PRACTICE OBSERVED

Minimum Standards for Training

No longer a "cottage industry"

W G IRWIN

In this paper I discuss my ideas about the minimum standards of a training general practice because controversial new proposals for the appointment of trainers in general practice are at hand for discussion in trainer groups, which have emanated from some doctors on the Joint Committee on Postgraduate Training for General Practice. The task is made more difficult for me because I am chairman of the trainer selection committee of the Northern Ireland Council for Postgraduate Medical Education. It is appropriate to start by listing some standards that I consider (*a*) essential and (*b*) desirable (table).

From the list of essential and desirable standards obviously the practice characteristics of structure and organisation, records, resources, and ancillary staff must be carefully evaluated. Because some young doctors end up in less than ideal environments is no argument for deciding that "anything goes" in a training practice. On the contrary, each trainee is entitled to expect under a statutory scheme the highest possible training standards. The cottage industry image of general practice is surely a thing of the past. Well organised practices produce good candidates in the membership examination of the Royal College of General Practitioners.[1] Data show how many candidates score poorly in practice organisation, prevention, and the roles and relationships within the primary care team. A practice environment must be available that will enable a trainee to observe integrated care as a reality, and he must learn to understand and work with a bevy of independent professionals, especially various clinical nurses and health visitors, and have access to social workers and social services. The key to integration of care is effective communication with other members of the community care team. Nurses and health visitors at least must work regularly on the premises and the trainee should have easy access to hospital diagnostic procedures. Adequate space should be made available to encourage attachments of ancillary staff.

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Essential and desirable standards in a training practice

The training practice must:
(1) Have adequate space for an efficient record system (preferably A4 size)
(2) Develop a high standard of records, which must include:
  (*a*) letters and record cards in chronological order
  (*b*) concise summary cards of important illnesses or problems, or both
  (*c*) have easily accessible demographic data
  (*d*) have easily accessible information on risk factors
  (*e*) have easily accessible information on immunisation state and other preventive procedures
  (*f*) have a simple record system to monitor drug prescribing, particularly repeat prescribing
  (*g*) show the use made of age-sex and disease registers in service, teaching, and research
  (*h*) have concise encounter notes that indicate current diagnosis, medication, and management
(3) Have adequate space for a practice nurse
(4) Have easy access to attached health visitors and social services
(5) Have adequate consulting room space so that trainer and trainee can work simultaneously
(6) Have adequate receptionist and secretarial staff
(7) Have a small library of essential reference books and journals relevant to training for general practice
(8) Have available general practice diagnostic equipment appropriate to the needs of modern practice

It is desirable that a training practice should:
(1) Have an adequate sized common-seminar room for practice, clinical, and educational meetings, which should be a regular feature of practice life
(2) Have adequate space for health visitors to work regularly on the premises
(3) Have an organised system to practise preventive medicine
(4) Have easy access to hospital diagnostic procedures
(5) Have adequate cover for the trainee in the trainer's absence
(6) Have access to video technology and ideally have a camera, video recorder, and monitor on the premises

Record keeping

The training practice must develop a high standard of record keeping. In partnerships, especially, easy retrieval of clinical and social information improves the efficiency of patient care by improving communication. Good records are essential for clinical audit of performance and for identifying groups of patients with specific characteristics—for instance, schoolgirls of a certain age for rubella immunisation. Repeat prescribing has been much criticised by doctors and outside observers. Trainees are appalled to learn that between a quarter and a third of all prescriptions now written are issued without a consultation taking place at that time[2] and that the workload of writing these prescriptions is so great. All training practices must be able to show a simple and effective use of drug sheets to monitor prescribing. Trainees must be made cost conscious and aware of the adverse drug effects from loss of control of prescribing, especially for elderly patients. Further essential requirements would be chronological filing of letters and reports, preferably in A4 sized folders; availability of problem summary sheets listing important illnesses, medication, and risk factors; and concise encounter notes showing current diagnoses, medication, and management. All this will require extra work for trainers and some cost to them, but teaching practices must lead and bring into use age-sex and disease registers. The latter have well documented practical uses in service, teaching, and research. Training practices must hold regular clinical and educational meetings. It is desirable to have an adequate sized room for this, although suitable space may not be available in older premises. The format of these meetings between trainees, trainers, and partners will vary from area to area, depending on local circumstances, but the necessity for them remains the same. All who are concerned with training must have access to current publications and be aware of current research in general practice. A small library of books and periodicals of daily interest to trainees must be acquired in each training practice and trainees should be encouraged to read and to think critically about what they read. This is even more essential if main library facilities are far away.

Should all trainers be on the obstetric list? I don't think so. Undergraduate teaching emphasises the principles of human reproduction and normal obstetrics. The environment of a training practice should enable a trainee to observe sound antenatal and postnatal care, but only a few trainees are likely to enter practices that have a large obstetric component with heavy use of general practitioner obstetric beds. A balance of selection of trainers in relation to obstetric care in a locality is therefore advisable, to give trainees as wide a choice as possible.

I would hope that most training practices would have access to video technology and, ideally, have a camera, video recorder, and monitor on the practice premises. These facilities are costly and time is essential for their effective use in teaching the skills of history taking. Retrospective analysis of video taped consultations in practice, however, is a most effective means of teaching about communication and the process of the consultation.

MRCGP

I am conscious also that controversy surrounds the proposal that having the diploma of the Royal College of General Practitioners (MRCGP) must be accepted as a normal requirement for trainer selection.[3] I doubt the wisdom of trying to establish such a criterion, although I believe firmly that all general practitioner trainers should encourage their trainees to sit the examination on completion of training. Those who are active in general practice education appreciate the great need for a valid and reliable examination to test knowledge, skills, and attitudes in general practice. Everyone should reflect on the advances made in the past decade in teaching and assessment of areas of learning defined by general practitioners as necessary for the future general practitioner to study.[4]

Professor Walker recently provided data to show the validity and reliability of the MRCGP to test general knowledge relevant to daily general practice.[5] Competition for training places in the Northern Ireland Vocational Training Scheme is intense and the competitive urge has resulted in very positive attitudes to sitting the college diploma after completion of training. Most do so and are delighted to acquire a higher qualification in general practice, which represents a milestone in their academic careers. The growth of academic general practice is one of several major factors which has changed morale dramatically in general practice in many areas of Britain and Northern Ireland. Credit should be given to those who have made appreciable contributions to its development. I have laboured over the college examination, because general practitioners need a stimulus to learning, and no better assessment is available. Trainers must encourage trainees to be academically alert, curious, critical, and competitive. If they continue to do so standards will rise.

If the college diploma is not to be a "must" for trainer selection then each regional education committee for general practice must formally assess prospective trainers in other ways. Desire and ability to teach and other personal attributes must be subjectively evaluated at interview in the practice as well as the structure and organisation of the practice.

The time is past in general practice education when "anything goes." Statutory vocational training made sure of that. The criteria of selection that I suggest may cause disquiet to some competent general practitioners who work in less well structured premises. It is essential to ensure healthy development of general practice and training practices must conform to certain standards if trainees are to receive the best possible training. Effective education and properly integrated care of patients mean that the training practice must provide an environment in which the characteristics defined in this paper can be demonstrated.

References

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ONE HUNDRED YEARS AGO Dr. G. Schweinfurth, in examining the floral wreath on the mummy of the Princess Ugi-Khouni, of the twenty-first Egyptian dynasty, discovered, says *Nature*, at Deriel-Behan, found the folded leaves of a willow (*Salix Safsof*), perfect flowers of the corn-poppy, flower-heads of *Centaurea depressa*, and of *Picris coronopifolia*. The flowers of the corn-poppy appear to have been gathered in an unopened condition to prevent the petals from falling, and were in such good condition that Dr. Schweinfurth remarks that such perfect and well preserved specimens of this fragile flower are rarely to be met with in herbaria. It is worthy of note, too, that the character of this variety of the poppy (*Papaver rhoeas*, var., *genuina*), although gathered more than 3,000 years ago, are identical with those of the same variety known to-day. With respect to *Picris coronopifolia*, the author remarks that not a single peculiarity is apparent by which it might be distinguished from the recent small form, with low-spreading branches, now common on the outskirts of the desert. From the occurrence of this flower in the wreaths, it is possible to conjecture that the burial of the princess took place in March or April, since there would have been considerable difficulty in obtaining the flowers after the latter month. It has also been determined, by the capsules of the linseed-plant found in a Theban tomb of the twelfth dynasty (2200 to 2400 B.C.) that the flax used by the ancient Egyptians was derived from *Linum humile* Mill, and that the mustard-oil used by them was derived from one of two varieties of sinapis, both of which are still common in Egypt. (*British Medical Journal* 1884;i:870.)

Family Practice Abroad

In case of emergency dial 15: report from Rouen

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Some accident and emergency departments in the United Kingdom find it more and more difficult to cope effectively with acute medical and surgical cases because of growing numbers of patients attending with non-urgent problems who are either unable or unwilling to see their general practitioners. Patients also not uncommonly have difficulty in contacting their general practitioners or their deputies for emergencies out of hours.

This is a report of a pilot project—the Centre 15—first proposed in 1978 and started in October 1980 in the Seine-Maritime Département of France, whereby help and advice for any medical emergency may be obtained simply by dialling 15.

Aims

The aim is to provide a speedy and effective response to medical emergency calls in the region throughout 24 hours using the appropriate facilities. The response depends on the nature of the emergency—for example, the despatch of the flying squad to major accidents or life threatening illnesses, passing requests for emergency home visits to general practitioners, liaising with the public and private ambulance service, or giving medical advice or information about general practitioners' or chemists' emergency rotas.

Territory

The territory chosen represents roughly half of the Seine-Maritime Département and 620 000 people. There are four flying squads (Service mobile d'urgence et de réanimation) based at Rouen, Elbeuf, Neufchâtel, and Gournay en Bray. This catchment area is near to the average in regard to area, total population, and population distribution for a département.

Operation

Anyone may dial 15 for any medical emergency. The call is received by a trained receptionist (permanancier auxiliaire de régulation médicale), who works in a control room at the headquarters of the emergency ambulance service (Service d'aide médicale urgente) of the département. Details of every call are taken on a standard form. If the call is merely an inquiry of a non-clinical nature—for example, the name of the duty chemist, nurse, or general practitioner, or perhaps a general practitioner wishing to know the state of hospital beds—the receptionist provides the information herself. If the call, however, requires a clinical decision it is put through to one of the control room doctors (médecins régulateurs) while at the same time the form is passed over to the doctor's desk so that he may take action as follows:

(*a*) Calls of a non-urgent nature—such as influenza, cystitis). Advice is given and the caller is asked to contact his general practitioner in due course.

(*b*) Calls of a more urgent nature from patients at home—such as dyspnoea, chest pain, abdominal pain. The message is relayed to the patient's general practitioner (or if out of hours his deputy) who then visits.

(*c*) Calls about accidents with the possibility of severely injured people or life threatening emergencies at home or outside the home. The message is passed to the nearest flying squad, which consists of an ambulance equipped for cardiopulmonary resuscitation and management of trauma at the roadside, a driver, a qualified doctor—usually an anaesthetist of registrar grade—and a houseman or final year medical student.

(*d*) Liaison with private or public ambulances according to circumstances.

(*e*) Liaison with other public services—such as police, fire service, casualty department.

The control room is manned throughout 24 hours by a trained receptionist and two doctors (médecins régulateurs). One will be a hospital doctor (usually an anaesthetist of senior house officer or registrar grade, whose duties in the control room will be part of his hospital contract). The other will be a local general practitioner who is paid on a sessional basis (12 hour sessions). Both will have received special training for the work.

All calls are recorded on magnetic tape and stored for three months.

Administration

Two committees share the responsibility.

Le comité départemental de l'aide médicale urgente is presided over by the préfet (administrative head of a département) and consists of representatives from all the public and private organisations participating in the scheme—for example, ambulance, police, telephone services. Le comité technique médical consists only of doctors representing the various groups participating—for example, anaesthetists, general practitioners, accident and emergency doctors. This committee maintains a satisfactory standard of medical practice and also ensures cooperation between the private and public sectors (broadly speaking, general practitioners and hospital).

Budget

A grant from the Ministry of Health covered up to 75% of the total capital costs. The costs of running the service are covered by central government 26%, local government (département) 40%, and regional hospital (Rouen) 34%.

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Assessment of the first six months and after

The table shows the action taken by the control room doctor from 17 October 1980 to 31 March 1981 (166 days) and during the whole of 1982. Two trends emerge. The first is an increase in the average number of calls a day, which presumably reflects the increasing use of the system as well as, for instance, seasonal fluctuations and increase in population. The second is the increase in the proportion of calls deemed to require advice only and the corresponding decrease in the number of calls referred to the duty general practitioner for an urgent home visit. It would be interesting to know whether patient satisfaction had changed also.

Action taken by control room doctor over 166 days and over one year

Action taken	October 1980-March 1981: No (%) of calls	1982: No (%) of calls
Non-urgent, advice given	2 472 (14)	11 142 (23·2)
Referral to duty general practitioner	8 091 (45·5)	18 346 (38·2)
Despatch of an ordinary ambulance	4 350 (24·5)	11 239 (23·3)
Despatch of a flying squad	2 867 (16)	7 340 (15·3)
Total	17 780	48 067
Average No of calls a day	107	131

Unfortunately, during the past year it has become obvious that most general practitioners in Rouen are not interested in working regular sessions in the control room. They consider the work to be poorly paid and dull, and at present most sessions are filled by junior hospital doctors as locums. Thus one of the aims of the Centre 15, to improve relations between general practitioners and hospitals, has not occurred, at least in Rouen. This problem does not seem to have arisen in Troyes, where the first Centre 15 was opened in May 1980. At least four more Centres 15 now exist in France and more are planned. It will be interesting to see whether this problem recurs.

Discussion

The traditional way in which accident and emergency services are run in the United Kingdom is not ideal. A substantial proportion of patients, estimated to be roughly 12% in large urban hospitals,[1] either do not need to see a doctor (4%) or can be dealt with by a general practitioner (8%). This unnecessary caseload may divert limited resources away from serious cases and increase the waiting time for other patients. Rutherford *et al* suggested four ways to tackle the problem: (*a*) patient education by general practitioners and accident and emergency doctors; (*b*) sorting of patients at reception by a senior nurse; (*c*) a limited number of health centres could be open and staffed 24 hours a day; (*d*) a primary care deputising service based in hospital for out of hours calls.[1] The last of these was described in more detail by Kellerman.[2] He proposed an out of hours service in a community of 160 000, run from the casualty department of the local district general hospital, with two general practitioners on duty at any one time, one of whom would do house calls if necessary.

The Centre 15, which is now well established in Rouen, is similar to Kellerman's scheme, but is more complex and serves a larger population (600 000). Its advantages over the other schemes are simplicity for the patient, efficient coordination of all personnel who might conceivably participate, and a speedy response. There may be a place for similar schemes in the United Kingdom, especially in large towns and cities. In addition, the Centre 15 is ideally suited for participation in a major accident scheme. As in France, though, success depends on the cooperation and enthusiasm of both hospital doctors and general practitioners.

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Diary of Urban Marks: 1880-1940

In the following year, 1910, Messrs Baldwins began to build their works on the Burrows near Jersey Marine. When it was advertised that a works doctor would be wanted seven men applied. I can remember that Brice who lived at St Thomas, Curtis, and Hunter who lived near Brice were applicants and also myself, naturally. I never neglected an opportunity of adding to my income, especially as there was a family to provide for at this time. While the works were in the process of building, certain foremen were appointed to superintend the putting in of the machinery, etc. It was these foremen that we had to canvas for their favours since we knew that they would influence the men. I do not know what the other candidates did but I went to the works and held meetings in the chapel which had been erected temporarily for the men. In no other place but Wales would a chapel have been built. I used to get the various sections of the men together and explain to them why they should elect me as their medical adviser. Incidentally, it had been decided by the management that the men should elect their own doctor and therefore it was to the men I had to appeal. It turned out very shortly that I was a strong candidate but the furnacemen were rather against me while the finishing department were very much for me. In this department I had a very good friend in the foreman, called Whittingham, who happened to be not a Welshman and it was probably from this fact that he threw his influence in my favour knowing that I was not Welsh. The finishing department had more workers than the others and I awaited the outcome of the election with confidence. We all went to ballot and I was on the short list with Brice and Hunter. In the final ballot I was appointed, much to the disgust of the furnacemen. I was called before the electors and told that I should be expected to put a surgery in Port Tennant for the convenience of those who lived there. Considering that the workers at Baldwins lived all over the town—as far apart as Jersey Marine and the Mumbles—I thought their request was unreasonable but I did not say so at that moment. I was only too glad to get the job, which was worth £250 a year. The workmen paid threepence per week for themselves and families and this money was deducted from their wages and paid over to me monthly.