Learning general practice — the experience of one trainee*

PETER CHARLES STOTT, MA, MB, B.CHIR, DCH, DRCOG
Vocational Trainee, Shepherd's Bush, London

SUMMARY. I report my experiences in learning general practice as a vocational trainee with 12 months divided between two general practices at the end of a three-year course. A parallel between developmental milestones and a trainee's educational development is drawn and the reasons which brought patients to me as a trainee are analysed.

I suggest the trainee year should be a dynamic time of learning and that trainees should be in an educational environment including progressively less authority. The trainer/trainee relationship, like the doctor/patient relationship, is all important.

Introduction

I AM now nearing the end of my three-year vocational training course. The first two years were spent in hospital with one evening a week in practice. Then I changed trainers and my trainee year has passed rapidly and enjoyably in a busy, Inner London practice. When I started I was lost and confused; now I am at least pointing in the right direction. What has happened in the intervening three years?

Aim

Coming as raw recruits from hospital to join the ranks of experienced men trainees face many problems—problems of knowledge, skills, and attitudes. I shall try to show how adjustment to these problems involves oscillations in behaviour and then relate this to a project which I did during my own trainee year about diagnosis. Then I shall discuss learning theory before indicating, humourously, I hope, the type of behaviour one can expect generally from a trainee. I shall suggest those types of learning which my colleagues and I have found helpful at different stages of our training in respect of knowledge (methods), skills (strategies), and attitudes (concepts). Finally, I shall try to catalyse the process.

*An edited version of a lecture given at the North-West Thames trainers' course on 9 May 1978.

© *Journal of the Royal College of General Practitioners*, 1979, **29**, 53-58.

Trainee problems

1. *Knowledge*

a) Of what is normal (physically/socially/psychologically).

b) Extrapolation to extremes.

c) Of the patients' past and family histories.

d) Specific gaps in knowledge.

The biggest disadvantage in the knowledge trainees possess is that it is based on the extreme pathological processes seen in hospital. We have little knowledge of the normal range of day-to-day symptoms that people present to general practitioners so we tend to extrapolate minor symptoms to major morbid pathology. Thus indigestion is likely to be diagnosed as an ulcer and a simple sprain may become arthritis. Secondly, patients expect the doctor to know all about them: "After all, doctor, you've got all my notes there!" True, but that does not help trainees when the records are illegible and follow no system. Lastly, even the best training scheme will leave some specific gaps in knowledge. I found the use of good multiple choice questionnaires invaluable in helping identify my own.

2. *Skills*

a) Interviewing
b) Unscrambling
c) Managing time
d) Discriminating
e) Counselling
f) Reducing anxiety
g) Telephone technique
h) Managing people (e.g. receptionists)
i) Specific skills
j) Avoidance of modelling

Having been thrown in at the deep end with little relevant knowledge, trainees are expected to do things they have never done before and to use skills they will not recognize until the day after tomorrow. For example, such skills as we possess in interviewing are appropriate to the formal hospital setting where there is either plenty of time or at least the patient knows why he has come. Not only are these techniques inappropriate for general practice but they exclude skills for discriminating and unscrambling. The new trainee, therefore, tends to prescribe more and do so more

often. Early in my trainee year, one chemist rang me to say that he had run out of carrier bags and could I please let him know when I was going to hold my next surgery so that he could order more supplies!

Managing time was one problem which did not worry me much. When I started, the natives were pretty hostile and only about four people a day wanted to see me! (Most of these were Chilean refugees.) For many trainees however, lists are arranged so that they work slowly at first, then gradually speed up over the first two or three months as they acquire new skills for controlling the length of consultations.

Trainees must recognize not only that their skills are inadequate, but that their new ones may be no more than a simple modelling of their trainer's. Experience of more than one trainer may therefore be advisable.

3. Attitudes

a) Unlearning and reappraising:
   i) diagnosis versus management
   ii) reality versus theory
   iii) inappropriate doctor/patient techniques
   iv) anecdotal ideas of general practice.

b) Accepting:
   i) compromise
   ii) that anxiety is worth treating
   iii) that general practitioners hypothesize more often than they diagnose
   iv) that every problem does not have a solution
   v) responsibility
   vi) vulnerability
   vii) the contractual relationship and the part that money plays
   viii) the shopkeeper role
   ix) chronicity
   x) the fickleness of patients
   xi) that general practice and hospital are different and complementary.

c) Avoiding the 'rescuer syndrome' (that is, the inappropriate use of new-found techniques).

d) Recognizing the value of:
   i) the doctor/patient relationship
   ii) time
   iii) prescriptive behaviour
   iv) analgesics
   v) the patient retaining the initiative.

e) Reappraisal of personal beliefs.

f) Avoidance of modelling upon trainer's attitudes.

g) Specific (for example, career, buying a house, marriage).

Most of these are self-explanatory but I would like to expand a little on management and reality versus diagnosis and theory, and on anecdotal ideas of general practice.

Early in my trainee year I was travelling by car with my trainer to see a woman who she said had wobbly legs, numb fingers, and was partially blind. "Ah," I said. "Multiple sclerosis." "Well, yes," was her reply, "but it is much more useful to think of her as someone who cannot get her family off to school, who cannot function as a housewife, and who as a result of all this is pretty depressed." Making a diagnosis tends to stifle further thought. The reality and the management are much more relevant to general practice.

I cannot remember from where I got the idea that I wanted to be a general practitioner. I had anecdotal ideas of practice based on the terrifying stories that hospital doctors told me of the locums they had done. I had an innate distrust of the depressing picture painted by my hospital teachers. I had read with dismay referral letters to outpatients. I suspect that the most solid impression I had was that offered by television programmes like *"Dr Finlay's Casebook"*. Perhaps in part I turned to general practice because I rebelled against the hospital system and all that it stood for ideologically. It is a great pity that a graduate's ideas are still based on anecdote rather than experience.

Recognition and rectification of these problems in knowledge, skills, and attitudes is not straightforward but involves oscillations about a mean until a stable state is reached. Thus a trainee might vigorously embrace Balint's ideas in his first month, only to resort to behaviourism soon afterwards. Although he recognizes the value of specific tools, to be able to use them at the appropriate level takes time and experience. The inappropriate application of new-found techniques and beliefs is common in trainees and is known as the 'rescuer syndrome': "Now that I have seen the light, so shall ye also."

Changes in diagnostic behaviour during the trainee year

During my trainee year I have followed my own behaviour in one particular aspect; that is, in deciding the main reason why patients came to see me—determined, of course, quite subjectively. Figure 1 shows in graphical form the figures for the first nine months split into three blocks of three months each and showing only five out of a total of 22 diagnostic categories.

There are obviously many reasons for the changes:

1. I now recognize much better the reasons why people come to see me. They are not all coming for treatment, as I originally thought; some merely want certificates. Thus the proportion of upper respiratory tract infections has remained the same throughout the winter (one would have expected it to increase), whereas the proportion of administrative visits has increased.

2. I now recognize that many of the somatic complaints that I used to label 'cardiovascular' or 'gastrointestinal' are in fact manifestations of the psyche. Thus the proportion of psychoneurotic 'diagnoses' has in-

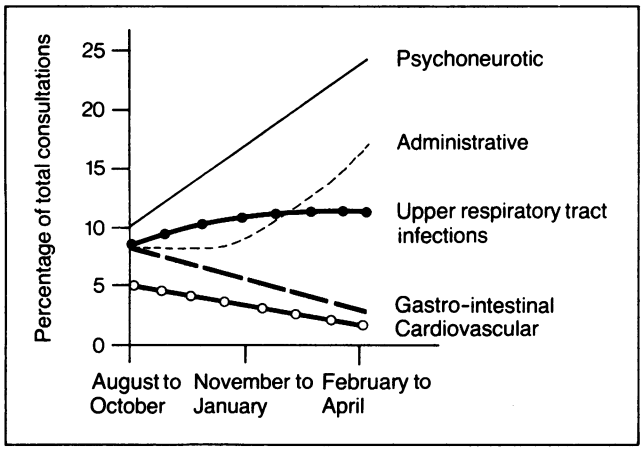


Figure 1. *Subjective assessment of main reason for patients consulting throughout trainee year.*

creased.

Figure 2 shows the sub-groups within the psychoneurotic category.

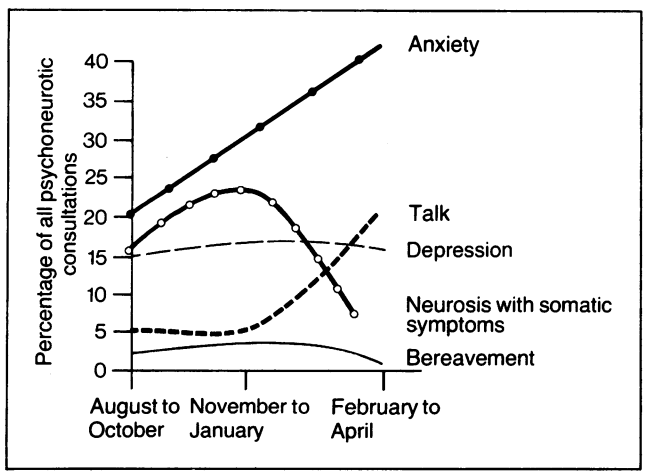
3. As the year progresses, patients start to use trainees in different ways. They come to accept them as one of the team and come along simply for a talk or for advice.

4. That the proportion of 'neurosis with somatic symptoms' has declined reflects the fact, I think, that I have stopped using what is essentially a hospital diagnostic label. Once made this invocation allows the energetic senior house officer to wash his hands and send the patient back to the general practitioner: "I have reassured him and sent him away!" Instead, they now form part of the general increase in 'anxious' patients that I see.

5. That the proportion of depressives has remained the same probably reflects the fact that my criteria for that diagnosis have not altered since I was in hospital.

6. The level of bereavements, which has dropped slightly in the last nine months, reflects, I hope, my arrival in the practice.

Figure 2. *Assessment of psychoneurotic consultations.*



The dynamics of learning

Galperin (1957) has defined five stages of learning which are, I think, helpful in describing the teaching methods used in vocational training.

1. Getting a preliminary idea of the task (anecdote, sitting-in, books, journals, own consultations).
I think that this is the most underrated stage. For me it took about a year or perhaps more, sitting-in once a week with a trainer who drew concepts from the 'hot' situation. It was rather like learning to play the piano—little and often. As such there is often conflict with hospital jobs and usually it has to be done on the trainee's afternoon off duty, a situation many find unacceptable.

2. Master the action (own consultations, role play/psychodrama, self-assessment).
This is the stage during which the teacher teaches strategies. The trainee knows what he is supposed to be doing and he sets out to attain it.

3. Master a description of the action using speech (case discussion, tutorials, lecturing).

4. Transfer to a mental plane (conceptualizing—writing about it, talking about it, thinking about it).

5. Consolidating (in which concepts already acquired are used to create ideas of future tasks—continuing experience, projects).

Having described the problems and the dynamics, it is next logical to describe the changes in behaviour of a trainee throughout his trainee year, using a concept which I call 'trainee developmental milestones'. It reflects changes in knowledge, skills, and attitudes at the various stages of gestation.

Trainee developmental milestones

At birth
Confident, decisive. Bound to succeed. Flooding with diagnostic zeal. Full of ideals. Prepared to give others the benefit of his skill. Sure that the world can (and will) be changed for the better.

Day one
Lost. Confused. Are people all like this? Why are patients not more logical, more intelligent? Trainer's behaviour seems irrational. Problems overwhelming.

Six weeks
First smile. Able to say two or three words. Follows trainer with eyes. Begins to focus. Displays reversion signs in threatening situations. Cries frequently at night.

Three months
Begins to form an identity of self (may be simple modelling). Able to use words coherently. Stage of conceptualization. Pulls himself to stand.

Six months
Development of survival mechanisms. Reverts to more primitive behaviour occasionally. Development of

strategies for coping, but tendency to extremes and to emotional disturbances.

Nine months

Development of learning and assessment strategies. Can almost walk unaided. Knows his patients and can count up to FP 1001. Reasons and forms judgements.

12 months

Can adapt himself in an intelligent manner to new situations as they arise. Accepts the inevitability of life. Still cries at night occasionally.

Although these milestones are apparently frivolous, the point is that throughout the year there is continual development. I can identify its evolution from the diary I kept throughout my own year. I have shown the milestones to doctors who did not have the benefit of vocational training and they have told me that they recognize that a similar process took place for them too, only it took longer. I am sure that for some trainees complete gestation (if it is ever complete) would also take longer than a year and I am glad that I had the benefit of those two years' contact with practice throughout my hospital training, continually being introduced to new concepts and strategies.

Teaching methods

Teaching methods can be related to gestational age. Table 1 lists most of the main teaching methods in the order of preference of 14 of the trainees at my half-day release course.

Although the number of trainees involved was very small, a pattern can be seen in their answers and I would like to describe some of them.

First, there was an authoritarian pattern—that given by the few trainees who gave higher marks for lectures, lecturing, books, trainer assessment, and examinations. There were three of these: two were in their first year of training, and one in the third.

Secondly, there was the heuristic pattern from those who chose group discussion, projects, case discussion, and mutual assessment for preference. There were two good examples of this: both third-year trainees, both of whom put 'authoritarian' methods at the bottom of their lists.

These patterns agree with what I felt subjectively: that I benefited from greater direction initially but needed more freedom later. On the 'milestones' model, on day one when I was lost and confused I benefited from instruction in what I was supposed to be doing and being told whether I was doing it well. At six months (adolescence) I was more able to survive on my own with less interference and at one year (adult, I hope) am coping with little direction, taking only a few problems to my trainer.

I also asked a select group of five trainers, all experienced, which of the methods they thought were most useful for their trainees. Although there were only five, their answers showed more agreement than I expected and were tinged with an authoritarian flavour. It was encouraging to see that both trainers and trainees agreed on the value of own consultations, mutual assessment, case discussion, tape and video recordings, projects, and the trainee giving a lecture. They disagreed violently on the value of summative examinations, the trainees putting them next to bottom, and the trainers third out of 19. Trainees liked, and trainers disliked, assessment by the trainer (perhaps reflecting a need for early feedback) and discussion of the trainer's cases (trainers feeling threatened?). Trainers liked, and trainees disliked, the written record (hard work) and the trainer sitting-in (trainees feeling threatened?).

Both groups agreed that three aspects were unhelpful: role play, social occasions, and the trainer giving a lecture. Of these, I was most disappointed by lack of enthusiasm for social events for I feel that this may represent a lack of empathy between many trainees and their trainers. At our Regional Trainees' Conference held recently it was disappointing to hear trainees saying: "Well, it's only for a year. I can put up with the old X for that long," and "Well, you've got to pretend that you get on with them or you won't get a good reference at the end." Because I got so much from the relationship I had with both of my trainers I find it difficult to understand why people do not recognize at an early stage that their relationship is not going to work

Table 1. Combined answers of 14 trainees asked to score which teaching methods they thought most useful (score 0 to 10).

Teaching method	Average score	Range
Your own surgeries or visits	7.5	5-10
Discussion of your cases	7.4	5-10
Mutual assessment	7.2	4-10*
A lecture given by yourself	7.0	5-10
Projects of your own	6.8	4-9
Books or films	6.6	3-10*
Trainer assessing trainee	6.2	4-10*
Discussion of trainer's cases	6.1	3-10*
Tape/video and analysis	6.0	2-10*
Outside visits	5.5	2-8*
Leader-centred discussion	5.3	2-7*
Free group discussion	5.0	3-8*
Sitting-in on your trainer	4.7	1-8*
Trainer sitting-in on you	4.6	0-9*
Role play and discussion	4.4	0-8*
Written record	4.4	1-10*
Trainer giving a lecture	4.0	1-6
Summative exams	3.4	0-8*
Social occasions	2.9	1-8*

*Indicates range of more than five marks.

and do not change their trainer or trainee. Learning how practice influences the trainer's way of life is important and the trainee can only do that if they are close. Quite apart from this, the relationship is of immense value as a source of motivation for learning. A bad relationship must mean a bad traineeship.

Learning knowledge

There are three kinds of knowledge that call for special attention: what one does not know, what one knows a little about, and what one knows much about but may not be able to apply in the setting of general practice.

First, to recognize the knowledge one does not know. There is a complete check list in *The Future General Practitioner—Learning and Teaching* (RCGP, 1972). In addition, I found the use of a good multiple choice questionnaire of a wide-ranging nature valuable for showing large defects. I soon met clinical problems which revealed specific gaps. At this stage I needed information urgently and authoritarian methods were suitable for teaching me about paperwork, the law, what to do in case of sudden death, or in order to admit people compulsorily. In addition there were gaps in my medical knowledge. Many trainees attend courses and take up clinical assistantships in outpatient departments specifically to remedy these.

Secondly, there is knowledge of which we have had little experience in hospitals, such as health education, records, or rehabilitation—or knowledge which may arise only once or twice during the trainee year, like care of the dying. Here the trainer can use himself and his experience as a resource to allow the trainee to put his own knowledge into the appropriate context. This perhaps fits a more socratic or heuristic approach.

Thirdly, there is that knowledge in which the trainee is well versed, such as general medicine, obstetrics, diseases, perhaps psychiatry, depending on the hospital posts previously held. What is difficult is the practical application of this knowledge in general practice and this may involve also the modification of attitudes. Here, the trainer is likely to find a counselling approach more suitable and the situation is such that mutual learning can take place.

Learning skills

The performance of skills involves the use of strategies. The trainer can help his trainee by providing these and showing him how to go about tackling a problem without actually telling what the result or answer will be. This is particularly appropriate to general practice where there are often no cut-and-dried answers to problems and where one's aims may more properly be defined as 'giving the patient the strategies and concepts with which to cope with *his* problems'. Methods which I have found useful include:

1. Interview technique (e.g. doctor/patient centred behaviour; Byrne and Long, 1976).
2. Counselling (e.g. the use of the reflected question).
3. Psychoanalytic models (Balint, Freud, gestalt).
4. Behavioural techniques—transactional analysis (Harris, 1973), games theory (Berne, 1970), concept of life roles (Browne and Freeling, 1976), behaviour modification and relaxation technique (Wilkinson, 1974).
5. Assessment as a learning tool:

a) Knowledge (multiple choice questionnaire)
b) Skills
   i) Modified essay questions for problem solving.
   ii) Tape recording for interview technique with assessment based on Byrne and Long's (1976) model.
   iii) Projects based on specific problems.
c) Understanding attitudes (McGuire rating scale; Freeman and Byrne, 1976).

6. The use of resource material.
7. That however one goes about general practice, it should be fun.

I am constantly adding to this list.

Evaluating attitudes

I have hesitated to call this section 'learning attitudes' since this would imply modelling of the most dangerous kind. However, there is no doubt in my mind that the acquisition of healthy attitudes towards the work we do can serve only to stimulate learning rather than to stereotype it.

Attitudes are formed by the personal evaluation of concepts which have been presented. When we enter medical school, for example, we are presented with such concepts as inflammation, necrosis, and enzymes, these concepts thereafter acting as models upon which our future attitudes to medicine are based. That they are so far removed from the actual human being and his behaviour is a pity since that would be much more relevant for future general practitioners.

The formation of attitudes to general practice similarly involves the presentation and evaluation of a whole new series of concepts, some of which I have tabulated below. It is in no way intended to be a complete list.

Concepts useful in forming attitudes relevant to general practice

1. Health care

a) Team approach.
b) Continuity of care.
c) Whole patient and family care.
d) Positive attitude to health.

2. The consultation

a) Levels
   i) of the problem (RCGP, 1972).
   ii) of the doctor (RCGP, 1972) (personal, family,

and so on).
iii) of the interview (Balint, 1964).
b) Stages (Byrne and Long, 1976).
c) Patterns (Balint and Norell, 1973) (e.g. collusion, failure, success, stability).

3. The relationship

a) Balint (1964) (apostolic function, collusion of anonymity).
b) Verbal (Byrne and Long, 1976) and non-verbal communication (Argyle, 1967).
c) Uses of empathy and sympathy (Browne and Freeling, 1976).
d) The role of the third party (Browne and Freeling, 1976).

4. Behavioural

a) The effects of groups on behaviour (Browne and Freeling, 1976) (family, peers).
b) Radical/social psychiatry and adaptive responses (Zigmond, 1978).
c) Modification of the environment (Wilkinson, 1974).
d) Games theory (Berne, 1970) and transactional analysis (Harris, 1973).
e) Role identity (Goffman, 1963; Browne and Freeling, 1976) (e.g. sick role, adolescent role).

Trainers as catalysts

In the final part of the trainee year, the trainee should be running free. He should have evaluated himself in terms of knowledge, skills, and attitudes, have developed critical faculties and be able to learn for himself and to cope when new problems arise. He should be involved in continuing education. If there is a healthy relationship he will be using his trainer as a colleague with whom mutual problems are discussed. The trainer then has another purpose and that is to catalyse the reaction.

Learning theory suggests that there are two main ways of doing this (Stone, 1960):

1. Create an optimal emotional environment: open, friendly, democratic, mutually satisfying relationships.

2. Create an optimal learning situation:
a). Concept of attainable goals (do not ask a chap to run before he can walk).
b). The continual creation of slightly higher goals (for example, the emotional problems of normal childbirth should be tackled before he starts on terminal care).
c). The teaching of stratagems.
d). Stimulate learning (adequate feedback, praise, the success of patients returning satisfied).
e). Leave some unfulfilled anxieties (one thinks a lot more about problems when one is not quite sure one did it correctly.)

Trainers often complain that their trainees do not seem to want to learn and point out that since vocational training will increasingly become an 'imposition' rather than a positive choice, this apathy is likely to get worse. The list I have given above is precisely the same list as is relevant to teaching poorly motivated learners. My wife, who is a teacher, tells me that the most important part of this process is the relationship between teacher and pupil. I am sure that I do not need to draw the obvious analogy between trainer and trainee. Just as the doctor/patient relationship is the most important part of our professional communication so the trainer/trainee relationship must be the most important element of vocational training.

My thesis is that the trainee year should be dynamic—dynamic in terms of the trainee's behaviour and development and in the content and methods necessary for teaching. I have tried to show how a trainee's behaviour is the result of unlearning old and acquiring new knowledge, skills, and attitudes and have tried to define some of the methods, strategies, and concepts my colleagues and I have found useful in our own gestation. Lastly I have tried to show how trainers may catalyse the process and that the most important factor in the whole educational process is the trainer/trainee relationship itself.

References

Argyle, M. (1967). *The Psychology of Interpersonal Behaviour.* Harmondsworth: Penguin.

Balint, E. & Norell, J. S. (Eds) (1973). *Six Minutes for the Patient.* London: Tavistock Publications.

Balint, M. (1964). *The Doctor, His Patient and the Illness.* 2nd edition. London: Pitman.

Berne, E. (1970). *Games People Play.* Harmondsworth: Penguin.

Browne, K. & Freeling, P. (1976). *The Doctor-Patient Relationship.* Edinburgh, London & New York: Churchill Livingstone.

Byrne, P. S. & Long, B. E. L. (1976). *Doctors Talking to Patients.* London: HMSO.

Freeman, J. & Byrne, P. S. (1976). *The Assessment of Vocational Training for General Practice. Reports from General Practice No. 17.* London: *Journal of the Royal College of General Practitioners.*

Galperin, P. Ya. (1957). In *Psychology in the Soviet Union.* Ed. Simon, B. London: Routledge & Kegan Paul.

Goffman, E. (1963). *Stigma.* Harmondsworth: Penguin.

Harris, T. (1973). *I'm OK, You're OK.* London: Pan Books.

Royal College of General Practitioners (1972). *The Future General Practitioner—Learning and Teaching.* London: *British Medical Journal.*

Stones, E. (1960). *An Introduction to Educational Psychology.* London: Methuen.

Wilkinson, J. (1974). *Common Neuroses in General Practice.* Bristol: Wright.

Zigmond, D. (1978). Adjustment or change? Radical issues in psychiatry. *Update,* **16,** 91-103.

Acknowledgement

I wish to acknowledge the debt of gratitude I owe both my trainers.

Addendum

Dr P. C. Stott is now a principal in general practice in Tadworth, Surrey.