Twenty years of vocational training in the west of Scotland: the practice component

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SUMMARY. A retrospective analysis of the experience and opinions of doctors receiving vocational training in general practice was obtained by postal questionnaire. Questionnaires were received by 974 doctors who had been vocationally trained in the west of Scotland between 1968 and 1987. The response rate was 64%. It was found that 94% of the respondents had enjoyed their trainee period, 82% had been given a choice of training practice and 86% had spent 12 months in a training practice. Only 81 respondents had trained in two practices. The most common method of monitoring the trainee's consultation was the trainer sitting in on the consultation; half of the doctors had experience of this (51%). For the majority regular tutorials were commonplace, but for 41% of respondents this was not so. However, those training after 1979 were significantly less likely to have never had tutorials than those training earlier. Nearly half of the doctors (49%) felt that certain aspects had been poorly covered or omitted from their training, notably practice management and finance. Again, this was significantly less likely among those training after 1979. When asked to give a rating of the training they had received 21% of the respondents rated it as excellent, 37% as very good, 30% as fairly good and 12% as poor/fairly poor or very poor. Notably, significantly fewer respondents training after 1979 rated their training as poor/fairly poor or very poor. Very few respondents had participated in a practice exchange but virtually all of those who had felt it had been beneficial.

In conclusion, while the trainee period was enjoyed by almost all respondents, it would appear there are still some areas which could be improved.

Introduction

THE aim of vocational training is that all doctors in general practice in the National Health Service should receive appropriate postgraduate training of a certain standard which enables them to perform competently the duties of a general practitioner. As Sir Denis Hill stated in 1969 'The family physician's role is a difficult one. If it is to be sustained and developed the general practitioner must become the most educated, the most comprehensively educated, of all the doctors in the health service.[1]

A one year traineeship has been a legal requirement for general practice since 1979 (NHS vocational training act, 1976). In August 1982 a period of at least six months spent in two hospital specialties after registration also became compulsory (NHS vocational training regulations, 1979 and NHS vocational training (Scotland) regulations, 1980). Vocational training for general practice was established in the west of Scotland in 1968. The aim of this study was to question those who had completed vocational training since 1968 and to ascertain their views on this training and any suggestions for improvement. The opinions of trainees have been obtained in the past, but most studies have involved only small numbers of trainees and, less commonly, principals.[2-9] This study involved a large number of doctors who had received vocational training over an extended period. The paper presents the respondents' views on the practice component of training. A previous paper[10] considered the hospital component and the respondents' career paths since completing training.

There are 16 formal schemes in the west of Scotland. The majority consist of two years in hospital posts and one year in general practice but some consist of two years in hospital posts and a six month period in one practice, at the beginning and end of the scheme.

Method

A questionnaire comprising 57 main questions was designed. The questions covered four areas: personal details, hospital component of vocational training, practice component and details of the training practice. A pilot study was carried out with a group of 10 general practitioners. After appropriate modification the questionnaire was posted in March and April 1989 to doctors who had been trained between 1968 and 1987, identified from lists of trainees held by the University of Glasgow department of postgraduate medicine. The doctors' names were matched with a current address in the medical directory. A reminder letter was sent to those who had not responded four weeks after the initial mailing. They were identified by a number on the first page of the questionnaire; the doctor's name did not appear on the questionnaire.

The data were analysed on an Amstrad computer using *Minitab* data analysis software (version 6.1). The data for all respondents were analysed collectively. Further analysis was performed on the responses of those training before the one year traineeship became compulsory (before 1980) and after this time (1980 onwards). Where significant differences existed in the responses of the two groups, these have been documented. Not all the respondents answered all the questions and therefore the baseline numbers on which the percentages are based vary throughout.

Results

Questionnaires were sent to 1255 doctors. The post office returned 153 as the doctor was no longer known at that address. A further 128 were returned as the name and address had been incorrectly matched and the questionnaires had been sent to the wrong person. A total of 543 responses were received after the first mailing and a further 76 after the reminder letter. Thus, the overall response rate is 64% (619/974).

Of the 619 respondents 243 (39%) were women and 376 (61%) were men. Their mean age was 34 years (range 25–56 years). Their dates of graduation ranged from 1956 to 1984. Scotland was the place of graduation for 530 respondents (87%), England and Wales for 45 (7%), Ireland for 19 (3%) and overseas for 18 (3%). Of the respondents 256 (45%) commenced their training before 1980 and 315 (55%) in 1980 or later.

Of those who responded to the question 338 (56%) had been on a self-constructed training scheme, 254 (42%) on a formal

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one and 11 (2%) had been on a combination of both. A total of 500 respondents (82%) had been given a choice of practice when deciding on a training practice. Five hundred and twenty nine respondents (86%) had spent 12 months as a trainee in general practice. Only 58 (9%) had spent 18 months and the remaining 28 respondents (5%) had spent three, five, six, nine, 10, 14, 16, 20 or 24 months. Eighty four doctors stated that they were dissatisfied with the way in which their training had been arranged or with its length. Table 1 lists the alternative arrangements or length they would have preferred. The most popular alternatives were some experience of general practice prior to hospital training and experience of two different practices. Only 61 of the respondents (10%) had participated in practice exchanges (short period spent in another practice). However, 93% of those who had participated found the experience helpful and 67% of the 440 respondents who had not participated and who answered this question felt it would have been helpful. Only 81 respondents had trained in two different practices, either for a period of 12 months and one of six months or two periods of six months.

Training

Encouragingly 575 respondents (94%) enjoyed their trainee period in general practice. Of those who did not, only 15 specified one or more reasons: little teaching (three respondents), felt overworked (three), personality clash with doctor in practice (three), little supervision/training (three), on-call periods too busy (two), and did not like general practice (three). When asked if they would select the same trainee post again 461 respondents (77%) stated they would. Despite the fact that so many enjoyed their trainee period 300 doctors (49%) felt that some aspects had been poorly covered or omitted from their training. The aspects considered to have been poorly covered or omitted are shown in Table 1. The aspect of general practice most commonly mentioned was practice management followed by finance, business and administration. The respondents in the cohort training prior to 1980 were significantly more likely to consider that aspects had been poorly covered or omitted than those training later (56% versus 46%; chi square=6.72, 2 df, $P<0.05$).

The respondents were questioned about the frequency of tutorials during the training period, and on their usefulness as assessed on a five point scale. Sixteen per cent of respondents had received no tutorials during their training and 25% received them only every few weeks (Table 2). The respondents training after 1979 were significantly less likely to have never had tutorials than those training earlier (6% versus 30%; chi square=61.05, 3 df, $P<0.001$). Most respondents rated tutorials as useful or very useful.

Table 1. Preferred training arrangements, and topics which had been poorly covered or omitted from training.

	No. of respondents
Preferred training arrangement/length	
Some time in general practice before hospital training	19
Experience in two practices	16
Two periods of six months	13
Two periods of eight months	7
12 months not 18 months	6
18 months not 12 months	6
Continuous training not split	5
General practice at end of training	4
Practice exchanges	4
One practice not two	2
Six months only	1
Five year training	1
Aspects poorly covered or omitted from training[a]	
Practice management	108
Finance	97
Business	40
Administration	37
Teaching	34
Clinical topics	13
Professional relationships	12
Regular tutorials	9
Partnership problems	7
Health board claims	3
Night visits	2
Private treatment	1
Examination preparation	1
Responsibility of practice	1
Stress management	1

[a] Some doctors stated more than one aspect of training.

Table 2. Frequency of tutorials during trainee period and their perceived usefulness.

	% of respondents
Frequency of tutorials (n=615)	
Weekly	30.6
Most weeks	27.8
Every few weeks	25.0
Never	16.4
Rating of usefulness (n=508)	
Very useful	15.6
Useful	64.2
Not particularly useful	16.5
Useless	2.6
Not sure	1.2

n = total number of respondents.

The most commonly experienced method of monitoring the trainee's consultations was the trainer sitting in on the consultation, experienced by 304 respondents (51%) (Table 3). Respondents training before 1980 were significantly less likely to have had experience of videorecording during the consultation than those training later (4% versus 22%; chi square=35.29, 1 df, $P<0.001$).

Study leave was permitted for 417 respondents (68%) and of those permitted 317 (76%) took such leave. Those respondents training before 1980 were significantly less likely to know whether study leave was permitted (29% versus 19%; chi square=7.03, 2 df, $P<0.05$). A total of 202 respondents (33%) had been encouraged to become involved in research, but of those who were encouraged, only 62 (31%) had taken part in any research. Those respondents training before 1980 were significantly less likely to have been encouraged to become involved in research (16% versus 47%; chi square=58.22, 1 df, $P<0.001$). The majority of respondents (512, 84%) had been encouraged to sit the MRCGP examination while they were a trainee. Respondents training before 1980 were significantly less likely to have received encouragement to sit the examination (75% versus 91%; chi square=28.59, 2 df, $P<0.001$). Almost all of the respondents (600, 97%) had attended a half-day release programme while they were a trainee. Of the 593 respondents who rated the programme's usefulness, 131 found it very useful (22%), 286 useful (48%), 136 not particularly useful (23%), 19 useless (3%) and 21 did not know.

Table 3. Methods of monitoring trainees' consultations.

Method of monitoring	% of respondents (*n* = 592)
Trainer sitting in on consultation	51.4
Parallel consulting[a]	26.9
Videorecording consultation	14.9
Audiorecording consultation	10.1
Case discussion	7.3
Patient feedback to trainer	0.7
Audit referrals	0.5
Audit prescriptions	0.3

n = total number of respondents. Some respondents were monitored by more than one method. [a]Trainer and trainee consult in parallel but with opportunity for communication.

The respondents were invited to give an overall rating of the trainee period as assessed on a six point scale. Of the 615 respondents, 128 found the trainee period excellent (21%), 227 found it very good (37%), 188 fairly good (31%), 48 fairly poor (8%), 15 poor (2%) and nine very poor (1%). Respondents training before 1980 were significantly more likely to rate their trainee period as fairly poor, poor or very poor than those training later (16% versus 9%; chi square=9.05, 3 df, $P<0.05$).

Training practice

Only 289 of the respondents (47%) trained in a practice where all the partners were involved in training. Four hundred and twenty eight respondents (70%) trained in a practice with a library, and training in such a practice was significantly less likely among the cohort who had trained prior to 1980 (48% versus 86%; chi square=91.70, 2 df, $P<0.001$). Just over half the respondents (358, 58%), had attended practice meetings and among the 252 who had not, in only 11 cases was it their decision and not that of the practice. The cohort training prior to 1980 were significantly less likely to have attended practice meetings than those training later (56% versus 68%; chi square=7.23, 1 df, $P<0.01$).

The respondents were asked to describe the out-of-hours cover provided by their training practice (Table 4). One hundred and fifty nine respondents (26%) had done less out-of-hours cover than their trainer during the trainee year, 384 (63%) had done the same and 63 (10%) had done more than their trainer. Overall, 509 respondents (84%) were satisfied with the amount of on-call work they had done. Respondents who had trained before 1980 were significantly more likely to have felt that they should have done more on-call work than they actually did compared with those training later (11% versus 6%; chi square=7.06, 2 df, $P<0.05$).

Table 4. Out-of-hours cover provided by the training practice.

Out-of-hours cover	% of respondents (*n* = 596)
All own practice	55.4
Shared with one practice	13.8
Local deputizing service	8.2
Occasional commercial deputizing service	5.4
All commercial deputizing service	5.0
Share weekend with one practice	4.5
Commercial deputizing service after 23.00 hours	2.7
Commercial deputizing service at weekends	2.0
Share with two other practices	0.8
Deputizing service at weekends and some nights	0.8
Mostly commercial deputizing service	0.7
Deputizing service at weekends and after 23.00 hours every night	0.7

n = total number of respondents.

Finally, the respondents were asked if they now wished they had pursued a different career — 81 (13%) wished they had and a further 78 (13%) were uncertain.

Discussion

Vocational training for general practice has altered quite considerably since it became compulsory. To ensure that standards continue to be raised and training improved, regular assessment and audit of all aspects of vocational training is necessary. One way in which this can be achieved is to seek the opinions of ex-trainees. This source of information, which has been recognized previously,[2-9] could then form the basis on which improvements to future vocational training could be based.

In this study more than 90% of ex-trainees enjoyed their time as a trainee, confirming the results of Thornham.[3] However, it is important to examine the reasons why those who did not enjoy the trainee period would not wish to repeat it. Only 15 respondents gave a reason and some problems would be difficult to alter, for example not liking general practice or a personality clash with another doctor in the practice. While only six doctors did not enjoy the year because they considered their training poor, 12% of the respondents rated their training fairly poor, poor or very poor. It would appear, therefore, that trainees can enjoy their trainee period without necessarily rating it highly. A possible explanation for this disparity may be that many trainees do not know what constitutes good training and may only gain this knowledge when they become a principal.

Disappointingly, almost half of the doctors felt that some topics had been poorly covered or omitted from their training, although this was significantly less common among respondents training after the trainee year became compulsory. As with previous studies the most commonly omitted or poorly taught subjects were practice management and finance.[2,5,7] Whether trainees are not taught about these topics, whether they are, but are not sufficiently motivated to understand them, or whether the topics have been forgotten requires further investigation. Again, rather disappointingly not all the respondents received regular tutorials. However, there are signs that this situation is improving as those respondents training after 1979 were significantly less likely to have never had tutorials. Similarly, the overall rating awarded to the trainee period by respondents was higher in those training after 1979.

Most respondents had been permitted to take study leave although not all took advantage of this, as shown previously by Whitfield.[7] It may be that study leave was not considered to be required by the trainees. However, it may be that study leave was permitted in theory but not in practice.

As found in similar studies few trainees had been encouraged to become involved in research and even fewer had in fact done so.[4,7] The reason for this is unclear. It may be that the trainees considered themselves too busy or lacked motivation. Perhaps the value of research should be stressed at the half-day release meeting in an attempt to increase motivation. This may already be occurring, as those training before 1980 were less likely to have been encouraged to become involved in research than those training subsequently.

More than 80% of the doctors had been encouraged to take the MRCGP examination while a trainee, especially respondents training after 1979. However, there is still discussion as to whether the trainee period should aim to prepare the trainee for the

MRCGP examination.[3,11] It has also been suggested that the MRCGP examination should be taken as an educational exercise after some time in practice as a principal.[12] However, the current state of affairs seems set to continue as trainees become accustomed to taking the examination at the end of the trainee period and its aquisition may be regarded as beneficial when looking for a permanent post.

Seventy per cent of doctors had trained in a practice with a library which is very encouraging, given that a library only became a training practice requirement in 1987. Very few respondents had taken part in a practice exchange, but of those who had almost all considered it beneficial. It would appear then that trainees should be encouraged to exchange practice for a period of time, as has been previously suggested.[6] The difficulty in implementing this may be that trainees only appreciate the relevance of the exercise once they have been in practice.

The amount of on-call work undertaken during the trainee period has long been of interest to trainees. While 90% of respondents in this study had undertaken the same or less on-call work than their trainer, it is of concern that 10% had done more. This finding requires further investigation. It is encouraging that 55% of the respondents had trained in a practice which provided all of its own out-of-hours cover. If those in practices which shared the out-of-hours cover with one or two other practices or shared weekends only are included this brings the total to 74%. Only 30 respondents (5%) had trained in a practice which used a commercial deputizing service exclusively and a further 73 (12%) had trained in a practice which used the service to some extent; a total of 17%. These figures compare well with the results of Donald[6] who quoted a figure of 20% for exclusive use of a deputizing service, although his sample size was considerably smaller, and that of Thornham[3] who quoted 11%. The current figures for England and Wales show that in 1989 46% of doctors applied for consent to use a deputizing service.[13] However, these data appear to relate to individual doctors and not to practices.

This study emphasizes that the opinions of ex-trainees are a worthwhile and underutilized source of information which is of great importance to all bodies involved in vocational training. Vocational training and the trainee year in particular are designed to enable the trainee to acquire the knowledge, skills and attitudes essential for a high standard of community medical care. In the current climate of audit, assessment and change, vocational training for general practice, and training in all branches of medicine, must reflect such change.

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