

PRACTICE OBSERVED

Practice Research

Teaching practices revisited

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Vocational training for general practice is a statutory requirement. The number of general practitioners appointed as trainers has increased greatly since Irvine conducted a survey in 1970 of 190 practices in England, Wales, and Northern Ireland that were then engaged in vocational training or taught undergraduates and were considered by course organisers to be "suitable for vocational training." Irvine attempted "to provide basic information about the practices themselves, their premises, equipment, organisation, and facilities for team work in patient care, and to compare them where possible with the practices in the British Medical Association planning unit study, which was based on a representative sample of all general practitioners."

Trainers today are selected against seven criteria: a desire to teach; the ability to teach; a readiness to make time to teach; clinical competence; relationships with professional colleagues and patients; experience and age; practice organisation and premises. The 13 categories of information relevant to practice organisation and premises clearly derive from Irvine's study. Considerable weight is attached to them because "the objective is to provide training experience of wide opportunities and high quality, and this may not be possible if the practice premises or facilities are limited or deficient."

Irvine's findings in 1970 contrasted sharply with those of the 1969 planning unit study. The trainers who have been appointed since 1970 must have come at least in part from the population of general practitioners sampled by the planning unit. In 1981 we sought to determine how the teaching practices in the South West Thames Regional Health Authority compared with the 1970 standard setters and to examine any relation between their organisation and premises and the characteristics of the trainers.

Method

A slightly modified version of Irvine's questionnaire was sent to 130 trainers in the South West Thames region, of which only one practice had been included in the 1970 survey. One follow up letter was sent to non-responders one month later. Two trainers did not receive a questionnaire: one was omitted in error and one was in partnership with one of us.

Results

Questionnaires were completed and returned by 118 (91%) trainers. One trainer was on sabbatical, and one practice with two trainers wrote refusing to participate. Fifteen practices had two trainers and one practice had four. Of 114 practices circulated, 107 (94%) replied. The denominator for our description of trainers is thus 118 and for their practices 107.

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ORGANISATION

Practice size (table 1)—The teaching practices in 1981 had more principals and smaller lists per principal than those of the 1970 respondents. The increase in number of principals is part of a national trend, and the reduction in list size reflects regional trends that are less pronounced than national ones. In 1981 the chance of becoming a trainer in the South West Thames region was increased by having a larger number of partners.

Surgery premises—There has been financial encouragement to form groups and improve premises. Sixty one per cent of the 1981 trainers worked from purpose built premises compared with 40% in the 1970 sample and 17% of all general practitioners in 1969. 30 worked in health centres in 1981 compared with 11 in 1970. Over half of the practices were still unable to provide a training with a

TABLE 1—Percentage distribution of trainers by number of principals in practice

	No. of principals in practice				Total
	1	2	3	4 or more	
1970					
All unselected principals in England	21	25	16	32	100
Trainers n=190	12	20	17	26	100
1981					
Trainers n=117	0	6	20	37	100
All unselected principals in South West Thames region	13	17	21	29	100
All unselected principals in England	13	23	19	27	100

consisting room for his sole use. Half of the practices working from purpose built premises were able to offer this facility compared with a quarter of those working from non-special clinics.

Equipment (table 2)—Medical care depends on equipment as well as premises. The 1981 trainers had more equipment than the 1970 responders (who were better equipped than the 1969 sample of all general practitioners). The proportion of trainers with peak flow meters and audiotapes had trebled: the proportion with baby scales, arm balance weighing machines, electrocardiographs, and cautery apparatus had increased by a half or more. Nearly half of the 1981 trainers had dipdials for urine culture, although 6% still did not have a proctoscope.

TABLE 2—Clinical equipment in teaching practices (n=107)

Equipment	1981 n=107	1970 n=107	1969 all general practitioners
Vital sign apparatus	100	97	69
Reflex hammer	96	87	69
Stethoscope	94	84	76
Proctoscope	94	84	76
Equipment for minor operations	89	83	78
Peak flow meter	87	28	—
Baby scales	87	49	—
Arm balance weighing machine	79	52	—
Electrocardiograph	69	37	10
Electroencephalogram	50	49	24
Cautery apparatus	46	27	—
Dipdial	46	37	26
Laryngoscope	46	37	26
Audiometer	35	12	—

Staff (table 3)—A practice manager or administrative secretary was employed in 93% of the 1981 practices compared with 38% of practices of the 1970 respondents. The number of teaching practices with nursing help had increased. All but a small proportion of 1981 teaching practices had a "basic" primary care team, and 36% of them had the help of staff likely to be able to counsel. Twenty per cent of the 1970 respondents had no nursing help.

TABLE 3—Nursing and counselling staff (number of respondents: 103)

Staff	Employed	Attended	Neither
Health visitor	3	99	1
Nurse	1	99	1
Midwife	1	72	29
Physiotherapist	1	72	29
State enrolled nurse	5	44	57
General medical worker	1	44	57
Physiotherapist social worker	1	10	92
Marriage guidance counsellor	0	10	93
Clinical psychologist	3	14	87

ARRANGEMENTS FOR PATIENT CARE

Only one of the 1981 respondents did not have some sort of appointment system compared with 7% of the 1970 respondents. 96% of the 1981 sample had a full appointment system, 76% of 1970 respondents. The rate at which patients were booked for non-teaching surgery sessions had altered a little (table 4).

The proportion of trainers consulting at the rate of 10 to 11 patients an hour had stayed the same but there had been a reduction in the proportion consulting at the rate of 12 or more. The mean

rate was 9.6 patients an hour when not teaching and 7.1 when a trainee was sitting in.

There had been an increase also in the percentage of teaching practices that held separate clinics for certain patient groups (table 5), the proportion holding a family planning clinic having doubled. Only 3 of the 1981 practices held no "special" clinics, while 43 held at least three types and 38 held five types or more.

TABLE 4—Distribution of trainers by number of patients seen an hour

	No. of patients booked an hour			
	1-6	7-9	10-11	12 or more
1981 Trainers n=114	16	35	24	25
1970 Trainers n=172	15	30	24	31
1969 Trainers with trainee present n=68	2	9	6	7

TABLE 5—Percentage of trainers holding special clinics

Clinics	1981 Trainers n=107	1970 Trainers n=187
Antenatal	91	82
Immunisations	89	79
General ophthalmology	80	55
General otitis	79	53
General otitis	6	20
General otitis	12	Notified

Figures exclude area health authority clinics.

ARRANGEMENTS AND FACILITIES FOR TEACHING

Eighty eight per cent of the 1981 respondents had an age-sex register (65% of trainers in 1970 and 15% of all doctors in 1969), 28% had a diagnostic index, and 7% had access to a computer. Of those who had an age-sex register, many stated voluntarily that they did not use it.

PERSONAL CHARACTERISTICS OF THE TRAINERS

Experience and age

The 1981 trainers were older than the 1970 ones, only 34 being under 45 in 1970 compared with 48 in 1981. 1981 48% of all general practitioners in the age group 30 to 44 were under 45, while in 1969 it was 46%. Thus the tendency among trainers is not that shown in the general practitioner population as a whole. The greater age of the 1981 trainers did not stem simply from being longer in post: 55% of the 1981 trainers had been in post for under five years and half of these were 45 or more, a sixth being aged 50 years or more.

The proportion of 1981 respondents who had only a basic medical qualification (20%) was virtually the same as that of the 1970 respondents (18%) and with the exception of the diploma of the Royal College of Obstetricians and Gynaecologists (DRCOG) (57% in 1981 and 35% in 1970) the 1981 trainers tended to have no more postgraduate qualifications than the 1971 respondents. In particular, only 56% in 1981 were members or fellows of the Royal College of General Practitioners compared with 74% in 1970.

The greater age of the trainers was not reflected in the proportion who sat on committees, since 39% in 1981 compared with 32% in 1970 had no committee activity at all. Half of the 1981 respondents had carried out no projects in the past three years (45% of 1971 trainers) and 86% had no publications over the same period (80% of 1971 trainers).

Desire to teach

Nearly all of the 1981 trainers had attended a course for trainers (32% of the 1970 sample but 30% had had no follow up training. Eighty one per cent of the 1981 sample took medical students in their practices compared with 88% of the 1970 trainers. This was odd when you consider the great increase in the number of medical

schools that include general practice in their curriculum: it may arise from the way in which the 1970 sample was selected to include practices teaching undergraduates but not yet teaching trainees.

EFFECTS OF SELECTION METHODS

Since practice premises and organisation are so important to the selection of teaching practices we looked for differences in the characteristics of trainers in teaching practices of different sizes but found little except for a tendency in larger practices for trainers not to sit on local medical committees or BMA committees but to have conducted some research or to have published articles. We looked also at trainers' characteristics by age—splitting the sample at age 45—and by having been a trainer at least five years. No appreciable differences were found in either analysis except for membership of local medical committees and BMA committees being more common for the older trainers.

Discussion

In terms of all the variables we used a remarkably homogeneous sample of trainers seems to have been selected. Their practices are similarly and understandably homogeneous. A teaching practice today, at least in the South West Thames region, is likely to have at least four partners, good premises, a practice manager, an appointment system, a "basic" primary care team, and to conduct several "clinics" for special groups. The practices are beginning to have the help on site of people who are not doctors and are likely to be able to counsel. The practices tend to be well equipped but 49% still see patients at the rate of 10 or more an hour, which is closely similar to that of the 1970 trainers, and we wondered how often the "extra" equipment was used.

The rate at which trainers saw patients seems to be related to average list size. The 48 trainers who booked fewer than 10 patients an hour had a mean list size per doctor of 2175, while the 56 who booked at 10 or more patients an hour had a mean list size per doctor of 2368.

The practices certainly resembled those of the 1970 trend setters rather than those of the 1969 representative sample of all general practitioners.

The results of a recent study<sup>1</sup> by Freeman and his colleagues suggest that although "the teachers' clinical knowledge and problem solving skills in patient management are major determinants in trainers' learning and performance" there are several other factors that "underpin these qualities in the teacher," such as the trainer's experience and membership or fellowship of the Royal College of General Practitioners. It was also found that trainers valued the opportunity to conduct their own surgery sessions in parallel with their trainers' surgery sessions.

Because more and more training places have been needed over the past few years it is unavoidable that more than half of the South West Thames trainers have been recruited in the past five years. On the other hand, 27 of the 54 trainers in post for three years or less were over 45, which is a little surprising. It is notable also that only 56% of our respondents were fellows or members of the college and that this was similar in the two age groups. The correlation found by Freeman may

stem from similarities between their methods of assessment and those of the college examination. Nevertheless, a high proportion of vocational trainees seem to sit the college examination and having a trainer familiar with its objectives and methods might be helpful to them. It seems, also, that as general practice emerges as a discipline, the percentage of trainers with experience of research projects has not increased nor has the percentage of those who have recently published.

In view of Freeman's report that trainees prefer to conduct surgery sessions "parallel" to the trainers' it seems a pity that nearly half the trainers could not have a room for their sole use and that they often had to practise in rooms with different layouts.

Conclusions

The findings of this postal survey in 1981 compared to a similar survey in 1970 of teaching practices in the South West Thames region are reassuring because the model of practice organisation being offered to trainees seems to be consistent. In 1981 compared to 1970 practices had more partners, proportionally smaller lists, better premises, and more equipment and staff. They were more likely to hold special clinics and to have appointment systems and an age-sex register. The proportion booking 10 to 11 patients an hour was the same. The trainers were older but not longer in post, and in both surveys one fifth had only the basic medical qualifications; fewer belonged to the Royal College of General Practitioners.

It has yet to be established that the young doctors in training will be able to function as principals in practices that lack the facilities and help to which they have become accustomed. Perhaps all trainees should be attached to a non-teaching practice for one or two weeks during their last three months of training. They would then be able to return to their trainers to discuss the problem of changing unorganised practices towards the model that they have been offered and to have some ground for forming opinions as to whether or not that model produces the kind of care patients need and want.

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Image of General Practice

Equality of experts

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I like my general practitioner to treat me as an equal. When I have a problem we need to approach it jointly. He (my present doctor) happens to be a man of medical knowledge, but without the how the problem affects me at the moment, I am the one who has to go through with the treatment, and it is I who will be most affected by the outcome. I want to be able to discuss with him the implications of possible treatments—or no treatment. Ideally, I would like rough probabilities attached to the different things that might happen.

But I do not want detailed technical information about the way things work. I recognise that it is a difficult tightrope for him to walk. He may assume that my knowledge is greater than it is and that I understand or will recall technical terms that in practice go in one ear and out the other, or he may tell me things that I know already, or he may bore me with minutiae.

Sometimes the problem is straightforward, the choice of action is clear cut, he explains, I accept his experience and expertise. On other occasions the possibilities may be wider, the scientific basis for action is unclear, the implications more complicated. In such a case I may start to read the literature about it: it is my problem so I have got a particular interest in it; for him it is only one among many. I usually find that there has

been a randomised control trial of the possible treatments: the data are not available to answer my question. Then, as so often in life, we have to make a decision without all the information we would like. If my doctor should claim to know the answer that would destroy my respect for him. The decision should be a joint one and has to be negotiated. It may require him to give me access to scarce resources, in which case he needs to think that this is reasonable. There may be risks, and we both need to understand this and to know that we can rely on the other's support and understanding if things do not work out as we hoped.

So we need to know each other and to build up our understanding, our trust, and our respect. Again I would like that to be mutual. Some doctors do not want this type of relationship. I have found a practice that seems to adopt this approach. It also has friendly receptionists but somewhat inadequate telephone connections. But in my search for this ideal have I gone too far from my home? So far I have not needed a home visit. I think my present doctor would be prepared to do the occasional one. But when I become old and frail I shall want to stay in my home and I shall want my doctor to encourage me to do so, to support me over this, and to visit me there from time to time, not just in emergencies. And I shall very much if I shall regard visits from a geriatric nurse or a social worker or whatever as an appropriate alternative, although I will be glad to have help from them as well if I need it. Basically I want those things we all have been discussing for so long and will continue to talk about because they are so fundamental—personal and continuing care, in the home when I cannot get to the surgery.

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ONE HUNDRED YEARS AGO

If the growing pressure of traffic and novel modes of conveyance have increased the risks of the passengers on horseback and in vehicles, pedestrians in the metropolises and in other large towns are also daily exposed to dangers which seem likely to have become more frequent. In London alone, according to the reports of the police, more than one hundred persons are annually killed in the streets, while two or three thousand individuals are more or less severely injured every year in the thoroughfares, and conveyed to hospitals. Under the causes of death or disablement are to be found records of injuries by wagons, carts, vans, cabs, cars, and omnibuses. But vehicular traffic is not responsible for all the perils to life and limb to which foot-passengers are exposed when they traverse the streets. During the prevalence of high winds, we bear of injuries from the falling of sign-boards, chimneys, walls, staves, bricks, scaffolding, and bill-stickers' boardings, or from the coming down of broken telegraph wires which have been stretched over streets. The placing of telegraph wires across streets is a source of danger which is rapidly on the increase, from the growth of

telephonic communication in populous districts. Telegraph wires cut like a sword when they strike in falling from a considerable height. Many cases of accidents to foot-passengers arise from blows from falling goods, which are either thrown from heavy railways vans or dropped from cranes occupying public footpaths. All these various perils appear to be growing amongst us, from the increasing concentration of population and commercial activity in the large urban districts of our country. To enumerate these dangers is to prompt the reflection that most of them are obviously avoidable, either by due watchfulness on the part of pedestrians or by due care on the part of those who have charge of vehicles, of goods in transit, or of high erections liable to demolition by storms. The sources of danger which we point out are in many instances capable of mitigation or prevention by the employment of proper precautions; and they are risks which the corporate and police authorities of towns would do well to inquire into, and to recognise and remove, with a view to their being efficiently remedied. *British Medical Journal* 1883; *2*: 573.