Middle Articles

GENERAL PRACTICE OBSERVED

Training for General Practice: Result of a Survey into the General-practitioner Trainee Scheme

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Training for general practice in England and Wales is, generally speaking, inadequate. Some recent suggestions for improving this were made by the B.M.A. (1963), largely concerned with the present trainee year, and by the Council of the College of General Practitioners (1965). The latter proposes a three-year postgraduate training period in suitable hospital appointments and a remodelled trainee period in general practice lasting two years.

The number of trainees has fallen from 284 in 1956 to 124 in 1965. Despite increasing interest in this phase of medical education, little is known about the trainee year or the trainees and why they accept a year of relatively low salary when a quicker reward is available as an assistant in general practice or as a registrar in hospital.

Generally speaking, the trainee year in England and Wales has a bad name. The reasons for this are many, but basically the cause seems to be the possibility of "exploitation"—the trainee being used as a "free" assistant in the practice. What constitutes exploitation and what constitutes a good training year from the point of view of the trainee are unknown. What is offered by trainers? What should they be offering? Basic information is obviously required before any new or modified scheme for training is started.

To try to provide this information I devised a lengthy questionary and sent it to all trainees in posts in England and Wales on 1 July 1965. From the 142 trainees 125 completed questionaries were returned. (One was excluded as an atypical case and two others arrived too late for inclusion.)

Of the 122 trainees replying, 19 (15.6%) had completed fewer than three months' traineeship, 42 (34.4%) four to six months, 36 (29.5%) seven to nine months, and 25 (20.5%) 10 to 12 months.

Information from the questionary is presented here under three headings—Trainee Practitioners, Trainers, and the Trainee Year.

Trainee General Practitioners

The age distribution and marital status of the trainees are shown in Table I: 77% were married, and just over 50% had one or more children.

TABLE I.—*Age/Marital Status Distribution of the Trainees*

Sex and Marital Status	Age in Years			
	<25	25–29	30–34	35+
Male, married	—	52	14	6
„ single	—	11	2	1
Female, married	—	15	4	3
„ single	1	8	3	2
Total	1	86	23	12

Before starting their traineeship most trainees had decided to enter general practice: 11% had decided before entering medical school, 16% during medical school, and 34% after qualifying and before the trainee year. Of the remainder, 9% had decided during the trainee period and 30% had decided either not to enter general practice or were undecided. Nevertheless, many of those who had decided to become general practitioners did not seem to have held the most appropriate hospital posts (see Tables II and III).

TABLE II.—*Pre-trainee Hospital Experience in Obstetrics and Paediatrics*

	Decided on General Practice	Undecided
No obstetric or paediatric jobs	25 (29%)	13 (36%)
Obstetric job only	32 (37%)	11 (31%)
Paediatric job only	4 (5%)	3 (8%)
Both obstetric and paediatric jobs	25 (29%)	9 (25%)
Total	86	36

TABLE III.—*Pre-trainee Hospital Experience in Other Specialties*

	Decided on General Practice	Undecided
Casualty	20	6
Anaesthetics	10	1
Psychiatry	5	—
Pre-registration only	8	5

What had the prospective trainee in mind when he applied for his traineeship?

1. Six had spent three to five years in short-service commissions in the Forces. These had presumably regarded the trainee year as an introduction to civilian practice and the National Health Service as well as giving time to look for a suitable practice.

2. Six were using the trainee year to introduce themselves to general practice in this country after extensive experience in various branches of medicine in countries overseas.

3. Seventy-five per cent had had no contact with general practice as students and 40% had had no experience of general practice before starting their trainee year. They could therefore have had little idea of what they were seeking. This is reflected in the fact that 63% did not look at a second trainee practice before deciding to start and in the ways by which they reached their traineeship: 50% by replying to an advertisement in a journal; 5% after a direct recommendation from a previous trainee in the practice; and the remainder in miscellaneous ways, except for five who were guided by their

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medical schools. This last remarkable figure further emphasizes the failure of medical schools to provide any introduction to general practice.

In spite of this lack of guidance many trainees showed a stout determination to persist. Thus in answer to the question "If, just prior to starting your trainee year, you had been offered a good 'assistantship-with-view' at a salary of £2,000 a year, which would be still open to you in one year's time, would you (*a*) have started the trainee year, (*b*) have started the assistantship?", 66% stated that they would have started the trainee year. However, 34% would have been lured away.

The Trainers

All but three of the trainers were male and the largest number were aged 40–49 years (Table IV).

TABLE IV.—*Age and Sex Distribution of Trainers*

	30–39	40–49	50–59	60+	Total
Male	8	51	38	22	119
Female	—	1	2	—	3

Of the trainers, 20% were single-handed practitioners (national average 23%) and 28% were in a practice with four or more doctors (national average 13%), suggesting that a group practice is more attractive to a prospective trainee or that a large group is more likely to have a trainer among their number. The most common training practice was the two-man practice (33%).

Of the practices, 46% were urban, 22% rural, and 32% mixed urban/rural (Table V); 24% were dispensing practices.

Forty per cent of the practices had no hospital beds directly available, 25% had both general and maternity beds, 20% had maternity beds only, and 15% had general beds only.

TABLE V.—*Patients Available to Trainee*

(a) *Total Practice List*

No. of Patients:	<3,000	3,000–	6,000–	9,000–	12,000+	Total
Rural	10	12	5	—	—	27
Urban	7	19	12	14	4	56
Mixed urban/rural	3	8	13	10	5	39
Total ..	20	39	30	24	9	122

(b) *Trainer's Personal List*

No. of Patients:	<2,000	2,000–	2,500–	3,000–	3,500+	Total
Single	3	4	10	5	2	24
Two-man ..	4	8	12	6	10	40
Three-man ..	1	3	10	3	7	24
Four or more ..	6	9	9	6	4	34
Total ..	14	24	41	20	23	122

The number of trainees that a trainer had had varied considerably. In 19% of cases it was the first. There was no significant difference expressed with regard to satisfaction between those trainers who were training their first trainee and those who were training their fifth ($P>0.20$) (see Table VI). Five did not know the number of previous trainees. This suggests that trainees are not exerting any real influence on trainer selection and that poor trainers are not necessarily "going out of business."

It is known that various incentives are used to attract trainees. These may consist of free or low rental accommodation or of a car allowance additional to that paid by the Ministry. Just over half (51%) of trainees had accommodation provided, and in just under half of these it was rent-free. No information was given about assisted rents, though three trainees said that assistance was given towards payment for accommodation the trainee had provided himself. Nineteen trainees stated that they received expenses in addition to the £220 car allowance paid by the Ministry.

TABLE VI.—*Satisfaction Related to Number of Previous Trainees*

No. of Previous Trainees:	0–1	2–4	5 and More	Total
Satisfied with teaching ..	30	34	26	90
Dissatisfied with teaching ..	8	7	12	27
Total	38	41	38	117

Trainee Year

Work Load

One persistent criticism levelled at the year is that trainees are used as a form of cheap labour. Their salary is paid by the Ministry of Health and their trainers are paid £150 a year training fee.

The number of surgeries attended each week by the trainees is shown in Table VII. The most usual duty for the trainees is six morning surgeries and four evening ones, which leaves little time for attending hospital departments, special clinics, etc.

TABLE VII.—*Number of Surgeries Attended Each Week*

No. of Evening Surgeries	No. of Morning Surgeries							
	1	2	3	4	5	6+	Variable	Total
0	1	1	—	—	—	—	1	3
1	—	3	1	1	1	2	1	9
2	1	3	2	5	6	2	—	19
3	1	4	3	6	6	8	—	28
4	—	—	2	9	10	30	—	51
5	—	—	—	—	6	5	—	11
Variable	—	—	—	—	—	—	1	1
Total	3	11	8	21	29	47	3	122

The number of half-days also conformed largely to a set pattern: 69% had one half-day off per week (Monday to Saturday noon). Evenings off-duty were very variable, and ranged from none (25%) to five (9%). Week-ends were also variable.

"Official" study time was not allocated in 60% of practices, though several trainees said that study time was freely available or that there was so much free time that no official allocation was needed. One trainee commented: "There is plenty of time for reading for exams but not enough money to pay the examination fees."

A common comment was that trainees would like a programme mapped out at the start of the year if possible. They would like to know when they will have their nights off, when they will attend hospital or local health authority departments, etc., and how long they will be sitting-in on surgeries.

The trainee year is—or should be—the best introduction to general practice. The trainee's work load should be light enough to give him time to orientate himself to his new environment. The time this introduction takes will obviously vary from trainee to trainee, depending on previous practice experience and other factors, including the personal wishes of the trainee. For example, a trainee with a year or more's experience abroad might find it irksome to have to sit in on another doctor's surgery for long.

Most trainees were satisfied with their period of introduction. The majority started unsupervised surgeries after the first week and before the end of the first month.

Some trainers (17%) limited the number of patients seen by the trainee at the beginning of the year; this seems a realistic way of ensuring that sufficient time is available for examination, treatment, and discussion. The number of home visits done daily by the trainee at the time of completing the questionary—that is, July/August—was between three and nine. The work load of the trainee may vary with the amount of

visiting of the chronic sick. Many old people find it hard to forgo the visit of their regular doctor, but it is necessary for the trainee to have good grounding and experience in this type of visiting. To the question, "Do you have continuous care of certain patients during your trainee year?" 25% replied that they did not.

Specialty Experience During Trainee Year

During the year 26% had attended courses: these included an introductory course to general practice by the College of General Practitioners and hospital and university refresher courses.

The College of General Practitioners (1965) recommends that the aspiring general practitioner should hold, if possible, six-month appointments in paediatrics, obstetrics (preferably with gynaecology), and psychological medicine. Thirty-seven per cent of the trainees had no hospital experience of obstetrics and 66% none of paediatrics. Despite this lack of hospital experience, trainee experience in these specialties was inadequate (Tables VIII and IX). There are still some trainee practices that do not provide obstetric training despite this being a condition of such a practice (Table X).

TABLE VIII.—*Trainee Obstetric Experience*

Attendance at Antenatal Clinics	No Hospital Obstetric Experience	6 Months' Hospital Experience or More
Never	8	15
Sometimes	10	24
Regularly	27	38
Total	45	77

TABLE IX.—*Trainee Paediatric Experience*

Attendance at Infant-welfare Clinics	No Hospital Experience	Hospital Experience
Never	50	25
Sometimes	18	13
Regularly	13	3
Total	81	41

TABLE X.—*Number of Deliveries Attended by Trainee During Year*

No. of Deliveries	Months Completed as Trainee			
	0–3	4–6	7–9	10–12
None	8	16	11	6
1–4	11	19	11	8
5 or more	—	7	14	11
No. of trainees in each group	19	42	36	25

Seven of the 45 with no hospital obstetric experience attended a hospital obstetric department regularly. Three of the 81 with no hospital paediatric experience regularly attended a hospital paediatric department. Only 15 of the trainees said they had been given instruction on helping parents of mentally ill or subnormal children.

Ninety-one (75%) had no regular hospital attendance. Of those that had, the jobs done were:

Medicine	5	Psychiatry	4	Anaesthetics	2
Paediatrics	6	E.N.T.	3	Others	5
Obstetrics	12	Dermatology	8		

Some trainees attended more than one hospital department during the year.

Social Application of Medicine

One trainee stated: "Having done some locums I was under the impression that there was a great deal to learn in regard to social services, etc. However, I have found very little teaching and worth-while experience as a trainee." Designing questions to investigate this function of general practice is difficult. I decided to choose several subjects from the "Syllabus of General Practice Subjects" (College of General Practitioners, 1965, Appendix) to try to find out how much instruction in these services was given and what experience was gained.

It will be seen from Tables XI and XII that the trainees who had completed seven to nine months seem to have had proportionately less instruction and experience in the social services than the others. It is of interest that 42% of this group were dissatisfied with the proportion of work to teaching they had been given as against 19% dissatisfaction in the other groups.

TABLE XI.—*Percentage of Trainees Who Had Instruction in the Social Services*

	Months Completed as Trainee			
	0–3	4–6	7–9	10–12
Health visitors	21	36	30	52
District nurse	42	55	36	76
Local health authority	26	29	33	56
Ministry of Labour Rehabilitation Scheme	11	21	17	24
National Assistance	21	19	22	44
Meals-on-Wheels Service	11	12	22	20
Marriage Guidance Council	5	5	0	16
Family Planning Association	5	17	14	32
Disease-group associations	0	2	6	12
Deaf and blind welfare	5	7	3	12
Mental welfare officer	32	36	17	36
Industrial medicine	16	21	14	12
Executive council	11	24	19	36
Percentage with no instruction in any of the above	47	26	33	16
No. of trainees in each group	19	42	36	25

TABLE XII.—*Percentage of Trainees who Had Experience of the Social Services*

	Months Completed as Trainee			
	0–3	4–6	7–9	10–12
Health visitors	37	60	53	72
District nurse	68	88	80	100
Local health authority	32	50	39	72
Ministry of Labour Rehabilitation Scheme	5	12	14	12
National Assistance	11	26	25	56
Meals-on-Wheels Service	11	17	28	28
Marriage Guidance Council	0	5	3	16
Family Planning Association	11	29	39	68
Disease group associations	0	0	6	12
Deaf and blind welfare	5	5	3	20
Mental welfare officer	37	38	45	56
Industrial medicine	11	14	14	12
Executive council	11	24	8	40
Percentage with no experience in any of the above	32	2	6	0
No. of trainees in each group	19	42	36	25

Organization of General Practice

It is surely reasonable that trainees should gain experience in the use of certain instruments. Which instruments are available depends on the cost, the availability of pathological facilities, the interest of the trainer, and, to some extent, the hospital experience of the trainee. Even so, it is surprising to note that 17% of trainees had not had general practice experience in the use of a vaginal speculum and that 80% had not the use of a microscope, though efficient general practice surely requires these simple tools.

TABLE XIII.—*Percentage of Trainees Using Instruments in Trainee Year*

	Months Completed as Trainee	
	0–6	7–12
Vaginal speculum	84	82
Microscope	23	18
Audiometer	2	2
Proctoscope	31	44
Tonometer	2	—
Peak expiratory flowmeter	5	10
E.C.G.	15	23
Haemoglobinometer	25	26
E.S.R. tubes	18	33
No. of trainees in each group	61	61

Research in general practice is something which some general practitioners find valuable and which many are unable to do through pressure of work ; but it is surely a matter in which trainees should at least receive instruction. It was interesting to see in a report on the effectiveness of pertussis immunization by a group of four Scottish general practitioners that one subsidiary object of the study was to " act as a training exercise in the planning of research in general practice for the benefit of the trainee assistants " (Wilson *et al.*, 1965).

One hundred and two of the trainees had had no experience in general practice research, 12 had had instruction only, and 8 had had experience, mainly of drug trials. One basic need for general practice research is an efficiently kept practice index—for example, age/sex register: 103 had had no experience in maintaining such registers, 14 had had minimal experience, and only 5 had had adequate experience.

During the trainee year a young doctor should be trained in all aspects of a general practitioner's life. One of these, surely, is practice finance and administration ; yet 53% had had no instruction in practice finance and only 27% regarded their instruction as adequate. Instruction in planning and organizing practice premises was also neglected: 61% had had no instruction and 26% adequate instruction.

It is surprising, considering the great variety of practice—single-handed, partnership, health centre, dispensing and non-dispensing, rural, urban, and industrial—that 99 trainees had had no experience of other practices during the year. It was arranged by the trainer in only 20 cases and by someone else in three.

Teaching

It could be expected that a trainee should spend a large proportion of his time being taught. One trainee commented: " I think teach is the wrong word. One cannot ' teach ' a man how to be a good G.P. If he has already done several house jobs, he's had the necessary groundwork. Discussion and direct experience are the important things." While this comment has some validity, there is surely no doubt that teaching must occupy a considerable part of the year. If discussion and direct experience are all that is required why not be an assistant ? The question, " Are you satisfied with the amount of teaching you are getting from your trainer ? " brought these answers: 39% very satisfied, 38% fairly satisfied, 19% rather unsatisfied, and 4% very satisfied. Sixty-one per cent said that teaching remained at a constant level during the traineeship ; 36% said it had decreased, which, after all, is only reasonable ; and 3% said it had increased.

Several trainees commented, " I would like to be left on my own more often." It might be thought that such a trainee would want less teaching. To the question, " In general, how satisfied have you been with the proportion of work to teaching you have been given ? " 25% replied they were dissatisfied. This suggests that, generally speaking, 25% of trainees were dissatisfied with the training aspect of their traineeship. In fact, 25% said that they would not recommend a trainee year to an aspiring general practitioner.

Greater satisfaction was expressed with supervision and help with surgeries and home visits, and 95% were satisfied with the amount of insight they had been given into a general practitioner's life.

Discussion

The College of General Practitioners' (1965) report has been received with little acclamation, though editorial comment was generally favourable.

Some young doctors are still voluntarily preparing for careers in general practice by taking suitable hospital appointments, but this survey showed that very few approach the College's ideal of three years' hospital training in the specialties. The reasons are many: the ease with which a young doctor can become a principal is surely the most important. Most doctors, especially those with family commitments, decide that, as no obvious benefit accrues from a long series of junior hospital posts (possibly with no salary increase after the first 18 months), they will start earning a higher salary as early as possible.

The College suggests that the most useful house appointments after registration are in obstetrics, paediatrics, and psychological medicine. The need to " qualify " for the obstetric list and the fact that obstetrics in general practice is payable by item of service, so increasing the income of those on the obstetric list, have ensured that the first requirement is most often achieved—that is, 63% have done an obstetric appointment. Why not institute a " paediatric " list, making routine pre-school immunizations and examinations payable by item of service ? This would be a realistic way of ensuring that more than 34% take postgraduate paediatric appointments.

The remaining two years of the five-year postgraduate training for general practice should, according to the College, be spent in practice, the first year being developed from the present training scheme. W.H.O. (1963), commenting on the British scheme, states: " The trainee learns by doing: he is given clinical responsibility ; at the same time he is protected from exploitation as a form of cheap labour, and by careful selection and continuing review of the trainer and the circumstances of his practice, the trainee is guaranteed an opportunity of observing optimum practice under reasonable conditions." The results of my survey show that this statement is not quite a true picture of the trainee scheme in 1965 in England and Wales.

Thirty per cent of trainees had not definitely decided to become general practitioners and a few had decided not to go into general practice. It has been suggested that there should be selection of trainees (Evans and Scott, 1960)—that is, some committee should screen the intending trainee for academic ability and general suitability before accepting him. Although rejected by the B.M.A. (1963), this might help, given some immediate or long-term financial incentive, to make the trainee scheme vigorous and attractive rather than, as at present, a declining one with more trainers than trainees.

Twenty-five per cent of the trainees were female. This high percentage may be explained in part by the comment of one of them—" As a woman I have no need to support a family and therefore I can do the best for my future knowledge "—but it is unfortunate in a training scheme that should be catering for a much greater proportion of male doctors.

The knowledge of hospital doctors at all levels about the trainee year is almost negligible. When a young doctor considers a trainee post he has little knowledge of what to expect from it nor any idea of what inquiries to make at the interview. It is perhaps hardly surprising that 63% did not look at a second trainee post before deciding to start a traineeship.

A quarter of the trainees were dissatisfied with the training they were receiving. I believe that, had they been aware of the possible fields of instruction they might have received, more would have been dissatisfied. Instruction in general practice research and practice finance and administration, and experience in other practices, were woefully neglected, despite the emphasis placed on these aspects by the B.M.A. (1963). Sixty per cent of the trainers gave no guidance on appropriate reading.

Dr. J. R. Ellis (1965) commented in the Sir Charles Hastings Lecture of 1964: " The framework of the trainee scheme remains to be revitalized and established on effective lines. It is a tragedy that this remarkable contribution to medical education should have so far failed because it was started ahead of its time and because it was unsupported by any realistic arrangement for the contribution which only hospitals can make to the training of the general practitioner." This survey supports Dr. Ellis's statement.

Apart from the need for more pay, the comment most often volunteered was "more hospital attachments are needed." The particular department(s) to be attended should be decided between trainee and trainer on the basis of past experience, time available, and the wishes of the trainee. There seems to be no reason why at least two or three sessions a week should not be spent in hospital, with a change after six months to other departments.

The amount of dissatisfaction expressed and the excessive work load of many of the trainees show why the trainee year has a bad name and why the number of doctors participating in it is decreasing.

The College of General Practitioners (1965) proposes that academic departments of general practice should be established in all university medical faculties and that these departments should control trainee posts in their area. Some greater measure of superintendence is obviously required because of the dissatisfactions, and because, owing to the inadequacy of supervision by some local medical committees, some trainees have no obstetric experience during their year and many are in practices where the trainer's list is outside normally accepted limits.

It will no doubt be some time before such departments are set up throughout England and Wales. Until they are, some central body should be given power to ensure that standards are maintained and that practices are suitable for training (Evans and Scott, 1960). This is an urgent need, since, with the recognition of vocational training as a means to a higher income, it is to be hoped the number of trainees may soon be increasing.

Summary

A questionary was sent to all trainee general practitioners (142) in England and Wales in 1965, and the 122 (86%) completed questionaries were analysed.

The results are compared with the proposals put forward by the B.M.A. (1963) and by the College of General Practitioners (1965). The hospital experience of trainees falls far short of the College's proposals.

Training practices are not adequately supervised, and in many instances are below accepted standards for training purposes.

The trainee year is often little different from an assistantship. 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.

Some suggestions are given for an urgent modification of the scheme.

In a survey of this nature one is very dependent on the co-operation of others. In particular I am grateful to Professor R. C. Wofinden for permission to use the facilities of the Statistical Unit of the Department of Public Health in Bristol University, and especially for the help of Miss E. H. L. Duncan (Lecturer in Medical Statistics). I also received considerable help from Dr. D. F. Hooper (Department of Mental Health), Dr. R. J. F. H. Pinsent (Research Adviser, College of General Practitioners), Dr. H. J. Wright, and Dr. M. B. Lennard. The survey was supported by a grant from the Ministry of Health. Finally, I am grateful for the keen interest and co-operation of my fellow trainees.

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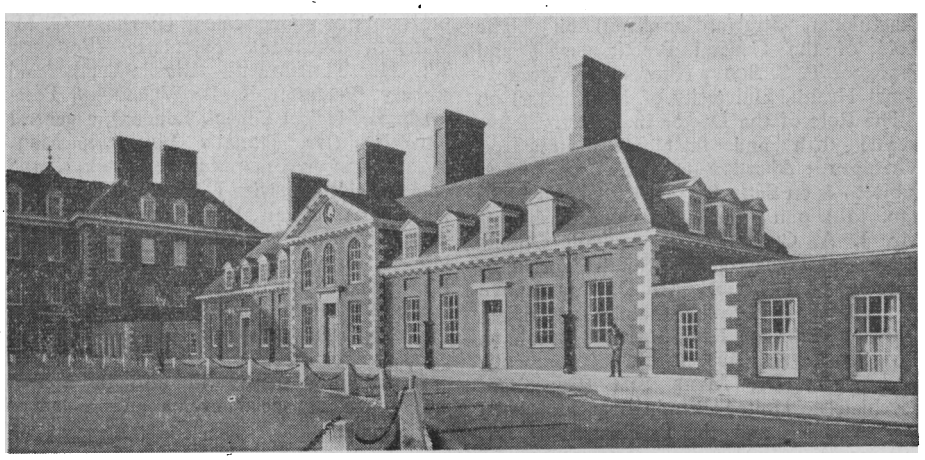
HOSPITAL TOPICS

Royal Hospital Chelsea

[FROM A SPECIAL CORRESPONDENT]

In its history the Royal Hospital Chelsea, home of the famous scarlet-coated pensioners, has had its own war wounds. In 1918 a five-hundred pound bomb destroyed most of the north-east wing of Wren's building; but by 1921 it had been restored on the same external lines. Once again at the end of the second world war on 3 January 1945 the same building was hit, this time by a V-2 rocket. The Physician and Surgeon (as the Royal Hospital's senior doctor is entitled), Major W. Napier, together with Captain Bailey—who had narrowly escaped being killed in the same building 27 years before—a pensioner, and two civilians were all killed.

Despite protests in press and Parliament the site remained derelict until 1963, when rebuilding was started by the Ministry of Public Building and Works. The new building, whose architect was Mr. G. C. Timmis, will house 64 pensioners altogether; it has cost about £147,000, which compares with £10,000 spent in 1921.



Externally the building follows exactly the others ranged around Light Horse Court, both in detail of style and in materials: hand-made bricks, matching course for course, with recessed pointing to give a weathered effect; lead drain pipes; Buttermere slates laid in diminishing courses; dressings and quoins in Portland stone—all correspond precisely with Wren's original design. Inside, however, a reinforced concrete structure has been used, but the interior follows the older style with stained and polished oak panelling, and the pensioners are accommodated in snug cubicles, each with divan bed, writing desk, wardrobe, chest of drawers, store cupboard, and shelves all neatly fitted in. An impressive staircase, also of oak, repeats Wren's thought for short-winded inhabitants with its specially shallow risers.

Wren went to a great deal of trouble in designing the ventilation for his great hospital. He would surely have approved of the arrangements whereby 29 pensioners can live in one end of the new wing supplied with purified air and protected by double doors. The atmosphere of London with its Thames fogs and polluted air has always been one of the few drawbacks of the Royal Hospital as a haven for old soldiers "broken in the wars," as the foundation motto has it.