General Practice Observed

The Trainee Year—A Critical Appraisal

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Summary

Answers to questionnaires distributed to all trainees in the Scottish south-east region in 1972 and 1973 showed a wide variation between the standard of teaching in individual practices. This was partly due to a failure of the organizing bodies to give proper guidance on the modern concepts of training to the trainers, and partly to a lack of enthusiasm by some of the trainers.

It is particularly important that the training practices are well equipped with equipment and books and journals relating to general practice. For the trainee vocational training programmes, attendance at day release courses, contact with fellow trainees, and appropriate "on call" duties are similarly important. If these and other recommendations were brought to the attention of the trainers by an effective, co-ordinating committee, the standards of general practice teaching would rise, as would the quality of patient care in the community.

Introduction

Though much has been written on training for general practice there have been few contributions from those receiving the training—the trainees,[1-3] and not many of the changes recommended in Whitfield's comprehensive study have been implemented.[4] He said: "training for general practice . . . is, generally speaking, inadequate" and ". . . the trainee year is often little different from an assistantship." The Royal College of General Practitioners has published official reports on vocational training,[5 6] selection of teachers,[7] teaching practices,[8] and teaching in general,[9] and these give excellent advice and information.

Unfortunately some of the general practitioners involved in teaching do not seem to have absorbed this advice, and much better communication between the various bodies responsible for postgraduate teaching and the teaching of general practitioners is necessary.

Objectives

I have tried to evaluate trainee teaching practices to elicit the differences between them, and to make recommendations based on four broad principles which, hopefully, will come to the attention of the trainers: selection of trainers; selection of practices; teaching in general practice; and conditions of service.

The problem does not lie solely with the individual teachers, but to lack of direction from a single source. Until now the following bodies have been concerned with the postgraduate education of general practitioners: Scottish Home and Health Department; executive council; General Medical Services Committee; local medical committee; Royal College of General Practitioners; General Practitioner Teaching Unit of Edinburgh University; and General Practice Subcommittee of Regional Council for Postgraduate Education via a regional adviser.

Method

Questionnaires by two trainees were circulated independently in 1972 and 1973 to each trainee attending the half-day release course. The trainee had the option of remaining anonymous to obtain more accurate answers; 96% of both questionnaires were completed. There are, of course, limitations to this type of survey: for almost everyone it was their first introduction to general practice and they had no previous experience with which to compare it. This tended to make the trainees less critical than they might have been, as Whitfield found in his study: "though 25% expressed dissatisfaction with their training, I believe that many more would have done so had they known what was available or needed in training for general practice."[4]

TRAINERS

The age of the trainers ranged from 45 to 70 and the average age was 52. Sixty-five per cent. had postgraduate qualifications and 60% had attachments or commitments outside their practice, such as service on a local medical committee.

PRACTICES

The practice size, which averaged 2000, corresponded with the recommendations of a memorandum issued by the Scottish Home and Health Department.[10]

TEACHING

It was difficult to evaluate the content and method of teaching and trainee-trainer meetings as there was very little formal teaching, most contacts occurring informally such as during morning coffee breaks. A general practitioner trainee course was provided by the general practice teaching unit of Edinburgh University on one half day a week for 20 weeks, and in general

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this was well attended. Seventy per cent. of the trainees were satisfied with the course. In 85% of the practices there were special clinics—for example, antenatal and well-baby.

CONDITIONS OF SERVICE

Thirty-five per cent. of the trainees had signed a contract of employment. The amount of time they were "on call" varied from nil to alternate nights and weekends—20% of the practices used deputizing services exclusively out of hours. On average the trainees were able to conduct 107 patient consultations a week, but the figures ranged from 50 to 173. During holiday periods the locum duties were shared by partners and trainees in half of the practices in the survey; the trainee did the full locum in 35% of the practices; and an outside locum was employed in 15%. But only 10% of the trainees were paid for full locum duties. Seventy per cent. of the trainees thought they should be reimbursed for full locum duties, night visits, insurance examinations, and pill prescriptions.

Discussion

TRAINERS

The average age of 52 is fairly high as at present the senior partner almost automatically becomes the trainer when he may not be the best qualified to do so. The present experience criterion of ten years as a principal makes it more difficult for a vocationally-trained principal to become a teacher, as he will have spent a minimum of an extra three years in hospital practice and less as a principal. This recommendation should therefore be amended to ten years postqualification if the principal is vocationally trained.

The question of postgraduate qualifications is not particularly important as there are many excellent general practitioners and teachers who do not possess any extra qualifications. But there is a correlation between practitioners who are interested in teaching and have specialties in their practice and those who have some form of extra qualification. Trainers should at least consider becoming members or associates of the Royal College of General Practitioners, because of the guidance offered through discussion with colleagues, or from the R.C.G.P. journal, and because the future of general practice training is more in the hands of this body than any other.

The ideas of the Newcastle upon Tyne vocational training committee and their methods of selection of trainers should be endorsed.[11] In this scheme two general practitioner members of the regional postgraduate committee visit each teaching practice on the short list, when the role of the potential teacher is discussed. The committee said that the trainer "has a continuing and time-consuming programme, which includes taking part in weekly seminars and a variety of assessment procedures, whereas in the trainee general practitioner scheme, in many instances, the trainer has little demand on his time." Undoubtedly the trainer grant is deservedly directed towards the former group and if the others do not take equal responsibilities and subject themselves to audit, then they are surely not qualified for the grant.

PRACTICES

At present the official criteria laid down in Midlothian for the selection of teaching practices are to be found in a few short sentences of a Scottish Home and Health Department memorandum.[10] Recently, however, an excellent and extensive basis for selection has been put forward by Irvine,[7] and I hope that many of these criteria will be adopted by the official selection committees. The surveys showed that over one-third of practices had inadequate premises, mainly because there was no separate room for the trainee.

Only 30% of the surgeries vetted had specialized equipment and in particular very few had E.C.G. machines, peak flow meters, and microscopes. But most of the practices were in towns where good open access to electrocardiography and reporting were available. Nevertheless, most doctors who have qualified in the past few years have fairly comprehensive experience of electrocardiography and no longer regard an E.C.G. as a luxury, and find it frustrating not to have this facility immediately available.

What is very much more important was the lack of literature available for easy reference on the surgery premises. Sixty per cent. of practices had no reference books at all and 70% no journals relevant to general practice. It is not enough for these books and journals to be in local libraries and scattered through the various partners' homes: they must be in the surgery premises if the practice is to call itself "teaching." A recommended minimum list could be easily drawn up by the relevant authorities.

It was pleasing to see that most practices supplied a complete emergency bag with instruments and drugs and I hope this practice will be expanded. Teaching practices could offer far more facilities, and in their report of February 1972 the R.C.G.P. Council found, in an analysis of five practices, "expenses directly or partly attributable to joining the (vocational training) scheme" varying between £213 and £1668 or an annual average of £637 per practice.[7] I found little evidence that this level of expenditure was occurring or indeed was necessary.

TEACHING

It has always been difficult to delineate the exact form that teaching should take. Nevertheless *The Future General Practitioner—Teaching and Learning* is a very useful guide and should be an essential reference source for every trainer and trainee.[9] It was heartening to see that nearly all practices contained special clinics, but only half of the trainees attended extra-practice clinics. Unfortunately, I did not analyse this further to determine the reasons for non-attendance.

On the other hand, attendance at the half-day release course run by the University Department of General Practice was almost 100%. This is run over 20 consecutive weeks from February to June—basically a lecture course with associated projects. The trainee's reaction to this course, its content, and timing could form the basis of another study, but on the whole reaction was favourable and its popularity was due partly to the opportunity it afforded for all the trainees to get together.

DANGER OF ISOLATION

I do not think it is appreciated that most trainees have come straight from hospital posts where they are in daily contact with other doctors and, on entering practice, often feel isolated because of the wide and often unbridgeable generation gap. It is important for trainees to maintain contact with each other throughout the training year, and at present our weekly course covers just over one-third of the year. I suggest that the best way of completing the remaining weeks is for the trainers to form a rota and for two trainers to take the training group each week for a half-day session in any topic of their choosing relevant to general practice. This could take the form of conducting the group round their own practices. All our trainees felt that a personal interchange between practices for, say, a short period of two weeks would be beneficial, and not logistically impossible.

Another highlight in the training year was one week spent at an intensive course run by the Department of General Practice at Dundee University. I cannot overestimate the value of this course and hope it will be repeated for our successors. Similar courses could be designed for the trainers.

The conference of trainees held in Newcastle upon Tyne in 1972 was favourably reported[12] and should be organized in a different region each year.

PERSONAL EXPERIENCE

For my experience of a trainee year I found the following teaching methods the most beneficial:

"Tandem Surgeries"

The trainer and trainee see patients in two separate surgeries at the same time so that a free interchange of advice, and patients if necessary, may take place. This is much better than the trainee "sitting in" with his trainer, which, from the surveys, was not popular and lasted on average less than two weeks.

Informal Meetings

Informal meetings should take place at least once a week with the other partners to discuss patients and all facets of practice management. This should not be difficult to arrange as it is already a criterion to qualify for the group practice allowance.

Half-day Release Courses

Half-day release courses might perhaps be extended to cover the whole year, as trainees should be given an opportunity to meet each other on a regular basis.

Half-day Releases to Local Clinics

These would cover, for example paediatrics, E.N.T., ophthalmology, and dermatology. Some form of didactic teaching should take place and no one found any difficulty in obtaining permission from local consultants for this, if the trainee attended regularly and showed enthusiasm.

Interchange of Trainees Between Practices

This would give them an opportunity to see different types of practice, such as single-handed, health centre, and rural, preferably on a changeover system, for, say two weeks.

Own Patients

The trainee should be encouraged to build up a series of his own patients so that he can learn one of the basic precepts of general practice—continuity of care. Several of the trainees in our group were so concerned with locums and fill-in surgeries for each partner that continuity was impossible.

These are relatively simple ideas for making the trainee year something more than an assistantship—it is important that a clear difference exists between an assistant and a trainee, and at present the margins are blurred. Furthermore, the trainee year should be modified to the needs of the trainee, emphasizing areas in which his training has been deficient. This might mean attending other teaching practices if the specialties are not available in the trainee's own practice.

I think the word "trainee" is misleading. From personal experience, if one is introduced as "the trainee," the lay public assumes that the doctor is only "learning." If the doctor was introduced as, say, the new "assistant" it would ensure a more trusting doctor-patient relationship.

Vocational Training Programmes

These courses are increasing, but their content tends to be too rigid and used as a means of supplying doctors for posts that would otherwise remain vacant. There are only 170 places in vocational training schemes for the 1000 required for the annual entry,[5] so 83% of practitioners will not have the benefit of a "special course." Many of the latter will have done their own unofficial vocational training—especially those who are not sure that they wish to go into general practice when they first qualify.

This rigidity is reflected in the criteria for sitting the membership examination of the Royal College of General Practitioners. At present this states "either four years as a fully registered medical practitioner, or three years if the candidate has completed a special course of vocational training recognized by the college." Surely the term "vocationally trained general practitioner" should be defined as those who qualify for the vocational training allowance, as defined in the terms and conditions of service, whether this is done via an official course or not.

CONDITIONS OF SERVICE

It would be in everyone's interest for a simple contract to be drawn up at the start of the year to cover such topics as teaching sessions, a reasonably explicit timetable, time off for clinics, holidays, arrangements for locums while partners are on holiday, research projects, and payments for extra duties. A simple timetable for a typical week is set out in the table.

Training practices differ in many ways from non-training practices—employment of a trainee means extra supervision and responsibility, time for teaching, and occasionally extra accommodation, staff, and equipment. Nevertheless, to balance this, there is generally a reduction in practice work load. In this survey patient-trainee consultations averaged 107 per week, and this is slightly higher than the figures from the Aberdeen group of 85 per week. Furthermore, there should be a reduction of "on call" by the partners, as in nearly all practices the rota was modified to include the trainee. This is as it should be if the trainee is to add emergency experience to his training. But, as the practices are paid by the executive council for providing 24 hour care, the trainee, who is supernumary, should contribute to the rota only so far as his training requires. He should, therefore, not be expected to do more than one night per week "on call" and one weekend in four in a group practice context, and should also have some choice in the matter. In two practices in the survey the trainee was compulsorily "on call" every Friday night.

Similar principles should apply to holidays and study leave. The regulations are very loose on these subjects and the range of holidays allowed varied from two to six weeks, some having

Timetable for Typical Week

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday, Sunday, and evenings
09.00-11.00	Surgery	Surgery	Surgery	Surgery	Surgery	
11.00-13.00	House calls	House calls	House calls	House calls	House calls	
14.00-16.00	Extra-practice clinic	In practice clinic	G.P. University course	Half-day off	Elective half-day	On call by rotation
17.00-18.00	Surgery	Surgery	—	—	Surgery	

a choice of timing and others not. There is no mention of study leave at all in the regulations and there appears to be no clear reason for this omission. It is quite unacceptable that as many as 35% of trainees did no emergency "on call" and that 20% of practices employed the emergency treatment service exclusively. These practices should be excluded from consideration as teaching practices.

We should not ignore the financial aspect, and trainers should consider spending at least some of their training grant, which amounts to the equivalent of two sessions per week, on equipment and books. There was very little evidence in the surveys of extra employment of ancillary staff, extension of premises, or new equipment as a direct consequence of having a trainee, as suggested by the R.C.G.P.[7]

Where the trainee does the locum duties for the other partners there is a substantial saving in fees. Nevertheless, though the trainees took a full share in the rota, including night visits, surgeries, home visits, and locum duties—all paid entirely by the executive council—only 10% of the practices offered any pay for this, and when questioned 70% of the trainees thought they should receive some payment, particularly for full-time locum duties.

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Conversations with Consultants

Falling Standards and Sagging Morale

FROM A SPECIAL CORRESPONDENT

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"If I had my time again," said the paediatrician, "I would not choose a career in the hospital service—it's not a career any more, it's a vocation. When I started up the hospital ladder a consultant was in charge of his own destiny. But I feel that my circumstances—my way of life and standard of living—are no longer under my control. What's more the present Government does not seem to care about medicine. Consultants are expendable."

In common with other young consultants he specially resented the accident of timing that had made his mortgage a nightmare. Consultants appointed in the middle 1960s could find houses—solid, detached, middle-class houses—that they could afford to buy on a whole-timer's income. Those being appointed now, while no longer able to aspire to anything more than a very basic property, could at least get one of the tax-free loans (brought in in 1971) to help with its purchase. A few, like him, had been caught between the two situations and faced a prospect of bankruptcy if the mortgage interest rate rose any higher.

Total despair was prevented by the satisfaction still offered by hospital work; but this group of consultants in a cathedral city saw no grounds for optimism about the future. The collapse of the hospital building programme had clearly had a disastrous effect on morale, for in their city (as in so many others) the prospect of a new district general hospital had been held out to every new consultant appointed. At present many of their day-to-day frustrations were directly due to having to work in two hospitals, a couple of miles apart, neither of which alone was large enough to fulfil the requirements of a district hospital. This led to wasteful duplication of resources; two sets of junior staff had to be on call at night; and there were endless journeys between the two buildings. Further complications came from the geriatric and psychiatric units being in two more hospitals in other parts of the city. Difficult working conditions were just about tolerable if they were seen as temporary; once converted into a life-sentence the prospect was appalling.

Effects of Work-to-Contract

The work-to-contract, supported by every one of the staff, would inevitably have long-term psychological effects. In the past waiting lists had been kept short by medical and nursing staff working long hours at a frantic pace. The only apparent effect of that effort had been to induce in the politicians a feeling of self-satisfaction. The work-to-contract had made outpatient clinics a pleasure rather than a chore, and no one saw any prospect of a return to the old ways of rush and scramble. Waiting lists were lengthening; but at the same time the numbers of requests for outpatient appointments were falling. Perhaps there would be a reassessment of medical priorities.

The main source of discontent, however, seemed to be the combination of inefficiency and bureaucracy that had overtaken so many features of the N.H.S. in the last few years. At the simplest level the standard of care on the wards had fallen.