

Comparison of standards in training and non-training practices

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SUMMARY. *The in-practice component of vocational training should take place in practices working to high clinical and teaching standards. By means of a survey of its members, the Severn Faculty of the Royal College of General Practitioners was able to compare training practices with the criteria of the Joint Committee on Postgraduate Training for General Practice, and with non-training practices. The training practices fell short of the criteria in a few areas, but the differences between the training and non-training practices were extensive. Progress towards achieving the standards set by the criteria should be monitored, and the criteria themselves should be made more precise.*

Introduction

VOCATIONAL training before entry into general practice is now compulsory. Despite the expense involved — in 1982 the cost of the in-practice component for England and Wales, including the salaries of trainees, trainers, course organizers and so on, was £24 million — it has been said that this training has 'resulted in the birth of a new era in British general practice'.¹ If the true potential of training is to be realized then it must be of a high standard and in order to maintain that standard it must first be defined. The performance of trainees can be compared with this standard as a measure of the effectiveness of their training.

There is evidence which shows that the qualities of trainers and their practices influence the trainee^{2,3} and there is also evidence of the dissatisfaction of trainees with some aspects of their training.⁴ As both primary care and training evolve there is a need for continual review of training standards.^{5,7} The responsibility for establishing training standards lies with the

Joint Committee on Postgraduate Training for General Practice (JCPTGP). The general practice subcommittees of the Regional Postgraduate Medical Education Committees (RPMEC) have the task of approving trainers and their practices.

The JCPTGP issues guidelines on the criteria for the appointment of trainers,⁸ which include recommendations concerning the desire and ability of the trainers to teach, their clinical competence and the organization of their practices. The characteristics of training practices have been studied,^{5,9,10} but little data are available that compare training practices with non-training practices. If there are differences between training and non-training practices, are they so great as to make education in the former largely irrelevant to work in the latter?

In 1982 the Severn Faculty of the Royal College of General Practitioners decided to conduct a survey of its members in order to investigate the differences between training and non-training practices and to compare the characteristics of training practices with the criteria of the JCPTGP.

Method

Information was sought about the characteristics of every practice in the Severn Faculty area (Avon, Gloucestershire, Somerset) that had one or more doctors who were members of the Faculty. A questionnaire was constructed consisting of 69 questions which asked for details of practice size, location, premises, clinical and clerical equipment, ancillary and attached staff, appointment systems, screening programmes, specific clinics and educational activities. The questionnaire was tested by members of the Faculty Board and a revised version was subsequently sent to all 363 members of the Severn Faculty in May 1982. A second copy of the questionnaire was sent to those who had not replied after three weeks, and those who still failed to return the questionnaire were contacted by telephone.

One reply only was requested from each practice although a number of practices had two or more doctors who were Faculty

Table 1. The practice location, premises and personnel of training and non-training practices; percentages are given in parentheses.

	Training practices (n = 69)	Non-training practices (n = 81)	Total (n = 150)
<i>Location</i>			
Mixed	41 (59.4)	28 (34.6)	69
Urban	18 (26.1)	30 (37.0)	48
Rural	10 (14.5)	23 (28.4)**(a)	33
<i>Premises</i>			
Purpose-built	16 (23.2)	15 (18.5)	31
Converted	35 (50.7)	43 (53.1)	78
Health centre	18 (26.1)	23 (28.4)	41
<i>Personnel</i>			
Mean number of doctors per practice	4.09	3.13***(b)	
Mean number of patients per doctor	2109	2016	
Practice manager	45 (65.2)	34 (42.0)**	79
Employed nurse	44 (63.8)	30 (37.0)**	74
Attached nurse	61 (88.4)	66 (81.5)	127
Attached social worker	23 (33.3)	31 (38.3)	54
Attached marriage counsellor	14 (20.3)	5 (6.2)**	19
Staff trainer	36 (52.2)	19 (23.5)***	55

** $P < 0.01$; *** $P < 0.001$. (a) 2 degrees of freedom (df); (b) $t = 3.72$.

Table 2. Deputizing and appointment systems of training and non-training practices; percentages are given in parentheses.

	Training practices (n = 69)	Non-training practices (n = 81)	Total (n = 150)
<i>Appointment system</i>			
All sessions	60 (87.0)	55 (67.9)*	115
Some sessions	8 (11.6)	20 (24.7)	28
None	1 (1.4)	6 (7.4)	7
<i>Deputizing system</i>			
Commercial	2 (2.9)	15 (18.5)**	17
Inter-practice	19 (27.5)	23 (28.4)	42
None	48 (69.6)	43 (53.1)	91

*P<0.05, 1df; **P<0.01, 2df.

members. The data were processed manually and the statistical analysis used was the chi-square test with Yate's correction when appropriate, but Student's t test was used when indicated.

Results

Of the 363 members of the Faculty, 101 were not active in general practice and these members were excluded from the study. The 262 active general practitioners worked in 153 practices and completed questionnaires were returned by 150 practices, a response rate of 98 per cent. Of the non-responding practices one thought that the form was too long and two did not wish to disclose details about themselves. There were a total of 338 practices on the Family Practitioner Committee lists of Avon, Somerset and Gloucestershire in 1982, so information was obtained on 44 per cent of these.

Statistically significant differences in a number of factors emerged from the comparison between training and non-training practices. Training practices were more likely to be in a mixed geographical area and less likely to be in a rural area (Table 1). Of the 34 dispensing practices only five took trainees (P<0.001). Training practices employed more staff, were more likely to operate a full appointment system (Table 2), and undertook preventive health screening more often (Table 3). They were

Table 3. Clinical activities and equipment of training and non-training practices; percentages are given in parentheses.

	Training practices (n = 69)	Non-training practices (n = 81)	Total (n = 150)
<i>Screening</i>			
Geriatric	8 (11.6)	7 (8.6)	15
Hypertension	30 (43.5)	19 (23.5)**	49
Developmental	45 (65.2)	38 (46.9)*	83
<i>Intrapartum care</i>			
None	22 (31.9)	30 (37.0)	52
Home deliveries	4 (5.8)	4 (4.9)	8
General practitioner unit deliveries	25 (36.2)	30 (37.0)	55
General practitioner unit and home deliveries	18 (26.1)	17 (21.0)	35
<i>Equipment</i>			
Electrocardiograph	56 (81.2)	49 (60.5)*	105
Proctoscope	60 (87.0)	57 (70.4)*	117
Sterile dressings	65 (94.2)	65 (80.2)*	130
Dictaphone	64 (92.8)	56 (69.1)**	120

*P<0.05; **P<0.01; ***P<0.001.

generally better equipped (Table 3), performed more educational activities and were more likely to agree to participate in local audit schemes (Table 4). They were more likely to have culled records and summary cards as well as special registers (Table 5).

Commercial deputizing was rare among training practices although they made as much use of inter-practice rotas as did non-training practices. There were no differences in the use of A4 records, problem orientated notes, typed notes or family folders, none of which were found in more than 10 per cent of practices. Both types of practice were equally likely to possess a photocopier, computer, peak flow meter, microscope, sigmoidoscope or resuscitation box and there was no difference in the provision of intranatal obstetrics (Table 3). Indeed, almost one-third of training practices performed no deliveries.

Table 4. Educational and research activities of training and non-training practices; percentages are given in parentheses.

	Training practices (n = 69)	Non-training practices (n = 81)	Total (n = 150)
Trainee	69 (100.0)		69
Medical student	51 (73.9)	41 (50.6)**	92
Individual research	24 (34.8)	17 (21.0)	41
Collaborative research	17 (24.6)	14 (17.3)	31
Library	64 (92.8)	38 (46.9)***	102
Educational meetings	38 (55.1)	20 (24.7)***	58
Internal audit	30 (43.5)	14 (17.3)***	44
Workload analysis	17 (24.6)	10 (12.3)	27
Willing to carry out local audit schemes	56 (81.2)	42 (51.9)***	98

P<0.01; *P<0.001.

Table 5. The use of different record systems by training and non-training practices; percentages are given in parentheses.

	Training practices (n = 69)	Non-training practices (n = 81)	Total (n = 150)
A4 record	7 (10.1)	6 (7.4)	13
Culled record envelope	42 (60.9)	21 (25.9)***	63
Neither	20 (29.0)	54 (66.7)***(a)	74
Summary card	48 (69.6)	27 (33.3)***	75
Age-sex register	52 (75.4)	37 (45.7)***	89
Diagnostic index	22 (31.9)	12 (14.8)*	34

*P<0.05; ***P<0.001. (a)2 df.

Discussion

A direct comparison of training and non-training practices has not been published before. As training practices are selected by criteria set out by the JCPTGP, these criteria can be used as a standard against which the training practices in this survey can be compared. There are no similar criteria for non-training practices.

Some caution is needed in drawing conclusions from this study as the 153 practices containing Severn Faculty members may differ from those practices without such members. Of the 338 practices in the Severn Faculty area 185 did not contain a Faculty member. These practices tended to be smaller than those studied having a median of two doctors and they were mostly non-training practices. However, the geographical distribution of

these practices was no different from the study group. The omission of data on these practices is unlikely to effect the conclusions drawn as in April 1982 there were a total of 78 training practices in Gloucestershire, Somerset and Avon, of which 69 (88 per cent) were studied.

The features investigated were in general found less often in the non-training practices (see Tables 1–5). Of particular interest were the large differences in record systems and the number of nurses employed. It was surprising that 30 per cent of non-training practices had no proctoscope. Although differences between the two types of practice are to be expected, they should not be so great as to create two classes of general practice. This study suggests that this may be possible.

The findings for the training practices alone were similar to those reported in other studies. The use of appointment systems together with staff and equipment in training practices are similar to those found in the South West Thames region,¹¹ and the proportion of training practices with an age–sex register is similar to that found in Devon and Cornwall in June 1982 (80 per cent),⁵ and in the Oxford region in 1978 (72 per cent).⁸

The typical training practice is a medium-sized to large group practice in a mixed geographical area, and is well organized, equipped and staffed. Urban, rural and dispensing practices are under-represented, and trainees are unlikely to experience these forms of primary care although many of them will eventually work in such practices. Although trainees are being exposed to the more desirable elements of practice such as good records and preventive care, the breadth of their experience may be limited.

In the light of the 'Report on training for obstetrics and gynaecology for general practice',¹² it is disappointing that 32 per cent of training practices performed no intrapartum care. The report suggested that the number of practitioners performing full care could increase, and that it would be necessary for training practices to undertake full care of some patients. Trainees who wish to manage deliveries when they become principals will need to choose their training practice carefully, or arrange secondment elsewhere in order to gain experience of general practice deliveries. The JCPTGP criteria do not cover the type of obstetric care desirable in a training practice, a question which should be considered in the future.

The Severn Faculty training practices met the JCPTGP criteria in most respects. However, one of the criteria is 'ready access to the relevant literature', and yet five training practices had no library. Another criterion is 'arrangements to enable trainees to critically audit their own work' but only 44 per cent had performed internal audit. A further criterion requires 'adequate clinical and office equipment', but nine training practices did not possess a proctoscope, surely an indispensable everyday tool for the general practitioner. The JCPTGP criteria make no specific mention of age–sex registers or diagnostic indexes. However, an organized preventive medicine programme is not possible without an age–sex register and 47 training practices had no diagnostic index.

The JCPTGP criteria are under debate¹³ and it would be helpful if the committee were to consider ways of increasing the proportion of urban and rural practices that undertake training and also the proportion of training practices that perform obstetric care. The inclusion in the criteria of a comprehensive list of equipment and necessary organization might help trainers and the RPMEC's to correct the deficiencies that have been demonstrated.

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Viral aetiology of diseases of obscure origin

Viruses have often been suggested as factors in the aetiology of diseases of obscure origin. Much of the work however, has been unacceptable or unreproducible, and considerable scepticism is advocated. In this review a short survey is given of the types of evidence for viruses in the aetiology of these diseases. Modern techniques for detecting virus-specific antigens or nucleic acid sequences, and modern ideas about disease processes, make it likely that more definite information will be available before long. Presence of viruses, however, can be *causal* or merely *casual*, and the difficult question of proof is discussed, with reference to updated Koch's postulates.

Diseases surveyed in greater detail include cancer, neurological diseases (multiple sclerosis, Guillain Barre syndrome, Parkinson's disease, Alzheimer's disease), connective tissue diseases (systemic lupus erythematosus, rheumatoid arthritis), Crohn's disease and ulcerative colitis, juvenile diabetes, autoimmune thyroiditis, Paget's disease of bone and atherosclerosis.

Finally, the possible mechanisms by which viruses cause such diseases are listed, with especial emphasis on the viral triggering of damaging autoimmune responses.

Source: Mims CA. Viral aetiology of diseases of obscure origin. *Br Med Bull* 1985; **41**: 63-69.