from the patient, who delays, curtails, and sometimes abandons replies. These problems are echoed in asynchrony in the non-verbal communication of the participants.

Some practitioners avoid creating these difficulties by, for example, glancing at the medical records or computer screen before the patient enters the office. If they need to use the records during the consultation they wait until the patient has finished speaking on a subject or seek permission before turning away. Thus they keep their attention on the patient, who is delivering information, and thereby avoid generating speech difficulties, missing important points, and, of course, undermining the relationship between doctor and patient.

Embarrassment during the physical examination

During the physical examination some practitioners inadvertently cause embarrassment for both them and their patients, which may make the patient tense and uncooperative. Sometimes the examination is even curtailed or abandoned. Such embarrassment may arise when doctor and patient are preparing for the examination. For instance, the orientation of the doctor's body and pattern of gaze may cause mutual embarrassment. An easy going doctor who engages in small talk and insists on mutual involvement before and during the examination (to put the patient "at ease") causes more problems than he or she avoids.

The physical examination is carried out more smoothly and with fewer difficulties when conducted formally, both visually and vocally, than if informality is attempted. When the practitioner asked the patient's permission to conduct the examination and then turned away and became occupied elsewhere while the patient prepared for the examination there were few difficulties. The practitioners who ignored a patient's preparation for the examination therefore allowed patients to distance themselves from

the examination and retained their cooperation. Thus relatively small differences in the non-verbal behaviour of practitioners can have an appreciable influence on the care with which the examination is conducted and its influence on assessment and diagnosis.

Doctor's behaviour is crucial

Analysis of the medical consultation shows that non-verbal as well as verbal communication is an important part of the process through which practitioners diagnose illness and recommend treatment. The coherence and the type of information the doctor is able to gather, the usefulness of the examination, the persuasiveness of the advice, and other aspects of practical medical work are greatly affected by the non-verbal behaviour of the practitioner. The success or failure of the consultation and the relationship between the patient and the doctor in both the short and the long term are inseparable from the nature of the communication. "Good" general practice depends on the non-verbal as well as verbal behaviour of the doctor. Research and training in communication in the consultation will help to maintain and improve quality in the delivery of primary health care.

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Practice Research

Are the recommendations being met in the general practice year of vocational training? Trainees' views in the West Midlands region

ALLAN MICHAEL CYNA, FRANCIS RICHARD PRZYSLO

Abstract

Vocational trainees in the West Midlands who were in their general practice year were sent a postal questionnaire to find out whether there were important differences between the criteria for training of the 1986 West Midland postgraduate education committee (based on national recommendations) and the perceptions of the trainees of their current trainers and practices. The response rate was 86.2% (75 out of 87). Sixty four per cent (48) of trainees reported that they received on average less than the recommended minimum of three hours of teaching time a week. They felt that experience was inadequate in paediatric surveillance (62.7%) and preventive medical care (37.3%). Most trainers gave topic teaching (90.7%), and few used role play (5%). Most of the trainees (52%) had not signed a contract, a third did not get help with recommended allowances, and 37% thought that their progress had not been reviewed.

Several trainees commented on the excellence of their training

practices, and most of the practices appeared to be keeping to the spirit of the recommendations. There are, however, discrepancies between what some trainees feel they receive and what is recommended.

Introduction

The present system of selecting general practice trainers and practices dates from October 1973 when general practice training came under the academic control of the universities. At the beginning of 1975 the Joint Committee for Postgraduate Training in General Practice became autonomous, representing the two main bodies of general practice, the Royal College of General Practitioners and the General Medical Services Committee.¹ The educational aims for vocational training were set out by the second European conference on the teaching of general practice.² In 1976 these aims were adopted by the Joint Committee as the basis for standards to be met by general practitioner trainers and their practices.³ These standards are applied to the general practice year that is undertaken by doctors as part of their vocational training, which has been a compulsory requirement since 1981 for every doctor who wishes to become a principal in general practice.⁴ In 1980 the fourth national trainee conference sought the views of trainees concerning vocational training and identified problems and unmet needs of trainees.⁵

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In July 1985 the recommendations of the Joint Committee were updated.⁶ In April 1986 the West Midland postgraduate education committee circulated to trainers and course organisers in the region its own version of the criteria for the approval and reapproval of trainers in general practice. The aim of our study was to find out whether there were important differences between the recommendations of the West Midlands committee and the training given, as perceived by West Midland trainees in their general practice year.

Methods

A postal questionnaire was designed from the West Midlands criteria using the headings: "Trainer as a doctor," "Trainer as a teacher," and "The training practice." We asked trainees to answer the questions with reference to their present or most recent practice attachment.

A pilot study of 11 past trainees in the Stoke-on-Trent area led to some minor amendments to the questionnaire. The regional adviser in general practice provided a list of current trainees and the addresses of their training practices. Questionnaires were distributed at the beginning of July 1986 to every trainee in the West Midland region at which time most trainees were completing a general practice training post. All questionnaires were code marked and posted to each trainee with an enclosed stamped addressed envelope. The number codes were used to follow up non-respondents; confidentiality was otherwise strictly observed. Each questionnaire gave up to 66 items of data. These were collated on an Apricot Xen microcomputer and analysed using Microstat.⁷

Of 87 trainees who were sent the questionnaire, 60 replied within four weeks. We tried to contact all non-respondents by telephone at their practice or new address before sending out further questionnaires. A final response of 75 trainees (86.2%) was achieved, which compares well with other postal surveys of this type.⁸⁻¹⁰

Results

Of the 75 respondents, 28 (37.3%) were women, 45 (60%) were men, and data were missing for two. The mean age was 29.1 years (with a 95% confidence interval from 28.1 to 30.1). Sixty two (82.7%) trainees had graduated after 1980. Thirty (40%) trainees were in urban practices, 17 (23%) in rural, and 28 (37%) in mixed areas. Two trainees (2.7%) were in a single handed practice.

Thirty one trainees (41%) thought that their trainer was "very" enthusiastic, 40 (53%) thought "moderately" enthusiastic, and only four (5.3%) thought "not particularly" enthusiastic. Fifty three trainees (71%) thought that their trainer was medically "very" competent, and the remaining 22 (29.3%) thought "moderately" competent. Fifty four trainees (72%) thought that the trainer was giving "very" good patient care, 20 (27%) thought "moderately" good care, and only one trainee (1.3%) thought that the trainer was not giving particularly good patient care.

TEACHING

Table I shows the average amount of undisturbed teaching time received and how much time trainees thought that they needed. Thirty trainees (40%) thought that they needed more teaching time than they were receiving, whereas eight (11%) thought that they were receiving more teaching than they needed. Twenty one trainees (28%) had been encouraged to keep a record of cases seen and 32 (43%) a record of tutorial subjects covered; nine (12%) trainees were encouraged to keep a record of the prescriptions they wrote and 30 (40%) a record of their visits.

Table II gives trainees' views on the adequacy of aspects of their practice experience. Twenty one trainees (28%) had had four or more arranged visits to places of interest relevant to general practice, 30 (40%) had one to three visits, and 24 trainees (32%) had no visits.

Table III shows the variety of teaching techniques that trainees had in their practices. Fifty five (73.3%) had had an opportunity to do a project or research work in the practice, nine (12%) had not, and six (8%) responded "not applicable." Sixty six trainees (88%) thought that their trainer was able to assess their knowledge, 55 (73%) their clinical skills, 65 (87%) their attitudes to patients, and 67 (89%) their attitudes to staff.

Table IV shows how often trainees' progress was reviewed in their training practices. Fifty four trainees (72%) stated that they had received help with, or encouragement to take, postgraduate examinations such as the diploma in child health, the diploma of the Royal College of Obstetricians and Gynaecologists, and the membership of the Royal College of General Practitioners. Fifteen trainees (20%) thought that the practice library was inadequate.

TABLE I—Teaching time needed and received in hours. (Figures are frequencies with percentages in parentheses)

Questions	Hours			
	0-1	1-2	2-3	3+
Does your trainer or partners spend with you in undisturbed teaching time per week on average?	20 (27)	28 (37)	20 (27)	7 (9)
How much undisturbed teaching time do you feel you need?	4 (5)	30 (40)	30 (40)	10 (13)

TABLE II—Trainees' views on the adequacy of their practice experience. (Figures are frequencies with percentages in parentheses)

Questions	Yes	No
Did you feel the practice provided you with adequate experience in:		
Maternity care?	53 (70.7)	22 (29.3)
Family planning?	51 (68)	23 (30.7)
Paediatric surveillance?	27 (36)	47 (62.7)
Preventive medical care?	45 (60)	28 (37.3)

TABLE III—Trainees' experience of teaching techniques in training practices. (Figures are frequencies with percentages in parentheses)

	Yes	No
Topic teaching	68 (90.7)	7 (9.3)
Random and problem case analysis	66 (88.0)	9 (12.0)
Consultation skill analysis	43 (57.3)	31 (41.3)
Video recording of consultations	41 (54.7)	34 (45.3)
Role play	4 (5.3)	71 (94.7)
Clinical case presentation	19 (25.3)	56 (74.7)

TABLE IV—Length of time in practice against progress review of trainees. (Figures are frequencies with percentages in parentheses)

How often has your progress been reviewed in this time?	Months in practice						Total
	4	5	6	10	11	12	
None at all	1	8	4	0	7	8	28 (37.3)
Once	0	1	4	1	5	4	15 (20)
Twice	0	1	1	0	5	3	10 (13.3)
Three or more times	0	3	3	1	8	5	20 (26.7)

PRACTICE ORGANISATION

Concerning attendance at the half day release course, 59 (79%) trainees "never," 15 (20%) "sometimes," and one (1.3%) "often" could not attend the half day release course owing to practice commitments, such as surgeries, visits, or being on call. One trainee (1.4%) "often" had difficulty getting leave for regional study days, whereas 12 (16%) "sometimes" did and 60 (80%) "never" did. Seven trainees (9.3%) thought that they were doing more work in the practice on average than their trainer, and 13 (17.3%) thought that they were doing more work than the partners. Sixty one trainees (81.3%) always had "cover" from their trainer or partners when on call at night, and four (5%) had "cover" often, six (8%) sometimes, and three (4%) never. Forty nine trainees (65%) reported that the working relationship and communication between practice members was "good," 18 (24%) "satisfactory," and eight (11%) "poor." Thirty nine trainees (52%) had not signed a contract, and 58 (77%) had not received a written guide to the practice, although 36 (62%) of these would have liked one.

Table V shows how many trainees were helped with recommended allowances and equipment from their training practices. Thirty six (48%) of the training practices had an index or recall system for identifying patients with diabetes, 19 (25%) had a system for epileptics, 60 (80%) for immunisations, and 67 (89%) for cervical cytology.

Table VI shows the use of summary cards and the extent to which patient records were in chronological order. Records were available for all patient contacts including home visits in 67 practices (90.5%) and were said to be legible and of a reasonable standard in 68 (90.7%).

TABLE V—Recommended allowances and equipment. (Figures are frequencies with percentages in parentheses)

Questions	Yes	No	Not applicable
Have you had any help from your trainer or other practice staff with:			
Accommodation?	20 (26.7)	8 (11)	47 (63)
Telephone allowance?	34 (45)	25 (33)	16 (21)
Other allowances?	22 (29)	29 (39)	23 (31)
On joining the practice were you provided with or reimbursed for:			
A medical bag?	47 (63)	24 (32)	4 (5.3)
Necessary additional equipment (such as a sphygmomanometer)?	43 (57.3)	24 (32)	7 (9.3)
Necessary drugs to carry out your duties?	72 (96)	2 (2.7)	0

TABLE VI—Quality of practice records. (Figures are frequencies with percentages in parentheses)

Questions	All	Most	Some	None
Is there a summary card of important events in every record?	13 (17)	33 (44)	26 (35)	3 (4)
Are continuation sheets, reports, letters fixed in date order?	46 (61)	25 (33)	4 (5)	0

ADDITIONAL DATA

Eight trainees (11%) always felt that they were working as an extra partner rather than as a trainee; 16 (21%) often felt that this was so, 43 (57%) sometimes thought so, and eight (10.7%) never thought so. Sixty nine (92%) trainees felt that they would be confident in taking on a post as a principal in general practice at the end of the trainee year. Overall, 60 trainees (80%) enjoyed their general practice attachment "very much," 14 (19%) "moderately," and one (1.3%) did "not particularly" enjoy the attachment.

Discussion

We were not concerned with the rights and wrongs of the West Midlands postgraduate education committee's criteria, which have been accepted by trainers and practices participating in vocational training in the region. In some aspects of training, however, there seems to be a discrepancy between what some West Midland trainees feel they receive and what is recommended. Our results highlight aspects that trainers may wish to review with their trainees. Important criteria in trainer selection have been the doctor's enthusiasm for teaching and general practice, competence as a doctor, and the delivery of good care to patients.^{6,11} Most trainees (95%) thought that their trainer was either moderately enthusiastic or very enthusiastic and gave either moderate or very good patient care. At the fourth national trainee conference it was thought that the cornerstone of training is a successful relationship between trainer and trainee.⁵ Perceived teaching time received by the trainee appears to be all important, both as a determinant of trainee satisfaction with training and as an indication of a trainer's enthusiasm and ability to transmit the positive aspects and potential of good practice to the trainee.^{5,12}

Despite the committee's criteria recommending an average minimum of three hours of undisturbed teaching a week, roughly one quarter of the trainees reported receiving one hour or less a week on average, with over 60% receiving two hours or less. Of all the various methods of teaching in the training practice the analysis of consultations is probably the most important.¹³ Less than two thirds of trainers appear to be analysing consultations and few (5%) use role play as aids to teaching. It is recommended that trainees should be encouraged to keep a diary or record of cases seen, yet less than 30% of trainees felt that they were encouraged to do so.

The ability to deliver comprehensive care for children including both prevention and surveillance might become a prerequisite for appointment as a trainer.¹⁴ Nearly two thirds of trainees thought that their practice failed to provide them with adequate experience

in paediatric surveillance, and over one third thought that their experience in preventive care was inadequate. A signed contract is recommended under the West Midlands criteria, and the trainer is bound by law to offer the trainee a contract,¹⁵ yet less than half of the trainees had signed a contract. A written guide to the practice is recommended, yet only a few practices provide one. Cover is still a problem; 4% of trainees never had cover when on call at night, while a further 13% were not covered on one or more occasions. To quote one trainee: "No partner is specifically on call with me but I can always ring round and hope!" Over a third had no help with telephone allowances from their training practices, and a similar proportion were not provided or reimbursed for essential equipment or a medical bag.

Although there will always be room for improvement, it is encouraging that most practices appeared to be keeping to the spirit of the recommendations. Indeed, several trainees commented on the excellence of their training practices. Nearly 10% of trainees, however, felt that they were doing more work in the practice on average than their trainer and 18% more than the partners. Eleven per cent of trainees felt that they were always working as an extra partner rather than as a trainee. A few training practices rely extensively on the trainee to carry an unfair share of the practice workload, paying little attention to teaching or cover. Many trainees who felt that they were sometimes working as an extra partner said that this experience made them feel like an integral part of the practice team. Some trainees who never felt that they were working as an extra partner stated that they would have liked more responsibility. Clearly, a balance is necessary as the needs and wants vary between individuals. Several trainees commented on the lack of regular feedback with their trainer. Some felt that they were "just muddling through" because there was no regular review of their work. Many commented that they should be kept up to date with their progress. Over one third of trainees felt that their progress had not been reviewed at any time, with a further 20% receiving only one review despite completing on average nine months of their trainee year.

A list of objectives on its own is of little use unless it is being continually reviewed and implemented. We think that trainees should be made aware of the recommended minimum standards agreed locally. In view of our findings perhaps more discussion between trainees and practice members is warranted, then with trainer and trainee working together the high standards recommended should be within reach of all.

We thank the regional adviser in general practice for providing a list of trainees and practices in the West Midlands; Dr Mike Collins, medical statistician, North Staffs Hospital Centre, for invaluable advice; Jayne Ludbrook for secretarial help; the practice staff at Wolverhampton Road, Stafford, for their tolerance and use of their computer; and all the trainees who replied so promptly and extensively to our survey.

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