THE FIRST G P TERM

a curriculum for the first three months which the intending practitioner spends in general practice

by

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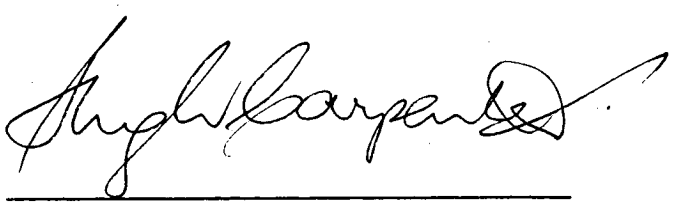
THIS IS TO CERTIFY THAT

the dissertation contains no material which has been accepted for the award of any other higher degree or graduate diploma in any tertiary institution and that, to the best of my knowledge and belief, the dissertation contains no material previously published or written by another person, except when due reference is made in the text of the dissertation



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ABSTRACT

"THE FIRST G P TERM", a curriculum for the first three months which the intending practitioner spends in general practice, addresses three questions: why is there a need for such a curriculum; how should it be constituted, and how should it be presented ?

The need for this curriculum is explored in terms of the background education with which medical graduates approach general practice. Medical science learned in Universities and Teaching Hospitals requires adaptation and additional competencies have to be acquired if the doctor is to become a general practitioner. In this process, the first three months in general practice is critical. Patterns of effective practice need to be established at the outset, patterns which will last a lifetime with continuing refinement. Among the comparatively modest literature about education for general practice, I have been unable to find a comprehensive curriculum for this significant transition from hospital to domiciliary practice, the first G P term.

The body of the curriculum addresses the other two questions; how and what to learn ? Throughout, I have drawn on my own experience of over twenty years in general practice education as scholar, tutor, and administrator. Three considerations are common to the whole dissertation: what is the present state of affairs; what alternatives are feasible; and why do I prefer my particular choice ?

The curriculum is presented in nine sections. These are:

the 'school' of Teaching Practices;

Scholars and their scholarship;

Tutors and teaching;

Management and co-ordination of the curriculum;

the syllabus;

evaluation of expectations, progress and outcomes;

continuing medical education;

an overview of these components;

a summary of recommendations.

In each of the first seven sections as listed here, a pattern is followed; namely, what selection is made (of Teaching Practices, Scholars, Tutors, Managers, syllabus, methods of evaluation and continuing education), on what basis, and how might this be improved; what expectations are involved and to what extent are these met ? Consideration of the most cost-effective alternative is a recurring theme.

Ways of learning, particularly the implementation of self-directed contract learning, are central to the dissertation. The selection of the most appropriate syllabus is studied, to facilitate the transition from hospital to general practice, avoiding the already known and the irrelevant. Evaluation is built in to every aspect of the curriculum, along the lines of illuminative evaluation (Parlett & Hamilton, 1972)[1].

The central features of the curriculum, together with recommendations for change, are drawn together in conclusion. Appended to the dissertation are documents in current use during the first G P term.

ACKNOWLEDGEMENTS

This dissertation incorporates my studies and experiences in two fields; medicine and education. Many professionals in both fields have contributed generously to my learning. Foremost in medical education, I have gained from a long association with Dr Wesley Fabb A M, Director and Director of Education of the Royal Australian College of General Practitioners' Family Medicine Programme (vocational education for general practice) since its inception in 1973. His influence in this dissertation is significant, particularly his views on pattern recognition in problem solving, which I have come to share. So, too, have I gained much from Dr Dennis Levet, my colleague in Tasmania, especially in the area of syllabus.

My views on evaluation have been shaped by tutorials from two principal sources: Professor Phillip Hughes during the year of studies into "Teachers as Evaluators" (University of Tasmania, 1986) and Dr Peter Fleming, Director of Educational Research, R A C G P Family Medicine Programme.

Professor Hughes, Dr Fleming and Dr Bevis Yaxley, Dean, Centre for Education, University of Tasmania, have widened my concept of a curriculum beyond a timetable. The themes of Curriculum Foundations (University of Tasmania, 1985), Curriculum Design and Development (University of Tasmania, 1987) and the Philosophy of the Family Medicine Programme are prominent in this dissertation.

Whilst emphasising my debt of gratitude to these tutors, they are not directly responsible for any part of this dissertation. The views expressed are based upon my experience, the recommendations are my own.

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INTRODUCTION

This dissertation has been written in China. The challenge has been formidable. Despite careful planning before leaving Australia in October, 1987, I have needed to refer to books and colleagues from time to time a continent away. Often I have had a text or a quotation in mind without reasonable access to the original. So I have remembered what I can, which has enabled me to complete the dissertation. Only the bibliography is less complete that I would have liked. Two days with Dr Helen Simons, Director of Curriculum Studies at the Institute of Education, University of London, in April, 1988, and four days at the University of Tasmania in October, 1988, including meetings with Professor Phillip Hughes and Dr Bevis Yaxley, have been invaluable opportunities for strengthening the factual foundation of the dissertation.

This study of a curriculum for the first G P term is based on my experiences, reading, recollections and deductions as a general practitioner since 1965. Between 1965 and 1970 I considered myself to be a student in my chosen career. In 1972 I became the principal of the partnership in which I had worked since 1969; was appointed preceptor to the University of New South Wales; and took my first medical student for his elective term. In 1978, in country practice in Tasmania, I became a tutor in the R A C G P Family Medicine Programme. Twelve medical graduates were appointed to my practice for their first G P terms during the next four years. In 1984 I became Director of the Family Medicine Programme in Tasmania; a position I held for nearly four years until my appointment as Medical Officer to the Australian Embassy, Beijing.

Having been appointed Director of Medical Education and having medical but no educational professionalism, I enrolled as a student of educational studies in the Centre for Education, University of Tasmania, in 1985. The balance of

data for this dissertation comes from tutorial notes, coursework and conversations with teachers involved in Curriculum Foundations, 1985; Teachers as Evaluators, 1986; and Curriculum Design and Development, 1987.

A synopsis of the dissertation was prepared in March, 1988 and submitted by Diplomatic Bag to my tutor, Professor Phillip Hughes for comment. Subsequently each section was written at monthly intervals, sent by Bag, and returned by Professor Hughes with most helpful suggestions for improvement. I have passed many hours in a sunny corner of our Beijing apartment typing and re-typing draft after draft. It has taken a little longer than the normal human gestation. My forbearing wife and children join my relief in presenting this, the final draft.

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TERMINOLOGY

Postgraduate medical practitioners preparing for general practice are referred to as 'scholars'. Their supervisors are called 'tutors'. Teaching and 'Teaching Practice' are universal terms, used here in the broad sense of facilitating. This includes, but is not restricted to, telling. Personal pronouns refer equally to either sex.

Commonly, scholars are called 'trainees', from which terms like 'trainer' and 'training adviser' are derived. The concept of trainers training trainees is misleading. We are not only concerned with extending capacity in a training programme, but also with the scholar's developing knowledge, understanding and attitudes. So training is an inadequate description of vocational education for general practice. The word and its derivatives have been avoided.

THE NEED FOR A CURRICULUM FOR THE FIRST G P TERM

Given that every general practitioner deals with the whole spectrum of medical and health concerns of his patients, and within the limited span of a consultation, it is fair to describe general practice as the most challenging medical career. Yet medical students, some half of whom become general practitioners, are taught mainly in colleges and hospitals on horizontal, undressed, captive patients.

This is a far cry from the vertical, dressed, autonomous patients of the general practitioner (Metcalf, D, 1986)[2].

In the controlled conditions of teaching hospitals, medical students learn medical science in a 'greenhouse'. A large American survey (Wilkerson, 1967)[3] showed that of 1,000 'medical' incidents, 500 are reported to someone else. Of these 500, 250 see their general practitioners; 50 are seen in hospital; of these only 1 reaches a University Teaching Hospital. From this 0.1% of disease and disability is most medical schooling derived; a very unrepresentative sample.

The certainty and narrow base of teaching hospital practice is quite unlike the uncertainty and broad base of general practice. In hospitals, patients depend on the staff. In general practice, once the consultation is over, patients are in control of their own affairs. Compliance with prescribed treatment depends upon the extent to which the doctor has understood the patient, and made himself understood to the patient and the patient's carers (Metcalf, 1986).

Thus, postgraduate vocational education for general practice is essential. In Australia it is voluntary and has tended to be an apprenticeship. Those patients who come to the teaching practice tend to determine the curriculum.

Freshly acquired and recently confirmed proficiency in medical science has to be applied to general practice. Medical science fits most comfortably into hospital practice where it was learned. Because of the essential differences between hospital and general practice, the transition is a critical period in the doctor's career. This period is the first G P term. The curriculum arises from the differences between hospital and general practice. The scholar has to be introduced to the domiciliary environment in such a way that he develops patterns of effective practice, which will

lead toward proficiency with continuing refinement over a lifetime. These patterns and the means to achieve them form the substance of this dissertation. Many of the issues which arise during the first term are generally applicable. Matters of importance later, like practice management and partnership affairs, are not in the scholar's agenda for the first term. They will be omitted from the dissertation.

CURRICULUM OVERVIEW AND ISSUES

The School of general practice presents unusual challenges. It is composed of dozens of individual Teaching Practices with one-to-one teaching. At the same time, Teaching Practices have to remain solvent by serving their patients. The service role is essential in providing work experience for the scholar. But it can crowd out teaching.

Scholars and scholarship are just as diverse as are the Teaching Practices which make up the school. It is a major curriculum task to match the personalities, abilities and career intentions of individual scholars with tutors and educational opportunities. Metropolitan, suburban, country town and isolated rural practice have their own emphases, to be used appropriately according to the scholar's choice.

Tutors and teaching are marked by a generally low level of educational professionalism. This may be compounded by the competing demands of teaching and service roles. Both tutors and teaching practices are in short supply. It can be necessary to accept all comers if there are to be enough first terms. This is a desperate situation.

Administration presents formidable problems. The difficulties are compounded by financial constraints and the voluntary nature of postgraduate education for general practice in Australia. This has not been resolved by the

recent government enquiry into Medical Education and the Medical Workforce (Doherty, 1988)[4].

The syllabus needs to concentrate on the adaptation of medical science to the circumstances of general practice, which have become unfamiliar to medical graduates. Recollections of home life before medical school have to be revitalised. Skills and attitudes which predominate in general practice but not in hospital practice, have to be emphasised. These include:

- the social and occupational focus of disability (the predominant feature of a farmer's fractured wrist may be the cows he should be milking, not the wrist);
- compliance with prescribed treatment (not a problem in hospitals; only 25% of a G P's prescriptions may find their way to a pharmacy);
- communication and counselling skills;
- the doctor's role in effective and efficient community health care teamwork;
- availability versus professional imprisonment.

Evaluation of the first G P term should be built in to every part of the curriculum: from assessment of the expectations and selection of scholars and tutors; the influences on progress and the changes that ensue; to the outcomes. We are evaluating a dynamic process in which the evaluation is both dynamic and influential. Comparisons will be made between different approaches, including their cost-effectiveness. Methods of reviewing consulting performance will be explored. Being confidential, consultations present particular problems if they are to be judged independently.

Continuing medical education becomes the acid test of successful completion of the first G P term. For the scholar who is developing patterns of effective general practice and who has acquired the habit of continuing refinement, the

future career is assured. Without continuing medical education the doctor cannot keep abreast of developments in a rapidly changing field and will quickly become professionally incompetent.

SCHOOL AND CURRICULUM

On the one hand, we have a collection of unique Teaching Practices. On the other hand, are there issues which affect the whole 'school' ? Is it sufficient for scholars to be well placed with compatible tutors, in appropriate locations, to get on with the job ? I am convinced that curriculum theory and practice need to be everyone's concern if standards are to be uniformly high. The range of problems with which any one scholar will be confronted during one term in one Teaching Practice, can never amount to a comprehensive curriculum. Tutors need teacher training. Administrators need to know what is actually happening, and to steer the curriculum on a course which satisfies the reasonable demands of scholars, tutors, patients and paymasters.

"The curriculum is <u>what happens</u> as a result of someone's intentions" (Hughes, 1987); "the curriculum is not the intention or prescription but <u>what happens</u> in real situations. It is not the aspiration but the achievement" (Stenhouse, 1975)[5,6]. (my underlining). Common to both definitions is 'what happens'. If this is to be known and to be consistent, all parties must take an active part in negotiating the curriculum. The whole 'school' must be involved. Only then can Hughes and Stenhouse be reconciled: what actually happens, the achievement, will correspond with the aspirations of those who intended a comprehensive curriculum, the prescription.

In an unstructured apprenticeship model, scholars tend to see casual callers on the practice. As a result, one essential feature of general practice is not experienced; namely, on-going care for an extended period. Patchy supervision, based largely on the scholar's calls for help, may place patients at risk. The inexperienced scholar may not appreciate the need for assistance from the tutor, due to mis-placed confidence or reluctance to interrupt.

Furthermore, as will become apparent later, it is often unwise for the scholar to copy the tutor, as apprentices copy their masters.

Without specified intentions, the curriculum is without substantial foundation. The intention of 'seeing patients' is insufficient. This is compounded when the tutor sees in the scholar an opportunity for cheap locum relief. Even when this sentiment is mitigated by the intention to do some teaching along the way as opportunities present and the demands of work permit, the result is a pale reflection of proper preparation for general practice. Yet this approach prevails.

If the tutor's approach to patients was this informal, the results could be disasterous. There are close parallels between good medical practice and good teaching practice. The parallels will be helpful in addressing curriculum issues; they will be readily understood by doctors and teachers alike. The purpose of medical practice is the better health of patients. The purpose of medical education is to enable the scholar to participate fully in the patient's achievement of better health. The purpose of the school of general practice is to bring scholar and tutor together to share a dynamic understanding of the doctor's skills in accomplishing his part in the health equation. Scholars need to refine their learning skills; tutors, teaching skills.

The locality of the practice colours its work. City practices tend towards occupational disorders and the ills of poverty, drug addictions and homelessness. Suburban practices predominate in the care of the very young and the elderly; they deal with the stresses of high-density high-rise living: anxiety and depression, malnutrition, indifferent hygiene and loneliness.

Country towns retain the broadest front of medical challenges. They enjoy the advantages of extended families and community spirit to support patients in need. Emergency medicine features prominently in isolated rural practices. Conditions which are easy to manage with sophisticated facilities to hand may test the isolated doctor's ingenuity. Harsh weather and economic stresses affect health, adding to the isolated doctor's load. The consequences of illness and injury may tax the patient's and doctor's resourcefulness.

These four distinct 'classrooms' in the school of general practice have to be matched with the scholar's career intentions. Opportunities for experience are specific to each locality. If the scholar's intentions are clear before the first term an appropriate placement can be made. If not as is often the case, then the broader the experience offered, the better. From this, the scholar's preferences will evolve. Country town practice gives the best general introduction. More specific experience can be gained later.

REQUIREMENTS OF A TEACHING PRACTICE

The basic constituents of a Teaching Practice are personnel, facilities, and programme. The personnel include those on-site (scholar, tutor, patients, reception and nursing staff, medical and ancillary staff in the building) and off-site (specialists, physio-, speech-, occupational-therapists,

domiciliary-, child- and school-nurses, pharmacists, podiatrists, fire, police and ambulance officers, home helps, etc) The list is presented in detail to emphasise the extent of the health care team with which the scholar needs to have professional relationships. Their place as 'staff members' of the school of general practice is seriously undervalued, to the detriment of doctors and patients. An important part of the first term curriculum is to establish the doctor's place in the health care team, with the emphasis on effective, efficient teamwork (Younger & Carpenter, 1986; Carpenter, 1987)[7,8].

The principal facility offered by a Teaching Practice is a carefully selected work load. There is no precise amount of work that is right. Given the uncertainty of general practice, the unpredictable incidence of disease and disability, the work load varies day to day and season to season. Interestingly the fluctuations are not entirely unpredictable. Analysis of appointments shows a pattern of demands, specific to the practice. Emergencies, home visits, brief, standard and long consultations, peak periods and slack times do occur rhythmically. Appointments can be planned realistically (North, 1977)[9].

The scholar's work must be planned within limits. Less than 50 patients a week provides too little experience and leads to boredom. More than 100 patients a week leaves too little time for reflection by scholar and tutor together and robs scholarship.

The scholar needs a well-equipped surgery of his own. Moving from room to room as partners vacate their offices to do sessions in branch surgeries or go on leave is unfair and unsettling for the scholar. He needs a place to learn to use a range of diagnostic and minor surgical instruments, a microscope, a modest laboratory and a library. Videotaping is the best way to assess consulting performance (see 'Evaluation' later) and surgeries should have cameras,

recorders and screens placed visibly but not obtrusively. The scholar will need to be encouraged to use all the facilities. Too often, if they are provided, the scholar will be left to help himself without appreciating the full significance of the different opportunities available.

The programme is most important. This must include a balance between consulting time, study time, assessment time and private time. The tendency is for too much time to be spent consulting, which earns money for the practice, and too little time in study and assesment, in which there is much less interest generally. The lack of inclination to reflect is a common deficiency which I will address below. Scholars are usually rostered for night and weekend duty to the same extent as their tutors, who will have to provide additional cover for the inexperienced scholar. For the scholar to be given the lion's share of out-of-hours work is happily unusual now. It used to be more common and resulted in jaded, dissatisfied and over-burdened scholars.

THE SELECTION OF TEACHING PRACTICES

It is relatively simple to document the facilities provided in a teaching practice (appendix [1].) Existing and intending practices can be assessed by inventory. Assessment of teaching skills and the commitment of staff to teaching and teacher training is far harder. It is natural to assess those things which are easiest to evaluate. If this covers the essentials and the limitations are publicised, no harm may result. But if, as is commonly the case, easy substitutions are made for critical features which are hard to assess, the results may be seriously misleading.

This is the case in the selection of Teaching Practices. The essentials concern the teaching. But selection is made on the basis of the demand by scholars for placement, surgery space, patient load, clinical records and resources.

These are important peripheral issues. They should not be central to the selection process.

Teaching Practices are selected by the Administration through public advertisement and by personal invitation. Applicants tend to be of two kinds: those with a desire to teach and those with surplus patients but insufficient to support an additional partner. Ideal practices are in both categories. Otherwise there is a risk that the first will have insufficient patients and the second will not teach.

Only token payments are made for teaching, so there is little financial incentive. A government subsidy barely covers the difference between the value of the scholar's consultations to the practice and his salary from it. If the scholar sees patients who could be accommodated by partners of the practice, then a scholar costs money.

Applicants are screened by members of the parent body, the Royal Australian College of General Practitioners; trustees of the $10,000,000 annual government salary subsidy and establishment grant. Those who accredit are volunteer College members in each State. Some have never been tutors. It is inappropriate for those without teaching experience to be involved in selecting teaching practices. For even though it is easy to check a practice against a list of requirements, the assessment of teaching potential matters most. This taxes the judgement of experienced tutors and is beyond the capacity of the inexperienced.

Against a background of scholars' known needs for city, suburban and country practices (the demands of isolated practice are too great for first G P terms, but being the hardest to fill, scholars may find their way to them at great risk to themselves and their patients), selection should be carried out by senior tutors and medical educators. More intensive enquiry is needed to identify potential Teaching Practices. Advertisements may pass unnoticed.

Without comprehensive area surveys, opportunities will be missed. Doctors who generate useful discussions at meetings and who express themselves well may be educated to become good tutors. Skilled teachers may be known to medical schools as preceptors. Doctors with surplus patients are the easiest to recruit; they may not be effective tutors.

Checking practice facilities should lead to provisional accreditation. No assumptions about teaching can be inferred without additional evidence. Indications may be gained from a questionnaire about attitudes to teaching and past teaching experience. It is valuable for a senior tutor to discuss teaching with the applicant. Too often, interviews concentrate on practice facilities.

In the event, favourable impressions have to be put to the test after provisional accreditation. The first time a Teaching Practice takes a scholar is always a gamble. Ideally the first scholar should be doing a second or third term, not his first. The uncertainty is acceptable providing it is recognised. However if a second, third, even a fourth placement is made before anyone tumbles to the fact that the practice is a teaching disaster (despite having all the prescribed hardware), a succession of scholars will have been needlessly disadvantaged.

A careful assessment of teaching performance is essential during the first placement. Assessment of scholar and tutor working together should be reviewed as well as the outcomes. The means will be dealt with later in this dissertation. The sooner deficiencies are recognised and remedied, the sooner can an unsatisfactory teaching practice be improved or withdrawn.

FINANCES

I have mentioned that becoming a Teaching Practice can cost

money. This raises a matter of principle. Some feel that this results in only the dedicated taking scholars. Others see it as an affront. I hold the view that teaching should be rewarded financially. If so, who pays ? Nearly all the annual grant goes towards scholars' salary subsidies and lean programme administration and educational resources. There is no likelihood of the substantially larger grant which would be necessary to cover teaching fees. In a voluntary system it is unlikely that users (scholars) would be prepared to pay. Many more than the half who currently enter general practice without postgraduate education would opt out of the system.

There is an established precedent. In every other medical field the government pays for postgraduate education, which occurs in institutions employing salaried teaching staff. In general practice clinical events attract fees; teaching does not. There can be no justification for excluding the most demanding medical discipline from paid teaching. This is not the place to argue the case for and against reimbursement of teaching events as well as clinical events. Generally the cost of postgraduate education is shared by scholar and government. Perhaps this should be true of all postgraduate medical education. Clearly the present bias against education for general practice is unreasonable. It should be mandatory like other medical education, with tutors being paid quite seperately from their clinical work.

The result of the present state of affairs is that there are too few applicant Teaching Practices, even with intensive canvassing. Selection becomes a matter of taking all comers to meet scholars' demands for first terms. This has more to do with providing employment than providing education. Reimbursement for teaching would increase the number of applicants from which to select Teaching Practices and a defined amount of teaching could be required. Exactly how much, of what kind, and about which topics, will form the balance of this dissertation.

SCHOLARS AND SCHOLARSHIP

Postgraduate education is increasingly the responsibility of the scholar as he advances in his chosen discipline. The first G P term may be the scholar's first taste of this sort of responsibility since kindergarten ! Too many have been told for too long, what to learn and how to study. Self-control of learning is not always welcomed. It may be forced upon a reluctant scholar by some mishap.

Against this background, I shall discuss the selection and expectations of scholars; how these matters can be assessed and improved; the influences which may be brought to bear upon them. Then I shall consider scholarship and the scholar's progress; ways of learning, particularly self-directed contract learning; the range of opportunities for learning both within and outside the Teaching Practice. The degree to which reasonable expectations can be met and the assessment of progress and outcomes will be addressed, the latter in outline here, to be developed later in the section on evaluation.

The scholar is central to this section of the dissertation. The tutor's role will be considered subsequently. This is no accident, since the scholar is increasingly responsible for his learning with the tutor's role supportive. For optimal learning, content and process have to be negotiated between scholar and tutor with the learning appropriate to the scholar's purposes, not the tutor's: the scholar has to own the scholarship. Negotiation, purposes and ownership are key concepts throughout this dissertation.

THE SELECTION OF GRADUATES FOR A FIRST G P TERM

Two contrasting views are held about who should have a first G P term. Some feel that G P terms should be restricted to

those with overt intentions of becoming general practitioners, and who are assessed as apt for this career. Others feel that all medical graduates, whatever branch of medicine they end up in, should be offered a G P term. I take the second view, at least in theory. I have noticed that in most fields of medicine, those who have experienced general practice have a professional advantage over those who have not. The better grasp of the complexities of life into which every disability, operation and prescription must take their place never comes amiss.

This is my view 'at least in theory'. Until there are sufficient Teaching Practices, some restriction is inevitable. Scholars decide whether or not to seek a G P term at the end of their first postgraduate or 'Intern' year. Many things influence this choice:

- scholars may intend to become general practitioners;
- they may intend to pursue another field but do some general practice first;
- the first G P term may be one quarter of a year's rotating residency in which the Resident wants some other term;
- the Resident simply wants employment in a particular hospital and the rotation with the G P term is available.

In my view, if there are not enough terms for all applicants they should be selected in descending order of these categories. Those who hold that the expensive and limited resources of teaching practices should be restricted to suitable intending general practitioners want to dissociate G P terms from rotating hospital residencies. In favour of this view is the fact that no-one benefits from a reluctant scholar. He will learn little and may disrupt the practice.

Ideally some residencies should be 'unstreamed'. If all the non-specialist rotations include a G P term the Resident's choice is unreasonably limited.

There is little evidence to support any method of selecting good doctors from 18-year-olds of reasonable intelligence. It is equally difficult to choose good general practitioners twenty years later, from recent medical graduates. There is some evidence that peer selection is more reliable; judgements by medical students and graduates about their contemporaries. So many mistaken predictions are found to have been made that self-selection is to be preferred.

Unless some clear contradiction makes a candidate unsuitable (an inability to communicate or inadequate medical science) those who seek a G P term should be accommodated as far as possible. As I will explain later, general practice is not a place to learn medical science. Unaccountably some do qualify with serious deficiencies, dangerous in general practice.

The encouragement to gain general practice experience should begin early in undergraduate schooling. It should come from all tutors, not just G P Preceptors. It should be reinforced throughout the undergraduate and Intern years. More undergraduate exposure to general practice is needed. This would modify many of the unrealistic attitudes towards patients and their problems which medical students acquire in the artificial environment of a teaching hospital, attitudes which have to be unlearned later. Currently some four weeks are spent in general practice during a six-year course.

This represents a totally inadequate exposure to the working environment in which half the graduates will take their place later. General practitioners need to be more involved in medical schooling. And specialist teachers who have experienced general practice are more likely to promote the desirability of at least one G P term for most medical graduates. Undergraduate teachers who belittle general practice have hardly ever experienced its challenges at

first hand. Happily their number and influence are declining.

EXPECTATIONS OF SCHOLARS

Students enter medicine with an enthusiasm for healing and an innate understanding of society to which they belong. Medical schooling dampens the enthusiasm with an information overload of biological bits and pieces coupled to modern medical technology. Social and sickness perspectives are distorted by the dependent environment and unrepresentative sample of problems encountered in teaching hospitals.

Thus the graduate comes to his first G P term with expectations reflecting the hospital, not the community. Many are negative. That general practice is lesser medicine lingers in the minds of some students and their teachers; that general practitioners deal with the trivial while hospitals manage major medicine. There may be an expectation of little 'real medicine', perhaps boredom, certainly professional isolation in the absence of large medical, surgical and obstetric teams; no grand rounds and guest lecturers.

These expectations are often coloured by some anxiety about the uncertainty and personal responsibilities of general practice. Scholars wonder how they will cope with such a variety of 'questions without notice'. Most fear missing something important with dire consequences. Many see the consulting room as a lonely place with only the patient for company, after the corporate activity of a teaching hospital.

The patient, not the disease, must be re-established as the focus of attention. Diseases may seem trivial; people never are. Three main factors influence expectations once the scholar is into his first G P term. Most significantly, the patients themselves are reassuring with their courage and resilience. It is an unfortunate scholar who encounters

a patient at the outset of the first term, who is overcome by disease. It may come as a surprise to learn just how much patients know about their ills and how well most cope. They require illumination and support; advice about what to do, not having things done for them. So the scholar comes to expect to co-operate with patients.

Secondly, by sharing his expectations with the scholar, the tutor influences the scholar's outlook. Scholars expect to need to know everything. Tutors know that this is not so; rather does the doctor need to help patients discover what they need to know, often learning himself at the same time. The doctor may refer the patient to an appropriate source; the doctor may find the information and pass it on; instead of needing to know everything, scholars come to realise that the need is to be able to find out what others know.

Thirdly, the expectation of professional isolation is dispelled by networking. Once the scholar accepts that the whole world is linked to the telephone on his desk, the consulting room no longer seems lonely. In fact constant interruptions may make it necessary for him to distance himself from the rest of the world by having the phone placed in the next room ! Specialist and para-medical facilities are comprehensive in all but the most remote localities; the scholar should be introduced to them early in the term and encouraged to take his place in the health care team [7,8].

Some of the scholar's expectations will relate to particular interests. He may hope to see children, to further an interest in paediatrics. If the tutor expects the same scholar to deal with the elderly in the main, conflicting expectations will lead to frustration and the tutor may doubt the scholar's application to his task. So it is important for scholar and tutor to share their expectations at the beginning of term. Usually, the scholar's reasonable expectations should be met.

What makes an expectation reasonable ? Expectations of technical feats; general surgery and anaesthetics, complicated obstetrics; have no place in general practice today. The state of the art has developed beyond that with which a general practitioner can keep abreast. Expectations of being all things to all men are equally unreasonable, in view of well established medical and health care teams. Reasonable expectations must lie within professional limits as well as lying within the limits of the scholar's ability at the time.

Expectations of professional development; of extending skills in dealing with uncertainty in diagnosis, of extending communication and counselling skills, of extending knowledge about particular groups of patients or diseases, of extending proficiency in the use of diagnostic, emergency and minor surgical procedures; these and many more are reasonable expectations. They need to be set down clearly at the start, reviewed and amended periodically. Only then can scholar and tutor be sure to address them and assess the extent to which they are being met.

LEARNING

Learning is meeting expectations. Everyone tends to learn only what they want to. So it is vital for scholar and tutor to <u>negotiate</u> a comprehensive spread of expectations to meet the scholar's <u>purposes</u>, with a programme <u>owned</u> by the scholar, not the tutor. This is the first step to drawing up a learning contract (appendix [2]), the principal instrument of learning. Precise expectations are listed in priority order down the left hand side of the page. Alongside each is written the means by which the expectation will be met, followed by the resources required. Finally methods to check the extent of achievement are devised.

The contract needs to be attainable. Many are too ambitious.

Failure is disheartening. The tutor may need to restrain an overly ambitious scholar. If the scholar's vision is too narrow it will need extending by suggestion and persuasion. The important thing is for the scholar to see beyond consulting. Without larger purposes, learning is stunted. Too often, scholars attempt too little. It may seem sufficient to complete the day's appointments without mishap. But opportunities to further pattern recognition and problem solving skills from the cumulative experience of the day will be lost without analysis and synthesis of commonalities.

This analysis and synthesis may be approached in several ways. Review of the case notes relating to both scholar's and tutor's consultations can be explored jointly at the end of the session; each may observe the other's consultations directly or through a one-way-mirror; consultations may be taped and reviewed by one or more colleagues. A diary of, say, 100 consecutive cases is a useful exercise. Age, sex, problem(s), management and prognosis are noted. Such a diary may be repeated once or twice during the term. Progress will be reflected. From the diary, significant incidents may be reported on more fully in a portfolio. These processes will be examined in detail in the section below on evaluation.

OTHER OPPORTUNITIES FOR LEARNING

Several other ways to enhance learning are available. Among these are: libraries; journals clubs; workshops; seminars; lectures; conferences; ward rounds and clinics. Together, these additional opportunities make the difference between learning which is limited by problems presenting to the practice and unlimited learning from which the scholar can select events to suit his purposes. They all require time away from consulting. Often such additional learning is excluded by the treadmill of consulting and exhaustion.

The learning contract should include additional activities necessary to fulfil the contract. This might involve a course in family planning, clinics for retarded children, field work with ambulance officers or sessions at a research institute. Having decided what extra-mural events are necessary, time must be set aside by scholar and tutor to allow the scholar to attend, as part of his working day. If they are relegated to 'spare time' they will not happen, as momentum builds up in the scholar's consulting load as the term progresses.

Libraries reflect the information overload. It is wise to confine one's reading to one regular review of developments in general practice (like the Australian Family Physician) and to cover topical issues of special interest to the reader.

Journals clubs are an efficient means of topical review. About six people meet monthly, each having prepared a synopsis of a recent article on the topic chosen by the group for the meeting. The synopses are presented in turn without interruption, each making notes on the other presentations. At the end the topic is discussed generally.

Workshops are used to enhance specific skills. About two-thirds of the way through the first term two days should be set aside to review the scholar's developing habits in consultations. Strengths are enhanced. Weaknesses can be remedied before they become entrenched. Video-taping and review of consultations may be conducted in groups of six scholars and two tutors. Essential features of the review, to minimise the threat and maximise the benefit, will be described in the section below on evaluation.

Seminars, lectures and conferences are useful means of filling gaps in knowledge. Presentation is all important. Tutors can assist in the selection of likely worthwhile lecturers, bearing in mind the scholar's agenda. Conferences tend to be expensive and require discipline on the part

or the registrant if distractions are to be avoided. Social contacts with colleagues are valuable. It will be novel for the scholar to meet experts informally. The scholar may wish to negotiate with his tutor, to attend one conference during the term.

One kind of seminar which deserves a mention is the weekly practice meeting. These are vital for every teaching practice. They have a clinical and administrative focus; they are not teaching events. But they are learning experiences, if the scholar observes at first, then takes part in discussions between partners and staff about the affairs of the practice.

Ward rounds and clinics are favoured because the scholar is on familiar territory. They tend to reinforce dependent attitudes and clinical certainty; features of horizontal, captive, undressed patients; inappropriate features in general practice. Providing the scholar recognises the different climate of hospital practice, then much can be gained from specialists in ward rounds and clinics.

Having explored the opportunities for learning both within and beyond the consulting room, we come next to the tutor's role in the scholar's achievement. Scholar and tutor will be sharing clinical and communication skills in tandem, with the scholar in front.

TUTORS AND TEACHING

The patchy influence of the present voluntary scheme is as much as can be achieved in a hostile environment. There are too few tutors and teaching practices, and they are being inadequately remunerated. But realistically, much can still be done to improve teaching, despite existing constraints. The search for tutors needs intensifying.

Four qualities are desirable:

- o good clinical standing among patients and peers;
- o good communication skills;
- o preparedness to give time to teaching;
- o perparedness to develop teaching skills.

THE SELECTION OF TUTORS

Selection should be based on all four factors: it tends to be made on the first. Little direct evidence is sought. Few tutors can provide taped consultations for assessment. This will change as today's scholars become tutors.

The tutor's communication skills can be assessed by interview. This needs to be conducted by an experienced tutor, himself a good communicator. Closed questions: "how many ?", "how much?", "do you do this, that, or the other ?": will reveal very little. "What do you think about...?", "how do you feel about...?" are much better questions. These are effective questions in both consulting and teaching.

The vexed question of commitment of time to teaching has to be confronted right at the start. The administrator has only himself to blame if a tutor is devoting too little time without having committed himself to teaching or training. It

is counter-productive to persuade a tutor to take scholars without spelling out what is involved. That this is done stems from the urgency to secure sufficient terms to meet scholars' demands. There is the feeling that prospective tutors might withdraw if they knew all that is involved beforehand. Many good clinicians who are good communicators are simply too busy to teach. This is not surprising: patients recognise these qualities too and seek out such doctors.

The problem is not insuperable if the doctor wants to teach. Every doctor has control over his work load if he chooses. This control is essential in striking a balance between unacceptable absenteeism and professional imprisonment. Time free of appointments has to be set aside for teaching. This will amount to one half-day a week; a two-day period each term for teacher training; short periods amounting to one consultation daily to address the scholar's immediate requests. The content of these teaching periods will be dealt with below. Here their necessity is emphasised. The prospective tutor has to be confronted by this commitment and must signify his agreement.

However apt, no-one has innate educational professionalism. The body of educational knowledge has to be learned just like any other body of knowledge. It is not taught in medical schools. It makes no more sense for doctors to assume to be able to teach than it would for teachers to assume to be able to heal. Yet the assumption prevails in medicine. Teaching skills need to be developed just like all other skills. Teacher training is best conducted in small groups, working with educationalists and experienced practitioner-tutors.

Given a choice between developing teaching and clinical skills, most tutors opt for clinical development. There needs to be a balance. Tutors must keep abreast of clinical developments but teaching skills must not be overlooked.

One reason for the clinical preference is obvious: medical education tends to increase earning power. Teacher training does not. And when the private practitioner leaves the consulting room he ceases to earn yet his overheads go on. Teacher training, like teaching itself, is just too costly for many promising tutors to undertake. Teaching events, like clinical events, must be remunerated.

ASSESSMENT OF SELECTION OF TUTORS

Mention has been made above of the possibility of a series of placements being made to a practice before anyone tumbles to the fact that it is a teaching disaster. The assessment of selection equates with the assessment of the tutor's performance with his first scholar. For their own guidance and to be accountable, tutors need to log their teaching programme and the time given to teaching. The tutor needs a teaching contract with the administrator and the scholar, running parallel to the scholar's learning contract. This needs to be negotiated between tutor, scholar and administrator to meet the tutor's purposes. These purposes have to be consistent with those of the scholar and the administrator, the product being owned by the tutor.

THE TUTOR'S EXPECTATIONS

Tutors expect to teach clinical medicine, as they were taught. Tutors expect scholars to see patients allocated to them and to give good service. They expect conformity with 'house rules' and availability and punctuality often exceeding their own ! These expectations are coloured by the tutor's experience as a novice general practitioner. Some of them need modifying.

General practice is not well placed for learning medical

science. And to their discomfort, tutors may know less medical science that their freshly graduated scholars. In this area tutors may be able to learn from their scholars. But because medical science is based on pathology, the study of disease processes, and practices are not pathology laboratories neither are general practitioners pathologists, medical science should be left to those with expertise and facilities to teach it. It is in the application of that science to patients and their problems in the community setting, which tutors should expect to teach.

Consulting and communication skills were hardly taught at all a generation ago. Yet these are central to the application of medical science.

If the scholar is to give good service to patients of the practice then the allocation of patients must reflect the scholar's abilities at the time, not the demands of the waiting room. At the start of his first term the scholar may be able to see only two or three patients an hour. By the end this number will have doubled. If the scholar deputises for an absent partner his load will reflect the day of the week or the month of the year, not his capacity.

Several influences come to bear upon the tutor's expectations. The resentment of some patients is a negative influence. If this comes as a surprise to the tutor it may undermine his intention to teach. With sensitivity, the introduction of a scholar to a practice can add to its prestige and patients can be supportive. If patients are taken aback to find a young stranger in place of 'my doctor', it is likely they will be disconcerted, perhaps resentful. If the scholar in introduced as a young colleague who is here to learn under careful supervision, whom the patients can help without risk to themselves, many respond positively. In selecting those to consult with the scholar, one must respect the patient's wishes.

In addition to patients, scholars themselves and practice staff, other colleagues and the financial consequences of taking a scholar will all have a bearing on the tutor's expectations. If scholar and tutor communicate well, a lively dialogue will evolve between them, pleasant and rewarding to both. The tutor will have the satisfaction of sharing his views on the nature and scope of general practice with the scholar, enlightening the latter's vision. The scholar will discover ways to pursue his interests and new interests to pursue.

Patient's comments and those from practice staff and colleagues combine to provide the tutor with a rough profile of the scholar's strengths and weaknesses, to be developed or remedied. This feedback should be encouraged, but not to fault the scholar, or because of the tutor's insecurity. All parties need to know that comprehensive accurate feedback focuses teaching and learning most appropriately. Feedback should hardly ever be used punitively.

Financial considerations cannot fail to impress the tutor. Most scholars 'pay their way'. This implies that the salary they receive from the practice is balanced by the subsidy plus the fees they earn for the practice. Most tutors find this satisfactory despite receiving nothing for teaching and seeing fewer patients because of the scholar. Less work, particularly out-of-hours, is a compensation. If the scholar is costing the practice dearly the tutor's enthusiasm is likely to cool.

Finally administrators need to influence tutors' expectations. Administrators know the risks in taking scholars and should help tutors to introduce scholars cautiously. Doctors tend to be shy about feedback in education yet they are frequently soliciting it in medicine. When a patient sees in the doctor's request for feedback an opportunity to present a fresh log of claims on his time and skill, the doctor may regret his habit of asking how things turned out.

Scholar and tutor are inevitably together, at least physically, even if they miss opportunities to talk to each other. By contrast, the administrator has to make opportunities to keep in touch with tutor and scholar. Close contact is an essential prerequisite if the administrator is to exert a beneficial influence. This theme will be developed further in the section below on management and co-ordination.

ASSESSMENT OF THE TUTOR'S EXPECTATIONS

Expectations are a mix of hopes and fears. Few people are ever asked about their expectations. Before a recent political mission to China, I enquired about the expectations. "There aren't any" was the surprising response, in view of the calibre and magnitude of the mission. It implied that the expectations had not been defined. Had I given notice of my question, the response could have been different.

It is essential to document expectations. Only then can scholar, tutor and administrator monitor the extent to which they are being met. They need to be congruent. Conflicts need to be resolved before dissatisfactions arise. This cannot happen if expectations are not shared between people.

Competent tutors may resign through unfulfilled expectations, or because of any number of extraneous reasons. If the resignation is a surprise to the administrator it suggests that communications were lacking and it may be that the tutor's expectations were insufficiently understood and addressed. As in all matters of management, an established routine pays dividends. Otherwise there is the risk that a sudden interest in expectations will suggest something is wrong. Expectations and their fulfilment should be discussed between scholar, tutor and administrator at the beginning, the middle and the end of each term. Each needs to know in advance, to prepare for the discussion.

TEACHING

In this section I am concerned with how to teach, not what to teach. What to teach will be the subject of the section below on syllabus.

A summary of principles is provided by Tyler (1949)[10].

1. What educational purposes should be sought ?
2. What educational experiences can be provided that are likely to attain these purposes ?
3. How can these experiences be effectively organised ?
4. How can we determine if these purposes are being attained ?

Tyler's summary may be developed into 'principles of procedure' in the following way (Man - A Course of Study, 1970)[11]:

1. to initiate and develop a process of question posing;
2. to teach a research methodology to discover answers and apply it to new ideas;
3. to use first-hand sources as evidence from which to develop hypotheses and draw conclusions;
4. to discuss in groups to learn to listen as well as speak;
5. to legitimise the search where definitive answers are not found;
6. to encourage reflection on experience;
7. to create a resource teacher, not an authority.

In this synopsis of teaching procedure from "Man - A Course of Study, 1970, I have modified only the language; the original describes a social science curriculum for children. The concept has been retained accurately. Without modification, it provides an apt framework for the first G.P term tutor.

Hilda Taba (1962)[12] describes the central purpose of teach-

ing being to "develop an enquiring mind and a scientific approach to problem solving" by:

- o developing interest, attitudes and aesthetic awareness;
- o observing, exploring and ordering observations;
- o developing basic concepts and logical thinking;
- o posing questions and devising experiments or investigations to answer them;
- o acquiring knowledge and learning skills;
- o communicating;
- o appreciating patterns and relationships;
- o interpreting findings critically.

Doctors reading this will recognise in Taba's prescription for teaching, the usual approach to patients and their problems. Well known principles of good practice are equally applicable to teaching. The doctor has to learn to translate consulting habits into teaching habits.

Taba goes on to outline four levels of teaching (1962)[12] :

1. training: learning skills;
2. instruction: learning and remembering knowledge;
3. initiation: familiarity with social norms and interpretation;
4. induction: understanding, relationships and judgements.

She continues: "The emphasis on (prescribed) behavioural goals borders on brain washing - someone decides what is desirable and sets out to achieve it in others". This reminds me of the master tutor who expects the apprentice scholar to 'be like me'. "There can be no educational development without teacher development. The best means of development is not by clarifying ends but by criticising practice. We do not teach people to jump higher by setting the bar higher, but by criticising present performance.

The improvement of practice depends not on prognosis but on diagnosis."

In devising a curriculum for the first G P term, it is necessary to guard against externally prescribed objectives which cannot be formulated to meet the diverse learning needs of individual scholars. Although intentions need to be described as precisely as possible in the learning contract, it should be seen as dynamic and open to continuing modification to maintain its relevance. Notwithstanding the important principle of the scholar's autonomy in the curriculum, it is necessary for specified content criteria to be met by all scholars if a comprehensive grasp of general practice is to be uniformly assured. There will quite properly be a non-negotiable core content prescribed by the administration. Learning processes and elective content should be fully negotiable.

An interesting model put forward by Stenhouse (1975)[13] sees the teacher as researcher. The curriculum is seen as a policy to be improved continuously and progressively by the study of its shortcomings and their gradual elimination. Success and failure become irrelevant. A curriculum without shortcomings has no prospect of improvement: it is insufficiently ambitious. "What we ask of a curriculum offering is not that it should be right or good but that it should be intelligent or penetrating. Its shortcomings should reflect real and important difficulties."

The teaching practice becomes a laboratory where proposals are put to the test. The origin of the proposal is not implied: it may come from scholar, tutor or administrator. The proposal is not a recommendation but a specification claiming only to be intelligent and worth testing, not 'correct'. The specification is not a package or syllabus to be covered, but an idea to be tested and redefined. It is a dynamic approach. The proposal will need to be adapted.

Because of variables, nothing can be prescribed universally. The characteristics of the tutor as researcher, as proposed by Stenhouse, are:

1. the commitment to a systematic questioning of one's own teaching as a basis for development;
2. the commitment and the skills to study one's own teaching;
3. the concern to question and to test theory in practice by the use of those skills;
4. peer review: group study.

Dennis Lawton (1983)[14] makes the cryptic comment: "is the learning really worth while? If not, do not test it; drop it !"

A V Kelly (1977)[15] sets out an integrated approach to teaching, which considers seven steps:

1. planning — assessing expectations of scholar and tutor, the rationale, pressures, constraints;
2. purposes: — defining objectives, alternatives, and procedures;
3. content: — culture, knowledge, development, interests, values;
4. integration: — forms of knowledge, reasons, purposes, social and political implications, practical problems;
5. evaluation: — types, modification, the evaluator;
6. social context of the development: — public accountability, influences and constraints, dissemination of innovations;
7. common curriculum: — the case for and against, implications for and against, principles & proceses.

Although designed for schools and children, Kelly's

principles provide a step-wise framework to guide the G P tutor, who may otherwise overlook important facets of teaching. Errors of omission as well as those of commission need to be avoided. The analogy of the differential diagnosis is pertinent: only those diagnoses appearing in the doctor's differential list can be made. If the correct diagnosis does not appear, a mistake is likely. The integration of teaching (4., Kelly's list) cannot be complete if significant factors are ignored.

Six schemes have been used to illuminate teaching. Tyler's basis suggests a 'teaching contract': intentions, matching experiences, organisation and evaluation. 'Man - A Course of Study' emphasises a questioning approach with the tutor a resource, not an oracle. Taba suggests how this questioning approach should be used to develop skills in eight areas to achieve problem solving ability. Problem solving is common and central to both teaching, learning and clinical practice.

Taba goes on to identify four levels of teaching: training, instruction, initiation and induction. Stenhouse develops his 'research model' of teaching, with teacher as researcher. This is a fitting role for the G P tutor. Kelly places teaching in the broad context of its local and general implications, of which scholar and tutor must take account, and within which the teaching programme needs to fit comfortably. Perhaps Aristotle should have the last word: "the action which follows deliberation should be quick: but the deliberation itself should be slow"[16]. All too often is the reverse true: the teaching is irresolute for want of a deliberate foundation.

HOW TO TEACH

There are four basic approaches to teaching (Fabb et al.,

1976)[17]:

1. the authoritarian: 'teacher-centred; all knowing';
2. the Socratic: questioning;
3. the heuristic: 'let's solve it together';
4. the counselling: emphasis on affective behaviour.

All have their place; all do not have equal merit. There is a limited place for the first, caricatured as 'jug-to-mug'; the transmission of knowledge from the expert to the novice. Only what is retained is useful. The teacher has to impart information which is relevant to the scholar with impact and in small 'doses'. Few even well presented significant facts are learned this way. There are advantages in this kind of teaching, which explains its popularity despite its relative ineffectiveness. It is simple and efficient. One expert can address a large class with a few slides (worse still, too many slides) and 'cover' a topic in an hour. So long as all parties recognise the limitations of learning through being told, there is no harm in a few good lectures. But like 'Vegemite', a little goes a long way and a diet of the stuff is a disaster.

Question and answer sessions are better than telling if the scholar is left to discover the answers. The tutor has to refrain from answering his own questions. He may lead the scholar to the answer through supplementary questions, or by suggesting how to find the answer. The tutor will need to check that the answer has indeed been found.

Open questions are to be preferred for most purposes. It is important for scholar and tutor to feel free to raise questions about the topic in hand. Right and wrong answers come to be replaced by acceptable and unacceptable viewpoints. Although open questions allow for many responses, the tutor must discriminate and avoid any temptation to overlook mistakes: it isn't a case of 'anything goes'.

The counselling style is an excellent way to teach, handled skillfully. It is taxing and time consuming. Circular arguments need to be avoided. It is all too easy for tutor and scholar to waste time in a rambling conversation, even if both enjoy it. Both have to agree to stick to the point and much can be learned. But doctors are notoriously anecdotal and proper perspectives may be distorted by incidents.

Personal factors bear upon the approach to teaching. Most people can give a lecture. It is 'safe'. The material can be prepared beforehand and the lecturer is in control. Questions may or may not be allowed. Similarly, the tutor is in control of question and answer sessions. There is a place for simple questions to open up a topic, but the tutor needs to move towards open questions used productively. This is a major teaching skill. Then further down the road the tutor should learn the art of teaching by counselling.

The personalities of tutor and scholar will influence the ease, pace and success of teaching. It is important for tutors and scholars to be well suited to each other. Awkward relationships frustrate teaching. In just the same way that doctors learn how to relate well to a wide range of patients, so tutors should be able to handle different scholars. It does require a conscious effort to come to terms with personalities which tend to clash with one's own. With sensitivity it is rare for this to be impossible. When insoluble conflicts occur the result can disrupt not only teaching but also clinical work. The administrator will need to relocate the scholar sooner rather than later. It is necessary for administrator and teaching practice to be closely in touch if such conflicts are to be recognised and remedied before damage is done.

The assessment of the tutor's performance parallels that of the scholar, and will be the subject of evaluation below. It needs to be said that whereas scholars expect to be assessed, tutors may not. They tend to see teaching as a private affair between themselves and their scholars. They

expect to report on the scholar but may resent to idea of the scholar reporting on the tutor. In teacher training sessions the threat of assessment must be dispelled. Once they are accepted as beneficial and necessary, and the first few have been accomplished without hurt, any reluctance will disappear. Assessments need to be an established part of the teaching programme. When tutors show a willingness to have their consultations and teaching sessions taped for review, then the routine is properly in place.

MANAGEMENT AND CO-ORDINATION

Is it appropriate for the selection of tutors and scholars and their placement together to be the product of newspaper advertisements ? Is it appropriate for the curriculum to be opportunistic and informal; a product of chance ideas as tutor and scholar go about their business ? To what extent should management be involved in placing scholars ? To what extent should the curriculum be devised centrally and prescribed for scholars and tutors ? Who should be involved in curriculum planning ?

How is the curriculum to be administered ? What checks and balances need to be built into curriculum administration to ensure that it remains relevant, effective and accountable; accountable to whom ? How may the demands of political masters; scholars, tutors and administrators, and patients, be reconciled when they conflict. What are the benefits of management and co-ordination, and at what cost ? Is the cost justified ?

These are some of the questions to which answers have to be found if the curriculum is to function optimally. The answers must be realistic, taking into account the voluntary nature of current general practice education, with management by consent. The geographical fragmentation of the 'school', with local differences and no inherent cohesion; fee-for-service private practice without remunerated teaching; these are realities which create management problems.

THE SELECTION OF MANAGERS

This is not the place to detail management skills. In the context of the first G P term, the successful administrator needs a variety of skills: interpersonal and communication

skills, business acumen, entrepreneurial flare and sound judgement. He will require educational professionalism. Some of these skills are likely to need developing during in-service training. He will need good clinical standing and tutorial experience.

Interpersonal and communication skills, innovative ability in the face of clinical problems, taking calculated risks and thinking laterally; these are features of general practice with which the applicant manager should be familiar. Business acumen is being thrust upon doctors with the viability of small businesses threatened. But few doctors have studied education. Managers have to do so if they are to grasp curriculum issues and their implementation.

The appointment of lay administrators is a vexed question; those with all the qualities required of administrators, but not general practitioners. In my view it is not easy for such people to direct education in a field with which they are familiar only as patients or observers. But they can be valuable members of a management team which includes general practitioners. After two or three years the lay manager may have acquired fluency in general practice education and be competent to direct the programme. But there can be no short cut to instant effectiveness.

The selection of managers is crucial to the success of the programme. Terms and conditions need to attract good candidates. Currently, an established practitioner faces a reduction of some 30% in income, to become a State Director. This reduction is off-set by holiday, sickness and superannuation benefits but those locked into their current incomes cannot afford to apply.

Applications should be considered by a panel of senior general practice educationalists, with experience in management. In fact the selection is made by senior members of the parent College, some of whom have no such qualifications.

The reasons for a particular selection should be recorded, together with the selectors' expectations of the candidate. These records should be compared with the manager's performance to monitor the accuracy of the selection process.

THE DEMANDS ON MANAGEMENT

Three groups make demands on management, sometimes conflicting. The groups are scholars and tutors; patients; and the parent College as trustees of government funds and standards in general practice. Successful management involves satisfying the parties whilst maintaining a comprehensive, relevant and effective educational programme: no mean task.

SCHOLARS' AND TUTORS' DEMANDS

Early involvement in the scholar's career reaps dividends. The manager should discuss general practice as a career, with students and Interns. As the pattern of intentions develops, the manager will be able to plan ahead to meet the anticipated demand for city, suburban and country practices. These cannot be brought 'on-line' at short notice if they are to be effective teaching practices.

Well matched placements of scholars with tutors is far preferable to newspaper advertisements; newspaper placements are preferable to thoughtless appointments - at least the tutor can choose between respondents. Personalities make such a difference to learning that it is essential for managers to know tutors and scholars well enough to judge who will suit whom.

Scholars require three other things from managers: support in obtaining resources not available in the teaching practice; support with the extra-mural educational programme; and administration of the assessment process. Scholars may

need journals, books and tapes from the central library: catalogues will have to be circulated so that they know what the library stocks. They may need introductions to experts in selected fields, advice about research methodology, notice well in advance of lectures, seminars and conferences, the arrangement of workshops, and help with arranging to attend. The manager has to make sure that scholars are released from their teaching practices to attend an agreed programme of extra-mural events. He must present an attractive, comprehensive educational programme.

Managers have to initiate and monitor the review process. This, too, should be comprehensive, covering the administration itself; placement of scholars; teaching practices, tutors and their teaching; scholars and their learning; the scope and acceptance of the extra-mural programme; and the progress of scholars towards their career intentions as competent, confident general practitioners.

The means of assessment will be examined in "Evaluation" later. As a management task it is formidable. Assessments tend to be left undone amidst the pressures of practice unless all are convinced of their value and are constantly reminded of the need to assess the relevance and implementation of each learning and teaching contract.

Tutors have ambivalent feelings towards management. On the one hand they appreciate good educational management. On the other hand they resist intrusions into the business of practice. The balance will reflect the tutor's commitment to teaching. Sessional payments and travelling allowances ought to be paid for teacher training now that a doctor must earn about $120.00 per hour to cover expenses and his income.

Having selected teaching practices and tutors, and placed well matched scholars, the manager's job is to encourage tutors to develop their teaching skills and to teach,

monitoring the tutors as they progress. The relevance and excellence of teacher training courses must be evident. In view of their cost to the tutor, the course cannot afford to fall short of the tutor's expectations or he is unlikely to come again. Questionnaires need to be circulated early to solicit the timing, content and programme which tutors would prefer. A carefully structured sequence of clinical, educational and social events requires impressive publicity well beforehand. Attention to the detail of the course is critical: bad speakers, faulty equipment, stuffy atmosphere and wrong temperatures, poor seating and visibility, indifferent food; all matter.

These things apply to all meetings. But whereas doctors are surprisingly tolerant of lapses in clinically compelling events, many are much less tolerant where teacher training is involved, as I have discovered to my shame.

Tutors require parallel support to that required by scholars in teaching practices. Complex arrangements have to be made for the smooth transition of a limited number of video equipments through practices to enable all scholars to tape and review their consultations during the first and last thirds of each term. Materials from the central library may be required in good time for tutorials. And like scholars, tutors have to be reminded of their commitment to the evaluation process.

PATIENTS' DEMANDS

These will not normally be made known directly to managers. If patients' needs are overlooked where they conflict with the needs of scholars and tutors the practice income will suffer. It will not be long before the tutor becomes dissatisfied and teaching fades. Collectively, patients as voters have far greater political clout than a few tutors. Their support or opposition to teaching influences the views

of its political masters, about the educational programme. Managers have to be aware of patients' views through feedback solicited during visits to teaching practices.

DEMANDS OF THE PARENT COLLEGE AND GOVERNMENT

These demands are the hardest to reconcile with the maintenance of a comprehensive, effective curriculum. Imposed financial constraints can make it impossible to fulfil the ligitimate expectations of the parent College, scholars and tutors. Tutors cannot be paid properly and there are not enough practices committed to acceptable teaching standards. The government grant is finite. Its apportionment is quite flexible. This leads to competing demands between States, between administration and field work, between first terms and the balance of a four-year programme.

Educational demands do not have the same limitations as financial ones. Much is agreed concerning the syllabus and its presentation. A prescribed 'core curriculum' is being refined; those aspects of general practice comman to all and necessarily covered by every scholar. To this is added an elective curriculum to be negotiated between the scholar, the administration and involved tutors, within broad limits set by the parent College and the political masters.

It is to these authorities that the programme is accountable: financially, educationally and publicly. Being recipients of public money, detailed accounts are required to acquit the grant. No such accounting is required of practices, who would see it as an intrusion. This works to their disadvantage. If the financial implications of the first term were properly audited, data would be available for a powerful argument to reward teaching events as well as consulting. While only occasional first terms are audited to show losses, they can be seen as exceptions. Plans are in hand to persuade teaching practices to acquit their first terms.

It is anomolous that scholars receive salaries while tutors receive their share of earnings after expenses. The salaries are those that apply to hospital Residents of the same postgraduate year. Occasionally this exceeds the tutor's income. Where scholars work in terms which are not part of a year's rotating hospital residency, their income is negotiated between tutor and scholar. A basic minimum plus a proportion of fees earned once the minimum has been exceeded is usual. This provides the scholar with a realistic appreciation of the way a general practitioner earns his living; an important lesson.

Management is accountable to the College educationally. In each State the Director is responsible to the Faculty Board to whom he reports monthly. Nationally, each Director reports to the National Director likewise, and at quarterly meetings. State programmes are reviewed and initiatives shared. Promising ideas are piloted and assessed before any general implementation. In addition to this global accounting, there is individual assessment by the College of each scholar at the end of the four-year course.

Difficulty has been encountered in coming to an agreed method of summative assessment of scholars, to satisfy the government requirement that a Certificate of Satisfactory Completion be issued, to signify an end-point. Yet the whole philosophy of the educational programme is formative (Fleming, 1985)[18]. All ongoing assessments are designed to identify strengths and weaknesses, not passes and failures. To be effective, this demands trust of the scholar, who alone may appreciate a weakness which he might successfully conceal, but on its remedy may hang a life one day.

In any case, an end-point is an artifact in the continuing process of general practice education. Moves are afoot to integrate the College Fellowship examination with this initial education. This will encourage the scholar to go on learning to complete the Fellowship and beyond, to comply

with the requirement that Fellows undertake continuing medical education. In the event, summative Certification does not appear to be inhibiting formative assessments in the way that examinations have been known to limit the curriculum.

Public relations have always been the 'Cinderella' of the medical profession. Medical Councils impose restrictions which does nothing to stop bad press about fee rises and malpractice suits. It does frustrate good press about the voluntary educational programme: general practice tutors could well be alone in having to pay to take scholars. All this is changing. Advertising restrictions are being relaxed. But I have yet to see a practice advertise its commitment to medical education. In other walks of life this is deemed a mark of excellence, which should not be overlooked by teaching practices.

CO-ORDINATION

This section was entitled 'Management and Co-ordination'. The question was posed "should the curriculum be opportunistic and informal; a product of chance ideas as tutor and scholar go about their business ?" The thrust of this dissertation has been to demonstrate that it should not be so. The alternative is not necessarily an imposed curriculum: one can have a co-ordinated programme, with management co-ordinating. Who and what is co-ordinated, with what benefits, and at what cost ? Is the cost worthwhile ?

The centralist - decentralist argument is not going to be settled here. I do not see it as an 'either / or' conflict. One can have an active central administration negotiating the curriculum with tutors and scholars. The central management, with the tutors' support, maintains standards. The scholar negotiates within real but limited choices, to tailor the curriculum to his particular needs.

Several examples of national co-ordination have been mentioned: administration of resources and the library; sharing of initiatives; and budget allocations. There are economies of scale. The national Resource Centre holds an extensive (and expensive) stock for everyone's use. A very small administrative staff (about 1 to 70 scholars) spread their expertise thinly but usefully to co-ordinate teacher training and the educational programmes for scholars in teaching practices throughout Australia.

Over 50% of the national grant of some $10,000,000 goes in scholars' salary subsidies. The balance pays for staff, resources and events provided in the programme. Of 2,000 medical graduates annually in Australia, about 1,000 will become general practitioners. Of these, about 500 will have first G P terms. In round figures this amounts to $20,000 per scholar over four years, with the greater part allocated to the first term.

No longitudinal studies have been done to compare those who enter general practice with and without vocational education. There are many reasons for this apparent oversight. Performance in practice defies accurate assessment without the co-operation of doctors and patients. Neither are happy about sharing the confidences of the consulting room except for specific and strictly limited educational purposes. No independant, reliable indicators of performance have been identified. Some limited studies suggest that scholars prescribe, investigate and refer more extravagently at the beginning than at the end of their first terms. But this could well be true of novices not in teaching practices but simply gaining confidence by themselves. Despite the lack of hard data, it stands to reason that medical education tailored to the individual's career cannot but be beneficial. "Not all that counts can be counted; not all that can be counted counts" (quoted by Marinker, 1984)[19].

CURRICULUM ADMINISTRATION

Curriculum administration needs to be data-based. It is not enough to base decisions on unfounded opinions. Those with an interest in the curriculum should be encouraged to contribute in any way they wish but should always be required to provide evidence for their views. Administrators need to foster good communications with all curriculum participants. Only then is it possible to allocate money, material resources and manpower time efficiently and agreeably. Curriculum administration involves the integration of the whole programme so that it achieves its objectives comfortably in the broad social context of the health care system.

OBJECTIVES, PRIORITIES AND DATA

There must always be clearly defined curriculum objectives. In the first G P term, these objectives are subject to the variables of scholars' career intentions and the ever-changing medico-political scene. This does not mean that the objectives should be less precise. It does mean that they need to be reviewed. The review process has to be handled cautiously. If the objectives are changed too much no-one knows exactly what they are at the time. If the objectives are left too long they become irrelevant. Minor modifications annually and a major review every three to five years is about right.

All reviews require data collection beforehand. Otherwise influential opinions without foundation intrude to distort objectives and priorities. Too much posturing and lobbying occurs by people pushing barrows of dubious worth, lacking data to confirm or deny their contentions.

Objectives and priorities for the first term will document the knowledge, skills and attitudes to be taught as a foundation for general practice. They will cover core and

elective curricula, the place of consulting and the input from extra-mural activities, the development of teaching and learning, with special emphasis on contracting.

The needs of scholars should predominate. The implementation and revision of the learning contract is the central objective of the first G P term. If tutors, patients, the administration, the parent College and the political masters derive benefit and satisfaction from the programme, so much the better. But this must never be at the scholar's expense. At the end of the term, stock-taking of achievement and the identification of outstanding matters to be carried over into the next term, completes the objectives.

MONEY, MATERIAL RESOURCES AND MANPOWER TIME

The major expenditure on scholars' salary subsidies only makes sense if the education received justifies the cost. Scholars, tutors and managers bear a heavy responsibility to ensure that the grant is well spent on education. It is irresponsible to use the grant to 'balance the books' quite independently of any educational considerations.

The efficient distribution and use of material resources, not merely their existence, is what matters. Books, tapes and journals gathering dust suggest inappropriate purchases or inadequate publicity or inefficient distribution. Better identification of scholars' and tutors' needs by questionnaire, and better communications after acquisitions, would enhance the value of resources.

Limited manpower and conflicting time pressures make it mandatory to put this scarce resource to good use. Group work is educationally preferable to one-to-one learning, and more manpower-time efficient. To re-iterate, tutors should avoid teaching medical science and concentrate on general practice. In practical terms, the telephone merits

special mention. Some 50% of business phones are engaged at 9.20 a.m. Many people have watches, listen to radios, or watch television, notice the hour or the half hour, and remember a call they had to make. Thus twenty-past and twenty-two mid-morning and mid-afternoon hours are the best times to telephone with most chance of speaking to the called party with least delay. For many people, telephone traffic has assumed a significant place in time management, an aspect that is poorly appreciated and badly managed. Contrary to Telecom advertising, most business should not be conducted by phone. There is no written record being generated by the caller; scholars and tutors do not enjoy their consultations being punctuated by calls. Only the most urgent matters should be dealt with by phone. Face to face encounters by appointment, with supporting documentation for later reference, and letters, are usually better.

QUALITY CONTROL

Quality can easily become the casualty of quantity. In no other area is data more important or harder to acquire. Quantity is always easier to establish than quality. Assumptions about quality are frequently made and are rarely justified. These include assumptions about teaching based on the tutor's known excellence as a doctor. The quality of educational events cannot be deduced from their number, the comprehensiveness of their coverage, or the skill with which they are promoted.

The quality of teaching cannot be predicted; it must be assessed by the participants at the time and reviewed afterwards. Good and bad presenters, worthwhile and fruitless topics, better and worse dates and venues, all need identifying and the information put to use. Presenters and preferences change. So what holds this year may not be true next. Preferences need constant updating; quality needs constant scrutiny. People may become stale and need a break.

INTEGRATION

The mark of success is the extent to which the educational programme demonstrably achieves its objectives by common consent. The aim is to satisfy scholars by meeting their ultimate expectations for their transition from hospital to general practice, and at the same time to realise the tutors' desire to share their expertise with novices. This must be done within budget constraints and the requirements of political masters and the parent College. Due regard has to be given to the sensitivities and confidences of patients. And the whole must sit comfortably within the philosophy and practicalities of medical and health care at the time.

The extent to which such a daunting ideal is achieved rests heavily upon the degree to which all the parties are aware of the objectives and involved in strategic decisions. There is no shortage of ideas and expertise. There is a real shortage of time and money. There are serious deficiencies in communications. This is not to suggest that more paper needs to be circulated. The succinct expression of important points to all who need to know is the key to success. In fact there is a pressing need for shorter reports and less paper containing more data. The initiative for these changes will need to be taken by management.

THE SYLLABUS

In this section I concentrate on the selection of the most appropriate syllabus to facilitate the transition from hospital to general practice, avoiding the already known and the irrelevant. Such a syllabus must deal with the adaptation of medical science to the circumstances of general practice, with which scholars are unfamiliar. It needs to emphasise knowledge, skills and attitudes which predominate in general practice but not in hospital practice. What are these factors ? What is to be included, and in what order ? Who decides ?

In the Australian Family Physician (1988)[20] the President writes about the educational aims of the Caribbean College of Family Physicians, inaugurated on 28 May, 1988, which he describes as very similar to those developed by the Australian College over the past twelve months. Here is the Caribbean Statement, which I consider to be an excellent topical basis for the first term syllabus:

"The doctor should be able to demonstrate that

> he has sufficient knowledge of disease processes, particularly of common diseases, chronic diseases, and those which endanger life or have serious complications or consequences;
>
> he understands methods and limitations of prevention, early diagnosis, and management in the setting of general practice;
>
> how interpersonal relationships within the family can cause health problems or alter their presentation, course and management, just as illness can influence family relationships;

the social and environmental circumstances of his patients and how they may effect a relationship between health and illness;

the appropriate use of the wide range of interventions available to him;

the ethics of his profession and their importance for the patient;

the basic methods of research as applied to general practice;

medico-social legislation and the impact of this on his patient;

the value of educating people in order to achieve behavioural change.

"Attitudes:

a capacity for empathy and for forming a specific and effective relationship with patients and for developing a degree of self-understanding;

a recognition of the patient as a unique individual, and the need to modify accordingly the ways in which he elicits information and makes hypotheses about the nature of their problems and their management.

an understanding that helping patients to solve their own problems is a fundamental therapeutic activity;

recognition that he can make a professional contribution to the wider community;

willingness and ability to critically evaluate his own work;

recognition of his own need for continuing education and critical reading of medical information;

"Skills:

how to form diagnoses that take account of physical, psychological, and social factors;

how to use the principles of epidemiology and probability in everyday work;

how to use the factor 'time' as a diagnostic, therapeutic and organisational tool;

how to identify people at risk and take appropriate action;

how to make relevant initial decisions about every problem presented to him as a doctor;

the capacity to co-operate with medical and non-medical professionals;

how to manage a practice;

how to use the principles of communication to educate patients and personnel in the health field."

A statement like this should be discussed by scholar and tutor at a time set aside for the purpose at the start of the term. At least one session of 3½ hours is required. The statement should be translated into core and elective studies, appropriate to the scholar's intentions and the opportunities inherent in the practice situation. By the end of this session an initial learning contract should have been drawn up, for review and development during the term.

In my experience this rarely happens. Instead, momentum is gradually built up as opportunities occur to scholar and tutor arising out of everyday work. In a term of only thirteen weeks, precious time is lost by an unstructured start. In their assessments, scholars highlight the lack of an effective introduction to the first G P term.

In considering the Caribbean Statement, relevance of the sub-sets to the first G P term, and their priorities, need to be established. The resulting syllabus must make only reasonable demands on scholar and tutor. It must allow for the scholar's electives and be directive without being oppressive. I have come to feel that a weekly syllabus of tutorials, with scholar and tutor working together for 3½ hours; a half-day of extra-mural activities; and casual discussions of problems as they arise, is preferable.

Tutorials work well in three one-hour segments. They need preparation by both scholar and tutor. The first hour is used to introduce the day's theme. "What shall we do today ?" is no way to begin a tutorial. Scholar and tutor need to reflect on the topic beforehand and decide what they hope to achieve, and how. Resources may need to be obtained. During the second hour, scholar and tutor may consult jointly, each observing the other. Afterwards the encounter is reviewed, emphasising any instances of the day's topic. The third hour may consist of reviews of selected medical records, previously taped consultations, diaries and portfolios, relevant to the matter in hand. The session ends with an assessment of achievement and what remains to be learned.

KNOWLEDGE OF DISEASE PROCESSES

Since common diseases occur commonly, including many chronic diseases, deficiencies can be identified readily. The risk is that the lack may pass unnoticed as the scholar passes on to the next patient without pause for reflection. It is essential to have a notebook to hand. Doubts must be recorded at the time, to be filled later. Knowledge of disease processes which endanger life or have serious consequences, will not necessarily arise during any one term. Yet understanding of the features of cardiac asthma, ruptured spleen, ectopic pregnancy, loss of vision and the like, must be included in the syllabus. These should be the subject of extra-mural activities.

PREVENTION AND EARLY DIAGNOSIS

This is a high priority for the first G P term. Since prevention has failed for patients to need hospital admission, teaching hospitals are not the place to learn preventive medicine. General practice is the appropriate environment.

Early diagnosis is best learned in general practice, the place of first encounter with the patient.

INTERPERSONAL RELATIONSHIPS AND THE FAMILY

These factors are not prominent in hospital practice. Still in evidence is the tendency for the staff to disappear during visiting hours. Relationships, the family and disease is an all-pervading part of the pattern of general practice. Anxiety and depression, heart disease and fats in the diet, active and passive smoking, asthma and bronchitis, the range of alcohol-related problems and sexually transmitted diseases, and inherited diseases, are a few among many. The area can only be sketched in one tutorial. It will be a recurring theme of several.

HEALTH & ILLNESS: SOCIAL AND ENVIRONMENTAL FACTORS

These cannot be seen at work in the hospital setting. They are ideal extra-mural activities for the first G P term. Scholars enjoy encounters with child and school nurses, police and probation officers, occupational therapists, industrial health and safety officers. They gain insights about the inter-play of social and environmental factors in health and disease. They experience at first hand, the health care team at work.

THE RANGE OF INTERVENTIONS

It is worth exploring the range of alternatives to medication in the management of many problems. There is an undue emphasis on prescribing in my assessment of hospital practice, together with major surgery which has no place in general practice today. The commercial influence of the pharmaceutical industry is immense. As an example, consider

the profit and promotion of baby food compared with breast milk. Medical journals depend financially on pharmaceutical advertising; educational events are sponsored by pharmaceutical companies.

Sometimes pharmaceutical interventions are the most appropriate, as with the contraceptive pill. Sometimes they need to be combined with other interventions, as with the combination of diet and drugs in sugar diabetes. The modern approach to high blood pressure involves wide ranging interventions, life-style changes being the most important. Yet scholars often consider drugs first.

From these few among many examples, it is clear that the tutor needs to broaden the scholar's vision by questioning the scholar's management. Having discovered the scholar's approach, and agreeing with an acceptable treatment, the tutor may say "and have you considered....?" to open discussion. Especially family and community support, not part of hospital practice, should be emphasised as commonly effective, inexpensive interventions in general practice.

ETHICAL MATTERS: MEDICO-SOCIAL LEGISLATION

Ethics and professoinal relationships are the concern of hospital and general practice alike. They need emphasising in the competitive setting of private practice. Medico-social legislation involves an understanding of the health service, health insurance and workers' compensation. Protracted settlements tend to prolong disabilities.

Doctors are faced with an increasingly litigious public. Professional indemnity premiums are ballooning. Defensive practice and the importance of comprehensive contemporary medical records have to be stressed in this context.

RESEARCH

Manual retrieval of data from patient-centred records seriously compromises research in general practice. Computers have changed all this. They provide the means of exploring patterns of disease and interventions, to which the scholar should be introduced during the first term. Both computer literacy and research methodology need to be mastered. Few tutors are computer literate. Expert help should be solicited during extra-mural sessions. As practices acquire computers, opportunities are increasing for scholars to programme medical records and extract correlations between different interventions for a variety of diseases in selected groups of patients.

PATIENT EDUCATION

The time frame of general practice lends itself to patient education. This is based on periodical reinforcement of healthy strategies. Since patients average five consultations a year with their general practitioner, there is an ideal opportunity to periodically promote healthy living. Many of those most in need of behavioural change will of necessity attend more often than average, which increases the number of promotional opportunities. This is in contrast to hospital practice, where patients tend to stay for too short a time to allow for any extended reinforcement of healthy strategies.

In hospital practice, compliance is rarely a problem. When compliance fails this is usually the staff's fault, not the patient's. Students and Residents come to expect advice to be followed. Yet in general practice this is far from true. It has been mentioned that about 70% of prescriptions are not taken as directed. For success with compliance, the patient must understand his condition, the purposes of treatment, side effects and likely benefits. Scholars need

to become far more forthcoming than is the practice in hospitals, where technicalities may be a barrier to easy explanations.

ATTITUDES

In general practice, communication skills feature second only to clinical skills. The brief encounters of hospital practice do not encourage empathy. Frequent consultations over many years in general practice do. One of the principal themes of this dissertation is the need for patients to own their conditions and remedies, in the same way that scholars need to own their learning. Whether as doctor or tutor, a common wavelength has to be established with patient or scholar, neither talking up or talking down.

By every means, scholars have to make clear to patients their genuine concern; that the problems which have prompted the consultation are accurately understood, and that the doctor's advice is relevant and practical from the patient's viewpoint, as well as being clinically sound.

Empathy cannot be taught in an afternoon. It is a continuing education. It will arise during many tutorials. It needs to be distinguished from sympathy: "I feel sorry for you" needs replacing with "I can understand how sorry you feel".

THE PATIENT AS A UNIQUE INDIVIDUAL

Although pattern recognition and disease protocols are important aids to rapid diagnosis and effective management, there is always the risk of forcing patients and their problems into preconceived patterns and protocols instead of tailoring the patterns and protocols to fit the patient. Practice can appear to be like the selection of the best

fit from a rack of ready-made suits. We should be into bespoke tailoring. The construction of a fitting diagnosis or the definition of problems, together with an appropriate plan of management, will arise in every review of a consultation and in very many tutorials.

HELPING PATIENTS TO SOLVE THEIR OWN PROBLEMS

Although patients should remain in control of their own affairs, including their health and sicknesses, owning the diagnoses and treatments, the doctor's place in achieving this is important. The drug 'doctor' is indeed a powerful therapeutic tool. The scholar has to come to recognise the force of his role, and how best to direct that force in the patient's interest. A most useful concept is that of a partnership between doctor and patient, with the patient as senior partner. The doctor should be an active partner, clarifying and suggesting options to solve the patient's problems; options from which the patient may choose those best suited to his circumstances.

Doctors have to curb their inclinations to take over direction of the patient's affairs. Ownership must be left in the patient's hands at the end of a consultation, since the patient is on his own afterwards. Patients who depend too much on their doctors are like scholars too dependent on their tutors. Both patients and scholars should be encouraged to cope in the absence of their mentors. Self-sufficiency is a major aspect of self-respect and a frequent casualty of the overly protective carer.

THE DOCTOR IN THE WIDER COMMUNITY

University teaching hospitals are particularly remote from the wider community. Many of their patients come from afar; they tend to be recipients of exotic diseases Statewide.

General practitioners, who are best placed to be involved in their local communities, are sometimes reluctant to be. This is partly due to jealousies between competing practices and partly due to the lack of remuneration for most community work. Television and the print media have been responsible for an upsurge in medical and health interest. With increasing numbers of family planning clinics, multidisciplinary health centres and health auxillaries, there are many opportunities for doctors to become involved with established groups. This involvement by invitation, sometimes through advertisement and selection, overcomes professional sensibilities.

Scholars need to be introduced to community affairs early in the term and encouraged to undertake a specific project as an extra-mural activity; a project which the scholar chooses to enhance his learning in accordance with his learning contract.

EVALUATION AND CONTINUING EDUCATION

These cardinal features of the first G P term curriculum are the subject of the next two sections in this dissertation.

SKILLS: FORMING DIAGNOSES

Taken literally, of the 23 sub-sets of the Caribbean Statement, this is the only one with which I have some discomfort. There is a tendency, born of the certainty of institutional heirarchies like hospitals, to catalogue everything into defined slots. Although diagnostic certainty is always desirable, it is not always possible. Diagnostic certainty is less common in general practice. Many patients present with ill-defined problems which defy diagnosis.

To form diagnoses where none can be deduced is dishonest.

The dishonesty may be overt if the doctor chooses to overlook conflicting evidence for the sake of diagnostic tidyness. Or the dishonesty may be covert if the doctor is blind to the contradictions to a pre-conceived diagnosis. It is essential that the scholar be aware of the dangers of forced diagnoses. Open-mindedness has to be cultivated. Problem definition is a universal challenge; diagnostic conclusions are to be approached cautiously. For once made they tend to close the mind to further deliberations. Physical, psychological and social factors must all take their place in defining every problem and in any diagnosis.

EPIDEMIOLOGY AND PROBABILITY

These skills underlie pattern recognition and form part of the approach to problem definition. Their value and their limitations have been discussed in the sub-set "The patient as a unique individual". Epidemiology is a science of medical schooling to be applied in general practice by a study of the patterns of disease as recorded in the scholar's diary of 100 consecutive cases. It should always be kept in mind that common diseases occur commonly. This will be a useful influence in selecting likely explanations and diagnoses. But probability needs always to be tempered by consideration of possibilities. One of the marks of the professional is the early appreciation of an uncommon possibility.

TIME

The significance of the factor 'time' is seriously neglected by most tutors and scholars. Time management is hardly mentioned. Yet on the effective use of time depends much of the practitioner's success. I would rank it third after clinical acumen and empathy in a priority list of essential learning. Used effeciently, much can be achieved; ineffic-

ient use of time not only robs achievement, it causes stress.

Scholars need to address time in four ways: consulting time; study time; domestic time and private time. Time ought to feature in the learning contract. It has been pointed out that unless time is set aside for extra-mural activities, they will be forced out as the treadmill of consulting gains momentum. Consulting time has two aspects: the pace of the consultation and its length. The contents of the consultation need to be negotiated between doctor and patient at the outset. Consultations must not be allowed to drift and too much should not be attempted at one time. Scholars have to learn to negotiate to meet the patient's expectations in fifteen minutes, and to keep the encounter on course.

The balance between consulting time, study time, domestic time and private time is critical to the doctor's achievement and contentment. It is a personal matter for each to decide. Those who make no decision risk confusion, exhaustion, boredom, frustration, anxiety, even divorce. There is the disappointment of finding the kids have grown up without you, for those who disregard domestic time.

Time management comes hard to the scholar, who is too used to having his time managed for him. Now he has to steer his own course between unacceptable absenteeism, insufficient continuing education, and vocational imprisonment.

PEOPLE AT RISK

Medical science teaches about risk factors in relation to epidemiology. This is a far cry from recognising those at risk in practice. It requires a high index of suspicion to recognise the risk of diabetes or high blood pressure in a patient who has called about a cut finger. Habits of enquiry have to be cultivated, to foster opportunistic health promotion. Enquiries need to be made judiciously.

INITIAL DECISIONS

Having defined a problem, with or without a diagnosis, the important thing is "what next ?" The responsibility for 'what next' is foreign to student and Resident. Scholars have to be introduced to this responsibility cautiously. Patients need to be selected, as far as possible, within the scholar's capacity to decide. Tutors have to impress on each scholar "if in doubt, ask". Initial decisions should be specific points of discussion in consultation reviews.

CO-OPERATING WITH MEDICAL AND NON-MEDICAL PROFESSIONALS

This is learned during extra-mural activities with health care teams and in referrals to specialists and hospitals, as well as inter- and intra-practice relationships. Attitudes surface during practice meetings, which will be convivial if partnerships are working well. Relations with adjoining practices are important in patient care. The patient may choose one doctor for her annual check-up, another whom she has heard is "good for headaches", and anyone she can get hold of in an emergency. With courtesy, good working relationships ought to be possible between adjacent practices. Competition and professional jealousies may be a problem, especially where too many doctors are serving too few patients. Such hostilities are almost always soluble if one partner is prepared to take the initiative. Scholars should be introduced by the tutor to the local medical and para-medical fraternity early in the term.

HOW TO MANAGE A PRACTICE

Practice management is rarely on the first term scholar's agenda. Running his own practice may seem a distant prospect. Apart from gleanings at practice meetings and essentials of the billing and record systems, it is unwise

to subject the scholar to unwelcome instruction. Many tutors heap their concerns on their scholars during tutorials, from which the scholar derives little benefit.

COMMUNICATION AND HEALTH EDUCATION

Communication skills are second only to clinical skills. On them rest the extent to which patients understand their conditions, comply with treatment, maximise their health and prevent avoidable disability. The principles of good communication are universal. But whereas a commercial enterprise may fail through poor communications, many institutions survive. Communications are not notably good in hospitals and are insufficiently emphasised in medical schooling. Many scholars are good communicators. Those who are not, need help. Those who do not respond should be counselled out of general practice, such is the importance of communication skills in this discipline.

The range of verbal and non-verbal communications have to be studied and mastered. The scholar has to become familiar with different approaches to patient education; listening and conversation, and the place of tapes, diagrams and literature. Literature handled personally with an explanation has far greater impact than that to which patients are invited to help themselves from a rack. The scholar will need to broaden his vision if he is to use the whole range of opportunities for patient education, to the patient's best advantage.

Having examined the twenty-three sub-sets of the Caribbean Statement, I have two more to add from my own experience:

HOME VISITS AND FIELD WORK

Home visits give the scholar unique insights about the interplay of the disability and the patient's environment. Most calls will be emergencies. But the scholar should be made aware of the value of home visits in understanding disease processes and their significance and consequences for the patient. Residents do not use doctor's bags. Most have never made a home visit or an on-site emergency call. The content and use of the doctor's bag needs careful consideration. The scholar will benefit from help in purchasing and stocking his bag.

The introduction of an intra-venous line or an airway into the windpipe, on a hillside in the rain, is a very different matter from the same procedure in an operating theatre. Fortunate indeed is the scholar whose tutor takes the chance of calling him to help in such emergency field work. These are among the challenges of general practice, happily rare, but unhappily rather badly managed by many general practitioners largely through lack of experience. It is important for field work to feature in the first term programme of extra-mural activities.

FUNCTIONAL ASSESSMENT

Scholars tend to see things in pathological terms; what is wrong with the patient from the standpoint of cells, tissues and organs. This habit should be retained in general practice, to keep hold of the nature of disease; medical science. But the scholar's thinking has to extend beyond the science to the effect. To the patient, gall stones and gout may be quite similar: both cause pain in attacks and limit activities. The clinician will contrast the quite different pathologies of gall stones and gout. The general practitioner must accommodate both viewpoints.

Four questions underlie a functional assessment (Carpenter, 1986)[21].

"What can the patient do despite the disability ?"

"What restriction is the disability causing ? Why ?"

"What could the patient do despite the disability ? How ?"

"What else could the patient do ? How ?"

The first three questions are self-evident. The fourth requires explanation. The first three questions refer to the patient's usual activities. The fourth needs to be negotiated between patient and doctor, to identify new activities for the patient to undertake. By this means, no-one need feel totally disabled. There is always something useful for all but the massively handicapped to do. Patient, doctor and carers have to put their heads together imaginatively. Scholars should never have to say to anyone "I'm sorry, there's nothing I can do for you".

A SYLLABUS

WEEK	TUTORIAL	EXTRA-MURAL ACTIVITY
1	Introductions to the Teaching Practice, staff, duty rosters study schedule, consulting sessions, billing procedures LEARNING CONTRACT	Introductions to the local medical and para-medical fraternity
2	THE PATIENT Interpersonal relationships & illness; social & environmental influences; the uniqueness of the patient; self-help approach	HEALTH CARE TEAM I: CRISIS CARE Ambulance service; police and probation work; social workers
3	COMMUNICATIONS Verbal and non-verbal communications; rapport & empathy; the drug 'doctor'; patient education; medical records	HEALTH CARE TEAM II Domiciliary nurses; geriatric services; functional assessment
4	ELECTIVE TUTORIAL	COMMUNITY PROJECT
5	THE PROBLEM Epidemiology and probability; pattern recognition; problem definition; diagnosis	HEALTH CARE TEAM III Pharmacist; physiotherapist; occupational therapist; industrial health & safety
6	INTERVENTION initial decisions; the range of interventions; health promotion & preventive medicine	HEALTH CARE TEAM IV Ante- & postnatal services; paediatric services; child & school health
7	MID-TERM REVIEW: revision of the learning contract	REVIEW OF EXTRA-MURAL ACTIVITIES
8	THE TIME FACTOR Emergency calls; home visits and the doctor's bag	OFFICE PROCEDURES Diagnostic and treatment skills; office surgery
9	COMMUNITY INVOLVEMENT Ethical matters; medico-legal affairs; professional relationships	CLINICS I selection from: eyes, ear nose & throat; skin diseases; chest; heart; neurology
10	ELECTIVE TUTORIAL	ELECTIVE ACTIVITY
11	RESEARCH The identification of groups at risk	RESEARCH AND COMPUTERS
12	CONTINUING MEDICAL EDUCATION	CLINICS II: orthopaedics
13	CONCLUDING ASSESSMENTS	ASSESSMENT OF ACTIVITIES

EVALUATION

Concurrent evaluation of scholar and scholarship; tutor, teaching practice and teaching; management, co-ordination and syllabus, is an integral part of the curriculum. The evaluation itself should be a powerful learning experience. The results should be shared between all concerned parties. Their value is greatly diminished if they remain confidential to the author or to the administration. Too often, there are deficiencies in the attitudes of those being evaluated; in the quality of the evaluations; and in their circulation. These deficiencies tend to be related. If the subject of evaluation feels threatened and is reluctant; if the evaluator is half-hearted; if trust and communications are inadequate; then the benefits of evaluation will not be realised.

Evaluations should be built into the curriculum, to illuminate its implementation. They should be owned by the participants and shared with the administrators, not owned by the latter. To own them, scholars and tutors need to conduct them with care, study them thoughtfully, and appreciate their worth.

It is proper for the curriculum to be publicly accountable. Among the parties with a legitimate interest in the evaluations are the parent College and political masters. The interest of these 'third parties' should be expressed openly and settled beforehand. Evaluations are sensitive matters and the frankness based on trust on which their success depends in part, can easily be disturbed if the interest of others arises later, as an unwelcome intrusion.

Evaluations will be either internal or external. Internal evaluations include diaries and portfolios of special incidents, medical record reviews, reviews of taped consultations or after direct observation, reports of community and

research projects. External evaluations include "Check", "viatel", surveys and examinations. "Check" is a published questionnaire of clinical problems with multi-choice answers. The scholar selects from the choices presented, responses to the problems. "Viatel" is a quiz of clinical questions with multi-choice answers, available through a telephone linked to a modified television receiver. In 1987, the Royal Australian College of General Practitioners became the first to use "Viatel" for its Fellowship Examination held in each State.

VALIDITY AND RELIABILITY

In discussing the selection of teaching practices (page 9) I wrote "It is natural to evaluate those things which are easiest to assess. If this includes the essentials of the matter in hand and the limitations are publicised, then no harm may result. But if, as is commonly the case, easy substitutions are made for critical features which are hard to assess, the results may be seriously misleading." And on page 44: "Performance in practice defies accurate assessment without the co-operation of doctors and patients."

Simple issues, like knowledge of pathological processes can be tested validly and reliably: the pathology may be complex but the issue of whether or not it is known is simple. The scholar may be presented with test results and asked to identify the cause. This is a valid test: what is intended is tested. There will be a right answer, without doubt: the test is reliable.

Complex issues, like consulting or teaching performance, raise problems of validity versus reliability. Review of a taped consultation is a valid assessment: feelings may be concealed (smells are missing) but with good vision and sound, the event is faithfully portrayed. But experienced

evaluators will disagree on all but the best and the worst performances. The method is unreliable. Several parameters were mentioned on page 44: prescriptions, investigations and referrals: indices of practice which are reliable, computed facts. However, detailed scrutiny has shown them not to be valid indices of consulting performance.

To a significant extent, the reliability of a test of consulting or teaching performance is inversely proportional to its validity. In the evaluation of complex issues like these, a compromise has to be reached between validity and reliability, with a bias towards validity. Every test should approximate to its intentions. Those that purport to do so, but in fact do not, are the most unsatisfactory. They may be positively misleading. If the test defies any consistent interpretation by experienced observers, it too must be discarded, however valid it may be.

THE EVALUATION OF TEACHING PRACTICES

"The aims of illuminative evaluation are to study the innovatory programme, how it operates, how it is influenced by the various school situations in which it is applied; what those directly concerned regard as its advantages and disadvantages; and how students' intellectual tasks and academic experiences are most affected. It aims to discover and document what it is like to be participating in the scheme whether as teacher or pupil; and in addition, to discern and discuss the innovation's most significant features, recurring commitments, and critical processes." (Parlett and Hamilton, 1972)[1].

Parlett and Hamilton's summary of illuminative evaluation is itself illuminating. It addresses a sequence of issues to be clarified if a comprehensive evaluation of the teaching practice is to be accomplished. These issues are:

- what is the intention ?
- is it innovatory ?
- how is the intention being implemented ?
- how is it being influenced ?
- what do those directly concerned see as its advantages ?
- and disadvantages ?
- how are scholar's knowledge and attitudes most affected ?
- what is it like to be involved in the programme ?
- how is this to be documented by both teacher and pupil ?
- what are the most significant features ?
- what are the most recurring commitments ?
- What are the most critical processes ?

These questions should be raised at teacher training seminars. They also need addressing by scholars and tutors during the initial tutorial session and again at the mid-term review. The discussion will help to ensure the relevance of the learning contract and its appropriate mid-term revision.

The intentions of the teaching practice can be seen from several perspectives: the scholar's intentions; the tutor's intentions; management's intentions. The scholar's intentions will reflect his career choice; the tutor's intentions will combine the scholar's intentions with the tutor's professional commitments, his abilities, and his perceptions of the strengths of the practice; management's intentions will be to support scholar and tutor, being mindful of standards of performance throughout the programme.

The documentation of intentions is unavoidably time-consuming if it is to be done well. As Parlett and Hamilton demonstrate, there is a great deal involved: far more than the casual observer might imagine. Influences, experiences,

strengths, weaknesses, most significant features, recurring commitments and critical processes, and their effects on scholar's knowledge and attitudes, all need to be determined and documented.

In reality, very little of this kind of documentation occurs. Sometimes only a learning contract and an end-of-term assessment are completed; sometimes even less. Lack of better records deprives scholars, tutors and managers of the data they need to monitor and revise the programme. Just as good minutes support good meetings, so does good reporting support teaching and learning.

The absence of adequate documentation is the more regretable in view of the importance doctors attach to good medical records. It should be obvious that educational records are just as important to teaching and learning as clinical records are to patient care.

THE EVALUATION OF SCHOLARS AND SCHOLARSHIP

This is rightly the central focus of evaluation. But it should not be exclusive: complimentary evaluations of tutors and teaching, management and the curriculum, are essential if the context of the performance of scholars is to be clearly understood.

Scholars themselves must bear much of the responsibility for their own evaluation. Self-assessment, though not of itself sufficient for public accountability, has great value. Many scholars are their own severest critics. The depth of insight and the detection of weaknesses depends largely on the scholar's capacity for self-appraisal. The tutor should encourage the scholar to develop this ability. It needs to be well developed in the tutor too. Conversely an insensitive tutor can thwart the scholar's willingness to expose his deficiencies. First he will hide them from

the tutor as far as possible; later he may cease to recognise them himself until they are revealed by some mishap that might have been avoided.

In summary, methods of evaluating the progress of scholars are:

- o medical record review;
- o diary of 100 consecutive cases, early- & late-term;
- o portfolio of critical incidents
- o log of educational events
- o "Check" and "Viatel" programmes
- o directly observed consultations;
- o taped consultations;
- o reports on community projects;
- o summary report form (appendix [3])
- o computed data about costs, prescriptions, etc.

Taken together, and with the scholar's co-operation, a clear picture emerges of the scholar's competence as a general practitioner. None of the assessments stands alone: each clarifies various aspects of competence: none demonstrates all at once.

CONFIDENTIALITY

In any review of encounters between patients and doctors by other people, confidentiality has to be considered. This includes observed consultations, whether the observer is in the consulting room or viewing through one-way glass, and taped consultations. Permission must be solicited and in a way that gives the patient equal opportunity to consent or refuse. In the event, most patients are glad to consent.

Taped consultations present special problems. The patient may not wish to have a permanent record of the encounter. Guarantees should be made, and honoured, that the tape will only ever be used for educational purposes by doctors. Occasionally patients will agree to a consultation being recorded, providing the tape is wiped imediately after it has been reviewed. And the patient has control of recording during the consultation, to stop the tape at will. Having had the request to record explained, if the patient consents the tape should be started and the request and consent repeated with the tape running. In this way the patient's informed consent is recorded on the tape.

MEDICAL RECORD REVIEW

This is the simplest method of evaluation. It should be done regularly and in two ways: the scholar should be encouraged to submit noteworthy records and the tutor should select a few random records; 'spot checks'. Records may be noteworthy for any number of reasons: clinical interest, uncertainty, difficulty, exceptionally good and bad outcomes.

From the pattern of recording, indications of the scholar's strengths and weaknesses emerge. The tutor should develop skills in deducing trends in the scholar's performance from the record. Good records usually mean good work. Poor records may be poor recording of good work; more often they indicate poor overall performance. The tutor must learn to avoid systematic analysis of records. Such analysis is altogether too repetitive. He should focus discussion on significant features which address the scholar's strengths and weaknesses. Then record review will give a high yield quickly and cheaply.

THE PATTERN OF REVIEW

Reviews of medical records, observed and taped consultations, diaries and portfolios, should be done systematically. None should begin with "Why didn't you do this, that, or the other ?" Such an approach is threatening, it takes the initiative away from the scholar, and inhibits discussion. Routinely, reviews should begin with the tutor inviting the scholar to discuss the strengths of the subject. The tutor may wish to comment on these strengths and add others from his own perceptions. Next, the scholar is invited to discuss those things which should or could have been done differently, with advantage. Only then should the tutor raise deficiencies which he may have noticed. The expression "should or could have been done differently" fosters frankness and minimises threat.

DIARY REVIEW

All kinds of useful information can be gleaned from the scholar's diary, and the comparison between diaries compiled early and late in the term. The diary entries should be compared with the learning contract. To what extent is the work matching the contract ? Are casual patients featuring too often with an emphasis on episodic rather than continuing care ? What patterns of practice and coping strategies is the scholar displaying ? How have these developed, in the comparison between initial and later diary entries ?

PORTFOLIO OF CRITICAL INCIDENTS

What does the scholar choose to record ? What does he consider to be a 'critical incident', bearing in mind that in most consultations some unusual feature is the rule. If the choices are confined to clinical incidents, the tutor will need to broaden the scholar's perceptions of social and

occupational events, which may be highly significant to his patient.

LOG OF EDUCATIONAL EVENTS

This will list tutorial topics, lectures, seminars and workshops, journals club subjects, community projects, research and private study. It will provide evidence of the scholar's attention to his learning contract and the syllabus. This is an essential pre-requisite to assessment of performance. But the log will not in itself provide evidence of how well the scholar has performed. Scholar, tutor and management all need to be assured that a comprehensive syllabus is in place.

"CHECK" AND "VIATEL"

These were cited as valid and reliable tests of knowledge. In this important area, they are valuable aids to learning and assessment. However, there is the risk that they will be over-emphasised because they are reliable. Once the capital costs are accommodated, they are relatively inexpensive to run and easy to do.

But only two skills are tested. One is fact-finding; the other, problem solving. If the doctor is incompetent in either, he cannot be a competent general practitioner. If he is skilled in both he may or may not be competent. For competence depends on much more than knowledge and problem solving ability. Communication skills, empathy, effective community health teamwork, preventive attitudes and health promotion are among essential competencies which "Check" and "Viatel" do not address.

Global assumptions about competence tend to be made from the results of these quite limited but attractive tests. This can be seriously misleading.

OBSERVED CONSULTATIONS

Discussions about observed consultations should follow the sequence outlined in relation to medical records review. Tutor and scholar need to develop skills in giving and receiving feedback. Personal threats should be avoided. "You hurt the patient when you...." is much better put "The patient seemed to be in pain when you....". Tutors should be introduced to feed-back skills in teacher training courses. They should be explored in tutorials with scholars, to decide on some ground rules and avoid resentments before they have a chance to arise. The scholar must be assured of the positive goals of feedback, and should be encouraged to make it a two-way flow between himself and the tutor.

REVIEW OF TAPED CONSULTATIONS

This provides the most valid assessment of consulting performance. The reliability of the method remains a problem. Reliability can be enhanced with practise, and comparisons between taped consultations by the same scholar are capable of more reliable assessment than comparisons of tapes by different scholars. Series of tapes are always more reliable, like a movie film, than is one tape or a single photo.

The review of taped consultations exhibits several unique features. It is the only way the scholar can see himself at work. This realises a fundamental principle of evaluation: that he who is evaluated is actively involved in making judgements. Disagreements arise in review of observed consultations and record reviews, about what did or did not take place. But with a tape, the dispute can be settled.

Exactly the same sequence, first the scholar then the tutor discussing strengths then weaknesses, should be followed in

tape review. Three aspects need considering:

- o what is done appropriately ?
- o what is not done, that could well have been included ?
- o what is done that might have been better done differently, or not at all ?

The answers to the first and last questions come straight from an appreciation of what is on the tape. The second question, the omissions, by definition, is not recorded. These are the hardest features to identify. A check-list of consulting features, derived from the accumulated systematic analysis of over 100 tapes, provides an invaluable cue to the discussion about what might well have been included. In conjunction with colleagues at the Clarence Community Health Centre, Hobart, I have compiled such a list. (Carpenter, 1985)[21].

The equipment is expensive (camera, monitor, player, tapes): the process is very time consuming. There is the initial consulting time slightly extended by the introduction of the patient to the intention to record the consultation, and taping his consent; there is the time for review and comment, which will take at least twice as long as the consultation itself. And there is the matter of confidentiality. But as an insight about consulting performance, the method has no equal. This kind of assessment should be carried out as the availability of equipment and time dictate. Careful consideration of cost-effectiveness will put the review of taped consultations into proper perspective, alongside competing demands of other aspects of the first term curriculum.

REPORTS ON COMMUNITY PROJECTS

These will include the elective project and other extramural activities with community health care teamworkers.

These reports should be reviewed in the same way as the portfolio of critical incidents: why has a particular selection been made; what has been deemed noteworthy ? The astute tutor will detect underlying attitudes which have influenced the scholar's selections, and significant omissions.

For example, in the report of a visit with the domiciliary nurse, to a stroke victim, a typical report will document the clinical features of the stroke and mention some resulting disabilities. The more perceptive report will mention the clinical features and give a detailed functional assessment in terms of what has been achieved; what else might be accomplished; and how. If the tutor finds the former report he will need to counsel the scholar about developing more appropriate attitudes towards the care of the chronically disabled in the community setting, as in the latter report.

THE SUMMARY REPORT FORM (appendix 3.)

At the end of term, the tutor is required to report to the administration on his perceptions of the scholar's performance. The Report Form identifies sixteen parameters of the scholar's behaviour. It has been designed to give a comprehensive picture of the scholar's competence in general practice.

Although addressed to the administration, the Report needs to be shared with the scholar. This sharing should include the compilation of the Report, not just the sharing of the finished product. Its value lies in the extent to which the comments illuminate the scholar's qualities. Well written Reports are invaluable. They take a global look at the scholar at a point in time. This enables scholar and the administration to plan for ensuing terms rationally.

Sadly, few Summary Reports fulfil these criteria. They are

frequently compiled in haste by a busy tutor who documents his 'gut feelings' about the scholar. Quite often Reports are received by the administration consisting of a series of ticks indicating competence, without any comments at all. Rarely are Reports discussed by the tutor with the scholar; very rarely has the scholar taken part in writing the Report. All this reflect badly on tutors. It indicates a lack of appreciation of the potential value of the Report. No scholar is unworthy of comment at the end of his first term. All have strengths and weaknesses in every parameter, which need to be known to both the scholar and the administration.

At best the Summary Report is just that: a summary. It is no substitute for the other evaluations I have described. These need to be considered together by scholar and tutor during the final tutorial if the scholar is to understand and own the messages. The real value of these evaluations is the illumination they give to the scholar on his progress towards competence in general practice. Therefore any assessment which is not shared with the scholar is thereby devalued. Too many assessments collect dust in the office files. They should be used by scholars who stand to gain most from comments about themselves.

COMPUTED DATA ABOUT COSTS, PRESCRIPTIONS, REFERRALS, ETC.

I have said that this data may give misleading indications about clinical competence and cost-effective practice. Quarterly patient costs are a case in point. This is the cost generated by a general practitioner in caring for one patient for three months. Some of the best doctors, who do a great deal for their patients, including procedures, generate precisely the same substantial costs as are generated by other doctors who do a great deal and achieve little. Some of the best doctors are very sparing in prescribing, investigating and referring and elect not to do procedural work, which they refer to colleagues. These may generate

identical quarterly patient costs as those who give their patients scant attention, doing and achieving little. So in both extremes, and inbetween, the best and the worst doctors cannot be distinguished. Yet a great deal of emphasis used to be placed on quarterly patient costs as a measure of effective general practice.

Despite their limitations as instruments of evaluation, these statistics are well worth studying. Changing patterns between the beginning and end of term; variations between scholars; the influence of location, the patient mix and the scholar's experience; these are important issues which merit discussion by scholar and tutor as they interpret the data together.

From the accumulation of all these evaluations, a clear profile of the scholar's progress towards competence evolves. What remains to be done will become equally apparent. One is looking for mastery, not for any comparison between first term scholars.

EVALUATION OF TUTORS AND TEACHING

Parlett and Hamilton's illuminating analysis of evaluation provides an excellent framework for the evaluation of tutors and teaching. The tutor's role must be innovative if medical science is to be applied to the domiciliary environment in ways which match the scholar's career intentions and his strengths and weaknesses. The tutor must ask himself "what is happening as a result of my own and the scholar's intentions" (Hughes, 1987)[5]. How is the teaching being received? What evidence is there of learning? What bearing are the locality, the community and the selection of patients having on the scholar's progress? Is the consulting load too heavy or not enough? Are extra-mural

activities dovetailing with tutorials and consultations in fulfilling the learning contract, or dislocating them ?

The tutor needs to consider the advantages and disadvantages of what is happening, soliciting the scholar's views. What is influencing the scholar most ? How is the programme influencing the views of scholar and tutor ? To what extent and how is the programme increasing knowledge and changing attitudes ? The tutor may well reflect on Parlett and Hamilton's next question: "what is it like to be involved in the programme ?" from his own and the scholar's viewpoint. Their answers need to be shared with the administrators.

Then the matter of documentation arises. Tutors tend to keep little or no record of their teaching, or of the progress of their scholars. Yet good teaching records are just as important in education as are good clinical records in medicine. Records of what has been attempted, how, and with what results, are an essential tool in the teacher's development and a guide to further teaching.

Parlett and Hamilton's three concluding questions are equally pertinent to tutor, scholar and administrator. "What are the most significant features of the programme ?" To answer this, a portfolio of critical programme incidents is needed, parallel to the scholar's portfolio of practice incidents. It is equally appropriate to reflect on the reasons for incidents which are included or omitted.

"What are the most recurring commitments ?" This evaluation will be revealing. Patterns of practice will emerge; common conflicts between consulting and teaching commitments; commonalities in the interests and shortcomings of a succession of scholars; common mishaps; popular and unpopular topics. If they are recognised, recurring commitments can lead to better perspectives and realistic priorities.

"What are the most critical processes ?" These the tutor

will come to appreciate with experience. What features of the programme have the most profound effect on the scholar ? They will often seem to be events, not processes. Yet it is the way things are presented, the way people feel, that make the difference between the excellent and the ordinary. Processes are central to successful teaching, learning, and general practice.

EVALUATION OF MANAGEMENT AND CURRICULUM

It is vital that evaluations are data based. Unfounded opinions cloud issues. Nowhere is this more evident than in the evaluation of management and the curriculum. The question can arise "who evaluates the evaluators ?" The answer must be "they do", and it can only be done with hard data. Any evaluation which is coloured by likes and dislikes, personalities, ambitions and innuendos, is destructive. This is all too often the case in top management areas where professional jealousies are common.

Evaluation done systematically, with carefully considered answers to illuminating questions like those posed by Parlett and Hamilton, will be constructive. The programme will grow. Management often facilitates gossip by failing to provide data about programme performance, leaving a vacuum which human nature fills all too readily.

Objectives and strategies must be clearly defined and well publicised. They need to be revised when evidence shows a need for change. The demands on management by scholars, tutors and authorities needs assessing by questionnaire to elicit the demands and by debate to balance them within prescribed curriculum boundaries. Accountability deserves greater attention. Ignorance of the programme leaves the way open to speculation. And speculation is rarely optimistic.

The research model of teaching (Stenhouse, 1975)[13] is helpful in approaching the evaluation of management and the curriculum. Management should be the laboratory where the curriculum is put to the test. The origin of the proposal is not implied. It may come from scholar, tutor or the administration. The proposal for study is not a recommendation but a specification, claiming only to be intelligent, not 'correct'. The specification is not a package or syllabus to be covered but an idea to be tested and redefined. This is a dynamic approach. The proposal will need to be adapted. Because of variables, nothing can be prescribed universally.

I have reproduced this paragraph from "An introduction to Curriculum Research and Development" with hardly any changes. Its relevance is self-evident. It demonstrates how educational principles hold good across the board, from Board Room to the most remote Teaching Practice. Yet management often fails to practise what it preaches in the field.

Assessments will be received from tutors about scholars and from scholars about teaching practices and tutors. From the accumulated data, management should construct a profile of overall programme performance. This will include trends and anomolies. They need to be distinguished by practice visits. Data should be collected about contentious issues. The extent of strengths and successes should be known and publicised, to enhance the standing of the programme within and abroad. Morale is raised if scholars and tutors know they are involved in a well recognised creative achievement.

Weaknesses and deficiencies need to be known too. They should not be exaggerated or denied by those they concern. Realistic appreciation of what is actually happening is the foundation of successful management. Unfounded assumptions are hazardous. Most are either too global, overlooking significant variations, or too vague without specific use.

Management which engages in continuous illuminative evaluation, rigorously researching important issues, is in a position to deliver a relevant curriculum of general acclaim.

The evaluation of management involves internal and external audits. These will be educational and administrative. They will discern the extent to which the curriculum is meeting scholar's needs. Educational evaluation has been fully explored. Administrative evaluations may best be left to experts: government auditors who examine the records of account; College executives who judge the budget allocations in relation to educational and administrative areas of expenditure; visiting experts in medical education who make regular independant appraisals of issues within their terms of reference.

Principles of evaluation have been found to have consistent application to every aspect of the first term curriculum. To summarise the cardinal features, these are:

- the need for realism;
- the need for evaluations to illuminate processes;
- the need for constructive outcomes;
- the need to avoid threatening impressions;
- promotion of the benefits to foster evaluation;
- sharing the results with those being evaluated;
- the need for evaluations to be relevant, reliable and valid in the view of those being evaluated;
- they should be negotiated with those being evaluated;
- they should meet the purposes of the parties involved;
- justice must be done and be seen to be done.

CONTINUING MEDICAL EDUCATION

By the end of the first term the scholar should have achieved the transition from hospital to general practice. This will have involved the adaptation of medical science to the community environment; a patient-centred setting. It will have involved the refinement of pattern recognition and problem solving in the context of a fifteen-minute consultation. It will have involved the development of communication and counselling skills to identify the patient's purposes, to negotiate a management plan and to ensure the patient understands his condition and prognosis.

The scholar will have worked through his learning contract, evaluating progress and the extent to which it has been fulfilled. Through reports by scholar and tutor, management will be aware of the scholar's career intentions as far as they are known, and the progress the scholar has made towards competence in his chosen career.

Habits of practice and learning will have been established. These habits will reflect the impact of the first term curriculum. To the curriculum core, the scholar will have added his elective choices. The whole will be stamped with the scholar's unique personality. There is no place for cloning. Education for general practice should not aim to create a typical doctor, not even a good one. It should aim to enable each scholar to maximise his particular talents, to his own and his patient's benefit.

Continuing medical education is the maintenance of the habit of learning throughout the professional's career, to keep abreast of developments and revise little used expertise. Habits of learning influence habits of practice. If the former is deficient the latter must suffer.

By the end of the first term, plans for the next should be in place. Too often the connection between successive terms is rudimentary. There is always unfinished business at the end of every term which needs to be carried over. Aspects of the learning contract may have proved impossible to fulfil. And none can perfect communication and counselling skills in one term. Ideas will have arisen during the term, too late or inappropriate for immediate attention. The important thing is not to attempt too much at once, but to record everything at once for attention later, and to review the record periodically.

This record and its implementation is the basis of continuing medical education. It is not just a matter of going to events on the spur of the moment, or for tax-free breaks. Neither is it enough to fulfil peer prescribed numbers of postgraduate events. Such selections tend to foster study of subjects in which the doctor is most proficient rather than those about which he knows least. Problem based continuing education ensures that study time is put to good use.

Pressures of practice tend to increase with the passage of time. Time management becomes increasingly important. Study time should always have a defined place in every doctor's schedule. Otherwise it may be crowded out. This time will be more willingly set aside if the study is rewarding. Most doctors have returned from conferences feeling tired and disappointed. This is usually forseeable. Disappointment often follows a conference about something in which one is expert.

Active learning is preferable to passive. Workshops are preferable to lectures. But the best guide comes from noting problems as they arise in practice and building an educational programme around them.

DIFFICULTIES WITH CONTINUING EDUCATION

Self-directed learning is not synonymous with solitary learning. But it is very different to the dependant learning of school and medical school. One of the tutor's most important tasks is to encourage the scholar to keep the habit of learning. With a sigh of relief, some scholars hope that study is over with graduation. It is true that one no longer has to study an imposed curriculum, with an examination at the end.

Whether or not the scholar studies now rests very largely with him: he will study for professional fulfilment and success. Solitary learning is harder to maintain. Small group work is mutually stimulating for the members, in journals clubs, courses and conferences, and peer review of each other's work, as in practice meetings. Solo doctors should establish collegiate relations with neighbouring doctors to compensate for the lack of practice meetings.

EFFECTIVE CONTINUING EDUCATION

To further problem-based learning, specialists should be approached to answer questions, not just for patient referrals. Very few general practitioners take the trouble to attend any ward rounds and clinics in subjects about which they need to know more. Yet their welcome is generally assured. "Viatel" and "Check" are not only for scholars. They should be studied throughout the doctor's career. And the library remains the corner-stone of problem solving. A literature search is invariably rewarding. The well read doctor has the same professional advantage in medicine as does his counterpart in every other walk of life. Computers have revolutionised access to recorded data and greatly facilitiate literary enquiry.

EVALUATION OF CONTINUING EDUCATION

Based on recorded problems, the habit of contract learning needs to be maintained life-long. The written record gives substance to evaluation. Means of evaluation will need to be selected from those presented in this dissertation, appropriate to the matter in hand. Review of taped consultations should always be included periodically. This is by far the best way to detect bad habits before they become entrenched. And no doctor is immune from the incidious onset of deficiencies in consulting behaviour.

Taking a scholar is an excellent way of ensuring continuing education. Scholar and tutor stimulate each other's learning and evaluation. This is the universal experience of tutors: each broadens the other's horizons.

So we have come full circle. We began with a scholar fresh from medical school and Internship. We have explored the curriculum for the transition from hospital to general practice during the first critical three months. We have seen how attitudes change, new knowledge and skills are acquired and medical science is adapted to the patient's circumstances. We have traced the career pathway of learning and evalutation which may lead to the scholar becoming a tutor. The key to success is the constant awareness of what is <u>really happening</u> and to ensure this equates with what doctor and patient <u>really need</u>.

PRINCIPAL RECOMMENDATIONS

During the course of this dissertation, a number of issues have been identified, where problems exist in the present situation. Sometimes I have suggested solutions; other times the problem seems to me to defy solution but some alleviation may be possible. This section summarises the principal recommendations. Page numbers refer to explanations in the body of the dissertation.

1. 'Scholars', 'tutors', teaching' and 'teaching practices' are preferred terms (page 1)
2. Vocational education for general practice should be mandatory (page 2)
3. The curriculum should arise from the differences between hospital and general practice (page 2)
4. The first G P term is a critical period when patterns of practice should be established to last a life-time (page 2)
5. The syllabus should concentrate on the adaptation of medical science to the domiciliary environment (page 4)
6. Curriculum issues should be everyone's concern (page 5)
7. The scholar should aim to do more than 'see patients' (page 6)
8. Tutors should not view scholars as locum relief (page 6)
9. To the extent it is known, where the scholar intends to practice should influence the choice of locality for his first term (city, suburb, country town) (page 7)
10. Country towns should be selected if the scholar is undecided (page 7)
11. The scholar should be introduced to, and work with, the whole health care team (page 8)
12. The scholar should see 50 - 100 patients per week (page 8)

13. The scholar should have his own well-equipped surgery (page 8)

14. Scholars should be encouraged to use all the practice facilities (page 9)

15. The curriculum should include a conscious balance of consulting, study, assessment and private time (page 9)

16. Teaching practices should be solicited after comprehensive area survey (page 10)

16. Teaching practices should be selected for teaching, not just because they fulfil other criteria (page 10)

17. Teaching practices should be selected by experienced tutors (page 10)

18. Isolated rural practices should not be selected for first terms (page 10)

19. Acceptable facilities should lead to provisional accreditation (page 11)

20. Performance during the first placement should be carefully assessed, before a second placement (page 11)

21. Teaching should be rewarded financially (page 12)

22. Selection of teaching practices should be related to education, not to providing employment (page 12)

SCHOLARS AND SCHOLARSHIP

23. The scholar should become increasingly responsible for his own education (page 13)

24. Content and processes of learning should be negotiated between scholar and tutor (page 13)

25. Study should meet the scholar's purposes and expectations, not the tutor's (page 13)

25. Scholars should own their scholarship (page 13)

26. As far as possible, all medical graduates should be offered a first G P term (page 14)

27. If there are insufficient first terms, scholars intending to become general practitioners should have preference, then those wanting G P experience (page 14)

28. Some 'unstreamed' rotating Residencies without G P terms should be provided by hospitals (page 14)

29. Self-selection of scholars with peer approval should be allowed to occur, unless the candidate is clearly unsuitable for general practice (page 15)

30. Encouragement to gain general practice experience should continue from early undergraduate days (page 15)

31. Undergraduates should see more general practice (page 15)

32. The patient, not his disease, should be re-established as the central focus for the scholar's attention (page 16)

33. The scholar should come to expect to co-operate with patients, not to direct them (page 17)

34. Tutors should influence the scholar's expectation of needing to know everything, towards being able to find out all that is known (page 17)

35. The scholar should be introduced to networking (page 17)

36. The tutor should know and meet the scholar's reasonable expectations (page 18)

37. Scholar and tutor should negotiate a feasible learning contract to meet the scholar's expectations and fulfil curriculum requirements for the first G P term (page 18)

38. Scholars should not attempt too little or too much (page 19)

39. Experiences should be analysed and synthesised (page 19)

40. Learning should be enhanced by extra-mural activities (page 19)

41. Time during the working day should be set aside for extra-mural activities (page 20)

42. Library selections should be discriminating (page 20)

43. Active workshops should be preferred to passive learning (page 20)

44. The scholar should attend weekly practice meetings (page 21)

45. Ward rounds and clinics should be valued, but the alien (hospital) environment needs to be recognised (page 21)

TUTORS AND TEACHING

46. Tutors should be selected for their teaching skills and their commitment to teaching and teacher education (page 22)

47. Tutors should be selected by experienced teachers, who are good communicators (page 22)

48. Tutors should be required to signify their commitment of time to teaching and teacher education (page 23)

49. Tutors should not just assume they can teach (page 23)

50. Teacher training should be conducted in small group workshops (page 23)

51. Tutors should log their teaching programme (page 24)

52. The selection of a tutor should be appraised at the end of the first placement, before a second placement (page 24)

53. Tutors should not expect to teach medical science (page 24)

54. Tutors should expect to teach the application of medical science to general practice (page 25)

55. Tutors should emphasise communication and counselling skills, networking, and the place of medical records (page 25)

56. Tutors should introduce scholars to their practices sensitively (page 25)

57. Tutors should solicit feedback from practice staff and patients (page 26)

58. Administrators should assist with the introduction of scholars and in the development of feedback (page 27)

59. Expectations should be documented (page 27)

60. The expectations of scholar, tutor and administrator should be congruent (page 27)

61. Each should appreciate the other's expectations (page 28)

62. Principles of practice should be applied to teaching (page 29)

63. There should be a non-negotiable core-content; a syllabus prescribed by the administration (page 30)

64. Learning processes and elective content should be negotiable between scholar and tutor (page 30)

65. The teaching practice should be seen as a laboratory where educational proposals are put to the test; with the tutor as researcher (page 30)

66. Established principles of education should be studied and incorporated into an integrated curriculum (page 31)

67. The tutor should maintain a problem-based teaching contract, reflecting the scholar's learning contract (page 32)

68. Deliberation should be slow; action quick (page 32)

69. Ways of teaching should be studied, to be implemented effectively and appropriately, with the emphasis on open questions and topic-orientated discussions (page 33)

70. The tutor should be careful not to let 'anything pass' (page 33)

71. The influence of personalities should be recognised (page 34)

72. When personalities clash, the administrator should relocate the scholar sooner, not later (page 34)

73. The assessment of tutors should be an established routine (page 35)

MANAGEMENT AND CO-ORDINATION

74. Managers should be selected for their administrative skills and educational professionalism (page 37)

75. Managers should be experienced general practitioners of good standing, with defined exceptions (page 37)

76. Most managers need in-service training (page 37)

77. Salaries should approximate to those in practice (page 37)

78. Selection of managers should be made by senior peers (page 37)

79. Reasons for the selection and expectations should be compared with the manager's performance (page 38)

80. Managers should keep closely involved with undergraduates, tutors, scholars and teaching practices (page 38)

81. Managers need to match scholars with locations and tutors, to meet the scholar's intentions (page 38)

82. Managers should monitor the extra-mural programme, arranging corporate activities as necessary (page 38)

83. Managers should ensure comprehensive curriculum content and effective processes (page 39)

84. Managers should encourage and facilitate teaching and teacher development (page 39)

85. Managers should ensure the quality of teacher training (page 40)

86. Managers should provide resources on request, for tutorials and for scholars (page 40)

87. Managers should be aware of patients' views about the first term, seeking feedback on practice visits (page 40)

88. Managers should keep within budget limits, carefully apportioning funds and documenting imposed constraints (page 41)

89. Managers should be accountable to the relevant authorities administratively and educationally (page 41)

90. Teaching practices should acquit their first terms (page 41)

91. Scholars should be paid an agreed minimum with bonuses, not the equivalent Resident's salary (page 42)

92. Summative assessment should not inhibit the scholar's preparedness to reveal his deficiences (page 42)

93. The Certificate of Completion should be integrated with on-going progress towards College Fellowship (page 42)

94. Teaching practices should publicise their commitment to general practice education (page 43)

95. Management should foster economies of scale (page 44)

96. The advantages of first terms should be researched, despite the difficulties inherent in the objective assessment of consulting performance (page 44)

97. Curriculum decisions should be data-based (page 45)

98. Curriculum objectives should be defined and documented (page 45)

99. The curriculum should be reviewed often enough to keep it relevant; not enough to be confusing (page 45)

100. The curriculum should be 'scholar-centred' (page 46)

101. The curriculum should hold in balance the legitimate needs of scholars, tutors, administrators and authorities (page 46)

102. Purchasing of resources should be based on the expressed needs of scholars and tutors (page 46)

103. The telephone should be used judiciously (page 47)

104. Quality should not be the casualty of quantity (page 47)

105. Quality should not be assumed from quantity (page 47)

106. Quality should be continuously assessed (page 47)

107. Reports should be shorter, containing all relevant data, and distributed more appropriately (page 48)

108. Effective communications should be fostered: successful implementation of the curriculum rests here (page 48)

THE SYLLABUS

109. Knowledge, skills and attitudes necessary to accomplish the transition from hospital to general practice should be identified and incorporated into an achieveable syllabus (page 49)

110. The syllabus should be discussed by scholar and tutor at the beginning of term (page 51)

111. The discussion should identify core and elective aspects for tutorials and extra-mural activities (page 51)

112. Tutorials should be planned and prepared for (page 52)

113. Extra-mural activities should be undertaken to gain knowledge not likely to come from the practice (page 52)

114. Prevention and early diagnosis (page 52), interpersonal relationships and the family (page 53), health & illness: social and environmental factors (page 53), the range of interventions (page 53), defensive practice (page 54), research (page 55), patient education (page 55), empathy (page 56), the patient as a unique individual (page 56), helping patients to solve their own problems (page 57), the doctor in the wider community (page 57), evaluation and continuing education (page 58), problem definition, diagnosis and problem solving (page 58), the place of epidemiology and probability (page 59), the time factor (page 59), risk factors (page 60), initial decisions (page 61), co-operating with colleagues (page 61), limited practice management (page 61), communication and health education (page 62), home visits and field work (page 63) and functional assessment of the patient (page 63) should all be addressed.

EVALUATION

115. Evaluation should be comprehensive, illuminating, and continuous throughout the programme (page 66)

116. Means of evaluation should be identified and built into every aspect of first term education (page 66)

117. Those being evaluated should be included in planning, active in the process and party to the outcome (page 66)

118. 'Third parties' should stake their claim beforehand (page 66)

119. Internal evaluations should include diaries, portfolios, record review, review of observed and taped consultations, community projects and research (page 66)

120. External evaluations should include "Check", "Viatel" and examinations (page 67)

121. Validity and reliability of various methods of evalattion need to be established (page 67)

122. Selected methods should be valid and reliable, with the emphasis on validity (page 68)

123. Substitution of easily evaluated factors which do not represent important factors which are hard to assess, or which defy evaluation, should be avoided (page 68)

124. The aims of evaluation should be understood and agreed upon by all those involved (page 68)

125. Evaluation issues should be part of teacher training and tutorials with scholars (page 69)

126. The intentions of any evaluation should be documented, together with the process and outcomes (page 69)

127. Self-assessment should be encouraged (page 70)

128. Confidentiality, especially relating to recorded consultations, should be closely guarded (page 71)

129. The patient's consent for a taped consultation should be openly invited and documented beforehand (page 72)

130. Medical record review should not be repetitive (page 72)

131. The pattern of review should start with strengths, then weaknesses; first the scholar's perceptions, then the tutor's (page 73)

132. Threatening language should be avoided: it inhibits frankness in the scholar (page 73)

133. Diary entries should be used to assess the appropriateness of the work load and maturing approaches (page 73)

134. The reason for selection of an incident recorded in the portfolio should be solicited (page 73)

135. The educational log should be used to assess the comprehensiveness of the syllabus (page 74)

136. The value and limitation of "Check" and "viatel" should be appreciated (page 74)

137. Taped consultations should be appreciated as the only way for a doctor to visualise himself (page 75)

138. Taped consultations should be reviewed in conjunction with a check list of consulting features (page 76)

139. Reports of community projects should be used to assess the scholar's performance in teamwork (page 77)

140. The domiciliary context should be apparent in the scholar's attitudes and approach to patients (page 77)

141. The Summary Report Form should be completed conscientiously by tutor and scholar together (page 77)

142. Deductions from the Summary Report should be discussed between, and implemented by, scholar and administrator (page 78)

143. Data stemming from practice (costs, prescribing, referrals) should be used circumspectly (page 79)

144. Documentation of teaching should be comprehensive, as a basis for its evaluation (page 80)

145. The most significant features, recurring commitments and critical processes should be identified (page 80)

146. Processes as well as content of teaching should be evaluated (page 80)

147. The ways of evaluating teaching performance are the same as those for consulting performance (page 80)

148. Evaluations should be data-based (page 81)

149. Evaluations should be constructive (page 81)

150. Because of variables, nothing should be prescribed universally (page 82)

151. Corporate strengths of the educational programme should be publicised (page 82)

152. Particularly should data be sought to resolve contentious issues (page 82)

153. Auditors and external experts should be engaged to assist with evaluations in their fields (page 83)

154. Evaluations should be realistic; shared; non-threatening; obviously relevant, reliable and valid; negotiated to meet the purposes of the parties involved (page 83)

CONTINUING MEDICAL EDUCATION

155. Appropriate habits of practice, education and evaluation should have been formed in the first term (page 84)

156. The transition from hospital to general practice should be complete (page 84)

157. Education should not aim to 'clone' (page 84)

158. Education should maximise each scholar's talents (page 84)

159. Continuing medical education should enable the doctor to keep abreast of developments in practice (page 84)

160. Terms should be connected, unfinished business being carried over from one to the next (page 85)

161. To be effective and efficient, continuing education should be problem based (page 85)

162. Study time should always have a defined place or it stands to be crowded out by practice pressures (page 85)

163. Problems for further study should be documented when they arise, and the record reviewed (page 85)

164. Group learning is preferable to solitary study (page 86)

165. Specialist advice, "Check", "Viatel" and literature searches should be prominent in continuing education (page 86)

166. The capacities of computers for organisation and access of information should be used (page 86)

167. Review of taped consultations should remain a regular feature of continuing education (page 87)

168. The scholar may consider becoming a tutor in time: an excellent way of remaining actively learning (page 87)

169. What is really happening should be known, and should match what is really needed by doctor and patient (page 87)

Beijing, China;
12 November, 1988

PAGE /
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APPENDICES

ACC:PA
(9/85)

CONFIDENTIAL

THE ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS

APPLICATION FOR ACCREDITATION - FAMILY PRACTICE TEACHING POST

DETAILS OF FAMILY PRACTICE

Name of Practice:_____

Address of Practice:_____

_____ Postcode:_____ Telephone:_____

Applicants for General Practice Supervisor Accreditation:

1.
2.
3.
4.

Personnel in Practice:

Medical

Name	Special Interests

Paramedical

Name	Interests

Other

Name	Duties

Has the practice any special activity you would like to mention?

_____

_____

Equipment used in the Practice: (Please tick)

		☐	Practice Library
☐	Scales	☐	Sigmoidoscope
☐	Refrigeration	☐	Centrifuge
☐	Dangerous drugs storage	☐	Microscope
☐	Ophthacmascope	☐	Electrocardiograph
☐	Vaginal speculae	☐	Cautery Apparatus
☐	Proctoscope	☐	Spirometer
☐	Sterilizer	☐	Tonometer
☐	Minor Surgery Equipment	☐	Pathology Equipment

Consultant Services - Is there ready access to: (Please tick)

Yes	No	
☐	☐	Public Hospitals
☐	☐	Private Hospitals
☐	☐	X-Ray
☐	☐	Pathology
☐	☐	Consultants
☐	☐	Allied Health Professionals

Spectrum of Patient seen by Practice: (Please tick)

	None	Few	Many
Obstetric	☐	☐	☐
Paediatric	☐	☐	☐
Adolescent	☐	☐	☐
Adult	☐	☐	☐
Geriatric	☐	☐	☐
Casualty/Trauma	☐	☐	☐

Teaching Facilities

Is a consulting room available for trainee: Yes/No

Is the Practice included in a regional hospital rotating programme: Yes/No

If yes, Name of parent hospital

Name of satellite hospital

Date / / Signed: _____

ACC:PC
(9/85)

CONFIDENTIAL

THE ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS

APPLICATION FOR ACCREDITATION - FAMILY PRACTICE TEACHING POST

DETAILS OF PRACTICE VISIT

Name of Practice:_____

Address of Practice:_____

_____ Postcode:_____ Telephone:_____

Premises:

Total number of consulting rooms ☐

Other separate examination rooms ☐

Is aconsulting room available to the trainee:

☐ Yes

☐ No

Is it adequate for his/her needs:

☐ Yes

☐ No

Are there any significant deficiencies in the practice facilities?
(Please specify)

_____

_____

_____

Patient access:

How many patient contacts does the practice average per week?

☐

What is the usual daily workload of the trainer?

☐

Is this load compatible with trainer responsibilities?

☐ Yes

☐ No

ACC:PC : ii
9/85

What are the weekday office hours?:

_____

Is there an appointment system?:_____

How often are the bookings made?:_____

Does the practice provide domiciliary care?:

☐ Yes
☐ No

Average number of home visits per week?:

☐

Does the practice conduct any special clinics?: (Please specify)

_____

_____

_____

What medical emergencies do you handle:

_____

_____

_____

What after hours service is provided?:

☐ None
☐ Group Practice roster
☐ Roster with neighbouring doctors
☐ Locum deputising services

Is the patient's personal doctor available to the duty doctor?:

☐ Yes
☐ No

Administration:

Who is the Practice Administrator?:_____

Is there a formal management committee which meets regularly?:

Are you prepared to allow the trainee to attend some of your management committee meetings?: or Are you prepared to instruct the trainee in practice management?

ACC:PC : iii
9/85

Records:

Is a medical record kept for every patient?:_____

Are they legible?:_____

Are they comprehensible?:_____

Is retrieval of information easy?:_____

Is the College record system used?:_____

Is this teaching post recommended by you for:

☐ Full accreditation

☐ Limited accreditation

If recommended for limited accreditation what is the area defined: (Please specify)

_____

_____

_____

This Teaching post is recommended for:

☐ Basic trainees

☐ Advanced trainees

☐ Both

Comments by visitor:

_____

_____

_____

_____

_____

Date / / Signed:_____

(Surname in capitals):_____

ACC:1
(8/87)

THE ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS (xviii)

ACCREDITATION UPDATE

[NOTES
1. This Update is to be completed after each meeting of a Faculty Accreditation Committee and forwarded to the Chairman of ACC.

2. Please ensure one ACC:PD form is completed and forwarded with Update for each accreditation, re-accreditation and withdrawal.]

ACCREDITATION OF GP SUPERVISORS (*please list name, address and advise if this is also an initial accreditation for family practice teaching post*)

RE-ACCREDITATION OF GP SUPERVISORS (*name and address*)

WITHDRAWAL OF ACCREDITATION OF GP SUPERVISORS (*name and address*)

ACCREDITATION OF GP MENTORS *(name and address)*

_____

_____

_____

_____

_____

ACCREDITATION OF HOSPITAL TRAINING POSTS *(hospital, address + clinical disciplines, if any)*

HOSPITAL: _____

(Clinical Disciplines: _____)

HOSPITAL: _____

(Clinical Disciplines: _____)

RE-ACCREDITATION OF HOSPITAL TRAINING POSTS *(hospital, address + clinical disciplines, if any)*

HOSPITAL: _____

(Clinical Disciplines: _____)

HOSPITAL: _____

(Clinical Disciplines: _____)

HOSPITAL: _____

(Clinical Disciplines: _____)

HOSPITAL: _____

(Clinical Disciplines: _____)

WITHDRAWAL OF HOSPITAL TRAINING POSTS *(name and address)*

_____

_____

COMMENTS: _____

_____

_____

SIGNED: _____ **DATE:** / / 19 .

(Chairman)

LEARNING CONTRACT — DR CHRISTINE — 1983

LEARNING OBJECTIVES	STRATEGIES/RESOURCES	ASSESSMENTS
1. To learn the principles of practice management — a. organisation b. billing procedure c. income/expenditure d. equipment — supply — purchase — leasing e. insurance f. taxation	**Resources** • practice partners • " staff • " accountant • " records • " suppliers **Strategies** • discussion with above personnel • suggestions from staff and GP Supervisor on how to pursue this objective . . . . . . a. b. c. d.	1. Do project "flow chart" on managment plan of the practice and have it reviewed and assessed by GP Supervisor and practice staff using "Project Assessment Form" — (FMP). 2. Continually review personal learning using "Self Assessment Protocol" (FMP). 3. Seek assessment from GP Supervisor and staff on my performance using modified "Self Assessment Protocol" — (FMP)
2. To learn the skills of effective consulting — a. identifying "critical incidents" in the consultation. b. reflective listening. c. use and understanding of "body language". d. confrontation. e. consulting with the family. f. dual/multiple consultations.	**Resources/Strategies** • GP Supervisor • local counsellors? • **texts** — ask Training Advisor " GP Supervisor • Audio/Video tapes — FMP? ask Med. Educators. • other suggestions: GPS/TA/ME . . . a. b. c. d.	1. Case discussions with GPs (and counsellor?) using "case records assessment" from FMP protocols. 2. Self assessment using FMP "self assessment protocols" and discuss with GP Supervisor. 3. "Direct observation" by supervisor — periodically. Assessment using FMP protocol.
3. Family planning — a. fertility control methods b. infertility c. sexual inadequacy d. counselling e. sterilization f. abortion g. STD h. procedures	GP Supervisor. FP Association — literature. FPA Course at future date. STD clinic at future date. CHECK on FP/STD. "Scope of General Practice." ASSERT course if possible.	1. Do AFFPA exam for certification later in 1983. 2. Do CHECK programme on FP and STD and have them assessed by GPS and do self assessment. 3. Compile personal Resource Folder on FP and STD in GP, and ask for assessment by FP Sister and GPS.

Australian Family Physician May 1983 — GP News

GPPR 2—85 *NOT TO BE RETURNED TO FMP*

The Royal Australian College of General Practitioners
FAMILY MEDICINE PROGRAMME (xx)

ASSESSMENT/FEEDBACK FORM FOR THE GENERAL PRACTICE TERM

PROGRESS REPORT

This form is designed to help FMP doctors identify their areas of clinical strengths and weaknesses, so that specific further training can be planned. Frank and constructive feedback from you is essential for this aim. Bear in mind that the doctor is aiming ultimately to enter general, rather than specialty, practice.

If you have insufficient information to answer a question, please indicate this.

FMP Doctor ..... Supervisor .....

PRACTICE..... TERM..... DATE..... TO.....

IS THIS DOCTOR PROFICIENT IN:

- obtaining information from patients and others and recording this on the medical record and in referral letters?
  Yes ( )
  Not yet — needs improvement in: .....
  .....
- performing patient examinations, diagnostic tests, and procedures?
  Yes ( )
  Not yet — needs improvement in: .....
  .....
- making decisions in diagnosis and management with the patient as a participant?
  Yes ( )
  Not yet — needs improvement in: .....
  .....
- developing effective relationships with patients, families, and medical and paramedical colleagues and practice staff?
  Yes ( )
  Not yet — needs improvement in: .....
  .....
- interpersonal communication and in working as a member of a team?
  Yes ( )
  Not yet — needs improvement in: .....
  .....
- providing continuing care, illness prevention and health promotion (eg. smoking, alcohol, diet) and coordinating the patient's total health care?
  Yes ( )
  Not yet — needs improvement in: .....
  .....
- the administrative aspects of the position such as paperwork and the effective use of time, practice organisation and financial management?
  Yes ( )
  Not yet — needs improvement in: .....
  .....
- assessing clinical information and reaching logical conclusions, but willing to change his/her mind in the light of new information?
  Yes ( )
  Not yet — needs improvement in: .....
  .....
- recognising the limits of his/her own knowledge, experience and ability and enlisting help?
  Yes ( )
  Not yet — needs improvement in: .....
  .....
- appreciating the social and psychological dimensions of the problem eg. the patient's family, ethnic, work and community environment?
  Yes ( )
  Not yet — needs improvement in: .....
  .....

DOES THIS DOCTOR:

- exhibit the personal and professional qualities required of a doctor eg. accepting responsibility, conscientious, caring, reliable, ethical?
  Yes ( )
  Not yet — needs improvement in: .....
  .....
- understand the Commonwealth, State and local health care system and make effective use of the community's resources?
  Yes ( )
  Not yet — needs improvement in: .....
  .....
- consider the cost of investigations, drugs and procedures to the patient and the community?
  Yes ( )
  Not yet — needs improvement in: .....
  .....
- show keenness to learn, plan his/her own learning and assessment, and accept and give feedback?
  Yes ( )
  Not yet — needs improvement in: .....
  .....
- exhibit ability to tolerate ambiguity and uncertainty, and to remain competent in a crisis?
  Yes ( )
  Not yet — needs improvement in: .....
  .....

CLINICAL KNOWLEDGE AND SKILLS

Of the clinical problems encountered during this term, which were handled very well by the doctor, and which require further attention?

Problems handled very well	Areas requiring further attention

GENERAL COMMENTS:

Please comment on the doctor's progress during the term — the extent to which the doctor's training objectives have been fulfilled. Include any additional comments that might help this doctor become a more effective general practitioner.

.....
.....
.....
.....
.....
.....
.....

I have discussed the above with the doctor.

Signed: ..... Date: .....

Thank you for your assistance in completing this form and discussing it with the FMP doctor.

GPSR 2 — 85

The Royal Australian College of General Practitioners (xxi)
FAMILY MEDICINE PROGRAMME

ASSESSMENT/FEEDBACK FORM FOR THE GENERAL PRACTICE TERM

SUMMARY REPORT

This form is designed to help FMP doctors identify their areas of clinical strengths and weaknesses, so that specific further training can be planned. Frank and constructive feedback from you is essential for this aim. Bear in mind that the doctor is aiming ultimately to enter general, rather than specialty, practice.

If you have insufficient information to answer a question, please indicate this.

FMP Doctor ..... Supervisor .....

PRACTICE..... TERM..... DATE..... TO.....

IS THIS DOCTOR PROFICIENT IN:

- obtaining information from patients and others and recording this on the medical record and in referral letters?
  Yes ( )
  Not yet — needs improvement in: .....
- performing patient examinations, diagnostic tests, and procedures?
  Yes ( )
  Not yet — needs improvement in: .....
- making decisions in diagnosis and management with the patient as a participant?
  Yes ( )
  Not yet — needs improvement in: .....
- developing effective relationships with patients, families, and medical and paramedical colleagues and practice staff?
  Yes ( )
  Not yet — needs improvement in: .....
- interpersonal communication and in working as a member of a team?
  Yes ( )
  Not yet — needs improvement in: .....
- providing continuing care, illness prevention and health promotion (eg. smoking, alcohol, diet) and coordinating the patient's total health care?
  Yes ( )
  Not yet — needs improvement in: .....
- the administrative aspects of the position such as paperwork and the effective use of time, practice organisation and financial management?
  Yes ( )
  Not yet — needs improvement in: .....
- assessing clinical information and reaching logical conclusions, but willing to change his/her mind in the light of new information?
  Yes ( )
  Not yet — needs improvement in: .....
- recognising the limits of his/her own knowledge, experience and ability and enlisting help?
  Yes ( )
  Not yet — needs improvement in: .....
- appreciating the social and psychological dimensions of the problem eg. the patient's family, ethnic, work and community environment?
  Yes ( )
  Not yet — needs improvement in: .....

DOES THIS DOCTOR:

- exhibit the personal and professional qualities required of a doctor eg. accepting responsibility, conscientious, caring, reliable, ethical?
  Yes ( )
  Not yet — needs improvement in: .....
  .....
- understand the Commonwealth, State and local health care system and make effective use of the community's resources?
  Yes ( )
  Not yet — needs improvement in: .....
  .....
- consider the cost of investigations, drugs and procedures to the patient and the community?
  Yes ( )
  Not yet — needs improvement in: .....
  .....
- show keenness to learn, plan his/her own learning and assessment, and accept and give feedback?
  Yes ( )
  Not yet — needs improvement in: .....
  .....
- exhibit ability to tolerate ambiguity and uncertainty, and to remain competent in a crisis?
  Yes ( )
  Not yet — needs improvement in: .....
  .....

CLINICAL KNOWLEDGE AND SKILLS

Of the clinical problems encountered during this term, which were handled very well by the doctor, and which require further attention?

Problems handled very well	Areas requiring further attention

GENERAL COMMENTS:

Please comment on the doctor's progress during the term — the extent to which the doctor's training objectives have been fulfilled. Include any additional comments that might help this doctor become a more effective general practitioner.

.....
.....
.....
.....
.....
.....
.....

I have discussed the above with the doctor.

Signed: ..... Date: .....

Thank you for your assistance in completing this form and discussing it with the FMP doctor.