POSTGRADUATE TRAINING FOR THE GENERAL PRACTITIONER

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OVER THE PAST YEARS the future of general practice and of the general practitioner have been the subject of so many investigations and discussions that one writer (1963) even came to the conclusion that "... this same concern for general practice accompanied always by assertions of its importance, might also be a symptom of a deeper defect than the (Gillie) committee have found. It is not, after all, generally found necessary to assert that hospitals are important, or say, that the U.S.A. is a world power. Such assertions are more usual when the case is not so obvious."

Ever since the advent of specialization, the functions of the general practitioner underwent a continuous process of shrinking. At the same time status (and income) of the specialist increased, for the very simple reason that he had enabled himself—by means of thorough training and hard work—to do something that others could not do or at least could not do so well. With the rise in prestige of the specialist a corresponding decrease in prestige of the general practitioner with his comparatively simple training was bound to take place.

To stop and even reverse this trend, the feeling of despondency in some general practitioners and the resulting thinning of their ranks, the College of General Practitioners was founded. It was to raise the standard and with it the status of the general practitioner. At Edinbrugh University a chair of general practice medicine was recently created with a similar aim in mind.

Yet practical results have so far been conspicuous by their absence. The reason for this can be found in the rather theoretical manner in which the question of raised standard was approached. At one stage even a check on the consulting-rooms of a candidate was discussed seriously. On the other hand the emphasis is often wrongly placed on 'allowing' the general practitioner to do certain work which others could do better, only for the sake of making him 'accept his lot'.

What seems to have been overlooked is the cardinal question:

Is there a real public demand for a general practitioner with postgraduate training? On the surface it will sometimes appear as if such a demand is a rather hypothetical one. One need only think of the well-known case of the man who apparently merely by listening carefully to the representatives of the pharmaceutical industry is able to maintain a *praxis aurea*, without ever undergoing any training beyond the undergraduate one.

If actual public demand is not always recognizable, at least the possibility of creating one exists. But public demand there must be, if postgraduate training and qualification of the general practitioner is to succeed. I would call it the first essential requirement.

The next question to be asked is intimately connected with the first: What can or could the general practitioner do that others cannot do or cannot do so well, especially when the general practitioner has received appropriate postgraduate training? The emotionally coloured answer ' Family Medicine ' does not hold water on close scrutiny as behind almost all the activities of the general practitioner the specialist looms ready to take over. And surely, it cannot be the aim to create second-class specialists. There would be little likelihood of them making any great impression upon the public.

What the public will always be looking for is a readily available *expert diagnostician*, as correct treatment is bound up with correct diagnosis, and the earlier correct diagnoses are arrived at the better for the patients. The public also wants an as readily available *expert helper in any acute emergency* from whatever cause. In another less clinical field, i.e. public health, there is also increasing need for the *expert in preventive medicine*, although even in general practice itself preventive aspects do not play a small role.

Thus with concentration on these three subjects a postgraduate training for the general practitioner would have a real meaning as the general practitioner would thereby obtain a knowledge (academically speaking) and ability (practically speaking) that is peculiar to him. A general practitioner thus qualified can then be expected to be in demand. And this in itself raises his status, even if not a single penny is added to his income.

The ability to *do* something that others cannot do so well, I would call the second essential requirement on which success of postgraduate training of the general practitioner depends. Only if these two requirements are met, can one hope to obtain the desired results, namely:

(*a*) *for the public*, i.e. the individual patient as well as corporate and public bodies:

(i) increased confidence in the general practitioner and resulting reassurance to the patient,

(ii) reduction of incidence, duration and degree of illnesses,

(iii) reduction in residual disabilities,
(iv) reduction in medical expenses.

(*b*) *for the general practitioner:*
(i) satisfaction which results from greater knowledge and skill,
(ii) satisfaction which results from the feeling of being in demand,
(iii) higher status both inside and outside the medical profession,
(iv) remuneration adjusted to that of the other specialists.

Having arrived at the conclusion that postgraduate training with a certain emphasis has a fair chance of success, provided the two essential requirements are met, one is confronted with the problem of the form which that training should take. Should one, e.g., follow the continental-European approach whereby time served in specialist work and training, not examinations or specialist diplomas or degrees, forms the basis of recognition as a specialist. Or should one follow the path so well trodden in the British Commonwealth, with examinations at the end of specialized training for diplomas and degrees.

As we have already embarked on the latter course in all other fields of medicine, the logical conclusion can then only be: Examinations for diplomas and degrees also for the general practitioner.

And so the question of type and kind of diploma or degree course comes up. As the field of work of the general practitioner is so wide, it is felt that the separation of the more clinical subjects from the preventive ones will be a definite advantage and will make the creation of two distinct careers based on a number of diplomas and two degrees possible. The following scheme is proposed:

DEPARTMENT OF GENERAL AND PREVENTIVE MEDICINE
of a Medical Faculty of a University

D.P.H. D.I.H. D.S.M.	Primary Examination D.G.M. D.E.M.
÷	÷
3 years' recognized work in the field of Preventive Medicine	3 years' recognized work in the field of General Medicine
↓	↓
=M.Med. (preventive medicine)	=M.Med. (general medicine)
↑	=F.C.G.P.
↑	↑
CORRESPONDENCE UNIVERSITY such as the University of South Africa	COLLEGE OF GENERAL PRACTITIONERS

At a later stage the splitting up of the Department of General and

Preventive Medicine into two separate departments, one for general medicine and one for preventive medicine, might be desirable. For the time being, however, it seems to be more useful to keep these two fields, which are so closely related one to the other, also closely together organizationally.

From the outset it should be realized that both the general practitioner and the public health officer usually have established themselves in a practice or hold appointments neither of which they will be inclined to give up readily, for reasons of work, security, promotion etc. To enable them either to continue in their work or to interrupt their work for comparatively short periods only, postgraduate training for them should be fractionated.

This concept of fractionation is quite different from concepts held with regard to other special training. But it suggests itself as in the other specialties the student starts out on a new career, which is in some way centripetal, i.e. based on population concentrations and on larger medical establishments. The general practitioner and the public health officer remain in their respective spheres of work, which are often enough subject to centrifugal forces.

Such a fractionated system allows the student to obtain any or all diplomas at a time and speed most suited to his peculiar circumstances. This in itself encourages postgraduate training. Having obtained the three diplomas in his particular field (the Primary being taken as a diploma equivalent) and having gained the necessary practical experience, the three diplomas can then be consolidated into one master's degree.

To obtain the necessary qualifications without holding a training post at a medical school, the College of General Practitioners should provide tuition or hold examinations in the field of general medicine for those working or residing away from medical schools. Similarly a correspondence university, such as the University of South Africa, should offer courses in the field of preventive medicine, the necessary practical aspects of which could be concentrated into certain periods and places.

For the *Master's Degree in Preventive Medicine* the *Diploma course in Public Health* would have to remain essentially unaltered. The same would apply to the *Diploma course in Industrial Health*, whilst the *Diploma course in Social Medicine* should round up the study of preventive medicine by offering training in such subjects as sociology, social diseases, statistics and medicosocial legislation.

For the *Master's Degree in General Medicine* one would first have to pass a *Primary Examination*, in which emphasis should be put on embryology, topographical anatomy, physiology, bacteriology and parasitology. The *Dipoloma course in General Medicine* would have

to stress (*a*) examination techniques and (*b*) differential diagnoses, whilst the *Diploma course in Emergency Medicine* (1964)—which taken alone should be of great value to all casualty officers, medical officers in the armed forces and in other emergency units—would have to cover traumatology in the first instance, but the emergency aspects of all other fields of medicine as well.

Although the foregoing may not be the last word in respect of postgraduate training for the general practitioner and public health officer, it offers a basis on which a start could be made without further delay. A system such as the one proposed here would combine compliance with practical demands and flexibility, and would bring postgraduate training within reach of everyone working in general practice or a corresponding hospital post and in the field of public health. It would also make it possible that in future all branches of medicine meet on the same high academic level—an ideal which can be realized by nothing but hard work.

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ELECTROCARDIOGRAPHY

A report on a postgraduate study

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DURING MY SIX YEARS in this relatively remote rural practice (the nearest main hospital being 28 miles away in Ipswich), I have managed to care for almost all my patients suffering with myocardial and pulmonary infarcts, and with deep vein thromboses, without sending them away. Treatment has been carried out in the patients' homes or in Aldeburgh Cottage Hospital and has consisted of routine clinical management, and (pace the recent Danish reports) anticoagulation.

My practice had recently obtained the use of a new Philips transistor electrocardiogram. One of my partners was skilled in its use and in the interpretation of its tracings. I was less skilled; and so it was with a sense of excitement of being once again *in statu pupillari*, that I left my partners with a full-time locum, and went to work in the cardiology department at Barts. One of the best and