



# Vocational training. For Whom?

The suspicion lingers that vocational training tries to layer honest general practice with a veneer of academic respectability; that the ivory towers cast their shadows over the whole business of earning a living from an honest get-on-with-it practice of medicine, making it harder than ever. Perhaps this is because vocational training began in South Africa as degree courses in university departments of Family Medicine, whereas in the UK, for example, it developed through practice-based apprenticeships.<sup>1</sup>

However, some of our leading academics, rather than drawing general practice into the academic fold, are actually playing an important part in devolving medical school teaching, both undergraduate and postgraduate, into community based contexts. These are first steps in the direction of the international campaign to revitalise academic medicine as recently launched by the BMJ Publishing Group.<sup>2</sup> This campaign will include initiatives to improve academic medicine in developing countries where it is said 'there is a lack of connection between academic and public health systems'.<sup>3</sup>

Today we know that the medicine we knew has to adapt or give way to many mushrooming alternatives. We know that "experience on the job" may mean better clinical decision making, better listening and explaining, and putting care back into caring. Which is why our elders often ask: 'So what is new about this family medicine?'

Yes, the *values* may be theirs. But frankly there is a lot that is new which is harder to acquire than the knowledge bases we start off with. New is the putting of these dimensions up front with programmes of defined and supervised learning and practice rather than formal teaching. Vocational training is accelerated experience.

It is the aims, objectives and activities of vocational training that must be well defined.<sup>4</sup> Venues have varied between being speciality-based (the rotation model), practice based (the apprenticeship model) or a mixture of the two.<sup>5</sup> Much vocational training in Britain is practice based. In South Africa practice bases have mainly been academic with a strong programmatic element.

The late Professor PS Byrne, one of the earliest professors of general practice, maintained that it took seven years for the untrained general practitioner to reach the level of expertise of his vocational trainees at the end of their two year programme.<sup>6</sup> I can find no study-based evidence that vocational training produces a better GP than time-honoured "experience on the job".<sup>7</sup> Hopefully that may come. Several deal with trainee satisfaction and their feedback.<sup>8,9</sup>

A task of the primary care physician is multi-dimensional problem assessment. The referral rate is an outcome measure that reflects not only problem assessment but behaviour in the consultation.

The study published in this issue could find no difference between the mean referral rates of trainees and trainers. There was as much variation among trainers as among trainees. It concluded that, together, these findings supported the thesis that factors other than clinical diagnosis within the behaviour of doctors, or within the interaction between doctor and patient, were determinants of the referral decision.

But it does not explain *why* there are differences, or assess *the quality* of the training intervention. It answered none of those questions, but only said look elsewhere than in the clinical problem.

I have revisited the Academy's National Vocational Training Programme for Family Practice booklet, the end result of a workshop as far back as 1985.<sup>10</sup> It is a prescient document, and I hope is not overlooked.

This booklet foresaw training spread over a variety of approved places and resources. It emphasised the quality of trainers and their supervision. McWhinney, in one of his classic publications, stressed supervision by a paid director and continuity, rather than serial attachments, to promote progressive responsibility.<sup>11</sup> The de Villiers have pointed out that teachers trained in the biomedical paradigm may need re-orientation to the patient-centred approach.<sup>1</sup> Nor must we be trapped by content. As you judge a pudding by eating, training must be evaluated by outcome.

The difference between trainees and trainers, teachers and learners, shifts. Both are challenged by their respective responsibilities. Let us talk of an 'Apprenticeship Plus' model. Practice principals who are approved trainers have to be more than passive role models. They are as challenged in their role as the trainees in theirs. Do not ask for whom vocational training comes. It comes for us all.

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