service general practitioners.

The obvious way forward is to conduct pilot schemes to determine the value of such arrangements. One has been set up in the south west Thames region and others are planned for Wessex and East Anglia. The Council for Postgraduate Medical Education has suggested that there should be four such trainees in each region and that evaluation should include assessment reports from the general practitioner trainer, the hospital educational supervisor and from the trainee involved. It seems that the profession is ready and willing to experiment in this way with the training of future hospital specialists. The DHSS too must respond to a challenge which would not only provide a broader based training for future hospital specialists but also have important benefits in terms of quality of patient care if a clearer understanding of each other's responsibilities led to better relationships between general practitioners and hospital doctors.

District medical education structure

The third paper from the council[3] presented a model for the organization of postgraduate medical education at district level; one based on a district medical education committee. This structure has been criticized by many general practitioners for its prescriptive approach and its concentration on the needs of junior hospital doctors at the expense of the equally important continuing education of consultants and general practitioners.

Undoubtedly there is a need for some sort of structure for postgraduate education at district level. In *The front line of the health service* the College presented its proposals for a national network of district tutors with responsibility for continuing medical education in parallel with vocational training course organizers.[7] Any district arrangement, however, must involve general practitioners in the management and running of postgraduate centres and their programmes, with proper representation in terms of numbers and interests, if the needs of general practitioner principals and trainees are to be fully met.

On its demise, the Council for Postgraduate Medical Education for England and Wales has left an important list of unfinished business. The standing committee on postgraduate education that is its successor must pursue these initiatives with vigour. All are important but at the top of the list for action must surely come the problems experienced by young doctors working in the senior house officer grade. The difficulties highlighted by the council's working party are not new and have been known for many years. The profession cannot continue to turn a blind eye to the working conditions of young doctors, and to their effect on the standards of patient care and the morale of junior hospital staff,[8] some of whom are beginning to regret that they ever embarked upon a career in medicine.[9]

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References

1. Council for Postgraduate Medical Education in England and Wales. *The problems of the senior house officer.* London: CPME, 1987.
2. Council for Postgraduate Medical Education in England and Wales. *Provision of experience in general practice for intending hospital specialists.* London: CPME, 1987.
3. Council for Postgraduate Medical Education in England and Wales. *A proposal for a district medical educational structure.* London: CPME, 1987.
4. Education Committee of the General Medical Council. *Recommendations on the training of specialists.* London: GMC, 1987.
5. Department of Health and Social Security. *Hospital medical staffing. Achieving a balance: plan for action.* London: DHSS, 1987.
6. Kiff RS, Sykes PA. Who undertakes the consultation in the outpatients department? *Br Med J* 1988; **296:** 1511-1512.
7. Royal College of General Practitioners. *The front line of the health service. Report from general practice 25.* London: RCGP, 1987.
8. Firth-Cozens J. Emotional distress in junior house officers. *Br Med J* 1987; **295:** 533-536.
9. Allen I. *Doctors and their careers.* London: Policy Studies Institute, 1988.

General practitioner workload: research and policy

HOW do general practitioners spend their time at work? In the past year two surveys sponsored by the Department of Health and Social Security (DHSS) have sought answers to this question. The first study[1] was undertaken by the department itself in cooperation with the General Medical Services (GMS) Committee. Two thousand one hundred general practitioners

were contacted and 58% of them agreed to keep a log diary recording their activities every half hour for one week. Five definitions were created in order to classify the data and these are important as they predetermine how the activity data were analysed and presented: (A) GMS duties and not on call, for example running a clinic while a partner handles emergency calls; (B) GMS duties while on call, for example attending NHS patients in the surgery while on call; (C) non-GMS duties and not on call, for example attending a course while a deputy is on call; (D) non-GMS duties and on call, for example dealing with a private patient while on call for NHS patients; (E) other and not on call, for example being on holiday during the survey week; (F) other and on call, for example, that restless activity we call sleep while on call.

It is clear that general practitioners are not all alike in the way they spend their time. So the frequency with which each activity was recorded varied over a wide range and to summarize the data the average hours for each category were calculated. How much time was spent on activities A and B, which were defined as GMS duties? Thirty-eight hours. When time spent on call (category F) was added, the average total was 68.7 hours per week. If non-GMS duties, defined as, for example, teaching students, learning, committees and insurance work, were included the average general practitioner reported that he was working or on call for 73 hours per week. Which figure best represents the work that we do?

The DHSS were in no doubt. Consider how the findings of the survey were interpreted for the white paper: 'The survey showed that on average a family doctor spent 38 hours per week on general medical services'.[2] This is a selective summary, which excludes time spent on call. But, surprisingly, on-call duties reappear three paragraphs later: 'Family doctors will continue to be responsible for the care of their patients for 24 hours a day'. Is it reasonable to exclude on-call hours from the results? It may be that lack of free time and being at the beck and call of needy people contributes over time to the lower psychological well being of some doctors, including alcohol problems and suicide, and to the considerably shorter life expectancy that doctors have compared with a class matched peer group like university teachers. So perhaps on-call hours are important and should be counted in calculations of workload.

Like any good employers the Secretaries of State expressed support for in-service training. 'We recommend that all general practitioners should be actively encouraged to undertake further education'. However, the DHSS Enquiry Unit decided that in-service training was not a GMS duty. They decided instead to combine time spent on courses (category C) with time spent seeing private patients (category D). Although as independent contractors we cannot necessarily expect to get paid to keep up to date, keeping up to date is quite different from seeing private patients. The first may be regarded as a professional duty, which may entail expense on the part of the doctor, the second is optional and attracts remuneration. Time spent on committees and in meetings was also excluded from working hours. One wonders if civil servants would exclude this time from a report of their own workload.

This question of how much time general practitioners spend keeping up to date was posed in another DHSS sponsored survey.[3] The investigators found that general practitioners reportedly spent an average of 2.9 hours per week on reading, research and training courses. Is this number of hours sufficient to keep up with developments in a continuously changing field? Probably not, but before coming to a view we need more detailed information about the way in which the time is spent and the value of different levels of educational activity.

What then is the average number of hours that general practitioners work each week — 38 or 73? It depends on the definition used. Words act like carrier bags; the investigator decides what to put in each bag and in doing this pre-determines to a large extent the content and the size of each package. Once the packs are full of data, they may be used in many ways.

Assessment of workload is clearly a complex affair. Investigators in this field need first to consider what questions will be asked of the data and what definitions are therefore appropriate. In future work, investigators should also consider new approaches. Large scale surveys have in the past relied on doctors completing questionnaires and estimating their own use of time. This is a relatively inexpensive way of obtaining data from many respondents. Buchan and Richardson used direct observational methods to assess the workload of 22 doctors.[4] Detailed quantitative and qualitative information was collected, classified and reported. This method is time-consuming and would be expensive to apply to a larger and more representative sample of general practitioners. But if investigators combine depth with breadth, this will be money well spent. We need to search for meaning, as well as cause, in building a picture of general practice which we can recognize and understand.

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References

1. Department of Health and Social Security. *General medical practitioners' workload. A report prepared for the doctors' and dentists' review body 1985/86.* London: DHSS, 1987.
2. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Promoting better health (Cm 249).* London: HMSO, 1987.
3. Butler JR, Calnan MW. List sizes and use of time in general practice. *Br Med J* 1987; **295**: 1383-1386.
4. Buchan IC, Richardson IM. *Time study of consultations in general practice. Scottish health service studies, no 27.* Edinburgh: Scottish Home and Health Department, 1973.

Coronary heart disease prevention: a general practice challenge

APPARENTLY rare at the beginning of the century, coronary heart disease is now the commonest cause of death in developed countries. In the UK coronary heart disease mortality rates are among the highest in the world with more than 150 000 deaths a year (30 000 before the age of 65 years), accounting for about one third of all deaths in men (and half of those in middle aged men) and a quarter of deaths in women.

A causal role for three key factors — elevated blood lipid levels, raised blood pressure and cigarette smoking — is now proven beyond reasonable doubt, as is the effectiveness of lowering them in reducing the risk. Other risk factors for heart disease include physical inactivity, excessive alcohol consumption, diabetes, a