Country Practice

Rural Norfolk: GP as a community property

I NEIL STEVENSON

A summer Sunday afternoon, the garden is looking very pleasing, and the grass is cut, so it's out into the sunshine after lunch for a rest with the Sunday papers. Round the corner of the garage appears a figure. "Afternoon, doctor. Thought I'd come and see how your onions are doing, mine aren't looking too sharp!" After a diagnostic comment on the ailments of the vegetables the real reason for the visit is revealed: "I'm a bit worried about the wife, doctor. Didn't get a wink of sleep last night."

Our urban colleagues, pursued at cocktail parties by fellow guests eager to display their laparotomy scars, probably dream of the peaceful country life, but the rural GP who wishes a rest from his public role has to flee to the anonymity of the city. For the country GP is considered to be community property, and, usually with courtesy and circumspection, but sometimes blatantly and even rudely, the community attempts to mold his life style. When my car needed emergency admission with a stenosed valve a friend lent me his bright red Japanese pick-up. It evoked many comments while I did my rounds, not all of them complimentary. The local garage owner drew me to one side for a fatherly chat. "You haven't bought that thing, have you, doctor?" I assured him that, much as I enjoyed driving it, I was not intending to keep it. "It's just that it's not the sort of vehicle people expect to see their doctor arriving in. I mean, you wouldn't expect the undertaker to turn up in a sports car, would you?"

Similar unsolicited comments are frequently forthcoming on subjects such as what time the surgery is open, the location of the local shops, and which school my children attend. When I first settled in rural Norfolk I was unprepared for the arrogation of my general life style as the subject of public comment and criticism. But over the years I have learned to appreciate the frankness and openness of local people. For medical advice to be acceptable the source is as important as the content, and in conservative rural Britain the confidence of local people in their GP depends as much on his matching the ascribed role as on his medical skill.

I am fortunate because I practise from a modern health centre, into which my partners and I moved three years ago. We enjoy working in a comfortable, well-designed building and have the benefit of close contact with our attached nurses, midwives, health visitor, and social worker. The opening of the health centre led to greater expectations by the local community, who looked for the type of service one might expect from an accident and emergency department. Protecting letters appeared in the local paper when it was discovered that no x-ray facilities had been included. The fact that most of us have not read a radiograph since we finished our house jobs was irrelevant; the local vets could x-ray their pets' fractured limbs, so shouldn't the same service be available at the health centre? The nearest hospital is over 20 miles away, so we have always done a great

deal of casualty work, sunburn lacerations, draining paronychia, strapping sprains, etc. It takes a deal of firmness to insist that a patient with a bad sprain or a child with a possible greenstick fracture should make the 40-50 mile round trip for their chest x-ray investigation. But the annual report of the Medical Defence Union reinforces our firmness.

The inadequacy of rural transport facilities underlines many of the problems of country life, and medical practice does not escape. We collect all our patients' specimens for pathology investigations except blood for prothrombin times, but our efforts to persuade the hospital or the ambulance service to provide a courier service have been unsuccessful. So everything goes by post, with boric acid crystals in the urine samples and air-dried films for haematology, but I wonder how reliable are the results of estimates of erythrocyte sedimentation rates. Visiting our patients in hospital is out of the question and opportunities for personal contact with hospital colleagues are few. We make good use of the domiciliary consultation service, and I take pleasure in accompanying consultant colleagues to the bedside of my patients.

Enthusiastic patients

There are few areas of Britain that are truly remote and where self-sufficiency is a necessity. We share with many rural areas the problem of relative isolation, but with an urban centre near enough for it to appear to planners that it is appropriate to concentrate resources there. Our patients suffer more than their doctors. The community in which I live has made much more to improve clinical facilities. In response to local initiative in the past decade there is now a mobile physiotherapy service (at first a local charity but now partly funded by the National Health Service), a citizen's advice bureau, a marriage guidance counselling service, a St Raphael Club for the disabled, a day centre for the disabled, and a successful campaign was waged to resist closing the local office of the Department of Health and Social Security.

The current campaign is for a community hospital and, if the past record is a reliable indicator, it has a good chance of success. To regard such local initiative as a problem would be insensitive—on the contrary, it indicates a vital and healthy community—but occasionally enthusiasm for a project overrides practical considerations. We were planning internal alterations to our health centre to provide accommodation for a practice nurse. The health authority had no money available and my senior partner happened to mention our plans to a patient. Within the week he had launched a campaign, championed by the local paper as the New Casualty Unit Fund. Work on the conversion should start later this year, and we are grateful for the help and interest from our patients. But despite much diplomatic effort on our part I am not sure that we have successfully fulfilled local expectations of a 24-hour casualty service with full diagnostic x-ray facilities and fracture clinic.

The clinical content of rural practice does not differ greatly from its urban counterpart. Despite the popularity of domestic

MRCGP Examination

An argument for the MRCGP exam

RICHARD HOBBS

Some degree of controversy surrounds most examinations: are they representative? are they selective enough? are they worth doing? These questions are rarely asked about the higher college examinations, which historically have come to represent the final portals before entry into the upper echelons of the profession. At least this was true until the arrival of the membership examination of the Royal College of General Practitioners. Here was a higher qualification registerable with the General Medical Council that was tailored for and open only to general practitioners. It was not, however, a prerequisite to becoming a principal. There would probably have been more to argue about it if had, but the establishment of a royal college and its organising an exam, after generations of general practitioners had gone without either, were bound to attract comment. My defence follows, and if at times it appears to be preoccupied with the status of general practice that is because the question of this status and the value of the MRCGP exam are inextricably linked.

The MRCGP examination first appeared in 1966 and became the only mode of entry (with rare exception) into the Royal College of General Practitioners in 1969. Some 1200 candidates now sit the paper, which is held twice yearly, of whom approximately 75% are present or recent vocational trainees in general practice. The pass rate is approximately 65%, though this is a truly open exam, and adjustments are not made to produce standard pass rates. There are five parts to the examination, each carrying 20% of the marks: a multiple choice question of 60 five-part questions; a multiple extended question, a traditional essay question; and two oral, the first exploring one's personal practice and general aspects of primary care and the second discussing clinical cases.

Since its inception in the early 1950s the Royal College of General Practitioners has sought to raise the status and performance of general practice. The most fundamental way in which this has been achieved has been through the introduction of a commitment to mandatory vocational training. But since this has become embodied in legislation then perhaps the most public statement of the college's aspirations is apparent in its entry requirements. My defence of the MRCGP examination briefly explores some of the advantages to those who take it and to the profession as a whole, and, finally, I support the method of assessment as the most appropriate and enlightening post-graduate examination open to general practitioners.

Benefits to the individual

The positive attributes of the exam are most immediately obvious to the potential candidates. Preparation is a prerequisite to any successful attempt, and thus the GP must read widely journals, papers, and books. This will of course have immediate

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benefits in improving levels of knowledge in many areas of general practice. These include not only the clinical aspects but also those issues—the doctor-patient relationship, public controversy in medicine, and the administrative aspect of the successful general practice. (Such studies may well be expected to improve the profits as well as the mind. Because the GP's income is entirely dependent on reimbursement, with item of service payments becoming more and more important, organising the practice is a key to profitability as well as to applying primary care.)

The immediate benefits of regular reading could have long-term advantages since education does not end with qualification at university, or completing a vocational training scheme, or even with taking the MRCGP exam. The promotion of post-graduate continuing education deserves our close attention; witness recent discussions over the future of section 63 funding. Personal involvement in continuing education is at its simplest in regular reading; studying for the exam helps to clarify the value of such work. A habit could develop of reading two or three journals regularly and perusing the libraries in the local postgraduate medical centre or medical school for books of interest. Bibliography in general practice is booming, and there must be literature of interest to most GPs, even though there are such diverse individual beliefs in this specialty. Furthermore, greater interest in the mechanics of primary care demands more research into methods and models of care. Your studies may provide the stimulus to attempt trials and may also provide the skills to organise these.

A realistic approach to the exam might be to attend lunchtime meetings for GPs at the local postgraduate centres or to join a course specifically designed for prospective candidates. These both provide excellent opportunities to exchange informed opinion and discuss aspects of primary care that are important to the practitioners. The exam is a good example of selective screening or the value and methods of self-audit. The list is endless, and again I would hope that regular attendance would become a habit even after the exam.

Taking the exam might well set the example to future partners, to your trainee or student, or to your consultant colleagues. It is inevitable that many principals will search curriculum vitae for any extras that might discriminate between candidates. The addition of the MRCGP could act as an asterisk to a young doctor's applications for a partnership, and because of the difficulties in getting jobs now this benefit may be urgently relevant. It is likely that future trainees in general practice will have more skills and attitudes, the traditional essay questions the ability to formulate reasoned and logical arguments on paper; the oral assess diagnostic vocabulary, clinical methodology, and the competence. The formulation of the exam is a great example of clinical relevance, degree of difficulty, and its methods are accountable. It lays different emphases on the examiners' view over the separate parts to produce suitable questions, and then all of them actually sit the whole paper to achieve standardisation.

It has been said that to produce a higher qualification without a clinical examination is a mistake. Including this would not, I feel, be inappropriate but would be of limited value. A GP's true skills in the continuing relationship with patients and their environment. The multiple extended question has evolved as a reliable assessor of these skills. The critics of the exam have also expressed fears that it may become compulsory for entry into practice. This, however, is not the case and indeed runs against college policy, which consistently supports the voluntary status of the MRCGP exam. Surely it is desirable for professionals to expose themselves voluntarily to peer scrutiny and judgment.

consumers will we secure a renewed investment in primary care. Finally, I support the exam because I believe that its content is fair and its methods accountable. It lays different emphases on its parts: the multiple choice questions test the acquisition of relevant and classifiable knowledge; the multiple extended question measures the ability to formulate reasoned and logical arguments on paper; the oral assess diagnostic vocabulary, clinical methodology, and the competence. The formulation of the exam is a great example of clinical relevance, degree of difficulty, and its methods are accountable. It lays different emphases on the examiners' view over the separate parts to produce suitable questions, and then all of them actually sit the whole paper to achieve standardisation.

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offered specific courses should they wish to examine deficiencies and retake the exam. Having become a member of the Royal College of General Practitioners, should you wish to use the exam as a barometer of your performance later this is possible with no payments for further attempts.

Benefits to the profession

I would now like to consider how the exam may offer some indirect benefits to the profession as a whole. Unfair as it may be, the funding of the National Health Service and its declared priorities are as much dictated by pressure groups as by evidence or analytical measurements of intrinsic merit. Inevitably, this has led to the establishment and proliferation of high cost medicine with willing proponents in the media and public, either encouraging direct government financing or raising huge sums of money to purchase capital equipment—sometimes to the acute distress of a health authority who may not be able to afford to maintain such gifts. The beneficiaries of this process are at the apex of a medical elitism that lays much emphasis on academic performance, the pursuit of research, and the attainment of professional peer approval. Since the inception of the Health Service general practice has lost out in this allocation of funds. This cannot be because of the relative unimportance of primary care in the establishment of a healthy society. A more active and intrusive influence by GPs using a more uniform approach to patient management would entail a reassessment of the GP's role. It would also necessitate extra funding to primary care to encourage, for example, paediatric surveillance, screening for hypertension, or doing operations in the surgery. I do believe, however, that this expenditure would ultimately be extremely cost effective to society. Perhaps the establishment of a royal college with long term aims and an examination of higher qualification were needed to raise the peer status of general practice. Only by building a new trust and respect for them and our colleagues and us and

Diary of Urban Marks: 1880-1948

Jack had not the remotest idea where his parents and son were but hoped that Anne, his only surviving daughter, would be able to find out. The Court would thus be fulfilled the parents would somehow get into touch with him. This happened within the year by Nettle writing to Ethel (Jack's wife), who for years had been a secretary to a doctor in London. The grandparents and Eric were living in Scotland and Harry had been earning a living selling watches and jewellery in the Lowlands. Plans were not made until the summer of 1948 when Jack, before Jack or Ethel or myself could find them Harry died and was buried. Nettle came to London and lived in Peckham Bay, where I lived her whenever I went to London. Eric was studying the wireless with a view of becoming an operator on a ship. But the poor lad was half starved and could not study. He has never qualified for a ship and is earning a living in a way as a salesman. But his health does not allow him to attend work constantly and he is more often workless than working.

Jack who by now is over 80 can only work occasionally owing to the chronic asthma. Ethel is earning only the boy and Nettle live in the street poverty and every now and then, much against her will, she has to appeal to me for assistance to keep the roof over their heads.

Some three years ago Neil and I went to Peckham Bay in the morning. I will not describe the room as it is. Beyond the fact that it was clean I want to forget it. I told Nettle that we would have lunch there. Eric was available at the time and I sent him out with a pound note with instructions to get sausages, potatoes, bread and butter, tea, sugar, and milk. There were not enough utensils for the four of us but we managed. I think it must have been the first square meal Eric and Nettle had enjoyed for years. While the young man had gone for the actual Nettle told me that his mother had got into touch with him. How this had been done I do not know. She had sent Eric an invitation to visit her somewhere in the south of England. On the advice of his

grandmother he went. He was met at the station by a large motor car in charge of two footmen or chauffeurs. He was driven some miles to a large estate—the house being approached through an avenue of trees.

During a meal at which Eric and his mother were alone she told him that she was now married to an extremely wealthy man. They had no children and she with the consent of her husband was now willing to take her son back and educate him for any position he liked. She hinted that he would probably inherit most of her husband's wealth. The conditions were that he should hold no communication with his mother. He was to be brought up by his stepfather and at all with his grandmother. She was not willing even to let the grandmother visit him for one day a year. Eric would not entertain the idea for one moment. He had never known any other mother but his grandmother and it was quite unlikely that he would desert her in her old age. He could have surrounded himself in luxury. He did not know from where the money would come but he remained loyal to his grandmother. His stepfather would not expect him to do otherwise.

They parted on friendly terms but she did not even give him 5s. though Eric had told her that his mother had got into touch with him. His grandmother had endured. She never expressed an offer from him again.

Perhaps Eric was wise to refuse such an offer from such a callous parent, although personally I think he could have gone to live with his mother for a time. As the weeks passed on and they would begin to know each other better it might have come about that Eric could have forced his mother to let him go. He would probably not wish to lose him again, either to receive Nettle into her house or make provision for her. Besides, there was the husband to take into consideration. He might have become so fond of Eric that the latter might have persuaded him anything and between them they might have influenced the wife.

However, who shall decide? Everyone must take his own decisions in this life whether they be for good or ill. What the future holds for Eric, especially when his grandmother has shuffled off this mortal coil, only God knows.

vegetable production, the diet of many of our patients leaves much to be desired: obesity, constipation, irritable bowel syndrome, and children with multiple caries are all common problems. Much is written of the stresses induced by modern urban life, but anxiety neurosis is the lot of man the world over, and we may stress-related disorders arising from marital discord, threat of redundancy, unemployment, and poor housing. Many sufferers from asthma and eczema attribute their symptoms to the unknown chemicals that seem to be an essential ingredient of modern agricultural production, often sprayed from hedge-hopping airplanes. My patients may be right, but I have no evidence to support their contentions. Fear of nuclear war is understandably widespread in this most easterly part of England, so thickly populated with American warplanes, where the ever-shattering passage of Phantom jets and F-111s and the low-flying practice of pairs of A-10s is a constant reminder that we live in a nation at a high level of preparedness for war. I have been asked by patients for assurance that "the death pill" will be available in the event of a war being declared, and for practical advice on the most humane method of killing a baby if "the bomb" should be dropped.

The lack of public transport results in a high level of demand for home visits, and I spend a great deal of time behind the wheel. Narrow Norfolk lanes are hazardous at the best of times,

but lumbering combine harvesters in summer and the mud spread by farm tractors in the winter add to the dangers. Reduction in local authority spending has stopped salting and gritting of all but the major roads, so in winter an extra degree of alertness is required on night visits and in the early morning if one is to avoid sliding into the ditch. All the partners in my practice belong to the local BASICS (British Association of Immediate Care Schemes) scheme and carry emergency equipment supplied by the Norfolk Accident Rescue Service. We are called to all road accidents where people are injured, and sadly too often the only medical duty we can perform is to confirm death.

The practice of medicine is concerned with helping people to prevent, to solve, or to cope with their problems. Many problems have no solution, and when there is a plethora of helping institutions it is all too easy to refer the patient to the appropriate organisation, when all that is required is a sympathetic ear and moral support. In a rural community most relationships are face to face, and the practice of medicine is made lighter by the caring spirit of the community and the informal networks of people willing to help. It takes a long time to identify all the informal contacts where help is available, but therein lies the strength of the local community and the reason for the relative lack of problems in rural practice.

responsive to the scores of the teacher. In summary, a good trainee will do well regardless, but will do better with a good teacher. A poor trainee, however, will do proportionately better than a good one if he has a good teacher.

One of the questions that must be asked is what constitutes a good teacher? As we have seen, factual knowledge and problem solving ability are important. The study set out to discover what other factors are involved. Trainees were asked to fill out questionnaires on their practice organisation, facilities, records, and teaching methods. These were followed up with discussions with trainers and trainees. Similarly, trainers completed questionnaires, including details of their medical experience, postgraduate qualifications, courses subscribed to, and practice facilities and organisation. They were also asked what postgraduate meetings they attended, what journals they read, and details of previous experience teaching vocational trainees. Again these questionnaires were followed up with discussions.

The trainees were then divided into three groups. Group A contained trainees whose trainers had recorded the greatest change in MCQ and MEQ scores before and after the course. Group B were trainees whose trainers had scored the least change, and group C were those whose trainers had scored the greatest change. An attempt was made to correlate which factors trainers in each group had in common. The trainers in group A had the most experience of planning and teaching the vocational trainees. They read medical journals more widely and were more enthusiastic about attending, and encouraged their trainees to attend, postgraduate meetings and courses. The trainers in group B had less experience of planning and teaching the vocational trainees. They read medical journals less widely and were less enthusiastic about attending, and encouraged their trainees to attend, postgraduate meetings and courses. The trainers in group C had less experience of planning and teaching the vocational trainees. They read medical journals less widely and were less enthusiastic about attending, and encouraged their trainees to attend, postgraduate meetings and courses.

The results of the study have provided some quantitative evidence about the factors affecting the successful teaching of vocational trainees. The data suggest that the trainer's clinical knowledge and problem solving skills are the major qualities in determining a trainee's performance and that the learning process is more likely to be successful if the trainer has a good understanding of the trainee's needs. The study also suggests that the trainer's personal qualities, such as his ability to establish a rapport with his trainee, are also important. The study was a hypothesis suggesting trainees be placed with trainers on the basis of their MCQ and MEQ scores at the beginning of the course in order to ensure that the trainee's needs were met. It is thought that personally will always play a major part in a teacher pupil relationship, and that a choice both for trainer and trainee should be made. The study was not designed to test this hypothesis, but it is thought that personally will always play a major part in a teacher pupil relationship, and that a choice both for trainer and trainee should be made. The study was not designed to test this hypothesis, but it is thought that personally will always play a major part in a teacher pupil relationship, and that a choice both for trainer and trainee should be made.

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The Influence of Trainers on Trainees in General Practice

The Royal College of General Practitioners has recently published an Occasional Paper, *The Influence of Trainers on Trainees in General Practice*. The aim of the paper is to show what qualities in trainers most affect the performance of trainees during their year in practice. Since the Freeman and Byrne study in 1976 it has been known that trainees' factual knowledge, measured by multiple choice questionnaires (MCQs), and problem solving skill, measured by the modified essay question (MEQ), improved during their courses in general practice. Hitherto it has not been clear exactly what qualities in a trainer accounted for this improvement, or its degree. The study of 76 trainees and 76 trainers in the north of England set out to examine what these qualities were and to what extent they influence trainees. A research plan was drawn up using MCQs and MEQs, and also standard intelligence and personality tests using accepted methods such as the Wechsler Adult Intelligence Scale and the Eysenck Personality Inventory. Questionnaires, interviews, and group discussions were organised for both trainers and trainees to examine the types of practice and teaching methods used. Each trainee in the study completed the full battery of tests at the beginning and again at the end of the year in practice. Each trainer completed the same battery of tests at the beginning of the year with the particular trainee.

The results are interesting. Trainees showed a statistically significant improvement in MCQ scores after the course. The trainers' MCQ scores were significantly higher than the trainees' scores before the course, but subsequently trainees' scores were slightly higher than those of their trainers. This latter finding was not significant. The difference between trainers' MEQ scores before and after the course was also statistically significant, but scores both before and after the course tended to be below that of their trainers. Analysis of the results of MCQs showed a positive correlation between the score of the trainer and the percentage change in the score of his trainee. It implies that the trainer's score was a good indicator of the score of his trainee. The study also found that trainers with high pre-entry scores did better than those with low pre-entry scores if they were attached to trainers with high scores. These findings emphasise the importance of the teacher's influence on the trainee. The study also found that trainers with high pre-entry scores did better than those with low pre-entry scores if they were attached to trainers with high scores. These findings emphasise the importance of the teacher's influence on the trainee. The study also found that trainers with high pre-entry scores did better than those with low pre-entry scores if they were attached to trainers with high scores. These findings emphasise the importance of the teacher's influence on the trainee.