Training for General Practice

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This article is a description of work in progress and a request for help. It is not possible to train doctors for general practice without the help of Fellows and Members of this College, even though the main burden of organisation and teaching rightly and inevitably lies on general practitioners themselves. Early postgraduate training is the issue. Undergraduate education, very much the concern of this College, no longer prepares doctors for any particular branch of medicine. Suffice to say that 40 per cent of students are needed each year to staff the general medical services and it is therefore vital that they should see something of medicine in the community, including general practice. It is also vital that attitudes in teaching hospitals should not be biased against general practice as a career. This has sometimes been so in the past (Fox, 1960).

The scheme of medical care in this country depends on a balance of generalists working mainly in the community and specialists working mainly in hospital, linked by referral and good relationships. Following the General Medical Council’s (1967) and Royal Commission’s (1968) reports, this pattern seems likely to continue in the foreseeable future. The only change in the personal doctor service that is actually being tried (in Birmingham and Woolwich) is a division into separate doctors for children and adults. The development of larger group practices could open the door to specialisation at the level of primary care, with direct access by the patient to a specialist. Most of us feel this would be a retrograde step; in this connexion contemporary American experience is relevant and interesting (American Medical Association, 1966a, b).

The work, organisation, and training of the general practitioner has been the subject of many reports since 1948. The most critical ones have been the most valuable. Both the Royal College of General Practitioners and the General Medical Services Committee have acted on these reports. Were general practice as fragmented, unorganised, unprepared and of as low morale in the face of specialisation as it was twenty years ago, it would by now be disappearing, as it has largely disappeared in the United States. If the general and personal doctor is to survive and flourish, both organisation and training are vital.
There are three main reasons why a general practitioner must be specially trained for his work. The most important is purely educational. He needs a particular combination of knowledge, skills and attitudes. Although his area overlaps those of many specialists, the combination is unique. For example, he has to be a primary diagnostician across the whole field of medicine, he needs a broad understanding of human development, behaviour, and relationships, and he requires skill and understanding in organisation (of himself, of his group practice, or of the whole domiciliary team in a health centre).

This combination of knowledge and skills could not have been provided solely in the undergraduate period, even when the aim of undergraduate medical education was to turn out a safe doctor by the time of registration. Now that the aim for the undergraduate period is changing, early postgraduate preparation for general practice is inevitable.

The other reasons for special training are recruitment and morale. If medical students and young doctors see that general practice requires less training than other branches and attracts lower remuneration over a lifetime but demands equally hard work and increasing responsibility, is it surprising that for most it is a second or third choice? Meanwhile, for those who have chosen general practice, there is usually a period of disillusionment when they find that they cannot use parts of their hospital training and that they are up against a large number of problems (chiefly psychological and social) for which the training given was little or no help.

These are the reasons why early postgraduate (vocational) training for general practice is needed. Some part in the undergraduate curriculum is also needed (and in most medical schools is now provided). The aim at the undergraduate stage is, of course, not a training in general practice, but a view of the way in which most of the population receive their medical care most of the time.

The Royal College of General Practitioners believes that a five-year period of training after registration is needed. This is the objective in the longer term. For the present, three years must be accepted as a first stage that is within reach of attainment, a term now agreed by all the official organisations concerned. It means training while working, earning, and taking increasing responsibility under supervision—not very different from what many young doctors take already on their own initiative (Mechanic, 1968).

The preferred pattern is two years in hospital posts, after registration, and one year in at least one training practice. These proportions may later need to be reversed. Hospital posts that are relevant are in general medicine, paediatrics, psychiatry, geriatrics, casualty, obstetrics (for some), gynaecology, dermatology, eyes, ear, nose and throat work, and rheumatology. These
subjects are listed here in their order of importance to the general practitioner. A referendum to the whole membership of the Royal College of General Practitioners (1964) produced a remarkable consensus of opinion.

The annual entry of general practitioners in England, Wales, Scotland, and Northern Ireland is approximately 1,000. The objective is therefore a three-year postgraduate training for 1,000 doctors, partly in hospital posts, partly in teaching practices, partly on courses. If this objective were near attainment, there would be no need for this article.

The Present Position

Many doctors entering general practice have been organising their own training for one to six years after registration, chiefly in hospital posts. Not all of this training will have been relevant, because it may have been aimed at a first choice of some other branch, later abandoned. About a quarter of the annual entry is now availing itself of part or all of the training schemes. There are at present 170 trainees in the Trainee Practitioner Scheme (one year in a selected practice). Only about one in twenty of new entrants is taking part in a three-year scheme. On the other hand, very few enter immediately after registration.

Experimental schemes involving a formal sequence of hospital posts, training practices, and two-year courses started in Inverness in 1952. The Wessex scheme, from 1960 onwards, was the first three-year scheme. There are now 40 cities or towns with formal two- or three-year schemes, and new schemes are appearing almost every month in some part of the country. Not all the places on three-year schemes are filled.

The number of doctors entering general practice has decreased each year since 1962, failing to keep pace with the recent increase in population. Lists have therefore been increasing in size. This trend was reversed in 1969, and there was an increase in that year of 700 principals in England and Wales alone. If this new trend is continued, it will be highly significant for the subject of this article, even though a proportion of the new doctors are not indigenous.

The training content of three-year schemes has recently been set out in a brief summary (Royal College of General Practitioners, 1969) which is now being developed in detail. Clinical medicine in the setting of general practice is, of course, by far the most important item, stress being laid on the range of the normal, the natural history of diseases, prevention, early diagnosis, diagnostic and therapeutic methods. Another familiar area is practice organisation, which now includes the whole domiciliary health team. Less familiar but increasingly important are the other three main areas, human development, human behaviour, society and medicine. In these we shall
draw heavily on the behavioural sciences and need the help of their university departments to teach our own teachers; such help is forthcoming.

We need 1,000 to 1,500 general practitioners keen to teach, worthy to be selected, able to give time and willing to be trained as teachers. There are 23,000 general practitioners in all. Fortunately, the full quota of teachers is not needed immediately. At the present time there are more doctors wanting to teach than trainees to be taught, for reasons to be discussed later in this article. Courses for teachers have been available and filled in the last four years.

Are there enough junior hospital posts? This has been studied by the Central Committee for Postgraduate Medical Education and the answer is not fully known. It looks as if the existing posts are enough, except in general medicine. In psychiatry there is a need for specially designed appointments.

Clearly the training of general practitioners after registration is a very big task, much of which is new and unfamiliar. Relatively few general practitioners have the experience or time to organise so big a venture. The solution is being sought through the appointment of a special subcommittee of the University Postgraduate Committee in each region. In addition, a general practitioner adviser is likely to be appointed in each region to advise the postgraduate dean and to be the executive officer of the subcommittee. This is a half-time paid appointment in existing instances.

DIFFICULTIES AND NEXT STEPS
There is too little pressure from below because too few young doctors are seeking to be trained. This reflects the relative unpopularity of general practice as a career choice in the last 14 years and the economic pressure on those who do choose this career to accept a junior partnership at a high share, without first taking proper training. Both these influences may be changing now. The very high standard of the postgraduate students on some of the three-year courses, together with the opinions expressed by some medical students, encourage this view. The economic pressure to neglect training will inevitably diminish if the increase in numbers entering general practice is maintained and if there is no increase in emigration.

There is too little pressure from above. Although vocational training for general practitioners is now becoming the accepted policy of all bodies concerned with medical education, action partly depends on the appointment of the Central Council for Postgraduate Medical Education, which has only just come into being. Regions are going ahead on their own, but there is little extra money at the regional level.

There is a particular problem concerning hospital posts. In many places where a sequence of posts has been planned in one hospital, preference is given
to a man or woman who is aiming at another specialty. The problem of ‘consultant status’ is the obstacle. If general practice is regarded as an inferior choice, it is natural that consultants will wish to see their house physician as a candidate for another specialty. Although there have been exceptions, this problem has arisen in so many places that it has to be faced.

The Help Needed

Junior Hospital Posts. It is undesirable that training for general practice should take place only in posts that are not wanted for training in other specialties. In some regions certain posts may have to be earmarked for the training of general practitioners; a reasonable proportion of the best ones is needed for this purpose. A few should be seen to be in teaching hospitals, but the majority are likely to be in district general hospitals where the clinical experience is usually more appropriate. In some experimental schemes the same post in general medicine is being used in alternate appointments for doctors who intend to be hospital physicians and general practitioners. This is one way of implementing the agreement between this College and the College of General Practitioners that the same junior posts in general medicine should be recommended by both.

Special Training Needs of Future General Practitioners while in Junior Hospital Posts. Although some doctors in these posts may not yet have committed themselves to a particular career, a number will have done so. Service needs will largely determine the clinical experience they get. From the training point of view, the more they deal with the commoner disorders, the better. The more the ‘before and after’ of the patient admitted to hospital is emphasised, the better. To accompany the chief on domiciliary visits may be difficult, but is valuable training. Discussion of referrals, particularly comment on good and bad referral letters from general practitioners, is valuable. A special effort to involve local practitioners in ward or outpatient discussion of their own patient is helpful. In teaching, special emphasis might be put on the natural history of diseases, early diagnosis, and prevention. Could this patient have been managed at home? What after care is needed? The influence of social and psychological factors in the causation of diseases and even on the outcome of hospital admission (Querido, 1959) is of great importance. The young doctor may have much to learn from the example of his chief in the assessment and management of anxiety and depression as accompaniments to any illness. But it is, of course, the concentrated clinical experience with relatively sick people that remains the chief contribution of junior hospital posts to the training of generalists.

Support. If general practitioners are to succeed in raising their level of
training they need all the help they can get. They already have many reasons to be grateful to colleagues in other branches for help in continuing education and in experimental schemes of vocational training. They intend to carry the main load of vocational training themselves. But they need from doctors working mainly in hospitals even greater interest and involvement in the problems of medicine in the community—Sir Geoffrey Vickers’s ‘World of the Well’. Their relationship with specialists should be one of different roles on the same level, each dependent on the other. Acceptance of this aim is needed while raising the standard of training, organisation and clinical work.

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Department of no Progress
‘The analogies between the mental and physical development of an individual and of a nation or society have been often set forth and commented on; but there is one point where the analogy fails as regards the products of mental activity, and that is, that as yet to have devised no process for getting rid of the exuviae. Growth and development in the physical world imply the changes of death as well as of life—that with the increase of the living tissues there shall also be the excretion and destruction of dead, outgrown, and useless matters which have had their day and served their purpose. But litera scripta manet. There is a vast amount of this effete and worthless material in the literature of medicine and it is increasing rapidly . . . for the most part with material which has been characterised as superlatively middling, the quintessential extract of mediocrity.’

These words were written in 1881 by John Billings who two years prior to this had started the Index Medicus. If he viewed the output of medical literature in his time with such distaste, what would he make of today’s production, and would he have been able to stem or purify the ever-rising tide?