performance and consultation skill work. The trial GPs improved their detection rate significantly, both compared to their performance at baseline and compared to the control group.

Everyday consulting requires GPs to switch their attention quickly from perhaps an elderly arthritic patient, a patient with diabetes, a feverish child, and someone with headache, backache or persistent tiredness which may be caused by physical disease or be a sign of underlying psychological distress. Longer consultations would help, but it is probably just as important to make the best use of the time that is available and to organize the practice so that there is continuity of contact between the patient and a specific GP. It has been shown that the presence of a personal list system in practices is associated with increased patient satisfaction with accessibility, availability, continuity of care and medical care.[19] Strategies are available to improve the ability of GPs to detect mental health problems and these can be supplemented by the judicious use of patient-completed questionnaires. Several different workers[20-22] have shown that detected disorders have a better outlook than those that remain undetected so helping GPs sharpen their recognition or management skills will directly benefit patient care.

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Vocational training: The end or the beginning?

VOCATIONAL training has had a good innings. It was seen as one of the success stories of the 1970s and 1980s.[1] How things have changed! Recruitment is at an all-time low and it is fashionable to blame this on the health care reforms. While the latter have been a contributory factor, there are opportunities to try and think ahead to the type of service which will exist in the next decade and beyond. If the late 1960s and early 1970s were the so-called 'golden era' for creative developments in postgraduate education, we are now in a period when the original structures of vocational training need radical review.

The 'corridor talk' that I overhear includes comments such as: 'Young doctors don't want to work hard'; 'There isn't the commitment there used to be'; and 'Dedication doesn't exist anymore'. Is this a form of transference of inner beliefs related to low morale rather than a true reflection of what keen young doctors are really like? We have to be honest enough to find out if there is a widening gulf between the values and attitudes of established practitioners and those in training. Registrars are also less willing to accept paternalism, voicing concerns about rigid training schemes, the perceived tyranny of assessment and inflexible partnership arrangements.

The differential between the salary of a registrar and an equivalent training post in hospital can present dilemmas for those contemplating how best to proceed in their careers. After vocational training, when faced with the prospect of entering full-time practice, many young doctors are reluctant to 'sign up' for a long-term commitment offering little room for manoeuvre later in life. Current working patterns and financial disincentives will have to be overcome if general practice is to become an attractive option once again.

If we are to heed the evidence of Allen's studies of *Doctors and their Careers,*[2] then there are major implications for policy makers and those in leadership positions in education establishments. From Allen's rigorous scrutiny of young doctors' needs, some key issues emerged:

(1) careers advice;
(2) the content and structure of postgraduate training;
(3) part-time opportunities, back-to-work programmes and job sharing;
(4) issues concerning women doctors; and
(5) leadership for cultural change in medicine.

Barriers to bringing about changes in policy have to be addressed. In the hallowed cloisters of postgraduate education, leadership that values the traditional strengths of medical education has to be matched with an understanding of the shifting needs of potential general practitioners. The highly structured environments of institutions, largely dominated by men, have to learn to listen more and direct less. Young doctors are seldom involved in decision making about their training and they have to be included in any partnership for change. In a detailed analysis of a cohort of doctors who graduated in 1986, Allen has provided considerable evidence that career structures have been slow to adapt and failed to react to the changing profile of graduates, 50% of which are women who intend to work less than full time for at least part of their careers.[2] Cultural change is a reality which has to be recognized by those at senior levels in National Health Service management and education.

Next steps

The policy of the Royal College of General Practitioners,[3] endorsed by the National Association of Health Authorities and Trusts,[4] is to have a 5-year period of post-registration training. This is a laudable aim, but is unlikely to occur for some time. Within the current 3-year training period, increasing the quantity and quality of time in general practice is justified on a number of grounds. There is a growing body of opinion that experience in general practice should be extended to 18 months, with a parallel reduction in hospital posts.[1,3,4] This option appeals to a significant proportion of doctors, and regional postgraduate deans and regional advisors have to be encouraged to remove the obstacles to this development. It is a lame excuse to say that financial arrangements are complex and difficult to unravel. Similar arguments apply to general practice experience during the pre-registration year.[5,6]

With a burgeoning interest in the notion of a primary-care-led health service, there are opportunities for creativity and flexibility. Waiting in the wings of primary care are nurse practitioners, practice nurses and a range of allied health care professionals. While retaining sympathy for the pleas to retain the core values of general practice,[7,8] it would be a mistake to try and maintain a monopoly in the provision of primary medical care. If we truly believe in the concept of teamwork in primary care, then there is an urgent need to develop pilot training schemes which include both doctors and nurses working side by side. If they are to work together in practice, then an appreciation of roles at an early stage in training could enhance collaboration in the future. Why not have day-release schemes which comprise a mixture of those in training posts?

It is somewhat paradoxical that one of the most enlightened documents about postgraduate medical education has recently come from the USA.[9] The Pew Health Services Commission was created in the USA to assist the nation's health professions develop programmes which would be responsive to the changing health care needs of Americans, and has advocated public policy options that support change in the education of health care professionals. We have a tendency in the UK to be insular and it is worth remembering that the diversity of the North American culture provides ideas which are often in advance of our own thinking.

The Pew Commission has set out a number of ideas which are a good starting point when thinking through how we can best move forward in vocational training. These themes are: (1) Build from a Foundation of Values; (2) Concentrate on Core Educational Activities; (3) Redefine Political and Economic Relationships; (4) Focus on the Health Needs of the Community; and (5) Strengthen Tools for Change. The Pew Commission has also delineated a set of competencies which are important for practitioners in a changing health care system.[10]

(1) *Building from a Foundation of Values* will ensure that education is centred on a clear set of principles that explore the relationship between traditional professional attitudes to patient care and the changing health care system. Young doctors are not attracted to jobs where the old structures are not adapting to changing circumstances. Their beliefs and aspirations have to be acknowledged as we strive towards improvements in patient care.

(2) *Core Educational Activities* reflect what has also been stated by the General Medical Council in relationship to the need for a core curriculum.[11] If specific educational outcomes are clear, the next step is to design the teaching and learning processes to achieve these outcomes. The apprenticeship model has many strengths but can result in a narrow focus as opposed to broadening the minds of young doctors. Calman's statement on the subject is particularly apt: 'to be trained is to have arrived; to be educated is to continue to travel.'[12]

(3) *Redefining Political and Economic Relationships:* Within these, the identification of new partnerships in primary care will be crucial in establishing a career structure that will appeal to the next generation of general practitioners. One example of this could be the creation of housing and health cooperatives in deprived areas where a combination of service delivery and training schemes would enhance patient care.

(4) *The Health Needs of the Community:* Although a primary-care-led service remains 'unproven', health care professionals have to be educated in a manner which creates a skill mix unfettered by restrictive practices. Here, again, shared learning can foster an integrated approach to patient care. Despite the fact that 90% of medical care occurs in primary care settings, the driving forces in education and training still emanate from a hospital perspective.

(5) *Strengthen Tools for Change:* Support for those charged with responsibility in training will have to include an appreciation of how best to harness the available tools for patient care and education. The qualifications for leadership in postgraduate education remain ill-defined and holding on to long-established pyramidal structures will not allow innovators to challenge the *status quo.*

Future directions in vocational training will have to give equal emphasis to non-competitive formative assessment as well as summative assessment, otherwise the educational process will be viewed as a form of tyranny. It is paradoxical that it is now registrars, rather than students, who are being given more and more hoops to jump through. By way of contrast, undergraduate education is attempting to be more learner centred with less emphasis on testing within traditional examination systems.

Conclusions

In his book, *The Empty Raincoat,* Handy[13] remarked that words like 'hierarchy', 'loyalty' and 'duty' no longer carry the weight they once did. Other words like 'freedom', 'choice' and 'rights' are now at the forefront. Postgraduate training exists within deeply entrenched formations with little room for flexibility, and the present models do not seem to match the needs of many of those in training.

Training schemes are inextricably linked to systems of providing patient care. Long-established patterns of employment and partnership agreements can be hindering forces in the organization of primary care. A reluctance to create opportunities which include part-time work, job sharing and the option of salaried employment will hamper efforts to provide careers which will attract able young graduates. Are role models for service provision and training still stuck in a time warp of the 1970s?

In 1972, the publication of *The Future General Practitioner*[14] had a major impact on general practice in this country. While the content of this report still remains extremely relevant, the structure of general practice training needs loosening rather than tightening. We need to encourage people involved with postgraduate training to extend their horizons and look at the future through a wide-angle lens which captures striking viewpoints. The final chapter of *The Future General Practitioner* contained the statement 'by questioning our thinking and our practice the "trainee" makes us look at ourselves'. This statement is just as pertinent today as it was 24 years ago.

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