A pilot study of community-based training of hospital obstetric senior house officers

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SUMMARY

Most senior house officer (SHOs) posts have little relevance to general practice. This problem was addressed in a pilot community teaching placement, of up to one session per week over four to six months that was set up to learn community-based obstetrics from primary health care teams. The nine participating SHOs were interviewed; qualitative analysis revealed seven themes that were important to the SHOs that should help guide further community-based teaching. Such sessional release for improving the practice-based component of vocational training merits evaluation in a larger study.

Keywords: pilot studies; community-based training; vocational training; obstetrics; senior house officers.

Introduction

GENERAL practice is unique in being the only medical discipline where most of the training takes place outside of the discipline — being in various secondary care junior doctor posts — that have been increasingly criticized as educationally unsound.[1,2] A pilot study for obstetric SHOs was set up to investigate the practicalities of addressing these problems by permitting sessional weekly release for community teaching. Obstetrics was chosen because it has been criticized[3,4] and changes have been suggested.[5]

Method

This was a particularly complex pilot study to set up. Approval was required from the Regional Postgraduate Medical Dean (who also paid practices to take SHOs at medical student rates), the Regional Adviser in General Practice, and the Royal College of Obstetricians and Gynaecologists. Seven of the 12 trusts in the old South West Region expressed an interest, were sent details, and were visited by the author. Five eventually agreed to release one or more SHOs to the pilot. The relevant GP course organizer in each area was contacted and asked to identify training practices that could take an SHO. The release of an SHO in a particular Trust was mainly determined by who could be 'spared' from hospital commitments at a time when a practice had their antenatal clinic. Trusts were not paid to participate.

The author undertook semi-structured taped interviews with all SHOs during the final month of their community attachment, to seek their views of the pilot. It was felt that this would aid understanding of the SHOs' points of view, but might introduce response bias in the form of socially acceptable replies. Transcripts were analysed for common themes,[6] which were also searched for disconfirming evidence. Questionnaires and log diaries were used to triangulate themes. A summary of the analysis was sent to all participating SHOs for comment.

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Results

Nine SHOs were released from five Trusts for up to one community session/week over four to six months. Four were able to attend more than 75% of the sessions, three attended between 50% and 75%, and two attended less than 50%. Seven major themes ran through the SHOs' experiences (Box 1), four of which were positive.

The most important theme was that SHOs believed the attachments had put their hospital obstetric training in perspective (relevance of hospital experiences to future role; motivation to focus on relevant learning needs; better understanding of primary–secondary care relationships). Secondly, they learnt about caring for uncomplicated pregnancies, which they tended not to experience in hospital. Thirdly, the midwives' teaching contribution was valued and crucial. Fourthly, all SHOs made positive comments about the concept of the pilot.

Three areas of concern arose: lack of structure to sessions, low GP caseload, and not seeing patients with GPs. The latter related to the need to match the released hospital session with the GP's clinic, maintaining protected time at hospital and practice ends, variable support from consultants and junior colleagues, and the GP being there to provide a role model.

Discussion

This study is unusual in that it has qualitatively assessed the beliefs of hospital SHOs who have had community educational placements over the duration of their hospital post. Future teamwork should improve because SHOs will understand better what was relevant to them as future GPs, how to manage uncomplicated pregnancies, the role and competence of community midwives, and the relationship between primary and secondary care.

If a larger study is to be contemplated, then there needs to be better co-ordinated protected release of all of a Trust's SHOs, matching of sessions with GPs' antenatal clinics, co-ordinated input from both GPs and midwives, adequately motivated SHOs, exposure to an appropriate GP role model[4] and caseload, and sustainable funding of community placements (medical student rates in pilot).

Further studies need not be limited to obstetrics but must be fully evaluated. Trusts and practices could liaise to select a discipline appropriate to their local circumstances. If more teaching and training for the discipline of general practice is to be, rightly,[7] transferred to within its own discipline, then it must be shown to improve teaching and, ultimately, the care provided by its graduates.

References

1. Grant J, Marsden P, King R. Senior House Officers and their training. I. Personal characteristics and professional circumstances. II. Perceptions of service and training. *BMJ* 1990; **299:** 1263-1268.
2. Crawley HS, Levin JB. Training for general practice: a national survey. *BMJ* 1990; **300:** 911-915.
3. Ennis M. Training and supervision of obstetric senior house officers. *BMJ* 1991; **303:** 1442-1443.
4. Smith LFP. GP trainees' views on hospital obstetric vocational training. *BMJ* 1991; **303:** 1447-1452.
5. Royal College of Obstetricians and Gynaecologists and Royal College of General Practice. *General practitioner vocational training in obstetrics and gynaecology*. London: RCGP, 1993.

6. Strauss A, Corbin J. *Basics of qualitative research*. Newbury Park, CA: Sage, 1990.
7. Royal College of General Practitioners. *Education and Training for General Practice*. [Policy Statement 3.] London: RCGP, 1994.

Putting their hospital obstetric SHO training in perspective
'It has made me realize how important it is at this stage in my training to the care that I will be able to provide when I am a GP. Having the two running simultaneously — it is so important not to waste the six months you have as an SHO.'

' ... [it has] highlighted for me the great difference between the hospital and the community for the same subject ... so I went back to doing things in the hospital that I might normally have thought were a bit of a drudge really, I would realize their importance for the future in general practice.'

' ... it [community placement] gives me confidence to know that when patients go home from here [hospital] and I am concerned about them that I know they will be followed up and watched carefully in the community. I know that the network is there and works very well.'

Learning to care for uncomplicated pregnancies
'I learnt an awful lot about low-risk antenatal care. Normal pregnancies ... and the way it can be dealt with without the hospital being involved at all. This surprised me really because I assumed when I started the job that everybody went to hospital and was looked after in hospital.'

' ... seeing normal people in general practice whereas a lot of patients we see here [hospital] aren't; seeing normal ladies progress in normal pregnancies.'

Learning about community midwives
'I learnt an awful lot of factual information from the midwives and a lot of useful things that as doctors we don't get taught.'

" ... and my relationship with the midwife was much, much better and I found that worked a lot better once I was back in the hospital with the team midwife that I had been out with.'

Getting to see patients with GPs
'[There were] limitations of an afternoon when the poor GP is trying to get as many antenatal ladies as possible when it wasn't his antenatal day.'

'That has been the main difficulty — just getting away — especially the last two months. It has been very hard. A lot of SHOs are taking their holidays ... I have not been able to attend the sessions that I was supposed to.'

' ... he [consultant obstetrician] was very sceptical and did not think that it was going to be very valuable at all.'

'They [the other SHOs] were a bit jealous really ... it sometimes caused a bit of friction in that the other SHO had been called in to cover me.'

' ... I have had a good [GP] teacher and she has gone out of her way to make sure it is relevant to me.'

The need for more structure to individual sessions
'It is difficult to make the work more structured ... it might be quite good for GP trainees having a log book ... perhaps a bit more formal about what you want to get out of it.'

Box 1. Themes that ran through SHOs' learning experiences during their community teaching sessions.

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