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Pointers

New Approaches to Psychiatry: Dr. William Sargant in his Watson Smith lecture makes a plea for integration of psychiatry and medicine in a mechanistic approach to treatment (p. 257). Dr. D. M. Shaw discusses some of the alterations in cellular mineral metabolism and their possible importance in affective disorders (p. 262). Leader at p. 253.

Plasma Renin and Hypertension: Dr. J. J. Brown and his colleagues report on plasma renin concentration in relation to treatment of patients with hypertension (p. 268).

Neurogenic Bladder Dysfunction: Dr. Ejner Pedersen and Dr. Vagn Grynderup, from Denmark, review the long-term use of hydramitrazine (p. 271).

Phaeochromocytoma of the Urinary Bladder: Mr. P. McR. Higgins and Mr. G. C. Tresidder describe three cases and review seventeen other recorded cases (p. 247).

Open Reduction of Fractures: Mr. J. C. Griffiths reports four cases of nerve lesions after plating forearm bones (p. 277).

Acute Non-specific Pericarditis: Dr. Anthony Martin describes nineteen cases (p. 279). Leader at p. 254.

Pyonephrosis: Generalized peritonitis due to spontaneous intraperitoneal rupture (p. 281).

Anodontia in Mongolism: Case report (p. 282).

Fluoridation of Water: Dr. Roy Duckworth reviews the scientific evidence on its effectiveness and safety in his Current Practice article (p. 283). Leader at p. 256.

Intrauterine Transfusions: Dr. L. A. Lees describes a grid for accurate localization (p. 287).

Postgraduate Education: Discussion on Vocational Training for general practice (p. 292). Report on conference at College of General Practitioners (p. 298). Leader on this page. Work of medical centres at Canterbury and Norwich (p. 295).

Pertinax: "Without Prejudice" (p. 299).

Abortion Bill: Majority of 194 at Second Reading of Mr. David Steel's Bill (p. 311).

Disciplinary Committee of G.M.C.: Report of proceedings (*Supplement*, p. 87).

G.M.S. Committee: Report of meeting on 21 July (*Supplement*, p. 89).

Vocational Training for General Practice

Most doctors have now come to accept that some sort of vocational training is necessary before a doctor enters general practice. The emphasis has shifted from arguments about the necessity for training to questions over details. How long should vocational training last? What should it aim to do? Who should organize it? What proportion of the programme should be spent in hospital appointments, in formal courses, and in traditional apprenticeship in general practice?

Inevitably such discussions will continue for some time, as indeed they should. But three facts are apt to be overlooked. These are, first, that the call for vocational training was made almost 20 years ago, and since then the details of a suitable course have been debated at length. In 1950—two years after a B.M.A. committee[1] had recommended that postgraduate training for general practice was necessary—another special committee (also under the chairmanship of Sir Henry Cohen, now Lord Cohen of Birkenhead) outlined a scheme for vocational training.[2] Emphasizing that any scheme must be flexible, the second report recommended that three years should be spent after registration in training for general practice. The first year would be spent in training under the supervision of a general practitioner, the second in specially designed (preferably resident) hospital appointments, and the third in supplementary training as a clinical assistant in hospital or as an assistant in general practice. Though there have been some variations in detail, subsequent proposals —for example, in the Gillie Report[3] and by the College of General Practitioners[4]—have tended to follow these original suggestions, and they are reiterated in the B.M.A.'s recent Memorandum of Evidence to the Royal Commission on Medical Education.[5]

The second point that has often been ignored is that Britain is not alone in its plans for vocational training. In some countries, such as Australia and the U.S.A.,[6] these remain proposals, but in others, such as Israel, Yugoslavia, and Czechoslovakia, the schemes have been put into effect—as Dr. J. P. Horder points out at p. 292 of this week's *B.M.J.*

The third point is that, though they have concerned relatively few entrants to practice, several schemes have already been tried out in Britain itself. Of these, the trainee practitioner scheme, called by J. R. Ellis[7] "this remarkable contribution to medical education," has affected the greatest number of doctors. In response to criticisms various details of the scheme have been changed since it was introduced, particularly after the review by the G.M.S. Committee in 1963.[8] Nevertheless, it seems likely to continue, though both the College of General Practitioners[4] and the B.M.A.[5] think that the term "trainee" should be replaced by that of "registrar in general practice." Both bodies also say that during his

registrar post the doctor should receive some organized teaching, particularly in such subjects as psychological and preventive medicine, practice management and organization, and finance and medical ethics. A few of the vocational schemes in Britain—as at Canterbury[9] (whose work is described briefly by a special correspondent at p. 295 of this week's issue)—have included formal teaching; others, as at Inverness, have tried a combination of posts in hospital and general practices.

Whatever may emerge as the final pattern of training (and there may well be several different ones) it seems to be generally agreed that to make these schemes compulsory would be undesirable,[10 11] or "unrealistic," in Dr. Horder's words. Instead, the incentives are envisaged to be enthusiasm, membership of the College of General Practitioners, and the special payments recently proposed in the Seventh Report of the Review Body. Yet even if half of all the new entrants to general practice every year were to receive vocational training many new posts would have to be created both in hospitals and in general practices undertaking training. Authorities who wished for practical guidance about setting up training programmes might also find their task difficult—for, whereas much has been written about the proposals in theory, relatively little has appeared about their actual working. Thus the final report of the Wessex scheme, which has recently appeared,[12] is particularly welcome and valuable.

The Wessex "Experiment in Training for General Practice" was started in 1959, and was sponsored by the University of London together with a grant from the Nuffield Provincial Hospitals Trust. The trainees (or "Nuffield Practitioners") spent the first half of the two-year programme in hospital appointments and the second in selected training practices. Winchester, Southampton, and Portsmouth were chosen for the experiment, and an interim report was published in 1962.[13] Those organizing the scheme thought that a resident course in obstetrics for six months was essential; otherwise the appointments in the rest of the hospital year were arranged to suit the wishes of the individual practitioner—psychiatry, paediatrics, and anaesthetics being especially popular. The pattern of the general practice year varied according to the trainer, some allowing the Nuffield Practitioners considerably more responsibility at an early stage than others. In all cases, however, the practitioners were fully sharing the work in the later months. Besides visits to a variety of other practices—ranging from a rural practice to an academic department of general practice—the Nuffield Practitioners were also introduced to industrial medical and community health services and to the workings of executive councils and local medical committees.

The report says that the quality of the applicants for these posts was always high. With two exceptions, all the 15 practitioners completed the course; of these, eight are full partners in general practice, two are principals, one is an assistant with a view to partnership, one is working temporarily in Australia, and one is a medical registrar in a regional hospital. Both the practitioners and their trainers have summarized their experiences in appendices to the interim and final reports. All of the Nuffield Practitioners obviously enjoyed their training period, though they differed widely about the optimum length of each post and the content of the hospital year. Several pointed out the value of outpatient clinics for covering a wide field, since "these allowed [the] consultant to teach, practical procedures could be carried out, routine was avoided and continuity ensured by attending some sessions weekly." More than one practitioner thought that there should be more hospital appointments (pre-registration, post-registration, or both), but that they should be shorter. One suggested programme comprised four-month pre-registration posts in medicine, surgery, and paediatrics; then three-month post-registration posts in otolaryngology, orthopaedics, ophthalmology combined with dermatology, and in psychiatry; and finally six months' obstetrics.

The commentaries from the trainers were similarly enthusiastic about the Wessex scheme, and the report concludes that the experiment has "amply supported" the importance of vocational training for general practice. It also points out that even at the end of the two-year period most Nuffield Practitioners would have liked further experience in some subjects. This, it suggests, could be provided by part-time, in-service training while the doctors were acting as full assistants or young principals in general practice. In this way such training would form a link between the programmes of vocational education and continuing education, which for established general practitioners has always existed in the form of refresher courses and which is now also being provided by most of the medical centres in Britain.[14–16]

Several problems will have to be solved before schemes for vocational training can be introduced on a large scale, some of which were discussed at a recent conference at the College of General Practitioners (see p. 298 of this week's issue). Paramount among these at present is the question of incentives at a time when Britain is critically short of general practitioners. There is also the difficulty of selecting and training the trainers. The report on the Wessex scheme suggests that usually younger doctors should be invited to become trainers, and that they should attend special courses in teaching methods. Yet another problem is to devise suitable hospital appointments for the trainees, which at once give the right mixture of clinical experience, responsibility, and time for study.

All contributors to the subject of vocational training have emphasized the need for flexibility, and this, together with experiments with a variety of schemes, is probably the most important factor in working out their content in the future. Whatever the final pattern of training for general practice, the Wessex report will remain a valuable record of an exciting effort, which should be read by all those concerned with postgraduate education.

1 *The Training of a Doctor*, 1948. B.M.A., London.
2 *General Practice and the Training of the General Practitioner*, 1950. B.M.A., London.
3 *The Field of Work of the Family Doctor*, 1963. H.M.S.O., London.
4 *Special Vocational Training for General Practice*, 1965. College of General Practitioners, London.
5 *Medical Education: Memorandum of Evidence to the Royal Commission on Medical Education*, 1966. B.M.A., London. See *Brit. med. J.*, 1966, **2**, 125.
6 *Lancet*, 1963, **2**, 231.
7 Ellis, J. R., *Brit. med. J.*, 1965, **1**, 1571.
8 *Brit. med. J. Suppl.*, 1963, **1**, 139.
9 Horder, J. P., *Postgrad. med. J.*, 1966, **42**, 103.
10 Cameron, J. C., *Brit. med. J. Suppl.*, 1966, **2**, 72.
11 Happel, J., ibid., 1963, **2**, 54.
12 *Final Report on an Experiment in Training for General Practice*, 1966. British Postgraduate Medical Federation, London.
13 *Interim Report on an Experiment in Training for General Practice*, 1962. British Postgraduate Medical Federation, London.
14 *Brit. med. J.*, 1966, **2**, 45.
15 Ibid., 1966, **2**, 103.
16 Ibid., 1966, **2**, 167.