PRACTICE OBSERVED

Vocational Training

Choosing a practice

BRIAN BEAUMONT, MALCOLM MCCOURBIE

Correct choice of partners remains nearly as important as choice of mate; separation from either is likely to be unpleasant, difficult, and expensive. Practices choosing a new partner soon realise that selection is a two way process and may welcome an applicant's assessment of them. Some assessment is done at subclinical levels, and accurate rating of traits such as rigidity and empathy is problematic. Much of the assessment, however, although complicated, is factual and worth analysing.

Vocational trainees in general practice from three districts who were attending joint half day release courses and working in small groups attempted to classify and then detail those factors which they felt could be assessed accurately. They excluded preparatory work, such as appraising advertisements, producing curricula vitae, and applying for a vacancy, and left interviewing techniques to later sessions on teaching and learning. The check list, used as a tool for organised thought, may help others to identify their needs and wants and is presented for those brave enough not to accept the first job offered.

(1) Situation

Type: suburban, inner city, urban-rural, rural
Practice area and family practitioner committee designation
List size: stability, age distribution, social mix
Other practices
Population: ethnicity, unemployment, industrial disease, mobility
Housing: cost of three bedroom detached house with quarter acre garden
Recreation, sport, arts

The Health Centre, Hobden Bridge, W Yorks HX7 8AG

BRIAN BEAUMONT, MB, MRCGP, general practitioner

MALCOLM MCCOURBIE, MB, MRCGP, general practitioner

(2) Partners

Age
Sex
Marital status
Qualifications
Religion
Politics (and involvement)
Health
Medical interests
Outside interests

(3) Work

Lists separate notional, zoning
Appointments open: "last minute" arrangements, consultation rates
Special clinics: participation by newsmen; screening?
Visiting rates, including chronic sick
Rota equality: hours on call second on call use of deputising service
Night visiting rate
Practice meetings
Research
Vocational training involvement
Undergraduate teaching
Outside practice: hospital sessions, dental anaesthetics, insurance, industrial, governmental, local medical committee, family practitioner committee, district management team, Royal College of General Practitioners, police

(4) Facilities

Premises: owned (by whom?), rented (from whom?) length of lease?, cost rented
Branch surgeries
Dispensing
Convenience: separate examination rooms, lighting, common room, library, typing room, treatment room
Equipment: dictaphone, electric typewriter, electrocardiograph, computer, skin testing kit, vitagraph, sleep, resuscitation box, video recorder, surgical equipment, photocopier, audiometer
Records: Lloyd George A4 (adequacy?), age-sex register, at risk

register, summary card, repeat prescriptions recall systems, therapeutic protocols
Cottage hospital
General hospital: consultants on first name terms?
Access to pathology, x-ray examinations
General practitioner obstetric beds
Postgraduate centre, library
University department of general practice—approachability

(5) Staff

None age spread, turnover
Appointed: manager (qualifications), nurse practitioner, practice nurse (scope of work), secretaries, receptionists, bookkeeper
Attached (full, shared, geographical), health visitors, community nurses, midwives, social workers
Liaison: social workers, sick visitors, hospital liaison nurses, education welfare officers, health education unit
How often are practice meetings, staff meetings, attached staff meetings, and liaison meetings held?

(6) Money

Sources: National Health Service, private
Distribution
Vocational training, seniority, assistantships pooled?
Party
Capital introduction
Personal income: non-medical
Accounting procedures: budgeting
Car allowances: shared individual level
Efficiency of allowance claiming: cervical smears, immunisation
Superannuation shares
Expenses: shared individual level
Taxation: shared individual level
Illness: accident insurance, life insurance, pensions
Staff pension commitment

(7) Contract

Six to 12 month trial?
Sickness (short term, long term)
Maternity/paternity leave
Leaving/dissolving the practice: time
Geographical limits?
Fixed retirement age?
Replacement/partner arrangements
Study leave, sabbaticals

(8) Spouse involvement or job prospects in the area

(9) Indicators

Other opinions of the practice are probably worthwhile getting. Some obvious sources may or may not be discreet: family practitioner committee administrator, consultants, pharmacists, course organiser.
More useful will be the local vocational trainees, particularly those working in the accident and emergency department, if it isn't a training practice. Don't forget the patients themselves, frequently found to be in local pubs, shops, and cafes.
Practice prognostic signs may include: frequent use of first names and nicknames; large coffee/jag; office Christmas party; toleration of audit; discussion of patient participation; smoking partners; Jaguar; Mercedes cars; exclusive generic prescribing; abundance of drug company goodies; fixed views (either way) on home confinements.
Finally, form an opinion on the most important facets of general practice: caring, coping, changing, moaning.

We thank the trainees from Calderdale and Kirkcaldy who in 1980 and 1983 did most of the work for this article.

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Practice Research

Training for general practice: clinical behaviour in trainers and trainees

D J G BAIN

Abstract

A study of 20 trainers and their trainees in general practice showed that trainees had a statistically significant improvement in their diagnosis of otitis media during their training year and also became quicker in the time taken for history taking and examination. There was a fall in trainees' prescribing of antibiotics for otitis media during the study but this was accompanied by a notable rise in prescribing of decongestant-antihistamine mixtures to a level similar to that of the trainers. Trainees seemed to accept readily their trainers' prescribing policies and were hesitant to challenge them. An im-

portant finding was that trainees had little influence on trainers' prescribing, the latter showing no appreciable changes during the study.

Introduction

During the past 20 years general practice has emerged as an independent clinical discipline and one consequence of this has been the recognition by the profession and the government that the responsibilities of general practice require appropriate training. Reports from the Royal College of General Practitioners have emphasised the influence of trainers on trainees during their training year in general practice.^{1,2} and Stott indicated that the relationship between the trainer and trainee was the most important single factor in his training.³ One aspect of the relationship between the trainer and trainee that has received little attention is the influence of trainers on the development of trainees' behaviour in diagnosis and treatment. Furthermore, the effect

that trainees may have on their trainers' clinical practice is unknown.

This paper reports the results of a study of the diagnoses made and treatments given for acute earache in children by trainers and trainees at the beginning of the training year and six months later. Comparisons were made between the performance of trainers and trainees on the two occasions. Otitis media was chosen as the clinical condition because it is common in general practice and treatment still gives rise to controversy.

Methods

Twenty four trainers and their trainees in the Westex region who agreed to take part in the study were interviewed separately. They were asked to examine the case histories of five children aged three to five years who had begun to have earache about 24 hours previously. In none of the children were there any abnormal findings in the throat, nose, or chest. Accompanying each case history was a photograph of an eardrum mounted on a revolving disc which fitted into a model head (figure). The technique used to photograph the eardrums has been described elsewhere.⁴ By introducing an auscope into an aperture representing the external meatus and ear canal the appearances of the five eardrums could be examined in sequence.

Trainers and trainees were asked to make a clinical diagnosis from the case histories and appearances of the eardrums and then asked to decide on treatment for each. The procedure was repeated six months later using the same series of case histories and photographs. The time taken by trainers and trainees to complete each of the simulated consultations was also recorded by an independent observer. The photographs of the eardrums were examined by a consultant ear, nose, and throat surgeon and by a general practitioner with a special interest in disorders of the ear, and they agreed that the appearances of the five eardrums were typical of the following: (a) a normal eardrum; (b) a drum with prominent blood vessels; (c) an acutely inflamed drum—acute otitis media; (d) a bulging hyperemic drum—acute suppurative otitis media; (e) an opaque drum with fluid levels—serous otitis media.

Results

In the analysis of the findings comparisons were made of the diagnoses and prescriptions of the trainers and trainees on the two separate occasions when they were asked to assess the case histories and appearances of the eardrums. Of the 24 pairs of trainers and trainees it proved impossible to carry out the follow up interviews in four pairs. The diagnoses made by the remaining 20 trainers and trainees at each of the two interviews are shown in table I. Whereas trainers were consistent in their interpretation of the case histories and appearances of the eardrums, there was a highly significant ($p < 0.001$) improvement in the diagnoses made by the trainees.

Similar comparisons were made of the prescribing of antibiotics and of decongestant-antihistamine mixtures. Trainers or trainees who prescribed either of the above treatments for four or more of the case histories were designated as high prescribers, while those who prescribed either drug for one or two of the case histories were designated low prescribers. With one exception trainers remained in their categories of prescribing in the two interviews. Two trainers were consistently high prescribers for both antibiotic and decongestant-antihistamine mixtures and there were four trainers who were consistently low prescribers for both antibiotics and decongestant-antihistamine mixtures. For antibiotic prescribing alone there were three high prescribers and 11 low prescribers. For decongestant-antihistamine alone there were 12 high prescribers and six low prescribers.

Notable contrasts were found in the prescribing by trainers and table II shows the differences in the prescribing between the two

TABLE I—Diagnosis of otitis media

	No correct diagnosis (n = 100 consultations)	No correct diagnosis at follow up (n = 100 consultations)	Significance of differences (p = 0.001)
Trainers (n = 100 consultations)	71	74	
Trainees (n = 100 consultations)	30	62	

interviews. The number of simulated consultations where antibiotics were prescribed fell from 71 to 59. This change, which was not statistically significant, was largely accounted for by the reduction in the prescribing of antibiotics for cases 1 and 2 where the appearances of the eardrums were normal. Conversely, the prescribing of decongestant-antihistamine mixtures by trainees increased between the two interviews from 23 to 61, the difference being highly significant ($p < 0.001$). Table III shows the time taken by trainers and trainees to consider the case histories and examine the appearances of the eardrums. There were no significant differences among the trainers on the two occasions, but the trainees became quicker in the time taken for considering the case histories and inspecting the eardrums.

TABLE II—Changes in prescribing

Prescribing	Initial interview (n = 100)	Follow up interview (n = 100)	Significance
Trainers	71	59	No significant
Trainees	30	62	No significant
Trainers	23	61	No significant
Trainees	23	61	No significant

TABLE III—Consultation time: time taken in case histories and examination of ear drum

	Consideration of case history (min)	Average time taken for examination of eardrums (minutes)
Initial interview	1.9	0.7
Follow up interview	1.7	0.6
Initial interview	5.1	1.1
Follow up interview	4.2	0.8

Discussion

This study was designed to investigate changes in the clinical practice of trainers and trainees during the first six months of their relationship and to compare their diagnostic and prescribing behaviour. Otitis media was chosen as the clinical condition because it is common in general practice and treatment still gives

rise to controversy. The trainees as a group showed a statistically significant improvement in diagnostic performance and also became quicker in the time taken to consider case histories and examine eardrums. With regard to trainers' use of the case findings are similar to those made by Buchan and Richardson, who found that trainers reduce the time taken for consultations during their training year.⁵ Howie and Dingwall-Fordyce, who used simulated consultations of respiratory illness at the beginning and the end of the training year, showed that the behaviour of trainers as a group changed over the period so as to approach closely that of their trainees as a group.⁶

In the present study the prescribing of antibiotics was probably justified in three of the five simulated presentations. In the other two, in which the eardrums were normal, it was reassuring that there was a reduction in the trainers' prescribing of antibiotics. The increase in trainees' use of decongestant-antihistamine mixtures might be regarded as a less desirable outcome. Although the use of decongestant-antihistamine mixtures has been aimed to improve the prescribing of antibiotics, a recent controlled trial in children with acute inflammation or middle ear effusion have shown that these preparations offer no benefit compared to a placebo.^{7,8} Most of these results, however, appeared in journals not regularly referred to by general practitioners. The competing forces that operate to affect general practitioners' prescribing are many and complex but a great deal of information about prescribing is obtained from extra professional sources, such as the drug industry,⁹ and the effect of published reports in medical journals and books is largely unknown. The increased prescribing of these preparations by trainees probably reflected the frequent use of decongestant-antihistamines by trainers, whose influence on prescribing in this respect is open to question.

The opinions of trainers about prescribing that are passed on to trainees may not be based on any sound evidence. Similarly, little is known about the influence of day release programmes on trainers' prescribing. It follows that in a relationship between trainer and trainee mutual cross questioning about rational treatment is all important, exchange of ideas being as valuable to trainers as to trainees who have the advantage of much more recent instruction on therapeutics and pharmacology. It was notable that trainees seem to have had no influence on their trainers' prescribing, the latter showing no appreciable changes during the study.

The potential benefits of the relationship between trainer and trainee could be greatly reduced if trainees were to develop prescribing habits that were not subjected to rigorous scrutiny.

Discussions with the trainers who took part in this study showed that they readily accepted their trainers' prescribing policies and were hesitant to challenge them in case this led to patients becoming confused, or resulted in a disturbance of the relationship with their trainers. The opportunity to question conventional treatment of common conditions is part of the process of learning and the findings reported here provide evidence that trainees improve their diagnostic skills during their training year, but there was less evidence to show that this was accompanied by a critical appraisal of either their own prescribing habits or those of their trainers.

I am extremely grateful to the trainers and trainees whose willing cooperation enabled this study to take place.

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Aldermoor Health Centre, Aldermoor Close, Southampton SO1 8ST
D J G BAIN, MB, MRCGP, professor of primary medical care

were to be taken against her. As she continued to refuse, the coroner (Dr. Reese) gave her into the custody of the police, and she was locked up. Mr. Price was then called, and he raised the same objection; but, when being threatened with committal, he gave evidence that he was the father of the child. It had not been baptised, as the ancient Druids, of whom he was one, did not make use of that practice. The child was five months old, and had died of convulsions. The mother was afterwards prevailed upon by Mr. Price to corroborate what he had said, and was then released from custody. The medical evidence showed that death resulted from natural causes. A verdict to that effect was returned. The coroner gave Mr. Price, as the father, a certificate of burial, and, in reply to the superintendent of police, said he had no power to order that the body should be decently interred. Mr. Price said he should take care of the body. The superintendent thereupon said he should detain the body. An investigation before the magistrates was commenced on Wednesday. The question of the disposal of the body was discussed, and ultimately, after some hesitation, Mr. Price consented that the body, if given up to him, should be interred in the ordinary way. On this condition, it was returned to him; and he has administered a full and proper charge in honour for the attempted cremation. (*British Medical Journal* 1884;1:123.)