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Geneva, 29 October - 2 November 1956

Report

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1957

CONFERENCE ON PUBLIC HEALTH TRAINING OF GENERAL PRACTITIONERS

Geneva, 29 October—2 November 1956

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CONFERENCE ON PUBLIC HEALTH TRAINING OF GENERAL PRACTITIONERS

Report

1. THE PROBLEM

Introduction

The proceedings of the Conference were more limited in scope than the official designation of the meeting tends to imply. Its terms of reference stated that " although the broad aspects of the problem will, no doubt, be analysed in the course of the proceedings, principal attention is expected to be given to that group of general practitioners who besides their clinical practice also hold jobs as part-time medical officers of health and who have had little or no training in public health matters at all ".[1]

The Conference understood and employed the term of " general practitioner " in the functional sense, irrespective of his administrative relationship, if any, to the public health service and regardless of the sources of his income, both of which depend on how medical care (individual therapeutic care) is organized in any particular country.

A general practitioner was considered to be the duly licensed graduate of a medical school who, as a rule, did not specialize in or confine his practice to any one discipline—clinical, laboratory or public health—but who assumed the responsibility of serving any patient seeking his advice or care. It was also understood that the general practitioner should possess the requisite knowledge and skill to meet the average needs for medical care in his community, but that the scope of his work is inherently limited by what services a single doctor may reasonably be expected to render in the vast field of general medicine and by whatever facilities he may have at his disposal.

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[1] The Conference noted that some relevant aspects of medical education were covered in the first and second reports of the Expert Committee on Professional and Technical Education of Medical and Auxiliary Personnel (*Wld Hlth Org. techn. Rep. Ser.*, 1950, **22**; 1953, **69**); and that the Expert Committee on Public-Health Administration, in its first report (*Wld Hlth Org. techn. Rep. Ser.*, 1952, **55**), also referred to training problems in connexion with the need for professional personnel to carry out comprehensive public health programmes.

Some general practitioners are charged with public health duties in their communities, the extent of which may vary considerably.

In those countries which have what might be called a " dualistic " system of health services—part of which is private and part of which is public—medical care is usually not within the purview of the public health authority. Whenever a general practitioner is appointed as a part-time medical officer of health, he assumes his public health responsibilities in addition to his private practice. The remuneration received from the public health authority may constitute only a fraction of his income, the overwhelming part of it being derived from fees collected from his private patients.

There are countries, on the other hand, where public authority assumes far-reaching or complete responsibility not only for all public health work but also for the medical care of the population. In this case the general practitioner employed by the (public) health service assumes the responsibility for medical care in his capacity as, and as part of the duties of, the medical officer of health. He may be allowed some or no private practice at all; the main part of his income will consist of the salary received from the (public) health authority. There exist numerous variants and combinations of the two systems outlined.

Significant as these administrative features are in many respects, there may be very little difference between the actual work of general practitioners employed by either type of public health authority. In both cases the doctors have to assume the responsibilities for medical care and for public health work and have to divide their time between them. Thus, from the functional point of view they may all be called part-time medical officers of health, and it was in this sense that the term was used in the proceedings of the Conference.

The health responsibilities of general practitioners can therefore essentially be grouped into four categories:

1. Where the practitioner is solely engaged in the private practice of clinical (therapeutic) medicine and his statutory responsibilities are only those which are the legal obligations of all doctors.

2. Where the practitioner in addition to his private practice also performs some limited specific duties for the health department (for instance, employment as school physician or in tuberculosis or venereal disease dispensaries).

3. Where the practitioner is primarily engaged in the private practice of clinical (therapeutic) medicine but in addition also holds a job as part-time medical officer of health with varying degrees of responsibility for the different aspects of public health.

4. Where the practitioner is primarily the health officer of a designated area and where in this capacity he is also charged with some or often full responsibility for individual therapeutic care. It is mainly in rural areas that this type of " integrated practitioner " can now be found both in advanced and under-developed countries.[1] He may be allowed to engage in some private practice, or may not be allowed to have any private practice at all.

The terms of reference of the Conference do not pertain to category 1 but apply to some extent to 2 and mainly pertain to related categories 3 and 4.

The Conference considered some of the historical features—political, administrative, social, economic, etc.—which play a role in shaping the organization of health services in any country and elaborated on a few examples.

In Great Britain, for instance, the part-time medical officer of health is now almost non-existent. In the nineteenth century the high death rates from endemic and epidemic diseases made control of the environment the major activity for which the public health service was designed. Full-time health officers first assumed the responsibility for what we now call environmental hygiene or sanitation. However, towards the end of the century it was already realized that sanitation was not enough. The public health services also had to provide personal medical attention for the sick poor and for certain groups of people with special needs such as infants and schoolchildren. To these were added later on the care for pregnant and parturient women and their infants who were suffering from preventable disorders which did not or did not quite respond to environmental improvements. It was also found that better control of mass diseases such as tuberculosis and venereal infections required a community medical service. The existing health officers sponsored these new activities and gradually such services were instituted, staffed and developed by the full-time health officers. Thus, in the end, full-time medical staff were found not only in senior and administrative posts but throughout the public health services.

In many countries, both with advanced and under-developed health services, part-time officers play important roles in protecting the public's health. The Conference had the impression that the employment of general practitioners as part-time medical officers of health was not dependent upon the economic level of the country. In New York State, for example, there are 500 part-time health officers for many rural areas in addition to 41 full-time officers who give health services to the more populous areas. The majority of the medical officers in the Public Health Service of Norway

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[1] The full-time medical officer of health, who is solely engaged in community-wide public health responsibilities and who should presumably have completed formal post-graduate training as a specialist in public health, is not considered in this report.

are part-time, and part-time health officers are used extensively in many of the less developed countries.

Such interesting trends were also noted as exemplified by the situation in Denmark. In that country an increasingly great proportion of limited specific public health duties is entrusted to general practitioners (category 2) without hiring them into the public health service as part-time medical officers of health, whose number is therefore progressively decreasing.

As a result of these deliberations the Conference concluded that great discretion has to be exercised whenever any country contemplates adopting the organizational features of the health services of another. Some of the countries now setting out to create health services of their own are not so hampered by traditions or vested interests as those more developed. The former are therefore in a position to adopt whatever suitable features they may find in the long-established health services of other countries and avoid the unsatisfactory or unsuitable. Any health service should, however, aim at the co-ordination of all health work, at promoting the preventive attitude in every phase of it and at supporting all the social, educational and economic efforts of the community. Manifest trends and expected improvements in the health situation should also be given due attention because the organization of health services has to be flexible if it is to meet the changing needs of their communities.

In considering training matters proper, the Conference again had to give thought to problems of terminology and nomenclature. It was realized that existing differences in usage were not merely of an academic nature but were also due to the varying patterns of health services in different countries.

Wherever part of the health service is public and part is private, the meaning of the term " public health " is, as a rule, limited to organized community efforts in the field of health and disease; individual therapeutic care is more or less excluded. In other countries, where all health services are public, the meaning of the term " public health " becomes virtually all-embracing. Similarly, " preventive medicine " is sometimes used to denote the application of preventive principles by a doctor in dealing with individual patients. In other instances, however, it is used in a sense so wide as to include organized health activities of the community as well. The Conference therefore refrained from trying to define such terms as " public health ", " preventive medicine ", " community medicine " and " social medicine " which mean different things in different countries. It was, however, agreed that the phrase " public health and preventive medicine ", when used in the proceedings and in this report, should have a much wider meaning than that of traditional " public health ". It was accepted to mean not only the organized actions of the community to prevent occurrence as

well as progression of disease and disability, mental and physical, but also the timely application of all means to promote the health of individuals, and of the community as a whole, including prophylaxis, health education and similar work done by a good doctor in looking after individuals and families.

The Conference realized that only a fraction of any recommendations it may make is likely to be applicable to any given area or country. It therefore decided not to go into such details as draft sample curricula for training courses, but to attempt to outline some fairly generally valid principles which could serve as a guide in the planning of public health training for general practitioners.

As regards the background of the problem it was proposed to examine the causes of the common apathy of the general practitioner concerning public health and to consider how interest could be aroused. In dealing with these questions the Conference extended the scope of its deliberations to general practitioners of all categories mentioned above, because practically all part-time medical officers of health are recruited from the ranks of general practitioners and all public health administrations have a vital interest not only in their part-time medical officers of health but also in enlisting the co-operation of those general practitioners who do not form part of the public health service.

Reasons for the general practitioner's lack of interest in preventive and public health work [1]

1. *Inadequate education*

(*a*) *Undergraduate*

Students entering training for the profession of medicine are probably among the more socially-minded of young people and it is disappointing to find that by the time they graduate their interest in social affairs is often diminished rather than increased. Since this phenomenon is so widely observed there is reason to believe that some of the orientation they receive in the course of their medical studies may be responsible. The fact that in most medical schools the curriculum at present consists almost entirely of the teaching of diagnostic and therapeutic medicine may provide an

[1] In a way the paediatrician was also thought of as a general practitioner: the general practitioner of the child. Although it was realized that integration of the preventive and therapeutic approach was probably most advanced in the field of paediatrics, the Conference thought that some of the considerations set out in this section also applied to paediatricians as well as to other clinical specialists in appropriate circumstances.

explanation. If the medicine taught were "comprehensive" in the sense that it embraced adequately the preventive as well as the diagnostic and therapeutic, the interest of the student in the social aspects of medicine—and probably in social affairs in general—might be stimulated rather than quenched.

However, as already intimated, in most medical schools insufficient attention is given—either in time or in content—to make the student understand that medicine does not merely consist of diagnosis and treatment of a specific episode of illness in a patient, but also entails consideration of the patient as a person, as a member of his family and at times as a member of the community. The preventive point of view is also often lost in conventional clinical instruction because this rarely provides sufficient continuity of observation of the patient to permit the student to learn the social implications of disease and, when necessary, rehabilitation medicine.

Recently, however, there has been a welcome trend in some medical schools towards giving the student a chance to work in health centres or with general practitioners and to take part in organized community health activities. Such training may arouse the student's interest in the preventive and social aspects of medicine. At present, however, there are only few schools which offer these opportunities, and for some time to come there will be only very few graduates who have had what might be considered adequate undergraduate training in preventive medicine and public health. Most of the preventive work in day-to-day practice will have to be carried out by doctors whose training was deficient in that respect. The Conference thought that all medical schools should try to convey to a new generation of doctors such attitudes and technical knowledge which, in addition to their therapeutic work, may make them accept public health responsibilities more willingly and would—under the auspices of a supervisory office—qualify them better than is now the case to carry out the work of a part-time medical officer of health.

(*b*) *Subsequent to graduation*

In many countries graduates of medical schools have to undergo a mandatory period of training before being licensed to practise medicine on their own. Only rarely is provision made for them to acquire experience outside hospitals, and the provision varies considerably wherever in existence. In Norway, for instance, the graduate is attached as an assistant to a part-time medical officer of health for six months; in Japan, work in a health centre for two weeks is prescribed. In most countries, however, the early post-graduate training of the young doctor [1] ("graduate training"

[1] As an intern, resident, registrar, house physician, extern, or whatever else his designation may be as varying from country to country.

in the American use of the term) is confined to hospitals where he continues to receive the same orientation as in his undergraduate education. In very few, if any, of them is the attempt made to bring to his attention the difference in the kind of medicine he will have to practise when, on leaving the hospital, he establishes himself as a general practitioner, particularly in a rural area. Should his work include part-time responsibilities as a medical officer of health, his training will be even less adequate.

This is, however, not to say that the inadequacies of such training are not being increasingly realized. The American Medical Association Council on Medical Education and Hospitals, for instance, recommended in 1955 that " throughout the internship (residency) program . . . stress should be laid on understanding and evaluating the patient's family relations, his economic and social status and his position in the community. It is only by grasping the importance of the patient as a composite entity that the physician can attain the fullest mastery of his profession ".[1]

When on completion of his hospital training the young doctor settles in practice, he is quite naturally guided by the understanding of the scope of medicine acquired in his previous training: he endeavours to maintain the high standards of diagnosis and treatment which he has learned and tries to keep abreast with relevant current developments. However, as long as the general practitioner retains the purely diagnostic-therapeutic conception of his duties, he can have relatively little influence on the general level of health of his community. As society progresses the contribution of medicine towards its progress is judged as much on how far it improves the health of whole populations as on how well it can treat established disease. After some years in practice, when, by experience gained the hard way, the practitioner comes to realize the limitations of his original understanding of the scope of medical practice, he may well be receptive to further training in public health and preventive medicine if approached in the right manner and if good quality of training is provided.

Some health departments have tried to meet the training needs of such general practitioners who have been in practice for a varying number of years with or without specific public health responsibilities. As great as the general need is for such training, there are many practical obstacles which make it difficult and at times impossible to meet them. The material and personnel resources of the country play an important role. When there is, for instance, only one medical officer in a district, he has to be replaced when absent. If most of the part-time medical officer's income is derived from private practice, the financial loss entailed by attending a course may be a deterrent and the cost of meeting the general practitioner's

[1] *J. Amer. med. Ass.*, 1955, **158**, 1373

losses may be beyond the resources of the health department. As a result, many part-time medical officers of health have had to work for many years without any formal instruction designed to help them in carrying considerable public health responsibilities which may sometimes be the major part of their duties.

2. *Problems of status*

It was realized that besides inadequate education a number of other factors, expediently grouped under the general heading of " status ", also accounted for the general practitioner's interest, or more often lack of interest, in public health work. The concept of " status " of the general practitioner and of the part-time health officer in particular, as understood by the Conference, included such diverse and yet inter-related features as his professional standing, his remuneration and economic security, the extent of his administrative authority, the character of his professional relationships, his social position in the community, etc. These are all carefully weighed by the young doctor when choosing general practice as his career, and also—whenever he has a choice in the matter—in accepting or refusing the position of a part-time medical officer of health. All these features were not exhaustively dealt with but only to the extent that they were thought to be within the terms of reference of the Conference. It was finally also appreciated that these features differed so considerably from country to country—and even within countries—that it was in most respects impossible to generalize.

Due to the remarkable evolution of the medical sciences, the practice of medicine has undergone important changes. Increasingly elaborate diagnostic and therapeutic methodology and an ever-growing scientific body of knowledge have led to the present high degree of specialization. There is a fairly widespread desire among young doctors to specialize, not always because mastery in a narrower field is preferred to the limitations which the wide scope of general practice imposes, but mainly because of the greater prestige, conveniences and revenue which go with specialization.

However, for a long time to come, the occasionally-voiced opinion that the general practitioner is likely to disappear entirely seems to be unfounded, although his role and position are undergoing adjustments in our rapidly changing world. The present problem is not that a critically low percentage of young doctors go in for general practice, but rather that they are reluctant to practise in remote and relatively isolated rural areas. As a result, there is in big cities—besides the natural concentration of specialists—a conglomeration of general practitioners in and around them as well. In the cities there are often full-time medical officers of health; if not, there are a number of general practitioners from among whom the part-time ones can be

selected. However, when settling in a rural area—often as the only physician on the spot—the general practitioner has to assume public health functions. When looking at the problem from the point of view of education, it may be said that if better education made public health work more attractive, the young doctor might be more amenable to selecting rural practice as a part-time officer of health as his career. However, when looking at the problem from the point of view of status, it can also be said that if the working and living conditions for the rural part-time medical officer were made more attractive he might also show greater interest in public health work.

The reasons why the Conference extended the scope of its deliberations to the relationship between public health administrations and general practitioners of all categories have already been given above (see page 7). This relationship naturally differs depending on whether the general practitioner is solely engaged in private practice or whether he is a part-time health officer and thus himself part of the public health department. When the part-time health officer is the only doctor practising in the area, his duties and responsibilities are clear. There are relatively seldom conflicting duties and causes for friction when all the doctors in an area are employees of the health department. Certain difficulties may, however, arise when doctors entirely in private practice and health department doctors are working in the same area and possibly at times with the same patients.

There is no doubt that there has been in the past much misunderstanding between public health departments and general practitioners, and even at present friction can easily arise whatever the type of organization of the health services may be. Such friction tends to diminish the interest of the general practitioner in public health work. As long as the public health authorities engaged only in impersonal sanitary services, there was a gap which separated them from the practitioner who was primarily interested in personal services to his patients. Since public health authorities have extended their work to varying degrees to include personal services, a borderland has been created which is potentially a source of co-operation as well as of friction between general practitioners and the public health department. In order to derive mutually satisfactory results, it is essential to foster friendly co-operative relations. Health departments are in the better position to take the initiative, and in doing so they should bear in mind the many sensitivities of general practitioners who are usually individualistic, harassed by the volume and irregularity of their work and not much given to clerical tasks. The general practitioner, on the other hand, not only has to appreciate the value of administrative and organizational work in community-wide health activities, but also has to learn how to make use of the varied advantages which a modern public health depart-

ment offers to him in solving many of the problems of his patients in day-to-day practice.

Any health department official—medical or paramedical—visiting a patient without the attending practitioner's knowledge or without informing him of the result of such visits is likely to create adverse feeling in the general practitioner towards the public health authority. Reports from hospitals, clinics and laboratories must reach the general practitioner without fail and promptly. When, for instance, in the course of mass campaigns, specialized teams dealing with the prevention of particular diseases, such as yaws or malaria, or with specialized groups of populations such as schoolchildren or expectant mothers, operate in the area of the doctor's practice, he should be kept fully informed and, if possible, given a part in their activities. However, even with the most strenuous of efforts the health departments cannot always hope to satisfy all practitioners. In any group of people there will be some in whom " rugged individualism " verges on the anti-social.

2. CORRECTIVE MEASURES

Arousing the general practitioner's interest in public health work

Success in arousing the general practitioner's interest in public health work will partly depend on his educational background. If the undergraduate training of the general practitioner was purely along diagnostic-therapeutic lines, he might be less responsive than if training had inculcated in him the appreciation of the preventive and social aspects of medicine. The great importance of undergraduate training was repeatedly stressed in the proceedings of the Conference.

Another factor which has some bearing on the responsiveness of the general practitioner is the performance of the health department he deals with. Its standards of work should—under the leadership of a nucleus of enthusiastic full-time health officers—be such as to command respect. Some of the projects of the health department are likely to be of interest to the general practitioner and they cannot fail to be noticed because they impinge on his activities.

General practitioners are often working in isolation. It is therefore important to keep them informed of the general and specific aims as well as of the activities of the health departments. Besides the written and printed word the possibilities of the radio should also be considered. Periodic health bulletins have proved useful in many countries. In some instances they are sent not only to part-time health officers but to all general practitioners and their contents vary according to local needs. They may

—and some of them do—carry educational articles or informative material on health problems in their own as well as in other areas of the country, with comparisons of and attempts to explain existing differences and, finally, they also carry health news from other parts of the world.

Such printed information—essential as it may be—should, however, be only complementary to and not a substitute for personal contacts. The prevailing type of organization of the health services and of medical care in particular will largely determine the suitable approach and contents.

In countries where the health services are established along the lines of what has above been called the " dualistic " system, the private practitioner (category 1) is virtually independent of the public health department. Except for what are the legal obligations of all doctors, his co-operation with the public health department has to be sought on a voluntary basis. The work and interests of both, however, converge and meet on matters of family health. Realization of the fact that the family is the basic unit of health work may make active co-operation easier. Meetings arranged on subjects concerned with individual patients or families are therefore suitable first contacts. The health officer should start by showing the general practitioner how the health department can assist him in his private practice. He may then also try to interest him in other public health activities where the practitioner can learn much himself and, in the process, may develop interests in new aspects of health work.

Whenever graduate or public health teaching is carried on, general practitioners should be invited to attend seminars and the like, where they can make most valuable contributions in discussions on prevention by drawing on their personal experience. General practitioners practising in the proximity of medical schools can also be asked to help in undergraduate teaching by allowing students to assist them in their practice or by attending students' discussions on medico-social problems arising in some of the families under their care. As a rule, the practitioner knows more about certain public health problems than he himself realizes and he almost certainly has some information on people and conditions in his area which the health authorities lack. He is likely to be encouraged and pleased when he finds that both his experience and collaboration are valued.

A great deal of what has been said also holds true for part-time medical officers of health, whose public health responsibilities are sometimes very limited. However, in their case there exists a formal link—an employer-employee relationship—with the health authority, and their co-operation is therefore not sought merely on a voluntary basis. One way to encourage a part-time health officer to think systematically of health problems is to complete with him a prepared schedule asking a variety of questions about

social characteristics, health problems and health services available in his area which may also be considered a first step in his in-service training.

There may be a large untapped source of goodwill and co-operation in local medical societies and—wherever they exist—in general practitioner academies or colleges, in associations of part-time health officers, etc. The health officer can often influence the choice of subjects discussed in medical societies so that topics of public health interest are included. It may also be possible to establish sections on preventive medicine and public health in medical societies and to ensure good health department participation.

Whenever health associations are meeting or central or local conferences of health department staffs are arranged, practitioners should be encouraged to attend and to make contributions both by presenting papers and by taking part in the discussions. Whenever possible—particularly in the case of part-time health officers—attempts should be made to defray all or part of their expenses. Whenever graduate or refresher courses are arranged for practitioners in clinical subjects, the opportunity should be taken to introduce discussion on preventive and public health aspects in the relevant speciality.

In countries where medical care has become largely or entirely a public (government) responsibility and where the general practitioner mainly conducts his practice in the capacity of a health officer (category 4), the personal contacts are essentially between health officers of the various echelons of the health department. These personal contacts will be influenced by the fact that they are all taking place in a group more closely knit by common ties of employment, and by an *esprit de corps*. All these factors do not make careful fostering of personal relations less important.

Specific courses in preventive medicine and public health as a means of post-graduate education are considered in the next section, but they may also be valuable as a means of arousing first interest in the subject. Their contents should, whenever possible, be based on the views of the practitioners consulted either as individuals or through their local medical societies. The subjects of such first courses have to be chosen carefully so that they are relevant to common, easily recognizable problems, and should preferably be of some therapeutic as well as preventive and/or epidemiological interest.

In certain circumstances an effort might be made to devote part of the post-graduate internship to public health work. This would prove particularly valuable in countries where there is difficulty in providing adequate undergraduate education in the subject and where a majority of the new graduates would be working as the only doctors in rural districts, perhaps with some non-medical assistants.

Training courses for part-time medical officers of health

Arranging set courses of instruction for part-time health officers raises many difficulties and in no two communities are the best arrangements likely to be the same. Provisions may have to be made for the practitioners' ordinary duties to be performed while they are away, and it is also important to avoid their incurring undue financial loss by attending courses. The genuine desire of the attending practitioner to receive instruction is essential to the success of any course. When courses have become well-established they will probably advertise themselves, but in the beginning the personal approach to practitioners is advisable. The courses would be more attractive if they counted towards promotion or qualified for a higher salary.

1. *Aims of the courses*

The courses should aim at:

(*a*) influencing the orientation of the doctor towards the meaning and purpose of public health;

(*b*) improving skills and techniques essential to the carrying out of health duties;

(*c*) helping part-time health officers feel that preventive medicine and public health are an integral part of their work;

(*d*) increasing the understanding of health administration policies and of the ways in which health officers are expected to implement them;

(*e*) improving the understanding of the scope and limitations of the work of the non-medical health personnel of the department.

2. *Duration of the courses*

The duration of the courses will usually be determined by the time the practitioners can spare, the amount of training they require, the funds and teaching staff available, and the nature of the health problems in their areas. It should also be remembered that in training older persons, a little time is lost early in the courses before they re-acquire habits of study or become accustomed to some of the new teaching methods, especially those in which they have to participate actively.

In general, courses of the above aims should not be shorter than two weeks and not longer than three months or at most half an academic year.

3. *Content of the courses*

The basic approach to the problems of preventive medicine and public health should be the same in any training programme, but its contents will differ in extent depending on whether it is meant for undergraduates or for doctors intending to become either part-time or full-time medical officers. The emphasis on the various fields to be covered will also vary from country to country. However, almost any course should include such subjects as:

(*a*) the role of the physician in society;

(*b*) the socio-economic problems related to health and illness and the community welfare measures required to meet them;

(*c*) the role of the public health administration and means and ways by which general practitioners can collaborate with it;

(*d*) how health statistics serve as a tool of administration and how the medical officer should evaluate vital statistics;

(*e*) how epidemiological methods aid the health officer in evaluating problems of disease;

(*f*) the role of paramedical personnel in the health team;

(*g*) the health officer as leader of the health team;

(*h*) the importance of environmental sanitation to community health;

(*i*) the importance of factors other than the health services in raising the level of health (social and educational services and measures designed to improve the income level of the community);

(*j*) the close connexion between therapeutic and preventive medicine (early treatment);

(*k*) new problems in a changing pattern of health needs.

It follows from what has been said that in general there should be four basic features common to the contents of any public health training course for medical personnel, regardless of the specific political, social, financial, educational and health conditions in which it is conducted:

(1) There are some aspects of training of which the person of the physician is the focal point. The training programme should aim at developing in him the appreciation that, besides being merely the healer of the sick, he has a much greater role to play in the society he serves. This will more often than not presuppose a reorientation from the concept of medicine

acquired in medical school. The target of this part of the training programme is the physician's professional frame of mind.

(2) The focal point of some other aspects of training is the community in which the physician practises. Whilst medicine taught in medical schools is more or less the same anywhere, the differences in the practice of medicine are considerable in various types of communities in different parts of the world. Training should here aim at helping the physician to apply or adjust his general skill and knowledge to the particular needs of his community.

(3) Aspects of training which concern the physician's technical skill and knowledge, the improvement of his professional armamentarium.

(4) The resources, other than the physician's own personal and professional qualities, which are available to him in fulfilling his role in the widest sense of the word. The physician must be made aware that he is not alone in carrying out his mission; he has to appreciate the full contribution that can be made by his paramedical and ancillary co-workers, as well as the extent of support potentially available to him from governmental or municipal sources or from the civic or voluntary organizations of his community.

4. *Choice of place and teaching staff for courses*

Local circumstances determine the place where courses are held and the choice of instructors. In principle, however, the training should be under the joint auspices of an educational institution, a health department and the organized medical profession. Where an appropriate university department or a school of public health is available, they are likely to be the most suitable places because they usually have the necessary teaching facilities. In other situations, courses may be held in a health department. As much as possible of the training of rural health officers should take place in a rural training centre. The latter should have living quarters and proper physical facilities for seminars. Whichever body takes the responsibility for organizing the course should consult with local health departments, universities, medical societies and other relevant institutions as regards the organization and content of the course and the choice of teachers.

Teachers should have had practical experience in their subjects and should include some practising health officers who are familiar with the conditions in which part-time health officers work. In making the choice, teaching ability should be considered besides technical skill.

One person should be charged with directing the course, to be responsible for determining priorities and guarding against instructors going into too

great detail in specialized subjects. Where compatible with the above suggestions, a relatively small number of teachers should take care of a high proportion of the instruction in order to prevent overlapping and to ensure that the whole programme is covered.

5. *Method*

Methods of instruction suited for undergraduates are often unsuitable for teaching qualified doctors, many of whom have had wide experience. Didactic teaching should be reduced to a minimum, and even there informality should be encouraged by allowing the trainees to interrupt lectures by questions instead of waiting for a question period. Discussion groups and seminars are the methods of choice and public health nurses, veterinarians, sanitary engineers, lay administrators, schoolteachers and social workers, etc., may sometimes be usefully brought in. Practitioners should be invited to make prepared contributions on various topics, to give their own views and to describe their own experiences. As the part-time health officer's work is mainly with people, the case-conference is also a very suitable method of instruction: clinical, social and environmental factors relating to the condition of a patient or family can be jointly analysed and thus give indication as to how occurrence and/or progression of the disease might be prevented. It may also point out the kind of assistance which available health and welfare organizations may be able to give in the particular instance.

Well-organized visits to health centres followed by discussions, or participation in small community studies or epidemiological investigations, can also be valuable. Indeed, field work of all kinds preceded or followed by consideration of the implications of the particular experience are effective methods of teaching. More information is retained for longer periods if imparted by such techniques than if didactic methods are used.

Modern audio-visual aids can effectively add to instruction and may sometimes substitute for time-consuming visits to those sanitary installations of which the part-time medical officer needs no detailed technical knowledge.

6. *Follow-up programmes*

The full benefit of instruction is jeopardized if at the end of the course the trainees revert to the state of isolation in their practices. They should keep in touch with their teachers by correspondence: discussion of the conduct and results of the course, advice on the application of lessons learned, experience gained in applying these lessons, may be the main object of these contacts. This may stimulate interest in attending future meetings or other courses.

When practitioners go home after a course, they are more likely to pay attention to printed public health material which, if appropriately chosen, can continue the instruction. The doctors should be asked for their views on the need for and content of future refresher courses. Indeed, consideration of the methods of follow-up work should be part of the planning of any course.

It is important to try to assess the results of such instruction by a properly controlled method of evaluation. Most questionnaires have little value and are not to be relied upon as the sole method. Personal interviews planned in collaboration with social scientists who are experts in such procedures are more dependable and preferable.

Other group training schemes

Short periods of training such as are provided by week-end courses, meetings and one- or two-day seminars have a place of their own in the training programme and are not to be regarded as substitutes for the longer courses described in the preceding chapter. They are useful as a follow-up measure after more lengthy courses; they may serve to impart information on some topic requiring the urgent attention of practitioners or health officers, for example, teaching the rationale and technique of a new immunizing procedure. They may serve as a stop-gap to arouse the interest of part-time health officers and to give them some instruction until more suitable arrangements can be made. In some areas, repeated short training schemes may be the only feasible solution to the training problem, and where most general practitioners have had a sound undergraduate education, a series of one- or two-day courses may meet their minimum needs. Finally, they may be of value in taking advantage of the temporary presence in an area of a number of authorities on a particular subject.

Arrangements for such courses have to be made with particular care in order to make the best use of the little time available. Some of it is inevitably lost on administrative arrangements and until the students settle down. The temptation has to be resisted to crowd too many lectures into one day and too much information into didactic lectures; discussion and seminar methods should take up at least half of the time.

Every encouragement—financial and otherwise—should be given to part-time health officers to attend meetings arranged by health departments and public health associations.

In several countries the employment of teaching teams or so-called teaching missions, recruited either from national resources or with help from other countries, has been a most successful method in arousing the interest of practitioners and in improving the standard of practice. Such

teams have usually visited hospital centres, have given demonstrations, lectured and led discussions on a variety of subjects of interest to local specialists and general practitioners. So far, the emphasis has mainly been clinical, but the method has also been used to combine public health and clinical subjects with emphasis on preventive aspects. There is much to suggest that international teaching missions and WHO visiting teams of medical scientists have done useful work in many countries. Although their functions are much broader, the principle of the team going to the actual areas where the doctors work has been an important factor in their success.

Finally, it may also be noted that in some places the enthusiasm of medical societies, health departments and universities has resulted in such a surfeit of meetings, conferences and courses as to impair the interest of the practitioners. This can be overcome by limiting the number of meetings and by improving their quality in collaboration with all relevant institutions and the practitioners concerned.

The role of health education materials

The part-time medical officer of health will only exceptionally find time to read any of the elaborate texts on preventive medicine and public health. However, many health departments have standard reference booklets, such as guides on public health, welfare and voluntary services available in their area, manuals on the legal obligations of the practitioner and health officer, ready reference guides on communicable disease control including standard immunizing procedures. An excellent example is the American Public Health Association's booklet entitled *The Control of Communicable Diseases in Man.*[1] Such manuals which have practical applications are usually appreciated and in constant use.

Periodic bulletins or news sheets are useful and have already been dealt with in a previous chapter.

Printed material may save time by supplementing verbal instruction during training courses. It also has considerable value in the follow-up phase. However, since the practitioner receives a great deal of printed material in the form of books, journals, pamphlets and circulars, any material sent to him should be of high quality, brief, to the point, possibly coded and of carefully designed uniform format for easy standard filing. The material sent should preferably contain information not readily available elsewhere.

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[1] American Public Health Association (1955) *The control of communicable diseases in man*, 8th ed., New York

The widely read medical journals should also be used for advertisements, inspired articles and scientific contributions from the health department. Special supplements may be published occasionally on matters of preventive medicine and public health. It may be possible to obtain free space in these journals as well as in the daily press for regular features and announcements of public health significance, if the material is interesting and presented attractively.

Correspondence courses can be organized to meet special situations.

Exhibits, professional films on timely public health subjects, and loans of lantern slides with printed explanations can be used with advantage to reach groups of practitioners in hospitals or gathered at medical meetings. Closed radio and television " hook ups " have also been used to reach widely scattered medical audiences and can even be arranged to permit questions and discussion.

The terms of reference of the Conference limited its deliberations to the training of part-time medical officers of health. However, in conclusion, the participants in the Conference also wished to stress the importance of the training of those general practitioners who have no official public health duties. These doctors have many opportunities for positive health work and they are the future recruits to appointments as part-time health officers. Most of the methods which require no prolonged absence from home stations are applicable to their training, and no opportunity should be missed to approach them. The best ways are probably the individual approach or through the medical societies whose members are mainly general practitioners.

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