Postgraduate Education for General Practice (1993), **4**, 203–208

The hospital component of vocational training for general practice: the views of course organizers

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Summary

A questionnaire enquiry was undertaken of course organizers in the United Kingdom to determine their views on the hospital component of vocational training and to explore their relationship with hospital consultants.

Less than a quarter of course organizers thought that hospital consultants involved in vocational training were aware of its aims. Communication between the two groups was infrequent and unsatisfactory from the course organizers' point of view. Consultants' unwillingness to co-operate with day/half-day release courses was the main source of difficulty for almost 40% of course organizers. For a third, lack of consultant interest in vocational training was a major problem. Three-quarters of course organizers expressed some degree of dissatisfaction with consultant involvement in vocational training for general practice and with the hospital phase overall.

There has been little innovation in promoting learning during the hospital phase of vocational training over the last 20 years. Consultants need help to understand the aims of vocational training and the relevance of experience in hospital specialties for it. Course organizers are well placed to co-ordinate developments in this field.

Introduction

Course organizers are key people in the establishment of good quality vocational training programmes. They have responsibility for securing appropriate hospital posts for inclusion in local rotations; recruiting trainees to schemes; developing day/half-day release and other meetings; reviewing the progress of individual trainees, and working closely with local GP trainers. To be successful, they must be able to integrate the learning of the hospital component of training with that of the general practice attachment. In order to achieve this, close working relationships need to be established with those hospital consultants whose junior posts are occupied by GP trainees.

Consultants may experience problems when working with trainees who are not intending to pursue a hospital career (Taylor, 1989). They need guidance to ensure that their teaching and the experience acquired by trainees is relevant to general practice. Course organizers have a role in advising consultants about the requirements of vocational training and how they relate to specific hospital posts, as well as helping them to monitor the progress of individual trainees through the scheme. A good working relationship between consultants and local course organizers should help ensure high standards of training. This study explores aspects of this relationship.

Method

A questionnaire for course organizers of GP vocational training schemes was constructed which focused upon day or half-day release, contact with consultants and the assessment of trainees.

In the initial phase of questionnaire construction, semi-structured interviews were conducted with course organizers in different regions in order to establish the main issues of concern. Seven course organizers were interviewed (from NE Thames, NW Thames, SE Thames, SW Thames, the North West, Trent and Scotland). The information obtained from the interviews was used to construct a pilot questionnaire sent to seven course organizers. An item analysis of the pilot data led to the version of the questionnaire that was used in this study.

All regional advisers in the UK were subsequently asked to provide an up-to-date list of all vocational training schemes in their regions. For each region, a random sample of vocational training schemes was selected for inclusion in the study. In total, 131 schemes were randomly selected from the 214 known to us, which represented 63% of schemes overall, ranging between 50% and 80% in each region. For administrative reasons, all of the course organizer questionnaires were sent to one representative course organizer in each scheme, who was asked to distribute them, together with reply paid envelopes, to his/her colleagues. In mid-January 1992, each representative course organizer from whose scheme no or few questionnaires had been received, was contacted by telephone. Two weeks after this another round of calls was made. A total of 197 course organizer questionnaires were sent out for completion. Responses were received from 105 course organizers in 72 schemes, representing a response rate of 53%.

Results

Time in post

The length of time in post as a course organizer varied from three months to 18 years, with the average being 5.08 years (sd = 4.33 years).

Consultant awareness of course aims and objectives

Course organizers were asked how familiar they thought consultants involved in vocational training were with its aims and objectives. Their replies show that consultants were considered to be limited in their awareness of the aims of vocational training. Less than a quarter of course organizers thought that a reasonable number of consultants were well-informed about training aims (Table 1).

Table 1 Course organizers' views of consultant awareness of training aims (n = 104)

View	*Number of course organizers*	*%*
None well-informed	39	37.5
A few well-informed	40	38.5
Some well-informed	22	21.2
Most well-informed	3	2.9

One respondent did not answer this question.

Communication with consultants

When course organizers were asked how often they communicated with a consultant during a trainee's attachment to a post, a fifth reported no contact at all, and a further two-fifths reported contact on one occasion only (Table 2).

Enquiry was made about the frequency and manner of communication between con-

Table 2 Frequency of contact with consultant during attachment (n = 101)

Number of contacts	*Number of course organizers*	*%*
None	20	19.8
One occasion	45	44.6
Two occasions	28	27.7
Three or more occasions	8	7.9

Four respondents did not answer this question.

Table 3 Satisfaction with consultant contact (n = 104)

Degree of satisfaction	*Number of course organizers*	*%*
Very dissatisfied	25	24.0
Slightly dissatisfied	51	51.0
Satisfied	22	21.2
Very satisfied	4	3.8

One respondent did not answer this question.

sultants and course organizers. The modes of communication investigated were by letter; by telephone; through formal or informal one-to-one meetings; through formal or informal group meetings and in meetings when the trainee was present.

Almost three-quarters (n = 72, 74.2%) of course organizers indicated that they had no meetings with consultants when the trainee was present. For a third (31 of the 90 respondents who answered this question), there were no meetings in formal or informal groups, and a fifth did not meet face-to-face. The average number of communications per year by letter or telephone between course organizers and consultants was 2.46 (n = 100; sd = 1.56). The average number of one-to-one meetings per year was 2.33 (n = 92; sd = 2.46), and the average number of group meetings per year was 1.81 (n = 90; sd = 2.83).

Only a quarter of course organizers expressed any degree of satisfaction with the contact that they had with consultants (Table 3).

Past problems

Almost four-fifths (81 out of 103 respondents; 78.6%) of course organizers indicated that they had encountered problems in the past with consultants in running the vocational scheme. Unwillingness to co-operate with the half-day release course was the main source of difficulty for two-fifths (29 out of 74 respondents; 39.2%) of course organizers. Over a quarter (20 out of 74 respondents; 27%) stated that the lack of consultant interest in vocational training was the main problem; for a fifth (15 out of 74 respondents; 20.3%) it was differences of opinion about postgraduate education, and for over a tenth (10 out of 74 respondents; 13.5%) it was insufficient consultant time devoted to the scheme.

Overall, almost three-quarters of course organizers (76 out of 101 respondents; 72.7%) expressed some degree of dissatisfaction with hospital consultant involvement in vocational training for general practice, with 16.5% (17 out of 101 respondents) being very dissatisfied.

Suggestions for improvement

When asked how the contribution of consultants to vocational training might be improved, approximately equal numbers suggested more time being spent by consultants in teaching/training (30 out of 96 respondents; 31.3%) and acquiring an understanding of the needs of GP trainees (29 out of 96 respondents; 30.2%). Rather more (37 out of 96 respondents; 38.5%), suggested that tailoring hospital posts more towards the future needs of GP trainees would be most helpful.

Table 4 shows the overall level of satisfaction of course organizers with the hospital component of training. Only 25% were reasonably (or very) satisfied.

Table 4 Overall satisfaction with hospital component of vocational training (n = 103)

Degree of satisfaction	*Number of course organizers*	*%*
Very satisfied	2	1.9
Satisfied	23	22.3
Slightly dissatisfied	61	59.3
Very dissatisfied	17	16.5

Two respondents did not answer this question.

Correlation of factors

There was a significant relationship between the dissatisfaction of course organizers with the hospital component of training and the unwillingness of consultants to co-operate with the half-day release. Course organizers were more likely to be satisfied when informal one-to-one meetings took place between themselves and consultants ($n = 94$; $r = 0.38$; $p < 0.0002$), with the caveat that, if these took place more than four times a year, then satisfaction was reduced. The lack of formal group meetings was also associated with dissatisfaction, but again dissatisfaction increased if these meetings became too frequent ($n = 97$; $r = 0.22$; $p < 0.05$).

Regional analysis

Analysis of variance was carried out with the general satisfaction measure as the dependent variable for nine regions with five or more respondents ($f = 2.30$; $p < 0.05$). There were differences between regions. Fisher's LSD test identified two extreme groups consisting of Group 1 ($n = 13$) with low satisfaction, and Group 2 ($n = 39$) with high satisfaction. These two groups were analysed in an attempt to identify the major sources of this difference. The following factors emerged.

- In Group 1 (low satisfaction) regions, 69.2% of course organizers did not have a day/half-day release course, whereas in Group 2 (high satisfaction), only 5.1% did not (Chi square 24.02; $p < 0.0001$).
- In Group 1, 75% of course organizers reported no formal group meetings with consultants, whereas in Group 2, 27% had no such meetings (Chi square = 18.58; $p < 0.0003$).
- The course organizers in Group 1 regions were more likely than those in Group 2 regions to believe that the consultants were not well-informed about the aims and objectives of vocational training ($t = 2.43$; $p < 0.02$).

Discussion

The dissatisfaction of trainees with the hospital phase of vocational training for general practice has been well documented (Reeve and Bowman, 1989; Crawley and Levin, 1990; Kearley, 1990; Styles, 1990). The disaffection of course organizers in the educational provision of the hospital years is less well recorded. That three-quarters of course organizers should express some degree of dissatisfaction is a matter of the greatest concern. It needs to be addressed promptly if good quality, relevant and fully integrated programmes are to be readily available to prepare tomorrow's GPs for their future clinical responsibilities. Inadequacies in communication between course organizers and hospital-based consultants involved in training undoutedly compound the problems caused by the service pressures of hospital posts, and the long hours that junior hospital doctors are obliged to work.

Infrequency of contact between consultants and course organizers, and the lack of shared purpose between them, are major factors in precipitating poor communication. The main area of conflict seems to be centred on support for the day/half-day release programme, but there are other fundamental differences, which have resulted in trainees questioning the educational value of the hospital years (Styles, 1991). That most will spend two-thirds of the three-year training programme in a hospital setting (Styles, 1991), emphasizes the seriousness of the problem, and the need for it to be addressed as a matter of urgency.

The current system of vocational training was developed in the late 1970s and early 1980s, so why are there still major difficulties in communication between course organizers and hospital consultants? The most likely reason is that the difficulties reflect the uneasy clinical relationship between consultants and GPs, and the implicit hierarchy that is the result of conditioning during under-

graduate and postgraduate training. Denis Pereira Gray (1980) has described the social attitudes that result in GPs feeling inferior to specialists, which are reinforced by rates of pay, working relationships and education. As 'just GPs', the tendency has been for some course organizers to adopt a deferential attitude to consultants involved in vocational training; they have been grateful for the bestowal of junior posts and have not challenged indifferent educational arrangements.

Such an unhealthy relationship has compromised effective communication and, as a result, there have been few developments in the hospital component of vocational training. Without the benefit of a questioning and constructively critical dialogue between course organizers and consultants, working together as equals, the quality of hospital training has stagnated. It has made little educational progress in the last 20 years and employs learning strategies that have changed little in that time.

If long overdue improvements in the hospital phase of vocational training are to be fostered, then consultants will need more help and guidance about its content and learning methods than has hitherto been available to them. The most appropriate sources of help are local course organizers, who should discuss more openly their expectations of hospital staff. Progress will be limited unless they take this lead, as it is unrealistic to expect unprompted changes in consultant attitudes and behaviour.

The recent incorporation of course organizers into the framework for postgraduate education (Beecham, 1992), with levels of remuneration on the consultant scale, will help to ensure that their discussions with consultants will be a dialogue between equals: course organizers no longer need to see themselves as supplicants for hospital favours. As equals, they will be able to secure enough time for a full discussion about the educational requirements for each of the hospital posts used for general practice training. They will be able to ensure adequate time for educational purposes, and agree with consultants how it will be used.

The Royal College of General Practitioners has agreed a series of statements (RCGP, 1993) with the other Royal Colleges and relevant specialist organizations, on the educational content of a range of hospital posts and the methods for achieving it.

These statements cover geriatric medicine, paediatrics, psychiatry, obstetrics and gynaecology, accident and emergency medicine and palliative care. They are readily available from the RCGP and provide a worthwhile starting point for local discussions between course organizers and consultants, to facilitate working together towards a more planned approach to teaching and a more planned approach to teaching and learning during the hospital phase of vocational training. The statements should also provide a basis for developing explicit educational contracts for vocational training for senior house officers.

Undoubtedly, problems and disagreements will arise, but only when these are addressed openly can there be any hope of finding mutually acceptable solutions. On occasion, such discussions should make it possible for consultant and course organizer together to make a case to local hospital managers, against the background of an educational contract, for financial resources or to change existing arrangements to ensure training opportunities. Such a shared approach could go some way towards overcoming the perceived conflicts between the service and educational responsibilities of junior posts, which can lead to disagreement between course organizers and consultants.

However, responsibility for bringing about improvements in the hospital component of vocational training does not rest solely with course organizers. Strong support is needed from their regional advisers in general practice, and from regional postgraduate deans.

Future arrangements, whereby the deans will hold the training budget for all junior doctors, should be a powerful lever in ensuring that the training programmes that they finance are of an acceptable standard. In

association with regional advisers and course organizers, they will be able to ensure an acceptable training contract for every vocational training senior house officer post.

The Royal College must continue to give clear and explicit guidance about its expectations for training and must withdraw recognition from hospital posts that consistently fail to reach previously agreed educational standards.

At local level, there is much that GP trainer groups can do to help consultants appreciate how their units can contribute effectively to vocational training. Such dialogue would also give consultants a greater sense of ownership of local schemes, and of their role as members of local medical educator teams. The exclusion of consultants from some of the more enjoyable aspects of vocational training, such as trainers' workshops, may have contributed to the dysfunctional communication between them and course organizers that has been highlighted by this study. The development of local systems for working together in vocational training would go a considerable way towards better sharing of aims and agreement on acceptable methods of achieving them.

Acknowledgement

The research reported in this paper was fully funded by a grant from the Nuffield Provincial Hospitals Trust, which we are pleased to acknowledge.

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