PRACTICE OBSERVED

What Annoys Me Most

Getting the run around

A PATIENT

Dear Dr X:
May I introduce myself? I am one of your patients, but so far I have been unable to meet or consult you. I am still trying, but I can't find the right words to use to get an appointment with you; each time I've asked I've been told that I must see someone else—a nurse, or a health visitor. Once they even said that I should see the social worker, and I can't think what I have to do or say or have wrong with me so that I can see *you*, doctor.

My family and I moved into this area a few months ago. We were recommended to this practice and to you in particular. When we registered, however, we were told that this was what they called a group practice and that the doctor's name on our new medical cards might not be yours. They said the name didn't mean anything. I was a bit puzzled about this—somehow I thought it should have.

We had a few problems after we moved here, doctor, and it would have been a help to have seen you or even to have had your advice on the telephone, but you don't take telephone calls during your surgery hours and of course I do understand that it might be disturbing for you, but you see our difficulties never seemed bad (or should I say good) enough for your receptionists to give us one of your extra appointments or even an ordinary one. You were always booked up, you see. The appointment system was new to me as our old doctor didn't have one, though you could always see him during his surgery hours, and you didn't have to wait very long unless he had an emergency.

I did have to telephone you one night, I'm afraid. Actually it was about 2 am and I was really worried about disturbing you because I know you are always so busy and overworked and you need your sleep, but the baby had croup and was really quite ill. We aren't on the telephone yet ourselves—they keep saying they will come and connect it but we are still waiting—so I had to go to a call box and that took time because the first one wasn't working—it had been vandalised. When I dialled the surgery number (your own number isn't in the directory, is it doctor—they said it was what they called XD) I got one of these answering machines, and it sounded so formal and impersonal but that was probably because I was so worried by this time and it would have been reassuring to have had a real person to speak to. Anyhow, the message said that none of the four doctors in your practice was on duty and that I was to ring another number which would be the deputising service. I hadn't heard of this either and I hadn't any more money with me so I had to run back to the house to get some and the baby was getting worse all the time. When I got through to the new number, though, the girl there was very helpful and reassuring; she wasn't a doctor or even a nurse but she had children of her own and she understood and said she'd send a doctor quickly—she did and we were grateful for that.

We decided after this not to bother telephoning if we wanted to see you but to come up to the surgery and ask the receptionist in person to get us an appointment with you, but we still seemed to have a battle. The girls at the desk do try to help but they are always so busy and that glass partition there makes you feel that it's a case of them and us and that you are asking a favour every time. It isn't very private either, because you always have to say why you want an appointment and everyone in the queue (there always seems to be a queue) can hear. I don't always want to say why I want to see you doctor, but I understand that the receptionists have to know—it's so that they can decide if its really urgent or even necessary; they have to protect you a bit and make sure you don't see too many of us and don't do anything that someone else like the nurse could do instead.

When I needed to have my ears syringed (my old doctor used to do this about once a year for me) they told me I'd have to see the nurse because you didn't do ear syringing now, and when I said I really did have to see you because I also wanted my pill prescription renewed and needed to talk to you about it they said that the nurse did that, too, and the doctors mustn't be bothered with trivial things. I was a bit puzzled about this because I didn't think it *was* trivial. And I just went away. Later on when I tried to see you about the children's immunisations they still wouldn't let me, saying that the nurse or the health visitor did these, and when they found out that the baby was only 5 months old they got quite excited and said the health visitor would want to see me at her clinic and examine the baby and do a hearing test. I wanted to consult *you*, doctor, about the immunisations. My old doctor did all those himself and he got to know us and the children and all about us. We could talk to him and he would listen to you when he was doing what they call trivia. I don't want to see a health visitor, doctor, and the baby is hearing perfectly well. If I'm worried about the children it's you I want to see, not someone who hasn't got a family and perhaps isn't even married. Anyhow I don't like clinics. I told them that. I said I just wanted to see my doctor.

My husband had an accident at work recently and cut his hand rather badly. The factory doctor was there at the time and he attended to it and stitched it up himself. He didn't even send him to the casualty department as he could have done. But he did ask my husband to come and see you a week later and have his hand looked at and the stitches taken out. I think he was a bit concerned about it and a hand is rather important, isn't it? But the receptionist said my husband couldn't see you for that, the nurse was there for that sort of thing. We wouldn't have minded, doctor, if you'd just looked at it first, but they said it wasn't necessary. Of course we do understand you don't do things like taking out stitches now but its getting a bit difficult to know just what you do do. My husband has to have a medical too for his new job so that he can be taken on permanently but when I asked about that they said the nurse would do most of it. Well that did puzzle me, doctor, because I thought that that was something you had to do yourself; after all, you have to sign the forms and I thought that as my husband was a new patient you might have been interested in things like his blood pressure and so on.

The last time I tried to see you was when we were all told that it was very important for women to have breast examinations and cervical smears carried out and I did especially want to see you about that, doctor, but they wouldn't let me—it was the nurse again.

Anyway I've been a bit busy lately what with the move and so on and I started this letter some time ago. I've come back to it now because I'm really excited. At last I'm going to be able to see you. I am now a real patient because I'm pregnant! I never did get that pill prescription and I'm pregnant. So I'll be coming to see you. I don't mind when they tell me to come or where you'll want to see me, but this time I'll win. I'll get that appointment and meet you at last.

PS: It's no good, doctor. You may not believe me, and I suppose they didn't either, but they've told me (yes you know, don't you) I have to see the nurse first with a specimen and if she says I am then . . . I'm sorry, doctor, but do you mind signing our medical cards? You see there is another practice not far away where I can see a doctor. That's all I wanted, just an appointment with my doctor.

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Rethinking Established Dogma

Vocational training for general practitioners: II

MICHAEL A VARNAM

The modern world is filled with men who hold dogmas so strongly that they do not even know that they are dogmas.

G K Chesterton. *Heretics.*

In Part I (4 August, p 291) I posed 11 questions about aspects of training for general practice. Here are nine more. They do not cover every detail of a doctor's preparation for a career—nor are there 20 answers that may be easily stated. In posing these questions I ask myself as well as others to rethink carefully and in depth both the principle and the practice of vocational training. Solutions are never easy to find and will usually depend on local circumstances. But the questions apply to all those who either organise or participate in training on both formal and informal programmes as well as those who watch from the sidelines.

Trainers

However vocational training is arranged, whatever benefits accrue from the learning experience in both hospital posts and the half day release course, the cornerstone of a doctor's preparation for general practice must be the year with an approved trainer. The relationship between trainer and trainee and between both of them and the practice is the vital ingredient without which this learning experience will be of limited value. Because of this it has always been accepted (even before vocational training schemes existed) that not all doctors would be likely to have all the necessary personal qualities and practises all the necessary characteristics, and so it was necessary to seek approval to become a trainer.

This was done originally through local medical committees, and the few who applied were usually accepted. In 1973 the regional postgraduate committee and its general practice subcommittee became responsible for appointing trainers, though in many regions there was little practical difference. Trainers were then in very short supply and if an applicant was well liked, reasonably organised, and keen to "teach," then he was likely to be appointed. Since the course organiser was probably in the same category (except that he was likely to be self selected) this system had much to commend it *at that time*. As the number of publications on postgraduate training for general practice increased, and as trainers as well as course organisers developed a clearer understanding of what might be achieved, the role of the trainer could be described. It followed automatically that performance could then be reviewed. But to what extent does the average trainer know what is expected of him or her?

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(12) What is the role of the trainer in vocational training in general and your local scheme in particular?

This job definition is not something that can or should be imposed on trainers. It must be worked out for each scheme through its trainer's group (and after discussion with its trainees). By all means read and study the guidelines but, as with any subject, learning is best achieved by doing. If the participation of trainers in all aspects of the scheme is encouraged then they are likely to perform more effectively.

(13) Does it matter how the trainer performs?

I would hope that all would be prepared to answer yes to this question. The next is harder.

(14) Against what standards is the trainer's performance to be measured?

Many check lists and recommendations have appeared over the years suggesting ways in which this might be approached. The first ones were likely to be "structure" orientated and concern themselves with those aspects of organisation that could be easily measured. During the early 1970s Byrne and Freeman in Manchester designed and used several tests to measure changes in trainees.[1] Although their work was directed initially at trainees rather than their trainers, most accepted that if trainees "did well" it was because the learning environment provided by their trainer was appropriate.

The more recent work produced from the north west has provided the first definitive evidence that trainees make more progress (as measured in various ways) when certain positive characteristics are present in their trainers.[2] The trainers who had trainees who progressed most were more likely to: (*a*) have had had trainees for more than one year; (*b*) design and execute a planned teaching programme using various methods including "tandem surgeries"; (*c*) attend the day release course with their trainees; (*d*) arrange attendance at various "extra" clinics or meetings; (*e*) provide regular case related feedback; (*f*) help the trainee develop an understanding of continuity of care by encouraging the build up of a trainee's own list of patients; (*g*) help trainees who undertook projects while in the practice; (*h*) express interest in the professional obligation of their teaching role; (*i*) be more widely read and buy five or more medical books a year; (*j*) have a practice organised for teaching in terms of both records and facilities; (*k*) be members of the Royal College of General Practitioners. Most importantly, these trainers were more likely to have a good relationship with the trainee and to be perceived by the latter as being a caring and effective clinician.

These attributes of a trainer look more at what happens in the teaching practice and emphasise the importance of the benefit of a learning experience rather than merely its provision. Regions where the criteria for selection of trainers are arrived at by discussion with all who are concerned after consideration of such factors are likely to provide "real" standards against which performance may be measured. One criterion for appointment that all agreed on is that all trainers should regularly attend a "workshop." The name has become part of established folk lore but what changes occur as a result?

(15) What is the role of the trainer's group in your scheme? What evidence is there of a change in behaviour as a result of these meetings?

The trainer may be central to postgraduate training for general practice but his or her role depends on others. In many respects it is with the professional bodies that established dogma needs to be most actively reconsidered.

Trainees

If the trainee's year in general practice is indeed the most important part of the edifice of vocational training how is the time to be organised and what should the trainee be doing? Trainees seem to prefer, and most courses now provide, an introductory period in general practice of from one to six months, followed by the hospital posts, with the balance of one year to complete training.[3] There is only anecdotal evidence that the length of the introductory period makes any difference. But, of those trainees on an approved scheme who have the opportunity:

(16) In what ways are the learning needs of trainees different in their first and second attachments in general practice?

If trainers and course organisers find it difficult to assess the learning needs of trainees it is not surprising that trainers have difficulty in deciding what they should be teaching. Various tools (from many sheets of paper to the delights of the video cassette recorder) have been used to assess needs and progress, but none is perfect. What cannot be denied is that it is the responsibility of each trainer to ensure that the trainee first is helped to realise what his needs are and then follows an active programme to meet these needs.

If trainees are to learn by doing does it matter what "they practice on"? The results of Hasler's comprehensive study in the Oxford region confirms what many have suspected—namely, that some trainees see few patients with so called chronic diseases and that most of these do not return to the trainee doctor.[4] The tendency for this to occur is understandable—partners are loth to give away the patients they know best, patients prefer to have continuity of care for long term illness, and trainees who see such patients may not always show complete confidence. Some confident trainees in the same practice for one year may see more patients with chronic diseases. Hasler's work, however, shows that all trainers must find their own answer to the next question.

Course organisers

(17) How is the trainee in my practice to become familiar with the management of patients with long term illness?

Who is responsible for vocational training? The trainee in practice is employed by the trainer but that is about the last definite statement that can be made about the complicated and sometimes contradictory "establishment" of vocational training. All schemes will have an organiser but what he or she does and the breadth of their responsibilities vary widely.[5] All will be appointed by the regional postgraduate committee through the network of regional advisers but because there is often only one applicant they may in effect be self selected.[6] Some arrange a half day release meeting for 10 trainees while others are responsible for all aspects of the training scheme for 40. Yet all are considered to be doing the same job as far as payment is concerned and come under the regulations in the *Statement of Fees and Allowances* as a trainer "who has been designated as a vocational training scheme course organiser."[7] The argument for allowing some flexibility seems so overwhelming that:

(18) Why are course organisers still considered solely as trainers?

This issue has been debated at recent conferences of local medical committees and turned down more than once. Does this mean that this obvious anomaly cannot be corrected? If you think strongly on this issue say so to your local medical committee or regional adviser, or write to the chairman of the General Medical Services Committee or the Secretary of State. For it is only by altering the *Statement of Fees and Allowances* that a solution to this problem can be found.

Selecting trainers

Nowhere is there more confusion in vocational training than in the criteria for selecting trainers and the respective roles of the General Medical Services Committee, the Royal College of General Practitioners, and the Joint Committee for Postgraduate Training in General Practice. The last is the autonomous body set up to administer the vocational training regulations and to issue certificates of proscribed or equivalent experience. The other two have substantial equal representation on this body, which also includes nominees of other interested parties. Usually working by consensus, it may be seen that if a vote is needed the representatives of no one body command an absolute majority. The work of the Joint Committee is important, and the industry of its leading figures impressive. But what is its role and where is it going? Will it (and by implication its two parent bodies) see its role as proscriptive in the sense of building up case law to add to the rules for vocational training laid down in the *Statement of Fees and Allowances*, or will it take a wider view and encourage variation, innovation, and development?

There are likely to be those in both parent bodies who would seek to be authoritarian, but for different reasons and with different aims. At one extreme of the argument concerning criteria for selecting trainers is the view that any general practitioner who thinks that he would like to have an extra pair of hands has only to apply to be accepted. At the other extreme will be a minority (I hope) who would seek to lay down many preconditions for trainers and instructions that must be slavishly followed before any doctor may be either appointed or reappointed as a trainer. As with many concepts, the ideal surely lies somewhere between these two views. (It is perhaps worth noting that despite the considerable publicity that one or two cases have been given relatively few doctors fail to be reapproved and, of these, very few have successfully appealed.) The Joint Committee must produce its guidelines which should encourage movement and the development of ideas. Regional committees will want to establish criteria that are considered by their trainers (and the profession as a whole) to be reasonable, are understood by both organisers and teachers, and which not only look well on paper but can be assessed in practice. Of vital importance is the learning environment of the practice. There are, of course, factors in the personality of the trainer, the organisation of the practice, and the planned teaching programme that make the trainee's experience more likely to be effective. But it is how the trainer performs rather than his credentials on paper or the structure in which he works that really counts.

(19) How can the flexible educational development of training for general practice be encouraged by the Joint Committee?

This rhetorical question is addressed to the Joint Committee, and its members and constituent bodies. While the appointment and terms and conditions of service are the responsibility of others, your task (as well as issuing certificates) must surely be to lead in improving the learning experience of trainees. The weapon to undertake this crusade is already in your hands. Each vocational training scheme is visited by a panel sent out by the Joint Committee, so arranged that each region receives a visit every other year. The status of their report and the relationship between the Joint Committee and the regional subcommittee are undergoing scrutiny. Undoubtedly, however, the visitors, who are mostly experienced course organisers or regional advisers, exert a powerful influence. Yet the results of Whitfield and Hughes's survey of course organisers showed that only 59% found the visit helpful, 59% said it was useful, 54% found them stimulating, and 41% found them thorough.[8] Though one might expect a course organiser to be a little defensive, these figures do little to suggest that the visits are educationally successful. The Joint Committee, as well as looking at its guidelines for the selection of trainers and its "Notes for Visitors," will need to review its method of working if the full potential of training for general practice is to be achieved.

Conclusions

Preparing for a career in general practice either formally through a vocational training programme or informally by doing hospital posts and a year in practice is well established. Former trainees now practise in difficult urban areas as well as in the leafy suburbs; some are now trainers and a few course organisers. Whether or not those responsible for vocational training are able to examine positions and statements before they become established dogma will depend in part on these new entrants to practice. Will they have the drive, energy, and a degree of irreverence to challenge the establishment by creating the "divine discontent" out of which new ideas can develop?

(20) Will vocational training make a difference to the service received by patients?

It can do; it should do. If it doesn't, either because trainees have not been properly prepared or because at the end of training they can't find jobs, then vocational training doesn't deserve to survive. Finally, if the challenges of the 1990s are to be faced and overcome by these emerging doctors then isn't it time that the name trainee was abandoned in favour of registrar, or doctor, or . . . anything?

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ONE HUNDRED YEARS AGO The British public has been much disappointed with the animal which, during the past week, has been the talk of London. There can be no doubt that the average Englishman has long been under the impression that the sacred animal of Siam is a variety of elephant as brilliantly white as a white mouse, or, at least, of a "deadwhite" hue, or very pale drab, like some seabirds. The truth is, that a perfect "white" elephant is a real albino: the natural colouring matter of the epidermis being absent, the colour of the blood in the cutaneous vessels gives a pale pink tint to the hide. Precisely the same condition causes the blood-red colour of a white rabbit's iris. This pale pink coloration resembles that seen in a well fed Berkshire boar, and the black mottling in the ears of the elephant now deposited at the Zoological Gardens by Mr. Barnum further reminds us of a pattern very common in domesticated pigs. In a leading daily paper, Professor Flower has already described the peculiarities of the new arrival with scientific accuracy; Sir Joseph Fayrer informs us, and several Anglo-Indians concur in his opinion, that the peculiar local deficiency of pigment in this elephant is very frequently seen in British India, and this animal has been chosen in his own country, long before he was sold to Mr. Barnum, to represent the rarer purely "white" elephant, because an example of that purer type could not be obtained. Possibly the arrangement of the very little "white" on Mr. Barnum's elephant's hide was sufficient, according with some local superstition. This elephant is not a fine specimen of his kind, being hog-backed and small for his age, but his tail is perfect, and his tusks are very well formed. He may be instructively compared with the male Indian elephant presented by His Royal Highness the Prince of Wales, a far nobler animal, bigger for his age, and well formed. He is, however, a "muktar," that is to say, an elephant whose tusks are never developed. The Hindus speak of a specimen of this variety as though it were a different animal from the "hottar," or long-tusked elephant. (*British Medical Journal* 1884;i:179.)