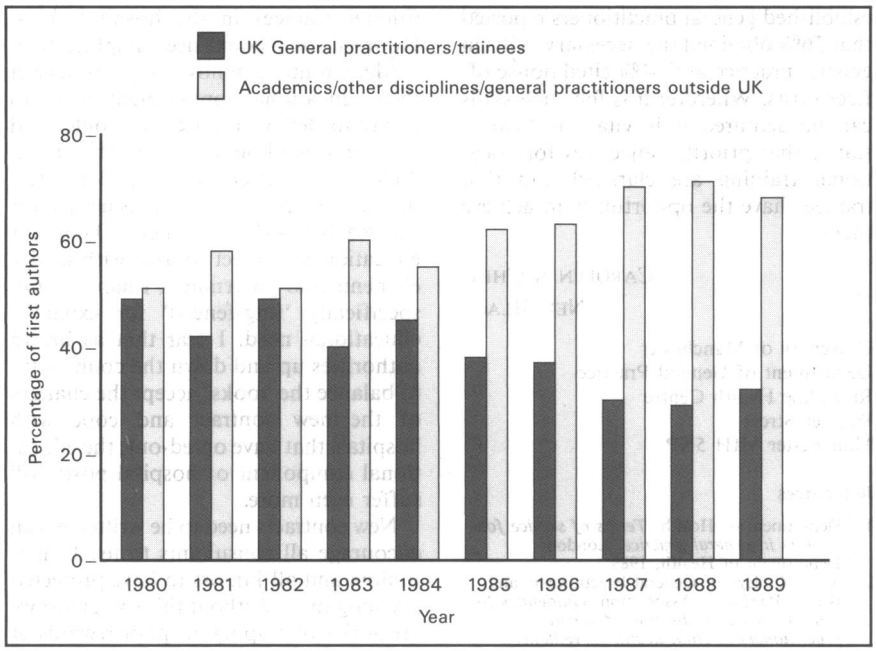

Figure 1. *Proportions of papers in the* British Journal of General Practice *with UK general practitioners/trainees or academics/others as first author.*

the relevance of the *Journal* to the 'ordinary' UK general practitioner is now being questioned. This is happening at a time when the role and relevance of the Royal College of General Practitioners itself is under scrutiny. A great deal is learned from research and audit within practices but a change in editorial policy away from strict quantitative methods, and towards a section where ideas could be floated could go some way to redressing these issues.

Without some form of committed support and encouragement, and with the increased workload of the imposed contract, this trend is likely to continue.

JOHN PITTS

Hythe Medical Centre
Hythe
Southampton
Hampshire SO7 5ZB

Training for the new contract

Sir,

The paper by Dr Kearley (October *Journal,* p.409) and letter from Dr Castle (October *Journal* p.430) were particularly timely.

The trainee sub-committee of the north west England faculty of the Royal College of General Practitioners are concerned that general practitioner trainees may not be equipped to deal with many aspects of the new contract.[1] We are aware of problems that have arisen over inclusion of general practitioners on the new minor surgery and child health surveillance lists. We therefore carried out a study in April 1990 to assess trainees' confidence, training and experience in these areas.

Questionnaires were distributed by course organizers and completed by trainees in general practice on their day release course. Questions were included on the nature of the training scheme (organized or self-construct), additional qualifications and previous hospital posts held. Respondents were asked whether they felt they had received adequate training, had experience and were confident in particular child developmental examinations and minor surgery procedures. The questions were structured with yes/no alternatives and there was a section for respondents' comments. Data were analysed using the SPSSX statistical package.

Seventy four out of 137 trainees completed the questionnaires, a disappointing response rate of 54% possibly due to poor attendance at day release courses and preoccupation with the forthcoming MRCGP examination. Thirty four of the respondents (46%) were on organized vocational training schemes with the remainder constructing their own scheme, a pattern characteristics of the north west region. Fifty nine respondents (80%) had held senior house officer posts in hospital paediatrics but only four (5%) had worked in community paediatrics. Nine respondents (12%) had held senior house officer posts in general surgery. Eleven trainees (15%) possessed a diploma in child health; no one had a higher surgical qualification.

There was a wide variation in trainees' perceptions of the adequacy of their training in child health surveillance examinations (Table 1). While 89% of the trainees reported adequate training and experience and expressed confidence in neonatal examination, only 30% were confident about the pre-school examination. Only 17 respondents (23%) reported confidence in all procedures. There was no significant difference between trainees on organized as opposed to self-constructed schemes. The trainees who reported experience and competence in the pre-school examination were also more likely to have held a community paediatric post ($P<0.05$ and $P<0.05$ respectively) or to have obtained the diploma in child health ($P<0.01$).

So, how many trainees would be eligible for inclusion on child health surveillance lists? If confidence in all examinations is required then only 23% of trainees would be eligible. If family health services authorities demand the diploma in child health examination then only 15% are eligible. If the guidelines of the Royal College of General Practitioners and British Paediatric Association[2] which have since been revoked had been adhered to, possibly none would be eligible. If the MRCGP qualification is acceptable, then the 29 who obtained this in summer 1990 may be eligible.

How can this situation be improved? It seems evident that more community paediatric experience is required for general practitioner trainees. This could be provided at the senior house officer level with mandatory time in a community paediatric post; alternatively, experience during the general practitioner trainee year could be provided either by secondment to the same or by a compulsory requirement for training practices to have regular child health clinics.

A similar wide variation in trainees' responses to questions on minor surgery was seen (Table 2). Responses ranged from 80% who felt they had received adequate training and were confident in draining abscesses, to 3% who had received training, experience and were confident in ligation of varicose veins and injecting haemorrhoids. No trainees were confident in all procedures listed: only two trainees reported training in eight of the procedures (but confidence in carrying out only seven).

Even with the recent removal from the minor surgery list of the requirement to be competent in the ligation of varicose veins, applying the current Department of Health criteria, none of these trainees

Table 1. Trainees' responses to questions about training and experience in child health surveillance.

Stages of examination	Percentage of positive responses ($n = 74$)		
	Training adequate	Experience	Feel confident
Neonate	91	89	89
6 weeks	80	82	88
6–9 months	57	61	55
2 years	45	50	39
Pre-school	31	32	30

Table 2. Trainees' responses to questions about training and experience in minor surgery.

Minor surgical procedures	Percentage of positive responses ($n = 74$)		
	Training adequate	Experience	Feel confident
Injections:			
Joint	57	58	50
Varicose veins	10	8	7
Haemorrhoids	4	3	3
Aspirations:			
Joints and bursae	55	66	55
Ganglia	18	18	15
Removal of toenails	57	57	49
Incisions:			
Abscesses	80	80	82
Thrombosed piles	20	18	19
Cautery and cryocautery	42	46	43
Ligation of varicose veins	10	5	3

would be eligible for inclusion in minor surgery lists. Once these trainees become general practitioner principals, will they operate, and risk possible medico-legal complications, or will they refer all minor surgery to outpatient departments?

A worrying feature of our survey was that some trainees reported confidence in carrying out a number of procedures while confirming that they had not received sufficient training or experience in these. As Irvine and colleagues stated (letters, October *Journal,* p.434) it is vital that doctors completing vocational training for general practice have achieved a satisfactory standard of competence and performance as judged by external, set standards.

Additional surgical training is obviously required, but at what stage in a prospective general practitioner's career should this occur? Castle in his survey of established general practitioners reported that 36% obtained the necessary skills in general practice and 41% cited house officer posts. Wherever it is felt such skills can be acquired it is vital, as Kearley states, that priority objectives for vocational training are clarified and that trainees have the opportunity to achieve them.

CAROLYN A CHEW
C NEIL BLACK

University of Manchester
Department of General Practice
Rusholme Health Centre
Walmer Street
Manchester M1H 5NP

References

1. Department of Health. *Terms of service for doctors in general practice.* London: Department of Health, 1989.
2. Royal College of General Practitioners and British Paediatric Association. *Guidelines for training and accreditation of general practitioners in child health surveillance.* London: RCGP and BPA, 1989.

General practice training in the hospital

Sir,

We were interested in the editorial by Dr Styles on general practice training in the hospital (October *Journal,* p.401) as until recently we have all been intensively involved in the north Devon vocational training scheme.

Consultants have been closely linked with the scheme ever since its start, in the 1970s. They have been well represented on the vocational training scheme committee and in this committee they have proved of great help in our deliberations. Over the past three years or so, the consultants and senior house officers in the scheme have had joint meetings with the trainers. About 18 months ago we acted as facilitators for the consultants looking at video recordings of their teaching sessions with their senior house officers.

Here in north Devon consultation between the various teachers does take place and is beginning to broaden.

A J B EDWARDS
D B R OSBORNE
J G TURNER

North Devon Medical Centre
North Devon District Hospital
Barnstaple EX31 4JB

Sir,

Dr Style's editorial (October *Journal,* p.401) covers most of the fundamental points related to training for general practitioner trainees in the hospital years. However, some points need amplification.

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. Training is not free; time and government money is needed for the teacher and the taught. Time for education is in direct conflict with service elements and government finance is not specifically 'ring-fenced' for extended educational need. I fear that as health authorities up and down the country try to balance the books, accept the changes of the new contract and cope with hospitals that have opted-out, the educational component of hospital posts will suffer even more.

New contracts need to be written which encourage all consultants to teach their juniors and all juniors to have protected teaching time. Without this safeguard we are at risk of reaping the poor rewards of inadequate investment in training.

Meanwhile, trainees need to make the best of a bad job, attempt to protect their learning time and organize it to extract the most from each post. To this end, a trainee in Gloucestershire has constructed a curriculum guide for hospital trainees (available on request from Syntex Pharmaceuticals Ltd, St Ives Road, Maidenhead, Berks SL6 1RD). The number of curriculum guides and the fact that they continue to be produced by teachers and are now produced by trainees indicates that they are highly desirable and practical organizers of teaching time.

While I share Dr Style's view that the greatest scope for progress is at a local level, I feel that trainees need authority given to them from above, by liberal interpretation of the vocational training act, to support their needs in these difficult times.

PAUL PRESLEY

St Michaels Surgery
St Michaels Square
Gloucester GL1 1HX

Sir,

I would like to point out an omission in William Styles' editorial (October *Journal,* p.401) and Karen Kearley's article (October *Journal,* p.409) on the hospital component of general practice training. Greater reference should have been made to accident and emergency medicine as a six month component of vocational training schemes.

It is accepted by the royal colleges that if the Royal College of Surgeons gives educational approval to posts in accident and emergency medicine, then the Royal