but most of the books are written by people whose vocabulary, language, attitudes, experience, and expectations are more likely to coincide with those of the educated reader, and even when this is not so a potential reader may be put off by his previous experience of books that were above his head or seemingly irrelevant to his own experience. It is therefore pleasing that only 22 books were judged to be boring or difficult to understand and that over 90% of readers thought that they would use the library again. We hoped that the introduction of audio cassettes might broaden the library's appeal to the non-reader. In fact, the style of many of the cassettes is reminiscent of Radio 4 and of others heavily American. Thus a social mismatch may be much more evident to the listener than to the reader of a book. We think that there is a glaring need for a Terry Wogan or Jimmy Saville style of presentation.

One of the most noticeable recurring statistics in the results is that women use the library more than men. This may be explained only partially in terms of the relative crude consultation rates, although the fact that a mother rather than a father attends with most children who consult must also be taken into account. None the less, one is left wondering whether women desire information on health topics more than men or are just less satisfied with the information they receive from other sources. Perhaps it is no more than a reflection of the fact that contraception, child care, and diet are seen as the domain of women.

In a national health service which has been criticised as being sickness orientated it is pleasing to see the extent of interest in health as opposed to disease. Both the borrowings (table I) and the list of most popular titles (table III) show evidence of this. As regards specific problems, it is clear that patients most want information about chronic and recurring disorders, particularly backache and sleep disturbance in which doctors are probably less helpful than they might wish to be.

One aspect of the use of the library that has gradually

increased with familiarity has been the extent of its prescriptive use by members of the health care team to reinforce and extend their advice. Most patients have been pleased to be recommended a source of information, particularly on a complex area such as pregnancy or baby care, or on a chronic disorder, such as anxiety or heart disease. On the other hand, most use of the library was opportunistic. People who happened to be in the waiting room for some other reason borrowed books, took them home, and in most cases read them. In other words over 400 books were read by people who would not otherwise have done so and with very little prompting from anyone. Nearly all of these patients found their book useful and claimed to have learned from it. What is more difficult to assess is the extent to which their reading has altered their behaviour or health.

As people's health expectations become more sophisticated, the role of the doctor and his team in communication and explanation will continue to increase. We must be prepared to broaden our use of educational tools including books, audio cassettes, video recordings and other audiovisual aids as well as traditional posters and leaflets. We have described the establishment and use of one such aid. It is neither the ultimate educational aid nor even a vital one. It is merely a useful weapon in a steadily broadening armamentarium. "Why should the Devil have all the good tunes?"

References

- Golen FB, et al (1974). A health education library for patients. *Health Serv Rep* 1974;89:236-47.
- Hodgkin K. *Towards earlier diagnosis*. Edinburgh: Churchill Livingstone, 1973:23.

(Accepted 15 December 1983)

ONE HUNDRED YEARS AGO When in America, Sir William MacCormac was invited to a lecture at the Bellevue Hospital Medical College. He chose as his subject his Personal Experiences of Surgery in Time of War. A picturesque and interesting account was first given of Sir William's experiences in the Anglo-American Ambulance at Sedan, when the deserted city became suddenly flooded by the defeated and retreating French army, and when, after having felled with impatience a delayed transport and unwilling idleness, the staff of the ambulance found themselves suddenly overwhelmed with work. Those were the days before Listerism, and Sir William bewailed the number of cases that ended fatally from blood-poisoning. "In cases of ligature for hemorrhage, the bleeding too often recurred, and the reactions, in many instances, either ended in amputation or in death. Most of the reactions of joints were in the so-called secondary period. I agree with Langenbeck in thinking the primary reactions, though performed immediately after the injury, are unsatisfactory. The power of regeneration, the probability of curing a useful limb or joint, are much less. In the secondary stage, the periosteum has become thick and vascular; it can be more readily detached from the bone, and its powers of aseptic reproduction are enormously increased. Immediately after any injury, it is very difficult to detach and preserve it to any extent; it possesses very little power of forming new bone. Besides, there is in the secondary period a better delimitation of the injury; its extent is better known; some of the fragments have necrosed, others show vitality. Cases only fit for amputation have already been disposed of. In resections for gunshot injury of joints, we may lay down for certain the necessity for preserving the periosteum as a condition of success, and we may also affirm that these operations should not follow the formal rules for excision of joints, for in most instances we can save portions of the joint; and, whenever it is practicable, partial excisions are to be performed; they are less dangerous to life, and the

functional results are better. I know of several cases in which very complete reproduction of the lost parts has followed, even where large portions of bone were removed. The ankle-joint and the elbow-joint are the articulations most suitable for surgery of this kind, and after them, the shoulder and the wrist. The hip and knee have been seldom successfully excised for gunshot-wound. For these, conservative treatment is the only applicable method, viewing the great mortality after operative interference in these two articulations. Indeed, for the cases of penetrating wound of the knee-joint, Bergmann and Keyser have demonstrated, by their experience during the Russo-Turkish war, that the method of antiseptic occlusion, healing under an antiseptic seal, with complete immobilisation in plaster-of-Paris, is by far the most successful method of dealing with gunshot wound perforating this articulation. These results, published in Volkmann's *Vorlesung*, are most surprising. If I remember rightly, nineteen out of twenty-one cases recovered, not only with preservation of life and limb, but actually with free and in some cases perfect movement of the joint." Sir William warned his hearers against probing too freely for a missing bullet, and gave a remarkable example of a patient found after death in the knee-joint, wedged beneath the articular surface of the condyle, which it had entered after ripping up the front of the tibia. Its position had not been recognised, and the wound had, therefore, not been probed. The man recovered with a movable joint. Contrasting the non-antiseptic treatment of wounds in the Franco-German war with the strictly antiseptic system of the late Egyptian campaign, Sir William pointed out that whereas, in the former, pyemia, erysipelas, and secondary haemorrhage made terrible havoc, in the latter not a single case of erysipelas, or pyemia, or blood-poisoning occurred—a result quite unprecedented in the history of military surgery in any part of the world. The lecture concluded with a few grateful words of compliment and encouragement. (*British Medical Journal* 1884;2:235.)

Approval of trainers and training practices in the Oxford region: criteria

THEO P C SCHOFIELD, JOHN C HASLER

Abstract

New criteria for approving practices for training general practitioners have been accepted by the Oxford regional postgraduate subcommittee for general practice. These criteria cover the trainer, the practice, and the training. Two further papers will discuss new methods of assessment and their evaluation.

Introduction

This is the first of three papers that examines the arrangements for the approval and reapproval of trainers in general practice. Although it relates to the Oxford region, the general principles apply to all regions. Approval and reapproval in each region is the responsibility of the general practice subcommittee of the Regional Postgraduate Medical Education Committee, as laid down in the *Statement of Fees and Allowances* para 38.1. These subcommittees, while operating within these regulations, have the responsibility of setting their own criteria for approval and must take several factors into account.

RESPONSIBILITY TO THE TRAINER

Trainers for general practice spend only one year with a trainee: in most programmes the whole period is spent in a single practice. The quality of the training and experience that the trainee obtains is, therefore, crucially important. At the end of that year the trainee is expected to be able to become a principal in any general practice, not just one similar to the training practice, and must be equipped to continue to learn and to develop throughout his professional lifetime. Day release courses may supplement, but are no substitute for, the training practice, and, indeed, if trainees cannot relate the ideas that they are offered on their courses to their experience in their training practice then they are likely to discount them. There is now evidence that characteristics of both the trainer and the training practice may influence trainees' learning and performance.¹

The fact that all prospective general practitioners are now compelled by law to spend a year as a trainee adds a further dimension to our responsibility to them.

PUBLIC ACCOUNTABILITY

The financial resources that have been made available for vocational training are considerable. The benefit of approval to a training practice includes not only the training grant (currently £160 a year) and related allowances but also the contribution to

the care of the practice's patients made by the trainee. In return for this investment the public has a right to expect value for money.

RESPONSIBILITIES TO THE TRAINER

The training grant is included as part of the average net remuneration of all principals and the right of every general practitioner to apply to be a trainer should not be unreasonably restricted. To start training requires much adjustment and investment in the practice and withdrawing approval cannot be done lightly.

NATIONAL GUIDELINES

The Joint Committee on Postgraduate Training for General Practice publishes guidelines on matters for the approval of trainers² and also visits the regions regularly to review the arrangements for vocational training, in particular the extent to which these guidelines are being observed.

METHODS OF ASSESSMENT

In the past there was a tendency to select criteria that may not have been the most important for a training practice but were easily and objectively assessable. There is a danger, for example, in concentrating solely on factors such as time for teaching or the state of the medical records, rather than the quality of teaching or the quality of care given. Indeed, some people have expressed anxieties that subcommittees are more interested in standardising style and method rather than examining what the trainer sets out to achieve.

PARTICIPATION OF TRAINERS

Although each general practice subcommittee has the responsibility for setting criteria and giving approval, it is the trainers who actually have to teach. It is therefore essential that they participate in setting the criteria and accept them as those to which they aspire.

LEVELS OF CURRENT PERFORMANCE

Distinction must be drawn between setting criteria that are agreed to be desirable and the level of performance which is currently current or regarded as acceptable at any particular time. This acceptable level may vary with local circumstances and with the length of time any practice has been teaching trainees. This avoids the complexity that may be produced by achieving minimum levels of performance and encourages the continued development of trainers and training practices.

Devising and reviewing regional criteria

With these considerations in mind, and in particular the importance of consulting both providers and consumers, the

Oxford regional postgraduate subcommittee for general practice set up a working party in November 1981 which included a trainer from each district's group, two trainee representatives, two course organisers, and the two regional advisers. The brief was to examine the criteria and the methods for appointments. The working party prepared a statement of principle and a draft set of criteria, which were discussed and agreed by the trainers in each district trainees' group, and by the trainees' representatives group. A final set of criteria were then prepared which have now been accepted by all the trainers' groups and the general practice subcommittee.

Criteria

STATEMENT OF PRINCIPLE

Teaching practices and trainers are selected for the educational opportunities that they offer to their trainees. Trainees may learn from (a) experience and example working in the training practice; (b) teaching from the trainer, the partners, and from other members of the practice team; (c) the other educational resources and opportunities available in the practice. All these areas must therefore be examined when granting approval.

Each teaching practice is part of the regional and district training schemes. They should subscribe to the regional aims for training and contribute appropriately to their district scheme. The responsibility for the education of each trainee in the practice, however, remains with that trainer and trainer.

CRITERIA FOR THE ASSESSMENT OF TEACHING PRACTICES AND TRAINERS

(a) Trainer

Professional values—The trainer should be a doctor committed to providing a high standard of care for his patients. He should be of good repute and known for his integrity and have good relationships with his colleagues and staff. He should encourage self help in patients and keep in balance his need to be needed. His clinical decisions should reflect the true long term interests of his patients. He should be able to provide a service to his practice population, sharing with others his responsibility for promoting, preserving, and restoring the health of the individual patients. Trainers should not display racial or sexual prejudice either in their practice or in their training.

Previous experience—A trainer will have at least three years' experience as a principal in a training practice or normally five years' experience in a non-training practice. If he is not vocationally trained it is desirable that he has had additional equivalent experience.

Clinical competence—The trainer should display a high standard of clinical competence in his consultations, the long term care of patients, preventive medicine, prescribing, record keeping, and appropriate use of other members of the practice health care team and of colleagues in agencies outside.

Continued education—The trainer subjects his work to critical self scrutiny and peer review and accepts a commitment to improve his skills and widen his range of services in response to newly disclosed needs.

Commitment to teaching—The trainer will regard teaching and meeting the educational needs of his trainees as a major commitment. This will be reflected in time, enthusiasm, and the desire to develop as a professional teacher.

Preparation for teaching—The trainer should be aware of new ideas and developments in general practice and with the main publications of general practice. He should be familiar with the educational aims for vocational training and the methods of

teaching and assessment. He should have attended a residential course for trainers and also have participated regularly in the meetings of his teachers' group for six months before beginning training.

Teaching ability—The trainer should be able to develop and maintain an open, honest relationship with his trainee and generate enthusiasm and motivation in the trainee. He should have the ability to understand his trainee's problems and to communicate with the trainee. He should show an ability for logical and critical thought and willingness and ability to encourage the trainee to direct his own learning.

Contribution to the district scheme—A trainer should belong to his district trainees' group and be willing to work with and to support his colleagues in the development of their teaching and to assist and support the course organiser with the organisation of the scheme.

Examination of the Royal College of General Practitioners—New trainees should normally have passed the membership examination of the college. This shows a willingness to be assessed, and preparation for the examination is also valuable preparation for teaching. The trainer should also be able to help the trainee prepare to sit the examination at the end of vocational training.

(b) Teaching practice

Responsibilities of the partnership—The trainee needs to be accepted and treated as a colleague in the practice and involved in the work of the practice by all its members. All partners should be willing to accept the educational purposes of the trainee attachment and their own responsibilities as members of the teaching practice. These responsibilities include welcoming the trainee as a colleague and being willing to share the care of their patients. They should recognise the contribution that the trainee and the trainer make to the practice and be willing to support them and allow adequate time for their educational activities. They should also recognise the financial contribution that training makes to the practice and be willing to participate in and support the development of the practice for teaching. It is also desirable that they should be willing to make their own contribution to the training.

Time for teaching and other educational activity—The trainer and partners must make adequate time available for teaching. They will need to be accessible to the trainee to discuss problems when required and also provide at least two hours uninterrupted a week for teaching. The trainee will also require the opportunity for regular joint consultations and must be free to attend courses organised outside the practice. The trainer will need time to attend the trainers' group, teachers' courses, and also for his own educational activity.

List size and workload—The size of the list of patients and workload of the teaching practice should be large enough to offer the trainee adequate clinical experience but not too large to prevent time being available for teaching and for both trainer and trainee to attend courses or to prohibit a high standard of patient care.

Arrangements for seeing patients—The teaching practice should have arrangements for seeing patients, usually an appointment system, that allow adequate access of patients to the doctors, for both urgent and non-urgent problems. These arrangements should also encourage continuity of care and allow adequate time for each patient. The arrangements for a trainee to see patients should be planned to meet his educational needs. These include seeing a representative cross section of patients, including those with long term problems, and opportunities to establish continuity of care for patients. Trainees need to have the opportunity both to have time to study patients and their problems in depth and also to experience working at a similar rate to the partners in practice. Trainees would not be seen at times when they do not have the opportunity to obtain advice from a partner in the practice.

Night and weekend work—Arrangements for out of hours

cover by a teaching practice should allow the doctor on call access to information about the patients and enable him to ensure continuity of care. The trainee will require adequate experience of emergency and out of hours work in the practice. When the trainee is on duty a partner in the practice should always be available to help and advise. The trainee should not normally be expected to be on duty more often than the other partners in the practice. The training practice is responsible for making arrangements for telephone cover while the trainee is on call.

Medical records—The medical records in a teaching practice should be adequate to provide a high standard of clinical care. The trainee should be able to obtain rapidly and accurately all information that is required when a patient is seen. Therefore: (i) Record cards, letters, and results of investigations should be filed in chronological order after suitable pruning. (ii) A legible entry should be made at each doctor-patient consultation from which the management, and in particular medication, should be clear. (iii) Each patient record should contain an updated summary card or problem list of past and present problems.

Preventive medicine and performance review—The teaching practice should be committed to organised preventive medicine and to the study and audit of the care that they provide to their patients. The trainee should have the opportunity of seeing these methods in practice and of auditing his own work. It is therefore desirable that teaching practices should maintain age-sex and disease registers. It is also desirable that teaching practices should recognise the importance of research in developing our discipline and that the trainee should have the opportunity of seeing research done in practice.

Practice premises—The premises of the teaching practice should be adequate to allow a high standard of patient care, practice organisation, and teamwork. The trainee should be able to consult in a well equipped room and it is desirable that a library should have a consulting room of his own.

Librarians and journals—A teaching practice should have a library, containing adequate up to date reference books, books relevant to general practice, and recent copies of the major journals relevant to general practice. The trainee should have ready access to this library.

Staff, equipment, and organisation—The teaching practice should display a high standard of practice organisation and administration. It should have adequate staff and equipment for practice organisation and patient care. The trainee should have access to these facilities.

Health care team—The teaching practice should be committed to teamwork. It should have close working relationships with district nurses, health visitors, midwives, and social workers. Normally, a teaching practice will also have a nurse working in a treatment room. The trainee should have the opportunity of participating in this teamwork and of attending special clinics, particularly antenatal, child health, and family planning.

Practice meetings—It is desirable that teaching practices should have partnership meetings and meetings with the staff and the health care team for discussions on practice organisation, planning, and clinical matters. Trainees should be encouraged to attend all such meetings in the practice, including those on business and finance.

Contract: letter of employment—The trainee is an employee of the training practice and should be provided with a letter of employment or written contract. This contract should not contain conditions that restrict the trainee's rights under the *Statement of Fees and Allowances* or that interfere with his training.

(c) The teaching

Assessment and curriculum planning—The trainer should initially assess with the trainee the trainee's needs and be able to use appropriate methods in the area of knowledge, skills, and attitudes. He should also continuously assess the trainee's progress in these areas during the attachment. The trainee should negotiate educational goals and plan a curriculum with the trainee which is directed towards the trainee's needs and is relevant to the overall curriculum for general practice. This curriculum should be reviewed in the light of the continuing assessment.

Teaching methods—The teaching should be planned, prepared, and directed towards the curriculum. The trainee should encourage the trainee to direct his own learning and should encourage the development of self awareness and critical thought. He should be able to use a variety of appropriate and effective teaching methods himself and be willing to direct the trainee to additional resources when required.

In the next paper we shall look at methods of assessment.

We acknowledge the contribution that the members of the working party, Drs P. Anderson, M. A. Beale, J. D. Campbell, J. M. Carey, R. P. Evans, J. P. Ferrier, M. J. Fitzgerald, L. I. Holmes-Smith, D. N. MacLennan, D. H. Matthews, J. S. Smith, T. C. Winkle, and H. Youl, made to developing these criteria, and thank all trainers in the Oxford region for their time and commitment in both discussing and implementing them.

References

- Statement of fees and allowances payable to general medical practitioners in England and Wales. Department of Health and Social Security, Welsh Office.
- Freeman J, Roberts J, Metcalfe D, Hillier V. *The influence of training on trainees in general practice*. Occasional Paper 21. London: Royal College of General Practitioners, 1982.
- Joint Committee on Postgraduate Training for General Practice. *Criteria for the selection of trainers in general practice*. London: JCPTGP, 1980.
- Joint Committee on Postgraduate Training for General Practice. *The training year in general practice*. In: *Training for general practice*. London: JCPTGP, 1982:10.

(Accepted 9 December 1983)

Diary of Urban Marks: 1880-1849

I found that constant cycling was undermining my health and I therefore had to invest in a motor car. It was a two cylinder Darracq of 10 horse power. I obtained it from John Brown for £105 and it was of course secondhand. It had a Cape Cart hood and the legs were exposed to all the draught since there was no door to it. I paid Brown £55 down and £50 at the end of the year. The car needed repairing from time to time and was very expensive to run. Tyres were expensive and only ran 1500 miles before they gave out. Punctures occurred every five hours. Still I managed to get about quicker on it and without so much discomfort to myself. The hours at 30 Port Street were from 9-10 am and 5-6 pm and at Trinity Place from 10 am to 11 and 6 pm-7 pm. I found that a branch surgery did not pay. When I was at one I was paid at the other and patients would not wait. Still I had to keep Baldwin's at my own cost.

Medical School Offices, John Radcliffe Hospital, Headington, Oxford OX3 9DU
THEO P C SCHOFIELD, MRCGP, FRCP, associate regional postgraduate adviser in general practice
JOHN C HASLER, MD, FRCP, regional postgraduate adviser and clinical lecturer in general practice
Correspondence to: Dr Schofield.