The Guildford (University of Surrey) release course for trainee general practitioners

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SUMMARY. A day-release course for trainee general practitioners is described, where the trainees decide on their own educational needs and work out a curriculum each term to meet those needs.

Introduction

PART of the mythology of past generations of doctors was that general practice could not be taught—the only way to learn how to be a general practitioner was to become one. This 'learning' period was a frightening and lonely time for the young general practitioner. It was a time when he had to acquire what the public called 'the bedside manner', or in other words, to establish a good doctor–patient relationship, and for this acquisition he was dependent on his own temperament and instinctive ability to relate to others. In those days it was not thought possible that the bedside manner could be taught, or that the ability to empathize with a patient might come more quickly with the help of someone else. The idea of training general practitioners did not gain ground until the late 1960s, when vocational training schemes (VTS) were instituted and trainees were encouraged to take time off from the general practice component of their training to attend day-release or halfday-release courses, usually organized by someone who had been a trainer himself. On the whole, the emphasis of the courses was on clinical and administrative material rather than the doctor–patient relationship.[1]

One major factor in organizing day-release courses has been that the organizers decide the content of the course from their own experience. Rarely have the trainees been asked what they felt they needed to equip themselves for their future role, or to choose the whole course themselves.

History and theory

In 1973, Heron, an educationalist at the University of Surrey, demonstrated to a group of prospective trainers that there were other ways of learning than being taught didactically.[2] The principle of the self-directed learning group was introduced; participants chose what they wanted to learn on their course and, as a result, increased their awareness of and skill in handling issues arising between them in the group.

The trainers involved in this course were struck by the appropriateness of these concepts for training in general practice and, unlike Josephs,[3] who questioned the value of behaviourly orientated courses, they asked that these concepts should be applied to a release course for trainees in their general practice year. This was done and the course was started in 1974 by the first author and J. D. Scobie. After four terms, it was continued by the authors (J.A.B.W and J.M.T) when Scobie left to start the Roehampton release course.

The Guildford course was formed later than the six local vocational training schemes (VTS) from which it draws its participants. It is held at the University of Surrey in Guildford under the auspices of the Department of Educational Studies (there is no department of general practice in this university). There is no direct influence by the course organizers on any individual VTS, although there has always been close contact with the general practitioner trainers involved.

Participants

Course members were trainees in the general practice part of the vocational training schemes in the Guildford region, based on nine district hospitals. Fifty per cent of participants arranged their own rotation of posts. This has meant that on the course there could be a mixture of those who had just finished their pre-registration jobs without ever having taken a general practice surgery and all variations of trainees through to those in their last three months of a three-year scheme.

By the summer of 1979, the number of participants had risen from six to 26.

Aims

The aims of the Guildford course are that trainees should identify their own educational needs and remedy them themselves.

Methods

Structure

The course evolved slowly but with increasing momentum over the first five terms, with its structure and the method of running it changing continuously. The key for this change was the repeated feedback from the trainees, who at the end of each weekly session were given an opportunity to express their views on the day and adapt the course content as a result. They were also able to fill the gaps in their learning as they identified them during the term. This was done by asking the organizers to provide time to treat some subjects in greater depth.

On the first day of the term, in January 1974, the trainers were given the task of planning the curriculum for the term, in the light of various learning needs already expressed earlier that day. By the third term, they decided to start each term with a 24-hour residential session. The introduction of the residential session was so successful that it has begun each term ever since. The purpose of this session, which was largely structured in advance by the organizers, was to:

1. Form a cohesive and supportive group.
2. Allow trainees to try out new techniques of learning so that they might gain some insight into their own and others' emotional and behavioural responses.
3. Help trainees to become aware of the increased possibilities open to them in identifying their needs for the general practice year.
4. Produce a programme which would satisfy those needs.

Trainees and organizers met at 18.00 and dined together. After dinner, there was an evening session for all those present to get to know one another and be introduced to various learning techniques. Exercises designed to foster a closely knit group were utilized, for example those described by Pfeiffer and Jones.[4] In addition there was a demonstration of interview techniques, such as the use of silence and the recognition of nonverbal cues.

The next day, more experiential learning ideas were introduced.[5] Taboos on touch and personal space, 'role play', the concepts of feedback, 'brainstorming' and other educational techniques were used.

The course participants were thus given the opportunity to experience new methods of learning before they planned their course, in the expectation that as they became aware of their needs they would wish to develop the appropriate skills for dealing with them.

The first task for participants was to define the educational objectives they wanted to achieve during their year as a trainee in general practice. This was done in small groups and distilled into a consensus, choosing the most appropriate venues for different topics—either with the trainer, the trainer/trainee group, on outside visits, at hospital outpatient departments or on the course. Those aspects which could, on the whole, only be done on the course—video work and role play, small-group work, experiential learning techniques, personal feedback and so on—were separated from purely clinical work, which could be done elsewhere. Management (practice, financial, and staff), relationships (doctor–patient and other interpersonal areas), and emotional responses (such as are provoked by care of the dying, death, bereavement and psychosexual problems) were all considered to be course topics, despite the fact that there would possibly be overlap with work done in their own practices and trainer/trainee groups. Those topics considered appropriate to the release course were incorporated in a provisional programme.

Initially the course was arranged as a half-day per week in a 10-week term, but the time gradually increased until the eventual format became an 11.30 start and 16.30–17.00 hours close. The hour for lunch was considered by the trainees to be one of the most valuable parts of the day, when they could meet and discuss common problems. The pre-lunch session was usually an informal talk by an invited speaker on a subject selected by the trainees, who sat with the group in a circle; the most successful speakers were those who adapted to this style. The afternoon was spent on projects and role plays. The projects were mainly pooling information from trainees' practices about their trainers' methods of management, contracts, details of practice agreements, and so on. The role plays frequently consisted of a consultation re-enacted by a trainee who may have had some difficulty in his surgery with a patient the previous week and who wanted to find out where things had gone wrong. He would brief another trainee to act as the patient, and then replay his own part. Despite the apparent artificiality of the scene, the consultation techniques and the emotions aroused in both doctor and 'patient' could be clearly seen on videotape by the whole group.

Discussion tended to range over clinical details, ethical considerations, overall management, attitudes and skills of interviewing (using an analysis devised by Heron)[6] and the doctors' and patients' emotional reactions.

Mid-term residential session

By the fifth term (summer 1975) the demand for experiential learning was such that the members requested a further period which would be specifically set aside and designed for them to develop awareness of their own and other members' feelings. A 30-hour residential session was therefore arranged which was based loosely on encounter, or T group lines,[7] usually with an experienced guest facilitator. This concept of providing a (voluntary) session for more intensive group work proved to be highly popular and has continued ever since. An average of 80 per cent of the course members attend these sessions, some being absent for holidays and some by choice.

Difficulties

The greatest difficulty was that there were so many needs to be satisfied, with so many areas relating to general practice covered insufficiently at medical school that a day-release course was not nearly long enough to fill all the gaps.

Another problem has been the fact that course members have been at different stages of their general practice experience, and in the early years of the course those who had completed one or more terms found that trying to satisfy the needs of new members made the course repetitious. It was eventually agreed that all new members should begin only at the start of each term with everyone else, to avoid disruption of an established group. After a while, the organizers noted that the same subjects were being asked for every term and it was then decided to plan some subjects in advance, on a yearly cycle, with course members having the final decision. Prospective lecturers have always been firmly told in advance that the decision rests with course members at the beginning of each term.

The difficulty of forming a cohesive group from people of varying cultural and family background was largely overcome by the techniques used at the residential sessions. Some members never settled in and left without their difficulties being resolved, but those that stayed seemed to work through the problems.

Attendance at the Guildford course has always been optional, and while from the beginning there were enthusiastic trainers who sent their trainees even if it meant crossing regional boundaries, there were many who, like Josephs,[3] were against behavioural work. This hostility was gradually

overcome, partly because more trainers attended their own course, but mainly because of the enthusiasm of trainees, who talked to their colleagues in hospital and practice about the course. Freedom of choice to attend was felt by the organizers to be essential, not only to benefit the individual trainee but to avoid the disruption that coerced members might cause within the group.

Results

The topics and speakers chosen at the beginning (January 1974) were heavily orientated towards management, social services, terminal care, medicolegal pitfalls, NHS reorganization, prescribing, and the role of the trainee, but the second term's planning (summer 1974) showed a shift in the emphasis. Although hard facts about finance, practice management, medicolegal aspects, abortion and psychiatric services were asked for, there were also more requests for information on counselling, interpersonal skills and self-awareness.

In these first two terms of the course just over a fifth of the time available was devoted to various topics which can be conveniently grouped together as 'behavioural', such as handling emotional situations, counselling, interview techniques, bereavement and psychosexual problems. The percentage changed markedly in the third term. From the fifth term, about three quarters of the time was spent on behavioural subjects. The range of other subjects chosen was wide and over the years included clinical matters such as dermatology and the management of the dying, paraclinical subjects such as medical defence, practice organization in all its manifestations, and hearing from members of allied professions. While the behavioural subjects took up a fairly consistent proportion of the time (although on an annual basis it was boosted by Elizabeth Stanley's sexual awareness reorientation programme),[8] the time given to other subjects varied considerably from term to term.

We found that as the course was designed by the trainees themselves they were more committed to it, there was little absenteeism, and trainees felt encouraged to participate fully in group work. As they gained more idea of their own and others' responses, the interactions between members were examined in greater detail to improve interview techniques and other interpersonal skills. Perhaps the most encouraging response for the organizers was that the trainees, once they were introduced to this new style of learning, were so enthusiastic about it that they demanded more.

Discussion

Within the first two years, it became obvious that trainees felt their areas of need were more in their own and their patients' attitudes and emotions than in clinical knowledge, a view that was confirmed subsequently by Freeman and Byrne[9] and Gray.[10]

Our findings have not always been echoed elsewhere; in Oswald's survey in 1977 of 11-day release courses,[11] trainees reported that too much emphasis was put on the doctor–patient relationship, the consultation and methods of counselling. Some, however, felt aggrieved that they had little say in planning their course; only in some courses was it possible for trainees to modify the prepared programme, although Oswald did not state what teaching methods were used.

Three years later, in complete contrast to Oswald's findings, the replies of 1,500 trainees to a questionnaire at the 1980 National Trainee Conference,[12] showed that trainees were more likely to feel a course was worth attending if they had chosen more than a quarter of the contents, and had used small-group teaching methods with discussion groups. Jewell's experience[13] of the Ipswich scheme from 1977–80 convinced him also that organizers should respond to the trainees' needs with supportive small groups which, among other things, could give insight into behaviour in the consultation.

Richardson[14] has emphasized the need for more objective evaluation of courses, but Freeman and Byrne,[9] in a research project to assess the training programmes of seven large centres, reviewed the literature on evaluation and assessment of the effectiveness of teaching and found many complexities in the general field of objective assessment. However, the validity of this type of evaluation of a teaching course has been questioned.[15–19] To evaluate whether educational objectives have been met by a particular teaching method may ignore the extent to which self-directed learning compensates for ineffective teaching. If the act of learning is assumed to be self-directed, then the fixing of educational objectives at the start of the course and evaluation of these objectives to see if they have been met at the end, does not allow learners to modify their objectives in the light of changing needs.

Cooperation between organizers and trainees on the course[20] is the model for educational enquiry which we have adopted for the course. To do this, we have concentrated on the subjective evaluation of the course by the trainees themselves. In practice, this has meant setting aside time for retrospective assessment of each day and having enough flexibility in the programme to have space to develop and discuss any theme which may be brought to the surface by this evaluation. It can be seen therefore that the programme could always be modified by the members as the term progressed. A full record of the discussions were made every session and handed to each trainee the following week. Overall assessment has been made at the end of each term from suggested improvements and by course members filling in a questionnaire devised by the trainees themselves.

Conclusions

From our experience at Guildford, it seems that if exposed to experiential learning techniques and asked to choose their own course, the majority of trainees will

accept the challenge enthusiastically and demand a much higher content of behavioural work than has been assumed when courses have been chosen for them.

References

1. Howie JGR. Day-release programmes. *Update* 1977; **15:** 1035-1038.
2. Heron J. *Course for new teachers in general practice. Jan.-June 1973. Human potential research project.* University of Surrey, Centre for Adult Education, 1973.
3. Josephs C. Trainer-teaching techniques. (Letter). *Br Med J* 1975; **4:** 224.
4. Pfeiffer JW, Jones JE. *Structural experiences for human relations training.* San Diego, California: University Associates, 1974.
5. Heron J. *Experiential learning techniques. Human potential research project.* University of Surrey, Centre for Adult Education, 1973.
6. Heron J. *Six category intervention analysis. Human potential research project.* University of Surrey, Centre for Adult Education, 1975.
7. Lakin M. *Interpersonal encounter. Theory and practice in sensitivity training.* New York: McGraw-Hill, 1972.
8. Stanley E. The way we teach: human sexuality. *Med Teach* 1979; **1:** 184-189.
9. Freeman J, Byrne PS. *The assessment of vocational training for general practice. Reports from general practice no. 17.* London: Royal College of General Practitioners, 1976.
10. Pereira Gray DJ. *A system for training for general practice. 2nd ed. Occasional paper no. 4.* London: Royal College of General Practitioners, 1979.
11. Oswald NTA. Assessing release courses in vocational training. *J R Coll Gen Pract* 1979; **29:** 33-37.
12. Ronalds C, *et al. Fourth National Training Conference. Report, recommendations and questionnaire. Exeter, 1980. Occasional paper no. 18.* London: Royal College of General Practitioners, 1981.
13. Jewell MD. How I would organize a day-release course. *Br Med J* 1982; **284:** 1532-1538.
14. Richardson IM. Vocational training for general practice—does it work? *Update* 1981; **23:** 43-49.
15. Parlett M, Hamilton D. *Evaluation as illuminations: a new approach to the study of innovatory programmes. Occasional paper no. 9.* University of Edinburgh: Centre for Research in the Educational Sciences, 1972.
16. Society for Research into Higher Education. *How long is a piece of string? Report.* London: SRHE, 1975.
17. Stanton HE. *Helping students learn: the improvement of higher education.* Washington DC: University Press of America, 1975.
18. University Teaching Methods Unit. *Evaluating teaching in higher education.* London: University of London, 1975.
19. Reason P, Rowan J, Eds. *Human Inquiry.* Chichester: Wiley, 1981.
20. Parlett M, *et al.* Philosophical basis for a new paradigm. *In: Human inquiry.* Eds Reason P, Rowan J. Chichester: Wiley, 1981.

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