What are the problems?

Those who presented their case histories at the Department of Health and Social Security's symposium Women in Medicine[1] indicated that there were problems with role identification, varying responsibilities, and difficult interpersonal relationships. Those who train part-time will have different problems, but these are likely to fall into the following categories.

(1) Personal problems. The part-time trainee needs to think carefully about attitudes to domestic activities, finance, and relationships to a spouse (if any). While all doctors will have the same areas of concern, the difficulties facing the part-time trainee are greater and are much more likely to produce conflicts both for the trainee and for close personal and professional contacts. Someone who attempts to be a half-time doctor and a half-time parent usually ends up with a commitment that is rather more than full-time.

(2) Career problems. It is my impression that part-time trainees have not clearly thought out their plans for the future. There is the risk that training may be used as an insurance policy and therefore may be entered into with no clear objectives. Though there may be an element of this in most training programmes, if it is seen as the most important aspect the experience is likely to be less than satisfactory.

What are the opportunities for finding a worthwhile job at the end of training? There are still vacancies for doctors who seek full-time work, but as the vacancies may not be geographically or chronologically evenly spaced they may not be appropriate for doctors with domestic ties. A few of the Nottingham part-time trainees have found it easy to get part-time jobs, but the choice is not usually great. Full-time principals of both sexes often need to be convinced that a part-time commitment to general practice can be useful to the practice as well as to the doctor concerned. Those who seek a part-time vacancy will have to come to terms with the problems posed by a spouse's occupation and the educational and other needs of children.

(3) Administrative. Those who are training part-time will need more help and co-operation from all concerned compared to those working full-time. Few regions have faced this problem and appointed extra personnel to look after the interests of part-time trainees.

Can these problems be solved?

If those who seek, and those who administer, part-time training are keen that it should succeed then most organisational problems can be overcome. It is helpful to consider the parts played by those concerned.

Course organiser—Every part-time trainee must be considered individually. After defining the personal and professional needs as suggested by Fabb[10] a training programme should be designed for the trainee. This is time-consuming but is something that a trainee should expect, whether full-time or part-time.

Trainer—The practice where the trainee is to work must always be chosen with care. This is even more important when the trainee will be part-time. A trainee working 50% of full-time will require more than 50% of the time usually spent by the trainer. Because trainees working part-time have often had a gap with no medical contact there is the "returned to medicine" syndrome.[11] The trainee will want to discuss cases more often and need more direct help. The teaching time needed will be, if anything, greater than for a full-time trainee. A trainer will certainly earn his reduced training grant. The rewards are, however, potentially greater, in terms of the satisfaction that comes from seeing doctors trained into "primary care physicians."

Patient—It is perfectly possible for a part-time trainee to provide continuity of care during training. Surgeries, however, need to be carefully planned. In Nottingham part-time trainees see more patients pro rata than their full-time colleagues. Furthermore, trainees who are known to have young children have had an extra following among patients who perceive a deeper understanding of shared problems.

Part-time trainee—This training will either succeed or fail in response to the motivation of the trainee. Without a high degree of enthusiasm for practical organisation no trainee will be effective. Apart from areas already discussed, the trainee will need to be very perceptive about his or her effect on others. Trainees as well as patients have difficulty coping with a high level of expressed anxiety. So while the trainee has to be concerned in self-assessment more than most, some of this will need to be silent. If advice is sought during every consultation patients will soon get the message that the trainee is not worth seeing.

Establishing relationships with the trainer, the practice staff, and the patient is harder for the part-time doctor and so will require greater effort. The personal needs of those with domestic responsibilities are important, but the trainee would do well not to dwell on them.

The part-time trainee's spouse has an important contribution to make to the success of training. Who would otherwise collect children, do the washing, answer the telephone at night, and stand in when a practice emergency arises? If a part-time trainee with domestic commitments does not have a spouse then there will need to be a "nanny figure" very close at hand for training to be effective.

What is the educational value?

Is all the extra effort of organisers, trainers, and trainees worth while? As it is very difficult to show in a scientific way the progress made by the full-time trainee, we must not expect a mathematical answer to this question.

The part-time trainees in Nottingham (all women so far): (*i*) can assess their own needs; (*ii*) can provide continuity of care; (*iii*) are at least as able to contribute usefully to the half-day release programme as their colleagues; (*iv*) see as widespread a pattern of disease as their full-time colleagues.

Though there are other aims of training for general practice these four suggest that part-time training can be of educational value.

Conclusion

It is likely that 5 to 10% of trainees will want part-time training. The practical problems are considerable but may be overcome if everyone concerned is prepared to give extra time and effort. Growing subjective evidence suggests that when there is a high level of motivation part-time training can be enjoyable, useful, and of benefit to the trainer, the trainee, and the patient.

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ACCIDENTS

Accidents are the largest single cause of death in this age group (table III). Road accidents are the main cause, followed by accidents in the home; but drowning, suffocation, and poisoning must not be forgotten. Nearly 80% of children aged 5 to 9 who are killed or seriously injured in road accidents are pedestrians.[3] GPs and health visitors can do much to encourage families to become aware of the risks to their children and to consider reducing hazards in the home and the car, as well as seeing that their young children are well versed in road drill.

TABLE III—*Deaths from accidents, violence, and poisoning (England and Wales 1976) (Source: Office of Population Censuses and Surveys, 1978)*

	Sex	Deaths by age group (years) 0-4	5-9	10-14	Total
All deaths due to accidents, poisoning, or violence	M	407	259	247	913
	F	241	135	112	488
Motor vehicle transport accidents	M	89	138	116	343
	F	48	73	49	170
Drowning	M	38	39	26	103
	F	17	13	7	37
Inhalation and ingestion of food	M	88	3	7	98
	F	34	1	1	36
Falls	M	31	18	21	70
	F	14	7	4	25
Accidental mechanical suffocation	M	23	3	24	50
	F	25	1	1	27
Homicide	M	35	1	3	39
	F	27	10	9	46
Poisoning	M	11	5	4	20
	F	6	3	4	13

CONTRACEPTION

Two girls a day aged 15 or under now have therapeutic abortions in England, in addition to the unwanted illegitimate pregnancies that go to term. A quarter of all abortions performed in England and Wales since 1978 were performed on girls aged 15 to 19.[4] By developing a relationship with young patients GPs and health visitors may find an opportunity to raise the subject of sexuality and contraception at an appropriate time. GPs should inform young patients that contraceptive services can be provided without an internal examination. Care must be taken in discussing contraception with the under 15 year olds not to undermine parental responsibility. Some GPs prefer to discuss this with parents and encourage them to raise the subject with their children.

NUTRITION

Improving the nutrition in this age group is fundamental to health, as it is to the care of their teeth. But there is a danger that the discussion of this subject may encourage the advertiser's false message that "thinness" and not "good nutrition" is what is desired. The mention of food or of obesity by the GP must be done with care so as not to add to the growing incidence of eating problems, especially bulimia and anorexia.

SMOKING, ALCOHOL, AND DRUG ABUSE

Smoking starts early. Bewley[4] showed in 1973 that in the final year in primary school 6·9% of boys and 2·6% of girls were regular smokers in Derbyshire. Attitudes to alcohol, glue sniffing, and experimentation with drugs are also formed early. Here the crucial influences on attitudes in developing children must be the family, the school, the media, and society at large. If general practitioners raise the subject of smoking or alcohol abuse with parents, especially within the hearing of the children, they may be able to counter some of these influences. Some GPs go further and give talks in schools, youth clubs, or on television. Others feel that as a profession we should bring more pressure on the media and other influences in society, including the soft approach of the Government to the sponsoring of sports by tobacco industries.

EMOTIONAL, BEHAVIOURAL, AND LEARNING PROBLEMS

There is a high incidence of emotional, behavioural, and learning problems during the years 5 to 15. Every GP can recount his experience of parasuicides, anorexics, drug abuse, truanting, learning problems, and abnormal psychological and even criminal behaviour in the children on his list. It is a sad fact that we in general practice can do little to buffer our young patients from the influences of advertising, social change, and disintegrating marriages.

England now has the highest divorce rate in the EEC. "Currently one in four marriages is likely to end in divorce. Some 60% will involve dependent children . . . between one in five and one in six children born today may witness their parents' divorce before they reach 16."[5] Many children return to an empty home after school because their mother is out at work. One in seven children are now brought up in a one-parent family. Many children suffer overprotective parents or parents who themselves are depressed and unable to give them the warmth they need. Far too many children suffer from inadequate housing and poor play facilities.

Can the GP do anything to prevent some of these problems?

Here are a few suggestions, largely based on *Prevention of Psychiatric Disorders in General Practice*, published by the Royal College of General Practitioners.

—Attempt to identify "overprotective" mothers, and avoid encouraging children of these parents to be kept off school unnecessarily after illness.

—Emphasise to overprotective parents what their child can do on its own.

—Encourage as much as you can any form of support for children whose parents are unable to provide warmth, and make an extra effort to avoid hospitalising these children.

—Pay more attention over the long term to the children on the list who are in care and may be experiencing a rapid turnover in adults looking after them, and encourage social workers to have them fostered.

—Identify early and get remedial teaching for children who have learning difficulties or communication problems.

—Identify families where the parents have psychological or sexual difficulties and see if they can face these problems and accept help before it leads to breakdown of the marriage.

—Try to prevent children from being used by their parents as pawns when marriages do break down, by pleading the children's case.

Can busy GPs do these things?

Lists of desirable things that primary care teams can do for any age group are easy to compile. Those who work in general practice know how difficult it is to implement them. What children on our list need is that we do more than just read about prevention. In deciding if any of these suggestions could be implemented the reader might find the following of some help:

—It seems that much of the GP's time is taken up in advising parents on simple self-limiting conditions, such as colds, diarrhoea and vomiting, constipation, sprains, dandruff, etc, so that little time is left to deal with children's real needs in the field of prevention. Yet each consultation is an educational opportunity, one that can be extended by written material. The

Practising Prevention

Children aged 5 to 15

C F DONOVAN

During the years 5 to 15 many things happen to our patients. They move from home to school. They grow physically, emotionally, and sexually. Their attitudes are formed, and the skills of socialising, learning, and carrying responsibility are acquired. During this process some of our patients have to cope with handicaps and difficult emotional and physical environments. In this article I discuss a few of the areas in which GPs who "think prevention" can help these patients.

Clinical care (secondary prevention)

It is a mistake to think of prevention as separate from good clinical care (tables I and II). Nowhere is prevention more important than in recognising rare but serious conditions early. The case of meningitis, torsion of the testicle, malignant melanoma, or leukaemia that one sees only once in several years is still sometimes diagnosed late, with serious consequences. Less traumatic conditions that the GP sees more often can, if not diagnosed early, also lead to unnecessary problems—for example, glue ear, appendicitis, scoliosis, and urinary reflux. Good clinical care and prevention also overlap when the GP makes an effort to limit the medication, investigation, or hospitalisation of his young patient. Constantly questioning the need to prescribe drugs such as antibiotics, steroid creams, tranquillisers, or even cough linctuses, not only prevents iatrogenic illness but also prevents the breeding of attitudes in future adults that simple self-limiting conditions require a doctor's consultation and prescription. Prevention in general practice also includes occasional curbing of enthusiasm for that extra investigation or even questionable operation, such as tonsillectomy.

Continuing medical conditions (tertiary prevention)

The periodic supervision of the treatment of patients with chronic medical conditions by the GP and the primary care team can prevent complications. Keeping the morbidity and age/sex registers up to date enables the team to identify and review schoolchildren with diabetes, epilepsy, asthma, or fibrocystic disease and also those with physical and emotional handicaps or those in a one-parent family. Preventing complications in these conditions may be achieved if good communications are built up and maintained with paediatric departments, the school medical service, members of the primary care team, and, above all, parents of the children concerned.

London NW11 7TE
C F DONOVAN, MB, DRCOG, general practitioner and part-time senior lecturer, Royal Free Hospital

Primary prevention

In this series of articles on prevention in general practice many subjects have been discussed that are relevant to this age group, but some have special importance.

TABLE I—*Paediatric work load in general practice: percentage of patients and annual number of doctor contacts*

Age groups (years)	No of consultations per year 0	1-5	6-10	10-
0-4	13·2	65·0	14·7	7·1
5-14	17·9	64·5	11·2	6·4

TABLE II—*Childhood illness in general practice. (Source: Office of Population Censuses and Surveys, 1974)*

Diagnosis	Episodes in a year (per 1000 population) Age (years) 0-4	5-14
Diseases of respiratory system	1009	521
Acute nasopharyngitis	470	152
Acute pharyngitis and tonsillitis	213	196
Acute bronchitis and bronchiolitis	185	73
Catarrh	48	22
Symptoms and ill-defined conditions	343	168
Cough	113	49
Acute vomiting and/or diarrhoea	112	31
Infective and parasitic diseases	209	160
Measles, rubella, chickenpox, whooping cough	64	51
Intestinal infectious diseases	63	17
Viral warts	5	42
Diseases of nervous system and sense organs	312	161
Acute otitis media	186	83
Conjunctivitis and ophthalmia	70	19
Diseases of skin and subcutaneous tissues	214	150
Eczema and dermatitis	100	30
Infective conditions	55	60
Accidents, poisonings and violence	92	113
Lacerations, abrasions, and superficial injuries	49	58
Sprains	10	28
All episodes	2873	1505

IMMUNISATION

Ten to 20% of schoolgirls miss their school rubella immunisation.[1 2] It is theoretically possible for general practitioners to identify the patients who remain at risk and offer a back-up service to that of the school medical service. Polio immunisation is especially important in older children who are going abroad, as is giving gamma globulin to those who may be going to places where hepatitis is rife.

refusal of the doctor to prescribe for a cold, the advice to go to a chemist to buy something for dandruff or to advise on a high roughage diet for constipation are educational in themselves—so is handing out a pamphlet, such as *Minor Illness*, produced by the Health Education Council, which has been shown to increase parents' knowledge and reduce the number of surgery consultations.

—Picking out the preventive needs of one member of the family in the age group 5 to 15 is liable to give a false picture. The needs of a child are often the needs of the whole family. Preventing the father having a coronary or mother slipping into a depressive breakdown, or helping both parents to cope with a bad patch in their marriage, or with granny, may help our young patients more than any preventive measure mentioned above.

—GPs who "think prevention" should heed the warnings of Illich and not undermine but enhance the self-coping powers of families so that they can carry their own responsibility for preventing sickness and promoting the health and development of all the members of their family.

A new suggestion

The working party that wrote the RCGP's document *Healthier Children—Thinking Prevention*,[7] suggests that GPs should put aside time for a special surgery to which those aged between 12 and 13—identified through the age/sex register—could be invited. In such a session for older children, run on the lines of the well-baby clinic, GPs could show their interest in the development of these children and provide an opportunity to discuss problems that the patients might have found difficult to present at a consultation. The GP could also do the following during these sessions: check height and weight; check for scoliosis; check for rubella status of girls; check for immunisation status of boys and girls; discuss attitudes to smoking, alcohol, or drugs; discuss academic progress; if appropriate, raise the subject of contraception and attitudes to sexuality and sex problems that may be present; mention the GP service available to his patient, and how the relationship with his general practitioner will change when he is 16 (table IV).

TABLE IV—*Checklist for adolescents*

	Problems/abnormalities
History	
Establish relationship with patient	
Home relationships	
School relationships and progress	
Any other problems	
Physical examination	
Record weight and height	
Scoliosis	
Review	
Check immunisation status	
Females: note rubella and rhesus status	
Teaching topics	
Anti-smoking leaflet and advice	
Discuss puberty	
Sexual: contraceptive information as appropriate	
Discuss accidents and prevention	
Problems, plans, referral	

Adapted from Eggertsen SC, Schneeweiss R, and Bergmann JJ. An updated protocol for pediatric health screening. *J Fam Pract* 1980;**10**:No 1, 25-37. Published by Appleton-Century-Crofts.

Conclusions

Time does not wait for the developing child. Since the Court Report was published, a generation of children has grown seven years older without any appreciable changes being made in the child care services which, many agree, are in need of improvement. Collectively, GPs, through the Royal College of General Practitioners, have made a new attempt to rekindle the will of those concerned to implement these long called-for changes, with special emphasis on prevention, by publishing *Healthier Children—Thinking Prevention*. For the sake of all future children it is vital that GPs, civil servants, politicians, and parents do not let the suggestions in this report go the way of those that have preceded it. In the meantime, this article has listed some ways in which GPs can begin to provide a better preventive service for those in the age group 5 to 15 years.

Tables I, II, and III are reproduced from *Child Health in the Community*, 2nd ed, 1980, R G Mitchell, editor, with the permission of Churchill Livingstone. Table IV is reproduced from *Healthier Children—Thinking Prevention*, with the permission of the Royal College of General Practitioners.

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Papers wanted for international meeting

The World Organisation of National Colleges and Academies of Family Medicine (WONCA) invites general practitioners in the United Kingdom to submit papers for the next meeting, which will be held in Singapore in 1983. Doctors who submit papers for consideration should be prepared to pay their own way to Singapore. Details may be obtained from the Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU.

Clinical curio: Injuries in the elderly caused by their pets

A 68-year-old woman had a six-year history of seropositive erosive rheumatoid disease. The disease was reasonably controlled by weekly gold injections and the use of a non-steroidal anti-inflammatory agent. She had little early morning stiffness, and apart from some slight soft-tissue swelling around the small joints of both hands her joint disease was quiescent. While some relatives were on holiday, she offered to walk their dog, an Afghan hound. Unfortunately, in a manner typical for the breed, the dog took off in pursuit of a distant friend despite being on the leash at the time. The sudden and unexpected acceleration resulted in a severe strain of the patient's shoulder presenting as a rotator cuff syndrome. Despite treatment from physiotherapists and local steroid injections, the shoulder is still giving trouble more than a year later.

Shoulder injuries in the elderly may lead to prolonged discomfort and sometimes permanent restriction of movement. Such cases may be resistant to treatment, and prevention is a better alternative. Ideally, elderly people and those with arthritis should not take large dogs walking on a lead. A simple device, however, may lessen the risk of shoulder injury in those who are forced to do so. Leads are available—for example, "Flexi" leashes—which uncoil from a spring-loaded wheel; a constant tension is maintained on the leash but sudden alterations in strain are not transmitted to the dog handler. A simpler and cheaper alternative is to include a length of shock cord in a standard lead. The use of either such device should be recommended for the elderly and the arthritic.—THOMAS PRICE, senior registrar in rheumatology and rehabilitation, Harrow.

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