

Vocational Training Column

A further response from the "Training the trainers' workshop comes from Dr Laurence Wood who attended the workshop held in Durban in September 1985. Dr Garth Brink, Chairman of the Natal Coastal branch of the Academy and Regional Coordinator for Vocational Training, kindly forwarded the contribution.



Family Practice, Primary Health Care and Vocational Training

The target of Family Practice/Primary Care

The ultimate target of all medicine is the individual:

- body (as moulded by chemical and physical stimuli);
- personality (as moulded by emotional stimuli); and
- soul (as moulded by the forces of good and evil).

A PHC doctor must be able to minister at least adequately to these three facets of—

- any individual;
- with any problem;
- at any time.

He must, however, have a "holistic" approach: Beyond his ministry to the individual, he must be aware of, and subsequently if necessary modify, repercussions of this problem, (in this patient, past patients and future potential patients), on—

- the family;
- the community; and
- society.

This is the wide-angled lens of the PHC doctor.

Definitions

Primary Health Care (PHC) as used in the declaration of Alma Ata, is a concept not to be bound strictly to the very first professional viewing of the patient or family or community, but covers the

whole range of non-specialist (some would say non-confinist) disciplines involved in care of people, eg. family practice, community medicine, community nursing.

A **PHC doctor** is one who gives or organises or is central to the whole and basic care of any health problem.

A **Family Practitioner** is a vocationally trained PHC doctor whose team looks after the health problems of individuals in the setting of their families; families in the setting of their community; and the community in the setting of the social, political, cultural, economic, etc. background of the territory. Often a family practitioner leans, due to pressure of work, towards the "individual health" end of the PHC spectrum.

A **Community Physician** deals with the non-individual end of the spectrum of health problems handled by a family practitioner, eg. statistics, epidemiology, medical administration, industrial medicine, community development, health promotion, disease prevention, and 'social responsibility'.

A **General Practitioner** is the same as the family practitioner, but the name is preferred by some, as some 'PHC' doctoring is not necessarily only concerned with families.

A *Rural Hospital Doctor* would like to have the resources to provide a family practitioner service for his patients, but does not have these and so concentrates on those aspects of PHC where his limited resources will have maximum effect, and his team lean towards the community health end of the PHC spectrum.

Health care improvement is part of the *development of a community*, which also includes development of education, training in artisan skills, roads, phones, water, crops, livestock, sanitation, handcraft, arts, culture and trade. Common factors in attempting to develop these things in a community are—

- that it involves the passage and acceptance of much new knowledge; and
- that it requires the recipient community's people to be willing – and wanting – to change.

A *specialist* is someone who becomes an expert in a particular field. Usually, the term is used for an expert in a confined discipline. As one could become an expert in family practice, some feel that one who confined himself to a subdiscipline should be called a confinist.

Family Practice is bigger than the sum of the confined disciplines, because it considers the whole patient as well as reverberations of disease.

A specialist, in a confined discipline, should not seek to do this, but simply to supply the answers (and if necessary skills) to questions asked by the family doctor. Having applied his specialist talents he then hands the patient back to the family doctor.

Execution of Family Practice/Primary Care

Sub-disciplines

It may be seen from the above, then, that Family Practice/Primary Care comprises the disciplines:

- clinical medicine to the individual;
- social medicine to the family;
- management, (of, e.g. practice or rural hospital);
- epidemiology;
- research/education/learning.

The doctor must not only be competent in these areas, but also in evaluating his competence in these areas.

Requirements

In order to perform these functions the doctor requires—

- knowledge; thinking; common sense; reasoning; "cognitive" skills;
- communications; listening; "perceptive" skills;

- physical examination skills; practical skills; (I do not like the word "psychomotor");
- empathy; compassion; love – not a skill but a state of mind (or state of affect);
- an attitude of enthusiasm; self-appraisal and commitment to the task of uplifting health.

Holistic Approach

As emphasised in the first paragraph, the family practitioner/primary care doctor must be aware of—

- physical, social and spiritual implications of the disease of the individual (i.e. the curative/rehabilitative roles);
- the prevention of this disease in the family and the community;
- the promotion of physical, social and spiritual health in the individual, family and community.

Vocational Training Scheme (VTS)

What is the VTS?

The VTS is a two year programme encompassing controlled exposure to a variety of disciplines, experiences and learning environments, whilst working as a doctor in an urban hospital, an urban family practice and a rural hospital.

The aims of VTS

In two years only a certain amount of knowledge and wisdom can be disseminated, and so a key aim of the VTS is to promote a certain pattern of thinking and behaviour, which, it is hoped, would continue throughout professional life. It is to be hoped that the doctor would appreciate the importance of:

- the community as well as the patient;
- the health team approach;
- a cost effective use of resources;
- the national priorities in health and disease;
- the pursuit of health in addition to the treatment of disease;
- continuing education;
- evaluation of services.

In other words, the VTS is attempting to shape a doctor with the correct attitudes and approach, and requirements and training in various disciplines.

In these aims, one does not need to differentiate, in training, between doctors even though they may end up in any of a wide range of family practice/primary health care jobs.

Education of the doctor

Why VTS? The modification of a "growing" doctor's knowledge, attitudes or behaviour must be a well-thought out and coordinated process. This is better achieved within a programme into which much expertise has been poured.

What are 'aims' in education? Aims are the broad ends to which the doctor works. It is important to specify these for each phase of the education process. Just as in travelling on a journey, it is easier to get there if you know where you are going.

... **and 'objectives'?** These are generally more narrow and specific than aims. The objectives indicate what the trainee should be able to do at the end of the programme. Again, it can be very constructive to lay these down in advance, although too much rigidity here may interfere with the flexibility necessary to any learning process. The broader the aim, the more the number of objectives within that aim.

Learning methods

"Experiential learning"

The trainee begins with certain knowledge, attitudes and skills. He has a "concrete experience" e.g. a patient consultation. He deliberates on this, (reflective observation); the trainer helps him put that in perspective (abstract conceptualising). The trainee now experiments with his new and higher level of knowledge, attitudes and skills. The trainer assesses the value of his care before and after, specifically being aware of residual inadequacy.

As Sam Fehrsen says, "our patients are our curriculum."

Balint Group

Essentially, the problem is presented by one member to the group and discussion continues until the person, whose problem it is to solve, has sufficient saturation of new thought.

By discussion of a problem in this way, all aspects of it can be added bit by bit, until it is much more solid and able to be tackled. The discussion should be in the mood of reflective contributions by the members rather than cross-questioning. Talk should be steered away from being too personal, although the psychology of the individual is one of the aspects dissected. (Avoid, however, the temptation to psycho-analyse group members). Care should be taken not to make members feel threatened or ill at ease.

There can be more than one leader, and it can be a big asset to have an expert as part of the peers rather than as a leader.

Ultimately, it is the patient who is intended to benefit (not the doctor!), by virtue of the doctor feeling more comfortable with the problem.

Other learning methods

These include:

- trainee sitting with trainer;
- chart review;

- spreadsheet review of day's consultations;
- x-ray meetings;
- discussion of referrals;
- journal clubs;
- being taught practical procedures;
- looking at statistics;
- analysis of individual cases in depth (e.g. clinical diagnosis, personal diagnosis, contextual diagnosis);
- health team discussions;
- topic discussions;
- private study; and
- courses.

Teaching by these methods

In general, the trainer must be prepared for each of these situations, having thought out in advance what is to be learnt. The trainer must be aware that the trainee will, to an extent, model on him, especially in attitude and humaneness towards patients.

Patient orientated learning in general has more to offer than non-patient orientated, but a topic discussion on a weak point, for instance, can be very valuable. The trainee should be trained in an atmosphere where he feels very free to say "I do not know", and to expose his weaknesses. In this way, these weaknesses can be eradicated. Too often, teachers promote showing of knowledge by their pupils, rather than exposing the lack of it.

In any of these learning situations, different trainees may see different levels of value. The trainer should listen to the appraisal of value of that teaching method by his trainee, but then set this within the total picture of what is possible and what is necessary. The trainee must in turn also be flexible. He, the trainee, must also be aware that a particular attitude, mode of speech or choice of handling towards a patient may not be as ideal as he perceives, and he must be amenable to growth (which may mean change).

The trainer must be aware that from time to time the trainee will touch on a subject which triggers anxiety in the trainer. He must be in control of his emotions and must show calculated common sense and humility when this happens. Having a trainee can, and should, make a trainer reappraise his own values.

Remember that trainees will, themselves, be simultaneously training others (e.g. PHC nurses).

Curriculum development

As the training proceeds:

- re-look at aims and objectives;
- re-look at ways of achieving these;
 - knowledge (e.g. books, courses, experience)
 - new methods (e.g. video, Balint); and
- evaluate.

It should not be just the trainee who is growing, nor only the trainer; but the course and methods.

SS DOMPERIDONE
K/5.7.2/261 Tablets 10mg/tablet
N/5.7.2/92 Suspension 10mg/ml

Motilium
JANSSEN
domperidone

Indications



Dosage

adults

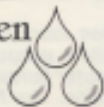


One tablet (or 1ml suspension) 3 times per day, 15 - 30 minutes before meals and, if necessary, before retiring.



In acute cases, e.g. nausea, vomiting and hiccups, two tablets (or 2ml suspension) taken as above.

children



Suspension: One drop (0.3mg) per kg body mass, taken 3 times per day before meals and, if necessary, before retiring.

In acute cases, e.g. nausea, vomiting and hiccups, two drops (0.6mg) per kg body mass taken as above.

Motilium
JANSSEN
gets the lazy stomach
moving again

JANSSEN
PHARMACEUTICA

328 Kent Avenue, Parkside, Randburg 2194

© Janssen Pharmaceutica (Pty) Ltd South Africa

MOT. BM 8/85

Trainer/trainee relationship

In leading this sort of teaching process, it is valuable for the trainer to be aware of the similarity between the trainer/trainee relationship and the doctor/patient relationship.

- How do you tell if the trainee is not attending?
 - Non-verbal clues;
 - trainer interrupts trainee;
 - trainee repeats;
 - trainee gives up.
- Trainer and trainee: two people with two sets of needs - whose are being met?
- The trainer should not make unwarranted assumptions about the trainee's needs.
- In each interaction there should be attempts to increase honesty, decrease anxiety, increase listening, increase communication, increase reassurance of trainer to trainee (or doctor to patient) and decrease dominance, dictatorship and blocking by trainer to trainee (or doctor to patient).
- Teachers are also learners.

In other words, there must be good will, good humour, honesty and in the Christian sense love, between trainer and trainee; and between doctor and patient.

Prepared September 1985 - February 1986

Laurence Wood

Medical Superintendent St. Mary's Hospital,
KwaMagwaza.

Vocational Training Opportunities

In 1983 your Academy organised a workshop in Pretoria on 'Primary Care', with special reference to services in the underdoctored areas, sponsored by Eli Lilly.

The reasons for the maldistribution of doctors and other health professionals are many and most of them fairly self-evident. Obviously a more appropriate selection of medical students who might settle in the underdoctored areas and better financial and other incentives, such as better working facilities, could go a long way to resolving the problem.

At the workshop, it was pointed out that due to the explosion in medical knowledge, medical schools can only produce a 'basic' undifferentiated doctor. Therefore, the new medical graduate intending to enter family practice requires and wants training for the job, vocational training for the same reason as his or her specialist colleagues.

In fact, it is considered by more and more members of the medical profession throughout the world unethical to engage in unsupervised clinical practice unless one has undertaken vocational training appropriate to one's responsibilities.

The introduction world-wide of vocational training for family practice/primary care over the last three decades, has not only fulfilled the need of thousands of medical graduates, but much of the training has taken place where it is most needed. It has resulted in a better distribution of medical manpower because the young doctor is shown opportunities that he or she would not otherwise have seen.

Through the initiative of the Academy and its members in actively promoting the necessity and benefits of vocational training, the Academy and university departments of family practice have sown the seed throughout the country, and those seeds are taking root and spreading.

In November 1985 Stirling Winthrop sponsored a workshop organised by the Academy to draw up a 'blue print' for vocational training for this country.

I would like to draw your attention to one of the proposals put forward:

- that Drs John Smith and John McMurdo be given the task of gathering information on the existing educational resources which are available for the earliest implementation of a National Vocational Training Programme, and that they be empowered to co-opt other Academy members as and when required.

- that each and every delegate to this workshop be exhorted to document the available and potentially available resources in his or her own region, e.g. family practices which are suitable for day release, potentially suitable hospitals, and posts, clinics and community health centres, etc., and that lists of these be forwarded to Dr John Smith in Cape Town.

I would be grateful if you will assist us by providing

relevant data with regard to your practice and others in the area, whether in the public or private sectors, that could in the future be involved in vocational training either in the hospital phase, the family practice/primary care phase or the half day release. Details are available in the Academy's booklet on the Vocational Training Scheme and in the *Family Practice Handbook - A guide to teaching and learning*.

If you are uncertain of what information is required, do not hesitate to contact me or a member of the Academy's national or regional executive.

As I stated at the beginning, vocational training opportunities now exist throughout the country. Please bring this fact to the attention of interns and other new medical graduates who may wish to make family practice/primary care their vocation. If they write to the address given below I will let them know what opportunities are available.

DR JOHN A SMITH
National Co-Ordinating Director for Vocational Training
SA Academy of Family Practice/
Primary Care
Medical House, Central Square
Pinelands, 7405

Accounting for INCOME INCOME INCOME

**Concentrate on patient care
without losing control of the
business aspects of
medical practice.**

Knowing what's going on financially in your practice has never been more important. Inflation, high interest rates and patients not timeously paying their accounts can seriously impact your practice. Manual accounting methods and computer bureaux have severe limitations in the complex environment of contemporary practice. The Practice Management System provides computerised practice accounting and allows medical practitioners to concentrate on patient care whilst administrative chores are automated. For as little as a tax deductible R400 per month you can computerize your practice today. The Practice Management System is easy to use, accommodates the latest legislation, reduces month end workload, provides state of the art 'convenience' features and comprehensive information available on demand.

Making your plans come together — Call Alan on (011) 440-4239

MEDICAL METHODS

Computer Systems (Pty) Ltd PO Box 92197 Norwood 2117

