A Henderson, C Byrne and A Crowther


Letters to the Editor

BRUCELLOSIS

From Col E E Vella, L/RAMC

SIR—The following extract from a modern well known dictionary will indubitably send icy shivers down the spinal cord of many of our rank and file and into the core of the very souls of our Caledonian confreres.

"Brucellosis, named after Sir David Bruce (1855-1931). Australian bacteriologist and physician."

Someone at present wearing or who has worn our ‘In Arduis Fidelis’ cap badge, or perhaps even you, Sir, should demand a public written apology from the Editors and the Publishers of Collins Dictionary of the English Language, 1979, p 192, or else an early dawn appointment in Hyde Park.

I am etc.,

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16 April 1985

POSTINGS OF RMOs/GPs

From Major D W Smith, RAMC

SIR—I should like to comment on the letter from Colonel (now Brigadier) Beale stating the AMD 3 policy on the postings of RMOs/GPs. In his letter he states that PGMOs "after five or more years of medical training, house-jobs and PGMO, want to get 'stuck in'." Get 'stuck in' they do want, but under supervision.

We, in the Army Medical Services, have always prided ourselves in the fact that we provide a peace-time medical service as good as or better than the National Health Service. However, it is now illegal in the NHS for any doctor who does not have a certificate of GP Vocational Training to have full responsibility for the primary care of any patient. The regulations of the National Health Service Act 1977 do not of course apply to the RAMC but we must not ignore them or our standard of medical service will manifestly deteriorate.

Already there has been some minor criticism of vocational training of Army general practice by an eminent member of the Royal College of General Practitioners. This prompted a reply from Brigadier Beale. How long will it be before there is criticism of the actual service we provide?

Ideally to provide a GP service equivalent to the NHS every GP/RMO who is not working in a group practice under the supervision of a trainer, ought to be vocationally trained. Clearly this would be impossible to achieve, but I think we could reach a better compromise than the one we have at the moment.

All GPs/RMOs who are not yet vocationally trained should not work in single-handed practices looking after troops and families. I feel that they could fill true RMO posts where their clinical responsibility is only to soldiers but when it comes to looking after wives and children they ought to work in a group practice with other doctors, ideally with a trainer and at least with a more experienced doctor. It is possible in BAOR for medical officers working in group practices to fulfil the roles of GP and RMO. This has been highlighted by Major Needham.

The single-handed family practices of which there are several in BAOR should be filled by vocationally trained GPs who are either ineligible or do not wish to become trainers. This is the least we must achieve to be able to compare ourselves favourably with NHS general practice. There are many examples of these doctors who are working in large group practices, neither trainees nor trainers.

If we can offer GPVT in combination with their RMO posts to potential GPs immediately on completing the PGMO course, we shall have two or three years of useful general practice from them before the end of their Short Service Commissions. More of our general practitioners will be "as good as" their equivalents in the NHS and I also firmly believe that, if they are treated in this manner, more will convert to Regular commissions. I know of many young doctors who have been totally disillusioned with the
RAMC by being posted to a single-handed family practice early in their careers.

I should like to see three policy decisions on the postings of PGMOs and GPs.

1. **PGMOs who wish to be GPs should be posted if at all possible to start GPVT.** Failing this they should be posted as RMOs with family commitment to a group practice where they will work with at least one more experienced doctor.

2. **PGMOs who wish to be hospital specialists should be posted to RMO posts where there is no family commitment.**

3. **Trained GPs (the equivalent of NHS principals) who are ineligible or do not want to become trainers should be posted in the first instance to single-handed family practices and if these practices are filled to non-training practices.**

I am etc.,

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REFERENCES


POSTINGS OF RMOs/GPs

*From Brigadier W G Kilpatrick, L/RAMC*

SIR—The above refers to the fact that it is now mandatory for Principals in General Practice in the NHS to have completed Vocational Training or to have had equivalent experience before appointment. As Major Smith states, this does not apply to AMS but the RAMC has, in all disciplines of Medicine, been endeavouring for many years to produce similar Training requirements to those pertaining in the NHS practice.

The problem of single-handed stations responsible for families is one which has always been before the Posting Branch, particularly in these past few years since the inception of Mandatory Vocational Training in the NHS.

At the moment there are 13 posts responsible for families which are manned by recently joined medical officers and where there are no other experienced General Practitioners in the Practice. There are also, at the moment, nine posts not responsible for families which are occupied by trained doctors.

It should be said that there are a number of reasons for appointing experienced doctors to these last posts. Trained doctors request a Home posting for personal reasons or in order to look for posts in NHS following the completion of their Commission. Some posts, while not responsible for families, require experienced Service doctors for Service reasons. Likewise, experienced doctors who are potential Trainers awaiting their application for Trainer approval being accepted, are posted to Training Practices to obtain training experience during this waiting period. The presence of some experienced doctors who are not Trainers in Training Practices has been intended to provide some continuity for the Practice and clinical support for the Trainer, allowing him time to spend training.

Even allowing for these factors, out of the nine posts occupied by Trained doctors, two were required to be experienced in Service matters. Thus, even using these seven doctors there is a shortfall of six posts which would have to have been occupied by newly joined doctors. There is a basic shortage in the Army of trained experienced doctors in the middle grade. This last factor is one which may improve over the next few years and when this occurs, the problem could be solved.

Lastly, the idea of sending of newly joined medical officers to Training Practices as their first posting is attractive but does not always work practically. Some of these doctors find the transition from hospital pre-registration job to Army officer, Army doctor and the initiation into GP Vocational Training quite difficult, and often training suffers.

The ideas Major Smith suggests are sensible and have been guiding Postings Branch. However, when consideration of the personal needs of doctors whether Trainers, Trained or Trainees enter into the equation it does result in some of the anomalies he mentioned.

It is the writer’s view that all GPVTs should complete at least a year in an RMO/Unit MO post with no responsibility for families nor training, before commencing GPVT proper, and preferably starting with the hospital modules. However, the mechanics of fitting in the number of doctors wanting GPVT and providing a service to the Army makes this a difficult proposition at times.

Major Smith’s pertinent comments are welcome in continuing this debate on a problem which has been concerning many of us for some time.

I am etc.,

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