Training practices in the Oxford region

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SUMMARY. Considerably more time for training has been made available by trainers in the Oxford region since July 1976, with regular tutorials being held in all training practices. However, in spite of this by January 1978 nearly half the trainees still received training which was largely unplanned, and some of the reasons for this are briefly discussed.

Introduction

THE introduction of vocational training for general practice has been one of the most remarkable features in general practice and in medical education in the last decade. It has been remarkable in terms of the numbers of people involved, in its achievement in bringing together hospital consultants and general practitioners in widely scattered and differing service practices, and in the speed with which developments have taken place.

However, the pivot around which all activities revolve is the individual trainer and the training practice, even though only one year of the three-year programme is spent there. The other two years are normally spent in hospital and we are still not entirely clear about the main purpose of the hospital years. In any case senior house officer posts used for general-practice training are unlikely to alter much in the foreseeable future and in the final resort general practice can be learnt only in the community. As facilities in the training practices become more sophisticated there will be an increased demand for more than one third of the programme to be spent in the surroundings in which the trainee will ultimately practise. So how are these practices faring and are they capable of meeting the needs of training?

Standards

The last few years have seen a steady growth in the number of trainers, reaching 1,480 in England and Wales by April 1977. It was as recently as October 1973 that the authority for approval was transferred from local medical committees to the general-practice subcommittees of regional postgraduate committees. Although the regulations for the mechanism of approval are laid down in the Statement of Fees and Allowances (DHSS and Welsh Office, 1977), each region sets its own criteria based on advice from the Joint Committee on Postgraduate Training for General Practice (1976) and regions vary considerably in what they expect and demand.

While some trainers may regard the regional general-practice subcommittees, and in particular the regional advisers, with some suspicion, it is important to realize that the regional subcommittees are composed largely of colleagues and peers and the standards set are the standards of the day, with the intention of charting the way and setting the pace, but never leaving behind the majority of doctors involved. It takes time for each region to decide what these standards should be, and still more time for subsequent reappraisals.

Since April 1977 the criteria in the Oxford region for doctors wishing to become trainers for the first time have been:

1. Attendance at a trainers' course.
2. Involvement in a trainers' group for six months.
3. Passing the MRCGP examination.

The last is included, not as a means of recruiting members for the College, but because it is at present the only available objective method of assessment of clinical ability in general practice. Conditions for remaining a trainer are:

1. Regular participation in a local trainers' group.
2. Periodic attendance at a trainers' course.
3. Regular weekly tutorials of not less than two hours in the training practice.

The trainers

In October 1974 (a year after the change of approval

procedure) there were 57 trainers in the Oxford region, compared with 76 in January 1978. But while everyone has grown older by more than three years, the average age has risen by only one year from 44 to 45. There are now eight trainers under the age of 35, compared with two in 1974; four of them are doctors who have been through one of the Oxford region schemes and some are ex-trainees from other regions. Four trainers are also course organizers.

In 1974, 13 of the 57 trainers (23 per cent) had passed the MRCGP examination, rising to 29 out of 76 (38 per cent) in 1978. The figure rises to 40 per cent if the five (non-training) course organizers are included. Two trainers have proceeded MD. In 1974, 82 per cent had attended a trainers' course; now there are only three trainers who have not attended a course, and this will be rectified this year. Experience with trainees has also increased: only five trainers now have never taken on a trainee, compared with 16 in 1974.

By contrast practice facilities and premises have been relatively static with 62 per cent of all trainers practising now from purpose-built premises, compared with 58 per cent in 1974. Practices with age-sex registers, however, have increased from 54 per cent to 72 per cent. Perhaps age-sex registers are one of the best examples of practice facilities which have yet to be exploited; several trainees from practices with age-sex registers were unaware of their existence or did not know what purpose they served. The concept that the age-sex register is a tool for supervising a practice population in a preventive and epidemiological capacity *(Journal of the Royal College of General Practitioners,* 1977) is still foreign to many general practitioners.

Reports from trainees

At first it might appear that with reasonable regional standards for training it is merely a question of time before all is well. All trainees finishing appointments in training practices in the region complete forms about their training and 54 of these forms returned in the 18 months before January 1978 have been analysed. No trainee had any major problems with training although there were two trainees who did not wish to complete forms because there had been relationship difficulties with their trainers. The trainees were unanimous that their trainers had made a conscientious effort to train them and had provided regular tutorials—a considerable advance from two years ago when only 33 out of 47 practices provided regular tutorials (Hasler, 1976). Only one of the 54 trainees said that the time devoted to teaching was not always adequate. Indeed, if the trainees mean what they say, exploitation in the traditional sense has ceased: a remarkable achievement in two to three years.

However, any cause for congratulations ends there. Fifteen of the practices had records considered by the trainee to be inadequate for assessing the patients' problems quickly, and the figure would be higher if trainees were more critical. The problem lies in the size of the task and the difficulty in getting partners to agree on standard policy.

Absence of initial assessment

Of more concern was the information from the trainees on the educational aspects of the training practice. It was apparent that 24 of the trainees had received no effective initial assessment of their needs, and usually their trainers were relying on the trainee's own perception of his needs. Superficially most trainees perform well and unless needs are looked for they may lie dormant for the whole of the training period; it is only too easy for this to happen in a busy practice.

Absence of joint consultations

Twenty-four trainees had experienced no joint consultations after sitting in with their trainers in the first or second week. They were never observed and some of those who were said the occasions were "insufficient" or "too infrequent", the tendency being for the trainee to watch the trainer rather than *vice versa.* It is clear that many trainers feel embarrassed watching (although not, it appears, being watched) and yet without a view of the doctor performing in a consulting room it is impossible to know what really happens.

Absence of a curriculum

Twenty-six trainees had no planned curriculum for the six or 12 months they spent in practice and many of those that did were merely working through a list. Often the tutorials were merely discussions of problems which had arisen the previous day. Although these figures relate to the Oxford region, there is no reason to believe that the situation is different elsewhere.

Problems

It is worth examining why trainers, having made the commitment, find it difficult to use the time to the best advantage. First, there are several common misconceptions. Trainers assume that in the course of 6 or 12 months trainees will see all important conditions and become reasonably proficient in their management. My research suggests that trainees do not see the same range of chronic disease as the average general practitioner, and this evidence of possible inadequate experience is supported by recent information from one of the family medicine programmes in North America (Stewart, 1978; personal communication).

There is confusion too between detailed knowledge of hospital procedures and the latest investigations possessed by trainees, and the knowledge of management of disease in the community, including prevention, case identification, early diagnosis, and long-term management, which is needed by the general practitioner. There is also the common assumption that the interaction between the doctor and the patient is something that does not need examination, although recent work by Byrne and Long (1976) suggests otherwise.

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Therefore, what the trainee knows, what he sees, and how he performs need careful scrutiny. There are some further problems. We have found that a considerable number of trainers find a critical approach to the trainee's work difficult; a critical approach seems to be equated with something destructive. Such methods of assessment as are used need some practice and if trainers cannot achieve instant success some are disheartened. Other trainers require objective proof that a system of assessment works and feel that any appraisal that has a considerable subjective element is of no value. Some trainees only experience tutorials based on spur-of-the-moment problems which cannot be prepared for, and they find this approach unsatisfactory when used for a topic tutorial, which requires preparation and reading, with the result that topic tutorials are often felt to be not very relevant or helpful.

Some training practices have found that the presence of a trainee has crystallized difficulties within the practice, and some trainees, while superficially prepared to learn, are not motivated to use the time well.

Busy trainers find it only too easy to provide a purely demand-orientated service. All of us involved in training must become more educationally rigorous both in terms of clinical performance and teaching. Too few trainers audit their work and records are inadequate.

In educational terms there is still an immature approach to defining what is to be done and assessing trainees before and during the programme. The reluctance to prepare for tutorials, to monitor prescriptions or records, and to watch trainees consulting is worrying. Dealing with these various problems should be the urgent tasks of all trainer groups or workshops, and courses for trainers need special attention.

If this educational maturity in each trainer is to be realized and if some of the difficulties are to be overcome, it follows that regional advisers and course organizers must seek to achieve a closer and more effective relationship with trainers and training practices. No amount of direction will achieve the development of a trainer after the ground rules have been laid.

Regional advisers in general practice must remain practising general practitioners and they must participate in educational as opposed to purely administrative matters.

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