

Course organizers' pay: what next?

At long last the battle for better pay for course organizers of vocational training in general practice in the United Kingdom has been won. The new remuneration, which came into effect on 1 April 1992,¹ is a fair and realistic reward for course organizers who, despite years of frustration and neglect, have continued to play an important role in the development of vocational training for general practice. Whether or not the difficulties of recruitment will now ease and, for the first time there will be competition for course organizer posts, remains to be seen.^{2,3}

It is timely to consider the possible implications of this hard won battle. As a result of the new arrangements, the course organizers' remuneration now forms part of the postgraduate dean's budget for postgraduate medical and dental education. However, because of the limitations of the budget, it is likely that there will be greater demand for accountability with regard to the work and the number of course organizers in post. In contrast with the previous open ended arrangements under the regulations of the *Statement of fees and allowances*, the regions will be forced to decide how many course organizers they require and, more crucially, how many they can afford. In this, they may have to be guided by an agreed national criterion. In 1985 the National Association of Course Organizers suggested that the number of course organizers should be related to the number of trainees in post, and that each course organizer should have no fewer than 10 trainees.⁴ However, Department of Health statistics show that between 1985 and 1991 the number of course organizers increased from 233 to 368, an increase of 58%, and the trainee to course organizer ratio fell correspondingly from 8:1 to 4:1. Thus, there appears to be an 'excess' of course organizers, which could be used as a justification for future cutbacks in their numbers.

Another important consideration in any such calculation, will be the enhanced role of clinical tutors who, despite taking on new responsibilities for training, audit, management and the administration of the local educational budget, can only be remunerated up to a maximum of two sessions per week (Health service guidelines (92)5, annex C). This new anomaly in remuneration could lead to resentment on the part of clinical tutors who may regard the situation as unfair and divisive. There will also be increased pressure on the postgraduate dean's budget from the emerging group of general practitioner tutors in continuing medical education, as they will require at least the same degree of recognition, remuneration and support as their course organizer colleagues. Therefore, the regional postgraduate medical education budget will have to cope with the expense of appointing and supporting a whole range of medical educationalists working under the titles of clinical tutors, course organizers, general practitioner tutors in continuing medical education, and specialty tutors — the latter are appointed for each hospital specialty and their expenses are now met by the postgraduate dean's budget.

Thus, as a profession we now need to focus on the question of the future of postgraduate medical education with particular reference to general practice and its infrastructure. There is little doubt that the growth of academic general practice has been rapid and, not surprisingly, at times haphazard. Consequently, we now find ourselves surrounded by a whole host of individuals and groups working in education, with different titles, but doing the same thing at almost the same time. In 1991 the Royal College of General Practitioners suggested that course organizers and general practitioner tutors in continuing medical education

should be replaced by some kind of 'generic' educationalist (RCGP education division. The future development of associate adviser posts in England and Wales, May 1991, discussion document). This is a promising start but it does not address the wider issues of postgraduate medical education in general practice. In line with the paper's suggestion, there is an urgent need to consider the merging of some of the existing posts but without losing sight of the specific responsibilities of each type of educationalist. To do this, a comprehensive but flexible job description must be defined, incorporating the criteria by which such appointments can be made and monitored. This will help to create a career path for those who wish to pursue a mainly educational role in general practice. The lines of accountability and the number of sessions permitted for this purpose must be negotiated and agreed. The number of sessions should be as flexible as possible in order to relate to the requirements of a specific job. Under the supervision of the regional adviser in general practice, there should be a well defined and continuing process of appraisal and personal development so that those who wish to can progress and those who need a career change can be counselled accordingly. The postgraduate medical educational boards, who will provide the funding for such posts, will need to be aware of the range and the cost of training support that individuals holding the posts will require.⁵

Furthermore, to avoid confusion, the title of these educationalists should clearly reflect their function which may vary from time to time and from district to district. The proposed title of associate adviser in general practice has certain attractions because it conveys a multiplicity of functions (RCGP, discussion document). But, since there are already associate advisers in post with different functions in Scotland and the rest of the UK, using an existing title for a new post could add to the present confusion. A better title might be tutor in general practice which would allow the post holder to move from continuing medical education to vocational training and vice versa and also has similarities to the specialty tutor in hospital medicine.

At the level of the postgraduate unit in each district, it is important to define the relationship that tutors in general practice would have with the new breed of clinical tutors and others involved in postgraduate as well as undergraduate medical education. This relationship must clearly be one of partnership and teamwork without being in any way hierarchical. On the national scene the National Association of Course Organizers, which has done so much to further the cause of vocational training,⁶ could be enlarged to include the new generation of general practitioner educationalists.

In parallel, there is also an urgent need to streamline the various national committees and organizations. For instance, it would be more sensible for the General Medical Services Committee to concentrate on matters relating to terms and conditions of service rather than education which should be the role of the RCGP. The recently constituted RCGP/GMSC liaison group⁷ is a welcome development but it should clearly define the remit of each parent body in order to avoid more confusion and division. The Committee of Regional Advisers in General Practice in England (CRAGPIE), the Conference of UK Advisers, the education division of the RCGP, the education subcommittee of the GMSC and the working parties of the Joint Committee on Postgraduate Training for General Practice should be unified into a more dynamic forum for education in the UK, saving an enormous amount of time and energy and, more im-

portantly, bringing greater consistency to national decisions on educational matters.

The settlement regarding course organizers' pay and their inclusion in the regional postgraduate medical education structure, provides a unique opportunity to debate the future needs of general practice education and the strategies necessary to meet those needs.

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Automated external defibrillation

SUDDEN death from a cardiac arrhythmia remains a leading cause of death in the community. A lethal ventricular arrhythmia, particularly ventricular fibrillation, is responsible for the majority of such deaths.¹⁻³ Several reports have testified to the effectiveness of defibrillation performed by general practitioners;⁴⁻⁶ in one study over 40% of patients surviving cardiac arrest went on to leave hospital.³ Recent advances in technology have revolutionized the practice of defibrillation. It is timely to review the way that recent developments may affect the general practitioner.

The automated external defibrillator incorporates developments in electronics that make it a very different machine from that which most doctors will remember from their hospital experience.^{7,8} Operation has been simplified; the only requirement of the operator is to attach two adhesive electrodes to the chest wall of the patient and to activate the machine by a single control. The electrodes serve the dual function of monitoring the electrocardiograph and delivering the direct current shock. The electrocardiograph is processed electronically and interpreted automatically by the machine. If an arrhythmia responsive to countershock (ventricular tachycardia or fibrillation) is present, the device will charge itself to a predetermined level and advise the operator that a shock is indicated. This is administered by pressing a second control. Written instructions are provided on a liquid crystal display screen and some models also incorporate synthesized voices to instruct the operator.

These new defibrillators are accurate⁹⁻¹¹ and eliminate the need for training in the complex skills of electrocardiograph rhythm recognition. The simplicity of operation decreases the time and expense of initial training and increases considerably the range of personnel who can operate the defibrillator. It is the automated external defibrillator that has enabled such rapid introduction of defibrillators into the ambulance service; at present every front line ambulance crew in the United Kingdom is equipped and trained to use the defibrillator. Automated defibrillators have also been used by lay personnel in a variety of industrial and recreational environments and in the UK voluntary aid societies are now training their members to use the automated external defibrillator.¹²⁻¹⁷

One consequence of these developments is that many more attempts are being made to resuscitate the victims of cardiac arrest outside hospital and it is inevitable that general practitioners will be involved with an increasing number of these. The risk of cardiac arrest in acute myocardial infarction is greatest in the early stages of the attack and the priority is clearly to

bring the defibrillator to the patient as quickly as possible. If the general practitioner is unable to do this or if there is likely to be a considerable delay in attending, it seems sensible for the doctor (not the patient) to mobilize the ambulance service initially and meet the ambulance crew at the scene as soon as possible. The doctor can then provide diagnostic skill and give intravenous opiate analgesia when appropriate; at least the defibrillator is present as soon as possible. Considerable success has already been reported from Scotland where the automated external defibrillator is in universal use.^{18,19}

General practitioners provide the initial medical care for many victims of myocardial infarction, a group of patients at high risk of developing ventricular fibrillation. Approximately 5% of all victims (perhaps 10 000 people in the UK each year) actually experience a cardiac arrest in front of their general practitioner (either in the surgery or at the patient's home).^{5,20} The automation of several stages in the processes of defibrillation is an additional advantage to the general practitioner who may initiate resuscitation with only limited help available. A practice contemplating the purchase of a defibrillator should consider the automated external defibrillator; the cost is no greater than a manual defibrillator. All practice partners can learn to use the machine within a matter of hours regardless of previous experience, and the simplicity of operation reduces the need for refresher training. Other members of the practice team, for example nurses, might also learn to use the device. Most models incorporate a control or pass card that will change the defibrillator into the manual mode of a traditional defibrillator, should this be preferred by individual practice members.

The automated external defibrillator has brought the practice of defibrillation within the capability of all medical and paramedical personnel who care for patients outside hospital. The ability to give life saving treatment is now easily available to all general practitioners either by owning their own machine or by working with the ambulance service. This chance to reduce mortality from sudden cardiac death should be exploited immediately.

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