Overcoming Isolation

Research as a solution in the North East

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During the early years of vocational training each of us graduated from Newcastle University and intended to make a career in general practice, joining the Newcastle vocational training scheme. Much of the development of the Northumbria training scheme was taking place then and each of us was active in the training organisation. From these similar beginnings we each joined our training practices as partners.

AH went to a mining town in the north-east coal field, a boom town of the late 1880s, which has until recently withstood the state of mine closures. In a town of 24 000 people six principals serve 14 000 patients, many of whom do heavy manual work. The practice has a high consultation rate—up to 1000 doctor-patient contacts a week during the winter. Yet, since the town is compact and on the edge of the coal field adjoining sea and unspoiled country, all patients live within four miles of the practice centre.

In contrast, TC joined a semi-rural practice in a market town in Northumberland. Founded in 1869 by a single doctor, the practice has slowly grown into a partnership of four doctors in 1982, with a total list size of 7800. It has an elderly population, 18.4%, aged over 65 years with an average social class distribution. Twenty per cent of the patients live over three miles from the practice in a very pleasant rural area covering the Tyne valleys and Hexhamshire—over 200 square miles in all.

The sudden change from belonging to the protected world of a general practice to the harsh realities of being a principal can be quite startling. It is during these first few years, which can be the most isolated of a general practitioner's career, that a family doctor is expected to learn to cope with many of the problems of practice which, however good the training, still have to be managed in the context of his new responsibilities. While group practice may overcome some of that isolation with the help and support of others, one misses the stimulation of one's peers from the trainee years.

Principals are forming audit groups in this and other parts of Britain as one avenue of overcoming the isolation of the early years. This, however, is not available to either of us. Neither of us sought research with the idea of overcoming isolation, but that was the effect that it had upon us.

Rich sources

From the tentative thought of exploring some avenue of research one is immediately brought into contact with many different people—at first by just discussing the topic with

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colleagues, then exploring journals and libraries. Finally, contact with unitaries and departments of general practice, research units of the Royal College of General Practitioners, and Medical Research Council research units brought each of us into contact with many doctors, statisticians, and research workers from different fields that provided a stimulation and contact that we would have otherwise missed.

In tandem with this, since both of our practices were concerned in training, we had the opportunity to maintain contacts and develop teaching skills so that in three to four years each of us was appointed a general practice trainer. This was an exciting time in the development of graduate education in general practice, coinciding with the advent of the "small group" for teaching.

The opportunity to examine the mass of information available to general practice is one of the least recognised, but most exciting, aspects of being a family doctor. Research projects often arise from ideas that at first sight may not seem to be important.

TC noticed a difference in work load and in the morbidity of the patients who were seen by a partner in contrast with that of a trainee in the same practice. This remained an anecdotal comment until he got a chance invitation to visit the Birmingham Research Unit of the Royal College of General Practitioners. Dr I. Pines, its co-director at the time, gave such an inspiring day that it motivated latent research ideas. Convincing the partners and trainees in the practice to complete a full year's recording of work load and morbidity proved fairly easy: they did not know what they were letting themselves in for.

This study of one year's work load and morbidity showed that the trainee saw appreciably less chronic illness than a principal in general practice, while at the same time seeing appreciably less life-threatening illness, psychiatric illness, and obstetric and gynaecological problems. Analysis of the data, however, showed appreciable differences between the partners in the same practice, particularly in regard to the age-sex ratio of the patients seen and the age structure of the morbidity of the patients who consulted them. The partners saw different numbers of young men with acute illness, depressed women patients, and middle-aged physically ill patients. These variations seemed to have been caused by different policies of different partners.

This concept is now being tested by an analysis of 16 000 consultations recorded by 97 general practitioners (principals, partners, and trainees) in nine very different practices in the north-east of England. The work is supported by a grant from the Northern Regional Health Authority.

Investigating the effect of health education about rubella on the principal interest in AH after a review of the clinical records in the practice suggested that as much as 40% of 350 pregnant women might be susceptible to rubella on serotyping for haemagglutinating antibody inhibition. This interest coincided with the rubella epidemic in 1978, which caused such national concern and resulted in a major health education campaign in the UK. With the help of a small grant from the Department of

Shortlisting Trainees

Democracy reigns in Aberdeen

DENIS DURNIO

Towards the end of each year tension rises in our area as potential trainees jockey for positions in vocational training schemes. Despite general practice being the intended career of most applicants, they are still prepared to follow the traditional route of two further years in hospital; even if this hospital experience means continuing as a "house officer" at senior level.

They have obviously selected our scheme as their first choice because of its high reputation—a reputation which must have grown from the hard work of the scheme organiser. After all, most of our trainees eventually pass the Royal College of General Practitioners' exam and find partnerships in general practice.

Perhaps since Aberdeen is a university town it is just convenient applying for a local scheme? It may even encourage applicants to buy a flat or a small bungalow. Girlfriends, boyfriends, fiancés, husbands, and wives may also have secure employment in the area, which strengthens their resolve to secure a place in a local scheme. Who can really tell what is in the minds of these young doctors.

The scheme

The Aberdeen Vocational Training Scheme was established in August 1971 after initiatives were made by the Department of General Practice, University of Aberdeen, the local faculty of the Royal College of General Practitioners, and others interested in promoting training in general practice. The scheme is based on two years in hospital and one year in general practice. The hospital posts comprise six months in accident and emergency, two months each in skins, eyes, and ENT, periods of training in obstetrics and gynaecology and paediatrics, and a three-month elective period. The elective is left entirely to the choice of the trainee, who usually selects general medicine, pneumatology, or psychiatry. The scheme has an intake of 12 trainees a year. There is no opportunity to spend an introductory period in general practice. This has been looked at but the timetable was too complex to include it.

I can still vividly recall the anxiety of the organisers in 1971 that they would have sufficient applicants to fill the 12 places. I also still share with Professor Richardson the fears of attempting to get our first group of 12 trainees to establish a self-sustained learning group in general practice. The department of general practice in Aberdeen was responsible for all aspects of the scheme in its first few years, till a regional adviser was appointed in 1974.

Our scheme is advertised each year in the *BMJ*, the *Journal of the Royal College of General Practitioners*, and on the notice

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boards of the local hospitals. The advertisements usually appear towards the end of November or in early December. The closing date is the end of January, and the interviews take place early in March for an intake at the beginning of August. The advertisement details the scheme as described above. It also states that on completion of training applicants will be eligible to sit the RCGP exam, and most do. Details are also given about the provision of a day-release programme.

The administrative work concerned with placing the advertisements, processing the application forms, and general inquiries is dealt with by the administrative staff in the south district offices of the area health board. The administrative secretary, the regional adviser, and one of the specialists in community medicine (who happens to be the chairman of the general practice subcommittee of the regional postgraduate education committee) collaborate closely by telephone towards the end of January to assess the response to the advertisements. After the closing date all the applications are sent to the regional adviser for assessment. The applications are sorted into the following groups: Aberdeen graduates; Scottish and UK graduates; Eire graduates; overseas graduates. The table gives the number of applications processed over the past three years for these groups.

	1980	1981	1982
Aberdeen graduates	32 (11 successful)	27 (11 successful)	28 (11 successful)
Scottish graduates	10 (3 successful)	10 (3 successful)	10 (3 successful)
Eire graduates	1 (0 successful)	1 (0 successful)	1 (0 successful)
Overseas graduates	1 (0 successful)	1 (0 successful)	1 (0 successful)
Total	44	49	40

Local graduates clearly have an advantage for selection, but we are anxious to identify doctors from other parts of Britain who might help to enhance the quality of medical care in the city. Doctors who have already completed training beyond the pre-registration period are considered less favourably than those who have just completed pre-registration posts. We are anxious to identify doctors who have completed a further two years of appropriate hospital training rather than extend training that the applicant has already completed. My aim at this stage is to identify approximately 24 candidates who might be called for interview. Those candidates most likely to succeed at this first hurdle are doctors completing pre-registration; local graduates; those selecting Aberdeen as their first choice; those with an outstanding referee's report; those doctors who have arranged personal interviews with the regional adviser. This initial call reduces the number of applicants by half.

When this first stage is reached it has been customary for the

Health and Social Security a comparison of the effect of health education methods was made on a randomised sample of women aged 15 to 35 years. A postal invitation was sent to each woman to visit the practice where a nurse counselled, took blood samples, and vaccinated those who were susceptible to rubella, the latter accounting for 10.4% of 1245 women.

The direct effect of the national campaign for immunisation on the group was disappointing, since only 58 women (3%) requested rubella screening of their own accord. In contrast, 62% of the group were screened as a result of an organised screening programme in the practice in which letters were sent to each woman inviting her to attend for screening.² Further information was obtained from women who refused screening so that, with an overall contact rate of 78% of the study population, an analysis could be made of the effect of the national campaign and of the reasons women gave for accepting or refusing rubella screening.

Our research projects have taught us the fundamentals of the discipline and have led to an inquisitiveness about all aspects of practice. Moreover, we agree with Harrington's³ point, made in another article, that a doctor who does not question what he does, or why he does it, is moribund.

Learning the mechanics of research as it stimulating as the study itself. Few doctors who enter vocational training now have had to use libraries and reprint services. We found that the libraries of both the Royal College of General Practitioners and the BMA were helpful and stimulating, and we were often exposed to papers and journals we would never have considered ourselves. This also led to the habit of reading papers, which we did initially purely for the research projects, but which has

become a valuable part of our continuing education—in itself a method of overcoming isolation.

Years of research have been ruined for the want of proper control and planning in the initial stages, and taking the advice of other professionals concerned in research in the Health Service is essential in developing an idea. It is often during this stage that one comes into contact personally with so many other professionals from so many specialties of medicine that one finds the most reward.

Finally, writing a research paper taught each of us, we suspect for the first time, to write English as opposed to notes, and seeing the result published is a reward far in excess of seeing one's name in print. Publishing research from general practice is paramount with the general practice of training all contribute to the final decision. Some of our local graduates may be eliminated at this stage. This preliminary discussion to establish a shortlist usually requires up to two hours' work. For candidates who come from other parts of the United Kingdom we are very dependent on the information given to us in the application form—in particular, when they first decided to become a general practitioner and what attracts them to the Aberdeen scheme. The contribution of non-Aberdeen graduates to the scheme's development has been invaluable.

The selection panel is normally convened by the chairman of the general practice subcommittee of the regional postgraduate medical education committee. The panel itself is usually drawn up under the guidance of the regional adviser. The hospital posts are represented, using a formula which the consultants have agreed to. The consultants in the accident and emergency department said that they would like to be represented each year. The minor specialties of skins, eyes, and ENT are represented by rotation, and the departments of obstetrics and gynaecology and paediatrics rotate in alternate years. The adviser and associate adviser are normally present. Two general practitioners from the GP subcommittee are also there to represent general practice. The panel usually comprises seven or eight doctors. The administrative secretary also attends as she is responsible for scheduling the interviews and for all subsequent correspondence.

The board room of the local hospital is normally used for the interviews and each candidate is given approximately 15 minutes. The interviewing panel spend a very hard day from nine in the morning till usually well after five in the evening, with only a short break for lunch, and a common view is that the purpose of the interview is to establish the motivation of the candidate for a career in general practice and to try to identify the personal qualities that one would expect appropriate in a good general practitioner. Not an easy task.

Diary of Urban Marks: 1880-1949

About six weeks before the final examination commenced and three weeks before we had to send an intimation to the secretary of the examining board that we wished to sit for the examination Leapingwell and I went for our usual walk after dinner. We found ourselves in Westbourne Grove, and my attention was drawn to an advertisement hanging above a shop. It was rather windy and the advertisement sign was swinging and rattling as it flew. I looked up and remarked to Leaper that surely this was the domicile of his mother's later clairvoyant. He consulted a letter from his pocket which confirmed this.

"I persuaded him much against his will, to go to see her. I forgot her name. We walked up some stairs and came to a room evidently over the shop below. We knelt, and presently a fat old woman with four chains came in answer. He asked her if Madam X was at home and she told that she was answering the knock. The lady asked us if we wished to consult her and having announced that that was our intention, invited us to enter a small room which was in semidarkness and contained among other things two large basket chairs facing one another. She first asked us whether we had been recommended to her, to which we replied that it was just a chance visit having seen her sign outside. She elected to take my case first. She sat herself in one of the basket chairs while I took the other, Leapingwell disporting himself on a sofa, quite prepared to amuse himself and watching the waste of money. The fee was half a crown, which at that time was a huge sum of money for either of us to squandering on such foolery.

The clairvoyant asked me if I had anything on me which no one else had worn or had worn very little. It so happened that I had a gold ring which represented two guineas. I had worn as a chemistry prize when I first entered St Mary's on 1 May 1889. This ring I handed to her. She put it on her little finger, twisted it round, and after a short time went into a convulsive spasm. Then she spoke thus: "You are one of seven children. Your father is a violent man who buys and sells. You are at a corner house in the capacity of a student. I see a number 123 but what it means I cannot say unless you answer me this. Am I right when I say you are a student?" "I replied that she was correct, and she then frankly made a guess that the corner house was St Mary's. I confirmed this, and she then said: "Are there any first, second, or

third classes in the examinations you are about to take?" I asked her how she knew. I was sitting for an examination. She said that the *did* know and I present I was in a state of flux and I myself was doubtful of the result.

"But if there is no classification in the examination then you will be known as number 123 and you need have no doubt of the outcome. The fates have willed and ordained that whatever you do in this examination you are going to be qualified." Again I expressed my surprise that she knew the examination would complete my final. She made no comment and continued as if such remarks were unimportant. You will cross the sea twice. You will be married twice and have four children. Your first wife will be the girl to whom you are engaged and who at the moment is somewhere in the North—it is now the South since you see a great distance between you and her. She is knitting or mending socks in a house bordering on the river. An older woman, probably her mother, has just entered the room. It is now 9.15 pm, and you can confirm this. I listened, I did so and found it correct. Behind your chair a woman who has recently passed over has now appeared. This I guess is your mother, and she is holding in her hand a bunch of wheat. This signifies that you will never be in want. In fact you are one of the lucky ones of this earth, and everything you do will be successful. At the age of 59 you will look back on your life and wonder how you got to the position you will be in with such little effort on your part. Your stars are certainly fighting for you."

Clinical Curio: Longevity

I recently attended a baby who is the sixth generation of the family of the intervening generations are patients of mine. Of this baby I have treated the parents, grandparents, two pairs of great-grandparents, and two pairs of great-great-grandparents, and the great-great-great-grandfather, many great-great-uncles, great-uncles, grand-uncles (and corresponding aunts), and of course, many sisters and brothers. One generation—J. J. O'Connell, general practitioner, London NW9.

chairman of the general practice subcommittee, the professor of general practice, and the regional adviser in general practice to meet to discuss the list of applicants and to decide on a final shortlist. It is at this stage that we are particularly indebted to Professor Richardson, who has been most helpful in providing the scholastic and undergraduate records of the local applicants. These details greatly assist the panel in making their final choice. The panel work systematically through the application forms to draw up the final shortlist for the interviews. How the applicant has presented his application—for example, if it is typed, does it have a curriculum vitae attached?—details of any personal interviews with the regional adviser, and the scholastic and undergraduate records (particularly those concerned with the general practice part of training) all contribute to the final decision. Some of our local graduates may be eliminated at this stage. This preliminary discussion to establish a shortlist usually requires up to two hours' work. For candidates who come from other parts of the United Kingdom we are very dependent on the information given to us in the application form—in particular, when they first decided to become a general practitioner and what attracts them to the Aberdeen scheme. The contribution of non-Aberdeen graduates to the scheme's development has been invaluable.

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MIDWINTER. I consider it derogatory to any liberal man to assume the office of a nurse, of an old woman, and that it is an imposture to pretend that a medical man is required at a labour. The craft therefore involves imposture, mischievous interference, and gross indecency. What! this signifies that you will never be in want. In fact you are one of the lucky ones of this earth, and everything you do will be successful. At the age of 59 you will look back on your life and wonder how you got to the position you will be in with such little effort on your part. Your stars are certainly fighting for you."

THE GENERAL PRACTITIONER. General practitioners form the great majority of the faculty; they have almost entirely superseded the apothecaries. The superior qualifications of general practitioners may be well guaranteed to the public, by obliging those gentlemen to become members of the Royal College of Surgeons before they are permitted to practice; and this will effect the exclusion of all those individuals, who, not being regularly educated, can never be equal to the performance of those duties connected with the station they usurp. General practitioners are the medical favourites of the

community; the majority of persons having long wished for a class of the faculty to whom they could apply with confidence in any description of case in which medical and surgical aid was necessary. (*Medical and Physical Journal* 1815, 24, 191.)

FIXED DISEASES. Diseases are generally feigned from one of three causes: fear, shame, or the hope of gain. The spirit of revenge, and the hope of receiving exorbitant damages, have also induced some to magnify slight ailments into serious and alarming diseases. The extent and finish to which the art of feigning diseases is carried out . . . is at present brought to such perfection as to render it as difficult to detect a feigned disease, as to cure a real one. . . . The haughty advocates of the art of feigning diseases. Alteration of the pulse; altered state of the urine; haematuria; incontinence of urine; suppression of urine; mania and dementia; dropsy and tumours of various kinds; excretion of calculi and various foreign matters; urines; haematuria; haematemesis; jaundice and oedema; fever; pain in various parts; syncope and hysterical diseases of the heart; apoplexy; paralysis; epilepsy; convulsions; cataplexy; nostalgia; near-sightedness; ophthalmia; blindness and deafness, and many other undomestic. (*London Medical and Physical Journal* 1825, 85, 393-404.)