

# An evaluation of the hospital component of general practice vocational training

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**SUMMARY.** *The contribution of the hospital component of vocational training to the needs of the future general practitioner was investigated by undertaking semi-structured interviews with a representative sample of doctors involved. The findings indicated that, in general, training was failing to address objectives perceived to be important for general practice by the study sample. Problems related to the context and style of hospital training also emerged, which appeared to be limiting the learning potential of this type of experience for general practitioner trainees. It is apparent that there is a need to clarify priority objectives for the hospital component of vocational training, and ensure that it provides the opportunity to achieve them.*

## Introduction

**B**OTH undergraduate medical education and postgraduate vocational training for general practice take place predominantly in hospital: during the nine years between entry to medical school and emergence as a principal, an average of only about 12% of time is spent in general practice. It follows that the contribution of hospital experience to the education and training of general practitioners merits scrutiny.

Historically, general practitioners had lost responsibility for teaching medical students by the end of the nineteenth century.<sup>1</sup> Over the past 30 years some progress has been made towards developing the potential contribution of general practice to undergraduate education,<sup>2</sup> but the 'short duration of many courses in general practice suggests it may not be realistically possible to achieve course objectives'.<sup>3</sup> This state of affairs may even lead to vocational training for general practice providing for the 'shortcomings of undergraduate education'.<sup>4</sup>

At postgraduate level, mandatory vocational training continues in the same trend, providing only one year in general practice within a three year programme. The Royal Commission of Medical Education in 1968 proposed two years training in general practice, within a five year programme, but this was never implemented 'partly due to convenience and finance ... and partly because the full educational needs of general practitioners had not been fully established'.<sup>5</sup> By 1977 there was 'a great dearth of evidence for or against the relative efficiency' of the three year programme of vocational training for general practice.<sup>6</sup>

Since that time, doubts about the hospital component of general practice training have emerged: 'we are training for too long in one context for practice in another';<sup>7</sup> and being taught by those 'with no direct experience of general practice'.<sup>8</sup> Some objectives of general practice training are felt to be unattainable within, even compromised by, hospital experience;<sup>8</sup> the general practice year being used to counteract previous influencing factors and to introduce new perspectives.

Recently 'serious educational deficiencies'<sup>9</sup> in the hospital component of training have been revealed and an imbalance between service commitment and education clearly demonstrated.<sup>10,11</sup> In particular, little or no general practice oriented

teaching in hospital was reported in both the 1981 national survey among trainees<sup>12</sup> and in its 1989 sequel.<sup>13</sup>

However, the Joint Committee on Postgraduate Training for General Practice recently expressed concern 'that in the future it should not become more difficult for intending general practitioners to obtain training in good quality hospital posts' and, among trainees, there is an unmet demand for posts in obstetrics and paediatrics.<sup>14</sup> Thus, notwithstanding problems, the hospital component is perceived as having an important contribution to make to vocational training.

In these circumstances, an attempt to evaluate hospital based training for general practice in a more systematic way appeared appropriate. The present study was undertaken in one National Health Service region (Mersey) and comprised interviews with a representative sample of those involved in vocational training for general practice, both as teachers and learners. This paper describes the findings and considers the actual and potential contribution of hospital experience to general practice vocational training. The aims of the study were: (1) to define a selection of objectives for the hospital component of vocational training; (2) to evaluate the extent to which these are being achieved; and (3) to explore factors influencing trainee learning in the hospital setting.

## Method

### Sample

Four groups of doctors were interviewed: hospital consultants whose establishment included senior house office posts regularly used by vocational training; general practice trainees currently undertaking the hospital component; principals in general practice who had experienced vocational training for general practice within the last five years; and general practitioners who were appointed trainers for the practice component of vocational training. Given the range of hospital disciplines involved in vocational training, an early decision was made to limit the study to obstetrics and gynaecology and paediatrics, both of which form part of the hospital component for the majority of trainees. For similar logistic reasons the samples of doctors were drawn from just three districts of Mersey region: the city of Liverpool, the Wirral peninsula and Cheshire. They include a wide range of hospitals (teaching and district general) and contexts (urban, suburban and rural) within which general practice is conducted.

The sample of doctors from the four groups above was drawn from lists provided by the regional adviser in general practice, the relevant hospitals and the appropriate family practitioner committees. Of a total of 56 doctors approached only four (two consultants, one each in paediatrics and obstetrics and gynaecology, and two general practice trainers) declined to be interviewed. In a pilot study interviews were carried out with 22 doctors and for the main study a further stratified random sample of 30 doctors was used — six consultants and three trainees in each discipline, six general practitioner trainers and six general practitioner principals. Thus data from 52 doctors contributed to the findings. In the quotes given doctors in the main study are identified by numbers and those in the pilot study by letters.

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### Interviews

The pilot study was used to explore perceptions of vocational training for general practice in general and to derive the form and content of semi-structured interviews which constituted the main study. For the main study, interviews lasting between 30 minutes and one hour were recorded on audiotape for subsequent analysis.

A number of subjects discussed in the pilot interviews were selected for quantitative analysis in the main interview: (a) sexually transmitted diseases, (b) psychosexual problems, (c) behaviour problems in children, (d) needs and services for handicapped children. The perceived relevance to general practice of each subject was assessed by asking doctors to grade its usefulness for a general practitioner on an 11-point visual analogue scale. This was compared with the quality of experience obtained during hospital training. Type of experience was coded as: good (known to have been exposed to the clinical situation and be managing it appropriately), fair (some understanding, assumed to have been exposed to the clinical situation and be managing it appropriately), poor (limited experience, if any). Consultants and trainees in obstetrics and gynaecology were asked to respond to (a) and (b) only; consultants and trainees in paediatrics were asked to respond to (c) and (d) only; trainers and principals were asked to respond to (a), (b), (c) and (d). There were thus only 21 respondents to the specific questions on obstetrics and gynaecology/paediatrics. A question was also included about the importance of feedback about performance to trainees.

### Results

#### *Definition of objectives for the hospital component of vocational training*

From the pilot study interviews, certain common issues emerged which were used by the author to define a set of objectives for the hospital component of vocational training:

1. To give an understanding of relevant clinical material in the discipline (obstetrics and gynaecology/paediatrics).
2. To develop an insight into the interface between community and hospital services.
3. To develop and improve interpersonal communication skills.
4. To increase understanding of and skill in dealing with ethical issues.
5. To increase understanding of the roles of allied professionals and how to work with them appropriately.

At no stage was this intended to form an exhaustive list of objectives. The aim was to define a short list of objectives which attracted general support among the four groups of doctors and which could be evaluated in this study.

#### *Evaluation of the set of objectives*

*Objective 1: to give an understanding of relevant material in the discipline.* To explore what might constitute relevant areas of clinical practice, doctors were asked 'What aspects of obstetrics and gynaecology/paediatrics are most useful to a general practitioner in practice?'. The findings are listed in Table 1. A majority of these responses however were also mentioned in reply to the question 'Do you feel that there are aspects of obstetrics and gynaecology/paediatrics which, although relevant for general practice, are not addressed in the hospital post?'. It would appear that many of the areas of obstetrics and gynaecology/paediatrics perceived to be most useful for general practice, are not necessarily being addressed during hospital experience.

'A lot of community paediatrics is important for general practitioners ... which I think the conventional post does not address.'

(consultant, paediatrics 3)

**Table 1.** Topics perceived as most useful for a general practitioner, in order of frequency mentioned ( $n = 21$  respondents) and topics which at least one respondent ● and at least five respondents ●● felt were not addressed in the hospital post.

<i>Paediatrics</i>	
●●	Minor self-limiting illness (infectious disease; ear, nose and throat)
	Recognizing a sick child
●●	Developmental surveillance
	Dealing with children
●	When to refer/working with the hospital
●	Chronic diseases (eg asthma; eczema; handicapped)
●	Care of the newborn
●	Behavioural problems
●	Prevention/education (eg immunization)
●	Teamwork with allied professionals
	Acute illness (eg gastroenteritis; meningitis)
●	Outpatient experience
●	Family problems eg non-accidental injury
●	Communication
	Diagnosis and examination
	Therapeutics
<i>Gynaecology</i>	
●●	Family planning
●	Cervical cytology
	History and examination
●	Vaginal discharge/sexually transmitted diseases
●	Outpatient experience
	Menstrual disorders
●	When to refer
●	Therapeutics
	Infertility
	Abortion/ectopic pregnancy
●	Psychological factors
	Familiarity with hospital treatment
	Pelvic pain
●	Psychosexual problems
	Menopausal problems
	Natural history of common diseases
<i>Obstetrics</i>	
	Antenatal care
	Postnatal care
	Recognizing problems/emergencies
	Intrapartum care
●	Psychological factors
●	When to refer
	Anticipation of risk
	Understanding of hospital investigations.

'Family planning is surprisingly poorly taught. They will come here even after a years job not competent to fit an IUCD [intrauterine contraceptive device] and not au fait with differences in the chemical composition of [oral contraceptive] pills.'

(trainer 1)

Figure 1 shows the comparison between perceived relevance of subjects to general practice and quality of experience during hospital training for the four subjects: sexually transmitted diseases, psychosexual problems, behavioural problems and needs and services for handicapped children. It is clear that, although these subjects were perceived by all groups to be useful to a general practitioner, they were not adequately addressed in the hospital training.

Table 1 shows that many of the aspects perceived to be of most use for general practice would occur in the context of outpatients. However, it is also apparent that this type of experience was, perhaps surprisingly, often not included in the hospital senior house officer post.

'Senior house officers are on the whole dealing with in-patients ... from the general practitioner's point of view it's quite a disadvantage ... they don't do clinics in general.'

(consultant, paediatrician 4)

From the interviews it became clear that the general practitioner

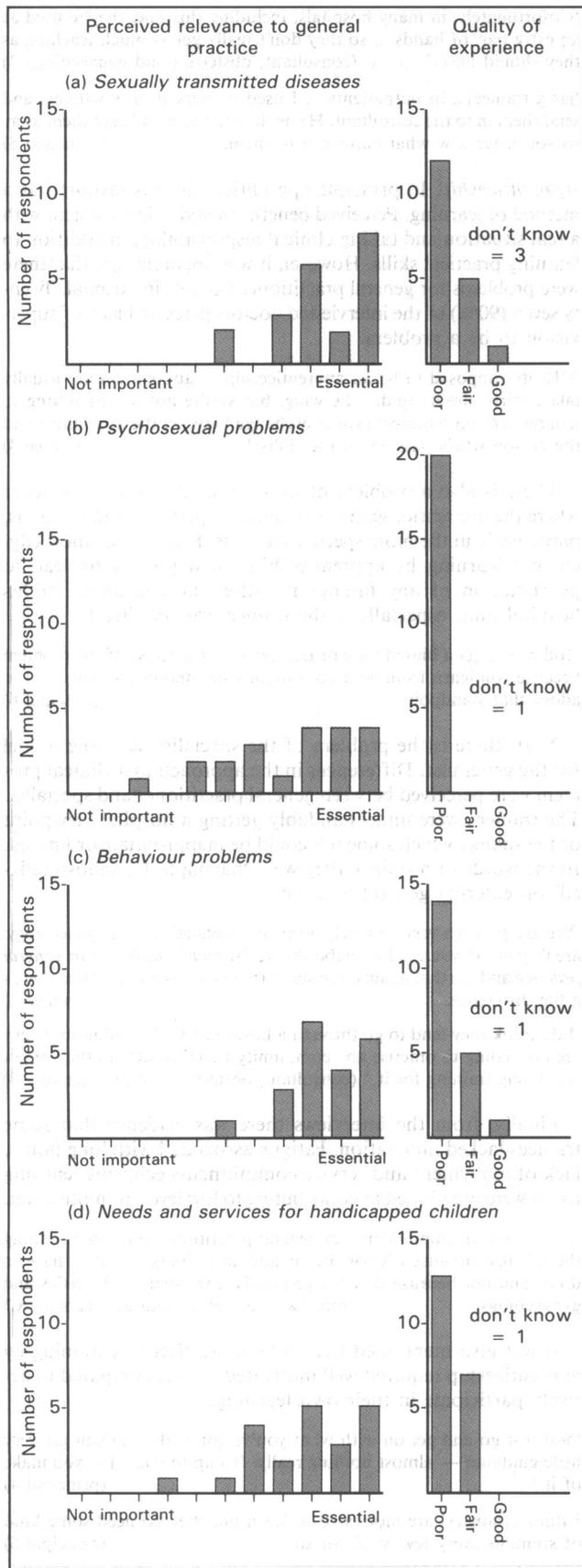


Figure 1. Comparison between perceived relevance of subjects to general practice and quality of experience (n = 21 respondents).

trainee is often assumed to have the same training requirements as the career senior house officer which may, to some extent, explain the obvious mismatch between what is perceived to be useful and what is addressed in relation to both content and context. This is demonstrated by the following quotes:

'I forget who's going into general practice and who's not. As far as I can see there's no difference in their training programme at all at this stage.'  
(consultant, obstetrics and gynaecology 3)

'An awful lot of hospital based paediatrics has got nothing to do with general practice whatsoever. It's a great shame that a lot of the consultants don't look on the general practitioner trainee as a different sort of doctor. They are not a budding hospital doctor, they are a budding general practitioner. So when they come into general practice, they have not seen any of the stuff that's relevant.'  
(trainer 2)

**Objective 2: to develop an insight into the interface between community and hospital services.** Of the 30 doctors 27 (90%) recognized problems at the interface of primary and secondary care; their unprompted responses are shown in Table 2. Nevertheless, only three doctors (10%) felt that the trainee gained a good insight into these problems during hospital training; 27% thought there was limited insight; 27% no insight; 27% that the hospital view only was gained and 10% thought there was no problem.

'[the senior house officer post] gives the hospital doctor's view of general practice in terms of his more senior colleagues' view of general practitioners. It depends on whether the trainee has done some general practice what sense he makes of that.'  
(trainer 5)

In particular, despite widespread recognition of communication problems across the interface, there was little or no constructive discussion during hospital training concerning written communication. Furthermore it emerged that indications for referral were not always well understood (Table 1).

'[as a trainee] I occasionally took a step back and wondered "How would I have managed this as a general practitioner? Would I have sent this in yet?" and if I was feeling very alert I'd actually ask the consultant what he felt would have been best. Quite often I found if you asked them they weren't entirely sure. I remember asking one consultant paediatrician when croup should be referred. He said: "It must be difficult really. It must be hard to decide."  
(principal 1)

**Objective 3: to develop and improve interpersonal communication skills.** By far the majority of doctors were in favour of trainees learning about interpersonal communication but for most trainees this did not occur; 22 doctors (73%) felt there was no input at all and five (17%) felt guidance was limited to noticeably poor communicators. It appeared that the ability to communicate well was often assumed; communication skills were

Table 2. Problems at the general practice-hospital interface volunteered by respondents (respondents could indicate more than one problem).

Problems	Number (%) of respondents (n = 30)
Communication breakdown	22 (73)
Failure to understand each others role/ constraints	7 (23)
Inappropriate referral by some GPs	7 (23)
Long waiting lists/short inpatient stays	6 (20)
GP and specialist do not know each other	4 (13)
Different attitudes in primary and secondary care	4 (13)
GP seen as inferior to specialist	3 (10)
Poor relationship and conflict	3 (10)
Hospital taking over primary care of patients	3 (10)

generally given very low priority in hospital training; and there was some scepticism and little knowledge about learning methods among all groups of doctors except the trainers. Relevant quotes include:

'What do you mean by communication skills? Do we teach them to talk proper? To write proper letters? ... communication is increasingly by computer. We do teach them to use the computer ... communication skills, these are things you have or you don't. They are not specifically part of a medical training.' (consultant, obstetrics and gynaecology A)

'I think most consultants just pay lip service to communication abilities, think that it's something that's innate, and don't really recognize the need for training.' (trainer 6)

**Objective 4: to increase understanding and skill in dealing with ethical issues.** The majority of trainees never have the opportunity to discuss ethical issues within the hospital post; only two doctors (7%) felt that time was set aside for this. Although 25 doctors (83%) would favour exploration of ethical issues during training in hospital, it appeared that, in general, these issues were given low priority and often neglected. Relevant quotes include:

'It's useful for someone to ask you what your feelings are ... or you perhaps just think you know what you feel. It's important to hear other viewpoints ... consider the patient's rights on the matter ... decide what your eventual opinions are.' (principal 1)

'... There is a place for a broader debate of some issues beyond medicine; [for a] philosopher, lawyer, theologian to come in.' (trainer 5)

'It's up to the individual to make his or her decision about these things and it's nothing to do with your training. We all have our sense of what's right and what's wrong.' (consultant, obstetrics and gynaecology A)

**Objective 5: to increase understanding of the roles of allied professionals and how to work with them appropriately.** It was clear from the interviews that hospital based training gave no opportunity for experience in the community and trainees worked only with those professionals encountered in the hospital setting. The extent of this contact was generally felt to be very variable, depending on each individual senior house officer post. Three doctors (10%) felt that hospital experience was completely unhelpful — one trainee, one trainer and one principal.

It also emerged that there was often a potential for increased liaison with allied workers; for example, although case conferences were held, some trainees were unable to attend.

'One was aware that these people existed, but never came across them.' (principal 3)

'It's obvious to them [the trainees] that the whole thing's a team deal.' (consultant, obstetrics and gynaecology 6)

'They can't learn [about team approach]. In my experience hospital very rarely works as teams. The concept involves sharing and hospital works as a hierarchy where sharing means orders.' (trainer 4)

### Factors influencing trainee learning in hospital

**Service versus education.** The evidence from the interviews strongly suggests that educational needs are being overlooked because of service requirements. Moreover, because service requirements are generally high, it is often assumed that these will inevitably eclipse the learning requirements of the senior house officer and a compromise is not therefore sought. This acceptance of the situation is justified by some consultants who feel that merely by performing their duties the junior senior house officers are learning. It is difficult to escape the conclusion that some trainees are being exploited and that the present balance between service and education is inappropriate.

'Unfortunately, in many hospitals, including this one, they're used as an extra pair of hands ... so they don't really get as much teaching as they should have.' (consultant, obstetrics and gynaecology 3)

'[as a trainee]... in outpatients ... I used to clerk in new patients and send them in to the consultant. He dealt with them and sent them away so you never saw what happened to them.' (principal 5)

**Apprenticeship.** In principle apprenticeship was favoured as a method of learning. Perceived benefits included involvement with a real situation and taking clinical responsibility, in addition to learning practical skills. However, it was apparent too, that there were problems for general practitioner trainees in hospital. Twenty seven (90%) of the interviewed doctors perceived lack of supervision to be a problem.

'OK, its supposed to be an apprenticeship ... apprentices are usually taken fairly closely under the wing, but you're not in this setting ... [apprenticeship requires] proper exchange between the apprentice and the person who's passing on the skills.' (trainee 4)

There is also a problem of bias occurring; situations occur where the apprentice gains unbalanced experience and opinions, particularly in the more specialized posts. Everyone acknowledged that learning by apprenticeship could potentially lead to perpetuation of any failings in either the consultant or his hospital unit, especially if the trainee was uncritical.

'You can ... get a biased view of treatment or the cause of the problem because you learn from your consultant's standpoint and you tend to adopt that standpoint.' (principal 6)

Next, there is the problem of the specialist as a role model for the generalist. Differences in the approach to a clinical problem were perceived between general practitioner and specialist. The trainees were understandably getting a hospital viewpoint of the subject which some felt could be inappropriate or limited. In the words of a trainee they were 'having to be dehospitalized' on entering general practice.

'You are getting a very definitely hospital orientated view of gynaecology, aren't you? If you read a textbook like *Women's problems in general practice* and see that against the standard gynae textbooks, then there's a big difference.' (trainee 4)

'I do think they tend to go through a hospital based training so if they are ever going to practise any community based obstetrics they've got the wrong training for it.' (consultant, obstetrics and gynaecology B)

Finally, from the interviews there was evidence that some trainees lacked motivation. Fatigue associated with long hours, lack of enjoyment and service commitments eclipsing learning needs were mentioned as contributing to low levels of motivation.

'I often get the impression that general practitioner trainees are doing the job just because it's part of vocational training and they have to do it, and not because they are genuinely interested in obstetrics and gynaecology.' (consultant, obstetrics and gynaecology C)

It was also mentioned that to be most effective, training by apprenticeship required well motivated trainees prepared to actively participate in their own learning.

'You just go and get on with what you've got to do and you get very little guidance — almost nothing really. It's up to you what you make of it.' (principal 4)

I think [trainees] are motivated to learn but they do need some kind of stimulus every few weeks or so.' (principal 6)

**Perceived Relevance.** General practitioner trainees and principals felt that appreciating which aspects of obstetrics and

gynaecology/paediatrics were of particular relevance to general practice was highly important and general practitioner experience early in training was generally perceived to be an advantage. It was felt that if the trainee fails to understand what will be of use to him or her as a general practitioner, then he or she may fail to maximize on the potential learning available in the hospital post.

'...most of the trainees have learnt how to be a hospital doctor in terms of diagnosis and treatment, but have not thought widely enough about relating what they're doing either to the patient in the community or themselves as a community doctor.' (trainer 3)

'I don't really know what general practitioners actually do ... I've only ever done hospital stuff so I have to imagine what I think might be relevant.' (trainee 2)

The idea that the general practitioner trainee might find aspects of the subject more relevant than others was strongly opposed by three of the 12 consultants; some consultants had difficulty understanding the concept, while others accepted the idea but had not considered what might constitute general practitioner priorities. Several consultants were attempting to focus trainee learning on their perceptions of relevant areas. The need for priority objectives was expressed by all groups although there was a concern that:

'who draws up the list [of objectives] determines to whom they are important.' (principal 1)

Relevant quotes include:

'We're not teaching them general practice, we're teaching them paediatrics.' (consultant, paediatrics 5)

'I don't think there is any structure to hospital general practitioner training at all ... it didn't strike me that they'd necessarily even thought about it.' (principal 6)

'I would like to have more information from the department of general practice or the regional adviser on, if you like, a checklist of what they want us to do for general practitioner trainees.' (consultant, paediatrics A)

'The obstetrician says "these are the 66 things you have to learn" and the general practitioner says "these are the 144 million things you need to know" and the trainee says "I'd like to learn about something else." ' (trainer 3)

**Formal teaching.** In general the trainees appeared to receive little formal teaching, although this varied between senior house officer posts, ranging from nothing at all to several sessions weekly. Service commitments either prevented attendance at teaching sessions or led to frequent interruptions. Although the majority of doctors felt it would be desirable to set time aside for teaching or learning, for most (83%,  $n=24$ , trainers excluded) this did not occur. Overall, 71% of doctors stated that little or no teaching was oriented to general practice.

However, it was generally felt to be highly desirable for trainees to discuss the knowledge gained in hospital in the context of primary health care and many of the interviewees favoured joint teaching from both general practitioners and specialists; in fact general practitioners were never involved as teachers within hospitals.

'general practitioners must be there to put the learning in context ... the teaching may get a lot of information across but its relevance to general practitioner may be nebulous.' (principal 1)

A majority of the doctors (80%,  $n=30$ ) were in favour of half day release for trainees during hospital training. Although most consultants were in favour of this in principle, they felt it was impossible owing to the service commitments of the unit.

'There is no time ... for day release ... they could not have an afternoon

off ... there is no study leave at senior house officer level. It's highly undesirable ... that's the way it is.' (consultant, paediatrics B)

'Day release gives them [trainees] a continuing contact with general practice. It makes them think what their particular specialty's relevance is to general practice at any one time. Otherwise you can go on and on ... I'm doing a one in three ... I'm really working bloody hard ... I'm up all night ... This is terrible ... Pulling babies out ... Stitching episiotomies ... and you're not actually thinking what you're doing.' (trainer 2)

**Feedback.** Although feedback about performance to trainees was perceived to be highly important by the group, very little feedback was provided (Figure 2). Concern was expressed that feedback should be constructive and not necessarily received from specialists only. Relevant quotes include:

'What sort of feedback does anyone ever get? Other than ... "pull your socks up" ... if you step out of line ... or silence if you're doing alright. That's not ideal, but I guess that's what happens. Or you just get a bad reference at the end and no one says anything.' (principal 3)

'How important is feedback? Dear me, I've just said I don't give them any ... it would be a delightful privilege if we had time.' (consultant, paediatrics 1)

'In theory it's got to be very important — I suspect they don't get much feedback and so if I put this high up the scale I'm admitting to another deficiency.' (consultant, obstetrics and gynaecology 4)

## Discussion

Because of its regional basis and the selection of just two hospital disciplines, this study cannot claim to reflect the entirety of hospital based vocational training for general practice. Nevertheless, these disciplines were studied because they are chosen by more trainees than any others; equally, there is no evidence that hospital-based vocational training in Mersey region is in any way atypical. The methodology employed, while less familiar in medical research, has an honourable tradition in the social sciences.<sup>15</sup> This combination of small scale, selective focus and unfamiliar methodology may lead some to dismiss the findings. Rather, the present study should be seen both as a pilot for research on a national scale and justification for such research. The findings of the present study do not stand alone: they are, if nothing else, support for the view, widely articulated among trainees, that in its present format the hospital component of vocational training for general practice is educationally of questionable value. If this is true, how has this situation arisen? Objectives for vocational training in general practice in paediatrics and in obstetrics and gynaecology have been published.<sup>16,17</sup> Unfortunately, they aim to be comprehensive, with all this implies educationally,<sup>18</sup> in particular, failure to delineate priorities for trainees and to relate objectives to the learning context. Both these factors are of crucial importance to vocational training in general practice: the first because learning must compete with service delivery; the second because training takes place in widely different settings; hospital and general practice.

It is implicit in the present regulations governing vocational training in general practice that the process should equip trainees with generic skills and certain subject specific skills, depending on the chosen mix of hospital posts. This study evaluated a short list of objectives which included both generic and subject specific items. The findings are unequivocal: trainees, hospital consultants and vocationally trained general practitioners agree that the objectives defined from preliminary interviews are important; surprisingly, there is broad agreement that the hospital component of vocational training for general practice fails to address these consensus objectives. The problems associated with general practitioner training within the hospital context, which

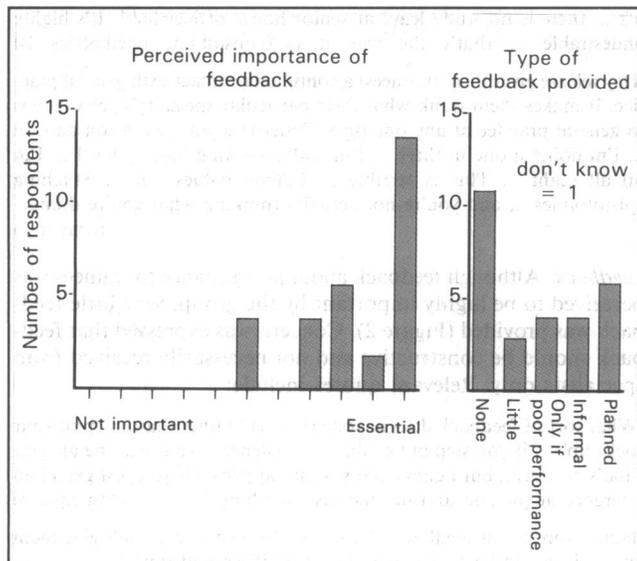


Figure 3. Comparison between perceived importance of feedback and type of feedback received (n = 30 respondents).

have been clearly identified in this study, go some way to explaining this paradox.

The need for vocational training before entry as a principal into general practice is well recognized, although some have questioned the relative distribution of time between hospital and general practice.<sup>7,19</sup> However, the findings of this study seem to indicate more fundamental problems: a failure to identify core skills for general practice (whether generic or subject specific), to make use of appropriate learning opportunities within hospital or to demonstrate that agreed skills are being acquired by the end of training.<sup>20</sup>

Much could be done within the existing framework to improve the educational value of hospital posts for vocational training for general practice. Priority objectives need to be established for this component of training on the basis of a series of conferences or by appropriate committees; clearly, existing regional and national bodies (regional general practice sub-committees and the Joint Committee on Postgraduate Training for General Practice) have insufficient specialist and trainee representation to undertake this task. Greater use could be made of learning opportunities available during hospital training: attending outpatient clinics; gaining related experience outside the consultant's unit (for example, community child health, sexually transmitted disease clinic); and participating in interface activities such as domiciliary consultations or outreach services. Finally, continuing contact with general practice during vocational training is essential if the experience is to provide: a relevant perspective and stimulus throughout the three year programme; a forum in which specialists and generalists can negotiate the form and content of training; and protected time for reflection, discussion and appraisal.<sup>9,10,11,20</sup>

At the moment it is difficult to answer the question: who is managerially responsible for hospital vocational training? Greater supervision of approved hospital posts by regional advisers in general practice and a more effective process of visitation by the Royal College of General Practitioners would seem to be necessary. However, to be fair to hospital specialists, the fundamental problem is not simply lack of regulation of hospital-based vocational training, but a failure to involve them as active participants in planning and providing what is needed.

It is self-evident that general practitioners need a training

which focuses on the skills required to deal most effectively with the problems presented to them by their patients and their community. It is not evident that general practitioner training within the hospital context is fulfilling this goal.

## References

1. Loudon ISL. Historical background. In: Fry J (ed). *Trends in general practice*. London: Royal College of General Practitioners, 1979.
2. Association of University Teachers of General Practice. *Undergraduate medical education in general practice. Occasional paper 28*. London: Royal College of General Practitioners, 1984.
3. Fraser RC, Preston-Whyte E. *The contribution of academic general practice to undergraduate medical education. Occasional paper 42*. London: Royal College of General Practitioners, 1988.
4. Wright J. What is to be taught and learned. In: Cormack J, Marinker M, Morrell D (eds). *Teaching general practice*. London: Kluwer, 1981.
5. Hasler JC. History of vocational training for general practice: the 1970s and 1980s. *J R Coll Gen Pract* 1989; **39**: 338-341.
6. Gray DJP. *A system of training for general practice. Occasional paper 4*. London: Royal College of General Practitioners, 1979.
7. Byrne PS. Medical education and general practice. *J R Coll Gen Pract* 1979; **25**: 785-792.
8. Oxford Region Course Organisers and Regional Advisers Group. *Priority objectives for general practice vocational training. Occasional paper 30*. London: Royal College of General Practitioners, 1985.
9. Reeve H, Bowman A. Hospital training for general practice: views of trainees in the North Western region. *Br Med J* 1989; **298**: 1432-1434.
10. Council for Postgraduate Medical Education in England and Wales. *The problems of the senior house officer*. London: CPME, 1987.
11. Wilkins G (chmn). *Review body on doctors and dentists remuneration. Seventeenth report*. London: HMSO, 1987.
12. Ronalds C, Douglas A, Gray DP, Selley P. *Fourth national trainee conference. Occasional paper 18*. London: Royal College of General Practitioners, 1981.
13. Crawley H, Levin J. Training for general practice: a national survey. *Br Med J* 1990; **300**: 911-915.
14. Styles WM. Analysis of the hospital experience completed by general practitioner trainees in 1984-87. *J R Coll Gen Pract* 1989; **39**: 96-97.
15. Bulmer M (ed). *Sociological research methods*. 2nd edition. London: Macmillan, 1984.
16. Joint Working Party of the Royal College of Obstetricians and Gynaecologists and Royal College of General Practitioners. *Report on training for obstetrics and gynaecology for general practitioners*. London: RCOG, RCGP, 1981.
17. Joint Working Party of the British Paediatric Association and the Royal College of General Practitioners. *Training general practitioners in child care. Some aims for training for general practice. Occasional paper 6*. London: RCGP, 1978.
18. Foulds DM, Sterling R, Wood PR, et al. The current place of learning objectives in paediatrics. *Med Educ* 1989; **23**: 407-408.
19. Tait I. Agreed educational objectives for the hospital period of vocational training. *J Assoc Course Organisers* 1987; **2**: 179-182.
20. Joint Committee on Postgraduate training for General Practice. *Assessment and vocational training for general practice: report of a working party*. London: JCPTGP, 1987.

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