PRACTICE OBSERVED

Practice Research

What happened to the Croydon trainees of 1977-81?

CLIFFORD B FLOYD

At the end of 1981 I completed five years as a course organiser in Croydon. About 12 doctors were on the course each year, and they could join at any time during the year. Over the five years 58 doctors left, half of them having qualified in medicine outside the United Kingdom. Two doctors failed to complete the course.

Method and results

Questionnaires were sent to the 58 doctors during the last two months of 1981. Second letters with duplicate questionnaires were posted to non-responders, and telephone calls were made as a final reminder. Forty-eight questionnaires were collected over nine months—a response rate of 85%—from 27 United Kingdom graduates and 21 overseas graduates. Some information was collected from trainees about the two United Kingdom and eight overseas graduates who did not respond.

CHARACTERISTICS OF TRAINEES

Of the 29 United Kingdom graduates, 22 had qualified in London. Of the 21 overseas graduates who responded, 15 had been trained in India, two in Pakistan, two in Sri Lanka, one in Dublin, and one in Czechoslovakia. The male to female ratio in 1:1 for the United Kingdom graduates and 2:1 for overseas graduates. The average age of United Kingdom graduates was 29 years and that of overseas graduates 39. All the responders from overseas were married compared with just over half of United Kingdom graduates.

At the start of training a third of United Kingdom graduates and two thirds of overseas graduates had no prior training experience. Some had taken more than one (table 1). Seventeen responders had taken examinations during or after training. One was an overseas graduate

Croydon, Surrey
CLIFFORD B FLOYD, FRCP, course organiser and senior tutor in general practice, St George's Hospital Medical School, Tooting
Correspondence to: 501 London Road, Thornton Heath, Surrey CR4 6AR.

TABLE 1—Results of postgraduate examinations taken before joining the release course for trainees

	Doctors who qualified			
	In the United Kingdom (9)		Overseas (14)	
	Passed	Not passed	Passed	Not passed
Membership of the royal colleges of Physicians (MRCP) Part I	5	0	2	0
Part II	2	2	0	1
Diploma in Child Health (DCH)	2	0	0	1
Diploma in Obstetrics and the Royal College of Obstetricians and Gynaecologists (DObstRCOG)	2	0	1	1
Membership of the Royal College of Surgeons (MRCS) Primary	1	0	1	0
General	1	0	1	0
Diploma in Anaesthetics (DA)	0	0	3	0
Membership of the Royal College of Pathologists (MRCPath)	0	0	0	1
Other	1	0	2	0

(trained in Dublin) who sat and failed the membership examination of the Royal College of General Practitioners (MRGCP). One passed the membership examination of the Royal College of Obstetricians and Gynaecologists (MRCOG) and returned to work in hospital. Eight of the nine United Kingdom graduates passed the diploma in obstetrics of the Royal College of Obstetricians and Gynaecologists (DObstRCOG). Seven sat and five passed the MRGCP. Seven United Kingdom graduates who were not trainees passed examinations: four MRGCP, two DObstRCOG, and one passed both.

CAREERS AFTER THE COURSE

Fifty six trainees completed the course, and 40 (71%) are in general practice: 12 men and eight women United Kingdom graduates and 15 men and five women overseas graduates. Of the 10 doctors (29%) not in general practice, six are men (four from overseas) and 10 are women (three from overseas). Half of the women United Kingdom graduates are not in practice: four are housewives—mothers who will

could keep their seniority awards for themselves, while six paid the money into the practice. Only one doctor stated that he was unable to keep his vocational training allowance when the senior partners were able to keep their seniority awards for themselves.

Training in retrospect—Doctors were asked about their training practice and the half day release course (table 2). None of the three doctors who found their training practices unsatisfactory is in general practice.

Discussion

Many papers have been published recently on selecting suitable candidates for vocational training. The paper examines the characteristics of 58 doctors who passed through the Croydon course for trainee general practitioners over five years and describes what has happened to them since. Because the doctors have been divided into small groups to describe the data some of the samples are too small to examine for statistical significance. Nevertheless, the figures show trends that have been particularly helpful for giving career guidance to prospective and established trainees.

Of fifty six trainees who completed their training, 40 are now in practice. Of the remainder, some are mothers with children and some are seeking further experience before settling. There is still a core of eight doctors (14%) who I believe are unlikely to enter practice. Two of them are United Kingdom graduates and are not in general practice by choice. The six overseas graduates seem to want to enter practice but are unable to do so. Two of them have the fellowship of the Royal College of Surgeons. Overseas graduates have to combat many problems in settling into practice. Some difficulties may be of their own making. The pronounced reluctance to take examinations, such as the MRGCP, which would show their level of clinical competence, is to be regretted. They are paid less on entering prac-

Training in General Practice

How to interview candidates

BARBARA J COHEN

When confronted with the need to select an employee the employer all too frequently jumps first into the middle of the selection process. He finds the candidate and starts to interview without any clear idea of what he should be looking for. It is little wonder, then, that with such an ad hoc approach to selection the end result should often be far from satisfactory. Yet systematic selection is not a mystique. It is a rational and straightforward way of dealing with the problem of selecting people for particular jobs. Doctors spend much of their professional lives interviewing people. Their craft depends on their capacity to know what they are looking for, to weigh up other possibilities, and to home in on the right diagnosis. Selection is not so different, and yet it seems that the doctor who is selecting a candidate may often fall prey to all the folk law and woolly

Neville Lodge, 14 Aston Road, Moor Park, Middlesex HA2 2LD
BARBARA J COHEN, BA(HONS), APM, consultant in occupational psychology

tice, and some are willing to become salaried partners when there seems to be little prospect of a share partnership. Their partnerships are likely to be small, and their ultimate income seems to be lower than that received by United Kingdom graduates. The wide range of income received by doctors in similar sized practices must cause concern. Those on a low income may need to examine the business arrangements in their practices.

Nine doctors had been through the three year vocational training scheme. The competition for such posts is great, and trainees prefer such an appointment to organising their own rotation. One advantage is said to be that it is easier to get a job in the area where you train. Yet only four of those nine doctors are now in general practice, and only two of them have settled in Croydon. A further surprise is that two doctors on the three year training scheme failed the MRGCP but all the one year trainees passed.

The cost of training general practitioners is considerable. Many young doctors enter their training practice with little idea of what general practice is about. Unsuitable candidates do not want to be told that they will find it difficult to get a job at the end of training—for so often they are also unable to make a career in hospital medicine. Should teachers be more selective in accepting trainees for training posts? Those who are not appointed need career guidance and help, which many find difficult to obtain. Perhaps more career guidance should be available for doctors at all stages of their training.

I express my sincere thanks to the 48 doctors who answered my questionnaire, and in particular to those who entrusted me with the information on their financial arrangements. I thank Mrs Sue Brighman for helping to prepare the questionnaire, Mrs Eleanor Axell for collating the answers and typing the paper, and Dr Paul Freeling for helpful criticism of the paper.

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intuition that he would roundly eschew in the rest of his professional life.

Know what you want

The very first stage in selection is to identify the components of the job that you want to fill. What exactly will this doctor (or nurse or receptionist) have to do in a working day? What tasks will he regularly or occasionally perform? What responsibilities will he have for people, for equipment, for information? What aspects of this job have people in the past typically enjoyed, and which have caused problems or dissatisfaction? Your reaction may be "But anyone knows what a general practitioner does." Even so, the discipline of looking objectively at the position under consideration is vital, because once you have defined the job objectively you can go on to define just as objectively the person who can do this job.

You need to work out which qualities and qualifications are essential to the performance of the job and which would be

desirable. The essentials encompass the attributes without which you would simply not appoint to the job. They would include minimum qualifications and experience, as well as an assessment of the personal qualities that are vital to the job. Flesh is put on this skeleton with the "desirables," and you may also like to note undesirable characteristics and any "disqualifiers"—attributes that would make the candidate a certain failure in this position. Indeed, failure may be valuable when one is considering personnel selection. If you can remember which people have failed in the job under consideration and work out why this is then you are a good way towards identifying important criteria.

Find the one who has got it

When you know what you are looking for you have simply to identify the person. This is where the selection interview comes into place. Interviewing is only one of several methods of selection—for example, tests may often be used—but it is the method with the highest face validity and is most commonly used in our society. But it is seldom used to full effect, and thus a potentially sharp and valuable instrument is often rendered blunt and ineffectual.

The problem lies less in establishing whether a candidate has the necessary qualifications and appropriate practical experience than in how to assess the nuances of personality and behaviour that will determine exactly whether he will be right for the job. Interviewers recognise this dilemma but do not know how to overcome it. Essentially, however, the procedure is straightforward. As an interviewer you need to make certain judgments about the candidate and to do this you need information about the candidate. A systematic interview will provide this, so that you may be reasonably sure at the end that you have a comprehensive and valid picture of the person before you. (At the same time the candidate is using the interview to obtain information and to make judgments about you, your practice, or the hospital.)

To create an atmosphere that allows you to collect the information that you need the candidate must be helped to feel as much at ease as possible. The tone of the interview is set at the outset: a courteous reception, friendly greetings, and a comfortable waiting area do much to dispel anxiety and put a candidate in a relaxed frame of mind. The quality of your attention and manner towards the candidate has a profound influence. That effective interviewing requires dedicated attention on the part of the interviewer would be taken as a sine qua non by most, yet how many times has an important interview (or a consultation?) been carried out accompanied by interruptions—phones ringing, bells buzzing, a colleague's head popping round the corner, or the very unwillingness of a candidate (and it does not do much for the interviewer either). If a candidate is helped to relax then information gathering becomes a pleasant and straightforward task for the interviewer, who can then use the information to make a selection. In the time allowed to make valid judgments at the end of the interview. (Note, incidentally, that judgments are formed after the interview, not during it. The risk otherwise is that premature decisions may well affect your quality of the questions that you ask and the way in which you interpret the responses.)

The past is important

The best way to predict future behaviour is to look at what the person has done in the past. This should be flashing meta-physics in your mind before the eyes of every selection interviewer. It is much more valuable to ask how someone has performed in a particular situation than to ask the hypothetical "What would you do if...?" You will, accordingly, want as much information as you can get about a person's life history, and if you interview systematically you will do a more comprehensive job in the time allowed. Several schemes have been devised, and a very practical one is the "seven point plan" by Professor Alec Rodger. This is

a breakdown of the characteristics of an individual that should be explored to make a valid decision on selection. The seven points of the plan cover physical make up, attainment (both educational and occupational), general intelligence, special aptitudes, interests, disposition, and circumstances.

The interviewer will be able to ask questions directly under four of these headings and from the information obtained should have enough evidence to form judgments on the less defined areas of intelligence, aptitudes, and, importantly, disposition. People are often surprised that a selection interviewer should be concerned with areas other than recent qualifications and occupational history. Although these are clearly important and relevant, there is evidence that the comprehensive biographical interview is a much more effective tool in selection than the usual superficial slice of recent life and work experience. With a broader view you may see patterns of behaviour emerging and evidence of recurring strengths or weaknesses and thus make a more valid selection. The candidate's disposition based on evidence and not just on intuition—"Well he seemed a splendid chap to me" or "I didn't really like to him."

Do's and don'ts

The scope of the interview is therefore critically important. Equally important is the technique. There is space for little more than a few "do's" and "don'ts." Do allow the candidate to speak for himself. Indeed, allow him to speak. A daunting number of interviews prove to be monologues by the interviewer, punctuated by the occasional "yes" or "no" from the candidate. When you follow up the candidate's answers by asking "why" and "how did that happen?" you can generate useful information. One of the most valuable phrases in interviewing is "Tell me about..." It is an invitation to the candidate to expand or develop a point without—and this is important—giving any clue as to the response you expect. The next "do" is to be neutral. Try to ask open questions and not indicate any bias or prejudice of your own. A sensible candidate will otherwise give his interviewer what he thinks that interviewer expects or wants to hear, and thus a distorted and arguably valueless dialogue may ensue. Do show your interest and encourage the candidate with a nod or smile. Again, non-committal murmurs are probably less intrusive than repetitions of "I see, I see" and "Fine." Since the object of the interview is to get the candidate to talk freely many of the "don'ts" centre on behaviour that would inhibit this flow of information. Don't, therefore, ask questions that can be answered by a single "yes" or "no." A run of such questions in an interview can make the whole exercise very jerky and uncomfortable. Don't prejudge the situation or make assumptions. It would distort your whole approach to the interview and lead again to judgments being made on subjective feelings rather than on objective evidence. Don't be abrupt with a candidate. If he wanders from the point bring him back to it gently. If a candidate is particularly glib ask him to give a brief account of his background and experience, for example. If necessary you must interrupt, but not in the middle of a sentence. Don't use the interview as a "test" for the candidate (a test in which you know the rules and he does not). It is seldom helpful to ask questions because it is almost impossible to evaluate the answers. Lastly, don't criticise or show disapproval. A relaxed candidate will be much more forthcoming than one who is tense.

Finally, do enjoy your interviewing. If interviewing is approached systematically and directly it can be as most effective method of selection and an interesting exercise for both you and your candidate.

Reference

1 Rodger A. The seven point plan. National Institute of Industrial Psychology Paper no. 1. London: NFER Publishing Co. 1952.

probably return—one is a lecturer in gynaecology, one works for a pharmaceutical company, and one is on the doctors' retainer scheme. Three women overseas graduates are not in general practice: two hold hospital posts and one is a clinical medical officer. The two men United Kingdom graduates had no further examinations, but one was in hospital, the other as a clinical medical officer.

Of four men overseas graduates, two hold hospital posts, one is a medical officer, and one returned to India because he was discouraged by his inability to get work. He had been offered one partnership conditional on a cash payment of £2000. He took his trainer's advice and did not accept the post but regretted it afterwards because "at least I would have had a job." Comments made by overseas graduates not in practice were disturbing: "Could not get jobs," "Humiliated," "Should not have joined traineeship," "Previous surgical career now jeopardised."

Fourteen United Kingdom graduates were living within five miles of Croydon but only 11 overseas graduates. Regardless of where they had qualified or lived, 70% were in general practice and 30% out of practice. Married men were more likely to have moved from Croydon six out of eight, whereas the single men stayed five out of six. The pattern was the reverse for women, single women having moved four out of eight and married women staying in Croydon five out of eight.

DOCTORS FROM THE VOCATIONAL TRAINING SCHEME

Nine doctors, all qualified in the United Kingdom, completed the three year vocational training scheme: five men and four women. Only four were in practice here: three men and one woman, two in Croydon. Of the remaining five, one man is a single handed general practitioner in New Zealand, one man in community medicine, one woman has become a medical adviser to a pharmaceutical company, and two are mothers or housewives.

DOCTORS IN PRACTICE

Of doctors who were in general practice, 54% seem to have found their posts from personal recommendation and 30% through the BMJ (table 1). Eleven of the 12 men United Kingdom graduates entered practice immediately, although one was a locum for 10 weeks first. The twelfth was in New Zealand. Of eight women United Kingdom graduates, two entered part time appointments and two full time share partnerships straightaway. Two undertook locums of one year and seven months while finding partnerships. One is in her third partnership, while the eighth is in the doctors' retainer scheme.

Of the men overseas graduates who responded, 11 are in practice (two in their training practice). Seven entered practice immediately, one after doing an 11 week locum. Two had held partnerships before their present appointment, and two undertook locums of four months and three months before settling. Of the four women overseas graduates in practice, two entered practice immediately, one into her husband's practice. The third had held a partnership of nine months before the present one. The fourth had held a locum and assistantship, both of six months, before joining her partnership.

Financial arrangements—Thirty three responders provided data (table 11). One of the salaried United Kingdom graduates was on a trial of six months before entering a share partnership. The other six salaried partners seemed to have no agreed time limit to their present status.

The accuracy of the figures given may be questioned and may say something of the doctor's own assessment of his value to the practice. Twenty eight doctors started their beginning salary before deduction of tax. In 1977 the average annual starting salary for both United Kingdom and overseas graduates was £2500. By 1981 it had risen to £13 000 for United Kingdom graduates but to only £11 000 for overseas graduates. The doctors on a fixed income were receiving an average of £900 a year.

Doctors became share partners either immediately on appointment or within two years by agreement, and once a share partnership was agreed average time to each party was 2.5 years. Three doctors, however, reserved party on appointment as share partners. Eighteen share partners stated their annual income before tax and their percentage share of profits. Party figures were calculated and show a wide spread of net profits. They range from £20 000 a year to £12 000 a year. The average income for the 18 responders was £18 845, nine doctors earning more and nine less. There were seven United King-

TABLE 11—How they found a practice

	Doctors who qualified			
	In the United Kingdom		Overseas	
	Men	Women	Men	Women
Personal recommendation	1	5	0	0
BMJ advertisement	2	2	2	4
Half day release course	2	2	0	1
Directly from retainer scheme	1	1	1	1
Advertisements	5	4	9	9
BAT advertisements	1	1	1	1
BMA Personal Services Bureau	1	1	1	1
Risk Service	1	1	1	1
Police	1	1	1	1
Other	1	1	1	1
Joined husband's practice	1	1	1	1
Locum provided practice	1	1	1	1
Total No.	18	15	15	15

TABLE 12—Financial arrangements in present practices (32 doctors)

	Doctors who qualified			
	In the United Kingdom		Overseas	
	Men	Women	Men	Women
Full time share partners	8	5	4	3
Part time share partners	2	0	0	1
Part time salaried partners	2	0	3	1
Full time salaried partners	0	0	0	0
Total No.	10	7	11	5

TABLE 13—Number of doctors with practice agreements

	Doctors who qualified			
	In the United Kingdom		Overseas	
	Men	Women	Men	Women
Practice agreement	6	4	3	2
No agreement	4	1	2	1
Plans	1	1	2	1
No plans	1	1	1	1

TABLE 14—Satisfaction with training over five years

	Doctors who qualified			
	In the United Kingdom		Overseas	
	Men	Women	Men	Women
Training practice	11	5	9	4
Very satisfactory	12	4	10	3
Satisfactory	4	1	4	0
Unsatisfactory	0	0	0	0
Half day release course	9	14	11	15
Very satisfactory	0	0	0	0
Satisfactory	0	0	0	0
Unsatisfactory	0	0	0	0

BMA graduates and two overseas graduates in the high income group. In the low income group the three highest earners were United Kingdom graduates and the rest were overseas graduates. Arrangements in the practices of the high and low earners were compared. The high earners had an average of 4.43 partners compared with 3.08 for the low earners. The high earners employed fewer staff themselves—0.86 per doctor—and more area health staff—1.36 per doctor—compared with 1.10 employed staff per doctor and 0.94 area health staff per doctor for the low earners. Average list sizes per partner seem to have little to do with the variation in income, the high earners having an average of 2354 patients and the low earners, 2229.

Practice agreement—The importance of a practice agreement is emphasised on the course each year, yet 42% of doctors have no agreement (table 14). I have counselled four re-examinees while their practices were breaking up. None had a practice agreement, although the solicitors' fees for preparing one are only about £100. Answers were collected about agreements between partners. Twenty two ex-trainees were eligible for their vocational training allowances, of whom 16 were allowed to keep the allowance. Twenty two older partners