

What do Wessex general practitioners think about the structure of hospital vocational training?

Paul Little

Abstract

Objectives—To assess the views of general practitioners about the structure and content of hospital vocational training and its relation to the training year.

Design—Postal questionnaire.

Setting—Wessex, England.

Subjects—General practitioner trainees undertaking practice training year (n=144), course organisers (n=22), and a random sample of two thirds of trainers (n=135).

Results—Questionnaires were returned from 86% (260): 84% of trainees (121), 92% of trainers (124), and 68% of course organisers (15). Most respondents in all groups (84.3%, 95% confidence interval 79.7% to 88.8%) wanted more jobs lasting two and three months to allow a greater range of hospital specialties to be experienced and some of the training year to be carried out before hospital jobs (66.3%, 60.4% to 72.1%). Most hospital specialties were rated at least 6 out of 10 as "useful" for general practice training. A substantial minority of training posts did not have regular weekly teaching (166/541; 30.7%, 26.8% to 34.6%) and had no half day (224/541; 41.4%, 37.3% to 45.6%), and over half gave no study leave (293/541; 54.2%, 50.0% to 58.4%).

Conclusions—The structure of hospital training should be reviewed as it does not reflect the views of most trainees, course organisers, or trainers. Individual posts need closer supervision to ensure the availability of basic training requirements. More trainees should be allowed to spend a short time in the general practice before hospital rotations and to choose a greater range of shorter jobs.

Introduction

Evidence is accumulating that general practitioner trainees in hospital vocational training schemes and their course organisers are dissatisfied with the hospital component of training for general practice.¹⁻⁸ The usual structure of the vocational training schemes in England includes four hospital posts for six months each.⁹ It is not clear why schemes are structured like this, other than for administrative or service reasons. Furthermore, there is no information on the preferred

duration for each post or on general practitioners' preference for some of the training year to be held before hospital jobs. There is also no information from a national survey published in 1990 about the number of trainees who are not getting regular weekly teaching, a regular half day, or study leave.⁹

I examined the views of general practitioner trainees, trainers, and course organisers on the structure of hospital training in Wessex by questionnaire.

Methods

Questionnaire—In addition to closed questions—for example, on preference for jobs lasting two to three months—the questionnaire had an open section for comments.

Power calculation—From the pilot study (in 50 trainees) I estimated that 80 subjects were needed to give 95% confidence intervals of plus or minus 10% for the percentage preferring more short jobs.

Reliability—Fifteen trainees answered both pilot and final questionnaires. Preference for more short jobs and for introductory time in practice were identical between questionnaires.

Mailing—To guarantee a sample of 80 trainees and 80 trainers, with an assumed response rate of 50-60%, all trainees in Wessex (of 144 training in August 1993), all course organisers (n=22), and a 60% random sample (n=135) of the trainers in Wessex were sent the questionnaire. A second questionnaire was sent after six weeks to non-responders.

Analysis—I have used median values with interquartile ranges rather than means and confidence intervals to avoid assumptions of normality for artificial scales (such as "usefulness"). Unless stated numbers and percentages refer to individual people who responded to a question.

Results

The response rate was 86% (260/301): 84% for trainees (121/144), 68% for course organisers (15/22), and 92% for trainers (124/135).

Tables I-III summarise the answers to the questions. Most of the respondents in each of the three groups would have liked to have had more posts lasting two to

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TABLE I—Details of respondents' answers to questionnaire on hospital training posts for general practitioners. Figures are numbers (percentages; 95% confidence intervals) unless stated otherwise

Preference	Respondents			Total	χ^2 * Or Kruskal-Wallis H	P value
	Trainees	Trainers	Course organisers			
Some 2 and 3 month jobs to allow more specialties	97/118 (82.2; 75.3 to 89.1)	100/116 (86.2; 79.9 to 92.5)	12/14 (85.7; 57.2 to 98.2)	209/248 (84.3; 79.7 to 88.8)	$\chi^2=0.73$	0.7
Some of practice training year initially	80/119 (67.2; 58.8 to 75.7)	76/119 (63.9; 55.2 to 72.5)	11/14 (78.6; 49.2 to 95.3)	167/252 (66.3; 60.4 to 72.1)	$\chi^2=1.3$	0.5
Initial time (months) in practice (median (interquartile range))	1 (1-3)	1 (1-3)	1 (1-3)	1 (1-3)	H=1.5	0.5

*Yates's correction, 2 df.

three months and to have had some of the training year before hospital jobs. Only a minority of the trainees (36/119; 30%), however, had a split training year, and very few trainees had had posts in the minor specialties—for example, less than a quarter had had a post in otorhinolaryngology and less than 15% in dermatology and ophthalmology. In all specialties there were higher “usefulness” ratings (median 1, except accident and emergency, which was 2) if the respondent had had a job in that specialty, which was significant (at $P < 0.05$) for all specialties except dermatology and rheumatology. The preferred median job duration was six months for medicine, paediatrics, and obstetrics and gynaecology; nothing for general surgery; and three months for all the other specialties.

Discussion

Most general practitioners in Wessex involved in vocational training want some general practitioner training before hospital posts and more shorter hospital posts to allow a greater range of specialties. This contrasts with the minority in the present study and in a national survey who underwent any of their training year before hospital posts⁹ and a minority who had done posts in minor specialties. How feasible is it to restructure hospital training to allow more shorter jobs? Locally—for example, the posts lasting two to three months in the Portsmouth scheme or elective (outpatient) attendance at different specialties for six months in the Winchester—and internationally—for example, New Zealand—short posts can be feasible without apparently sacrificing service commitments.

How much time is required to achieve appropriate clinical competence in a subject? Competence for a

Practice implications

- Training schemes for general practitioners usually entail four hospital posts lasting six months each
- Little is known about general practitioners' preferences for the structure of schemes
- This study found that most trainees, trainers, and course organisers would prefer to have more hospital shorter posts and some training in general practice before hospital posts
- Training within hospital posts is sometimes poor in terms of weekly teaching and study leave
- Hospital training should be reviewed, and closer supervision is needed for trainees in hospital posts

specialist career will have different priorities than competence for general practice; competency profiles need to be defined and assessed more clearly for each individual postholder. It has been suggested that two months are required to learn the basic physical diagnostic and therapeutic decisions in a post.^{10,11} Furthermore, given that in some posts the teaching input is poor, it might not be difficult to provide more teaching and thus achieve more overall competence in a well structured attachment of two to three months than currently occurs in a longer post.

The issue of competence across the broad range of specialties that generalists require raises the issue of the length of vocational training. Currently vocational training for general practice is shorter than training for consultant posts. It does not follow, however, that much more time should be spent in junior hospital posts.⁶ The comments in the open sections of the questionnaires support previous work^{1,3,5,9,12,13} that there needs to be more linking between general practice and hospital vocational training and that teaching needs to be more relevant and preferably more outpatient based. Hospital vocational training still seems far away from the simple proposition that for each part of the scheme there should be an agreement of the “knowledge to be gained, skills to be acquired, and attitudes to be developed.”⁶ A broader, more relevant training could be achieved if the practice part of training was extended—for example, by an extra year—and included more intensive integrated outpatient teaching across a broad range of specialties.

In conclusion, hospital vocational training for general practitioners should be reviewed as the structure does not reflect the views of most trainees, course organisers, or trainers. Training should allow more shorter jobs and some of the practice year before hospital jobs and provide teaching more relevant for general practitioners' needs. The figures on low teaching, half days, and study leave highlight the need for closer supervision of individual posts; the assessment and review process needs to be more effective, with rapid feedback from postholders. To complement this we need more research to study how best to achieve competencies appropriate to general practitioners in a wider range of shorter attachments.

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TABLE II—Median ratings (interquartile ranges) of respondents for perceived usefulness of hospital posts (1=useless to 10=very useful) for general practice.† Also shown are median usefulness ratings by respondents who had done post in that specialty

Specialty	Respondents				
	Trainees (n=119)	Trainers (n=118)	Course organisers (n=14)	Total (n=251)‡	Post done (all groups)‡
General medicine	8 (7-10)	9 (8-10)	8 (8-9)	9 (8-10)**	9 (8-10)** (n=181)
General surgery	4 (3-5)	4 (3-5)	2 (2-3)	4 (3-5)	NA
Paediatrics	9 (8-10)	9 (7-10)	8 (8-9)	9 (7-10)	9 (8-10)** (n=179)
Obstetrics and gynaecology	9 (8-10)	8.5 (8-10)	8 (8-9)	9 (7-10)	9 (8-10)** (n=214)
Psychiatry	7 (6-8)	7 (5-8)	7 (6-9)	7 (6-8)	8 (7-9)** (n=82)
Geriatrics	7 (6-8)	7 (6-9)	8 (7-9)	7 (6-8)	8 (7-9)** (n=92)
Accident and emergency	9 (8-10)	8 (7-10)	8 (6-10)	8 (7-10)	9 (8-10)** (n=138)
Otorhinolaryngology	7 (6-8)	7 (5-8)	7 (6-8)	7 (6-8)	8 (7-9)* (n=47)
Ophthalmology	7 (5-8)	7 (5-8)	7 (5-7)	7 (5-8)	8 (7-9)* (n=27)
Dermatology	7 (6-8)	7 (6-8)	7 (6-9)	7 (6-8)	8 (7-9) (n=29)
Rheumatology	7 (5-8)	6 (5-8)	7 (5-8)	6 (5-8)	7 (6-8) (n=31)

†Usefulness rating of other posts (specified by respondents in all groups): orthopaedics (n=16), 5 (4-8); terminal care (n=15), 8 (8-10); community paediatrics (n=4), 8 (8-8); anaesthetics (n=10), 4 (3-8); radiotherapy (n=1), 6; neurology (n=2), 6; oncology (n=1), 9; pathology (n=3), 5; genitourinary (n=2), 7.5; histology (n=1), 8; research (n=1), 9; chest medicine (n=2), 8; neurosurgery (n=1), 7; public health (n=3), 7.

‡Comparison between groups by Kruskal-Wallis test. Significant differences between groups quoted by total. Significant differences for respondents who had done posts (compared with respondents who had not done post) quoted by “post done” total: * $P < 0.05$; ** $P < 0.001$. N/A=not applicable.

TABLE III—Numbers (percentages) of trainees who had done a post in given specialty and details of training

Specialty	Post	No weekly teaching	No half day	No study leave application	Study leave no given
General medicine	74 (61)	30 (41)	43 (58)	42 (57)	43 (58)
Paediatrics	93 (77)	17 (18)	21 (23)	38 (41)	47 (51)
Obstetrics and gynaecology	94 (78)	31 (33)	27 (29)	41 (44)	46 (49)
Psychiatry	42 (35)	9 (21)	15 (36)	21 (50)	22 (52)
Geriatrics	54 (45)	25 (46)	29 (54)	27 (50)	27 (50)
Accident and emergency*	76 (84)	22 (29)	48 (63)	52 (68)	56 (74)
Otorhinolaryngology	29 (24)	11 (38)	11 (38)	16 (55)	17 (59)
Ophthalmology	15 (12)	6 (40)	6 (40)	7 (47)	7 (47)
Dermatology	15 (12)	2 (13)	7 (47)	8 (53)	8 (53)
Rheumatology	17 (14)	4 (24)	7 (41)	6 (35)	7 (41)
Other	32 (26)	9 (28)	10 (31)	12 (38)	13 (41)
Total (%)	541	166 (30.7)	224 (41.4)	270 (49.9)	293 (54.2)
(95% Confidence interval)		(26.8 to 34.6)	(37.3 to 45.6)	(45.7 to 54.1)	(50.0 to 58.4)

*Owing to administrative error (question omitted from questionnaire), only 91 trainees were able to respond to questions about accident and emergency posts.

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Commentary

The hospital component of vocational training for general practice

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Trainees and educationalists in general practice have some grounds for suggesting that the hospital component of vocational training should be restructured and teaching improved. However, the implications for other trainees and secondary care have to be considered. Changes that are needed include a curriculum for senior house officers in each specialty; appointment of training consultants with the necessary skills; and a different attitude by everyone towards study leave, including arrangements for funding. The optimum duration of hospital posts for trainees in general practice might be shorter than now, but the effects on others must be considered and competencies guaranteed in a briefer training period. Changes in the regulations for vocational training could help to improve specialist experience if trainees in general practice were allowed to be supernumerary. Alternatively, senior house officer posts for trainees in general practice could be split between secondary and primary care, thus encouraging a broader perspective.

Dissatisfaction with the hospital component of vocational training for general practice is forcefully expressed by many trainees and educationalists in general practice.^{1,3} There is also concern that implementation of the Calman report on specialist training⁴ may have unwanted effects on senior house officer posts available for vocational training for general practice; that attention to providing experience for those planning a career in the specialty will detract from the needs of trainees in general practice; and that less satisfactory posts will be allocated to vocational training schemes. Several surveys confirm that trainees and teachers in general practice consider that change is necessary; some suggest radical restructuring of the hospital component of the vocational scheme; few however, consider the views of trainees in other specialties who share the same training opportunities of consultants who supervise senior house officers.

The principal complaints of trainees, course organisers, and trainers in general practice are that:

- Teaching in the hospital component is not relevant to the needs of general practitioners
- Teaching is poor and irregular
- Study leave is often refused or trainees are refused leave to attend relevant courses
- The duration of senior house officer posts is too long.

Relevant teaching and competent learning

Action has and is being taken to make vocational training for general practice relevant. In conjunction with sister colleges and specialist societies, the Royal

College of General Practitioners has produced curricular requirements relevant for training senior house officers for a career in general practice in most of the "first list" specialties.⁵⁻¹⁰ This should form the basis for enhanced teaching and learning. The curriculum for senior house officers in these specialties is an important first step in deciding the appropriate clinical competence for a future general practitioner. It should also give clear guidance to consultants and course organisers on the range of experience that should be provided.

Assessment of the competence of trainees, whether seeking a career in general or hospital practice, will become a prominent feature of postgraduate training of the future. The Joint Committee on Postgraduate Training for General Practice has set a timescale for award of its certificate of completion of training, based on assessment of competence; it will be introduced in 1996. The implication of assessing clinical competence is, however, ill understood: the trainee should not move on to the next phase of training until the defined competence has been achieved. For a few this may mean longer rather than shorter periods in some posts and delay in certification.

Success in training general practitioners has been built on trainers who have learnt how to teach and are expected to maintain that ability and hone their skills. Hospital teachers are increasingly aware of the need to acquire these skills if they are to help implement the Calman report and in undergraduate education. Postgraduate deans have recognised the urgency of developing the teaching skills of educational supervisors and are using their budgets to "teach the teacher."

Expert teachers should answer the criticism that teaching is poor—provided that consultants have contractual time for the purpose. Unlike trainers in general practice, hospital specialists are not paid to teach. When a consultant is teaching the employer can justly claim that it pays so called "opportunity costs" as the teacher either will not be contributing to its business or has a smaller case load.

Regular teaching requires recognition of the responsibility in a consultant's contract. Nominal time for teaching is frequently eroded by other duties; few NHS managers recognise teaching as needing a "fixed" session. The professionalism of teaching is a feature of the arrangements for education of other health care workers: nurses are taught by full time teachers but doctors in training are not. Trained teachers—consultants with contractual time allowed for teaching—should meet the criticisms of trainees in general practice, particularly if these consultants are aware of curricular requirements and work in conjunction with the local course organiser. By extension, some consultants will not, in the future, be trainers—as is the case in general practice.

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