

but the relatively short time available for initiation into this work was not sufficient to prepare her fully. The A&E environment can be a threatening one, but in a different way to that posed by being alone outside hospital.

None of us initially knew quite what to expect from this attachment, nor how best to focus the general practice month to contribute to A&E training. Our "learner centred" approach seemed to help us identify a syllabus based upon recognised needs and interests; each A&E trainee felt that their own needs were fulfilled. We thought that the use of video techniques would be of value, bearing in mind their large role in general practice training.

Our month was fairly intense; the attachment could have been longer. However, there are many other core curricular needs to be met during the five years of higher specialist training in A&E medicine.

Since our first attachment in 1995, new funds—£45 million per year—have been negotiated to change the way that general practice out of hours work is carried out, by developing improvements in the service for the sake of doctors and patients alike. The Department of Health has avoided opening the Pandora's box of pricing general practice out of hours work separately, which would imply enabling a separate service to arise. General practitioners retain 24 hour responsibility for their patients' care. They must therefore deal with all out of hours calls themselves, or arrange for this to be done on their behalf.

General practices are increasingly using their share of new development money to form cooperatives, start primary care centres, or pay commercial deputising services to cover their out of hours responsibilities. Other general

practice developments which could have some bearing on A&E departments include setting up pilot "888" hotline phone services, which contract to provide skilled phone advice on a broad range of urgent situations, and creating special arrangements for seeing violent patients in secure surroundings.

A&E departments are funded differently to, and are distinct from, general practice services; there is no question of the two services somehow becoming "merged". Rather than a threat, these energetic new developments may be seen as an opportunity for fruitful cooperation between A&E departments and general practices.

Conclusion

Objective assessment of any secondment is difficult, but we hope that this account of our attempts to apply established general practice training techniques to an A&E secondment is of interest. The authors would strongly recommend a four week full time secondment to a training general practice for all specialist registrars in A&E medicine. All parties benefited from the attachments and the experiences were enjoyable as well as, at times, challenging.

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SHORT REPORT

General practice: a secondment from emergency medicine—so what!

Mark F Nicol, Chris A J McLauchlan

**Accident and
Emergency
Department, Royal
Devon and Exeter
Healthcare Trust,
Barrack Road, Exeter
EX2 5DW
M F Nicol
C A J McLauchlan**

Correspondence to:
Dr Nicol.

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Abstract

The Joint Committee for Higher Medical Training has issued a core curriculum for training in accident and emergency medicine. This article highlights some of the knowledge, skills, and attitudes one may usefully gain from a period of 6–12 months in general practice and how this can be integrated and adapted to a career in emergency medicine.

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Having clear aims and objectives for secondments is necessary to gaining the most out of them. A common perception among UK emergency department clinicians who have not spent time in general practice, is that it is of little use to emergency medicine. This situation is reflected in the lack of recognition of a year in general practice towards specialist training by

the Joint Committee for Higher Medical Training (personal communication, August 1996).

As far back as 1978 the Royal College of General Practitioners published a report on the training of general practitioners (GPs) in child care. Since then, the college has produced a series of booklets giving guidance on the content of training for a GP, to the extent of stating a core curriculum in each specialty.¹

The training environment within general practice is ideally suited to personal and professional development. The training practice must offer an approved trainer whose practice (computerised usually) can offer protected teaching time, an up to date library, and an assessment of registrar's needs at the start of post and subsequently.² The supernumerary registrar will usually have his/her own personal space in which to consult, and learn with the aid of trainer sitting in and periodically a video recorded consultation.³

The consultation is the hub around which the rest of general practice revolves. In contrast to the typical emergency department consultation the patient is welcomed into an area of privacy and not overheard through a curtain. The medical model of consultation satisfying a doctor's agenda is replaced by patient centred consultation.⁴⁻⁶ The coactive positioning of chairs allows the doctor to facilitate the voicing of ideas, concerns, and expectations through the use of listening skills. The patient's issues addressed, the doctor can then tackle house-keeping and reinforce health promotion topics pertinent to the patient. The result is a patient who, rather than going away with a diagnosis *per se*, leaves reassured that the diagnosis they were concerned about is unfounded! The treatment is agreed—which may be none, saving on a prescription destined for the bin. The wait-and-see non-interventional approach has many grateful patients, particularly stressed and anxious patients. Agendas of both patient and the doctor satisfied, unexpected returns decline as do complaints.^{7 8}

The weekly half day learner centred teaching in the local postgraduate centre is loosely based around problem and random case analysis by each registrar,⁹ and 12 months later the major topics affecting practice are covered. A prescriptive programme is avoided, as is the Socratic method of teaching, maintaining interest through the secondment. Registrars are encouraged to develop self awareness; this maximises personal and professional development. Discussions on avoiding burnout, coping with uncertainty, and coping with "heartsink" patients¹⁰ are always covered in the 12 months.

A striking difference between the registrar in general practice and the emergency department registrar arises in respect of management issues. Management issues are introduced at a much earlier stage of career, learnt alongside clinical issues, and not just as an observer, for example team meetings. Team meetings include, among others, the practice manager,

health visitor, and district nurse and are a regular part of the itinerary, and the registrar's attendance is expected. This results in a clear picture of the roles of others. A GP registrar may, at the age of 27, be involved with budgets, contracts, business planning, personnel issues, and partnership contracts. The emphasis of the training is towards a team based process contrasting with the hierarchical, control based structure in hospital.¹¹

The GP, like the emergency physician, may apply his expertise outside in the inhospitable elements, particularly if the practice is linked to the ambulance service/British Association for Immediate Care. The GP however, is also a clinician in people's homes; this is sometimes a humbling experience, always an insight into social problems, and frequently a lesson in time management. The hospital practitioner can only be more effective if he or she is aware of the social circumstances in which patients live and how these may contribute to the problems with which they present. The skills of clinical judgment a GP exercises, in a home or surgery, in the absence of expensive investigations have been much envied.^{12 13}

Lastly, having an awareness of the demands made upon a GP allows us to communicate more effectively with them with mutual respect, which must be to the benefit of the individuals we treat as their patients.

Conclusion

General practice offers more to the specialist registrar than just communication skills, providing an evidence based formula for training and patient care, which may serve as a model to regional training committees.

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