Vocational Training for General Practice

IV — Belfast

FROM A SPECIAL CORRESPONDENT

One of the most striking ways in which the Belfast scheme has differed from other vocational training programmes is that for the first two years the trainees have been left almost entirely on their own. Though any trainee can ask for help in getting the appropriate hospital posts, most of them find their own (chosen, as outlined in the Todd report, out of general medicine, obstetrics and gynaecology, paediatrics, geriatrics, chest medicine, psychiatry, and accident and emergency). There have been none of the regular weekly group meetings dealing with subjects related to general practice which forms such a feature of, say, the schemes at Ipswich (19 June, p. 704) and Newcastle (26 June, p. 763). Even so, the organizers now think that their policy may have been too extreme and are planning to hold quarterly meetings of all the trainees.

Surely, I asked, would not this "neglect" of general practice leave the trainees relatively unprepared for it when they started their third, general-practice year. And what about the benefits of feeling oneself part of a group; how were the trainees to maintain their enthusiasm for so long? But organizers, trainers, and trainees alike were convinced that this was the right pattern—at least for Northern Ireland. Trainees were too immersed in their hospital posts to have either the time or the right frame of mind to switch into another discipline once a week. Again, doctors might do house jobs in centres other than Belfast; it would be difficult for them to attend any regularly held seminars unless their posts were to become supernumerary, and this would destroy a central principle of the hospital experience—that it should be gained in in-service jobs. None of the trainees said they had ever felt lonely or isolated during their hospital years, though perhaps this was because most of the doctors on the house had known each other for years and the situation in England, where a single residents' mess might contain doctors from as many as ten different British medical schools—as well as from overseas, did not occur. Finally, they asked, why should trainees in general practice be singled out for a weekly dose of cheer-leading? Housemen working for the M.R.C.P. or the F.R.C.S. were not continually being told by the chiefs that they were doing a worthwhile job, and surely a similarly relaxed attitude should apply to people sitting for the Membership of the R.C.G.P.? The time to inculcate enthusiasm for general practice was during undergraduate training and during the general-practice training year. Already students in Belfast spent a week in selected practices, and there were no plans to extend this period to a month.

Six Years' Experience

The Belfast scheme is in fact one of the oldest in existence, going back to 1965—well before the Todd report appeared. Though at the beginning it was slow to get off the ground, in 1967 six doctors were accepted for training and last year this number had risen to 16, with a total to date of 69. Of this total, five had never started their training, while 13 have left the scheme. Even so, the relatively high proportion of doctors who have left is not regarded as condemning the scheme. Some of the trainees had become so involved in their house jobs that they decided to make a career in the particular specialty; others were suddenly faced with the offer of a partnership in the practice they had always wanted to enter; while one or two decided to emigrate. And anyway, it was claimed, the extra experience they had had from the scheme before they left it could not have failed to improve standards.

The hospital years in the Belfast scheme are spent in much the same way as in other vocational schemes, with a particular emphasis on flexibility of choice of posts. By the end of this period several trainees have acquired both the D.C.H. and the D. Obst., and the whole course itself is designed to lead up to the M.R.C.G.P. examination.

For their general practice year the trainees are asked to select a practice from a list of some 30 teachers all over Northern Ireland drawn up by the Northern Ireland Council for postgraduate medical education. At present there are more training practices than trainees, and the council has taken considerable care to ensure that the latter are not used as a mere pair of hands. It emphasizes that the general practice year is quite different from an ordinary assistantship in general practice. The teacher-in-charge must be available to the trainee for some part of every working day during the first month (a heavier imposition than it sounds, as the trainee year mostly starts on 1 August), and the teacher and his partners are not allowed to arrange their holidays on the assumption that the trainee can stand in as a locum. Moreover, during this year the trainee spends some time regularly at outpatient clinics (such as psychiatry) and at least two months outside the practice—two periods of a fortnight in other types of general practice and three weeks in a local medical officer of health's department to learn about some aspects of social and preventive medicine. There is also a series of visits to government departments and social service units.

Regular Review

The working of the scheme is reviewed at regular 6-monthly meetings of the trainers, though the secretary of the postgraduate council can settle urgent questions right away, on the telephone or by a personal visit. The scheme is also one of those taking part in the evaluation of vocational training being carried out at Manchester. But I was told that so much depended on individual opinions and needs that any objective evaluation of any scheme was difficult. Trainees might differ radically, for example on an issue so fundamental as whether they should do night calls: one might consider he was being exploited if he was ever asked to do them; another might fret if he went as long as a month without getting some experience of them. The same sort of debate could be applied to clinical responsibility in routine

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surgery consultations, and whether or not a trainee should be encouraged to develop his "own" lists of patients towards the end of his year.

One of the particular features of the Belfast scheme is that any trainee completing the scheme can obtain a grant of up to £300 for studying some aspect of general practice outside Northern Ireland. Comparatively few trainees had taken this up, though those who had spoke warmly of its generosity. In fact, altogether there seemed to have been fewer complaints from the trainees about the way in which they were penalized financially by undertaking vocational training than from those of their counterparts I had talked to in Britain. Perhaps there is more incentive for this in Northern Ireland, where there are roughly only 30 vacancies in general practice every year and the considerable imbalance between demand and supply seen on the mainland does not occur. Certainly Northern Ireland seems to have evolved a vocational training scheme which suits its own circumstances admirably.

Any Questions?

We publish below a selection of questions and answers of general interest

Atromid-S in Diabetes

Has atromid-S any value in the prevention of cardiovascular complications in an elderly person with unstable diabetes?

It is doubtful whether clofibrate (atromid-S) would prevent cardiovascular complications in the elderly diabetic. Although it is effective in lowering blood lipids, there is as yet no evidence that the drug delays the development of atheroma.[1] Insulin requirements may be reduced and retinopathy improved in some diabetic patients treated with clofibrate.

1 *British Medical Journal*, 1970, **3**, 632.

Diminutive Stature

A young man of 18 of diminutive stature and youthful appearance is anxious to grow bigger. His father was of average height. Is there anything he can do which would help him to increase in size?

Provided that the young man in question is fully developed sexually and, as I suppose, that his epiphyses are fused, there is nothing else that he can do which would help him increase in size.

Notes and Comments

Addiction to Diphenoxylate.—Dr. M. M. GLATT (St. Bernard's Hospital, Southall, Middlesex) writes: Regarding the risk of Lomotil addiction ("Any Questions?" 6 February, p. 343) the W.H.O. Expert Committee on Addiction-Producing Drugs[1] considered diphenoxylate "an addiction-producing drug comparable to morphine . . . ," and recommended that it should fall under the international control regimen (1931 Convention, Group I). However, at the same time the Committee suggested that two preparations containing 2·5 mg of diphenoxylate and 0·025 mg of atropine sulphate (Lomotil is one such combination) should be exempted from the provisions of international control, as ". . . there was no evidence that preparations of the composition stated could give rise to addiction . . ." According to Varenne[2] the world consumption of the drug rose tenfold between 1962 and 1968 (from 80-851 kg) without a case of addiction having become known. Fraser and Isbell,[3] who in 1961 described a series of tests, found that when diphenoxylate "was administered chronically in high dosage, nalorphine precipitated a moderately severe abstinence syndrome." They concluded that diphenoxylate "possesses abuse liability (which) . . . is definitely less than that of morphine . . . ," and that "although (its) abuse liability is comparable with that of codeine . . . ," (its) unsuitability for parenteral injection decreases the hazards that may attend its use in clinical practice." Regarding Lomotil (i.e., diphenoxylate plus 0·025 mg atropine) Goodman[4] quoting the findings of several investigators, stated that one patient out of 53 receiving Lomotil in very high dosage showed withdrawal symptoms after nalorphine.

Coming by chance across Fraser's and Isbell's report[3] we have since 1964 used a combination of Lomotil and the sedative-hypnotic chlormethiazole (Heminevrin) as the routine method of the withdrawal phase in heroin and other narcotic drug dependence among inpatients admitted to the St. Bernard's Hospital Addiction Unit.[5] Over a period of seven years this combined regimen was found to be an effective form of treatment of the withdrawal phase in a consecutive series of about 100 narcotic addicts. Within a period varying from four to seven days it was found possible, after a gradual and steady reduction of dosage, to discontinue both drugs altogether. Clinical observation and regular laboratory tests failed to show any harmful consequences. We did not observe any euphoria nor any evidence of development of dependence, though all these patients had shown by their previous history that they were personalities prone to drug abuse and the development of drug dependence. The average dosage used was, in the case of Lomotil, 1-2 tablets four-hourly throughout the day, in the case of chlormethiazole 2-4 tablets (0·5 g) four-hourly on average, the amount required to achieve deep sedation.

While the observation period is too short and the number of patients treated too small to draw far-reaching conclusions, our findings seem to warrant further trials with the combination of Lomotil and a potent non-barbiturate tranquillizer in the treatment of the narcotic withdrawal phase, in particular, as the usual regimen employed consists in the substitution of heroin by another powerful addictive drug, for instance, methadone. We are now studying the use of Lomotil for the purpose of mitigating narcotic withdrawal symptoms in outpatients whose narcotic drug amount is gradually being reduced, but it is too early to say anything more about this.

OUR EXPERT replies: Dr. Glatt's comments are interesting and valuable. They confirm that though diphenoxylate is an addiction-producing drug, the preparation Lomotil in the usual therapeutic dosage does not give rise to addiction, which was the question originally posed. I am sure his observations on the use of Lomotil in the treatment of addiction to narcotics will be of interest to those working in this field.

1 W.H.O. Expert Committee on Addiction-producing Drugs, 11th report. World Health Organization Technical Report Series, 1961, No. 211, pp. 5, 6.
2 Varenne, G., *L'Abus des Drogues*, Brussels, Dessart, 1971.
3 Fraser, H. F., and Isbell, H., *Bulletin on Narcotics*, 1961, **13**, No. 1, 29.
4 Goodman, A. L., *Southern Medical Journal*, 1968, **61**, 313.
5 Glatt, M. M., Lewis, D. M., and Wilson, D. T., *British Journal of Addiction*, 1970, **65**, 237.

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