Shortlisting Trainees

Needles in haystacks in Leeds

PHILIP L HEYWOOD

The last time we appointed a trainee to our small vocational training scheme there were 35 applicants for the single vacancy. Many of the applicants would have made admirable trainees. It follows that one of the major requirements for being selected is good luck. The selection procedure has remained virtually unchanged for seven years and has been used more than 10 times to choose about 18 trainees. This article describes the procedure and its inadequacies. It is similar to that used for all hospital senior house officer appointments.

Vocational training might be offered to the worst doctors—because they have the greater need for it; or to the best doctors—because, with training, they should make the best general practitioners. We have agreed to select from the latter group. We are therefore seeking people who are able, have potential, are critical, are interested in general practice, and are enthusiastic. Ability and potential are judged by previous performance; critical faculties are observed at all stages of the selection; interest in general practice is judged more by what has been done than by what is said; and enthusiasm is recognised at interview.

Advertisement

We have only one or two vacancies each year, which are advertised four to five months before they arise in the General Practice Training Posts of the *BMJ* on two consecutive weeks. A single column, three-line advertisement gives you little detail. Many doctors reply without requesting further details. Thus, they could apply for a three-year full-time appointment with less information than they would normally demand when buying a car or booking a holiday. As most selectors are looking for doctors who are questioning and inquisitive, you need not be reticent about asking questions and gathering information about the scheme. Basic information that should be available to you is listed in the text. Our prospectus is inadequate, so you must be prepared to approach several sources for information: the medical personnel department in the district authority; the course organiser or associate adviser; local trainers and consultants; the postgraduate centre; and, most importantly, the trainees in post in the scheme.

Application

Some applicants greatly underestimate the importance of the written application. It contains the only information available to us for shortlisting. We send an application form—so use it.

Leeds LS2 8AB

PHILIP L HEYWOOD, FRGP, DCH, course organiser

It is annoying to have two or three applications in a different format among a batch of 30 similar ones. I prefer applications to be typed, but accompanied by a short letter that demonstrates your handwriting. If the application is handwritten it must be neat and legible. Black ink is preferable; red, green, and sometimes blue inks may not photocopy well. Include your telephone number; occasionally you may be invited to attend for interview at short notice if shortlisted candidates withdraw.

You must ensure that every relevant detail is in the application or in your curriculum vitae. You are trying to tell yourself; we therefore need as much information as possible about your professional life and your outside interest. List all academic and other distinctions and any other information which shows that you are different from the crowd. Do not exclude information because you think it may be irrelevant; the interview committee represents a variety of interests, and some apparently specialised undergraduate project or elective period may interest one of us. In particular, include any contact that you have had with general practice, whether within the curriculum, during elective periods, or in your own time; and include a brief comment on your reaction to the experience.

We do not accept late entries, so ensure that the application is posted to arrive well before the closing date.

Shortlist

There are two purposes in shortlisting. Firstly, we wish to see all of the best candidates; and secondly, we wish to interview as few candidates as is practicable and fair. In practice, it has meant reducing the 40 candidates to between five and eight for interview. This is done by the course organiser, an experienced trainer, and a senior consultant.

Most applicants offer very little professional experience on which to make this selection. For this reason your application form is the best indicator of your potential. It is given to her, and removed out, as well as changes of address, is given to her so that the list is as accurate as possible. From this master list the routine surveillance examination programme is run. The secretary should also be responsible for identifying non-attendees, telling the health visitors and doctors (including the patient's own doctor if the practice maintains personal lists of patients for each partner) of the non-attendance, and then making the necessary arrangements for further appointments or a home visit to be made.

The health visitors with the practice midwife (when there is one) and the doctor who is responsible for the paediatric clinic service make up the rest of the preventive child care team. When the team works as one, with, for instance, minimal interference from nursing managers outside the practice, it usually becomes the most dynamic part of the practice. The health visitors greatly benefit from having a clinic secretary with the responsibilities I have mentioned. Their work becomes more satisfying and, when every preschool child in the practice has been identified, more effective.

Practising Prevention

The first five years of life

GRAHAM CURTIS-JENKINS

The rewards of prevention in childhood are unique because the benefits may last a lifetime. A general practitioner who runs a child health clinic in his practice that offers immunisation, nutritional guidance including accurate weighing, health education including developmental guidance, and routine surveillance examination at key ages has laid the foundations for an effective programme of prevention for children. Unless organisation and effective management are given priority, however, the medical inverse care law ensures that those who would benefit most from such a service are least likely to obtain it. It is not enough to say that a lot of children are immunised or that most children attend for routine surveillance examination. The job is not worth doing at all unless all the non-attenders are identified and every effort made to bring them and the services provided together.

It is not difficult for the general practitioner with his list of patients to define his target population. The organisation required to identify correctly the target population, keep the lists up to date, and run a routine examination programme using it is not complicated. It is not the health visitor's job, and every general practitioner who wishes to be effective should employ staff to do this work. Ideally, a well-chosen clinic secretary should be responsible for running the clinics, efficient book-keeping, and deploying medical time, matching it to the needs of the child population; but, above all else, the clinic secretary must be responsible for maintaining a register of all preschool children in the practice. This needs co-operation from the rest of the practice team to ensure that information on all transfers in and removals out, as well as changes of address, is given to her so that the list is as accurate as possible. From this master list the routine surveillance examination programme is run. The secretary should also be responsible for identifying non-attendees, telling the health visitors and doctors (including the patient's own doctor if the practice maintains personal lists of patients for each partner) of the non-attendance, and then making the necessary arrangements for further appointments or a home visit to be made.

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Ashford, Middlesex TW15 2TU

GRAHAM CURTIS-JENKINS, MB, DCOG, general practitioner

Who does what?

Demarcation disputes about who does what usually can be ended when the team asks itself the question: Who does what best? An untrained, unskilled doctor who takes it upon himself to carry out all the developmental medical surveillance, including routine vision and hearing tests, is courting disaster. The health visitors, with their special skills in developmental paediatrics, are certain to do the job better. When a doctor is sufficiently skilled, trained, and motivated, however, the health visitors should then be able to give up this routine work to concentrate on the far more important tasks of counselling, family casework, health education, and even moving out into the community to work with client groups in, for instance, health education and social support programmes.

In our practice health visitors have given up routine vision and hearing testing to trained doctors, who have incorporated this into the routine medical surveillance examination. Instead, their hearing testing skills are channelled into testing the hearing of all preschool children who have recently had middle-ear infection: 75% of children referred to specialist agencies because of hearing loss are detected in this way and 25% in the routine clinic examinations at key ages.

The team will not function without regular contact. Weekly meetings that should take priority over all other commitments are essential. Policy matters on subjects such as immunisation should be agreed and adhered to. A consensus on treatment strategies for night wailing, infant colic, and other common problems should be established. Every member of the team is diminished in the eyes of a young mother who gets different advice from each of them on a simple problem.

Examinations at key ages are the backbone of the preventive care programme in our practice. Careful timing ensures that all the examinations by appointment and all the mothers who come to the two paediatric clinics in the week who want to see a doctor about their children can be fitted into one service without the other only creates problems and drives mothers away to obtain help and advice elsewhere.

A dynamic programme such as I have described often stimulates patients to run self-help groups. These need supporting and encouraging. In our practice the atopy self-help group does sterling work and is strongly supported by the team. The co-operation of child-minders in bringing minded children for routine clinic appointments is actively encouraged by the high esteem accorded to them by the team and by an enlightened local authority that allows them access to toy libraries. The local child minder and play group association is also strong and sympathetic to our aims, so giving further possibilities of co-operation in the community and the free flow of information about children in that community.

Paediatric surveillance

That more than 90% of children keep their first appointment at clinic for their routine surveillance examinations is a measure

1174

Interview

The selection committee is composed of one consultant from each specialty on the rotation, the trainers from the practices to which you will be attached, the course organiser, the regional adviser in general practice, and the medical personnel officer. Fortunately, one or two members are usually unable to attend.

Probably performance at interview does not reflect performance in medical jobs. It is therefore unjust that if you wish to be appointed you must learn to interview well. The committee are asking themselves how you will appear to their patients. So the simple details are important. First impressions are unfortunately the only impressions. We expect doctors to look like doctors at interview. Your style of dress should err towards the formal and conservative within your own range of clothes. Be clean and tidy; your hobbies should be represented in your curriculum vitae and not under your fingernails. If you have been on duty all night, tell us; don't leave us to guess it from a ragged and unshaven appearance.

Arrive early and be prepared to wait; bring some light reading to pass the time. Enter the room with self-assurance; you are experienced doctors who should have learned to keep your head in a crisis. Self-assurance is necessary, but aggression is not. A degree of anxiety is natural, but diffidence is not. Full responses are preferable to monosyllables, but we do not like loquaciousness. And you will not get the job with obsequiousness, sycophancy, or flattery.

Most candidates expect merely to answer our questions. This is polite but of limited use to us. You will usually be given an opportunity to ask questions and should come prepared with intelligent queries about vocational training and the scheme. The implication is that you know what you want, and that you have critically examined the scheme and exercised an informed choice in applying. It demonstrates your motivation and critical capacities, which are usually very difficult to assess. Take care how you ask questions. To ask a general practitioner how often he uses the deputising service may imply personal criticism; to ask how the trainee gets experience with out-of-hours calls in a practice which uses the deputising service is perfectly acceptable. Very few applicants make any reference to their reading, and there is often little time to read during the preregistration year. But it is always profitable to be up to date with the leading articles in the *BMJ*, and this may have a profound effect if you mention an appropriate paper.

When everyone has been interviewed each committee member makes a provisional choice. The references of each candidate are then read. In general, the committee listens more to referees whom they know. These references contribute appreciably in two circumstances. If the referee makes only a balanced recommendation it can seriously reduce a candidate's chances; references are expected to be good. Occasionally a candidate offers an outstanding reference that lists specific reasons why the referee believes the doctor to be so special; this exceptional

BRITISH MEDICAL JOURNAL VOLUME 285 23 OCTOBER 1982

reference can tip the balance between two otherwise equal candidates.

The committee will make its final selection and offer the vacancy to the successful applicant on the same afternoon. You must accept or refuse it immediately. This may seem unjust if you are to attend an interview for a preferred scheme a few days later—but other people's careers are also at stake, and if you do not accept the job why did you apply?

Conclusions

This selection process is far from perfect. Judgments and decisions are made subjectively and on inadequate information. The organisers are "selling" their vocational training scheme and you are "selling" yourself. There are now too few vacancies for general practice training. If you are not appointed to one scheme it does not mean that you are unacceptable for training. It is a pity that your enthusiasm is not reduced by such apparent failure, because your enthusiasm is one of your most important attributes at interview. Never make a half-hearted application, and never less than your best at interview. It is a waste of everybody's time.

Information about a vocational training scheme that should be available to the applicant

Hospital posts—the nature of the specialties and what choice, if any, is available; the duration of each post; the hospital where each post is held; the names of the responsible consultants, and their interests; the nature of duties and on-call commitments; units of medical time; what other staff work in the unit; are the posts educationally approved; is time available to attend the release course for trainees?

Teaching practice—the timing of the general practice experience in the rotation; who are the trainers and which are the teaching practices; what choice is offered; are two six-month periods usually spent in the same or different practices; what are the practice arrangements for premises, staff, equipment, records, appointments, special clinics, out-of-hours cover, and dispensing; what is the trainee's responsibility for telephone, car, instruments and bag; involvement of a spouse and arrangements for time off, study leave, holiday, private patients, routine medicals, and private sick notes; what are the arrangements for teaching in the practice and what facilities are available—library, audio-cassette, slide projector, video-recording?

Release course—what is the nature of the course; its timing, its aims, and its style; what is the trainee's involvement in planning and implementation; what are the teaching methods and who contributes; what other educational activities are recommended—project work, courses, attachments, visits; what assessments are offered?

General—what are the residency and accommodation arrangements throughout the three years; are there problems particular to the area—transport, parking, housing, unemployment, demography; what does the area offer in education, entertainment, recreation, and sport?

is cut down the middle to the toe-part; hinges are then put on and a lock, which cannot easily be picked, attached to the centre of the leg. Two narrow slits are then made through the sole of the boot, one on each side of the hollow of the foot, through which a leather strap is passed, for the purpose of being attached to a circular one round the ankle. The importance of this device is that it prevents the foot from being pulled out of the boot, which would completely preclude the possibility of the person's drawing his leg through. When such characters came under my care in Deal Hospital, these boxes, in large letters, "Punishment for Importants"; and in each ward, when they were not in use, we had two of them placed conspicuously as a warning to all newly admitted patients. (*Lancet Medical and Physical Journal* 1824:81, 87-96.)

PHONED DISEASES [Leg ulcers were extraordinarily common in the Navy during the eighteenth and early nineteenth centuries, and were often the cause of death from the service. Some, it seems, were self-inflicted, either by cuts on the leg into which copper coins were inserted or by the application of acids or other irritants. Dressings would be removed by the imposition of further irritants could be applied—ISLL.] As a remedy or preventive against such importances, it has long been a practice in the navy and army to treat a well-supplied bandage from the toes upwards to the knee, to seal the end of the roller with wax, and to impress it with the surgeon's seal. [Even then, however, the impostor scratched and irritated the ulcer through the bandage with a needle.] To guard against this new device, I had a certain number of strong oak boxes, made in the shape of a large square boot, to come up about four or five inches above the knee, the lower part of the boot forming with the leg an obtuse angle, so that the muscles of the diseased leg might be preserved in a relaxed or bent position. . . . This boot, so made,

1176

Tasks for the primary health care team

Practice secretary	Clinic nurse	Health visitor	GP	Midwife
Conception and delivery	Preconception counselling, health education, immunisation, relaxation classes, social support	Preconception counselling, health education, immunisation, relaxation classes, social support	Preconception counselling, health education, immunisation, relaxation classes, social support	Meet mother on booking, share antenatal care
Enter baby into record and initiate child rearing and information given by health visitor	On day after birth make first visit to home; support with milk feeding; ensure baby in front of mother; follow-up appointment, if needed, referred to own doctor or clinic doctor if necessary; children advised referred to patient's own doctor	On day after birth make first visit to home; support with milk feeding; ensure baby in front of mother; follow-up appointment, if needed, referred to own doctor or clinic doctor if necessary; children advised referred to patient's own doctor	On day after birth make first visit to home; support with milk feeding; ensure baby in front of mother; follow-up appointment, if needed, referred to own doctor or clinic doctor if necessary; children advised referred to patient's own doctor	Introduce the mother to the baby's skills and examine the baby in front of mother; follow-up appointment, if needed, referred to own doctor or clinic doctor if necessary; children advised referred to patient's own doctor
7 months	Routine 7-month appointment; mother and child greeted on clinic day and shown into doctor; non-attendees noted and information given to GP and health visitor; another appointment made, if fails to attend, health visitor delivers appointment personally to parents	When it is confirmed that baby is fit and there are no contraindications, full immunisation given; information given to GP and health visitor	When it is confirmed that baby is fit and there are no contraindications, full immunisation given; information given to GP and health visitor	When it is confirmed that baby is fit and there are no contraindications, full immunisation given; information given to GP and health visitor
8-9 months				
12 months	Routine 12-month appointment; mother and child greeted on clinic day and shown into doctor; non-attendees noted and information given to GP and health visitor; another appointment made, if fails to attend, health visitor delivers appointment personally to parents	Second immunisation	Triple vaccine and polio	12-month assessment, as above
30 months	Routine 30-month appointment; mother and child greeted on clinic day and shown into doctor; non-attendees noted and information given to GP and health visitor; another appointment made, if fails to attend, health visitor delivers appointment personally to parents	Measles immunisation; given at 18-24 months	Advice about play schools given; group visits to regular contact with health visitor about children with problems	30-month assessment as above; each immunisation status for measles and advise having it
48 months	Routine 48-month assessment; mother and child greeted on clinic day and shown into doctor; non-attendees noted and information given to GP and health visitor; another appointment made, if fails to attend, health visitor delivers appointment personally to parents	Preschool booster diphtheria and polio	Continuing contact with children and parents, usually initiated by parents	48-month assessment, as above

COMMON TASKS

- (1) Identify all children at risk from physical and emotional deprivation, sharing this information, and making decisions as quickly as possible about action.
- (2) Continue practice to address commonly occurring problems, sleep problems, feeding problems, nappy rashes, and common variations in infant behaviour.
- (3) Regular monthly meetings to share information, discuss our strategies, and audit work of clinic. Practice workers and speech therapists, orthodontists, students, and practice visitors are often present to give information and contribute to the meetings in many positive ways. Informal practice case conferences often prevent time-consuming case conferences outside the practice and ease of communication facilitates decision making.

INDIVIDUAL TASKS

- (1) Update of yearbook and facts register to ensure accuracy in identifying target population.
- (2) Accurate recording of information.
- (3) Accurate recording of all immunisation, clinic record and patient's medical record.
- (4) Regular updating and reviewing of information on immunisation.
- (5) Accurate recording of all immunisation, clinic record and patient's medical record.
- (6) Accurate recording of all immunisation, clinic record and patient's medical record.
- (7) Accurate recording of all immunisation, clinic record and patient's medical record.
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- (9) Accurate recording of all immunisation, clinic record and patient's medical record.
- (10) Accurate recording of all immunisation, clinic record and patient's medical record.

of our success—not in terms of organisation, but showing that we are offering a service that parents judge valuable and worth while. The best test of success is the extent to which our prevention programmes in general practice should be judged. The guidelines that govern our team's activities are these:

- (1) The commitment to the philosophy of prevention is shared by all members of the team.
- (2) Effective organisation is the key priority to ensure that no child is "lost" and that all are seen at regular, agreed intervals.
- (3) Practice-wide policy ensures that all sick children are seen on the same day that a request for a home visit or consultation is made. This is essential to free the clinics from the inappropriate task of treating sick children and physically separating the sick from the well during the clinic.
- (4) Continuous audit of the team's effectiveness; immunisation rates; non-attendance rates; and disorder rates; regular spot checks of the team's target population register against the practice register to ensure that no child is lost; are carried out regularly and, when appropriate, acted on.
- (5) All members of the practice staff need to know what goes on in the child prevention programme and why. Caring for patients who are ill is their first priority. Asking the following questions regularly will help to ensure that your partners are making their contribution.

- (1) Do all your patients know your practice arrangements?
- (2) Do you know when one of your children is seen in an accident department or by a deputy—and do you find out why?
- (3) Do you visit the infant paediatric department?
- (4) Do all children get regular surveillance?
- (5) Do you explain to parents how to use the service you provide and make sure they understand?

If agreement is not sought early on the adequate provision of illness care the clinic service can become the quick way to see the doctor. In some community child health clinics 40% of all children seen suffer from acute illness. This is not really what preventive services are set up for!

MIDWIFERY I think it (midwifery) is considered rather as a manual operation, and that we should be very sorry to throw anything like discredit upon the men who had been educated at the Universities, who had taken time to acquire the improvement of their minds in literary and scientific acquisitions by mixing it up with this manual labour. I think it would rather disparage the high grade of the profession, and the high grade of the midwife, which is a manual operation very much. As to all the knowledge of the diseases of women and children, it is expected of us; and we hope that we are thoroughly informed upon them—Sir Henry Halliday, FRCS, (Select Committee on Medical Education, *Parliamentary Papers* 1834.)