

**ASSESSMENT OF VOCATIONAL TRAINING FOR GENERAL
PRACTICE BEFORE AND AFTER THE 1990 CONTRACT**

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DECLARATION

In accordance with the regulations of the University of Glasgow, I declare that this thesis has been composed by me. The work reported in this thesis is my own with all contributions from other workers clearly indicated in the text or in the acknowledgements section.

Diane Rutherford Kelly.

ABSTRACT

Vocational training has existed in the west of Scotland since 1968 and became a legal requirement in the United Kingdom in 1979. A literature review revealed few studies pertaining to vocational training; some evaluated one area of training and others, which were more global, involved small numbers.

The aim of this thesis is to evaluate vocational training in the west of Scotland on a scale and to a degree which had not hitherto taken place. The objectives were:

(i) to assess training since it began in the region by questioning 619 doctors who trained over the twenty year period and make comparisons of training over that time.

(ii) to study in more detail a smaller sub-group of doctors from within the large group with particular emphasis on the effect of the 1990 general practitioner contract.

(iii) to make a full assessment of the hospital component among the most recent trainees, with particular regard to the educational content of the posts.

The method employed to address these objectives was a series of retrospective questionnaires and a semi-structured telephone interview.

(i) The large scale study which assessed vocational training from 1968 emphasised the value of out-patient attendance during hospital training and showed that there was a need for more posts in medicine, paediatrics and

dermatology. It found that 94% enjoyed their trainee year, 49% felt some aspects had been omitted from their general practice training but only 12% rated their training as poor. The comparison of different time periods demonstrated that the training rating improved, respondents felt less had been omitted from training, more were permitted to take study leave and to gain experience in general practice research. This study, described in Chapter 1, was a large historical study and the issues it raised allowed the author to develop methodologies which were then used to address the more recent developments and issues in Vocational Training. The study described in Chapter 2 compared training before and after the adoption of new criteria for trainer selection. The purpose of this was to evaluate the effect of this intervention on training.

(ii) The study involving a sub-group of doctors revealed that respondents did not feel well prepared for the 1990 contract. Those who trained from 1989-92 felt more prepared for health promotion, paediatric surveillance and minor surgery than those training from 1981-88. However, they too felt poorly prepared to compile a practice report, perform audit or use a computer in general practice. Both groups considered themselves well prepared for clinical patient care except in the area of disease prevention.

The evaluation of the educational content of training found that during the hospital component teaching took place very occasionally or never for over 40% of respondents from both training periods (1981-88 and 1989-92). When it did occur it was usually orientated towards the specialty, not general practice. A day-release course during hospital training was attended by only a third of respondents compared to over 97% during general practice training. Audit and research were more likely to feature as tutorial topics among those

who trained from 1989-92 than from 1981-88. Trainee assessment underwent change as the use of video and the objective structured clinical examination (O.S.C.E) greatly increased. The number of trainees who had no assessment fell between 1981-88 and 1989-92.

(iii) The educational content of current hospital posts in the west of Scotland was found to be generally poor, particularly paediatric and obstetrics/gynaecology posts. The exception to this was psychiatry posts. Overall, protected time for study and teaching was lacking in the vast majority of posts.

In conclusion, this thesis has demonstrated that vocational training in the west of Scotland has undergone many changes since it began in 1968. These changes have been positive and have resulted in many improvements to the general practice component of training. However, significant educational deficiencies exist in the hospital component of training and need to be addressed.

Vocational training must remain sensitive to the needs of general practitioners and should reflect the changing content of general practice.

INTRODUCTION

Historical Review

The history of vocational training has been described previously, most notably by Horder and Swift (1979), Gray (1982), Hasler (1989); it is my intention to give a review of the important developments.

1882 - 1949

Horder and Swift (1979) stated that the concept of vocational training for general practice was referred to as long ago as 1882 when a working party of the Metropolitan Counties branch of the British Medical Association concluded that many general practitioners were unaware of the duties of practice before entering the profession. They recommended that prior to receiving a licence to practice, a student should provide certification confirming that a period of six months had been spent studying with a general practitioner.

The year 1948 is historically of great importance. During this year the National Health Service was founded and the Spens Committee published their report on the remuneration of general practitioners. They recommended that "after the completion of house appointments a doctor who wished to enter general practice should spend one and preferably two years as an assistant" (Ministry of Health Department of Health for Scotland 1946). Another report published in this year was written by a Committee headed by Dr. Henry Cohen (later Lord Cohen and president of the General Medical Council) and stated "the Committee does not, therefore, accept in its full implication the oft reiterated view that the aim of the curriculum should be to produce a competent general practitioner. General practice is a special form of practice which must be founded on general basic principles and appropriate postgraduate study" (British Medical Association 1948).

Another significant occurrence in 1948 was the development of the Trainee Practitioner Scheme. The scheme initially flourished although it was almost abolished when numbers dropped in 1966. However, the scheme survived and has now been incorporated into the practice component of vocational training today (Horder and Swift 1979).

1950 -1959

In 1950 the British Medical Journal published another report "General Practice and the Training of the General Practitioner" (British Medical Association 1950). This report divided postgraduate education into two components, "the period of training after registration for the special work of general practice and the subsequent continuous education of the general practitioner throughout his professional life". The committee recommended that a period of three years be spent preparing for general practice with the first year in practice, the second year in specially designed hospital posts and the last year at the choice of the trainee in either training appointments in hospital, clinical assistantships in different subjects, further assistantships in general practice, or locum appointments in approved general practices.

In 1951 the first seminars for general practitioners took place at the Tavistock Clinic supervised by Michael and Enid Balint. Although the actual numbers of doctors attending these meetings were small, some of the resulting concepts have become incorporated into vocational training.

The first integrated vocational scheme linking appointments in hospital with traineeships in general practice started in Inverness in 1952 and consisted of a two year programme (Gaskell 1967). The first trainee scheme in England, the

Wessex Nuffield scheme, was established in 1959 consisting of a year in practice and a year in hospital (Horder and Swift 1979).

Another important step in the history of vocational training was the foundation in 1952 of the College (subsequently Royal College) of General Practitioners (Gray 1982). At this period in time there existed no other academic body for general practice. In 1957 the Postgraduate Education Committee of Council sent a questionnaire to all College members asking them to comment on their level of satisfaction with the trainee practitioner scheme. The level of satisfaction was not high, with many reporting the scheme open to abuse and commenting on the lack of training actually taking place. Many of the suggestions made then have been incorporated into the current regulations, including a limited length of appointment for trainers and the development of an educational body to regulate training and to appoint trainers and trainees. Further, a trainee contract should exist with a defined training syllabus and there should be local supervision of trainers and local groups of trainers and trainees.

1960 -1969

The Christ Church Conference in 1961 on postgraduate medical education resulted in a major development for postgraduate training with its recommendation that "there should be a strong Regional Committee for Postgraduate Education", which "would be responsible for appointing the clinical tutors at the Regional Postgraduate Training Units" (Nuffield Provincial Hospitals Trust 1962).

Horder and Swift (1979) stated that in 1963 the General Medical Services Committee's Trainee Scheme Advisory Committee re-affirmed the need for the trainee practitioner scheme, but opposed the suggestion that it should be compulsory. The Ministry of Health agreed that local training scheme

committees for the selection of trainers should be established. These committees were the precursors of the Regional General Practice Advisory Committees.

This was followed in 1972 by a Department of Health circular recommending that all regional hospital boards should appoint an adviser contracted to the university. This was acted upon and within two years appointments had been made in all medical schools (Department of Health and Social Security 1972).

A previous Health Board circular, (Ministry of Health 1964), established the principle that the cost of postgraduate and continuing medical education is a proper charge on the NHS Exchequer funds, as educational facilities have a direct relevance to the delivery of care.

As a result of the high level of dissatisfaction expressed by many trainees at this time, the College Council set up a working party in 1964 to consider how to organise vocational training in Great Britain. The working party's first publication proposed that, from the time of qualification, five years should be spent in training for general practice. The pre-registration year would constitute the first year of training and of the other four years, two would be spent in hospital and two in practice (College of General Practitioners' Report 1964). However, the second year in practice has never materialised, with a compromise being reached between the Department of Health and the British Medical Association which resulted in the current three year training system.

The working party's second publication gave a more detailed description of how the proposed five year training would be constructed. It also listed which hospital posts were most relevant for general practice training. These were Obstetrics, Paediatrics, Psychological Medicine and any of the following: ENT,

Dermatology, Geriatrics, Ophthalmology, Medicine and Rheumatology (College of General Practitioners 1965).

The party's third publication, Evidence of the College of General Practitioners to the Royal Commission on Medical Education referred to "special vocational training for general practice" (College of General Practitioners 1966). It stated that "the special vocational training needs of general practice will change as the role of the general practitioners changes; the content and duration of training will need to be constantly under review".

The fourth publication of the working party described new developments in vocational training and gave further recommendations. It proposed a set of objectives for the hospital component of training and gave recommendations on the organisation of training, promoting the appointment of general practice advisers (Royal College of General Practitioners 1967).

One contribution of the reports was their influence on the Royal Commission on Medical Education which published its report in 1968 (Royal Commission on Medical Education 1968). Among its recommendations on professional training for general practice it advocated that "all would-be general practitioners undertaking a three-year period of general professional training, comprising a series of six-month, or perhaps twelve-month, rotating appointments". This would be followed by two years further professional training as an Assistant Principal in General Practice.

In 1967 the General Medical Council issued its 10 yearly report on medical education in which it accepted that all doctors, including general practitioners would require in future, special and extended vocational training for their chosen careers. It referred for the first time to "basic medical education", i.e. education

to the point of qualification, and postgraduate training became inevitable (General Medical Council 1967).

A report the following year by the British Medical Students' Association on Medical Education (1968) echoed the views of the GMC and stated "the function of the medical school must be to produce an EDUCABLE BASIC DOCTOR who has been adequately prepared to continue learning throughout his life and who can successfully embark on the programme of post-graduate vocational training in whatever field of medicine".

The Nuffield Provincial Hospitals Trust published a report in 1967 criticizing training for general practice (Nuffield Provincial Hospitals Trust 1967). They recommended two years should be spent in hospital (one being pre-registration) and one year in practice. A further year of training was suggested on a senior registrar level. They also emphasised the need for a "national regulating and supervisory body" to set standards and regulations, for regional committees, postgraduate advisers and part time organisers. Following this, the Trust was responsible for financing the first postgraduate adviser in Wessex.

In 1966 the decision was taken to establish a Central Committee on Postgraduate Medical Education which was later divided into separate committees for England and Wales, Scotland and Northern Ireland (Horder and Swift 1979).

1970 - 1982

The Joint Committee on Postgraduate Training for General Practice (JCPTGP) was formed in 1975 and its chief influence has been to produce guidelines for vocational training and to set up a process of inspection of each region in the UK.

The vocational training legislation was passed in parliament in 1976 (National Health Service 1976) and the regulations were issued in 1979 (National Health Service 1979). They took effect initially in February 1981 following which it was not possible to become a principal without having completed a trainee year, or being exempt. After August 1982 it became impossible to enter general practice without completing a three year training programme.

Vocational Training in the West of Scotland

Vocational training has existed in the region since 1968 with the main numerical expansion between 1980 and 1987. Currently around 150 trainees are in post, with half taking part in a recognised three year training scheme and half constructing their own training scheme. There are sixteen formal schemes, two of which comprise eighteen months in general practice, the remainder twelve months.

In August 1991 the Postgraduate General Practice Committee introduced a compulsory formative assessment package which is structured throughout the trainee year. Assessment had been taking place within the region prior to this but was on a voluntary basis. In 1993 a pilot end-point summative assessment programme was introduced for trainees completing their training in July 1993.

Review of Vocational Training Literature

Since the conception of vocational training, attempts have been made to assess whether it was necessary, whether it was effective and more recently whether it should be modified. Its necessity was supported by some early studies. An evaluation was made prior to the introduction of mandatory training of 24 trainees at the beginning and end of their trainee year in the west of Scotland. It was found that they improved in their factual recall and problem-solving skills. A group of young principals without a formal training was initially of the same

standard but did not show the same improvement (Murray et al 1978). A study based in Manchester (Byrne 1973) demonstrated that on comparing trainees with their trainers the degree of factual recall was similar. However, trainers performance in the areas of problem solving, patient management and communication skills was higher. It was shown that trainees substantially improved in the latter three areas by the end of their training. A later study (Grol et al 1985) examined the changes in attitude of trainees over the trainee year and compared them with those of their trainers. The conclusion reached was that by the end of training the attitudes of both were similar as there had been a strong shift in trainee attitudes in the intended direction towards attitudes considered relevant to general practice. A more negative study in 1977 (Cartwright and Anderson 1979) found that among a group of doctors in England and Wales training was unrelated to enjoyment of general practice and overall was not associated with an increase in desirable general practitioner attitudes. It was suggested that the main impact of vocational training lay in the future. Norell (1981) also expressed caution, particularly with the way training was organised and structured. He stated the future of training might be more optimistic once the JCPTGP began monitoring training schemes and once the opinions of trainees were listened to.

The views of trainees on their vocational training, both in practice and in hospital, have been assessed since the introduction of vocational training. However, the subject has not attracted much attention and often studies have involved a small number of trainees.

Among the earlier studies was one from England and Wales in 1966 which found that the hospital training fell considerably short of recent proposals by the BMA and RCGP and that the trainee year was often an assistantship with little supervision (Whitfield 1966). Freer and Reid (1978) assessing one training

scheme in Glasgow concluded that there appeared to be a lack of consensus on vocational training in terms of its structure and content, and called for larger nationwide studies. Similarly Donald (1975) noted that in south east Scotland there was a wide variation in the standard of training regarding teaching and conditions of service and recommended appropriate guidance for trainers from a single responsible body to raise the standard. A survey by Thornham (1980) found that trainees in the north west of England favoured 18 months in practice and called for a reappraisal of the hospital component of training and an increased level of awareness by hospital consultants of the needs of general practice trainees. The hospital component of training has also been studied by Styles who found that many doctors receiving a certificate of satisfactory completion of training do so without completing a post in certain important specialties and he suggested more innovative and imaginative training programmes which would include more posts in General Medicine, Geriatric Medicine and Psychiatry (Styles 1991). Reeve and Bowman examined the views of trainees in north western England and concluded that there were "serious educational deficiencies in hospital posts that are used to train general practitioners and other specialists". They found that there was no formal teaching in 37% of hospital posts, study leave was applied for in only 37% of posts, and in posts where teaching did take place in only 24% was orientated towards general practice (Reeve and Bowman 1989). A survey in the Trent region in 1989 similarly concluded that improvements were needed in the paediatric teaching content in hospital where in a fifth of posts there was no teaching, in the trainee year where a fifth of trainees did not attend Child Health Clinics, and in postgraduate training. They demonstrated that completing a paediatric post increased the confidence that new principals had in their paediatric skills and they recommended paediatric experience for all trainees (Polnay and Pringle 1989). Another study in 1989, of Obstetrics, Gynaecology and Paediatrics, identified that hospital training was failing to address objectives perceived to be important

for general practice. It was shown that while there was often agreement between consultants, trainees, trainers and principals as to which subjects were relevant to general practice, the subjects were often not adequately addressed in the hospital training. It was suggested that "educational needs were being overlooked because of service requirements" (Kearley 1990).

For the general practice component of vocational training the fourth national trainee conference in 1980 concluded that time for teaching, certain teaching methods, (case analysis, sitting-in, clinical audit) and certain criteria for training practices eg. existence of library, on-call back-up and courses for trainers were areas of importance (Ronalds et al 1981). Short (1987) examined the views of trainees in the Dartford region and found that the main areas where improvement was required was the teaching of practice organisation and the existence of a flexible day release course. An assessment of training in the West Midlands in 1987 concluded that the recommendations for training were largely being met but there were discrepancies between what is recommended and what some trainees felt they received regarding teaching time, preventative care, paediatric surveillance, existence of a trainee contract and performance feedback and they called for review and implementation of training objectives. (Cyna and Przyslo 1987). Crawley and Levin (1990) also reported that despite many improvements in the trainee year it could be improved further by enforcing the guidelines of the Joint Committee on Postgraduate Training for General Practice. They demonstrated that improvements had taken place in the general practice component of training over a nine year period in terms of amount of teaching, existence of a library, attendance at day release, consultation review, regular tutorials, case review, clinical audit, assessment of progress and on-call back up. Regarding hospital training they concluded that "the poor training in junior hospital posts reflected the low priority that training is generally given during tenure of these posts".

The value of vocational training has continued to be questioned with pleas for educational reform (Styles 1990b, Hayden 1991, Higgs 1991). Styles (1990a) stated in the William Pickles lecture that there were three educational goals for medicine in the future "First, we have to secure a greater contribution from general practice to basic medical education. Secondly, we need to ensure that general practice has a greater influence on the content and teaching methods of the hospital component of vocational training. Finally, we must define more clearly the educational and clinical responsibilities of general practitioners and hospital consultants".

Against this background it became apparent there existed an area within medicine which contained many unresolved dilemmas which had not been explored in great detail in the west of Scotland and this became the framework of this thesis. The hypothesis is that the training for general practice is appropriate to the needs of general practitioners. The objective was to ascertain whether vocational training reflects the needs of general practitioners. This was felt to be particularly appropriate at this time because general practice, and in fact the National Health Service itself, have recently been undergoing the most significant changes since the inception of the National Health Service in 1948. The changes began in 1990 with the government's contract for general practice and have progressed to encompass fundholding with the concept of a purchaser/provider health service, continuing postgraduate education, trainee assessment and principal performance assessment. It was felt that vocational training remained a relatively new discipline although one which had progressed considerably since its inception. It is important therefore to address whether training is evolving and responding to the changing needs of general practice and whether it is also striving for excellence. This thesis attempts to answer these questions.

THE JOINT COMMITTEE ON POSTGRADUATE TRAINING FOR GENERAL PRACTICE

The Joint Committee on Postgraduate Training for General Practice is an autonomous body formed in 1975 to implement the Vocational Training regulations. It is composed of representatives of the profession, mainly from the General Medical Services Committee of the British Medical Association and from the Royal College of General Practitioners but also from the universities, consultants and trainees. It is the body responsible for supervising specific training schemes and promoting high standards (through the accreditation of regional postgraduate organisations and individual vocational training schemes) and for the issue of certificates to doctors who have successfully completed training in general practice. Normally this is a certificate of prescribed experience issued to a doctor who has satisfactorily completed periods of training amounting to at least three years whole-time employment. The training period must include at least twelve months whole-time employment as a trainee general practitioner. This time may be continuous or divided between different trainers. The remainder of the training period must be carried out in hospital posts which have been educationally approved for vocational training and must include not less than six months whole-time equivalent employment in two 'A' listed subjects (Appendix B) (Joint Committee on Postgraduate Training for General Practice 1992b).

ACCREDITATION

The Joint Committee is responsible for accrediting regions and training schemes. In each region there is a general practice education committee comprising the regional dean and general practice advisers, representative local practitioners appointed by the local medical committee and members nominated by the local faculties of the Royal College of General Practitioners.

Accreditation takes place if the region or scheme complies with the Joint Committee's requirements for training, as demonstrated through information supplied to the Committee and the results of JCPTGP visits.

In 1989 the Committee altered the basis for accreditation. Until then it had been based on scheme visits by teams carrying out their own informal review every two years. From 1989 accreditation became based on a more comprehensive organisational audit. The Committee adopted the approach of indicating the purpose and aims of training, and the general framework in which it should take place. It then elected that the regions should decide how best to implement training in order to achieve the desired results. Accreditation was therefore to be based on the ability of each regional postgraduate organisation to demonstrate how they achieve their own, and the Committee's criteria and standards for training (Joint Committee on Postgraduate Training for General Practice 1992a).

TRAINER SELECTION

Regional postgraduate organisations are responsible for the selection and reselection of trainers. It is expected that the regional criteria for selection reflect the attributes of the general practitioner and agree with the principles published by the Joint Committee in its document Recommendations to Regions for the Establishment of Criteria for the Approval and Reapproval of Trainers in General Practice 1985 (Joint Committee on Postgraduate Training for General Practice 1992a).

The Joint Committee has specified particular characteristics and qualities for the prospective trainer and training practice. These are listed in Appendix C. It has also agreed certain minimum educational criteria which are essential for the selection process (Appendix D).

Information from both these sources was taken into account when designing the questionnaires utilised in this thesis. It was perceived important that the content of the questionnaires reflected the aims and objectives of the Joint Committee as much as was possible given that the thesis took place over an extended time scale during which there have been important Joint Committee publications. The areas which formed part of the questionnaire were: presence of a library, half-day release attendance, trainee assessment procedures, audit, health promotion, practice management and organisation and records/disease registers. Specific areas from the west of Scotland criteria were also included in the questionnaires, namely, time set aside for teaching, experience of research, use of video, preventative medicine and efficient appointment systems.

The West of Scotland Committee for Postgraduate Medical Education Criteria For Selection and Reselection As Trainers in General Practice are displayed in Appendix E.

HOSPITAL ACCREDITATION

The Joint Committee is responsible for the supervision and accreditation of hospital posts for vocational training in general practice. This can involve inspection but is also based upon information gained from trainees themselves who are interviewed and from specialty advisers, clinical tutors and other consultants on an informal basis.

In Scotland, hospital posts are approved by a regional postgraduate medical education committee for training in general practice which is obliged to demonstrate to the Joint Committee the criteria it uses, and the system by which these are implemented. The criteria should be based on the

recommendations of the Joint Committee. Certain of these recommendations formed part of the questionnaire. For example, relevance of the post to general practice, out-patient experience, protected time for teaching and education, half-day release attendance and trainee assessment methods.

HYPOTHESIS - The training for general practice has been and remains appropriate to the needs of general practitioners.

Vocational training has been established in the west of Scotland since 1968 and became compulsory nationally eleven years later. Since its introduction the value, both in educational and monetary terms, has largely been accepted without question. A few studies have evaluated one component of vocational training, for example the hospital component (Grant et al 1989, Polnay and Pringle 1989, Reeve and Bowman 1989, Smith 1991, Gillard et al 1993) or one year of general practice (Donald 1975) and many of them have involved small numbers of participants (Donald 1975, Freer & Reid 1978, Martys 1979, Thornham 1980, Short 1987).

The first study questioned a large number of doctors who had trained over a twenty year period to evaluate training since it began in the west of Scotland.

This thesis evolved in three stages. (Appendix F) As a result of the lack of large studies on the subject of vocational training assessment, the first study examined a large number of doctors who had trained over a twenty year period to evaluate training since it began in the west of Scotland. There had been no previous study of this size either within the region or nationally and it dealt with both the distant and recent past. It was a large, retrospective, historical study which looked at the doctors' opinions on the hospital and general practice components of their training and also examined their career paths. As the study examined events over an extended time scale it was then possible to compare the responses of those training at different times in order to make an evaluation of how vocational training had developed. The study group was divided in three different ways:

- into two groups: one training prior to 1979 and the other training after 1979, when vocational training became a legal requirement, to assess whether there were any differences in the training between the two groups.
- into three time periods to compare how vocational training had altered over the twenty years.
- into those training prior to and subsequent to the adoption of new criteria for trainer selection in order to evaluate these criteria.

Overall, this study generated a wealth of valuable information which allowed the author to elucidate the relevant issues for vocational training and to develop methodologies which were used to evaluate recent developments in training, eg. new criteria for trainer selection and the 1990 contract. This contract was responsible for the most dramatic change experienced by the Health Service in recent times and thus critical evaluation of its consequences and its effects on training were desirable. This part of the study examined not only the respondents' knowledge but also their skills and attitudes using a questionnaire and a perception of their telephone interview.

The doctors who trained most recently took part in the second study which aimed to examine what constituted current general practice, how vocational training had prepared them for this practice (in particular for the tasks highlighted by the contract) and how training might have to alter. The most recently trained group was selected as it was thought that they would be aware of current general practice concepts and should have had time to settle into the role of general practitioner.

As this group had trained prior to the contract it might be deemed reasonable that their training did not prepare them for all it entailed.

Therefore as a control group, doctors who had trained following the contract were questioned in order to evaluate whether vocational training had prepared them for the contract tasks any differently to the other group and to evaluate how training had altered in response to the changes the contract invoked.

In this latter study the educational content of training was assessed, as the original large study had raised questions regarding the educational adequacy of training. From the results it was apparent that there were particular educational difficulties in the hospital component. Therefore trainees, currently in their trainee year, were questioned in order to obtain information which was as recent as possible, about the educational content of hospital training in an attempt to evaluate its value and relevance to general practice.

CHAPTER 1(i)

SUBJECTS AND METHODS

A questionnaire comprising 57 questions, designed by the author, was mailed to a group of doctors which included Professors, Regional Advisers, Course Organisers, Senior Lecturers, Lecturers and Trainers for their comments. Some alteration took place as a result. It consisted of four sections: personal details, hospital component, practice component of vocational training and details of the training practice. (Appendix G). A pilot study was carried out on a group of 10 general practitioners. After appropriate modification based on their comments, the questionnaire was posted in March and April 1989 to the 1255 doctors identified by examining lists of trainees from 1968 to 1988 from the University of Glasgow Department of Postgraduate Medicine and matching their names with a current address in the medical directory. The maximum number of doctors who could be identified thus was 1255. A reminder letter was sent to those who had not responded four weeks after the initial mailing. They were identified by a number on the first page, it being present only for that purpose. The respondent's name did not appear on the questionnaire. The results were collated on an Amstrad computer using Minitab Data Analysis software version 6.1 and were analysed for all respondents collectively for the hospital and general practice components of training. However, further analysis was performed to compare the responses of those training prior to and subsequent to 1979 when a one year traineeship became compulsory (Chapter 1(iv)). Where significant differences existed in the responses of the two groups, these have been documented. In order to make some comparisons between the responses of those commencing training at different times the long time span of the study, respondents were grouped together as follows by year of commencing training: 1968-75 = 93

respondents; 1976-80 = 209 respondents; 1981-85 = 269 respondents (Chapter 1(v)). (Appendix F).

The methodology employed in this study relied upon respondents' recall of events which had taken place over a variable period of time. The question of memory and recall in retrospective questionnaire studies is an important one. This type of study had never been previously performed in the region, and over the period of time studied, many changes in training and general practice had occurred which had not been evaluated. However, it is important to examine the possible influence of recall on the results.

RESPONSE DETAILS

Initially 543 responses were received with a further 76 following a reminder letter. The General Post Office returned 153 as the individual was no longer known at that address. A further 128 were returned as the name and address had been incorrectly matched and the questionnaire had been sent to the wrong person. If these are deducted from the initial figure sent this gives an overall response rate of 64% $\frac{619}{1255 - (128+153)}$.

$$1255 - (128+153)$$

Data analysis used frequency counts by actual numbers and percentages, and chi square analysis. Significance was set at $p < 0.05$.

CHAPTER 1(ii)

CRITIQUE OF METHODOLOGY

The methodology employed throughout this thesis relied upon respondents' recall of events which had taken place over a variable period of time, and also their current opinion on the value of their training. The studies compared data from groups of doctors who were recalling and valuing events which occurred at different periods of time such as demographic details, number of posts held, presence of a library, methods of consultation monitoring/assessment, and study leave availability/uptake. The doctors were also asked to give their current opinions on aspects of their training, for example, the relevance of hospital posts to general practice, degree of enjoyment of trainee year, their rating of the trainee year, how well training prepared them for practice, level of satisfaction with quality and quantity of teaching in hospital and how well certain topics were covered in tutorials. The issue of memory and recall in retrospective studies is an important one and therefore a literature search in medical, social science, psychology and educational psychology databases was undertaken with assistance from Glasgow and Edinburgh University Libraries and the RCGP Librarian to examine this issue.

Cartwright (1963) wrote that "the accuracy of retrospective studies inevitably depends on memories which are often capricious and invariably selective.

Whether or not an individual remembers a particular event and can place it within the correct period of time depends on many things such as the nature of the event, the length of period he is asked to recall, the significance of both the event and the period for him, the circumstances under which he is questioned and many other factors...”.

Zarkovich (1966) also wrote on the subject of memory errors, “the accuracy of statistical data depends on a large extent upon how exactly past events are remembered”. He referred to the errors in data which occurred as a result of memory lapses as “memory errors” and the resulting bias the “memory bias”. He also described some memory characteristics. “Firstly, most events fade gradually from the memory so that progressively fewer details can be recalled. Secondly, the speed of the fading process varies from one item to another. Some events remain forever impressed on the memory while others fade fast and disappear completely”. This was supported by Gittins (1979) who stated that memory is very selective and what is remembered depends on what has been most important to the individual over time.

Sudman (1974) wrote on the effects of time and memory factors on response. He described two types of error, the “omission error” where a respondent completely forgets an event, and “telescoping” where an event is remembered as occurring more recently than it did. He stated that short and intermediate memory decay exponentially and with telescoping the errors are usually such

that an event is remembered as occurring more recently than it did. He also examined respondent variables and concluded that only age is related to memory. In his study he described an increase in under reporting of events in respondents over 55 years. In this thesis only six respondents were over 50 years, and only one was over 55.

Baddeley (1979) referred to the “forgetting curve” and wrote that the relationship between material retained and time is a logarithmic one, “whether the forgetting results from interference from prior events, from subsequent experience or from spontaneous trace decay”. He referred to two “classical theories of forgetting ... that memory traces decay spontaneously with time, while the other suggests that forgetting occurs because other material interferes with the retention of the relevant information”. He commented that in the 1930’s it was shown by Sir Frederick Bartlett that remembering is a process of reconstruction: the event is interpreted, in the light of the individual’s background knowledge, to reconstruct the event.

Much of the above relates primarily to the recall of actual events or incidents. This thesis also involved respondents giving opinions and giving a value judgement on past events. Thus, the comments on reconstruction are important, since people may re-interpret things which have occurred in the past in light of subsequent experiences. This would apply to the thesis and the respondents’ perceptions of their earlier training may alter as a result of their

intervening experiences. For example, a doctor who has worked in a single handed rural practice may have a different view of the adequacy of his training than a newly qualified doctor who has recently commenced a job in a six partner inner city practice. The latter doctor will be commenting on how he thinks his training has prepared him for practice but with less experience of what practice actually constitutes.

Thus Hindley (1979) described how people “apperceive” things in relation to their accumulated experience, and that this not only “implies that our perceptions are affected by the immediately present situation, but by our past experience, our feelings and attitudes, and our values”. Other factors affecting perception were: the level of specialised knowledge and interests, a poor level of understanding, low intelligence and mental illness. Many of which would not be applicable in this thesis. He discussed the finding that people tend to perfect their memory images, either to give a clearer form or to make them conform more closely to the interpretation the person has placed on the memory. He commented on the work of Freud on how feelings can lead to selective forgetting, to denial and suppression of unpleasant occurrences, and to projecting feelings onto others.

Sudman (1974) stated with regard to past experience that “it is possible to ask respondents about past and present attitudes and to compare them, but the

results are then a mixture of actual attitude change and memory error that cannot be separated”.

Hindley (1979) described three types of retrospective data which can be sought by interview methods. Firstly, actual events, secondly, past behaviour of self or others and lastly, past feelings, attitudes. In this thesis the respondents are being asked about current feelings and attitudes on past events and experiences but this is not directly addressed.

Hoinville (1977) also addressed the problem of memory and attitude measurements. “It is not possible, for example, to obtain accurate answers retrospectively about the attitudes that middle-aged respondents held when they left school and their aspirations at the time. Their subsequent work experience and the passage of time will mean that the answers are unlikely to be accurate.” Whereas this is not directly applicable in the thesis as respondents were being asked to give their current opinion on their past and not their past opinion, it does highlight a difficulty with the methodology employed in this thesis. Ways in which to improve recall have been documented but they mostly apply to recall of events or behaviour and not opinions. Simon (1969) suggested giving subjects diaries to keep a note of their behaviour over time. Another strategy is to compare recalled events with existing records. However, neither is directly applicable to this thesis.

Regarding the recall of factual information there were a number of studies found which were generally positive. However, it should be noted that all these studies lie within the medical field and not the educational field, which is the area of this thesis. No similar studies were found in the educational literature. In 1992 Nischan examined the accuracy of recall of use of an intrauterine device and found that "agreement on total duration, number of IUD episodes and time since last IUD use was excellent". Similarly in 1985 Tilley et al compared pregnancy history recall, after 10 or more years, with medical records. They found that "except for the history of hospitalisation and trunk x-ray, no differences were observed in agreement (questionnaire compared with record)". They also concluded "we also observed results that are encouraging for those doing retrospective interview studies". This was supported by Krall et al who studied recall of childhood illnesses, and found that self-reports at age 50 of several illnesses were highly accurate except for German Measles. Similar levels of accuracy were consistently found among a subset who also completed health history interviews 8 and 20 years earlier.

Byers et al assessed the reliability of retrospective dietary reports. They reported that the best estimate of diet from several years in the past may be derived directly from a retrospective dietary history which focuses on that past period of time. Another study examining diet was performed by Wu et al in 1988. They studied the long term recall of dietary intakes. They compared

retrospectively recalled and currently reported nutrient intakes and measures of body size with original reports obtained in 1972. They found that mean values of recalled nutrient intake agreed with mean values of intakes reported in 1972. In 1990 Hislop reported on a study to examine the reliability of dietary recall for the distant past using a food questionnaire. He found that for most food items there were similar degrees of agreement in response between the two questionnaires. In 1991 Blair et al studied the reliability of long term recall of participation in physical activity by middle aged men and women. They concluded that questionnaire assessment of long term physical activity recall appeared to be reliable, length of recall interval up to 10 years was not an important factor. Therefore it would appear that recall does not have a significant effect on the accuracy of results in retrospective studies.

Therefore to conclude, it would appear that recall and memory are of importance in the methodology of this thesis, and may have had some effect. However, from an extensive review of the wider literature it is difficult to quantify the precise magnitude of the effect of memory and recall in retrospective studies over time.

Cherry and Rodgers (1979) wrote that “the best that a retrospective enquiry can hope to achieve is an approximation of the event or condition as experienced by the participants”. Moss (1979) called for more research, stating “continuing research seems all the more necessary since it seems clear that, in some form or

another, retrospection - asking informants to recollect experiences or behaviour - will remain a necessary research tool". He also went on to declare that regarding social research methods, "perfection is not possible, the next best thing is awareness of error or the possibility of error and the clear recognition of the limitations of data when reporting research results".

Therefore it would seem that the aforementioned difficulties with memory and recall in retrospective studies are accepted. However, the evidence does support the methodology involved in this thesis, as retrospective studies remain a valuable research technique.

CHAPTER 1(iii)

An Assessment of the Hospital Component of Vocational Training

INTRODUCTION

The aim of vocational training is that all doctors in general practice in the National Health Service should receive appropriate postgraduate training of a certain standard which thus enables them to competently perform the duties of a general practitioner. As stated by Sir Denis Hill, "The family physician's role is a difficult one. If it is to be sustained and developed the general practitioner must become the most educated, the most comprehensively educated of all the doctors in the Health Service" (Gray 1986). Therefore it is essential that efforts are made to evaluate the effectiveness of vocational training. This chapter presents the views of respondents, who commenced training in the west of Scotland between 1968 and 1985 (completed by 1988), on the hospital component of their training and on their careers.

RESULTS

Characteristics of Respondents

Of the 619 who responded 243 (39%) were female and 376 (61%) male. Their ages ranged from 26 to 56 with a median of 34 years. The majority, 502/618 (81%), were married, 101 (16%) were single, 8 (1%) divorced, 3 widowed, 2 separated and 2 remarried. Their dates of graduation ranged from 1956 to 1984. Scotland was the place of graduation for 530/613 (87%), England and Wales for 45 (7%), Ireland for 19 (3%) and abroad for 18 (3%). The number of postgraduate qualifications held by those questioned ranged from none to six with a median of two. The types of postgraduate qualifications were; M.R.C.G.P. 364/511 (71%), D.R.C.O.G. 355/511 (69.5%), D.C.H. 69/511 (13.5%), Family planning certificate 60/511 (12%), M.R.C.P. 36/511 (7%),

M.S.C. 4/511 (<1%), Diploma Anaesthetics 17/511 (3%) and M.R.C.O.G. 3/511 (<1%). Of the respondents 338/603 (56%) had been on a self-constructed training scheme, 254 (42%) on a formal training package and 11 (2%) had been on a combination of the two.

A total of 1255 questionnaires were initially sent with 619 final replies. 218 were returned by the G.P.O. leaving 355 non-responders. In order to ascertain whether the responders are representative of past trainees the non-responders were examined by consulting the medical directory.

The medical directory provided information on 337 of the non-responders. Of these 138 (41%) were female, 197 (59%) male, or not known (two). They graduated between 1956 and 1986. The number of postgraduate qualifications held ranged from none to five. The qualifications were MRCGP 120/337 (36%), DRCOG 129/337 (38%), BSc 29/337 (9%), DCH 28/337 (8%), MRCP 26/337 (8%) and MRCOG 4/337 (1%).

While the sex ratio and date of graduation are similar for the responders and non-responders, the non-responders are significantly less likely to hold the MRCGP (chi-square=104 df=1 $p<0.00001$). It may be that although equally likely to hold other specialist qualifications non-responders are less academically orientated with regard to general practice and therefore less likely to reply to a general practice questionnaire study.

Career Path

Of those questioned 608 (98%) were in employment at the time of the study. Only 11 respondents were not working and in only one case was this involuntary. 83% of those employed were working in general practice. The range of jobs held by those not in general practice is shown in graph 1.

Unemployment had been experienced at some point by 202/609 (33%). More females had been unemployed 122/241 (51%) than males 80/368 (22%). This difference was statistically significant (chi-square = 54.8, df1 $p < 0.001$). The reasons given for a period of unemployment were as follows (some gave more than one answer): maternity and family commitments 74, no job available 51, awaiting job commencement 24, travel or holiday 28 and moving house 14. The number of jobs which respondents had held since completing vocational training ranged from 1 to 16. 305/559 (55%) had held only one job, 137 (24.5%) had held two jobs and 117 (20.5%) had held three or more. Just over half had worked as a locum 316/570 (55%). Time spent as a locum ranged from one session to seven years, with a median of two months. Other additional commitments were held by 284 respondents (46%). Graph 2.

Hospital Component of Training

The vocational training of the respondents commenced between 1968 and 1985. The number of post-registration hospital posts they held ranged from one to ten. All had post-registration experience in hospital, 11/587 had one post (2%), 29 had two posts (5%), 91 had three posts (15%), 317 had four posts (54%), 100 had five (17%), 34 had six (6%), 2 had eight and 3 had ten. The hospital specialties performed are shown in Graph 3. The respondents were asked to state which of the posts they considered most necessary to general practice. The results are shown in Table 1. Medicine and obstetrics were rated highest with 72% of those who had worked in each specialty considering them important. However, only 45% of respondents had held a medical post. Of those, 61% had been on a formal training scheme and only 34% on a self-constructed scheme, a statistically significant finding, (chi-square=77.65, 1df $p < 0.001$).

In retrospect 41% wished they had chosen a different hospital post, usually in addition to those held. The posts they wished they had held were: paediatrics 67, dermatology 52, medicine 46, psychiatry 43, ear, nose and throat medicine (ENT) 40, ophthalmology 32, accident and emergency medicine 17, gynaecology 26, geriatrics 11 and obstetrics 19.

In 1982 it became a legal requirement that two of the three years of training should be spent in hospital (NHS Act (1977), NHS regulations 1979). Of the respondents who trained before this 84% felt the length of time they spent in hospital was correct, 6% felt it too long, 8% felt it too short and 2% were uncertain. After 1982 the figures were not dissimilar with 83% considering the time correct, 6% too long, 10% too short and 1% uncertain. It did not appear that prior to 1982 less time was spent in hospital because 74% had held four or more hospital posts. Of the respondents 74.5% felt the majority of their senior hospital colleagues regarded them as a junior hospital doctor and not as a trainee for general practice.

DISCUSSION

Before discussing the results of this aspect of the study, it is important to consider its merits and demerits. One merit of this study is that it has not been performed before on such a scale either within the west of Scotland or nationally. Another merit of the methodology is that an attempt was made to identify the whole population.

The response rate achieved was 64%. This is a fairly average response rate for a study among doctors. Sibbald et al (1994) reviewed the British Journal of General Practice for the period January 1991 to June 1993 inclusive, and found 26 original papers in which British general practitioners had been surveyed. The mean response rate was 61%. They concluded that the true

situation may be worse than this as papers with lower response rates may not be accepted for publication.

Sibbald et al suggested that non-response to postal surveys was associated with lack of activity in the study area. Therefore the area in this study may have been considered too specialised or too academic. As mentioned in the next chapter the non-responders were found to be significantly less likely to hold certain general practice postgraduate qualifications and it is possible that they were less interested in academic general practice or did not perceive it relevant to themselves.

The questionnaire used in this study was long and therefore a 64% response rate despite this is good. Sibbald (1994) stated that the following are important factors influencing total response; perceived relevance of the questionnaire, number of approaches, investigating agency, type of population surveyed and questionnaire length. Therefore the response rate achieved could be classified as a merit of the study but also a demerit as ideally a higher rate would always be preferable.

The study was of a retrospective descriptive design, with results pertaining to only one region in Scotland and therefore the results may not be representative of other regions. However, the aim of this part of the study was to demonstrate an improvement within our own area and this objective could be applied elsewhere.

In this study male respondents outnumbered female respondents. Since 1979 the intake of medical students at Glasgow University has had a sex ratio of 1:1. However, some respondents entered medical school prior to this with a small

number graduating in the early 1950's and this may account for the ratio in the study of 1.6:1 (male:female).

The majority were married, with only 1% divorced, well below the current Scottish rate of 1 in 4 (Registrar General Scotland 1992). This is surprising for it is often reported in the lay press that the medical profession has a relatively high rate of alcohol abuse and marital discord compared with other types of employment. The low rate in this study may be due to the mean age of respondent (34) combined with a tendency to marry late.

It is interesting that only 9% had no postgraduate qualifications. If the 10% who failed to answer this question were assumed to also have no qualifications this would give a maximum of 19% which, given the scale of the study, is still low.

Encouragingly, 98% were employed, and unemployment, although covered frequently in the popular press did not seem to be a problem. However, 33% had experienced a period of unemployment and it therefore appears that many doctors do have career breaks for various reasons. This was also found in a study of doctors receiving a certificate from the Joint Committee on Postgraduate Training for General Practice during 1982 and 1983 (North 1985). Thirty two percent of respondents from 1983 had experienced unemployment with 17% from 1982 (North 1985). This was particularly so for females where the commonest reason was family commitments, as previously reported (Parkhouse 1989).

Over 80% were working in general practice, and of these 43% were in a training practice. However, in the west of Scotland only 26% of practices are training practices (personal communication T S Murray). The difference may

be because respondents in a training practice may have been more likely to respond to the study as they perceived it of relevance to them or because some respondents were working outwith the region.

It is interesting that 45% of respondents had held more than one job since completing their training but there was no trend over the time period of the study. It was not known from the results whether the jobs were in general practice but it may be that respondents who completed their training more recently are more mobile than their predecessors as they have effectively had more than one job over a shorter period of time.

The most commonly held hospital posts were obstetrics, gynaecology, psychiatry, paediatrics and medicine. This echoes the findings of Styles (1989, 1991) Short (1987) and Thornham (1980). The posts considered most relevant for general practice were medicine and obstetrics. Among the 18 arranged training schemes in the west of Scotland 13 include a medical post. However, those trainees on a self-constructed scheme obviously found it more difficult to obtain such a post (61% formal scheme, 34% self-constructed scheme). Equal proportions of respondents who had held an obstetric post had been on a self-constructed and formal training scheme. This is surprising as there is a myth that obstetric posts are difficult to obtain for trainees who construct their own scheme.

Another commonly held belief is that in terms of vocational training, medicine and geriatrics are of equivalent value. However, this was not the case in this study where geriatrics was rated relevant by 47% of respondents compared with a rating of 72% for medicine. Gynaecology was not rated as being particularly relevant as reported previously (Martys 1979). This is perhaps surprising as gynaecology is an important component of general practice.

However, this may reflect the fact that in some posts the balance of teaching is incorrect, with time being spent in theatre assisting and in admitting elective patients whereas attendance at outpatients may be more relevant.

Paediatrics was rated highly in terms of relevance to general practice. In view of this, it is therefore worrying that 48% of respondents had no experience of this specialty. Of those who had, 62% had constructed their own training and therefore it would appear that more formal schemes should include paediatrics. Dermatology was rated as the third most relevant post, although only 11% of respondents had held such a post. However, in view of the fact that those who worked in this specialty rated it so highly, perhaps it should become incorporated into more formal schemes. Ophthalmology and E.N.T. were not highly rated; however 40 and 32 respondents wished they had held a post in E.N.T and ophthalmology respectively. Perhaps the answer lies in promoting attendance at outpatient clinics in these specialties during the trainee year.

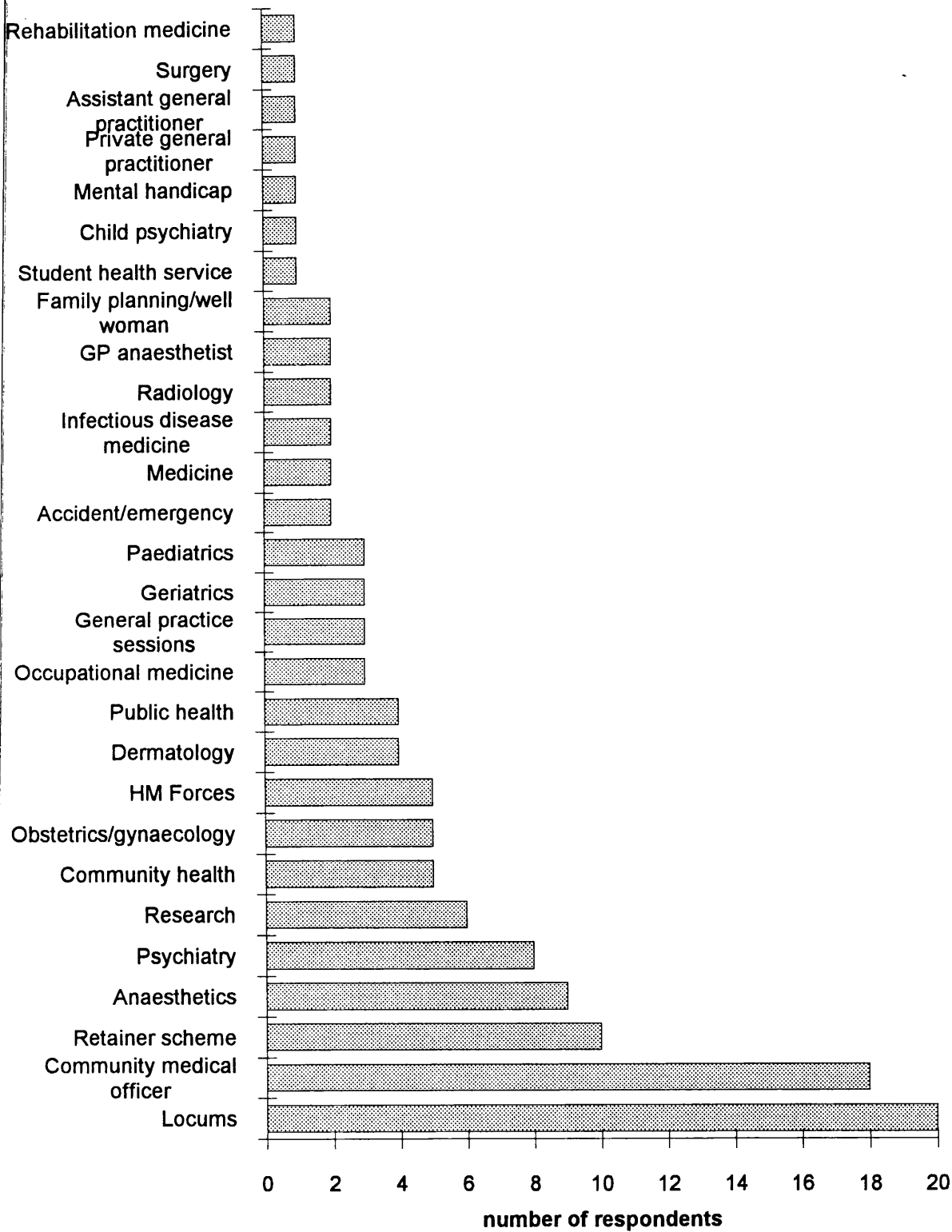
This study demonstrates that there is still a problem for trainees being identified as junior hospital doctors when they should be earmarked as trainee general practitioners (Crawley and Levin 1990). This needs to be corrected before training can be appropriately directed and focused during the hospital component of vocational training.

SUMMARY

This study found that career breaks were experienced by one third of respondents, particularly females. It appears that more posts are required for vocational training in medicine, paediatrics and dermatology and that outpatient attendance should be encouraged in gynaecology, ophthalmology and E.N.T. During hospital training it is not evident to senior medical staff which doctors are general practice trainees.

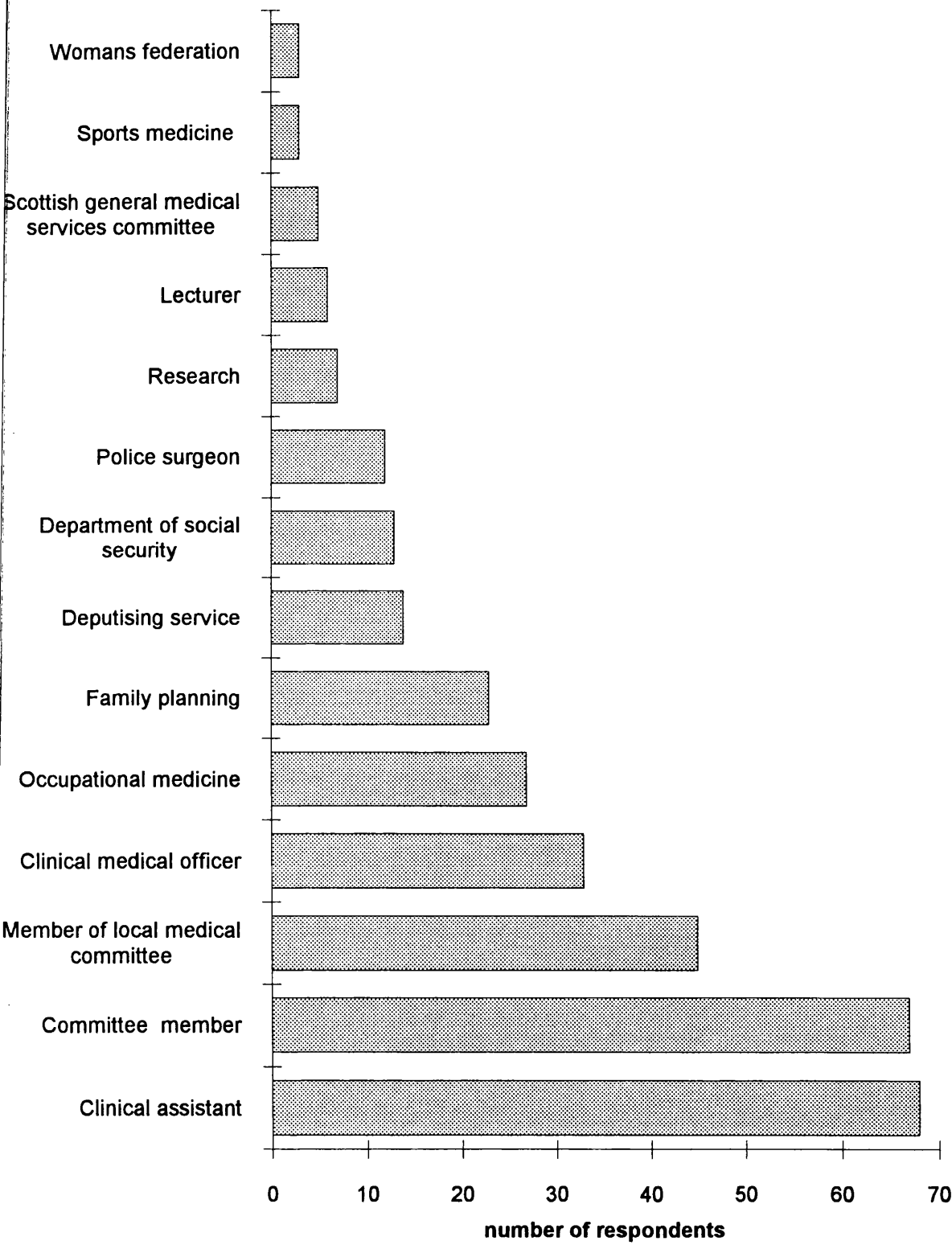
GRAPH 1

Current Employment



GRAPH 2

Additional Professional Commitments



GRAPH 3

Hospital Posts Held

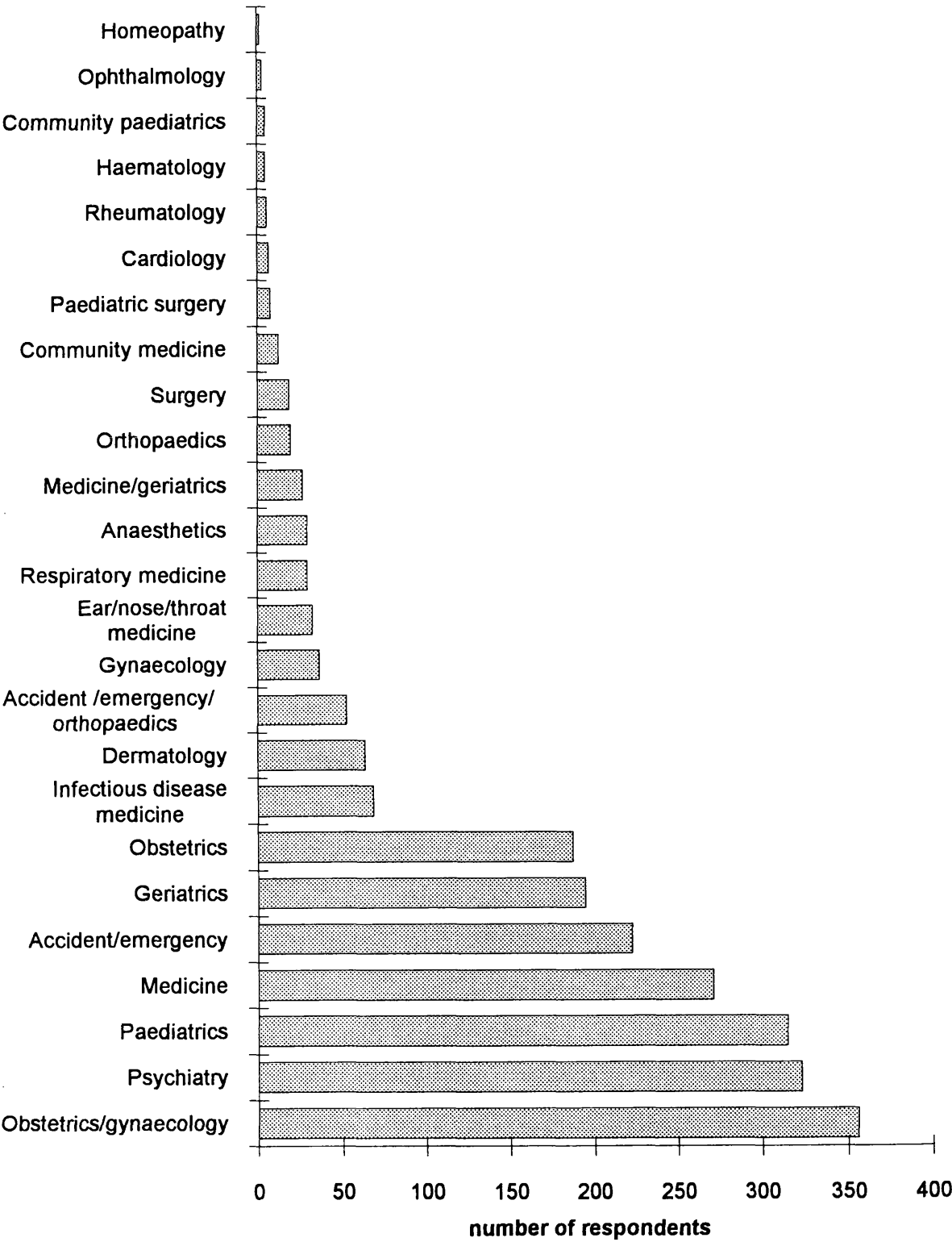


TABLE 1**The Most Necessary Hospital Posts**

	Number	Percentage
Medicine	162/225	72
Obstetrics	109/152	72
Paediatrics	181/259	70
Dermatology	33/48	69
Accident & Emergency	102/173	59
Psychiatry	150/259	58
Gynaecology	15/27	55
Geriatrics	73/155	47
Infectious Diseases	24/55	44
E.N.T.	9/25	36

CHAPTER 1(iv)

An assessment of the general practice component of vocational training.

INTRODUCTION

This chapter presents the views of respondents who commenced vocational training in the west of Scotland from 1968 - 1985, on the practice component of their training. As vocational training became a legal requirement in 1979, the respondents were divided into those who trained before and after this event (1968-79, 1980-85). The results presented relate to all respondents except where there was found to be a significant difference between those training before and after 1979, when those are presented in full in the text.

RESULTS

General Information

Among the 619 respondents 500/612 (82%) had experienced a choice when selecting a training practice. 529/615 of the respondents (86%) had spent 12 months as a trainee for general practice. Only 58 (9.5%) had spent 18 months. The remaining 28 respondents had spent time as a trainee ranging from 3 months to 24 months. Only 86 (15%) wished that the length of time as a trainee had been different (Table 2). Only 61/616 (10%) of the respondents had participated in practice exchanges but 93% of those who had participated found the experience helpful and 67% of those who had not participated felt it would have been helpful. However this question was only answered by 440 respondents.

The Training

Encouragingly 575/614 (94%) enjoyed their trainee period. Of those who did not, only 15/40 (37%) specified one or more reasons. The reasons given were as follows: little teaching (3), felt overworked (3), personality clash with doctor in

practice (3), little supervision/training (3), busy on-call (2), and did not like general practice (3). When asked if they would select the same trainee post again in retrospect 461/595 (77%) stated they would. The reasons given for not selecting the same post are shown in Table 3. Despite the fact that so many enjoyed their trainee period 300/612 (49%) felt that some topics had been poorly covered or omitted from their training. The topics considered to have been omitted are shown in Table 4. The respondents in the cohort training prior to 1979 were significantly more likely to have considered topics to have been omitted (139/250 56%, pre 79, 144/315 46%, post 79, chi square=6.716 df=2 $p>0.05$).

The respondents were questioned about the frequency of tutorials during the training period, and on their usefulness as assessed on a 5 point Likert scale. The results for tutorial frequency were: weekly tutorials 188/615 (31%), most weeks 171 (28%), every few weeks 154 (25%) or never 101 (16%). The respondents training after 1979 were significantly less likely never to have had tutorials (75/253 30%, pre 79, 20/313 6%, post 79, chi square=61.053 df=3 $p>0.001$). The results for tutorial benefit are: very beneficial 79/508 (15.5%), beneficial 326 (64%), not particularly beneficial 84 (16.5%), useless 13 (3%) and not sure 6 (1%).

The methods of consultation monitoring experienced are displayed in Table 5. Sitting in on the consultation was the most commonly experienced method of assessing trainee performance.

Study leave was permitted for 417/617 respondents (68%) and of those permitted leave 317/417 (76%) took some. Those respondents training prior to 1979 were significantly more likely not to know whether study leave was permitted (73/253 29%, pre 79, 61/315 19%, post 79, chi square=7.025 df=2 $0.02> p>0.05$). 202/607 respondents (33%) had been encouraged to become involved in research in general

practice, but of these only 62 (31%) had taken part in any research. Those respondents training prior to 1979 were significantly less likely to have been encouraged to become involved in research (41/252 16%, pre 79, 144/308 47%, post 79, chi square=58.219 df=1 $p>0.001$). The majority of respondents, 512 (84%), had received encouragement to sit the MRCGP examination while a trainee. 273/614 (45%) had been encouraged totally, 239 (39%) partially and 101 (16%) had received no encouragement at all. Respondents training after 1979 were significantly less likely to have received no encouragement to sit the examination (63/252 25%, pre 79, 29/313 9%, post 79, chi square=28.585 df=2 $p>0.001$). 600/616 respondents (97%) had attended a half-day release programme while a trainee. Those who attended rated the programme's usefulness as: very useful 131/593 (22.1%), useful 286 (48.2%), not particularly useful 136 (23%), useless 19 (3.2%) and did not know 21 (3.5%). The respondents were invited to give an overall rating of the trainee period as assessed on a six point scale. The results are displayed in Table 6. Respondents training after 1979 were significantly less likely to rate their trainee period in the category fairly poor/poor/very poor (39/252 15%, pre 79, 29/315 9%, post 79, chi square=9.054 df=3 $0.02>p>0.05$).

The Training Practice

Only 289/610 (47%) of the respondents trained in a practice where all partners were involved in training. 428/616 (70%) trained in a practice with a library although training in such a practice was significantly less likely among the cohort who trained prior to 1979 (123/255 48%, pre 79, 268/313 86%, post 79, chi square=91.699 df=2 $p>0.001$). Just over half, 358/615 (58%), had attended practice meetings and of those who had not (252) in only 11 cases was it their decision and not that of the practice. The cohort training prior to 1979 were significantly less likely to have attended practice meetings (124/254 49%, pre 79, 199/313 64%, post 79, chi square=7.233 df=1 $p>0.01$).

The respondents were asked to comment on the out of hours cover provided by their training practice. Their responses are detailed in Table 7. The proportion of out of hours cover they had done as a trainee was also ascertained. 159/614 (26%) had done less than their trainer, 385 (63%) had done the same, 63 (10%) had done more than their trainer and 7 (1%) did not know. 509/608 (84%) were satisfied with the amount of on-call they had done. Respondents in the post 1979 cohort were significantly less likely to consider the amount of on-call they had done to be about correct (28/250 11%, pre 79, 17/309 5.5%, post 79, chi square=7.055 df=2 0.02 $p>0.05$). Finally the respondents were asked if in retrospect they now wished they had pursued a different career. 81/613 (13%) stated they wished they had and a further 78 (13%) were uncertain.

DISCUSSION

One of the merits of this study is that it evaluates the effect that vocational training becoming a legal requirement had on training. To do this the respondents were divided into two groups, one training prior to and the other after 1979.

As the study sample is the same as that in Chapter 1(iii) (page 38) the comments on the response rate also apply here, namely that such a study has not been performed before, either in the region or nationally, that an attempt was made to identify the whole population and that the response rate of 64% is relatively good.

In this study over 90% of respondents enjoyed their time as a trainee as previously reported (Thornham 1980). However, it is important to examine the reasons given by those who did not enjoy it. Among the 15 who specified a reason some would be difficult to predict in advance, for example not liking general practice or a personality clash with another doctor in the practice. While only six gave poor training as a reason, if one looks at the respondents' overall rating of the trainee

period 72 respondents (12%) rated it as poor/fairly poor/very poor. Therefore it would appear that trainees can enjoy their time as a trainee without necessarily experiencing quality training. This may be because trainees have difficulty differentiating what constitutes good training and it may be only in retrospect as a principal that this becomes possible.

It was disappointing that almost half the respondents considered some topics to have been omitted from their training, although encouragingly this was significantly less among respondents training after the trainee year became compulsory. As in previous studies the most consistently omitted subjects were practice management and finance (Whitfield 1966, Freer and Reid 1978, Short 1987). Whether the problem is that trainees are indeed not well informed on these subjects or whether they are not sufficiently motivated to learn and understand them remains uncertain. However, this point formed one area of questioning in a subsequent study (Chapter 3(ii)). It is obviously not possible for the trainee period to cover all aspects of general practice nor could it, for the trainee year forms only one part of an educational spectrum which commences with medical school and may end with retirement. However, these topics are important ones and it should be possible for certain topics be covered with all trainees and then subsequent learning could depend on each trainee's identified learning needs.

Another important finding was that 16% of respondents had not had any tutorials and 25% had received them only occasionally. However, more positively, those respondents who trained after 1979, once the trainee year was compulsory and tutorials were recognised as a training regulation, were significantly more likely to have had tutorials.

Although most respondents were entitled to take study leave, not all did so, as reported previously (Whitfield 1966). There could be many explanations for this;

however, it is an important finding because study leave is educationally an integral part of training (Ronalds et al 1981). As may have been predicted and this study confirmed, few respondents had been encouraged to become involved in research as a trainee and even less had done so (Whitfield 1966, Martys 1979). This may be because trainees were disinterested, lacked motivation or felt time a problem perhaps reflecting the views of their trainers. Perhaps the value of research both personally and professionally could be stressed at a day release course and small projects could be promoted. This has now been occurring in the west of Scotland and from August 1992 when an audit project became compulsory as part of the region's end-point assessment scheme.

Considering that the presence of a library only became a requirement for a training practice in 1987 and this study extends from 1956, a surprisingly high number of respondents (70%) had trained in a practice with a library. Very few had taken part in a practice exchange whereby the trainee spends a short period of time in another practice which is different from his/her own. Of those who had taken part, almost all considered it beneficial and it would appear that trainees should be encouraged to exchange practices even for a short period of time (Donald 1975). This is in fact encouraged in the region but the main resistance is from the trainees themselves and it may be that trainees only appreciate the relevance of the exercise retrospectively, once they have been in practice.

The amount of on-call undertaken in the trainee year has long been recognised as of prime importance to trainees. The current recommendations are that a trainee should not be expected to have a larger on-call commitment than the trainer. While in this study 90% had experienced the same or less on call than their trainer, it is of concern that 10% had done more. This finding requires further investigation for it may be that some trainers employed a locum or a deputising service for their nights on call and therefore their trainee was effectively on call

more often than the trainer. It is interesting that 55% had trained in a practice which provided all of its own out of hours cover. If those in practices which shared the cover with one other practice, two other practices, or shared weekends only are included, this brings the total to 74% which is higher than may have been expected. Only 5% trained in a practice which used a commercial deputising service exclusively and a further 12% trained in a practice which used the service to some extent giving a total of 17%. This is somewhat lower than figures by Donald (1975), who quoted 20% for exclusive use, although his sample size was considerably smaller, and is slightly higher than Thornham's figure of 11%, (1980).

This study emphasises that the opinions of past trainees are a worthwhile and underutilised source of valuable information which is of importance to all bodies involved in vocational training.

SUMMARY

The main findings were that 94% had enjoyed their time as a trainee. The most common method of consultation monitoring, experienced by half of the trainees, was sitting-in on the consultation. For the majority, regular tutorials were commonplace; however, for 41% this was not so. 49% felt that certain aspects had been omitted from their training, notably practice management and finance. When asked to give a rating of their training only 12% rated it as poor. Few had participated in a practice exchange but almost all of those who did felt it beneficial.

TABLE 2

Reasons Given by those desiring a different
length/arrangement of the trainee period
(Number of respondents answering question - 84)

<u>Reason</u>	<u>Number of Respondents</u>	<u>%</u>
Some time in General Practice before hospital training	19	22.6
Experience of two different practices	16	19.0
Two periods of 6 months	13	15.5
Two periods of 8 months	7	8.3
12 months not 18 months	6	7.1
18 months not 12 months	6	7.1
Continuous training, not split	5	6.0
General Practice at end of training	4	4.8
Practice exchanges	4	4.8
One practice, not two	2	2.4
6 months only	1	1.2
5 year training	1	1.2
Total	84	100

TABLE 3

**Reasons given by those who in retrospect would
not choose to repeat their trainee year
(Number of respondents answering question - 92)**

<u>Reason</u>	<u>Number of Respondents</u>	<u>%</u>
Different training practice	39	42.4
Different career	9	9.8
Different trainer	9	9.8
Prefer 2 practice experience	8	8.7
More training	7	7.6
Less travelling	3	3.3
Longer time in practice	2	2.2
Practice in different area	2	2.2
More structured training	2	2.2
12 months continuously, not split	2	2.2
Somewhere involving more travel	2	2.2
Trainee year at end of training	1	1.1
On-call too busy	1	1.1
More cover when on call	1	1.1
1 practice not 2	1	1.1
Different appointment time	1	1.1
More feedback and audit	1	1.1
More Christian partners	1	1.1
Total	92	100

TABLE 4

Aspects omitted from training
(Number of respondents answering question - 300)
(Some named more than one omission)

<u>Aspects Omitted</u>	<u>Number of Respondents</u>
Management	108
Finance	97
Business	40
Administration	37
Teaching	34
Clinical Topics	13
Professional relationships	12
Regular tutorials	9
Partnership problems	7
Health Board claims	3
Night visits	2
Private treatment	1
Exam preparation	1
Responsibility of practice	1
Stress management	1

TABLE 5

Method of Consultation Monitoring Experienced

(Number of respondents answering question - 592)

<u>Monitoring</u>	<u>Number of Respondents</u>
Sitting in on consultation	304
Parallel consulting	159
Video	88
Audio	60
OTHER:	
Case discussion	43
Patient feedback to trainer	4
Audit referrals	3
Audit prescriptions	2

TABLE 6

Respondents' rating of trainee period

(Total number of respondents answering question - 615)

<u>Rating</u>	<u>Number of Respondents (%)</u>	
Excellent	128	(21%)
Very Good	227	(37%)
Fairly Good	188	(31%)
Fairly Poor	48	(8%)
Poor	15	(2%)
Very Poor	9	(1%)
Total	615	(100%)

TABLE 7

Description of out-of-hours care provided
by training practice

(Number of respondents answering question - 600)

<u>Description</u>	<u>Number of Respondents</u>
All done by practice	330
Shared with 1 practice	82
Local DDS	49
Occasional commercial DDS	32
All commercial DDS	30
Share weekend with 1 practice	27
Commercial DDS after 11 p.m.	16
Commercial DDS at weekends	12
Share with 2 other practices	5
DDS at weekends and some nights	5
Mostly commercial DDS	4
DDS at weekends and after 11 p.m. every night	4

CHAPTER 1 (v)

A comparison of vocational training over twenty years

INTRODUCTION

The aim of this part of the study was to question doctors who had commenced vocational training between 1968 and 1985 to demonstrate whether improvements had taken place in vocational training in the west of Scotland over this period. The respondents were divided into three groups: 1968-75, 93 respondents, 1976-80, 209 respondents and 1981-85, 269 respondents.

RESULTS

Basic Data

There were significantly fewer women among those who commenced training from 1968-75, 26% (24/93) as compared to 39% (81/208) in 1976-1980 and to 42% (113/269) in 1981-85 (chi-square = 7.7, df2 $p < 0.025$). The range of postgraduate qualifications held was from 0 to 6, median 2, and there was no significant difference in the number held among those training at different times. There was no difference between the three groupings with regard to the ratio of respondents who had been on a self-constructed or formal scheme.

Career Path

Overall 607/619 respondents were employed (98%). However, among those training from 1981-85 there were significantly fewer in general practice, 78% (208/265) compared with 1968-75, 90% (84/93) and 1976-80, 88% (180/204), (chi-square = 11.465, df2 $p < 0.005$). This finding was independent of the sex of the respondent. The likelihood of being a principal became significantly less over the three bands (chi-square = 6.204, df2 $p < 0.05$). Additional professional commitments were held by 284 respondents (46%). Additional

commitments became significantly less common over the three bands (chi-square = 10.5, df2 $p < 0.01$).

Practice Component

Overall from 1968-1985 83% (458/551) respondents had experienced a choice when selecting a training practice. This became more likely over the three time bands (chi-square = 8.008, df2 $p < 0.025$). Those responding were asked to give an overall rating of their trainee period as assessed on a six point scale (Graph 4). Over the three time bands the rating significantly improved (chi-square = 11.382, df2 $p < 0.005$). In parallel with this, over the time period surveyed, respondents were significantly less likely to consider aspects to have been omitted or poorly covered during their trainee period (chi-square = 8.324, df2 $p < 0.025$). Overall, however, 300/612 respondents (49%) felt some aspects to have been omitted. Among those training between 1981-85 144/315 (46%) felt some aspects had been omitted.

Of the respondents from 1968-1985, overall 78% (424/541) would choose to repeat the same trainee post. Respondents commencing training from 1981-85 were significantly more likely to choose to repeat the same post 83% (210/253) as opposed to 76% (67/88) from 1967-75 and 73.5% (147/200) from 1976-80, chi-square = 6.263, df2 $p < 0.05$). The respondents were questioned on the frequency of tutorials during the trainee period. Respondents who had commenced training from 1968-75 were significantly less likely to have had tutorials (chi-square = 83.491, df6 $p < 0.001$) (Graph 5). Overall the most popular methods of consultation monitoring were: sitting-in on the consultation 51%; parallel consulting 27%; video recording 15%; and audio recording 7%. The use of video was significantly more likely in 1981-85 than previous years, (1967-75 0/90, 1976-80 12/184, 1981-87 64/257, chi-square = 50.138, df2 $p < 0.001$) (Graph 6).

Two-thirds (68%) of those who responded had been permitted to take study leave and of those permitted, 76% took some. Both being allowed study leave and taking it became more likely over time (chi-square = 10.856, df4 $p < 0.05$) and (chi-square = 6.106, df2 $p < 0.05$). With regard to research 33% stated that as a trainee they had been encouraged to develop an interest in research. The respondents commencing training from 1981-85 were significantly more likely to have been so encouraged than the two earlier groups, 1967-75 15/92, 1976-80 41/205, 1981-85 129/263, (chi-square = 57.876, df2 $p < 0.001$). The majority of respondents stated that they had been encouraged to sit the MRCGP examination while a trainee. Those respondents commencing training from 1968-75 were significantly less likely to have been encouraged (chi-square = 34.78, df4 $p < 0.001$).

Only 10% of the respondents had taken part in a practice exchange and of these 93% considered the experience helpful. Respondents were significantly more likely to have taken part in an exchange if they had commenced training from 1968-75 (chi-square = 8.652, df2 $p < 0.025$).

The respondents were invited to comment on the proportion of out-of-hours cover they did for their training practice. Their responses were, less than trainer 143/558 (26%), same as trainer 359/558 (64%), and more than trainer 56/558 (10%). Those respondents commencing training from 1980-85 were more likely to have had the same amount of on-call as their trainer (chi-square = 12.759, df4 $p < 0.025$).

DISCUSSION

One of the merits of this study is that it divided the study population used in Chapter 1(iii) into three time periods (1968-75, 1976-80 and 1981-85) to allow

vocational training to be evaluated over this timescale. Such a study has not been performed previously either within the region or nationally.

One of the merits/demerits of this methodology is that the comments made on the study response rate in Chapter 1(iii) (page 38) also apply here as the study population is the same. Also while the number of respondents in groups 1976-80 and 1981-85 are similar, 209 versus 269, there are fewer respondents in the earlier time period 1968-75, 63 respondents.

It is encouraging that the respondents' overall rating of the their trainee year improved significantly over the time period studied. However, there is little room for complacency as overall 12% of respondents rated the trainee year as poor and of those 28% had trained between 1981 and 1985. In parallel with this the respondents were less likely over time to consider that certain aspects of general practice had been omitted or poorly covered during their training which provides further evidence of improvements to vocational training in the region. This is further supported by the finding that respondents training between 1981 and 1985 were significantly more likely to choose to repeat their trainee post in retrospect. It is also encouraging that those who had no tutorials were significantly more likely to have trained between 1968 and 1975.

Taking part in a practice exchange was an uncommon experience, with those respondents training most recently being least likely to have taken part despite the region's policy which seeks to encourage such exchanges. A more positive finding was that respondents' training most recently were also most likely to have been involved in general practice research .

This study has demonstrated that it is possible to study changes in vocational training over a period of time by means of a postal questionnaire. This has been applied in the west of Scotland and could be applied elsewhere.

SUMMARY

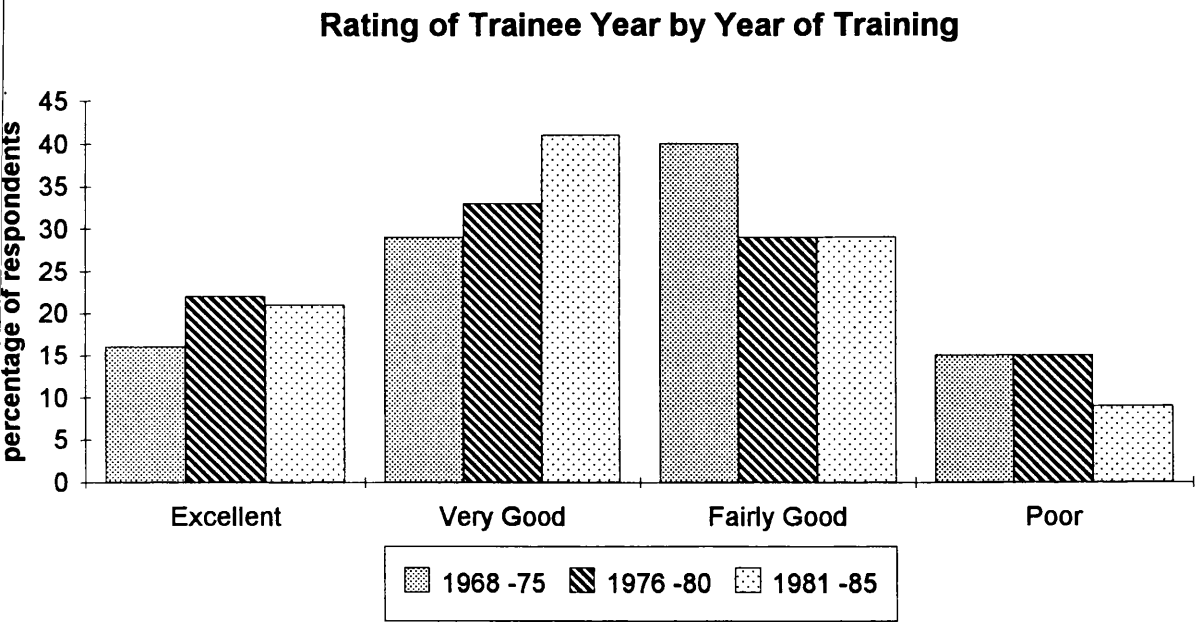
The primary aim of the study was to find out how satisfied a group of doctors were with their vocational training.

A secondary aim was to contrast the views of those training over different periods of time in an attempt to demonstrate that improvements had occurred.

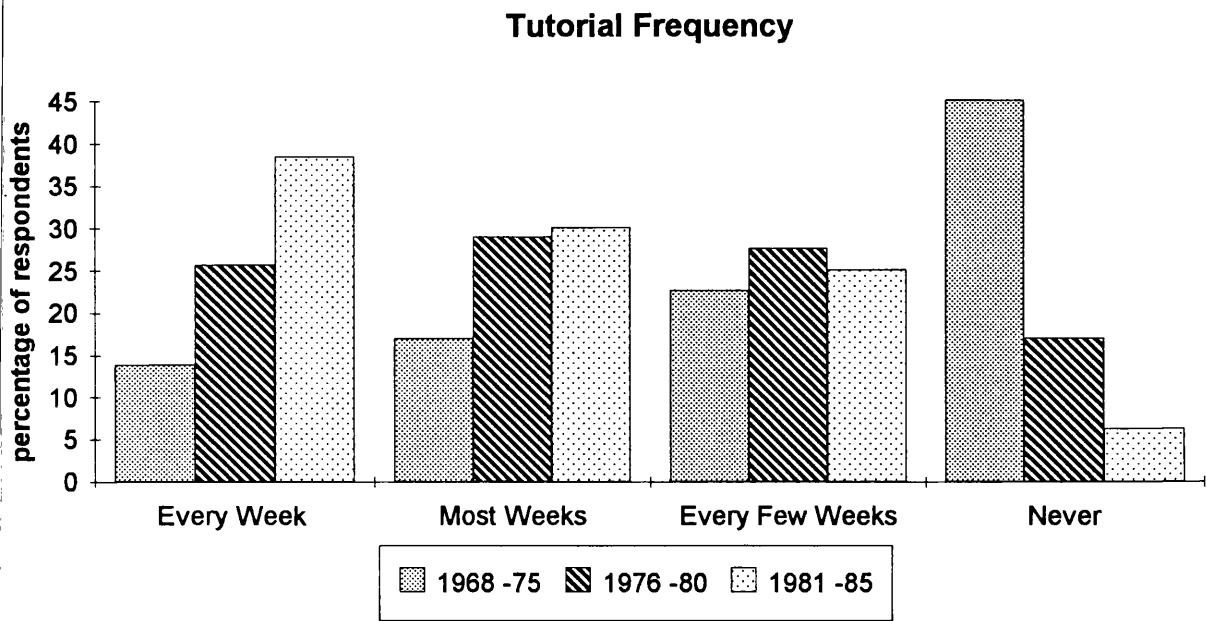
The main findings were that over the time period studied the rating given to the trainee period improved significantly and the respondents considered less to have been omitted or poorly covered in their training. Being permitted to take study leave and to gain experience in general practice research were significantly more likely among those who commenced training most recently.

Those respondents who trained most recently appeared most satisfied with their training.

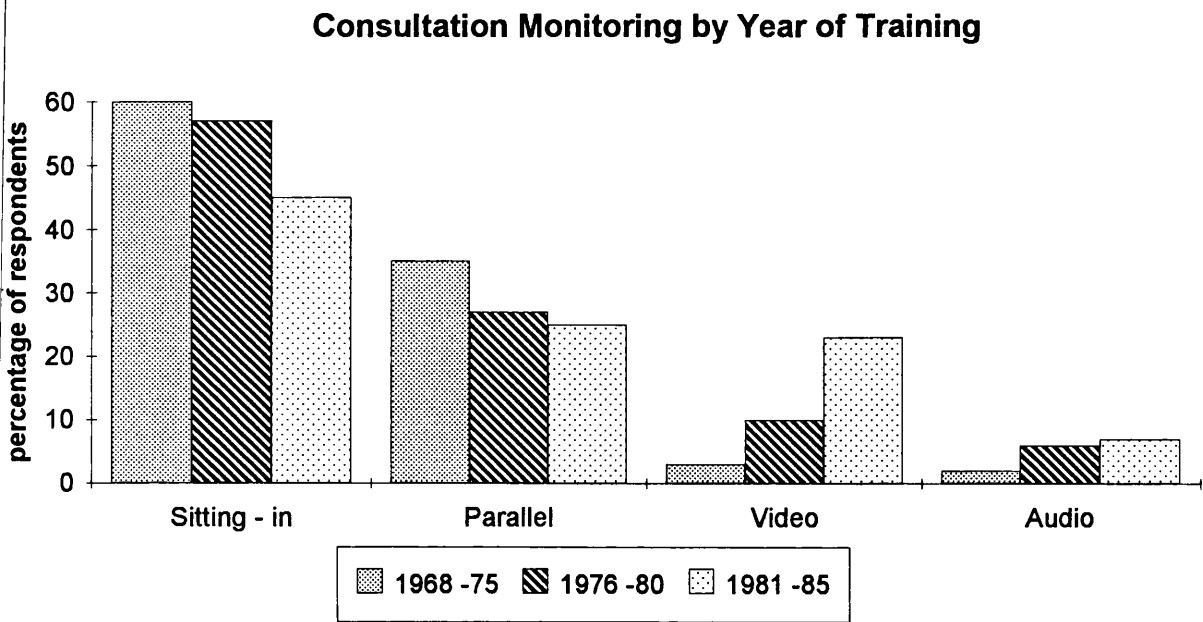
GRAPH 4



GRAPH 5



GRAPH 6



CHAPTER 2

Vocational Training Following Adoption of New Criteria for Trainer Selection

INTRODUCTION

A recent development in training in the region was that of new criteria for trainer selection and reselection. This intervention had occurred during the period studied in the historical study (Chapter 1) and its effect had not previously been assessed. This chapter describes the development of a methodology which was used to evaluate this intervention.

The west of Scotland region covers six health board areas with 1,802 general practitioners serving 2.8 million patients. The number of trainees in post each year has grown over the last ten years and is currently 148.

The terms of the Statement of Fees and Allowances for General Medical Practitioners allow principals in general practice to apply to their Regional General Practice Committees for approval as trainers (Scottish Home and Health Department 1990). Each region therefore requires criteria for the appointment and re-appointment of trainers. The Joint Committee for Postgraduate Training for General Practice gave their recommendations to regions for the establishment of criteria for the approval and re-approval of trainers in general practice in July 1985 (Joint Committee on Postgraduate Training for General Practice 1985). The West of Scotland Committee used these criteria to update their own and a new set were introduced in November 1985. The new criteria were presented in a more structured and succinct way, with a greater emphasis on teaching and learning. The original criteria consisted of a seven page document and the revised version a four page document both of which are included in the Appendix E and Appendix

H. However, the main differences are enumerated as follows. Firstly, the new criteria placed greater emphasis on a trainer's personal qualities, for example his/her desire to teach, enthusiasm, competence and ability to motivate and monitor the progress of a trainee. Secondly, prospective trainers were required to demonstrate a willingness to submit to peer assessment and to submit a proposed timetable for teaching. Thirdly, they were encouraged to have special interests with an emphasis on research and to recognise the importance of personal professional development and continuing education. The Committee also decided at this time that the criteria for appointment should be identical both for new applications and existing training practices. These criteria were circulated widely to those involved in training and a high profile was maintained to encourage adherence to the recommendations. This process of examining appointment criteria has been examined in other parts of Britain (Schofield and Hasler 1984).

SUBJECTS AND METHODS

Information for this study was obtained from two sources. The first source was the results of trainer applications to the Regional General Practice Committee for the west of Scotland, first time and re-applications from existing training practices, for two years prior to and two years following the introduction of the new criteria. The second source of information was the questionnaire described in chapter 3(i).

This questionnaire covered a period of training from 1968-1988 and for the purposes of the study described in this chapter only the responses of those doctors who completed vocational training two years prior to the introduction of the new criteria in 1985 (n=98) were compared with the responses of those who had completed vocational training two years following the new criteria (n=107). This meant that 1983 and 1984 trainees were being compared with those who were trainees in 1986 and 1987. This clearly divided the participants into pre- and

post- the new criteria. The analysis related to the questions which were specific to the differences between the old and new criteria.

The numbers in each group were comparable, 98 and 107. The male to female ratio was in favour of males in both groups, a ratio of 1.7:1 in the first group compared to 1.1:1 in the second group. This may be because the ratio of males to females entering medical school at Glasgow University, from where most respondents graduated, has been 1:1 only since 1979 and correspondingly in the earlier group there were more males. Among the respondents in group one 60% had constructed their own vocational training compared to 47% in group two. Currently just over 50% of trainees construct their own vocational training so these figures again appear to reflect events in the west of Scotland.

RESULTS

In the two years prior to the criteria 55 applications/re-applications were approved with only 9 not being approved. In the year leading up to the adoption of the criteria 36 applications/re-applications were approved and 9 were not. In the year following the introduction of the new criteria out of 28 trainer applications and re-applications only 11 were approved. Four of the 11 were new applications with the remainder being re-accreditation of existing training practices. Two years following the new criteria introduction out of 17 applications, only one was unsuccessful. Currently the number not approved is stable at around 10% and has been so since 1987.

In analysing the questionnaire, those respondents who had trained two years prior to the introduction of the criteria, (1983 to 1984), comprised group one and those training two years following the criteria, (1986 to 1987), comprised group two. Ninety eight respondents were in the first group (62 male, 36 female) and 31 of those now worked in a training practice. Of the 107 respondents in group two (57

male, 50 female) 29 were working in a training practice. The rating given to their training by the respondents shows a significant improvement between the two groups as shown in Table 8 ($\chi^2=13.018$ DF=3 $p<0.005$). There is also a significant increase in the frequency of their tutorials comparing respondents who had tutorials every or most weeks, with those who had tutorials every few weeks or never as demonstrated in Table 9 ($\chi^2=18.52$ DF=1 $p<0.001$). In the first group 85 (87%) enjoyed their trainee year and this rose to 102 (95%) in the later group ($\chi^2=8.6$ DF=2 $p<0.025$). Comparing those who had enjoyed the year with those who had not, 71% of the former would repeat the same year in the same practice in retrospect and this rose to 80% in the later group. However, this was not significant.

The half-day release was thought to be very useful or useful by 59/98 (60%) of the first group and 88/107 (82%) of the second group ($\chi^2=4.47$ DF=1 $p<0.05$). Research was encouraged in 35/98 (36%) in the first group and 67/107 (63%) of the second group. However, the number who actually carried out research was only slightly higher in the second group. Monitoring of the consultation showed that the use of video had increased markedly over the same period from 5/98 (5%) in the first group to 42/107 (39%) in the second group ($\chi^2=34.08$ DF=1 $p<0.001$).

DISCUSSION

The study group in this chapter is the same as that in Chapter 1(iii) (page 38). In addition to the comments in Chapter 1(iii) (page 38), a further merit of this study is that it evaluates the result of an intervention on vocational training, namely the adoption of new criteria for trainer selection. This has not previously been evaluated in the region or nationally. Another merit of the study is that the two groups studies are comparable in numbers (see page 70).

It has been suggested that the criteria for training were imprecise and that progress towards achieving the standards of the criteria set, required monitoring (Baker 1985). The setting of standards is important in general practice and the training model has been one example where actual measurements can be carried out. Unfortunately when standards are applied there are often a number of subjects who fail to attain the standard. The high failure rate experienced for trainer applications in the west of Scotland after the adoption of the new criteria was for a relatively short period only and it did seem to have a salutary effect on other applicants. The fact that the new criteria were widely discussed within the region, therefore maintaining a high profile and the fact that they were subsequently adhered to more rigidly may have prevented inappropriate applications, therefore resulting in the current situation where only 10% of applications are unsuccessful. Once standards have been set and then raised they require to be monitored and maintained. One method by which monitoring can occur is the trainee report forms which are fed back to the Regional Adviser at the completion of the trainee year. Feedback is an important part of the strategy within the region and there is regular feedback from trainee representatives, trainee reports and Associate Advisers.

It is noticeable that over the period during which the new criteria were introduced and adopted the trainees' enjoyment of the trainee year increased from group one to group two. The overall rating given to the trainee year by respondents also increased between the two groups as did tutorial frequency. This improvement is also reflected by an increase in usefulness of the half-day release course. An increasing use of video in training was demonstrated, allowing teaching and discussion on consultation skills which are now acknowledged as a most important aspect of general practice. The increased interest in research is encouraging but the small number carrying out research is still a cause for concern. The trainee year is an ideal time to encourage this important aspect of a doctor's professional

development and this should occur as much as possible with trainers taking an interest in developing or directing a trainee's research interest.

The results from the present study demonstrate the benefits of vocational training when clear local guidelines are set and then applied. There has been concern expressed by some that formalising training for general practice will produce clones and some would favour an apprenticeship system. This study provides some evidence to support formal teaching as it has demonstrated that a carefully planned programme of teaching has increased the trainee's learning experience and enjoyment of general practice.

In conclusion, the training model in general practice has been subject to evaluation by establishing tighter criteria for trainer selection and trainee teaching. This study has demonstrated that training has developed and improved as a result. It is a useful model for training in other specialties.

SUMMARY

Ninety eight doctors, who had trained in the west of Scotland before the introduction of new criteria in 1985 for the appointment and re-appointment of training practices, were compared with 107 doctors who had trained following the introduction of the criteria, by looking at their rating of training, the frequency of tutorials, value of teaching and research encouragement. There was a significant improvement in each of these areas in the group who trained after the new criteria were adopted.

This study demonstrates the benefits to vocational training for general practice when criteria are set and followed. This training model may be applicable in other fields of medicine.

TABLE 8

Trainee Rating of Training
Before and after New Criteria for Trainer Selection

	Before New Criteria		After New Criteria	
	Group 1	(%)	Group 2	(%)
Excellent	20	(20.4)	31	(29.0)
Very Good	34	(34.7)	47	(43.9)
Fairly Good	26	(26.5)	25	(23.4)
Fairly Poor *	12	(12.2)	4	(3.7)
Poor *	3	(3.1)	0	(0)
Very Poor *	3	(3.1)	0	(0)
Total	98	(100%)	107	(100%)

* These three groups were combined for statistical analysis.

TABLE 9

**Tutorial Frequency before and after
New Criteria for Trainer Selection**

	Before New Criteria Group 1	After New Criteria Group 2
Every Week/Most Weeks	56 (58%)	90 (85%)
Every Few Weeks *	34 (35%)	14 (13%)
Never *	7 (7%)	2 (2%)
Total	96 (100%)	106 (100%)

* These two groups were combined for statistical analysis.

CHAPTER 3(i)

SUBJECTS AND METHODS

The doctors who responded to the questionnaire in chapter one were used to provide a sampling frame for the next part of the thesis. Those targeted in chapter one were identified by examining lists of trainees who commenced vocational training from 1968 to 1985 (completed by 1988) in the west of Scotland. For this study a sample was selected, using random number tables, from those who had completed vocational training between 1981 and 1988. It was considered that this group of young doctors should be aware of current concepts in general practice yet have also had time to adjust to the role of general practitioner. Two hundred and twenty respondents had trained over this period. Following discussion with the Department of Statistics at Glasgow University 155 of the 220 respondents were selected in order to obtain our target of 100 responses allowing for a 60% response rate. The questionnaire used in this part of the study was developed following consultation with the Department of Sociology at Glasgow University, using information from research booklet No.4 compiled by the Association for the Study of Medical Education (Appendix I). The last page of the questionnaire consisted of 6 questions which respondents were invited to consider and then respond to by way of a telephone interview conducted by the principal author 1 to 2 weeks after receiving the questionnaire. The conversation was recorded, with consent, for analysis. These results are presented in section iv of this chapter. The questionnaires were posted from September 1991 to June 1992 in batches, on a weekly basis to allow telephone contact to be made with respondents at a steady rate.

The principle aim of the study was to determine whether vocational training had prepared trainees for general practice and whether there had been any

changes following introduction of the 1990 general practitioner contract. It was anticipated that respondents training three to nine years prior to the 1990 contract may not unreasonably consider that their vocational training did not prepare them for the changes it introduced and therefore the questionnaire was subsequently also mailed to a group of doctors who trained following the contract, who were currently principals in general practice. This group did not take part in the telephone interview. This group of doctors was identified by examining lists of newly registered general practitioners from each health board region and identifying those who had trained in the west of Scotland between 1989 and 1992, after the 1990 contract. One hundred and twenty four subjects were identified from records at the Department of Postgraduate Medicine of which 58 responded.

A secondary aim of the study was to evaluate the educational content of vocational training and to examine the views of respondents on their career present and future.

Statistical analysis was performed using minitab data analysis software version 6.1. Data analysis used frequency counts by actual numbers and percentages, and chi-square analysis. Significance was set at $p < 0.05$.

Response Details

Of the 155 questionnaires mailed to doctors training from 1981 to 1988, three were returned as not known at that address and three were unsuitable for analysis as the respondents had trained outwith the specified period, leaving a total of 149. 118 analysable replies were received, giving a response rate of 79%.

Of 124 questionnaires mailed to doctors training from 1989 to 1992, 82 replies were received. However, 24 were unsuitable as the respondents had trained outwith the period although they were new principals. Therefore the final number was 58 (58%).

124-24

CHAPTER 3(ii)

Vocational Training before and after 1990

INTRODUCTION

The practice of medicine, including general practice, is currently in a state of flux. This is exemplified by recent Government directives, in particular the 1990 contract (General Medical Services Committee NHS Regulations 1989), with its emphasis on greater accountability and audit, new health promotion criteria, community care, fundholding and the development of a purchaser/provider network. There are also changes from within the profession itself, particularly regarding trainee assessment and performance review. In order to meet these challenges, training for general practice needs to be continually appraised with alterations and improvements as necessary. The 1990 contract represented the most significant change experienced by the National Health Service in recent times and this study was undertaken to assess to what degree doctors felt themselves prepared by their vocational training for the contract. Two groups of doctors were examined, one training before (group one) and the other training after the 1990 contract (group two), firstly to assess whether training had equipped the doctors for current practice and secondly to assess whether training had altered in response to the contract.

There have been reports of a significant fall in applications for vocational training schemes following the contract and also of damage to the morale of young doctors (Donald 1990). This study also aimed to examine the present and future careers of the respondents.

RESULTS

Basic Data

Among the 118 respondents training in group one (1981-88) 50 (42%) were female, 67 (57%) male and one failed to answer the question. Their ages ranged from 29 to 49 with a median of 32 years. Among those training in group two (1989-92) 24, (41%) were female 33, (57%) male and 1 failed to answer the question. The sex ratio was not 1:1, as it has been at Glasgow University since 1979, because the doctors needed to be principals in general practice for comparative purposes. The sex ratio here therefore reflects those who had obtained a general practice post. Their ages ranged from 27 to 43 with a median of 29 years.

Of the 118 respondents in group one 113 were employed at the time of the study, with 97 being in general practice. Among those in practice 81 were full-time, 9 part-time and 4 were assistants. Only 33/97 (34%), were currently working in a training practice, with 8 respondents being the trainer.

Of those in group two all the respondents were employed in general practice with 48 full-time, 7 part-time. 18/97 respondents (32%) were working in a training practice.

Practice Component

In group one 61/116 (53%) of respondents had been on a self-constructed training scheme and 53/116 (46%) on a formal one (two respondents had been on a combination). The majority of respondents had spent 12 months as a trainee, only 12 did otherwise. The ideal length of time in general practice ranged from 9 to 24 months with 82/113 (73%) choosing 12 months and 28/113 (25%) preferring longer, up to 18 months and 1 person each choosing 9 months, 24 months and 36 months. In group two 29/58 (50%) of respondents

had been on a self-constructed scheme and 28/58 (48%) on a formal one (one respondent had been on a combination of the two). Of the 58 respondents 49 had spent 12 months as a trainee, 8 had spent 18 months and 1, 24 months. The ideal length of time in practice ranged from 12 to 24 months, with 42/58 (72%) choosing 12 months, 13/58 (22%) choosing 18 months, two choosing 15 months and one, 24 months.

As the main aim of the study was to ascertain how well respondents felt prepared for general practice, respondents were asked to rate how their training had prepared them to perform certain tasks pertaining to general practice. They were asked how their vocational training had prepared them to undertake health promotion, paediatric surveillance, and minor surgery. The percentage of respondents who felt poorly prepared fell between group one and group two, from 59% (60/102) to 34% (19/56) for health promotion (chi square = 8 df1 p=0.005), from 62% (63/101) to 29% (16/56) for paediatric surveillance (chi square = 15, df1 p=0.0001) and from 67% (68/101) to 45% (25/56) for minor surgery (chi square = 6.7, df1 p=0.009) indicating that training following the contract has adapted to include these elements. The two groups were also asked how prepared they felt to compile a practice report, undertake audit and use a computer. The percentage of respondents who felt poorly prepared for each task again fell between group one and group two, from 89% (90/101) to 74% (42/57) (chi square = 5, df1 p=0.02) for ability to compile a practice report, from 71% (72/101) to 53% (30/57) (chi square = 4.7, df1 p=0.029) for audit and from 83% (83/101) to 60% (34/57) (chi square = 9, df1 p=0.002) for computer use. However, the majority of respondents still felt poorly prepared, among those training from 1989-92, after the contract.

The study in Chapter 1 demonstrated that 49% of the respondents considered that certain aspects had been omitted from their training with particular

emphasis on practice management. In this study different management skills were examined in an attempt to identify specific problem areas.

Respondents were asked how they felt prepared to deal with staff, to understand their N.H.S. income and N.H.S. obligations under the terms and conditions of service. Staff management did not present a problem for although 33% (38/115) of respondents from group one did not feel well prepared, this fell significantly to 17% (10/58) of those from group two (chi square = 4.0, df1 p=0.04). Similarly N.H.S obligations were well understood with only 27% (30/112) and 15% (9/58) of respondents from groups one and two respectively not feeling well prepared. Respondents felt least well prepared to understand their N.H.S. income with 33% (38/115) and 28% (16/58) from groups one and two respectively. They were also asked how they felt prepared to understand appointment systems. The percentage of respondents who did not feel well prepared remained constant between the two groups, 50/114 (44%) group 1, 27/58 (47%) group 2. Regarding knowledge of records and disease registers 33% (38/114) and 31% (18/58) from groups one and two respectively did not feel well prepared. The number of respondents who felt poorly prepared regarding practice accounting fell significantly between group one 83/114 (73%) and group two 30/57 (53%) (chi square = 6, df1 p=0.014), but remained an area of difficulty. The respondents who felt poorly prepared for practice taxation similarly fell between group one 90/114 (79%) to 37/57 (65%) group two, but again remained an area of difficulty. Knowledge of partnership agreements posed less of a problem with 47/114 (41%) and 21/58 (36%) from groups one and two respectively considering they had not been well prepared.

Practice management tasks may be poorly rated for reasons other than inadequate teaching. Respondents were asked to indicate whether they felt

unprepared due to poor or absent teaching, disinterest or perceived subject matter irrelevance. In all cases poor teaching was the major problem with the number of respondents quoting other reasons being in single figures.

Respondents were invited to comment on how well they considered their training had equipped them for clinical aspects of patient care. They felt well prepared to recognise and manage medical problems, to recognise and manage psychosocial problems and to deal with medical emergencies. The one area where there was some difficulty expressed was in preventive medicine with 24% (28/116) of the respondents training from 1981-87 (group one), and 26% (15/58) of the respondents training from 1989-92 (group two) not feeling adequately prepared.

Respondents were asked whether they had had experience of audit while a trainee. Of the respondents from group one, 32/118 (27%) had experienced audit as a trainee compared with 29/58 (50%) of the respondents from group two (chi square = 8, df1 p=0.0046).

Respondents' attitudes to their career were sought. They were asked whether in retrospect they would have chosen general practice or in fact medicine as a career. The results are shown in table 10. There was no significant difference between the two groups in terms of those respondents who would choose not to do medicine. However, among those respondents who would not choose general practice as a career significantly fewer were from group two (chi square = 4.7, df1 p=0.003).

DISCUSSION

This study highlights deficiencies in certain areas of vocational training for general practice in the west of Scotland. It was anticipated that respondents

training 3-9 years prior to the 1990 contract might not unreasonably consider that their vocational training did not prepare them for the changes it introduced and therefore doctors who had trained around the time of the contract who were currently employed as a general practitioner were questioned. One problem encountered was that only 58 subjects could be identified. However, the author feels that the trends demonstrated between the two groups provide valuable information for all those involved in vocational training.

One of the merits of this study is that the respondents in group one were randomly selected using random number tables to minimise bias. Another merit is that a second group of doctors was selected (training after the contract) to act as a 'control'.

Among the demerits of this study is the response rate for each group. The first group, selected randomly from the large study in Chapter 1(iii) achieved a 76% response rate to the questionnaire. This is good considering the questionnaire was fairly lengthy (Appendix I) and also that they had responded before to a questionnaire in 1989. (Sibbald 1994) This may again support the comments on the non-responders made in Chapter 1(iii) in that the respondents were more motivated and interested in academic general practice than the non-respondents. The second group in this study achieved a response rate of only 58%. This group of doctors had trained more recently than those in group one. They may therefore have felt less qualified to comment on training issues. It is also possible that having recently completed vocational training they wished a break from the issues it raises, or that having recently become a principal they were too involved in coping with their new position to respond to academic research.

The principle aim of the study was to determine whether vocational training had prepared trainees for general practice. For some tasks highlighted by the contract this was not the case. Comparing respondents who trained from 1981-88 with those who trained from 1989-92 the numbers of respondents who felt prepared for health promotion, paediatric surveillance and minor surgery had significantly increased. However, in the case of minor surgery particularly, only 55% of respondents from 1989-92 felt prepared compared with 71 % for paediatric surveillance. The results concerning the level of preparation attained to compile an annual report, understand audit and use a computer were even lower and despite a small increase over the two groups, failed to reach 50% in any one task. It may not be possible for vocational training to cover all aspects of a general practitioner's remit but with increasing emphasis on identifying a trainee's personal learning needs and tailoring his/her training accordingly it should be possible to direct the trainee year appropriately both within the practice and at the half day release. Vocational training represents only one area on an educational continuum, commencing with medical school and progressing to continuing professional medical education and in that respect vocational training should aim to enable the trainee to identify his/her educational needs and fulfil these needs over his/her professional career.

Practice management has previously been identified as an area where trainees have reported difficulties (Freer and Reid 1978, Kelly and Murray 1991). In this study various aspects of management were examined in an attempt to ascertain where the difficulties lay. In order of increasing difficulty, the problem areas were found to be, knowledge of records/registers, partnership agreements, appointment systems, practice accounts and income tax. Over the time periods, 1981-88 and 1989-92, the percentage of respondents who considered that their training had prepared them for these management tasks did improve but the figures remained low and this still represents a problem

area. This is of importance for training for in this study the low figures do not solely represent disinterest on the part of the trainee but also that the subject was poorly taught. Practice management requires to be more trainee friendly and more directly relevant to trainees. This could be achieved at the trainee half day release by grouping the trainees into a mock practice situation in which they have to decide on areas of management relevant to them (as currently performed in some trainer groups in the west of Scotland) or by allowing the trainee to be in administrative charge in his/her practice for a short period with the trainer supervising.

Encouragingly, respondents felt well prepared in terms of clinical patient care which is of particular importance. One of the fundamental essentials of any vocational training programme must remain that it should ultimately result in improved standards of patient care. Disease prevention was the one area where respondents did not feel prepared and this is of relevance for those involved in training, particularly as the governmental guidelines for disease prevention/health promotion appear to be continually changing.

Reflecting recent increasing emphasis within the medical profession on the subject of audit, the percentages of respondents who had experience of audit while a trainee rose by 23% to 50% and it is predicted that this trend will continue.

There have been references to the level of discontentment among the medical profession in recent times (Donald 1990, Lear 1992, Lewis 1993, Gillard et al 1993). The figures in this study certainly reflect this disenchantment, as 21% of respondents from 1981-88 would not have chosen general practice and 25% would not have chosen medicine as a career. Of those respondents from 1989-92 the figures were lower, 11% would not have chosen general practice and

16% would not have chosen medicine. This may reflect the fact that over the past few years, particularly since the 1990 contract, general practice has altered dramatically and with great speed. This will obviously have had less effect on those who trained most recently as they were not at the forefront of these changes, being themselves still in training, with some in hospital posts. Therefore their discontent with general practice might be expected to be lower. Another factor may be that they are only just experiencing general practice as a principal and therefore may be less susceptible to burn out and disenchantment. However, their concern regarding medicine as a career is worrying although it may reflect a general discontent in the country as a whole as these findings may be similar among other professional groups.

This study has demonstrated the need for ongoing assessment of vocational training in order to maintain and improve standards and to match training most appropriately to the needs of future general practitioners and ultimately to the needs of their patients. Patient satisfaction and medical accountability are important issues and continually reviewing vocational training is one step in the process attempting to meet both.

This study demonstrated that in many areas vocational training does not adequately meet the demands of current general practice.

SUMMARY

The aim of the study was to determine the relevance of Vocational Training to current general practice by examining the views of doctors on their career both past and future and to determine how Vocational Training requires to develop to meet the demands of current practice.

Overall, respondents training from 1981-88 did not feel well prepared for the 1990 contract, particularly with regard to health promotion, paediatric surveillance, minor surgery, audit, computing and compilation of an annual report. Those training from 1989-92 felt more able to undertake health promotion and paediatric surveillance but still felt poorly prepared regarding audit, computing and compiling an annual report.

TABLE 10 - REGRETS REGARDING CAREER

Question - In retrospect would you choose to do general practice/medicine again?

	General Practice				Medicine			
	Group 1 n=118	(%)	Group 2 n=57	(%)	Group 1 n=118	(%)	Group 2 n=57	(%)
Yes	63	(53)	47	(82)	63	(54)	36	(63)
No	25	(21)	6	(11)	29	(25)	9	(16)
Don't know	30	(25)	4	(7)	25	(21)	12	(21)

CHAPTER 3(iii)

An Assessment of the Educational Content of Vocational Training

INTRODUCTION

The west of Scotland region has 16 vocational training schemes with places for 58 trainees each year. In any one year there will be around 145 trainees in the trainee year, therefore over half the trainees take part in a scheme which they have constructed.

In the west of Scotland changes have recently taken place in general practice teaching both in the undergraduate and postgraduate curriculum. General practice is slowly forming a greater component of the undergraduate course, with national debate as to whether it should form an even greater role as hospital teaching develops increasing difficulties due to specialisation, shorter hospital stays and day procedures. The actual teaching methods being adopted are also changing, with increasing use of small group teaching and problem based learning, thereby encouraging self-learning and relying less on the traditional didactic method of teaching. There is in addition increasing emphasis on assessment and feedback review both of the student/trainee and the course itself. Also in general practice vocational training there has been increasing emphasis on small group teaching, trainee participation in tutorials, the development of a tailored educational programme for each trainee, formative assessment and more recently end-point summative assessment (Campbell et al 1993). As with any alteration to an existing structure, monitoring of performance and outcome is essential to ensure that standards are implemented, and then improved.

This chapter evaluates the educational content of the vocational training experienced by the two groups of respondents training before and after the 1990 contract.

RESULTS

Hospital Component

Of the respondents training in group one (1981-88), 81/117 (69%) had carried out their hospital posts with general practice as their ultimate career goal compared with 45/58 (78%) of those training from group two (1989-92). In group one 49/115 (43%) wished that they had held a different post usually in addition to those they had undertaken, compared with 26/58 (45%) from group two.

The frequency of teaching during hospital training for the respondents training from group one and for those training from group two is shown in graph 7. In both groups teaching occurred weekly for only 23% and 20% respectively and over the time period studied there was little difference in the numbers of respondents who had teaching very occasionally or never. When teaching did take place it was orientated towards the specialty in 70% of cases (82/118 group one, 40/58 group two) and in only 6/118 and 1/58 cases was it general practice orientated. The day release course was significantly less well attended during hospital training 41/118 (35%) group one, 16/58 (28%) group two as compared with in the trainee year, 115/118 (97%), 58/58 (100%). These differences were statistically significant for both groups ($\chi^2=100.7$, $p<0.000001$ and $\chi^2=62.7$, $p=0.000001$ respectively).

Of the respondents in group one, 111/118 (94%) had gained out-patient experience and 99/111 (89%) considered it all helpful or the majority helpful. In group two, 56/58 (96.5%) had out patient experience, and 50/56 (89%)

considered it helpful. Respondents were asked to what extent they agreed with trainees receiving guidelines on learning objectives prior to commencing each hospital post. The results are shown in graph 8.

Practice Component

Respondents were questioned on the content of their tutorials during the trainee year. The results for the respondents from 1981-88 and 1989-92 (in parenthesis) were as follows; involvement in the selection of topics 77% (91%); clinical topics were discussed 95.6% (89.7%); consultation skills were discussed 77.9% (82.8%); audit/research were discussed 37% (51.7%); practice management and finance were discussed 76% (79%); and social medicine was discussed 60% (70.7%).

The length of time for protected formal teaching per week ranged from 0 to 5 hours (0 to 4 hours) with a median of 2 hours (2 hours). The length of time for informal teaching ranged from 0 to 18 hours (0 to 8 hours) with a median of 1 hour (1.25 hours). Of the respondents from group one, 16/106 (15%) stated they had no informal teaching and 5/112 (4.5%) no formal teaching. Of those respondents from group two, 4/58 (7%) stated they had no informal teaching and 2/56 (3.6%) no formal teaching.

Respondents were invited to assess which methods of teaching they felt most effective by ranking them on a Likert scale from 1 to 5 with 1 being the least and 5 the most effective. The median for each method is presented for the respondents from group one and group two (in parenthesis). Small group discussion 5 (5); lectures 3 (3); role play 3 (2); video 3 (3) and feedback on performance 3 (4).

They were also asked to rate their trainee year in terms of the training it provided on a six point Likert scale from excellent to very poor. The results are presented in graph 9. The majority of respondents considered their trainee year of good quality and there is an upward trend between the two groups.

Respondents were asked which methods of assessment were used to assess their progress while a trainee. The results for 1981-88 and 1989-92 were as follows: case review 68/116 (59%), 45/58 (78%); video consultation 34/116 (29%), 50/58 (86%); prescription review 31/116 (27%), 19/58 (33%); Manchester rating scale 21/116 (18%), 23/58 (40%); referral review 21/116 (18%), 14/58 (24%); objective structured clinical examination (O.S.C.E.) 13/116 (11%), 37/58 (64%); none 37/116 (32%), 4/58 (7%). Continuing on the subject of assessment, respondents were invited to indicate the extent to which they agreed with the following two statements: "trainee assessment to assess the level of knowledge, skills and attitudes, is a good idea", "principal assessment, performed during a general practitioner's career is a good idea". The results for both groups of respondents are displayed in graphs 10 and 11. Both groups were in favour of trainee assessment but with principal assessment more respondents were undecided, particularly in group two.

DISCUSSION

The study population examined here is the same as in Chapter 3(ii). Therefore the merits and demerits of the methodology employed apply here also, namely that random number tables were used to minimise bias when selecting the study sample. Also a second group of doctors (training after the 1990 contract) was selected to act as a 'control'. The response rate for the first group studied was 76% compared with 58% for the 'control' group. (Chapter 3(ii) page 84).

Of those respondents training from 1981-88, 43% wished they had undertaken a further hospital post particularly in dermatology, ENT and ophthalmology. This conflicts with the view that there should be less time spent in hospital training and more in general practice (Byrne 1975). This may be resolved by approved hospital posts becoming more orientated and relevant to general practice both in their teaching and clinical experience, particularly by a rotation through these specialties of shorter duration (for example periods of three months as suggested by Greig 1985) and by increased clinic attendance.

The overall frequency of teaching during hospital training was low, and orientated to the specialty rather than general practice, in keeping with previous studies (Ronalds et al 1981, Reeve and Bowman 1989, Kearly 1990). It is recognised that this is not a problem peculiar to general practice trainees but one for junior hospital doctors in general (Roberts 1991). As stated by Tait (1987) "In-service postgraduate education for junior staff in medicine has by tradition always been in education by "osmosis" rather than by logical planning and formative assessment. It is difficult to demand this for trainees when it is not provided for others". Studies have also confirmed the poor educational merit of some junior hospital posts (Grant et al 1989, Dent et al 1990). A series of recent events will hopefully target this area and lead to improvement in this state of affairs. The first of these is the recommendation that Regional Postgraduate Deans should be responsible for devising and managing the postgraduate and continuing medical education programme and that they become the budget holders. This gives them responsibility for the funding of general practice trainee posts (NHS Management Executive 1991). A second publication (NHS Management Executive 1992) on the funding of hospital medical and dental training posts proposed separate funding for training and service and once again gave budgetary responsibility to Regional Postgraduate Medical Deans. The final event is the publication by the Royal College of

General Practitioners of a series of six documents on the quality of hospital based training (Royal College of General Practitioners 1993a-g).

Attendance at the day release course continues to be poor during hospital training as previously documented (Ronalds et al 1981). It has been reported that trainees who construct their own training scheme are disadvantaged in this respect (Crawley and Levin 1990). However, in this region 50% of trainees are on a self-constructed scheme and there was no significant difference regarding attendance between the two groups.

With the publication recently of The Royal College of General Practitioner's guidelines for trainee posts in hospital (The Quality of Hospital Based Education for General Practice, RCGP 1993), it is of interest to note that in this study, 83% of respondents expressed agreement with guidelines on learning objectives. With formative assessment now a minimum criterion for all vocational training posts (from January 1993) the next few years should prove most interesting and repeating this study in the future should provide useful information on the application of the guidelines in our region. (Joint Committee on Postgraduate Training for General Practice 1992a).

The amount of time devoted to teaching, formal and informal, in the practice varied widely. However, one matter of concern was that a proportion of respondents appeared not to have had teaching of either nature. Obviously these results depend on subjective recall and those respondents training most recently may therefore have been more accurate in their responses. It is also possible that discussion of patient management problems was not considered to be informal teaching by some trainees. However, the following two points support the findings. The first is that the percentage of respondents with no informal teaching was higher than those with no formal teaching (15%, 4.5%

group 1, 7%, 3.6% group 2). This may be expected, as formal tutorial time is a criterion for training practices in our region following the revision guidelines for the accreditation and reaccreditation of training practices in 1985. Secondly, the percentage of respondents without any type of teaching was less in the group training most recently, which again may be expected following the revised guidelines. However, the fact that they were not zero is cause for concern.

In the environment of general practice teaching, the value of small group discussion as a learning tool has been appreciated for some time (Thornham 1980, Gray 1986, Forrest et al 1989, Samuel 1990, Sackin 1992) and in this study the respondents from both groups rated it as the most valuable teaching method. However, the true test of a method's effectiveness requires demonstration of subsequent alterations in behaviour as a result of the teaching. This was not examined here and would require further investigation.

Both formative assessment, which is continuous, and summative assessment which can be continuous and/or end-point, have assumed great importance in the field of vocational training in recent times. Reflecting this, the percentages of respondents in our region who had experienced assessment while training increased for all methods, except prescription review which remained static, and particularly for video assessment and the use of the O.S.C.E. (Thomson 1987). Encouragingly the percentages of those who had no experience of assessment fell from 32% of those who had trained from 1981-88 to only 7% of those who had trained from 1989-92. This provides evidence that the west of Scotland assessment policy appears to be being followed by the majority of trainers in the region. This policy only became compulsory in the region in August 1992 following the Joint Committee on Postgraduate Training for General Practice recommendations and these results are especially encouraging

as they examine the period preceding this. Overall, respondents from both groups were almost unanimously in favour of assessment for trainees. Perhaps more unexpectedly those respondents who trained most recently were slightly less in favour of the concept of principal assessment and the reasons for this are not apparent. Perhaps having just completed an assessment programme the respondents did not feel well disposed to the suggestion that they should undertake another as a principal. However, these figures are comparable with other recent studies (General Medical Services Committee 1992, Sylvester 1993).

Encouragingly, the respondents rating of their trainee year improved over the two groups with those training most recently being generally more satisfied.

An underlying assumption is that improving vocational training results in more competent doctors and ultimately in improved patient care. Early studies evaluated the effectiveness of vocational training (Byrne 1973, Murray et al 1978, Grol et al 1985). Improved patient care is more difficult to demonstrate, particularly as certain improvements in care may necessitate many years of study. With the introduction of compulsory summative assessment for trainees, the proposed performance assessment for principals and the recent development of audit in practice, it should become possible to make an assessment of patient care. These activities are both necessary and laudable but they do question the effectiveness of the national undergraduate education system. Traditionally, medical schools have concentrated on knowledge based teaching with students learning numerous facts in rote fashion, usually from lectures. Often much of this learning was forgotten during the course of their career as it was perhaps not directly relevant to their learning needs. Teaching is now moving away from this traditional curriculum with much greater emphasis on the importance of skills and attitudes and their development, both

of which are an integral part of normal adult learning. The General Medical Council acknowledge their relevance to professional development (General Medical Council 1987). It is of course essential that doctors have a basic clinical knowledge of medicine but it is also important that they understand the principles of problem solving and are therefore able to use a variety of resources to investigate and manage any problem presented to them. It is pointless if, at the conclusion of medical school, the new doctor has a wealth of knowledge at his disposal but is unable to apply it to clinical situations. It is possible that if the undergraduate curriculum were producing doctors who were competent in problem solving, it would not be necessary to introduce such rigorous assessment of trainees.

This study has demonstrated clearly that vocational training in practice is working well in the west of Scotland and provides encouraging feedback for all those involved. However, the study does identify deficiencies in the hospital training. This is not a new discovery and was highlighted as long ago as 1980 (Thornham 1980). Clearly the main priority in the region over the next few years must be to raise the standard of training in hospital to a level which is comparable with that in practice.

SUMMARY

The objective of this study was to evaluate the educational content of vocational training and to establish if improvements have taken place in the west of Scotland in the past decade.

It was found that during hospital training, teaching occurred very occasionally or never for over 40% of two groups of respondents training over different time periods. For those who did receive teaching it was usually orientated towards the specialty. A day release course during hospital training was attended by a

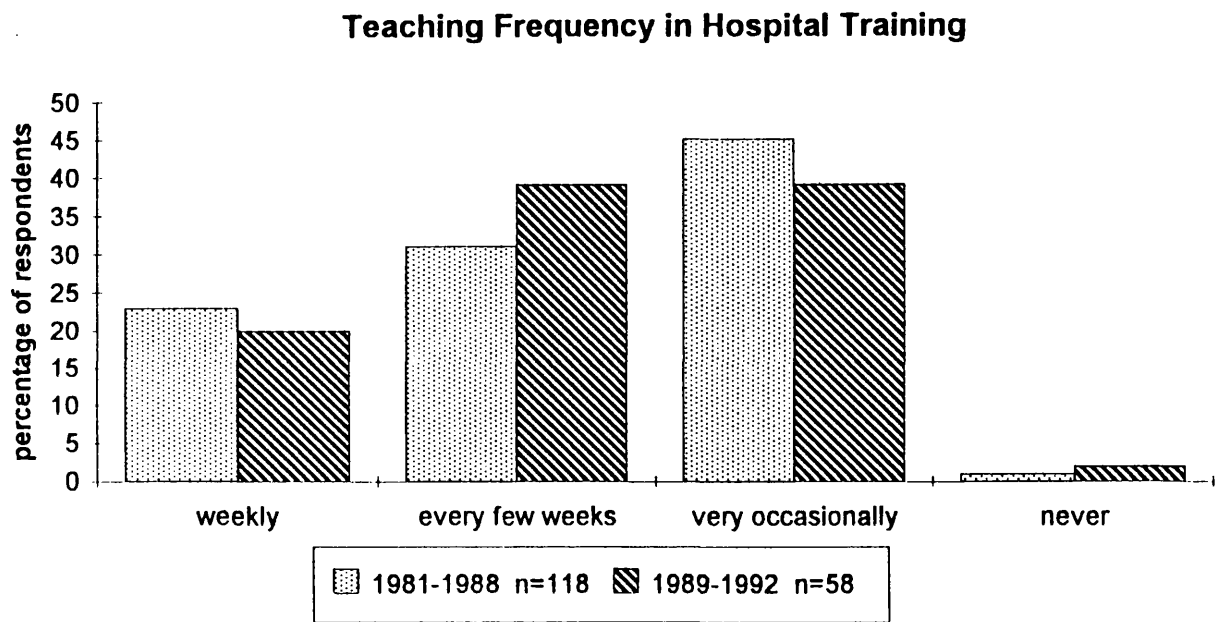
third of respondents compared to over 97% during the general practice training for both groups.

The majority of respondents in both groups were involved in the selection of tutorial topics but respondents training from more recently were more likely to have discussed audit and research during tutorials. Small group discussion was rated the most effective teaching method by both groups. The method of assessment most commonly employed for trainees from 1981-88 was case record review while the most commonly employed method for trainees from 1989-92 was video assessment, the use of which increased dramatically along with the use of the O.S.C.E.. The number of respondents who had no assessment fell markedly after 1989.

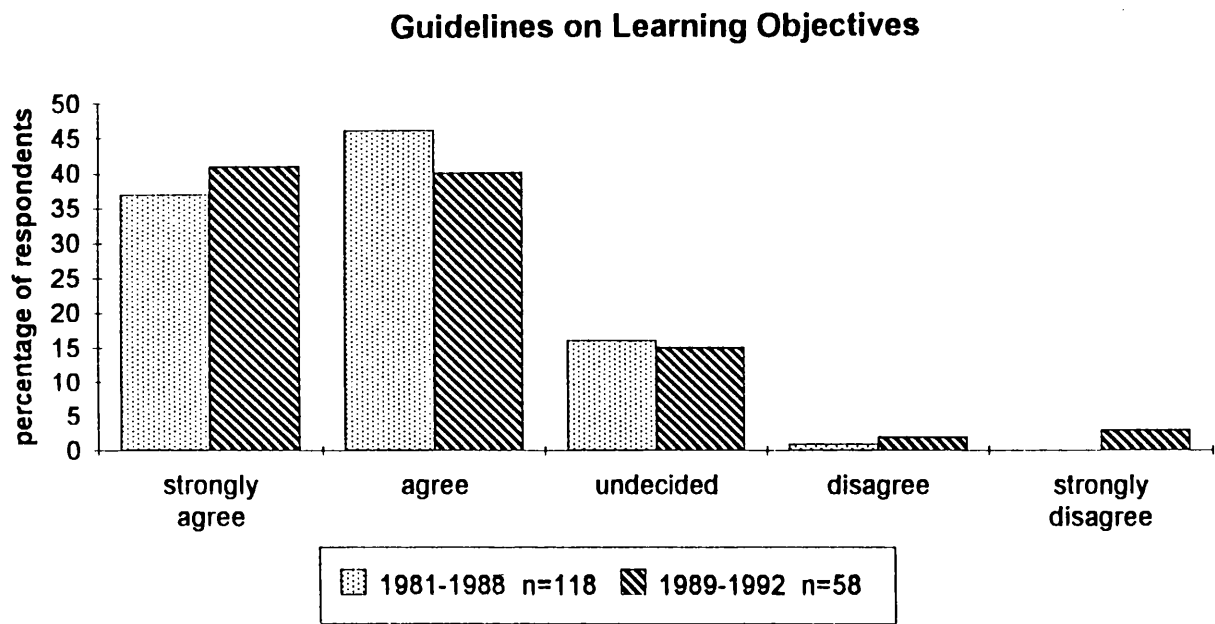
CONCLUSION

This study demonstrates that improvements have taken place in the practice component of vocational training over the past ten years but deficiencies still exist, particularly in hospital training.

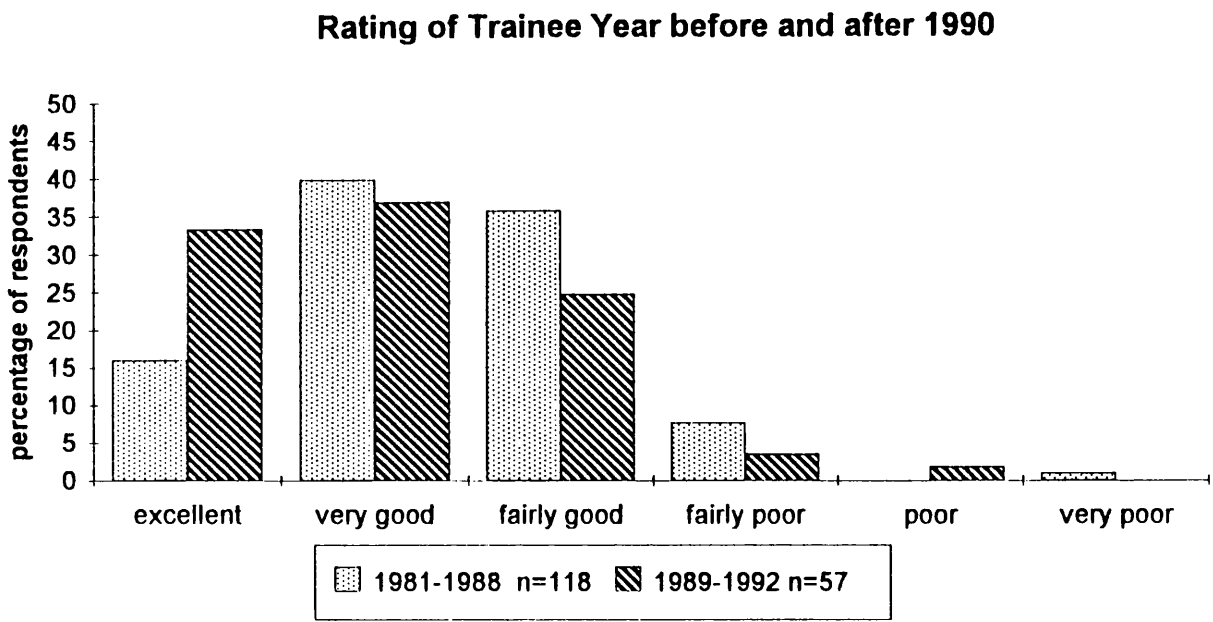
GRAPH 7



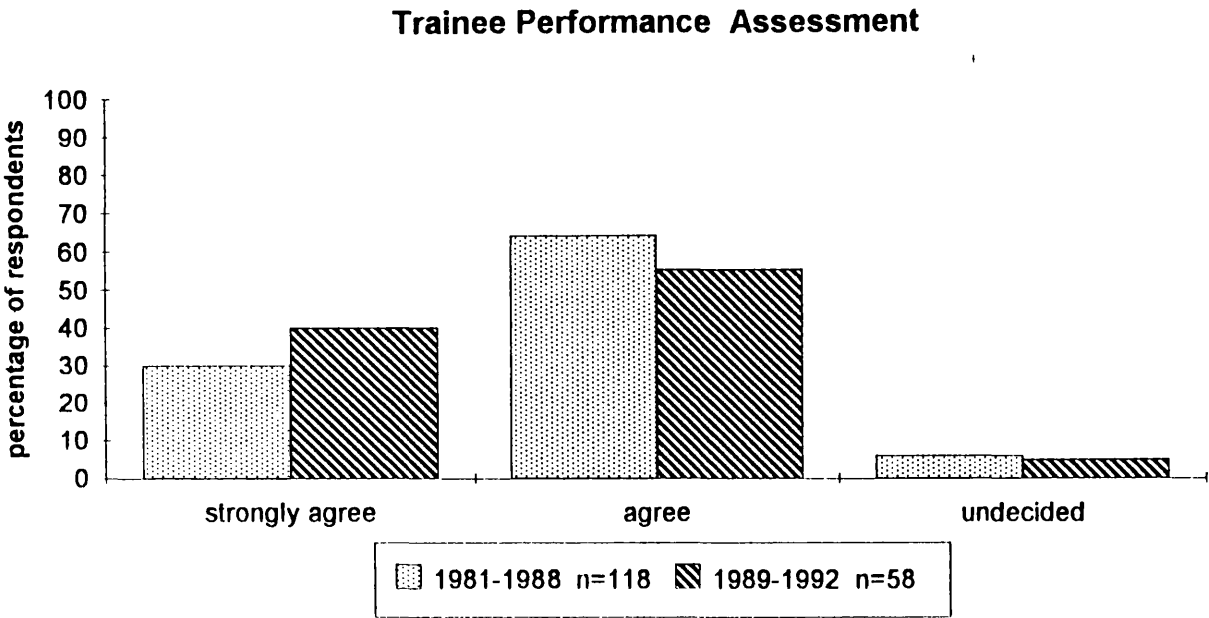
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GRAPH 9

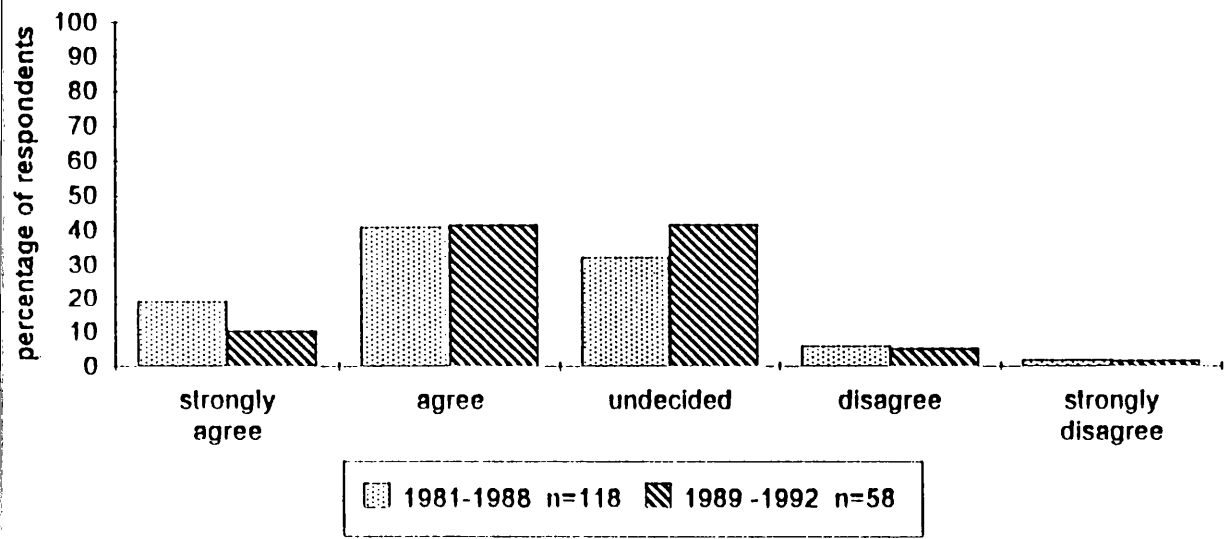


GRAPH 10



GRAPH 11

Principal Performance Assessment



CHAPTER 3(iv)

A Telephone Interview

INTRODUCTION

The primary aim of this part of the study was to ascertain whether vocational training was relevant to current general practice. Following discussion with the Department of Sociology at Glasgow University it was decided that a semi-structured telephone interview would elicit further information on this topic thus complementing the questionnaire study discussed in chapters 3(ii) and (iii) and allowing a more in-depth qualitative response. The telephone interview was conducted for those respondents in group one only (those training from 1981-1988).

RESULTS

Of the 118 respondents to the questionnaire, 99 were contactable for the telephone interview and all agreed that the interview be recorded. Of these respondents, 55 were male and 44 female.

There were a total of six questions asked during the interview. This section will consider each question in turn.

Question one: "Do you have any regrets concerning your career either in medicine or in general practice?" The overall response is shown in table 11 and table 12 lists the comments made by respondents in qualifying their reply. Those respondents who expressed regret regarding their choice of career were asked what they might have done instead. The results were as follows; accountancy or law 2, accountancy 1, architecture 1, engineering 1, teaching 1, computing or the stockmarket 1. Over a third of respondents expressed career

regrets (36%) with no difference between the sexes. The explanations given regarding expressed regrets were varied, with long hours of work and a change in the role of a family doctor being the most common.

Question two: "Has general practice lived up to the expectations you had while training?" There were five males and four females who did not respond to this question in a manner which was readily assessable. The overall result is shown in table 13 with the qualifying comments in table 14. Of the respondents 26% felt practice had failed to live up to expectations with the most common reasons being an increase in administration and an increase in workload.

Question three: "Do you feel your vocational training adequately equipped you for general practice today?" There were two males and six females who did not answer this question. The result for the remainder is shown in table 15 with their comments in table 16. Over half (51%) respondents, particularly females, did not feel their training equipped them for practice. The explanations most often cited were that there was a lack of training in management skills, administration and finance.

Question four: "Now that the government's new contract is in force do you think any alterations will require to be made to vocational training as you experienced it?" There were three males and nine females who failed to answer this question. The results are shown in table 17 with their comments in table 18. Almost all respondents (92%) felt further changes to training would be required. These changes would consist particularly of an increased emphasis on management, practice administration, business skills and computer skills.

Question five: "Do you think trainee's performance should be assessed? If so, how do you think it might best be done?" For this question seven males and five females did not answer. The results are shown in table 19 with comments in table 20. There was general agreement with 88.5% responding in favour and there was again a high percentage of females. The most popular methods of assessment were trainer assessment, continuous assessment and video assessment.

Question six: "Do you think that the certificate of prescribed experience issued by the Joint Committee for Postgraduate Training in General Practice is an adequate means of indicating satisfactory completion of training?" There were five males and six females who failed to answer the question. The results for the remainder are shown in table 21 with their comments in table 22. Two thirds of respondents (66%) felt the current situation was not adequate with again a higher percentage of females. The most popular alternative was to combine the certificate with assessment, in order to give it more credibility.

DISCUSSION

One of the merits of this study is that it is a qualitative study. Recently the value of qualitative research has been recognised in general practice (Britten 1993, McCormick 1994).

Another merit is that each stem question was a closed question, thereby allowing a yes/no response which is easily coded and analysed. The qualifying comments were categorised by one person (the author) after reviewing the audio taped conversations. All responses were written down and then examined (by the author), searching for key words or phrases.

Another merit of this study is that each respondent was questioned by the same person thereby allowing for some standardisation of questioning.

One possible demerit of the study is that having one person perform all the research and analysis means that any errors in questioning technique could be repeated. However, there may be substantial advantages in using a single researcher throughout the studies with a consistent approach and technique to the interviews.

Encouragingly, there was a very positive response to the telephone interview. The respondents answered the questions in an extremely frank and detailed manner, perhaps reflecting their support for the subject matter.

It would appear that at the time of the telephone interviews (September 1991 to July 1992) there was a degree of discontent regarding the respondents career which applied to both sexes. Examining the reasons given, it would seem that even 16 to 27 months after the general practitioner contract was imposed it was still exerting an adverse effect on the morale of those questioned. Many of the reasons were perceived to be related to the contract; an increase in administration, loss of the traditional family doctor image and a loss of professional freedom. Quote one: "I am now unable to influence the shape and future of my career and I have little to say. It's all decided by politicians. The ethos of being a traditional family doctor has been swamped by regulations". Quote two: "I am disillusioned as to what medicine has become. We have lost sight of the main aim - looking after patients - and have become more interested in business".

A quarter (26%), of respondents considered that general practice was not what they had expected while training and again this was similar for both sexes.

Again the contract appears to have had a strong influence (an increase in administration, change in the role of the family doctor). However, there are also other notable features. A proportion felt that general practice entailed a larger work commitment than they had realised which may be related to the contract but may also reflect the increased level of responsibility as a principal and a different work environment from that of the training practice. Some respondents gave this as a problem as their training practice was much better organised than their current practice, resulting in a reduction in expectations. Quote three: "My training practice was so good that nothing has lived up to that". Quote four: "The buck stops with you (as a principal) and brings home responsibilities in a greater way than I imagined". Quote five: "As a trainee you get a jaundiced view because you're in a good, organised practice and don't have the same responsibilities as a partner".

Perhaps there is a need for more structured career guidance for junior doctors, possibly during their residency programme, to ensure that doctors embark on a career which is best suited to their abilities, personalities and professional attributes as has been previously suggested (McIntyre and Parry 1975, Floyd 1983, Grant et al 1989) and is recognised as a defined training need by the GMC (General Medical Council 1987).

Just over half (51%), of respondents felt that their training did not adequately prepare them for general practice. If one examines the reasons for this it becomes clear that again the contract had a role to play with not enough emphasis during training on management skills, administration, financial matters, audit, computers and general practice as a business. It was acknowledged by some respondents that the contract could not have been totally foreseen and that perhaps they could not have been more prepared. However, it has been known for some time that the areas of finance and

practice management present problems for trainees and perhaps this has just been further highlighted by the contract (Whitfield 1966, Freer and Reid 1978 and Short 1987). The trainee year is of finite length and one could argue that it should be extended to eighteen months, not restricted to twelve. This would allow instruction in these topics in addition to the many other aspects of general practice determined by the educational needs of the trainee as identified by a checklist completed during their first month as part of the formative assessment programme. As these areas are difficult for principals and trainees alike it may be more appropriate to utilise a variety of teaching methods such as small group discussion and problem orientated learning, giving the trainee a specific task to solve and multiple choice questions.

Reflecting these findings is the fact that almost all respondents (92%), recognised that vocational training requires to change to take account of the above points. This demonstrates that it is crucial for vocational training to mirror current practice and that it should include new developments as they occur. Training has to then be as adaptive to change as general practice itself.

It would appear that some trainees find themselves unprepared for the fact that the practice they currently work in is quite different to their training practice. Quote six: "A lot of training practices don't equip you for where most people will work". Quote seven: "I was spoon-fed as a trainee - I didn't see what it (general practice) was like in the raw. It was a bit of a shock". It is difficult to know whether this could be addressed and if so how it could be done. Practice exchanges would perhaps be appropriate if they were arranged with a practice of a different profile. However, as mentioned before (Chapter 1(ii)) the main resistance to this proposal is from the trainees themselves. Perhaps trainees could also be encouraged to do some locum work for a short period if possible.

These options may become more feasible if vocational training were extended to 18 months in general practice.

The majority (88.5%), of respondents were in agreement with the principle of trainee performance assessment. They did have quite definite ideas on the subject, tending to favour continuous, informal assessment by the trainer for educational purposes, with feedback on performance (formative assessment), rather than any structured formal assessment with pass/fail potential (summative assessment). During the interview the possibility of the two co-existing was not explored. The College exam was perceived generally as being unsuitable as a form of assessment although the fact that the purpose of the exam is to achieve admittance to the College was not mentioned. It was apparent during the interviews that many respondents were unaware of the current situation. Quote eight: "Are we not being assessed?" Quote nine: "I think it's already assessed. The time for deciding whether someone is good enough to be a doctor is at finals".

There were ten respondents who disagreed with assessment and expressed doubts. Quote ten: "You're assessed during medical school. If you graduate that's more than adequate. If assessment is required it means the University is not doing it's job properly". Quote eleven: "There should be no assessment. What do you do with those who fail?" The opposing view was also expressed, quote twelve: "You should be told if you're not capable of the job. No-one says you're not suited to general practice".

Generally the certificate of prescribed experience issued by the Joint Committee was not perceived to indicate satisfactory completion of training (66%). It was felt that it signified simply a completion of training with no qualifying statement on performance. Quote thirteen: "If you complete the jobs

you get the certificate. You'd have to do something awful not to get it". Quote fourteen: "The certificate is not worth the paper it's written on. It's no reflection of competence". Although the numbers were not large in the study, there were more females who considered the current situation inadequate than males. This also applied to questions three to five. It is uncertain as to why this should be so. Whether it be that the females were more truthful or explicit, or whether the fact that the interviewer was female was of significance or whether females have higher expectations and standards is not known from this study.

It was acknowledged that the current situation could be improved if the criteria for issuing the certificate became more structured and rigidly applied, and also if assessment took place during training on which the decision to grant the certificate could then be based.

SUMMARY

This part of the thesis consisted of telephone interviews with 99 doctors who had trained from 1981-1988 in the west of Scotland. It has shown that there is an important degree of career dissatisfaction, in part associated with the 1990 contract and the changing face of general practice. A quarter of respondents felt that practice was not what they had expected and therefore perhaps more attention should be given to career guidance at an early stage. Vocational training had not prepared respondents for the changes the contract introduced and while this may not be unexpected, as they trained prior to the contract, the results from the second part of this study among respondents who had trained at the time of the contract showed little improvement (Chapter 3(ii)). This emphasises the importance of vocational training being receptive to changes in general practice and incorporating these as appropriate. Assessment was favourably received, with respondents tending to favour continuous, informal

assessment by the trainer for educational purposes (formative assessment), rather than any structured formal assessment with pass/fail potential (summative assessment). The certificate of prescribed experience issued by the Joint Committee was perceived as an inadequate statement of competence.

TABLE 11
CAREER REGRETS

	MALE		FEMALE		TOTAL	
	n=55	%	n=42	%	n=97	%
YES	18	(32.7)	17	(40.5)	35	(36)
NO	37	(67.3)	25	(59.5)	62	(64)

TABLE 12**COMMENTS QUALIFYING CAREER REGRETS**

Long hours of work	- 11 (5 male, 6 female)
Idea of family doctor changed	- 7 (4 male, 3 female)
Loss of professional freedom	- 3 (2 male, 1 female)
Too much administration	- 3 (3 male)
Intrudes on life too much	- 2 (2 female)
Dependant on whom you know	- 2 (1 male, 1 female)
Should be career structure	- 2 (1 male, 1 female)
Regret not going abroad	- 1 (male)
Regret entering present practice	- 1 (female)
Prefer longer in hospital	- 1 (female)
Lack of career guidance	- 1 (female)

(Some respondents gave more than one answer)

TABLE 13

HAS GENERAL PRACTICE LIVED UP TO RESPONDENTS' EXPECTATIONS WHILE TRAINING?

	MALE		FEMALE		TOTAL	
	n=50	%	n=40	%	n=90	%
YES	38	(76%)	29	(72.5%)	67	(74%)
NO	12	(24%)	11	(27.5%)	23	(26%)

TABLE 14

EXPECTATIONS OF GENERAL PRACTICE - QUALIFYING
COMMENTS

Amount of administration too great	- 11 (6 male, 5 female)
More work than realised	- 10 (9 male, 1 female)
No longer traditional family doctor	- 5 (3 male, 2 female)
Enjoyed it more	- 5 (2 male, 3 female)
Training practice better organised (than current practice)	- 5 (2 male, 3 female)
More responsibility than expected	- 4 (2 male, 2 female)
Reduced job satisfaction	- 3 (1 male, 2 female)
Dealing with same conditions frustrating	- 2 (2 female)

(Some respondents gave more than one answer)

TABLE 15

DID VOCATIONAL TRAINING EQUIP RESPONDENTS FOR
GENERAL PRACTICE?

	MALE		FEMALE		TOTAL	
	n=53	%	n=39	%	n=92	%
YES	30	(57%)	15	(38%)	45	(49%)
NO	23	(43%)	24	(62%)	47	(51%)

TABLE 16**PREPARATION FOR GENERAL PRACTICE - QUALIFYING
COMMENTS**

More needed on management skills	- 18 (9 male, 9 female)
More needed on administration/organisation	- 16 (11 male, 5 female)
Finance teaching poor	- 11 (5 male, 6 female)
More needed on business aspects of practice	- 9 (6 male, 3 female)
Much of hospital training irrelevant	- 7 (4 male, 3 female)
Trainee year not well organised	- 4 (3 male, 1 female)
No access to practice accounts	- 4 (1 male, 3 female)
Not equipped for `hardness` of practice	- 1 (male)
Not equipped for partnership problems	- 1 (female)

(Some respondents gave more than one answer)

TABLE 17

ALTERATIONS TO TRAINING REQUIRED?

MALES			FEMALES		TOTAL	
	n=52	%	n=35	%	n=87	%
<hr/>						
YES	45	(86.5%)	35	(100%)	80	(92%)
NO	7	(13.5%)	0	(0%)	7	(8%)

TABLE 18

ALTERATIONS REQUIRED FOR VOCATIONAL TRAINING - QUALIFYING COMMENTS

More on management skills	- 28 (16 males, 12 females)
More on practice administration	- 16 (9 males, 7 females)
More on general practice as a business	- 14 (9 males, 5 females)
More on computer skills	- 13 (6 males, 7 females)
More on financial matters	- 10 (5 males)
More on audit	- 9 (3 males, 6 females)
More on fundholding	- 6 (4 males, 2 females)
More on time management	- 5 (2 males, 4 females)
More on staff management	- 4 (1 male, 3 females)
More on research	- 2
More on specific contract tasks	
(i) health promotion	- 12
(ii) paediatric surveillance	- 8
(iii) minor surgery	- 8
(iv) screening	- 5

(Some respondents gave more than one answer)

TABLE 19

OPINIONS ON TRAINEE ASSESSMENT

MALE			FEMALE		TOTAL	
n=48	%		n=39	%	n=87	%
<hr/>						
YES	40	(83%)	37	(95%)	77	(88.5%)
NO	8	(17%)	2	(5%)	10	(11.5%)

TABLE 20

METHODS OF TRAINEE ASSESSMENT

Assessment of hospital training should take place	- 32
Assessment by trainer	- 29 (10 males, 19 females)
Continuous assessment	- 23 (8 males, 15 females)
Video assessment - yes	- 20 (10 males)
- no	- 7
O.S.C.E - yes	- 11 (9 males, 2 females)
- no	- 2
Not MRCGP	- 10
Informal assessment	- 6
Manchester rating	- 6
Patient assessment	- 4
Structured assessment	- 4
Written assessment	- 4
Assessment by partners	- 4
Independent assessor	- 2

TABLE 21

IS CERTIFICATE OF PRESCRIBED EXPERIENCE ADEQUATE?

	MALE		FEMALE		TOTAL	
	n=50	%	n=38	%	n=88	%
YES	22	(44%)	8	(21%)	30	(34%)
NO	28	(56%)	30	(79%)	58	(66%)

TABLE 22

**CERTIFICATE OF PRESCRIBED EXPERIENCE - QUALIFYING
COMMENTS**

Assessment needed	- 25 (17 males, 8 females)
Indicates attendance only	- 13 (6 males, 7 females)
Need to improve issuing criteria	- 13 (5 males, 8 females)
Trainers frightened not to issue	- 9 (5 males, 4 females)
Issue is automatic, a rubber stamp	- 8 (7 males, 1 female)
Hospital jobs need to be relevant	- 4 (1 male, 3 females)
Should be definite career structure	- 2 (2 male)

(Some respondents gave more than one answer)

CHAPTER 4

An Assessment of Current Hospital Training for General Practice

INTRODUCTION

The hospital component of vocational training has been the subject of much criticism since the introduction of vocational training, particularly in recent years (Polnay and Pringle 1989, Reeve and Bowman 1989, Crawley and Levin 1990, Kearley 1990, Styles 1990b and Smith 1991). There have also been reports on the inadequacy of hospital training for all junior house officers (Dent et al 1990). A recent study by Gillard et al (1993) found that despite progress in reducing junior doctors hours of work and providing induction courses, the training for house officers is still unsatisfactory. The General Medical Council's most recent publication on recommendations on General Clinical Training was published in 1992.

The quality of the hospital component of vocational training was questioned by the results of the study described in Chapters 1 and 3. Therefore this study was undertaken with the primary aim of evaluating the educational content of current hospital posts in the west of Scotland and determining their relevance to vocational training for general practice.

SUBJECTS AND METHODS

The subjects comprised 155 trainees who were in the general practice component of training in the west of Scotland in February 1993. A short questionnaire was designed by the author (Appendix J) and piloted on ten trainees. After slight modification it was distributed to all 155 trainees in general practice training via the thirteen regional trainee representatives in February 1993. Due to a slow initial response a reminder letter was sent to the representatives in March 1993 and then to all trainees in May 1993 from the

Regional Adviser in General Practice. One questionnaire was completed for each hospital post held in the region. A total of 88 trainees responded, providing information on 249 hospital posts. A small proportion of the trainees (30) had undertaken their hospital training in Ireland and therefore were deducted from the total of 155 trainees. The response rate was therefore 70% (88/125).

257 questionnaires in total were returned. Eight were discarded as they related to posts outwith the region, giving the final total of 249. Of these, 42 were as a result of the reminder letter in May 1993.

RESULTS

The responses were divided between the specialties as follows; obstetrics/gynaecology 45, accident/emergency 41, geriatrics 37, psychiatry 33, medicine 27, paediatrics 21, obstetrics 11, infectious diseases 7, gynaecology 5, anaesthetics and ENT 3 each, dermatology, oncology, ophthalmology and respiratory medicine 2 each, paediatric psychiatry, paediatric accident and emergency, and rheumatology 1 each.

The median length of time spent in each post was six months (229 posts) with the exception of twenty posts where the time ranged from 2 to 42 months.

Due to the small numbers in some specialties, the results in the remainder of this section will pertain to the following posts; accident/emergency, medicine, geriatrics, obstetrics/gynaecology, paediatrics and psychiatry.

Graph 12 demonstrates trainees' awareness of the existence of educational objectives in the hospital posts they had held. Overall the general awareness level was poor with obstetrics/gynaecology having the highest figure of 53% (24/45) and paediatrics the lowest of only 9.5% (2/21). Respondents were

then asked in posts where there were objectives, whether they felt they had been achieved. Of the respondents who held an obstetrics and gynaecology post 75% (18/24) considered that they had been achieved, with the remainder either disagreeing or failing to reach a decision. Regarding the other posts, the following results show the numbers who considered that the objectives had been met: psychiatry 11/13, paediatrics 0/2, geriatrics 11/12, medicine 8/10 and accident and emergency 14/17. The trainees generally agreed with the principle that educational objectives should exist for hospital posts with 81/88 trainees expressing agreement.

Graph 13 shows those respondents who had planned, and impromptu, tutorials during each post. The figures for planned tutorials were generally disappointing, particularly for medical, geriatric and paediatric posts although they were not unexpected.

Small group discussion was most likely to take place during medical and psychiatric posts and least likely during paediatric posts (Graph 14). Respondents were asked whether protected time with no other arranged duties existed. The results are displayed in graph 15. The answer was an overwhelming negative: the highest figure for protected time was only 22%, for psychiatry.

Study leave was permitted in most medical, psychiatric, paediatric and geriatric posts (Graph 16). This graph also shows the respondents who took study leave, expressed as a percentage of the total number of respondents. In all cases this figure was less than fifty percent. Outpatient attendance was enquired about as respondents in the first study had stated that they considered it of relevance for vocational training. The results were: obstetrics/gynaecology 45/45, medicine 27/27, psychiatry 31/32, geriatrics 21/36 and paediatrics 9/20.

Graph 17 compares the respondents who had no teaching with those with no formal, structured teaching. Teaching took place in all medical posts but in the majority of cases it was not structured. Psychiatric posts fared well as very few had no teaching of either format. Among the remainder there was a small but steady percentage of posts with no teaching and a larger percentage with no structured teaching.

Respondents were invited to describe their level of satisfaction with the quantity and quality of teaching they received during each post. Graph 18 displays those respondents who expressed dissatisfaction with each. Respondents who held a psychiatric post were the least dissatisfied either with the amount of teaching or its quality. However, respondents were most dissatisfied with the amount and quality of teaching in paediatrics and obstetric/gynaecology posts.

The final part of the questionnaire asked the respondents whether they considered that the hospital component of their vocational training had been of relevance to general practice and invited them to detail their responses in free text.

The number of comments for each hospital specialty was as follows, with the positive comments in brackets: obstetrics/gynaecology 28/45 (4), geriatrics 17/37, (7) accident/emergency 16/41 (4), paediatrics 16/21 (4), psychiatry 10/33 (6) and medicine 4/27 (0). This represented a total of 91 comments, which may reflect the level of feeling regarding the subject matter.

Some relevant quotes are listed below:

Accident/emergency posts:

- Actual experience of A+E invaluable..... However, very little training- mostly from experienced nursing staff.
- The on the job experience of A+E was relevant to general practice but this experience could have been significantly improved with a more structured teaching plan.
- Did not get any teaching.... It was considered a nuisance when SHOs asked questions.
- Relied on nursing staff for teaching.
- Absolutely no feedback on our treatment of patients. No guidelines given on simple procedures.

Geriatric posts:

- GP trainee placed with the consultant with no interest in teaching because the medical rotators complained so much. The job was worse than useless.
- Teaching style terrible. Basically "this is how I do it". Being a relevant subject for general practice, the teachers would have to be really bad to make it irrelevant.
- The daily routine of the job was appalling (e.g. filing). Only given formal instruction if you had done something the consultant was not pleased with. Postgraduate medicine is not suited to this trial and error approach.

- Very little involvement in decision making, no formal teaching. No commitment to useful general practice education.
- Too heavy a service commitment, teaching quality could have been so much better if consultants had a more responsible, adult attitude.

Medical posts:

- I felt I was there to fill a gap and had the impression that as a GP trainee wasn't worth engaging in intelligent conversation.
- Outpatient experience helpful but not every consultant had time to teach management principles properly.

Obstetric/gynaecology posts:

- Gyn - every third day spent in theatre holding retractors. Outpatient clinics - no guidance given. Obs - menial tasks of a resident. Occasional tutorials were arranged, none took place, all being cancelled at the last minute. Anything I learned was from the midwives.
- Continuity of care was very limited. Attendance at ward rounds was impossible and almost discouraged.
- Felt treated as a dogsbody to do any job that no-one else was available for.
- The structured tutorials were OK but the consultants seemed to think that non-career SHOs wouldn't be interested in anything.

- Time was spent performing menial tasks as fast as possible while being treated as an untouchable with no skills. (I learned how to take blood and do a basic clerk - in long before this job).
- A lot of irrelevant time spent in theatre and doing routine ward work.

Paediatric posts:

- Teaching depended largely on the attitude of the consultant. Tutorials were not protected times and I missed half due to pressure of work.

DISCUSSION

One of the merits of this study is that all trainees in the general practice component of their training were contacted, and 70% responded. Therefore the responses should hopefully be reasonably representative of the trainees and be as up to date as possible. The response rate is good, possibly due to the questionnaire being short and the fact that a reminder letter was sent. The replies covered a wide range of hospital specialties, however, one of the demerits of the study is that although information was received on 249 hospital posts, the final numbers per specialty and per hospital were not large.

Despite this, the information obtained is extremely important, particularly because the overall responses were very similar, in certain areas, across the specialties, particularly for protected time for study, educational objectives and planned tutorials.

There were a total of 91 comments perhaps reflecting the respondents' strength of feeling on the subject matter.

As may have been predicted, very few posts had stated educational objectives for the doctor in training.

The Royal College of General Practitioners recently published a booklet: *The Quality Of Hospital-Based Education For General Practice* (1993a). This outlines the College's educational appraisal of junior hospital posts. Previously a Royal College visitor attended joint hospital visits purely as an observer. Now the visitor will be empowered to appraise the post and formulate an independent assessment of the educational content of the post. This assessment will then be communicated to central College, the regional postgraduate dean and adviser, and to the Joint Committee on Postgraduate Training for General Practice. The post will be assessed using defined criteria, (the first essential and the second optional), which have been based on the Joint Committee guidelines. Among the optional criteria is the following "A separate 'educational contract' describing the educational experience and expectations of the post, should be offered at the beginning of the post."

In the west of Scotland few posts would currently satisfy this criteria. Although this criteria is at present optional, the booklet does indicate that this may require to change as standards improve.

Regular, planned tutorials have been an essential criteria for a training practice in the west of Scotland since 1985. It is disappointing, but not unexpected, that in the hospital component of training such teaching is rare except for some posts in obstetrics/gynaecology and psychiatry where figures of 78% and 76% were achieved. Also low figures were recorded for paediatric posts by Polnay and Pringle (1989) and Reeve and Bowman (1989) who reported that 37% of posts in the North Western Region had no teaching. Smith (1991) found that 25% of trainees had no formal teaching during obstetric posts for vocational training.

The figures for the presence of impromptu tutorials were generally even lower than those for planned tutorials. It is difficult to know whether this is due to trainees not recognising informal teaching when it did occur, or whether the figures represent wasted opportunities for teaching in hospital. The reasons for this may be twofold. Styles (1990b) acknowledged that there were serious concerns regarding the quality of hospital training. He felt there were three major areas of difficulty: lack of clarification over educational objectives, achieving a time balance between service commitment and learning, and the attitudes of some hospital consultants. Therefore in posts where there is a heavy service commitment opportunities for learning may not be achieved as both teacher and learner are otherwise occupied and in cases where the service commitment does allow time for teaching, this may not occur if the consultant does not hold the view that learning should occur by training and not by osmosis and by performing the job. Some of the comments from respondents illustrate that this attitude is still very much in evidence.

The importance of protected time for study has been recognised before (Ronalds et al 1981, Grant et al 1989). The General Medical Council stated in its Recommendations on The Training of Specialists (1987) that "trainees need to have enough time for reading and private study". The figures in this study are very disappointing and represent a large problem in the west of Scotland. Similarly, while study leave was permitted in most posts, only around 50% of respondents in fact took leave. One possible reason for this has been postulated by Presley (1991) who states "many trainees in hospital posts neglect their educational commitment owing to regard for fellow juniors who would need to work extra hours to cover the absent senior house officer". It would appear that the service commitment of many posts dominates the commitment training/learning. Difficulty in obtaining leave has also been described by Reeve and Bowman (1989) and Nasmyth (1990).

In this study there were only a small number of posts which had no teaching although in a high proportion of cases where there was teaching, it was not structured.

Overall, high levels of dissatisfaction were expressed by respondents regarding the quantity and quality of teaching received during hospital posts, with the exception of psychiatry. Ennis (1991) found deficiencies in the training and supervision of obstetric senior house officers. She found that 23% had no training in the use of forceps and of those who had, 35% felt their training inadequate. A previous study (Ennis and Vincent 1990), examined a review of obstetric accidents and concluded that many of the incidents could have been avoided. She suggested that middle and junior staff are inadequately trained and supervised. Similarly, Grant et al (1989) reported the results of a study in the South East Thames region and concluded "Overall, the findings disclosed the ineffectiveness of senior house officer training posts. Agreed definitions of what constitutes training and education are generally absent and learning occurs ad hoc.... the free competition between service and training will always be resolved in favour of service".

Senior house officer posts are traditionally training posts. The current situation is such that in many cases the service component of the post takes precedence above the educational/teaching component. "Training is defined almost entirely in terms of time rather than experience, so that juniors tend to be overexperienced but undertrained" (Blunt 1991). Defenders of the status quo consider that a doctor should learn on the job with direct hands-on experience, often as the defenders themselves did. This argument was dismissed in a report from the Council for Postgraduate Medical Education (Council for Postgraduate Medical Education in England & Wales 1987). The report called for a balance between training, service and education, and for

training for those involved in teaching junior staff. It also praised the principle of appointing a trainer for each trainee in general practice training and recognised that a similar system is needed during hospital training. "Consultants are not trained to train, they are not selected as teachers, they have no explicit teaching time and no remuneration for their training endeavours". The report contained a programme for implementing its recommendations at four different levels. It is apparent from the results of this study that these changes have not taken place in the west of Scotland. The recognition that there is little training for those involved in teaching and often less value awarded for good teaching, is not new. A report by the British Medical Students Association (1968) stated that "we would like to see more teachers appointed because of teaching ability rather than past research. Schoolmasters are taught to teach, but university lecturers are expected to have some divine dispensation".

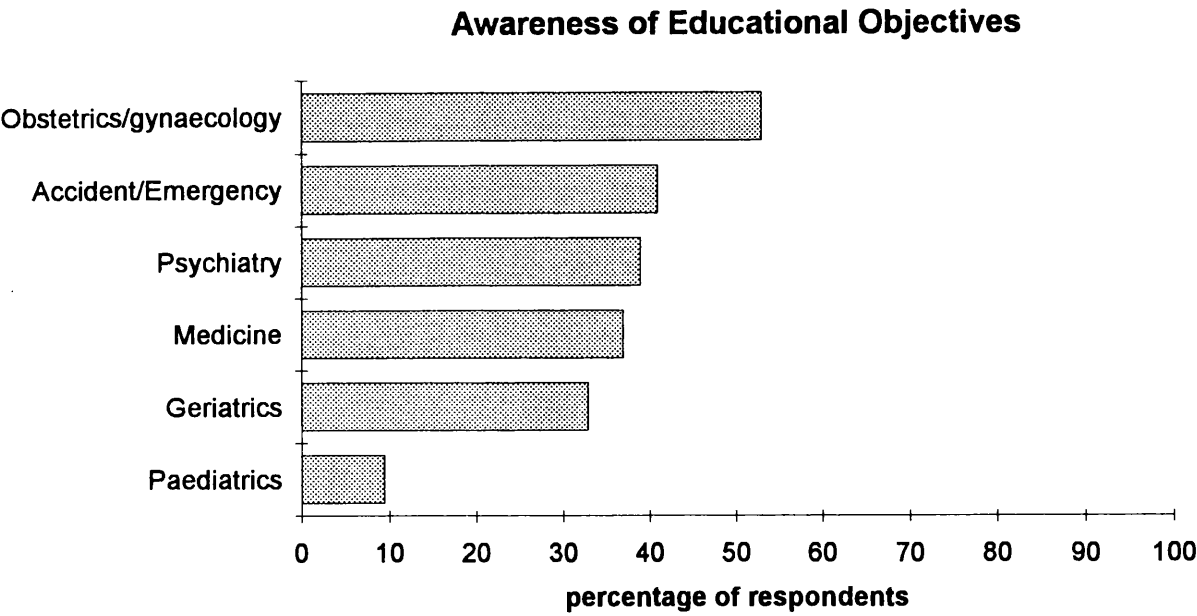
The need for structured training has been demonstrated very clearly (Wynne et al 1987, Marteau et al 1990) found that experience was associated with an increase in confidence but not with an increase in skills. They concluded that "experience is no substitute for training". Chew and Black (1991) found in their survey of 137 trainees in North West England that "some trainees reported confidence in carrying out a number of procedures" (minor surgery) "while confirming that they had not received sufficient training or experience in these". Therefore it would appear that there is an urgent need for agreed educational aims and objectives for hospital training with a structured learning programme .

With all this evidence, the main priority in the west of Scotland region over the next few years must be to raise the standard of vocational training in the hospital sector.

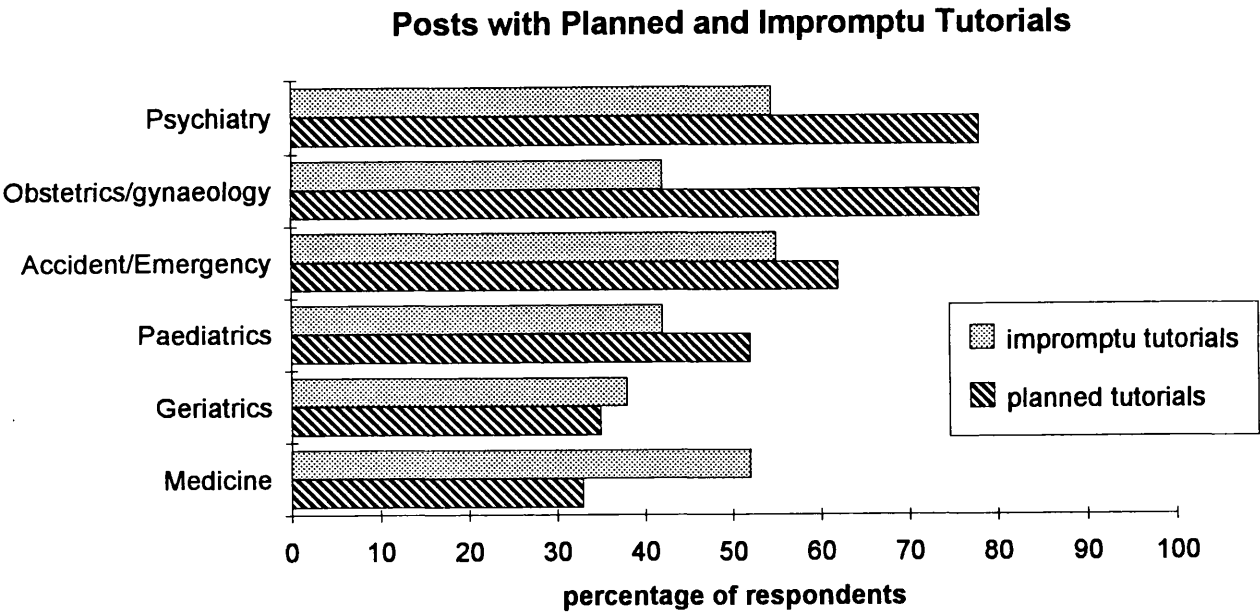
SUMMARY

The aim of this study was to evaluate the educational content of hospital posts in the west of Scotland and to ascertain their relevance to vocational training for general practice. The results demonstrate that the educational content of posts in the region is generally not of a high standard. This applies particularly to posts in paediatrics and obstetrics/gynaecology. Psychiatric posts appear most satisfactory in terms of structured teaching, planned tutorials, small group discussion and the quality of teaching. Protected study/teaching time is not occurring in the majority of posts.

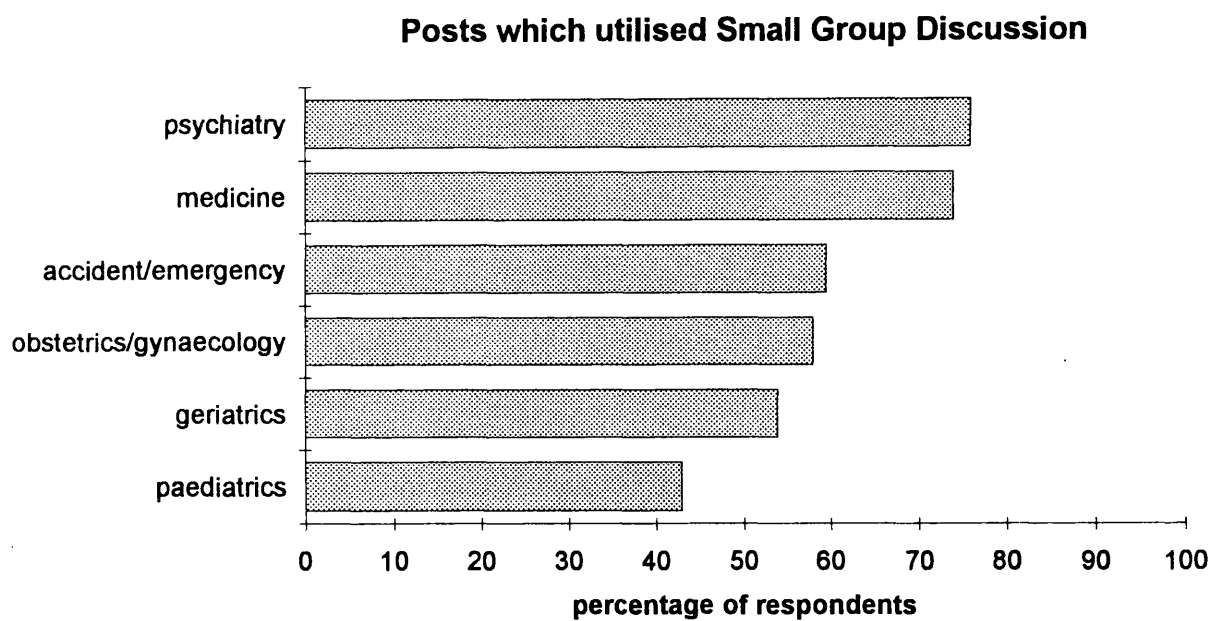
GRAPH 12



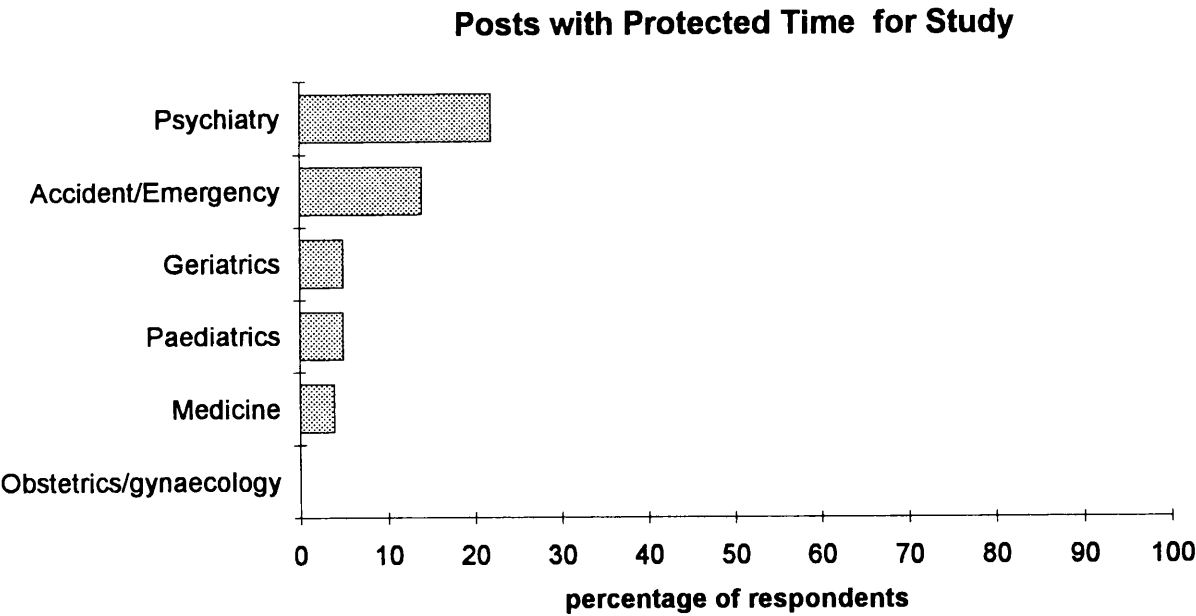
GRAPH 13



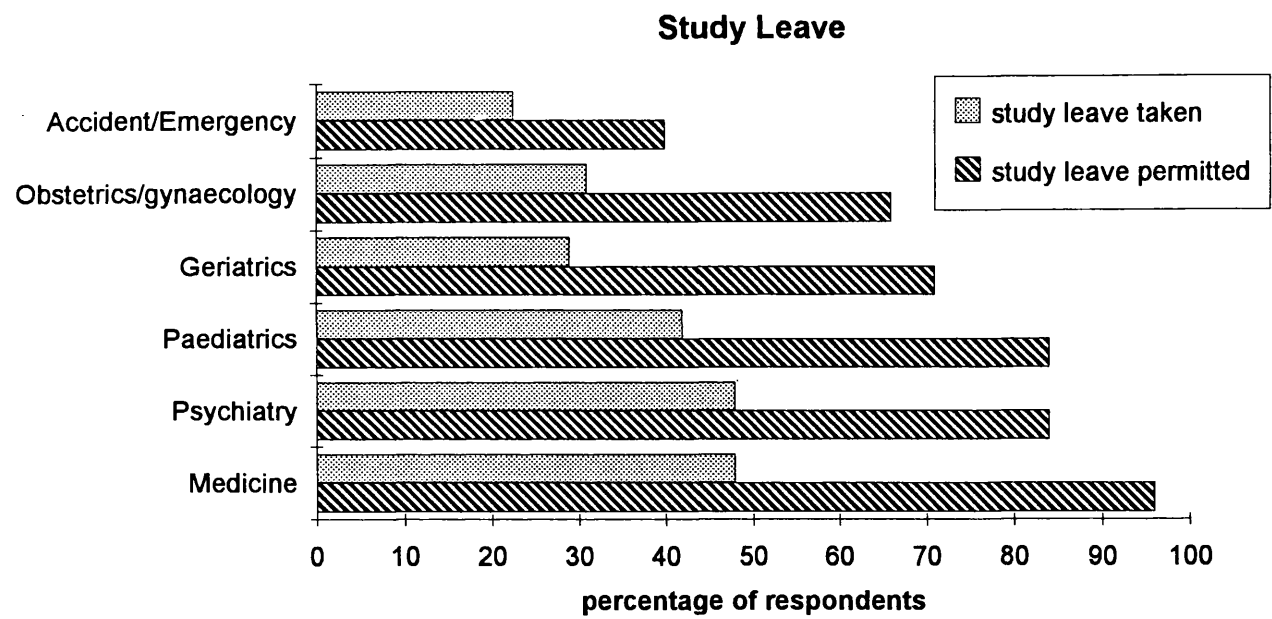
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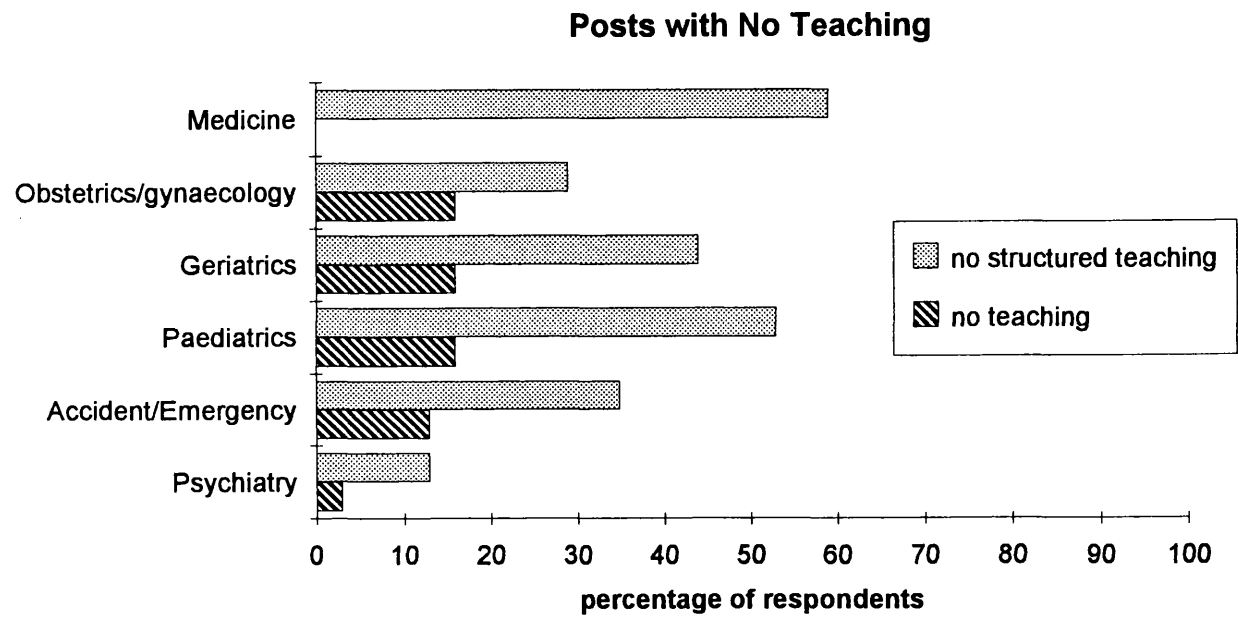
GRAPH 15



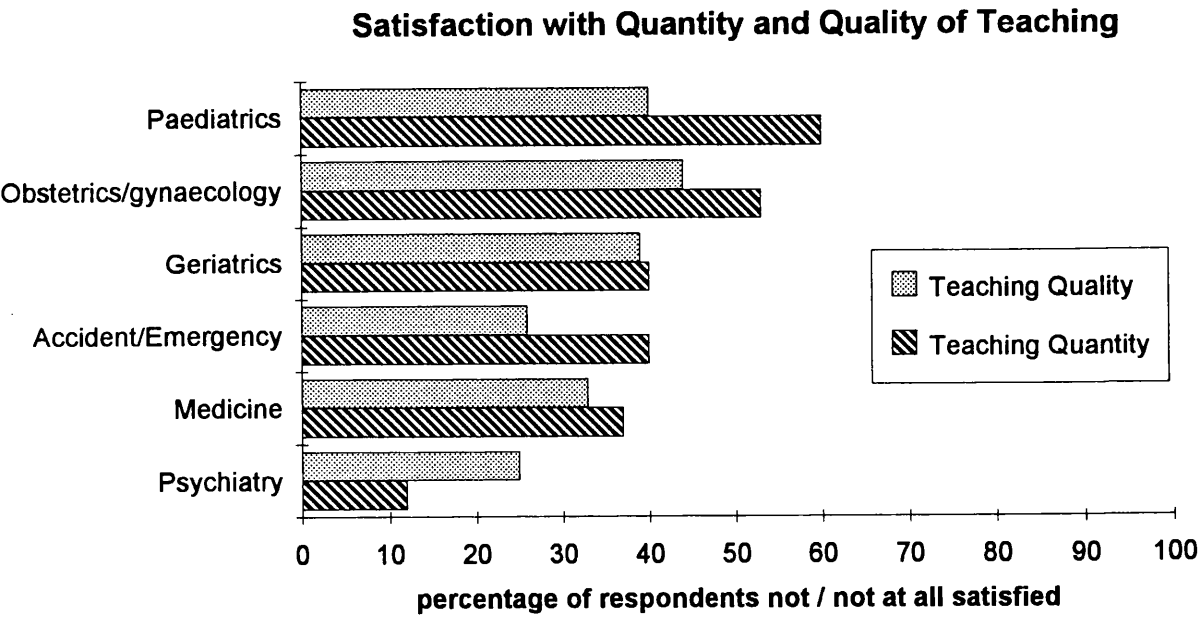
GRAPH 16



GRAPH 17



GRAPH 18



GENERAL DISCUSSION

The aim of this thesis is to evaluate vocational training in the west of Scotland on a larger scale than had previously hitherto been performed.

The first objective was to assess training since it began in the region by questioning doctors who trained over a twenty year period and to make comparisons of training over time. Chapter 1 addresses this objective looking at the responses of 619 doctors: a large scale study which had not previously been performed in the U.K. It demonstrated the feasibility of vocational training assessment using retrospective questioning of ex-trainees. A comparison of those training over the twenty years revealed that those who had trained most recently were on the whole most satisfied with their training, and improvements had taken place in the quality of training in general practice. Other factors such as the introduction of new criteria for the appointment of trainers also had a positive effect on vocational training in the region. Thus the importance of critically reviewing training standards was reinforced.

The second objective was to study a sub-group of doctors in more depth with particular emphasis on the effect of the 1990 general practitioner contract. The overall educational quality of training was found to be poor, particularly in the hospital component of training.

There were also deficiencies in the practice component where the main problem was in the teaching of practice management skills, financial and accounting skills, health promotion, and a low level of interest in research. Experience of audit was greatest among those who trained from 1989-92. With the completion of a cycle of audit now a compulsory minimum standard for trainees the next few years should witness a further increase in audit activity (Joint Committee on Postgraduate Training for General Practice 1992a). It has

been known for some time that trainees do not feel comfortable with practice management, finance and the business aspects of general practice (Whitfield 1966, Freer and Reid 1978 and Short 1987). This thesis demonstrates that the main reason for these deficiencies was poor teaching, although trainees did recognise that often the subject matter failed to interest them. This may reflect a lack of knowledge or a degree of reluctance on the part of the trainers and their partners regarding financial matters. It is clearly necessary to teach trainees on these topics in a way that is motivating.

Doctors training since the introduction of the 1990 contract felt more confident, particularly regarding minor surgery, paediatric surveillance and health promotion. However, although the confidence of those training after the contract was overall greater than the confidence of those training before (the degree depended on the particular task), the fact remained that many doctors, training at the time when the contract was at the forefront of general practice, did not feel their training prepared them for what the contract entailed.

The third objective was to make a full assessment of the hospital component of training among the most recent trainees, with particular regard to the educational content of the posts. The training afforded by 249 hospital posts was evaluated. It revealed that there was generally a low level of awareness of the posts' educational objectives, dissatisfaction with the quality and quantity of teaching provided and a lack of a structured teaching programme with planned tutorials, a lack of protected time for study and learning, and a lack of study leave. Clearly in the west of Scotland the hospital component of vocational training is failing to achieve even a minimum standard and this requires urgent attention.

This thesis has evolved from a quantitative, retrospective research format, to that of a present day qualitative format. This evolution occurred because analysis of the quantitative research raised further questions and ideas best suited to a more qualitative research approach. The qualitative component has suggested areas for further study regarding career selection, educational development and learning, which have relevance from an undergraduate through to a postgraduate level.

It is important to state that while the west of Scotland functions as an independent region it is also part of a wider, national training framework. Therefore recommendations and improvements applicable in this region could be applicable nationally.

This thesis has demonstrated that there have been many significant improvements made in the general practice component of vocational training. However, there remains scope for further improvement, particularly in the hospital component of training where the teaching requires to be developed and raised to the standard of that in practice.

FUTURE PROSPECTS

The studies performed in this thesis, although carried out in the west of Scotland, could equally be applied in principle to other regions as a means of evaluating vocational training.

General practice is perpetually in a state of change, the pace of which has been particularly intense recently with the 1990 contract, the evolution of fundholding and trust status, trainee assessment and proposals for re-accreditation. It is therefore imperative that the effect of changes in general practice on vocational training is determined, in order that training continues to reflect the needs of current general practice. This requires to be an ongoing, continuous activity and in the future, further studies could determine whether the findings reported in this thesis have been improved upon in terms of educational quality and relevance to general practice.

The Joint Committee on Postgraduate Training for General Practice (JCPTGP) has recently turned their attention to the hospital component of vocational training. As guidelines and criteria for training are produced, there will be enormous scope in the future to evaluate the extent to which the west of Scotland region is achieving the criteria. This thesis has demonstrated that in the region, the hospital component of training has many serious educational deficiencies. It would prove valuable to monitor future changes within this field and their effect on the quality of training in hospital posts in the west of Scotland.

The JCPTGP also has proposals to introduce end-point summative assessment for trainees at the end of the trainee year, prior to receiving their certificate of satisfactory completion of training. In the next few years it will be possible to study the effect of this on vocational training and on general practice. Once re-

accreditation is taking place it will be of interest to study the interaction of these two innovations.

This thesis has reported doubt as to the adequacy of the current situation of certification at the completion of training. In the future this looks set to change and it will prove interesting to study the effect this has on vocational training and ultimately on the standards of general practice and patient care.

ACKNOWLEDGEMENTS

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1. The most necessary Hospital Posts.
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4. Aspects omitted from training.
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6. Respondents' rating of trainee period.
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10. Regrets regarding career.
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12. Comments qualifying career regrets.
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15. Did Vocational Training equip respondents for General Practice?
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APPENDIX A

Original Publications

Kelly D R, Murray T S. Twenty years of vocational training in the West of Scotland. B.M.J 1991; 302: 28-30.

Kelly D R, Murray T S. Twenty years of vocational training in the West of Scotland - the practice component. BJGP 1991; 41; 353:492-5

Kelly D R, Murray T S. An assessment of vocational training in the west of Scotland. Med. Ed.1992, 26, 402-405.

Publications in Press

Thompson A M, Park K G M, Kelly D R, MacNamara I, Munro A. Training for minor surgery in general practice: is it adequate? 1994. British Journal of Surgery.

Publications in Preparation

Kelly D R, Murray T S. Vocational Training: Does it Adequately Prepare Doctors for General Practice?

Kelly D R, Murray T S. An Assessment of the Educational Content of Vocational Training for General Practice.

APPENDIX B

Educationally approved hospital posts `A' listed.

General Medicine

Geriatric Medicine

Paediatrics (Medical)

Psychiatry

Accident and Emergency Medicine or General Surgery

Obstetrics

Gynaecology

Obstetrics and Gynaecology

APPENDIX C

Trainer Selection Criteria (JCPTGP)

(1) The attributes of the trainer as a clinician will include:-

- a high standard of professional and personal values in relation to patient care - appropriate availability and accessibility to patients
- a high standard of clinical competence
- the ability to communicate effectively
- a commitment to personal professional development as a clinician
- a commitment to audit and peer review

(2) The qualities of the trainer as a teacher will include:-

- a personal commitment to teaching and learning
- an understanding of the principles and theory of education applied to medicine
- practical teaching skills
- a willingness to develop further as a clinical teacher
- a commitment to audit and peer review related to teaching

(3) A practice suitable for training will include:-

- partners and staff who practise a high standard of medicine and who are committed to vocational training
- good quality practice premises
- involvement in quality assurance
- exemplary practice records and registers

- effective practice management
- appropriate availability of hospital services
- a practice library and other teaching aids
- a volume of practice workload which ensures a balance for the trainee between the gaining of clinical experience and other opportunities for learning

APPENDIX D

Minimum Criteria for Training Practices (with implementation dates in brackets)

The Joint Committee has developed criteria and standards in specific areas as follows:

1. All medical records and hospital correspondence must be filed in practice notes in date order (January 1984).
2. Appropriate medical records must contain easily discernible drug therapy lists for patients on a long-term therapy (January 1986.)
3.
 - i) Regions should set and publish targets for the achievement of summaries in medical records in teaching practices.
 - ii) Practices should be seen to be making progress towards reaching these targets.
 - iii) Slow progress in an otherwise satisfactory practice should lead to a shorter duration of re-approval than the regional norm.
 - iv) Joint Committee visitors will expect to receive the region's policy statements on summaries in medical records and will review and report on progress in implementation of the policy (January 1987).
4. All training practices should be developing methods for monitoring prescribing habits as an important part of the audit process (January 1986).

5. All training practices should have a library containing a selection of books and journals relevant to general practice (January 1987).
 6. All training practices must provide opportunities for trainees to become familiar with the principles of medical audit and to participate in medical audit; and they must be able to demonstrate that trainees have actually done so (April 1991).
 7. Formative assessment, that is, assessment for educational purposes, should form an essential part of all posts approved or selected for general practitioner training (To be implemented January 1993).
- N.B. On 28 November 1991, the Joint Committee re-affirmed its current policy that individual regions should be responsible for issuing their own guidance on the keeping of medical records in training practices. However, the Committee agreed that medical records, whether manual or computerised, should be of a comparable standard and that they should be readily available and adequate for teaching purposes.

WEST OF SCOTLAND COMMITTEE FOR POSTGRADUATE MEDICAL EDUCATION

CRITERIA FOR SELECTION AND RESELECTION AS TRAINERS IN GENERAL PRACTICE

PERSONAL QUALITIES

The greatest influence on trainees in general practice is the example presented by their trainers as doctors. For this reason trainers must be enthusiastic, competent and caring general practitioners working in well organised practices. Most of a trainee's learning will derive from seeing and contributing to high quality patient care. The length of experience as a principal of a potential trainer will be important when taking these characteristics into account. The minimal experience will normally be 5 years as a principal with the upper age limit on first appointment age 55.

1. DESIRE TO TEACH

Enthusiasm for, and keenness to teach, as well as ability to motivate a trainee are particularly important. In addition to this is the appreciation of the need to monitor the progress of teaching and to discuss this regularly with the trainee and with peers.

To be assessed by:

- a) Past and present activities in teaching of undergraduates, postgraduates and paramedical staff.
- b) Interest in teaching methods including attendance at courses for teachers and plans for the further improvement of personal teaching skills.
- c) *Attendance should be on a regular basis at local trainers groups.*
- d) Willingness to submit to academic and operational assessment: applicants should demonstrate that they are aware of those areas in their practice in which changes are needed and that they have effective mechanisms for initiating and monitoring improvements.

The trainer and other members of the practice team would be actively involved in audit and would be able to demonstrate this to a trainee. The practice should be able to demonstrate Audits which have taken place and how this has led to change within the practice.

2. TIME TO TEACH OR READINESS TO MAKE TIME

The amount of time set aside for teaching and the way in which it is used is important. A training practice should spend the equivalent of two sessions per week on teaching responsibilities with a proportion of this time on undisturbed discussion between trainer and trainee.

* NEW CRITERIA IN ITALICS.

To be assessed by:

- a) Personal statement and submission of proposed timetable. Aims and objectives should be planned for the trainee year with a record kept of topics covered.
- b) Committee's local knowledge of practice.
- c) Trainee's reports (if practice has already been a training practice).

3. ATTITUDES TOWARDS PATIENTS, PARTNERS, PREVIOUS TRAINEES (IF ANY), COLLEAGUES AND GENERAL PRACTICE ITSELF

The contribution of other partners in the primary health care team to trainee teaching with the practice could be examined. There should be regular contact with other members of the primary health care team. *Representative members should meet regularly at least quarterly on a formal basis and the trainee should be involved.*

4. CLINICAL COMPETENCE

Clinical competence includes an ability to integrate physical, social and emotional factors in the assessment and management of patients. It also involves the ability to integrate other members of the primary health care team, hospital-based colleagues and other agencies in solving complex problems.

The practice should demonstrate quality of care through monitoring of their day-to-day work. Effective and economic prescribing is another aspect of clinical competence as is the ability to keep concise, informative and well-organised clinical records. *The practice should be able to demonstrate how prescribing data is handled and interpreted.*

The trainer should be able to communicate and co-operate with other members of the primary health care team and he should be able to communicate effectively, both within the consultation and outside it, and will be able to help trainees to develop these skills. *Regular use of video should take place involving both a doctor involved in training and the trainee.*

The practice should be able to demonstrate organised preventive medicine and effective care of patients with chronic disease.

The practice must show a degree of energy in the area of prevention and public health policy.

5. SPECIAL INTERESTS INCLUDING THOSE OF OTHER PARTNERS IN THE PRACTICE WITH SPECIAL EMPHASIS ON RESEARCH

The practice should have developed systems to help the trainee review his work. These could include age/sex registers, computers, a disease index and personal logs. *The practice should be able to demonstrate the basic skills in the use of information technology.* In addition, the development of preventive medicine also depends on the ability to identify patients and this could include morbidity and patient groups who are known to be at risk. *Training in child surveillance must be provided with an introduction to the requirements for minor surgery and health promotion. The practice should be familiar with the basic requirements for research in general practice.*

6. ACADEMIC QUALIFICATIONS

Trainers should be willing to have their clinical abilities assessed by their peers. The possession of the MRCGP examination is one example of such an assessment. The MRCGP examination is now the goal of most trainees and each trainer should be able to help the trainee prepare for this examination.

The trainer's attitudes towards this goal should be assessed during the visit.

7. CONTINUING EDUCATION

One hallmark of a good general practitioner can be seen from the importance which he attaches to personal professional development and continuing medical education. Potential trainers should be able to demonstrate ways in which they organise this. *All partners would normally fulfil the requirements for the postgraduate education allowance.*

The trainer will be familiar with the current medical literature and its implications for general practice and for general practice teaching. The practice should also have a number of up-to-date clinical and educational books and journals. The trainers should have knowledge of performance review and research projects.

8. ASSESSMENT

The trainer and trainee should jointly assess the trainee's needs at the start of the trainee year. Any difficulties must be conveyed to the associate adviser timeously and if necessary to the regional adviser's office. The trainer should make appropriate use of formal and informal methods of assessment during the year and this should fit in with the Regional assessment plan.

9. DEVELOPMENT

The practice should report the training achievements during the period of recognition with the aims for the period of re-recognition.

PRACTICE ORGANISATION AND PREMISES

1. ABILITY TO MAKE AVAILABLE THE NECESSARY TIME FOR TEACHING BY MEANS OF GOOD ORGANISATION

Trainers should be able to demonstrate the value of a well-run appointment system or other methods of access, flexible enough to allow patients to be seen immediately when necessary. They should also be able to demonstrate effective arrangements within the practice for home visiting and for services such as maternity, family planning and child health. The practice must provide readily available out-of-hours cover in which the trainee should take an active part.

The practice should have policies for home visiting, continuity of care and for emergency care. The trainee should obtain first hand experience of effective organisation, practice management and financial matters in a general practice. *The practice should demonstrate a system of management so that the trainee can learn through experience.*

Workload is a particularly important factor and when taking account of this there has to be a balance between ensuring that on one hand the practice can give adequate time to its teaching commitments and on the other, it can provide sufficient clinical experience comparable with that of the average general practice.

2. THE PRACTICE TEAM

Effective use of the practice team should be demonstrated in patient care.

3. PRACTICE REQUIREMENT AND PREMISES

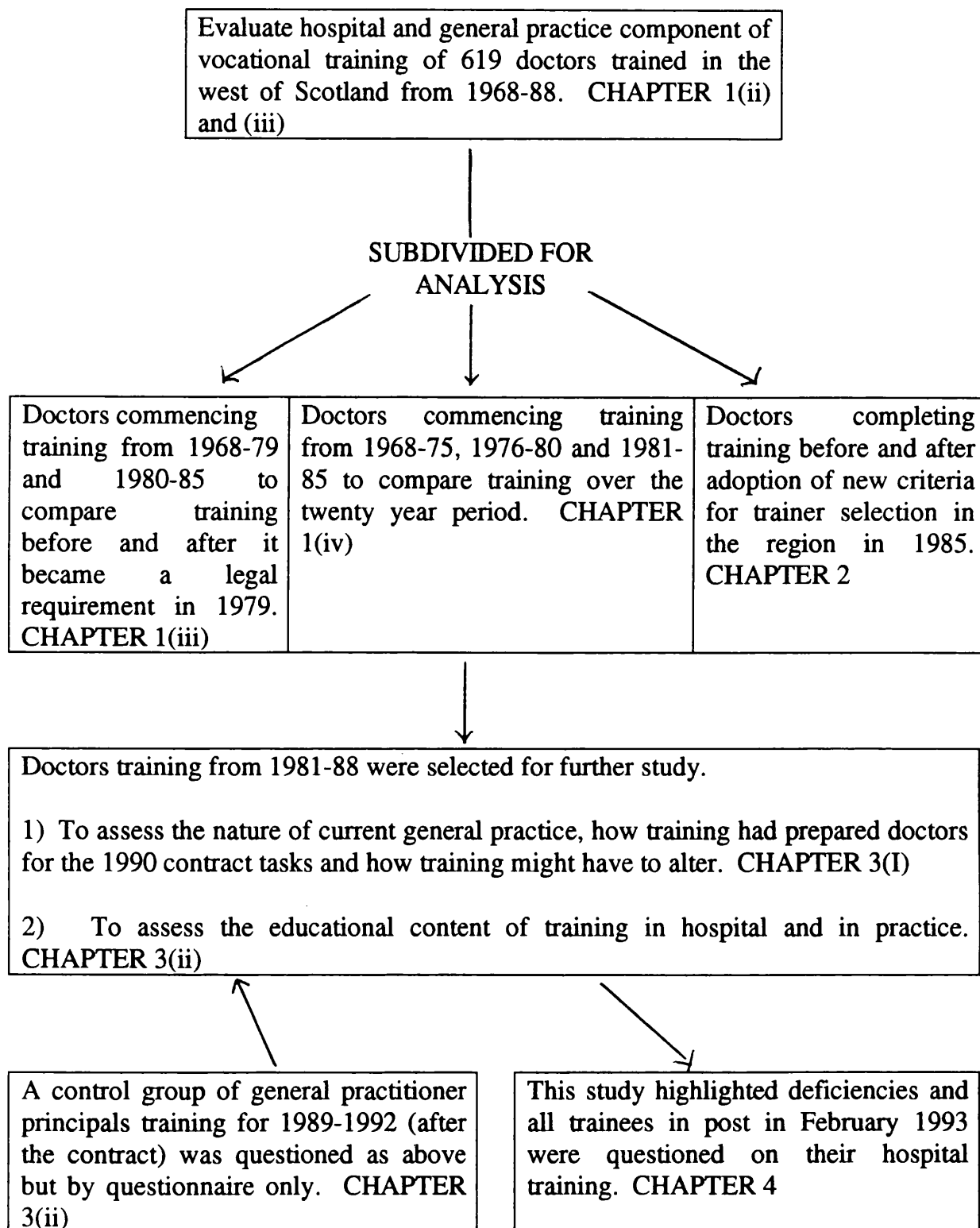
The premises should be adequate for the number of patients served. There should be a sufficient number of consulting rooms so that the trainee is able to consult during the same surgery sessions as the trainer or other partners. Adequate medical equipment should be readily available for the trainee to use.

4. AN EFFICIENT RECORD SYSTEM

Practice records must have the clinical notes, letters and results of investigations filed in chronological order. Long-term drug therapy should be clearly discernible in the records and important past events should be summarised. The records should be maintained for all doctor/patient contacts. *There should be a clear and effective system for the creation and updating of summaries. There should be a written statement about the content which should include preventive data.*

1ST AUGUST 1991

APPENDIX F



PRESENT - PERSONAL DETAILS

1. Sex Male ☐ Female ☐
2. Age ☐
3. Marital Status: Single ☐ Married ☐ Divorced ☐ Sep. ☐ Widowed ☐
4. Place and Date of Medical Degree :-
5. Postgraduate Qualification(s) with Date(s) :-
6. (i) Are you working at present? Yes ☐ No ☐
(ii) If yes what are you doing?
(iii) If yes when did you start?
(iv) If no what was your last job?
(v) If no have you chosen not to be working? Yes ☐ No ☐
(vi) Since graduating have you ever not been working? Yes ☐ No ☐
(vii) If yes for what reasons?
7. Including your present job, how many jobs have you had since completing your Vocational Training Scheme?

8. (i) Have you done any locums?

Yes

☐

No

☐

166

(ii) If yes for how long? (Total)

9. (i) Do you have any other professional commitments, e.g. member of committee, other jobs?

Yes

☐

No

☐

(ii) If yes please detail :-

10. (i) If you are working as a General Practitioner at present are you a member of a training practice?

Yes

☐

No

☐

(ii) If you are working as a G.P. are you a principal?

Yes

☐

No

☐

TRAINING - HOSPITAL COMPONENT

11. Date of starting Vocational Training

19

☐

12. Was the scheme

Self-constructed

☐

formal

☐

13.	Please outline hospital post	Length of time in post	Post	Name and Address of Hospital

Which post(s) did you feel were most necessary to you now in your current job and why?

If you did obstetrics how long did you do it for?

Did you feel the length of time you spent doing obstetrics was :-

Too long ☐ About right ☐ Too short ☐

(i) Would you, looking back now, choose a different post(s)?

Yes ☐ No ☐

(ii) If yes, please state which and why :-

If your hospital jobs were as a G.P. Trainee, in your opinion did the Senior Medical Staff consider you as a Junior Hospital Doctor or as a G.P. Trainee in training? Please tick relevant box.

They all regarded me as a V.T. ☐ They all regarded me as a JHD ☐

Most regarded me as a V.T. ☐ Most regarded me as a JHD ☐

Do you feel the length of time spent in hospital training was :-

Too long ☐ About right ☐

Too short ☐ Don't know ☐

TRAINING - PRACTICE COMPONENT

20. Did you have any choice in your training practice allocation?

Yes ☐ No ☐ Don't know ☐

21. (i) Time spent as a G.P. Trainee ☐ months

(ii) Was it continuous? Yes ☐ No ☐

(iii) If no, how was your trainee period split up?

22. (i) Do you wish it had been different?

Yes ☐ No ☐ Don't know ☐

(ii) If yes, how?

23. Overall how do you rate the training you received during your trainee year?

Excellent ☐ Very Good ☐ Fairly Good ☐

Fairly Poor ☐ Poor ☐ Very Poor ☐

24. (i) Were there any aspects of General Practice that were omitted or poorly covered in your Trainee year?

Yes ☐ No ☐ Don't know ☐

(ii) If yes, which aspects and why?

25. (i) Did you enjoy your time as a G.P. Trainee?

Yes ☐ No ☐ Don't know ☐

(ii) Please elaborate if you wish.

26. (i) If married did your spouse's job affect your career path?

Yes ☐ No ☐ Don't know ☐

(ii) If yes, how?

27. If you had the chance to go back would you choose to do :-

(a) A vocational training scheme? Yes ☐ No ☐ Don't Know ☐

(b) A self-constructed scheme? Yes ☐ No ☐ Don't Know ☐

(c) Follow a different career path? Yes ☐ No ☐ Don't Know ☐

28. (i) Would you choose to do the same job and trainee year?

Yes ☐ No ☐

(ii) If not, what would you alter and why?

THE TRAINING PRACTICE

29. Was your practice :-

Urban ☐ Rural ☐ Mixed Urban/Rural ☐

Dispensing ☐ Teaching ☐

30. Was it :-

Purpose-Built Private ☐ Converted ☐ Health Centre ☐

31. Number of doctors in total :-

Number of male drs. ☐ Female doctors ☐

Full-time doctors ☐ Part-time doctors ☐

Assist. doctors ☐ Trainees ☐

32. List Size Then, approximately :-

33. Please describe the social class mix of the patients in the practice :-

34. Obstetrics :- Full Care ☐ Shared Care ☐ Both ☐

35. How did the practice cover out-of-hours calls?

36. What proportion of out-of-hours did you do as a Trainee?

Less than your trainer ☐ The same as your trainer ☐

More than your trainer ☐ Don't Know ☐

37. Did you feel you should have done :-

more ☐ the same ☐ less than you actually did ☐

38. Appointments :- Yes ☐ No ☐ Full ☐ Partial ☐

39. Appointment Time :- 5 mins. ☐ 7½ mins. ☐ 10 mins. ☐ Other ☐

40. Staff Employed :- Practice Manager ☐ Practice Nurse ☐
Counsellors ☐ Receptionists ☐
Other ☐
.....

41. Staff Attached : - Midwife ☐ District Nurse ☐
Health Visitor ☐ Social Worker ☐
Physiotherapist ☐ Occupational Therapist ☐
Other ☐
.....

42. Diagnostic facilities to which open or direct access was available :-

Plain x-rays	<input type="checkbox"/>	Contrast radiology	<input type="checkbox"/>
Endoscopy	<input type="checkbox"/>	Mammography	<input type="checkbox"/>
Haematology	<input type="checkbox"/>	Biochemistry	<input type="checkbox"/>
Pathology	<input type="checkbox"/>	Bacteriology	<input type="checkbox"/>
Virology	<input type="checkbox"/>	Immunology	<input type="checkbox"/>
Other	<input type="checkbox"/>	
.....			

43. (i) Special Clinics, e.g.

Well Woman	<input type="checkbox"/>	Baby	<input type="checkbox"/>
Immunisation	<input type="checkbox"/>	Diabetic	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>
Other	<input type="checkbox"/>	
.....			

(ii) Did you attend any of them as a Doctor? Yes ☐ No ☐

(iii) If yes, which?

44. Did the practice own / have access to a computer?

Yes ☐ No ☐

45. Did the practice have its own library with G.P. Journals/Books?

Yes ☐ No ☐ Don't Know ☐

46. (i) Did you have a $\frac{1}{2}$ day Release Course?

Yes ☐ No ☐

(ii) If yes, where?

(iii) Did you find it :-

Very useful ☐ Not particularly useful ☐ Useful ☐

Useless ☐ Not sure if useful ☐

47. Did you have Regional Meetings?

Yes ☐ No ☐

48. (i) Were you as the Trainee encouraged to sit the MRCGP exam?

Totally encouraged ☐ Yes partially encouraged ☐

Not at all ☐

(ii) If not, please explain :-

49. (i) Were you encouraged to become involved in research?

Yes ☐ No ☐

(ii) If yes, please give details

50. Were there regular tutorials with time set aside each week?

Every week ☐ Most weeks ☐ A few weeks ☐ Never ☐

51. Did you find them :-

Very beneficial ☐ Beneficial ☐ Not particularly beneficial ☐
 Useless ☐ Not sure if beneficial ☐

52. (i) Did all the partners participate in training?

Yes ☐ No ☐

(ii) If not, please explain :-

53. Did you feel part of the practice?

Yes definitely ☐ Yes ☐ No ☐ Definitely not ☐
 Not sure ☐

54. (i) Did you attend practice meetings?

Yes ☐ No ☐

(ii) If not, was it by :-

Your own decision ☐ The practice's decision ☐

55. Were your consultations monitored in any way? e.g.

audiotapes ☐ videotapes ☐ parallel consulting ☐
 sitting in ☐
 other ☐

56. (i) Did you work in another practice for a short period as an exchange?

Yes ☐ No ☐

(ii) If yes, was it helpful?

(iii) If no, do you think it could have been of benefit? Please explain answer.

57. (i) Were you allowed study leave if you wished it?

Yes ☐ No ☐ Don't know ☐

(ii) If yes, did you take study leave?

Yes ☐ No ☐

(iii) If yes, how much did you take?

THANK YOU FOR TAKING THE TIME AND TROUBLE TO COMPLETE THIS QUESTIONNAIRE.
PLEASE RETURN IT TO DR. DIANE R. KELLY, SOUTHBANK SURGERY, 17-19 SOUTHBANK
ROAD, KIRKINTILLOCH, GLASGOW IN THE STAMPED ADDRESSED ENVELOPE PROVIDED.

CRITERIA FOR SELECTION AS TRAINERS IN GENERAL PRACTICE¹⁷⁶FOR MEMBERS OF SELECTION COMMITTEEPERSONAL QUALITIES

The greatest influence on trainees in general practice is the example presented by their trainers as doctors. For this reason trainers must be enthusiastic, competent and caring general practitioners working in well organised practices. Most of a trainee's learning will derive from seeing and contributing to high quality patient care. The length of experience as a principal of a potential trainer will be important when taking these characteristics into account. The minimal experience will normally be 5 years as a principal with the upper age limit on first appointment age 55.

1. A DESIRE TO TEACH

Enthusiasm for, and keenness to teach, as well as ability to motivate a trainee are particularly important. So too is the appreciation of the need to monitor the progress of teaching and to discuss this regularly with the trainee and with peers.

To be assessed by:-

- (a) Past and present activities in teaching of undergraduates, postgraduates and paramedical staff.
- (b) Interest in teaching methods including attendance at courses for teachers and plans for the further improvement of personal teaching skills.
- (c) Willingness to submit to academic and operational assessment: applications should demonstrate that they are aware of those areas in their practice in which changes are needed and that they have effective mechanisms for initiating and monitoring improvements.

2. TIME TO TEACH OR READINESS TO MAKE TIME

The amount of time set aside for teaching and the way in which it is used are important. A trainer should spend the equivalent of two sessions per week on his teaching responsibilities with a proportion of this time on undisturbed discussion between trainer and trainee.

To be assessed by:-

- (a) Personal statement and submission of proposed timetable.

- (c) Trainees' Reports (if practice has already been a training practice).

3. ATTITUDES TOWARDS PATIENTS, PARTNERS, PREVIOUS TRAINEES (IF ANY), COLLEAGUES AND GENERAL PRACTICE ITSELF.

The contribution of other partners in the primary health care team to trainee teaching within the practice could be examined. The visitors could also consider the use of other local facilities for learning, for example, general postgraduate activities.

This information could be obtained from those with local knowledge.

4. CLINICAL COMPETENCE

Clinical competence includes an ability to integrate physical, social and emotional factors in the assessment and management of patients. It also involves the ability to integrate other members of the primary health care team, hospital-based colleagues and other agencies in solving complex problems.

The practice should demonstrate quality of care through monitoring their day-to-day work. Effective and economic prescribing is another aspect of clinical competence as is the ability to keep concise, informative and well-organised clinical records.

The trainer should be able to communicate and co-operate with other members of the primary health care team and he should be able to communicate effectively, both within the consultation and outside it, and will be able to help trainees to develop these skills.

5. SPECIAL INTERESTS INCLUDING THOSE OF OTHER PARTNERS IN THE PRACTICE WITH SPECIAL EMPHASIS ON RESEARCH

The practice should, have developed systems to help the trainee review his work. These could include age/sex registers, diseases index and personal logs. In addition, the development of preventative medicine also depends on the ability to identify patients and this could include morbidity and patient groups who are known to be at risk. Child surveillance could be an example.

6. ACADEMIC QUALIFICATIONS

Trainers should be willing to have their clinical abilities assessed by their peers. The possession of the MRCGP examination is one example of such an assessment. The MRCGP examination is now the goal of most trainees and each trainer should be able to help the trainee prepare for this

The trainer's attitudes towards this goal could be assessed during the visit.

7. CONTINUING EDUCATION

One hallmark of a good general practitioner can be seen from the importance which he attaches to personal professional development and continuing medical education. Potential trainers should be able to demonstrate ways in which they organise this.

The potential trainer will be expected to be familiar with the current medical literature and its implications for general practice and for general practice teaching. The practice should also have a number of up-to-date clinical and educational books and journals. The trainers should have knowledge of self-audit, performance review and research projects. Performance review could look at such activities as repeat prescribing, immunisation programmes and care of patients with chronic diseases.

PRACTICE ORGANISATION AND PREMISES

1. ABILITY TO MAKE AVAILABLE THE NECESSARY TIME FOR TEACHING BY MEANS OF GOOD ORGANISATION.

Trainers should be able to demonstrate the value of a well-run appointment system or other methods of access, flexible enough to allow patients to be seen immediately when necessary. They should also be able to demonstrate effective arrangements within the practice for home visiting and for services such as maternity, family planning and child health. The practice should provide readily available out-of-hours cover in which the trainee should take an active part.

The practice should have policies for home visiting, continuity of care and for emergency care. The trainee should obtain first hand experience of effective organisation, practice management and financial matters in general practice.

Workload is a particularly important factor and when taking account of this there has to be a balance between ensuring that on one hand the practice can give adequate time to its teaching commitments and on the other, it can provide sufficient clinical experience comparable with that of the average general practice.

2. PROVISION OF APPROPRIATE ANCILLARY STAFF

eg. Receptionist, District Nurse and Health Visitors.

3. PRACTICE EQUIPMENT AND PREMISES

The premises should be adequate for the number of patients served. There should be a sufficient number of consulting rooms so that the trainee is able to consult during the same surgery sessions as the trainer or other partners. Adequate medical equipment should be readily available for the trainee to use.

4. AN EFFICIENT RECORD SYSTEM

Practice records must have the clinical notes, letters and results of investigations filed in chronological order. Long-term drug therapy should be clearly discernible in the records and important past events should be summarised. The records should be maintained for all doctor/patient contacts.

26 November 1985

QUESTIONNAIRE

BASIC DATA

1. AGE: []
2. MARITAL STATUS: Married [] Single [] Widowed []
Divorced [] Separated [] Remarried []
3. Are you working at present? YES/NO
(If NO please go to Question 9)
4. Are you in general practice? YES/NO
(If NO please give current job
and then go to Question 9)

5. If you are in general practice are you FT [] PT [] Assis []
Other []
6. How long have you been in your present post? [] years
7. Is your practice a training practice? YES/NO
8. Are you a Trainer? YES/NO
9. Do you have the MRCGP? YES/NO (if NO please go to Question 11)
10. Did you obtain the MRCGP as a Trainee? []
as a Principal? []
Other? [] please explain

CURRENT MEDICAL PRACTICE

11. If you are in general practice what is the list size of your
practice? []
(If not in general practice please go to Question 18)
12. How many partners are in the practice including yourself?
[] partners
13. How many have full time commitment? [] partners
14. Are your premises: purpose built [] converted []
health centre [] Other []

15. Under the terms of the 1990 New Contract which of the following currently exist in your practice?

- health promotion clinics ☐
- paediatric surveillance clinics ☐
- minor surgery clinics ☐
- a computer ☐
- a practice information leaflet ☐
- an annual report ☐
- audit of clinical topics relevant to general practice ☐
- audit of non-clinical topics relevant to general practice ☐
- full complement of ancillary staff ☐
- practice nurse ☐

16. In your opinion did your vocational training prepare you to perform the following new tasks?

- | | very
well | reasonably
well | not very
well | not at
all |
|----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| - health promotion clinics | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| - paediatric surveillance | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| - minor surgery | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| - compile an annual report | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| - audit | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| - use a computer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

17. If you have a practice computer do you agree that your vocational training equipped you with a basic knowledge to use it in general practice?

- yes strongly agree ☐
- agree ☐
- undecided ☐
- disagree ☐
- strongly disagree ☐

18. As a vocational trainee, did you receive any teaching on consultation/communication skills in dealing with patients?

- Yes ☐
- No ☐
- Don't Know ☐

19. Did you receive any teaching on consultation/communication skills in dealing with other professionals and members of the primary health care team?

- Yes ☐
- No ☐
- Don't Know ☐

Please indicate the extent to which you agree with the following statement:

20. Instruction in communication skills should form part of vocational training.

```
yes strongly agree    [ ]
agree                 [ ]
undecided              [ ]
disagree               [ ]
strongly disagree     [ ]
```

21. With regard to practice organisation, how well do you consider that your vocational training equipped you to deal with the following:

		Very Well	Reasonably Well	Not very Well	Not at all
i	dealing with staff	[]	[]	[]	[]
ii	knowledge of NHS income	[]	[]	[]	[]
iii	knowledge of obligations under NHS contract	[]	[]	[]	[]
iv	ability to monitor appointment systems	[]	[]	[]	[]
v	ability to monitor records, registers	[]	[]	[]	[]
vi	knowledge of partnership agreements	[]	[]	[]	[]
vii	knowledge of account keeping	[]	[]	[]	[]
viii	knowledge of income tax	[]	[]	[]	[]

22. If you answered NOT AT ALL or NOT VERY WELL to any of the above do you think this was because:

(You may tick more than one box)

i ii iii iv v vi vii viii

- | | |
|--|---------------------------------|
| - you had no teaching on
the subjects | [] [] [] [] [] [] [] [] |
| - you had poor teaching
on the subjects | [] [] [] [] [] [] [] [] |
| - you were uninterested
in the subjects | [] [] [] [] [] [] [] [] |
| - you failed to see the
relevance of the subject
at the time | [] [] [] [] [] [] [] [] |
| - other - please explain | [] [] [] [] [] [] [] [] |

23. Which, if any, of the following do you consider important to the personal development of a general practitioner?

- ☐ keeping abreast of current journals
 - ☐ research
 - ☐ audit
 - ☐ medical interests outside practice
 - ☐ interests outwith medicine
 - ☐ ability to recognise and adapt to change
 - ☐ ability to recognise changing needs of patients
 - ☐ performance assessment whether by self or peer group
 - ☐ other (please explain)
-

24. How well did your vocational training equip you to deal with time management?

- | | very
well | reasonably
well | not very
well | not at
all |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| - in consultations | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| - in the balance between patients/practice/family etc. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

25. How well did your vocational training enable you to deal with the following aspects of patient care?

- | | very
well | reasonably
well | not very
well | not at
all |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| - recognising patient problems - medical | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| - recognising patient problems - psychosocial | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| - managing patient problems - medical | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| - managing patient problems - psychosocial | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| - emergency care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| - prevention | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

26. When you began your vocational training year was it your expectation to be:

- ☐ a full time principal
- ☐ a limited commitment principal
- ☐ an assistant
- ☐ a job sharer
- ☐ on a retainer scheme
- ☐ outwith general practice
- ☐ other

27. At the conclusion of your trainee year was it your expectation to be:

- ☐ a full time principal
- ☐ a limited commitment principal
- ☐ an assistant
- ☐ a job sharer
- ☐ on a retainer scheme
- ☐ outwith general practice
- ☐ other (please explain)

28. Would you in retrospect now choose general practice as a career?

- Yes ☐
- No ☐
- Don't Know ☐

29. Would you in retrospect now choose medicine as a career?

- Yes ☐
- No ☐
- Don't Know ☐

30. Looking at the future do you see yourself:

- remaining in general practice ☐
- in another branch of medicine ☐
- not in medicine ☐
- other (please explain) ☐

- don't know ☐

G.P. TRAINING

HOSPITAL COMPONENT

31. How many years did you spend in hospital training postregistration?
[] years

32. Do you feel the length of time spent in hospital was:

- too long ☐
- too short ☐
- about right ☐
- don't know ☐

33. Which hospital posts did you do? (Specialty only required, no dates etc)

34. Were all of these posts undertaken with a career in general practice in mind?

YES [] NO []

35. Please explain your answer.

36. Which post(s) did you feel were most necessary to you now in your current job and why?

37. Would you, looking back now, choose a different post(s)?

YES [] NO [] (If NO please go to Question 39)

38. Please state which post(s) and why.

39. Did you gain out-patient experience during any of your hospital posts?

Yes []

No []

Don't Know []

(If NO please go to Question 42)

40. If YES - during which posts?

41. Did you consider the experience helpful?

yes totally []

the majority helpful []

half and half []

a little help []

no help []

Please indicate the extent to which you agree with the following statement:

42. Out-patient clinic attendance is relevant for general practice training.

yes strongly agree []

agree []

undecided []

disagree []

strongly disagree []

43. Did you receive any teaching during any hospital post(s)?
(If NEVER please go to Question 46)

every week	[]
every few weeks	[]
very occasionally	[]
never	[]

44. On the whole was the teaching:

- GP orientated	[]
- specialty orientated	[]
- both	[]
- other	[] (please explain)

Please indicate the extent to which you agree with the following statement:

45. Receiving trainee guidelines on learning objectives for each hospital post prior to commencing it is a good idea.

yes strongly agree	[]
agree	[]
undecided	[]
disagree	[]
strongly disagree	[]

46. Did you attend a day-release course or equivalent during your hospital training? YES [] NO []
(If NO please go to Question 49)

47. Did you consider it helpful?

yes totally	[]
the majority helpful	[]
half and half	[]
a little	[]
no	[]

48. The following methods are employed for day-release teaching. Please number them in order of value from 1-5. (1 = least valuable, 5 = most valuable)

lunch meetings	[]
evening meetings	[]
block course	[]
half day meetings	[]
other	[]

Please indicate the extent to which you agree with the following statement:

49. It would be beneficial for hospital trainees to have a named general practitioner available for discussion.

yes strongly agree []
 agree []
 undecided []
 disagree []
 strongly disagree []

PRACTICE COMPONENT

50. When did you begin your vocational trainee year? 19[]

51. Did you do: [] a self-constructed scheme
 [] a formal scheme
 [] other

52. Length of time spent as a GP Trainee: [] months

53. Do you wish it had been different? YES [] NO []
 (If NO please go to Question 55)

54. If YES, how?

55. What length of time do you feel should ideally be spent in practice?
 [] months

Please indicate the extent to which you agree with the following statement:

56. An introductory period in general practice prior to hospital training is a good idea.

yes strongly agree []
 agree []
 undecided []
 disagree []
 strongly disagree []

57. Did you have an introductory period as a trainee?

Yes []
 No []
 Don't Know []

58. Did you spend some time in another style of practice?

YES [] NO []
 (If NO please go to Question 60)

59. How long did you spend in another such practice? [] weeks

Please indicate the extent to which you agree with the following statement:

60. A period of time spent in another practice of a different style to the training practice is worthwhile.

yes strongly agree []
 agree []
 undecided []
 disagree []
 strongly disagree []

61. If you had the chance to go back would you choose to do:

self-constructed
 scheme []
 formal scheme []
 other []
 different career []

62. In retrospect would you repeat the same trainee year?

YES [] NO []

63. If you had tutorials during your trainee period please tick which of the following applied:

(You may tick more than one box)

- you were involved in the selection of topics []
 - clinical topics were discussed []
 - consultation skills were discussed []
 - audit/research were discussed []
 - practice management and finance were discussed []
 - social medicine was discussed []

64. What length of time was spent on teaching per week on average?

- formal teaching, with time set aside [] hours
 - informal teaching for example over coffee [] hours

65. Were there any aspects of general practice that were omitted or poorly covered in your trainee year? YES [] NO []
 (If NO please go to Question 69)

66. If YES, which aspects?

67. Did you take study leave while a trainee? YES [] NO []
 (If NO please go to Question 69)

68. What did you take it for?

69. Did you attend a day-release programme while a trainee?
 YES [] NO [] (If NO please go to Question 73)
70. If YES, how much did you attend?
 0-24% []
 25-49% []
 50-74% []
 75-100% []
71. (a) Which of the following took place at the day-release?
 (You may tick more than one box)
- small group discussion []
 - lectures []
 - role play []
 - video use []
 - feedback on trainee performance []
- (b) Please number the following in order of value (1-5) with regard to teaching purposes:
 (1 = least valuable, 5 = most valuable)
- small group discussion []
 - lectures []
 - role play []
 - video use []
 - feedback on trainee performance []
72. Would you describe the relevance of your day-release to practice on the whole as:
- total []
 - majority relevant []
 - half and half []
 - little relevance []
 - nil []

Please indicate the extent to which you agree with the following statement:

73. Research should be encouraged as a Trainee.
- yes strongly agree []
 - agree []
 - undecided []
 - disagree []
 - strongly disagree []
74. Did you have any experience of audit while a Trainee?
 YES [] NO [] (If NO please go to Question 76)
75. Please explain the experience you had.

76. Overall how do you rate the training you received during your trainee year?

excellent	[]
very good	[]
fairly good	[]
fairly poor	[]
poor	[]
very poor	[]

77. Which, if any, of the following were used to assess your progress? (You may tick more than one box)

Manchester Rating	[]
OSCE's	[]
Prescription Review	[]
Referral Review	[]
video consultation	[]
case record review	[]
none of the above	[]
Other	[]

Please indicate the extent to which you agree with the following statements:

78. Trainee assessment, to assess the level of knowledge, skills and attitudes, is a good idea.

yes strongly agree	[]
agree	[]
undecided	[]
disagree	[]
strongly disagree	[]

79. Some kind of Principal assessment, performed at some stage during a general practitioner's professional career, is a good idea.

yes strongly agree	[]
agree	[]
undecided	[]
disagree	[]
strongly disagree	[]

Thank you for completing the questionnaire. Your time and trouble is much appreciated. There now follows six questions. I will be contacting you within the next 1-2 weeks to try to arrange a suitable time to talk with you by telephone, to enquire about your replies to the six questions, if you consent.

Please detach and keep this page. Return only the questionnaire in the stamped addressed envelope provided. Thank you.

1. Do you have any regrets concerning your career?
2. Has general practice lived up to the expectations you had while training?
3. Do you feel your vocational training adequately equipped you for general practice today?
4. Now that the government's new contract is in force do you think any alterations will require to be made to vocational training as you experienced it?
5. Do you think trainees' performance should be assessed? If so, how do you think this might best be done?
6. Do you think the certificate of prescribed experience issued by the JCPGTGP is an adequate means of indicating satisfactory completion of training?

Please complete one form for each hospital post.

Please state for which hospital specialty this form applies.

In which hospital did you perform this post?

How long were you in this post?

During this post were you aware of the existence of any educational objectives which you should achieve during your time in this post? Yes ☐ No ☐ Don't know ☐

Do you consider that these objectives were achieved? Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐

Do you think that educational objectives should exist for hospital posts? Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐

Please describe any teaching which you received during this hospital post and also its frequency. Please tick as many as apply.

Frequency

	daily	1-2 times week	3-4 times week	every 1-2 weeks	every 3-4 weeks	None
Ward round discussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ward round lecture style teaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Planned tutorials	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impromptu tutorials	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Small group discussion with peers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lectures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Presentations of cases, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Departmental meetings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-teaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Computer assisted learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There was protected study time with no other duties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Computer assisted learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other, please describe

No teaching took place Yes ☐ No ☐ Don't know ☐

No structured, formal teaching took place Yes ☐ No ☐ Don't know ☐

Study leave was permitted Yes ☐ No ☐ Don't know ☐

Study leave was taken Yes ☐ No ☐ Don't know ☐

Did you attend out-patient clinics during this post? Yes ☐ No ☐

If yes, please go to next question. If no, please go to Question 12.

How useful did you find attending out-patient clinics?

Very useful ☐ Useful ☐ Undecided ☐ Not Useful ☐ Not at all Useful ☐

With regard to the amount of teaching you had during your time in this hospital post, were you
Strongly Satisfied ☐ Satisfied ☐ Undecided ☐ Not Satisfied ☐ Not at all Satisfied ☐

With regard to the quality of teaching you had, were you Strongly Satisfied ☐ Satisfied ☐
Undecided ☐ Not Satisfied ☐ Not at all Satisfied ☐

Now that you have spent some time in general practice could you described the relevance to general
practice of the training you received in the specialty.

Very Relevant ☐ Relevant ☐ Undecided ☐ Not Relevant ☐ Not at all Relevant ☐

Please explain your answer.

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