PRACTICE OBSERVED

DRCOG

Time for change?

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The diploma examination of the Royal College of Obstetricians and Gynaecologists (DRCOG) has been in existence since October 1931, and it remains one of the most sought after qualifications in the United Kingdom. The college's 55th annual report shows that approximately 1415 candidates sat the examination in 1983, compared with 1188 in 1981 and 1246 in 1982, underlining the growing interest in this examination.

A cynic might relate the increasing popularity of the DRCOG examination to its pass rate, which at approximately 80% must be well above that of any other postgraduate medical examination today (with the possible exception of the proposed part I of the membership examination of the Royal College of General Practitioners, with an envisaged pass rate of 95%). The traditionalist may question the "usefulness" of an examination that allows almost every candidate who sits it to pass. But the pass rate of an examination reflects only the acceptable level of performance—that is, the standard set by its examining body. And the standards may be changed according to circumstances such as manpower and public opinion. There is a widespread, though implicit, belief among doctors that the prestige of an examination depends on its pass rate, the lower the pass rate the more "important" must be the examination. This simplistic view ignores the most fundamental questions, which are What is the purpose of the examination? What does it measure? and How well is that being achieved?

As far as the DRCOG is concerned, before the days of the two part examination for membership (MRCOG), many candidates sat the diploma examination to sharpen their preparation for the real "thing," which usually followed a year or two later. And the examination at that time seemed to be a fair test of no serious consequence for these budding obstetricians.

Testing GP trainees

Now, however, with the two part MRCOG very few doctors with specialist aspirations would waste their time and money on the diploma, and therefore the latter has become quite reasonably more and more a test of competence in obstetrics and gynaecology for trainees in general practice. This fact has been well recognised by the examination committee of the RCOG and the syllabus and regulations of the present diploma make repeated references to general practice and its requirements. Yet the format of the examination—a written paper and clinical and oral examinations—has hardly changed over the years. The written part, which is still a traditional essay paper, suffers from all the drawbacks of this method of assessment, which has led to its abandonment from the part I examinations for membership of the Royal Colleges of Physicians and General Practitioners.[1] This is not too surprising as there is now ample evidence to suggest that the multiple choice question format is probably the most valid method assessing factual knowledge.[2] This must also be the experience of the RCOG, as the part I of the MRCOG examination now consists solely of a multiple choice question paper. Furthermore, there are inherent difficulties in evaluating clinical skills in any examination, and the clinical and oral parts of the DRCOG are no exception.[3]

More disturbing perhaps, is the reluctance to recognise the importance of defining standards of acceptable performance for the DRCOG. Although rigid standards are to be deplored, flexibility bordering on indifference also leaves much to be desired. The standard must relate to what is acceptable in general practice, and this is not easy since the examiners are chosen from among distinguished and experienced specialists who have little first hand knowledge of the problems of general practice.

The examiners of the DRCOG are changed every three years. Although this might seem to be a fair practice, by sharing the task and recognising the years of dedicated service, I believe that it does not allow enough time for an examiner to become fully familiar with the content, standards, and problems of the examination. Unlike the MRCGP, there is little opportunity for

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the examiners to meet informally, exchange ideas, and analyse their own experiences. Despite doubts about the efficacy of training examiners, I believe that there is a need to develop a more professional approach to the task of examining.[4]

The present examination can only assess some of the knowledge gained by the candidate as a result of six months' work in a modern obstetric unit—at best, a test of "hospital" medicine as practised in a specialist setting. How relevant this is to the skills and problems of general practice remains uncertain, especially if most of the experience of the assessors is from working in hospitals. Furthermore, there is a danger that the candidates' lack of proper and relevant knowledge may be brushed aside by the kind examiner in the mistaken belief that "He is going to be a general practitioner anyway, so what does it matter?"

As an examiner of the DRCOG I have often been appalled by the candidate who can see no option for the clinical management of patients except immediate recourse to real time scanner and cardiotocograph, ignoring the basic clinical skills of a general practitioner. Although these technological advances are undoubtedly valuable in many cases and the general practitioner should know something about them, I question the narrow range of training that we seem to provide for our general practitioner trainees in some hospital posts. Perhaps we should define the type of clinical experience that a general practitioner trainee should be exposed to during his six months of hospital training. Perhaps the emphasis should be more on education and less on training.[4] More importantly, the DRCOG should attempt to assess the candidate's ability in cognitive as well as behavioural skills that are relevant to general practice.

The examination committee of RCOG have been remarkably courageous over recent years in adding general practitioners to their rank of examiners. This is a welcome start and the college deserves every credit for it. But whether or not this will bring a fundamental change in the aims and structure of this examination remains to be seen.

I believe that with the imminent reorganisation of the obstetric list, which heralds a renaissance for general practice obstetrics, the diploma examination will attain even greater importance for all of us.[4] I therefore hope that my raising these issues will be seen not as an attempt to discredit the DRCOG but as an attempt to encourage a wide and serious debate for change. I am sure that we are all united in the aim to develop an examination which is fair, meaningful, and relevant.

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Practice Research

General practitioner and health promotion: what patients think

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Abstract

Although there has been growing interest in general practitioners' participation in promoting health, little is known about the attitudes of their patients. Thus we sent a copy of a self administered questionnaire (the Health Survey Questionnaire) to 3452 patients aged 17-70 who were registered with two practices in north west London. Questions about attitudes to and perceptions of general practitioners' interest in weight, smoking, drinking, and fitness problems were included. The patients were also asked whether they thought that they had a problem in any of these areas.

The response rate was 72%. Of those who responded, the proportions who thought that their general practitioners should be interested ranged from 72% in the case of fitness to 83% for weight, but only 38% thought that general practitioners had in fact been interested in fitness and only 48% thought so about weight. Forty one per cent of the respondents thought that they had a fitness problem, 42% a weight problem, and 58% of the smokers thought that they had a smoking problem. Four per cent of respondents stated that they had a drinking problem. Of those patients who said they had a problem, the proportions who thought that their general practitioners had seemed interested ranged from 43% for fitness to 69% for smoking.

The findings of this study suggest that greater participation by general practitioners in health promotion would be well received by most patients and that currently there may be considerable discrepancies between patients' expectations and their perceptions of their general practitioner's interest in these areas of preventive medicine.

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Introduction

There has been much interest in the potential for the participation of general practitioners in promoting a healthy lifestyle.[1]

This has arisen both because of the accumulation of evidence of the harmful effects of cigarette smoking, overweight, excessive alcohol consumption, and lack of physical exercise, and because of the recent findings that intervention by general practitioners can result in important changes in behaviour in the case of cigarette smoking.[2-4] Though the effectiveness of intervention for the other three areas has yet to be adequately evaluated, general practitioners are already coming under increasing pressure to incorporate health promotion of this kind into their routine clinical work.[5]

There is little recent information on what patients think about the practice of health promotion by their family doctors. We have therefore carried out a study to determine whether patients think that it is appropriate for general practitioners to be interested in problems relating to four areas of lifestyle—namely, smoking, weight, drinking, and fitness. In addition, we have examined the patients' perceptions both of their own health problems in these areas and of the interest actually shown by their general practitioners.

Patients and methods

The study population consisted of all the patients aged 17 to 70 years inclusive who were registered with two general practices in a health centre located on a council housing estate in Harlesden, London. Of the 3997 patients on the age-sex register of the two practices, 545 (14%) had changed address without notifying the practice or left the practice or died. Current addresses were available for a total of 3452 patients.

The self administered questionnaire which we designed for this study, the Health Survey Questionnaire, included questions relating to weight, cigarette smoking, alcohol consumption, and fitness. A simple multiple choice of four responses was used throughout. The three sections relevant to this paper are:

1. In your opinion should your family doctors be interested in: (a) weight problems, *(b)* smoking problems, *(c)* drinking problems, *(d)* fitness problems?

(2). From what you know of your family doctors, have they seemed interested in: (a weight problems, *(b)* smoking problems, *(c)* drinking problems, *(d* fitness problems? The possible responses to these questions were: definitely, probably, no, don't know.

3. Do you think you have a: (a) weight problem, *(b)* smoking problem, *c* drinking problem, *d* fitness problem? The possible responses to these questions were: definitely, possibly, probably not, definitely not.

A reply paid copy of the questionnaire was initially mailed to each patient in the study, accompanied by a covering letter signed by their general practitioners. Reminder letters were sent at three and six weeks, the latter including a fresh reply paid questionnaire. At two months the records of the persistent non-responders were tagged so that they could be identified on attending surgery and personally handed a copy of the questionnaire by one of their own general practitioners. Questionnaire responses were coded and double checked before computer analysis. χ^2 testing and Armitage χ^2 linear trend analysis were used for comparing results in different groups.

In addition to the patient questionnaire the five general practitioners who worked in the two practices each received a copy of a questionnaire that asked whether they had regularly given advice on smoking, weight, drinking, and fitness in their consultations over the 12 months before the start of the study. The responses to these questionnaires were analysed manually.

Results

The general practitioner questionnaires were returned satisfactorily completed. All five general practitioners stated that they had regularly given advice on weight, smoking, drinking, and fitness as part of their routine work during the 12 months before the study started. Of the 3452 patients included in the study, 2477 (72%) returned a questionnaire within six months of the original mailing. Questionnaires were received from 1394 of the 1859 women (75%) and from 1069 of the 1593 men (67%). Ten of the returned questionnaires had been incompletely identified before mailing and four others were returned with no decipherable response so the analysis is based on the remaining 2463 questionnaires. The response rates for men and women were significantly different ($p < 0.001$) and there was a significant trend for a greater response rate with increasing age for both sexes ($p < 0.01$).

Responses to: Should your general practitioner be interested? (Table I)—The completion rates for the questions in this section ranged from 88% to 93%. The overall proportions of respondents who thought that their general practitioners should be definitely or probably interested ranged from 72% for fitness problems to 83% for weight problems. The proportions for smoking and drinking problems were 81% and 80%, respectively. Significantly more women than men thought that their general practitioners should be interested in weight and drinking problems, but there was no significant sex difference between the responses for smoking and fitness. There were significant age trends for both sexes in the case of attitudes towards general practitioner interest in weight problems, with larger proportions of younger patients in favour. For men, the proportion decreased progressively from 79% in the age group 21 to 30 to 65% in the age group 61 to 70 ($p < 0.05$), while for women the proportions decreased from 84% in the age group 17 to 20 to 67%, in the age group 61 to 70 ($p < 0.001$). For drinking and fitness problems there were similar age trends for women only ($p < 0.05$ in both cases). There was no significant trend for either sex for smoking.

Responses to: Have your general practitioners seemed interested? (Table II)—The completion rates for the questions in this section ranged from 87% to 90%. The proportions of respondents who thought that their general practitioners had definitely or probably seemed interested ranged from 38% for fitness problems to 51% for smoking problems. The proportions for weight and drinking problems were 48% and 41%, respectively. Significantly more men than women thought that their general practitioners had seemed interested except for weight problems. The proportions of respondents who were unsure about their general practitioners' interest ranged from 33% for

TABLE I—*Should your general practitioners be interested?*

	Weight problems		Smoking problems		Drinking problems		Fitness problems	
	No (%) of men	No (%) of women	No (%) of men	No (%) of women	No (%) of men	No (%) of women	No (%) of men	No (%) of women
Should be interested	793* (83)	1096* (85)	777 (79)	1009 (81)	744* (77)	978* (81)	669 (72)	888 (73)
Should not be interested	129 (13)	97 (8)	149 (15)	143 (11)	163 (17)	153 (13)	179 (19)	200 (16)
Don't know	63 (6)	96 (7)	57 (6)	92 (8)	54 (6)	77 (6)	91 (9)	136 (11)

Comparison of men with women: * $p < 0.05$, † $p < 0.001$.

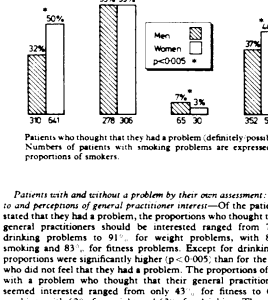
TABLE II—*Have your general practitioners seemed interested?*

	Weight problems		Smoking problems		Drinking problems		Fitness problems	
	No (%) of men	No (%) of women	No (%) of men	No (%) of women	No (%) of men	No (%) of women	No (%) of men	No (%) of women
Have seemed interested	461 (47)	574 (48)	528* (54)	595* (48)	425* (44)	449* (38)	392* (41)	437* (36)
Have not seemed interested	193 (20)	224 (19)	158 (16)	199 (16)	196 (21)	233 (19)	209 (22)	249 (20)
Don't know	325 (33)	393 (33)	290 (30)	444 (36)	335 (35)	515 (43)	358 (37)	545 (44)

Comparison of men with women: * $p < 0.05$, † $p < 0.01$.

weight problems to 41% for fitness problems, while for those who thought that their general practitioners had not seemed interested the range was from 16% in the case of smoking problems to 21% for fitness problems.

Responses to: Do you think you have a problem? (Figure)—Completion rates for the questions in this section ranged from 86% to 92%. Forty two per cent of respondents thought that they had a weight problem and 41% a fitness problem. Twenty four per cent stated that they had a smoking problem (43% of the respondents smoked and 59% of these thought that they had a problem). Four per cent of patients thought that they had a drinking problem (67% of the respondents stated that they had taken alcohol in the three months before receiving the questionnaire, and 6% of the drinkers felt they had a problem). Significantly more women than men had weight and fitness problems by their own assessment, and significantly more men than women had a drinking problem. The only significant age trend was for men with a weight problem, the proportions increasing progressively from 14% in the age group 17 to 20 to 34% in the age group 51 to 60 ($p < 0.005$).



Patients who thought that they had a problem (definitely possibly). Numbers of patients with smoking problems are expressed as proportions of smokers.

Patients with and without a problem by their own assessment: attitudes to and perceptions of general practitioner interest—Of the patients who stated that they had a problem, the proportions who thought that their general practitioners should be interested ranged from 79% for drinking problems to 91% for weight problems, with 89% for smoking and 83% for fitness problems. Except for drinking, these proportions were significantly higher ($p < 0.005$) than for the patients who did not feel that they had a problem. The proportions of patients with a problem who thought that their general practitioners had seemed interested ranged from only 43% for fitness to 69% for smoking, with 62% for weight and 63% for drinking. These proportions were all significantly higher than for the patients who did not think that they had a problem ($p < 0.05$). None the less, between 11% and 17% of the patients with a problem thought that their general practitioners had not seemed interested and a further 20% to 40% were unsure.

Discussion

The overall response rate of 72% to the questionnaire compares favourably with similar studies where rates have ranged from 40% to 59%.[6-8] Together with the generally high completion rates for individual questions, this indicates that our Health Survey Questionnaire was well accepted by patients in general practice. The higher response rates among women and older patients may be the result of their greater interest in health and related topics. These patients, however, also tend to have higher consultation rates and be better acquainted with their general practitioners and thus may be more inclined to participate in such studies.

Most of the patients expected their general practitioners to be interested in weight, smoking, drinking, and fitness problems, with small though statistically significant differences between the proportions for the four areas. Similar results were found in a UK study undertaken some time ago where 80% of patients in general practice expected to be given helpful advice on health at the general practitioner's surgery or the clinic, and in the United States in a more recent study where 90% of family practice patients expected to receive encouragement from their family doctor to lose weight, give up smoking, and take more exercise.[9,10] The observation that younger patients, especially women, have a greater expectation of general practitioner interest in weight, fitness, and drinking problems indicates that a change in attitude may have occurred with time. Because of the cross sectional nature of the study, however, it is not possible to distinguish between a cohort effect, with those born in more recent years having a greater expectation of general practitioner interest and a decline in patients' expectation of general practitioner interest with increasing age. In view of the lower response rates among younger age groups it is also possible that the younger patients with lower expectations of general practitioner interest were underrepresented. Whatever the explanation, the absence of an age trend for smoking indicates a longstanding and widespread awareness of the association between smoking and ill health.

Substantial proportions of patients felt that they had a weight, smoking, or fitness problem, and 4% thought that they had a drinking problem. Despite the statements by all five general practitioners that they had regularly given advice on these four areas, between 31% and 57% of these patients either thought that their general practitioners were not interested or were unsure about their interest. Although further information is required about the validity of the patients' concern about their health in each of the four areas, these findings suggest that there may be considerable scope for increasing the emphasis on health promotion in general practice. The finding that higher proportions of men thought that their general practitioners had been interested may reflect not only the larger proportions of men with objective evidence of cause for concern, but also the awareness of their general practitioners of the increased risks of ischaemic heart disease in men compared with women.

The effectiveness of general practitioner intervention has only been properly evaluated for smoking. Since the evidence from our study suggests that there is widespread demand among patients for general practitioners to become concerned in all four areas of health, and there is evidence that such expectations are largely shared by the general practitioners themselves, carefully designed trials of intervention in the three other areas should now be carried out.[4]

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