TEAM LEADERS

The teams are led by a specially selected senior trainer or course organiser whose responsibility it is to arrange the timing of the visit with the practice and the members of his team and to ensure that they all agree the arrangements. The team leader also coordinates the preparation of the report after the visit.

ORGANISATION OF THE VISIT

The members of the team have a copy of the trainer's application form and the last trainee's report (if it is a reapproval). It is essential that the purpose and nature of the visit is explained to all members of the practice beforehand and a timetable needs to be agreed. This may vary from practice to practice to fit in with the availability of partners and staff. The observation of the practice premises and the way they function is best done at the beginning of the day when the practice is busy and the visitors do not need to be accompanied by the doctor during this time. Lunchtime may be used for the visitors to meet all the partners, or the visitors may prefer to spend this time on their own to consider the topics to be raised during the interview in the afternoon. A specimen timetable might be as follows:

9 00–10 30	Observation of the practice premises and organisation, equipment, and records. Interviews with health visitors and nurses
10 30–11 30	Discussion with partners
11 30–12 00	Discussion with trainee
12 00–1 00	Videotape review
1 00–2 00	Lunch for the visitors on their own
2 15–3 30	Doctor interview
3 30–4 30	Preparation of report

It is important that there is some discussion beforehand among the visitors about the details of who will do what on the day.

Methods of assessment

Each of the separate methods of assessment provides information to evaluate a number of the criteria. For example, observing and discussing video recorded consultations not only provides information on clinical competence but also on professional values and preparation for and ability to teach. Information on the experience that the trainee obtains in the practice can come not only from the trainee but also from the practice staff, the trainer, the partners, and by direct observation. All the criteria therefore should be considered during each assessment.

OBSERVATION OF THE PRACTICE PREMISES AND ORGANISATION

During this phase the visitors are able to observe both the premises and the way the practice works at a busy time of the day. The visitors may work separately, looking at different parts of the practice, and this is both more economical and less intrusive. It is helpful if the practice staff are given time to talk to the visitors when they are not expected to be performing their normal duties. One visitor usually sits with the appointments clerk monitoring availability of appointments, while another may spend some time with the practice manager. The third may discuss with members of the health team their contributions to training.

Records—The visitors look at a random sample of the records of the whole practice. The size of the sample varies with the size of the practice but is usually between 50 and 100 records, and the visitors also look at the records of one of the trainer's recent surgeries. They record the proportion of records that are in chronological order, that have clear, legible entries of each consultation, and that contain a completed problem list or summary. They also look to see if there is a record of regular treatment or anticipatory care—for example, blood pressures recorded, smoking histories, and cervical smears taken—when it is appropriate. Their findings are recorded (figure). They also assess the efforts that the practice makes to improve the records and their overall value for patient management, teaching, and audit.

DISCUSSION WITH PARTNERS

The visitors meet all the partners to discuss the development of the practice as a teaching practice, the support they give the trainer, and their own participation in teaching. This is best done with all the partners sitting down together at a prearranged time rather than in casual encounters in the corridor, which are not really helpful. It also allows partners to ask questions of the visitors about training in general.

DISCUSSION WITH TRAINEE

If the practice is already a training practice the trainee can give a consumer's view of his training. He should be asked to comment on features that he particularly appreciates as well as areas of possible improvement.

VIDEOTAPED RECORDINGS

The visitors watch with the trainer several consultations that he has recorded in a recent surgery. This needs careful arrangement beforehand. Normally the trainer will have become familiar with the use of video equipment during his preparation for training and so the assessment visit should not be the first time on which he has used it himself.

Portable video equipment is available in all schemes in the region and several training practices have now installed their own. It is essential that the informed consent of patients is obtained before they are recorded and a specimen consent form is provided. It is our experience that most patients have no objection to being recorded.

The trainer needs to record a complete surgery, and it is helpful for him to make a list of the patients whose consultations have been recorded—their age, problem, the likely duration of the consultation, and the position on the tape of its beginning

		Random sample of practice records (not < 50)	Trainer's recent surgery
No of sample			
Legible entry of each contact			
Contents in chronological order			
Completed summary or problem list	No appropriate		
	No completed		
Complete record continued medication	On medication		
	Completed		
Men and women aged 35–65	No Blood pressure recorded Smoking habit recorded		
Women aged 35–65	No Cervical smear recorded		
Women aged 20–35	No Rubella immune status recorded		

Specimen record analysis sheet.

and end. When the consultation is being discussed it is helpful to have the patient's records available for reference.

The discussion focuses not only on the effectiveness of the doctor in the consultation, using the approach by Pendleton *et al*,[1] but also on the issues that the consultation raises and how they might be used in teaching. If the doctor objects to the use of video tapes one of the visitors sits in a consultation session with him. This is not so useful and has happened only once.

TRAINER INTERVIEW

The purpose of the interview is to clarify and expand the aspects of the practice that have already been assessed and to explore new areas, particularly the trainer's approach to teaching, curriculum planning, and assessment. It is essential that adequate time is allowed for the interview and that it is conducted as a non-judgmental discussion among peers. The team leader will judge what feedback is appropriate at this stage.

The report

The report includes: a factual description of the way that the practice and the trainer achieve each criterion; mention of the particular strengths that have been identified; areas of potential improvement; recommendations for building on strengths and correcting weaknesses.

The report is agreed by all members of the visiting team and is then sent to the trainer and to the appointments committee. The appointments committee is made up entirely of general practitioners and consists of the chairman of the general practice subcommittee of the Oxford region, the two regional advisers, the local course organiser in charge of the scheme, the team leader, a representative of the candidate's local medical committee, and another general practitioner member of the general practice subcommittee. The appointments committee makes the decision about approval or reapproval in the light not only of the visitors' report but also of the reports from previous trainees in the practice. Sometimes the committee think that the information is incomplete or that there are areas that the members wish to discuss with the trainer, and it therefore may invite the trainer for interview before making a decision. This also gives the trainer the opportunity to discuss the report with the appointments committee.

Discussion

This kind of visit by three general practitioners, taking up most of the day and at some stage involving every member of the practice, seems at first sight daunting and time consuming. There are, however, some important points to make.

Firstly, all trainers now participate in making assessments rather than just a small group. So each trainer is being looked at by his colleagues and peers (who may learn as much from the visit as the doctor being visited).

Secondly, it is possible to obtain much more objective evidence on which to make decisions than was the case before. It is fair to say that whereas previously with comparatively short visits it was sometimes difficult to come to a conclusion about whether to approve or not we now believe that we can make that decision much more objectively and fairly.

Thirdly, we believe that the visit must have a strong educational component. Therefore, the visit report is sent to the trainer so that he and the rest of the practice can see what was thought to be good and where it was thought that improvements might take place.

Fourthly, we believe that trainers should know on what basis decisions are being taken. This is another reason why they see their reports (and also the reports their trainees write about them). The standard of report writing has much improved as a result, since errors and recommendations based on no evidence are not usually acceptable to the recipients.

Fifthly, once a trainer is appointed he will have a major role in the lives of several, if not many, trainees and have an important influence on the local training scheme. Thus taking one day for the process of approval does not seem very long.

Conclusion

This method of assessment is similar in many ways to the methods described in *What Sort of Doctor*, particularly as it is a peer assessment based on direct observation of a doctor working in his own practice.[2] It differs, however, in two fundamental ways. Firstly, the assessment is based on criteria for a trainer and training practice rather than on just a doctor. Secondly, although the visits have much educational value for both the trainer and the visitors, the "bottom line" is whether the trainer is or is not approved. A degree of discomfort and threat is therefore inevitable and it is essential that the whole process is handled throughout with fairness, respect, and sensitivity.

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In the third paper we will describe the results of our evaluation of these methods of assessment.

Diary of Urban Marks: 1880–1949

I engaged a boy called Robert Muffky, who was not a Russian, to clean the car and come in it with me at a charge of 7/6 a week. Muffky saved me time by winding up the car when it had been stopped at a house. He was with me until 1913 when I took another boy called Kneath who at the time knew nothing about a motor. He had, however, a mechanical turn of mind and through the years taught himself all there was to know about a car. He has been with me now for 20 years and can take a car to pieces and rebuild it. He will have a few nuts and bolts left over but the car will go just as well as before it was dismantled. Kneath married one of my maids and his eldest son is also of a mechanical turn of mind and is now engaged in engineering. Cars are not Kneath's only speciality. He can dismantle a watch as easily as he can a car but the final result is not always so successful. Still, he is a useful man to have around.

A Difficult Case

A trainee patient

S J GILLAM

Seated round a table allocating the morning's visits over coffee, my trainer thrust an unusually thick and dog eared folder in my direction. "Ophelia," he said with a playful gleam in his eye, "now she has a number of interesting problems. A good one for you." What, I wondered, were the other partners sniggering about? Ophelia lived in a three room flat on the grim housing estate that comprised a third of our catchment. My memories of that visit haunt me now—the peeling wallpaper, the olfactory mingling of sweat and damp, the assorted bodies lying idly around in the front room, and, above all, Ophelia lying miserably on the only piece of furniture in the barren room she shared with her daughter and grandson.

I had encountered this widowed 54 year old woman several weeks before by proxy. Her daughter Goneril had appeared asking for painkillers for her mother who was confined to bed on account of arthritic pain and "didn't want to bother the doctor." I argued disingenuously that her mother should attend herself unless she really did need a visit. Goneril sighed and left, but my self satisfaction was shortlived.

That evening Ophelia generously lumbered into the surgery. I dutifully sought details of her unusual epigastric pain and noted her consumption of every conceivable type of analgesic. She was grossly overweight and had hypertension, and I fear that she even received a trite little sermon on the hazards of obesity. She consented, anyway, to barium meal examination.

Two days later she returned; the abdominal pains were better; she was now suffering chest pains on the left side. Various instincts suggested electrocardiography; they were promptly repressed. She proceeded to muse for half an hour on Goneril's problems: her financial difficulties, her violent unemployed husband, their son, the future.

Over the next few weeks I learnt much about Ophelia's other nine grown children, some of whom were emotionally and materially dependent on her: Ophelia junior with her housing difficulties, Derek in trouble with the law, David, and the rest. I emerged from these dreaded meetings as depressed as she was. What was I supposed to do to help her face such insoluble problems? Why me? For Ophelia was one of three or four hopelessly afflicted regular attenders at surgery who provoked a number of questions: Why do certain patients choose to consult the trainee? What, if anything, do they have in common? How do we deal with them?

The answer to the first question seemed simple. Flattering though it was to have patients return to me, sadly my greatest asset was not charisma, but novelty. Reading over Ophelia's case notes showed that she had attended my predecessor still more often and my successor bears witness to comparable devotion. The cyclical process—embrace of new practitioner, reinvestigation, reconciliation or rejection or both, re-embrace—may be gratefully accepted by trainers whose patience they have temporarily exhausted or whose responses they now anticipate.

Much has been written on "problem patients," how they are perceived, and what characteristics they share.[1 2] They suffer combinations of physical (often musculoskeletal), social (often related to isolation), and psychological (often depressive) problems. Presenting with intractable physical symptoms ("organ recitals"), they are often taking a large number of superfluous drugs. Groves has colourfully described four categories of "hateful patient": entitled demanders, manipulative help rejecters, self destructive deniers, and dependent clingers.[3] My patients fell smoothly into all four groups simultaneously but at least elicited a common sequence of responses: initially anxiety that a diagnosis had been overlooked, then irritation with feelings of inadequacy, and finally weary antipathy with a dash of true compassion.

What was I doing for such patients? The short answer is almost anything. Enthusiasts may subject them (along with the taxpayer) to unnecessary hardship trying out their latest diagnostic and therapeutic plaything. Major intervention is, however, not desired or required and therefore unlikely to be of more than temporary benefit. More appropriate psychotherapeutic approaches will have been suggested and met with equal resistance. Ophelia has been told many times that her "problems are psychological" and, indeed, concedes her capacity to deny personal conflicts and to project these on to her children. She is dimly aware of the ways in which, from the centre of her web, she has prevented her children "learning to deal with their own problems." While no new insights will alter the facts of her material deprivation, I am sceptical of her own proposed solution: migration to that mecca for the maladjusted, a new town.

Lesson learnt

What did I do for Ophelia? The short answer is almost nothing. I offered regular opportunities for indirect expression of her despair but was unable to get her to voice some of the disappointment with herself as wife and mother, which I suspected underlay her depression. I helped her to identify some of the positive aspects of her life but changed nothing. She is more acceptant, but also more acquiescent, in status quo. Though temporarily relieved, she is still prone to recurrence of real pain—and I failed to spare her an unnecessary barium meal.

What did I learn from Ophelia and from other "trainee patients?" Firstly, negative feelings constitute important clinical data about patients' psychology—my frustration mirrored hers. Errors in diagnosis and treatment result if such feelings are denied. It is interesting that doctors' perceptions of problem patients are remarkably uniform and that neither age nor length of time since qualification greatly affects them.[4]

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Among other things this presumably reflects the prevailing protestant ethic reinforced by unimaginatively consistent selection criteria for medical school. How inadequately does medical education prepare you for some of the most demanding of doctor patient transactions!

Secondly, such people provided an early opportunity to exercise essential counselling skills. Different schools of psychotherapy cherish different approaches to the problem of reorientating consultations, but those who champion simple sympathetic counselling without the advantage of fashionable figure heads or jargon may, I think, claim comparable results.

Finally, zealots benefit from exposure of their limitations.

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(*Accepted 13 January 1984*)

What Annoys Me Most

The kerbside consultation

HUGH M BAIRD

The kerbside consultation always takes place away from the safety and sanctity of the surgery and tends to occur in such places as the street, restaurant, or club. It seems almost as if a doctor's appearance in these places is sufficient to stimulate half forgotten memories of ailments and ill health, which, when recalled, so dominate the mind as to demand instant action. The perpetrator is nearly always someone who could well have come to the surgery and whose problem has probably been present for some time. Very few of these problems are genuinely urgent and when, rarely, some emergency does present in this way no one really minds. Most incidents are requests for advice or information or to discuss hospital reports and the result of investigations, but it is still surprising that an appreciable number of people seem to want to discuss very intimate matters, and though they seem happy to recount details of their piles, ruptures, and menstrual and reproductive disorders, I am certainly not prepared to do so in public.

The kerbside consultation has many variations, all of which are equally annoying. For instance, there is "While you are here doctor would you mind looking at. . . ." Or there is the proxy call, which is a request for a home visit left not at the surgery with the receptionist but at a neighbour's house which it is thought the doctor may visit later that day or week or month. As a result, not only may the doctor find himself with extra and unplanned house calls, but the message can so easily be forgotten and when subsequently remembered will often result in a late call to an area already visited. Yet another variation is the request for a home visit without actually implicating the person who made the request. Although the patient may be someone who has not been seen by the doctor for several years, the suggestion will invariably be made to "Tell him you were just passing and have dropped in for a chat!"

Management of the kerbside consultation is difficult and often disappointing. There is usually no escape once it has occurred. The sarcasm intended by offers of instant examination in public is not recognised as such and at worst may even be accepted. Bad temper and sheer rudeness seem to have little if any deterrent effect. Prevention is really the best answer, and perhaps if we made ourselves more accessible to the general public—on the telephone, for instance—some of these incidents might not occur at all. Be this as it may, a general practitioner can always try to walk at a brisk pace and look as if he is perpetually on his way to yet another emergency. "Developing situations" may sometimes be recognised early and avoided. For instance, persons seen loitering with intent to waylay may occasionally be dodged, while those who wait at the kerbside with hand outstretched, as if in the act of stopping a bus, may be given a cheery wave in reply as you drive past. For the rest of that day, however, you will probably be left wondering what was really wanted. The car, too, may be left ready for a quick getaway, and some cynical gentleman once remarked that it was easy to spot a general practitioner's car as it was nearly always reversed into a parking place for just such a purpose.

Lest anyone should think that these suggestions are intended to be taken seriously or that I do not enjoy my work as much as I really should, let me hasten to add that they are written very much with tongue in cheek. The kerbside consultation is an occupational hazard that is not necessarily restricted to the medical profession but which must be experienced by lawyers, dentists, vets, and members of many other professions. Undoubtedly, the best way of dealing with it is to employ those basic tools of the trade without which no doctor is adequately equipped for the rough and tumble of general practice. These are patience, tact, diplomacy, self restraint, and, above all, a sense of humour.

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