

HASLAM'S VIEW



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Lessons from DIY training for general practice

MORE YEARS AGO THAN I CARE TO REMEMBER, SOMEWHERE IN THE MIDDLE OF

my second preregistration post, the equivalent of a modern FY1, I finally made my mind up. General practice it was going to be. In those days, extraordinary as it may seem now, vocational training for general practice was not compulsory. If you wanted to be a GP, you could simply apply for a partnership straight after registration, something that quite a few people in my year at medical school seemed happy to do. Crazy!

Like you, on the day that I qualified I felt pretty confident that I knew enough to be able to do the doctoring, and after about ten minutes in my first job I realised that the depths of my ignorance were almost unfathomable. And when it came to having to know the range of topics that would be involved in life as a GP, then panic really set in.

And so I applied for the local vocational training scheme. As far as I can remember there were just four posts available each year, and unsurprisingly I failed to be appointed. I was beaten to the post by my very good friend Jane, who completed her training and promptly emigrated to Australia where she worked as a psychiatrist. Such is life.

Undaunted, I decided to create my own scheme and apply instead for each of the individual SHO jobs that made up the VTS, and ended up with first-rung-of-the-specialist-ladder jobs in obstetrics, paediatrics, and psychiatry. But the last six months of the SHO years posed

much more of a problem.

I managed to negotiate myself a post at the district general hospital which involved one session of teaching medical students, one overnight A&E session, one session in dermatology, one in genitourinary medicine, one in diabetes, and one in ophthalmology, as well as miscellaneous general medicine clinics. As a mix of experience designed for life in general practice, it couldn't have been better. However, there was one curious side effect.

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I distinctly recall seeing the same middle-aged woman in three separate clinics in consecutive weeks. I saw her for her diabetes, her retinopathy, and her skin (necrobiosis lipoidica if I remember rightly). I was surprised enough to see her, but you can just imagine how she felt – seeing the same absurdly young doctor in three different clinics. Indeed, when she saw me for the third time she made some comment that I really must be quite exceptionally clever to be a specialist in three separate specialties. I hope she was being facetious. I've an uneasy feeling that she wasn't.

But more than anything I simply couldn't work out why on earth she

needed to come to the hospital to see someone who was training to be a GP, when she had a perfectly acceptable GP back at home. So I discharged her from the lot. Indeed, when it came to the dermatology clinic, I discharged almost everyone.

They all seemed to have relatively minor cases of eczema or psoriasis, and turned up every six months to see a different junior doctor who said, 'keep on using the ointment and come back in six months'.

In those days, decades before GP commissioning, no one really seemed to be keeping an eye on issues like this.

I found that most patients in the clinic weren't at all sure what they got out of coming to hospital, and neither was I.

However, after a few months of discharging patients who didn't need to be there, and who were perfectly happy to say farewell, I got summoned to see an incandescently angry consultant who pointed out that my approach was out of line. Mainly, as far as I could see, because the waiting list to see him had reduced dramatically and this was playing havoc with his private practice. But maybe I am being unfair. Perhaps he was just concerned for the patients. Who knows?

Tell us what you think?

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