NEWS AND VIEWS

DISCUSSION DOCUMENT

Report on training for obstetrics and gynaecology for general practitioners

Discussion document by a Joint Working Party of the Royal College of Obstetricians and Gynaecologists and the Royal College of General Practitioners

A Joint Working Party was established in July 1980 by the Councils of the two Colleges, "To consider training in obstetrics and gynaecology for general practice, having regard to undergraduate education and training, and to make recommendations".

Introduction

The Working Party has met 13 times since the first meeting in September 1980 and has considered the reports from our two Colleges (RCOG and RCGP, 1974; RCGP, 1981), the report of the Social Services Committee of the House of Commons on Perinatal and Neonatal Mortality (House of Commons, 1980) and the General Medical Services Committee report on General Practitioner Obstetrics (BMA, 1981) amongst others.

We are agreed on the need to provide realistic and satisfactory education for general practitioners so that they can play a full part in a service that will deliver a high standard of humane care to women and their babies. In addition, ever since the Cranbrook report (Ministry of Health, 1959), it has been recommended that there should be a fully integrated service to provide for the needs of pregnant women in the United Kingdom. The increasing tendency towards delivery in maternity units has created opportunities for closer integration which have not been fully grasped, and so we agree with the Social Services Committee that full integration should now be achieved.

Although our remit was clearly to do with training, we found it impossible not to consider some of the wider aspects of obstetric care, and occasionally to venture into fields which might be considered outside our brief. We felt that it was important and inevitable that we did so, as we were conscious of the views of those who are openly critical of some of the arrangements for maternity care today.

We have considered those aspects of gynaecology relating to general practice, including family planning. Throughout we were concerned that training should be seen as a continuing process in a doctor's career and that hospital experience should not be seen in isolation from training practice experience nor from continuing education after the completion of vocational training.

Obstetric Care in General Practice

As regards obstetric care, general practitioners can be divided into three groups:

1. Those who offer complete maternity medical services including intranatal care (full care). In 1980 in England and Wales, 14.3 per cent of patients appear to have been delivered in the care of general practitioners.

2. Those who provide antenatal and postnatal care only, usually shared with specialists who take responsibility for the delivery (shared care). There has been a steady increase in this type of service.

3. Those wishing to play no part whatsoever in maternity care except in emergency.

We accept that not every general practitioner will wish to be trained for full care, but we consider that the numbers providing such care could increase. We say this for the following reasons:

a. Views of patients are being increasingly recognized and many are keen to see a return to personal care being given by one individual.

b. There is an increasing number of general practitioner obstetric units which are physically associated with specialist units where patients can receive care from their own doctors.

c. There is some evidence suggesting that low risk patients delivered in a geographically integrated general practitioner unit fare as well as a similar group booked in specialist beds (Klein, in press).

d. The advent of vocational training for general practice should result in improved training in obstetrics in both hospitals and training practices and thus encourage more practitioners to take up this rewarding aspect of maternity care.

Antenatal and postnatal care in general practice have important features not so readily learnt in hospital posts, including continuity of care of mother and baby, knowledge of the family and social factors, the management of coincidental illness and the involvement of other professionals in the community. This is likely to remain the major sphere for general practitioners providing obstetric care.

An Integrated Maternity Service

Integration can refer to the physical location on one site of specialist and general practitioner beds. It may also refer to the agreement between health professionals on the policies to be adopted for clinical practice, audit and continuing education, which we call functional integration. Clearly,

physical integration leads most readily to functional integration. An expansion of general practitioner beds within or adjacent to specialist units in all districts would allow a substantial number of women to be cared for in labour by general practitioners with specialist assistance readily available. The concept of functional integration is particularly important in isolated general practitioner units.

The policies regarding patient selection and management should be agreed at district level by all concerned in providing maternity services. All general practitioner obstetricians should be closely associated with the activities of the specialist unit and the consultant obstetricians should participate in those of the isolated units so that functional integration occurs.

Home Confinement

To the extent that only 1.4 per cent of deliveries currently occur in the patient's home, the policy of hospital confinement to which we subscribe is being widely applied. Even so, there is in some quarters a demand for a return to more home confinements. It is argued that the hospital environment is too clinical and impersonal, whereas home confinement provides a familiar environment with known attendants and no isolation of the mother from her family, who can then share fully in what is a very important family event. Whilst sympathetic to this view, we think it underestimates the risk factor. However carefully women are selected with regard to the risks of pregnancy and childbirth there will always be the unexpected emergency such as fetal distress, neonatal asphyxia or post partum haemorrhage which cannot as safely be dealt with in the patient's own home. The greater provision of general practitioner facilities fully integrated with the specialist obstetric unit, together with the development of a more personal hospital environment and an increased use of early discharge, can provide a sensible and sensitive compromise.

However, we consider that provision should be made for the small number of women who opt for home confinement despite the risks and that the general practitioner best placed to manage them is the one who has maintained practical skills and expertise by working regularly in an obstetric unit. We expect that in future in many practices there will be one or two partners who come into this category. Where the practice has no such doctor, there should be a wider use of the referral system to another general practitioner colleague who has such skills, so that the burden of care will not fall solely on the community midwife. In either case we believe that the local obstetric unit, with prior consultation, should be prepared to provide emergency support for the doctor or the midwife. Such an arrangement could well be made through the "Maternity Services Liaison Committee" which we describe later.

Recommendations

1. The functional integration of all maternity services within districts should be vigorously pursued so that there is agreement between all the professionals concerned on the policies for clinical practice, audit and continuing education.

2. General practitioners with recognized training in obstetrics should be given every assistance to have facilities within or adjacent to consultant units where they can deliver their selected patients. All consultant units should provide such facilities either within their unit or as part of a functionally integrated general practitioner unit.

3. Consultants, general practitioners and midwives together with other health professionals should ensure that these facilities are made available.

Basic Medical Education

The Education Committee of the General Medical Council (1980), in its recommendations on basic medical education, states that a student should acquire knowledge and understanding of normal pregnancy and child birth, the commoner obstetric emergencies, the principles of antenatal and postnatal care, and medical aspects of family planning and psychosexual counselling. Whilst endorsing these recommendations, it is our view that a doctor on qualification should have achieved the objectives set out in Appendix I.

It has been suggested in some quarters that undergraduate training in obstetrics is inadequate and that some students who qualify have never even conducted a normal delivery. A questionnaire we directed to university departments of obstetrics and gynaecology in England and Wales showed that, within the constraints imposed by reduced periods in the curriculum, obstetrics and gynaecology is adequately covered and that most students are given the opportunity to conduct ten or more normal deliveries. We are firmly opposed to any further cuts in the curriculum for obstetrics and gynaecology.

Given the objectives of the Education Committee of the GMC (1980) and the amplification we have suggested for undergraduate training in Appendix I, it is clear that all registered doctors wishing to provide other than emergency obstetric services should receive further postgraduate training.

Recommendations

4. The objectives of the Education Committee of the GMC and our amplifications in Appendix I should be achieved by all undergraduates.

5. There should be no further reduction in the time allotted in the undergraduate curriculum for obstetrics and gynaecology.

6. Undergraduate education is inadequate to meet the needs of general practitioners wishing to provide maternity services. We therefore recommend that all general practitioners wishing to provide such services should undergo a further period of training after qualification.

Vocational Training

As the majority of trainees will be undecided to what extent they will wish to provide obstetric care, we expect that most will opt for training for full care. Some, particularly those with family commitments, will decide on training for shared care only, but there will inevitably be some who have no wish to be trained further in obstetrics. Whilst we consider that it is to the advantage of all trainees to have postgraduate training in obstetrics and gynaecology, we do not recommend any alterations in the Vocational Training Act.

We have divided the educational objectives of training for general practitioners wishing to provide maternity services into two sections. The first, dealing with antenatal and postnatal care, we recommend all trainees should achieve (Appendix II). The second lists the additional objectives for those who wish to be trained for full care (Appendix III).

Whilst we have mainly concentrated on obstetric training, we realize that gynaecology, including family planning and genito-urinary conditions, are important areas in general practice; for these we recommend the objectives set out in Appendix IV.

Recommendations

7. All trainees should achieve the educational objectives for antenatal and postnatal care and gynaecology including family planning and genito-urinary conditions, set out in

Appendices II and IV.
8. Trainees wishing to provide full care should, in addition, achieve the objectives set out in Appendix III.

Achievement of Vocational Training Objectives

Obstetric Training

For full care by general practitioners, we propose a six month period of residential training in a post recognized by the two Colleges for vocational training in obstetrics and gynaecology for general practice. At present such posts are of three types:

1. Mainly obstetrics with a small component of gynaecology including family planning.

2. Combined obstetrics and gynaecology with concurrent duties in both.

3. Posts in which three months obstetrics is followed by three months gynaecology or *vice versa* (i.e. consecutive).

We firmly believe that the ideal obstetric training for those general practitioners who are going to offer full care especially in isolated units, is in those posts offering the maximum obstetric experience. With the increasing importance of medical gynaecology and family planning in general practice we submit that the second type of post would offer a good all-round training for vocational trainees for general practice and that the obstetric objectives in Appendix III could be met. With such training we consider that a general practitioner would be able to offer full care services, providing that the recommendations on continuing education and minimal experience are met.

In the third category of post we are concerned that three months obstetric experience alone might be insufficient training, particularly if it is diminished by annual, sick or study leave. However, it would create difficulties for both trainees and for the units concerned if approval was withdrawn from this small number of posts. We recommend therefore that all three types of post continue to be recognized, but where possible the consecutive type of training be altered to concurrent. Where this is not possible the visitors from the two Colleges should ensure that the trainees receive the necessary training to meet the objectives in Appendices II, III and IV.

Shared Care

We considered the view that the objectives of training for shared care could be achieved without a resident hospital component, but we believe the latter to be necessary as a contribution to the full-rounded experience which is so desirable in doctors doing this work. For this reason we recommend that a resident hospital post be a feature of all obstetric training programmes. Because hospital training for shared care can be supplemented with experience in training practices, we would accept three months in a combined obstetrics and gynaecology post as a *minimum* period of training for this purpose. We appreciate that such posts are not at present widely available, nor do we know the scale of future demand. Whereas it would not be impossible to create them, any major increase of three months modules could unbalance the service requirements in obstetric units, and their provision would have to be agreed locally between the professionals concerned.

Gynaecological Training

All residential appointments should have some gynaecological responsibilities and these, combined with training practice experience, should be sufficient for the achievement of the gynaecological objectives. For those trainees who have had no hospital gynaecological experience, their training practice experience could be supplemented by attendance at local gynaecological out-patient clinics.

Part-time Training

Part-time training in hospital is acceptable provided that it conforms with the recommendations in Appendix V.

Family Planning

Every trainee should achieve the requirements for the Joint Certificate on Contraception. The requirements for gynaecological attendance and, where possible, the theoretical and practical instruction, should be completed during the period of hospital training. Training practices should be able to provide substantial experience in this field and we welcome the trend towards the appointment of more general practitioners as trainers in family planning.

Training Practice Experience

In addition to a residental hospital appointment, trainees must have opportunities to learn about obstetric and gynaecological care in the training practice attachment. Although the gynaecological experience will usually be acquired during routine consultations, for obstetrics it will be necessary for the training practice to be holding a regular antenatal clinic, to be participating in a shared care scheme with the district hospital, and to be undertaking full care of some patients. The recommendations for training practices providing obstetric and gynaecological experience are listed in Appendix VII.

Change from Shared to Full Obstetric Care

Inevitably there will be a small number of doctors who at a later date feel the need to undertake full care but who have only been trained for shared care. For these we recommend an additional period of three months residential obstetric training.

Recommendations

9. For those general practitioners wishing to provide full care, a period of six months combined obstetric and gynaecological training in a post recognized by the two Colleges should be the minimum requirement.

10. For those general practitioners wishing to provide shared care only, a period of three months combined obstetrics and gynaecology in a post recognized by the two Colleges should be the minimum requirement.

11. Part-time training would be acceptable under the conditions set out in Appendix V.

12. Those general practitioners wishing to provide full services who have undertaken training suitable only for shared care should undertake an additional minimum period of three months resident obstetrics in a post recognized by the two Colleges.

13. Experience in those aspects of obstetrics and gynaecology which are obtained more readily outside hospital experience should be provided in the training practice.

14. All trainees should be enabled to achieve the requirements for the Joint Certificate on Contraception.

Hospital Posts and Training Practices

The Royal College of Obstetricians and Gynaecologists has a long tradition of inspecting hospital posts, and recently

joint visits have been conducted by the two Colleges for recognition of posts for general practice vocational training and for the Diploma of the Royal College of Obstetricians and Gynaecologists.

The vocational training regulations state that the selection by Regional Postgraduate Committees of educationally approved posts for prescribed experience shall be made from among those posts recognized by the appropriate colleges or faculties. The Joint Committee on Postgraduate Training for General Practice, which is responsible for determining standards for training and for exercising general oversight of the training arrangements, has published guidelines for such educational approval. We suggest aspects of training for the two Colleges to consider in Appendix VI.

In Appendix VII we set out proposed recommendations for training practices seeking to provide trainees with obstetric and gynaecological experience.

Number of Posts Available for Vocational Training in England & Wales

Concern has been expressed about the number of junior hospital posts available for training. In England and Wales there are 1,289 SHO posts, including 21 post registration HO posts, and there are currently a further 153 in Scotland and 58 in Northern Ireland, making a round total of approximately 1,500 posts, of which 234 are gynaecology only. Approximately 70 SHO posts are needed annually in the UK for specialty training, leaving approximately 1,196 posts for trainee general practitioners or overseas doctors intending to return to their own countries. Approximately one half of medical graduates in the past have become general practitioners. This means there could be up to 1,800 doctors wishing to train for general practice each year in the UK in the future, so even if all these doctors did six month posts in obstetrics or obstetrics and gynaecology, there would in theory be enough posts for them. We know, however, that there are problems over the geographical distribution of vocational training posts and that there are more posts in use for specialty training than the existing consultant establishment can absorb. The necessary provision of vocational training posts requires discussion in the regions concerned.

In any future changes of hospital staffing ratios affecting junior posts, the requirements for vocational training for general practitioners would need careful consideration.

Recommendations

15. The two Colleges should reconsider the criteria for approval of posts for vocational training.

16. The two Colleges should continue joint visits to hospitals for educational approval of posts for vocational training.

17. All obstetric and combined obstetric and gynaecological SHO posts surplus to specialist training requirements should be regarded as potential vocational training posts for general practice.

18. Training practices should be so organized that they provide the necessary supplement to hospital training outlined in Appendix VII.

19. Regional Postgraduate Committees should examine any difficulties over the local provision of posts for vocational training.

Diploma of the Royal College of Obstetricians and Gynaecologists

The DRCOG examination has always been regarded by the Royal College of Obstetricians and Gynaecologists as the examination appropriate for general practitioners providing maternity services. Originally confined to obstetrics, it now includes gynaecology relevant to general practice. We still regard this as the appropriate diploma for practitioners providing any type of obstetric care but particularly for those providing total care. We think that the examination could be made even more relevant by the two Colleges reconsidering the syllabus and format and by an addition to the panel of examiners of general practitioners engaged in providing full obstetric care.

Recommendation

20. That those practitioners wishing to provide maternity services, particularly those intending to offer full care, should obtain the DRCOG.

Continuing Education

We attach great importance to continuing education, particularly in the field of obstetrics. We have found it helpful to divide continuing education into the following areas:

In the Obstetric Unit

Good clinical practice and continuing education go hand in hand. Many specialist obstetric units have undertaken regular educational activities for many years, including teaching ward rounds for junior staff, case conferences and perinatal mortality meetings. We believe that these activities should be widened in scope to include the examination of problems which may occur or have their origins outside the hospital. All general practitioners working in obstetric units should take an active part in these meetings, and join in the teaching. It is important that junior staff working in obstetric units, whether intended for specialist or general practice, should recognize that there are important aspects of obstetric care which can be learnt from general practice. In summary we would like to see in all obstetric units, continuing education in which specialists and general practitioners are both involved.

In General Practice

We hope that the meetings referred to above would involve other general practitioners in addition to those responsible for intranatal care. Nevertheless, many general practitioners, providing only antenatal and postnatal care, will not be able to take part regularly in educational activities in the local obstetric unit. We think that these doctors should consider obstetrics and gynaecology as appropriate topics for small group discussions which could include their midwives and health visitors, in one or more practices. These meetings could take the form of practice review or audit meetings and concentrate on activities particularly related to antenatal and postnatal care and medical gynaecology.

Refresher Courses

The need for refresher courses will remain, but here too there is scope for development. Formal lectures will continue to be appropriate for introducing new knowledge or reviewing some aspects of practice, but the seminar type of meeting with active participation by the audience is becoming more popular and should be encouraged. General practitioners should be involved with their specialist colleagues in the planning of these educational activities.

Maintenance of Skills

For the practitioner providing full care, we cannot overemphasize the importance of maintaining skills by continuing to manage an adequate number of deliveries per year. We

welcome the recognition by the GMSC (BMA, 1981) of the importance of maintaining practical skills, and we would accept their suggestion that less than thirty deliveries in three years should warrant a practical refresher course, as a realistic start which should be reviewed in five years time.

Where a practitioner does not manage enough deliveries each year, an individual attachment to a specialist unit is the best form of practical refresher course. We hope that all district units will be prepared to provide such experience on an individual basis agreed locally. Locum appointments could be a useful way of providing this experience. We recommend that the practitioner providing intranatal care should attend the patient in labour and at delivery whenever possible.

Recommendations

21. Facilities for continuing education should be regularly reviewed by the professionals providing maternity services so that they are designed to meet the needs of all concerned.

22. All general practitioners offering maternity services should take part in regular educational activities.

23. Those general practitioners providing full care who deliver less than thirty women in three years should undertake a practical refresher course.

24. Attendance at the delivery should be regarded as the normal practice for those general practitioners offering full care.

Organization of Maternity Services

Maternity Services Liaison Committee

Integration of maternity services, to which we attach so much importance, should be at district level. We strongly support an organization, such as that recommended by the report of the Social Services Committee, which should represent all those professionals involved in providing maternity services in the district who can thus exchange views and information and report back to their respective colleagues. It should have the means to call for information and to make recommendations. Without such a group many of the recommendations in this report will not easily be achieved. The functions the group could undertake are listed in Appendix VIII.

General Practitioner Beds

All general practitioners having access to obstetric beds should have an honorary contract with the health authority. The terms of the contract would need to be negotiated locally and should be agreed by the professionals concerned. The contract would be expected to cover such things as:

a) the eligibility of general practitioners who wish to use the facilities.

b) responsibilities towards patients in labour, work of the unit, and the maintenance of proper records.

c) arrangements for transfer of patients to specialist care.

d) a statement of hospital services available to general practitioners.

Obstetric List

We recognise that the question of the obstetric list is a matter for those responsible for negotiating between general practitioners and Health Departments. However, the educational recommendations of our report have implications for the list, since it is proposed that there should be a two tier system of training. We support the proposal of the GMSC (1980) and the Social Services Committee (House of Commons, 1981) of a two-tier obstetric list since that would be compatible with our recommendations for training. We underline the importance of a clear-cut and single method of changing from shared care to full care so as to avoid the long-standing problems associated with Criterion VI in the current regulations. We would like to draw the attention of the GMSC to our recommendations under continuing education.

Recommendations

25. Maternity Services Liaison Committees representative of all those providing maternity services and with agreed terms of reference and constitution should be established in all districts.

26. General practitioner obstetric beds should be organized to enable practitioners with locally arranged contracts to provide full care for selected patients.

27. There should be a two-tier obstetric list, one tier for full maternity services and the other for shared care only.

Appendix I: Basic Medical Education

A doctor on qualification should:

1. Have a basic knowledge of the principles of human reproduction and family planning.
2. Have a basic knowledge of the principles and practice of normal obstetrics, including antenatal and postnatal care.
3. Have had enough practical experience to be able to deliver a baby in an emergency and apply simple resuscitation to the newborn.
4. Be aware of the inter-relationships between general disease and pregnancy.
5. Have a basic knowledge of important and common gynaecological conditions.
6. Be able to take a gynaecological history, conduct a pelvic examination and take a cervical smear.
7. Understand the principles of psychosexual counselling.
8. Be able to recognise common obstetric and gynaecological emergencies requiring urgent intervention and be able to provide appropriate first aid measures.
9. Be aware of the emotional aspects of childbirth.

Appendix II: Training Objectives for Shared Antenatal and Postnatal Care

The doctor should:

1. Appreciate the preventive role, and understand the significance of all routine procedures used in modern antenatal care.
2. Have a thorough understanding of the epidemiology of maternal and perinatal morbidity and mortality.
3. Be able to undertake the initial management of common and life-threatening emergencies in early pregnancy.
4. Know when pregnant women require referral for specialist opinion or care and which are suitable for shared care or full care by the general practitioner.
5. Understand the principles of counselling a woman faced with possible or real problems of fetal malformation.
6. Know the methods by which congenital malformation of the fetus may be detected.
7. Be aware of the methods of, and provision for education for pregnancy, childbirth and care of the newborn.
8. Understand the importance of social and emotional factors in pregnancy and childbirth.
9. Understand their own role and that of different members of the health team in this field.
10. Understand the management of common conditions for which pregnant women are admitted to hospital e.g. premature labour, pre-eclampsia, multiple pregnancy, fetal growth retardation, antepartum haemorrhage, maternal disease etc.

11. Be able to recognise the signs and symptoms of onset of labour.
12. Understand the principles and methods of the current management of labour.
13. Understand the importance of accurate and detailed records in all aspects of obstetric care and recognize the value of such records in clinical audit.
14. Be able to carry out routine examination of the newborn infant.
15. Understand the normal development of the newborn.
16. Recognize common diseases arising in the newborn.
17. Recognize congenital abnormalities in the newborn.
18. Understand how breast feeding is established and maintained.
19. Recognize and understand the management of physical and psychological problems of the mother in the postnatal period e.g. puerperal depression.
20. Understand the normal involutional processes in the postpartum period.
21. Understand the indications for maternal immunization with anti D and rubella vaccine and the importance of confirming their efficacy.
22. Be able to advise and provide suitable methods of family planning.

Appendix III: Training Objectives for Intranatal Care

For full care, in addition to the objectives in Appendix II the doctor should:

1. Understand the indications for the induction of labour.
2. Understand the physiology of uterine activity and the use of oxytocics to augment uterine action.
3. Know the principles and practice of continuous fetal heart rate and acid-base monitoring.
4. Recognize the abnormalities that may occur in labour necessitating transfer to specialist care e.g. fetal distress, haemorrhage, delay in labour, abnormal presentation, etc.
5. Be able to:

a) Induce labour where appropriate.
b) Provide obstetric analgesia and local anaesthesia including pudenal block.
c) Carry out a low forceps delivery.
d) Resuscitate a shocked mother.
e) Resuscitate a shocked baby.

6. Understand the management of other abnormalities of labour e.g. shoulder dystocia, breech, twins.
7. Be able to manage the third stage of labour including the immediate management of postpartum haemorrhage and retained placenta.
8. Be able to suture episiotomies and lacerations.
9. Be aware of special arrangements needed for home confinements.
10. Be able to communicate with women in labour so that they understand the procedures proposed for their own safety and that of their babies.

Appendix IV: Training Objectives for Gynaecology Including Genito-urinary Conditions and Family Planning

The doctor should:

1. Understand the role of the general practitioner in and techniques used from general practice:

a) for health education and sex education in children, adolescents and older women.
b) for prevention of gynaecological disease e.g. cervical carcinoma, genital infection.

2. Be able to take a gynaecological history, carry out a full and appropriate examination and conduct appropriate investigations on patients of all ages.
3. Understand the physical problems relating to congenital abnormalities of the female genital tract.
4. Be able to advise and provide suitable methods for family planning.
5. Understand the principles involved in counselling patients with psychosexual problems.
6. Be able to advise, investigate and where appropriate refer patients with problems relating to infertility.
7. Be able to manage abortion in general practice, including emergency treatment, counselling and aftercare.
8. Understand the management of common problems relating to menstruation e.g. amenorrhoea, dysmenorrhoea, menorrhagia, polymenorrhoea, pre-menstrual syndrome.
9. Understand the management of patients suffering from infections of the genital tract, including sexually transmitted disease.
10. Know the steps required for the early diagnosis of neoplasia of the genital tract and the general practitioner's role in management.
11. Understand the physiology and management of the menopause.
12. Understand the management of stress incontinence and prolapse.
13. Be aware of ethical and legal aspects of gynaecological problems e.g. chaperoning, age of consent, assault, sexually transmitted disease.
14. Understand the role of other professionals in these fields.

Appendix V: Part-time Training

Part-time training is acceptable providing that:

1. It achieves the objectives for full time training.
2. It is of equivalent duration to full time training.
3. It is not less than half time and is a consecutive unbroken period except for statutory annual and study leave.
4. It is in posts jointly recognized by the two Colleges to ensure that they are adequate in educational content and do not diminish the experience of full time trainees. The posts can then be selected by the Regional Postgraduate Committee for vocational training.

Appendix VI: Approval of Hospital Posts

Royal College of Obstetricians and Gynaecologists' Guidelines

The Royal College of Obstetricians and Gynaecologists has established guidelines for the recognition of hospital appointments, which the Working Party found very useful.

In particular the references to regular meetings for the presentation of cases, clinico-pathological conferences, perinatal morbidity reviews and similar educational activities to encourage critical evaluation of patient care were considered important. In addition we recommend that general practice aspects of obstetrics and gynaecology should be discussed. We endorse the statement that sufficient study time must be available for trainees and this should be at least half a day during the working week. We agree that in-service teaching should be the responsibility of the consultants.

Assessment

Satisfactory completion of a post will entitle the trainee to a Statement under the Vocational Training Regulations. The Statement must be signed by the supervising consultant.

A method of continuous assessment to monitor the doctor's performance is desirable and may be requested by a vocational training organizer or other body. Such a procedure should provide early identification of strengths and weaknesses leading to well directed and efficient remedies and at the end of the appointment, a clear profile of the doctor's capabilities. An informal, collaborative assessment after two months in the post is strongly recommended.

Conduct of Visits

An important feature of any visit is the private discussion with the doctors in training so that visitors may acquire first-hand information of their experience and opinions. We recommend that all visitors should be signatories to the report, which should be sent to both Colleges.

FOURTH NATIONAL TRAINEE CONFERENCE REPORT, RECOMMENDATIONS AND QUESTIONNAIRE

Occasional Paper 18

How much teaching do vocational trainees really get? What do they think about their trainers and how easily can they talk to them? This *Occasional Paper* reports on the proceedings of the Fourth National Trainee Conference held at Exeter in July 1980 and analyses the results of a questionnaire which was returned by 1,680 trainees throughout the country. This is the most detailed information so far published about the opinions of trainees, and from them a new 'value for money' index has been derived, based on sophisticated statistical analysis, which now makes it possible for the first time to rate a general practitioner trainer.

Fourth National Trainee Conference, Occasional Paper 18, is available now from the Publication Sales Department, Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU, price £3.75 including postage. Payment should be made with order.

INNER CITIES

Occasional Paper 19

The problems of general medical practice in inner cities are becoming increasingly well known and some important reports have recently been published, particularly about general practice in London.

Occasional Paper 19 by Dr K. J. Bolden, Senior Lecturer at the Department of General Practice, University of Exeter, is based on the report for which the author won the 1980 Upjohn Prize, and analyses problems of general practice in several inner cities in different parts of the country.

Whereas many are critical of doctors working in these areas, Dr Bolden illustrates vividly some of the difficulties which practitioners encounter and makes a number of suggestions as to how they can be overcome.

Inner Cities, Occasional Paper 19, is available now, price £3.00 including postage, from the Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU. Payment should be made with order.

Appendix VII: Recommendations for Training Practices Providing Obstetric and Gynaecological Experience

1. The practice should care for an adequate number of obstetric patients.
2. The trainer or a partner should be on the obstetric list and actively practising obstetrics.
3. The practice should hold a regular antenatal clinic.
4. A community midwife and a health visitor should be attached to the practice.
5. There should be family planning services provided by the practice.
6. The experience and instructions offered should enable the trainee to meet the objectives for gynaecology including genito-urinary conditions and family planning listed in Appendix IV.
7. There should be a proper system of records, especially for maternity patients.

Appendix VIII: The Maternity Services Liaison Committee

The functions of the Committee would be:

1. To monitor obstetric care in the District and provide information on statistics and trends in the local obstetric service.
2. To encourage research into aspects of obstetric care in the district.
3. To advise the educational authorities on continuing education for all the professionals concerned.
4. To consider observations from the social services, the Community Health Council, and patients' groups as well as from individuals either lay or professional.
5. To issue regular reports whilst maintaining strict confidentiality.
6. To consider, with all involved, the provision of obstetric care in order to bring about full integration of maternity services in the District.

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Composition of the Working Party

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Royal College of General Practitioners Dr M. J. V. Bull; Professor V. W. M. Drury; Dr J. C. Hasler; Dr M. McKendrick; Dr Lotte T. Newman; Dr J. S. Norell;

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