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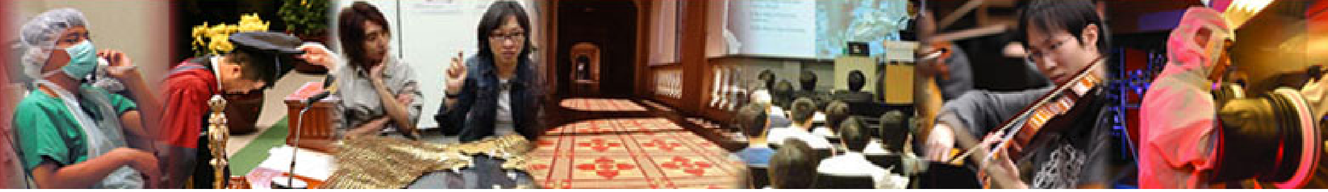

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Vocational training in family medicine: A qualitative study of perspectives of trainers in community-based training

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Summary

***Objective**: To investigate how trainers perceived the vocational training programme in family medicine in Hong Kong.*
***Design**: Structured discussion with trainers who had trainees in the community-based segment of the vocational training programme of the Hong Kong College of Family Physicians.*
***Subjects**: Forty seven eligible trainers were identified and invited to attend the discussion. Thirteen trainers participated in two structured discussions.*
***Main outcome measures**: The opinions expressed by the participants towards the vocational training programme.*
***Results**: The response rate was 27.7%. The trainers were clear about their roles but saw an overlap between their functions and those of the trainees' supervisors. They were unsure on what to teach and how to teach, and looked for guidance from the Hong Kong College of Family Physicians. They felt that there should be more varied training methods, more resources at training centres, better training arrangements and more co-ordination among training stakeholders. Some trainers experienced difficulties with their trainees. All trainers saw the benefit of an annual trainers workshop.*
***Conclusion**: It is recommended that the College provides better organisation for and training of trainers. A trainers co-ordinator, a trainers handbook and an annual trainers workshop are some suggestions.*

***Keywords**: family medicine, teaching, medical education*

摘要

目的：研究香港家庭醫學院的導師對現時在職訓練計劃的意見。
設計：邀請現時有訓練於社區受訓的家庭醫生的人仕進行有系統的討論。
對象：向四十七位確認合資格的導師發出邀請，有十三位參加了兩部分有系統的討論。
測量內容：參與者對現時在職訓練計劃所表達的意見。
結果：反應率為27.7%。訓練導師們都清楚他們的職責，但感到工作功能上與指導員部分重疊。他們未能肯定教導的內容及方法，希望尋求香港家庭醫學院的指引。他們認為應有更多元化的教學方法，更多的教學資源，更好的教學安排以及更佳協調。有些導師和他們的學員有困難的存在。所有導師都覺每年舉辦研討會有幫助。
結論：建議香港家庭醫學院能為導師提供更理想的組織和進行培訓。其他建議包括導師間的協調人，導師手冊和每年舉辦研討會。

主要詞彙：家庭醫學，教醫，醫療教育

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Introduction

In the past three decades, general practice/family medicine has enjoyed a renaissance in popularity and importance. Vocational training is now the recognised pathway to competence in family medicine and specialist status in the discipline. There is evidence that vocationally trained doctors become better family physicians. In a review of studies on the outcome of vocational training in family medicine, Harré Hindmarsh *et al*[1] found that vocationally trained general practitioners showed improved quality of patient care and specific

general practice skills, greater adherence to practice guidelines, increase in confidence and knowledge, and higher examination pass rates. The vocational training programme of the Hong Kong College of Family Physicians began in 1985 but expanded rapidly in the late 1990s when many young doctors registered with the programme upon finishing their internship. In 2001, many senior family physicians were recruited to meet the demand for trainers, mostly as part-time consultants in training facilities under the Hospital Authority (HA) as it provides the most training posts.

There has been no study in Hong Kong on the vocational training programme. Now that it has vastly expanded, the programme has come under pressure for review. In an attempt to find out how trainers perceive their work and role, a study was carried out in the form of structured discussion, focusing on trainers involved in the community-based segment of the programme. The difference in function, if any, between trainers and supervisors who organise the training centres was also investigated.

The vocational training programme of the Hong Kong College of Family Physicians

The programme lasts six years and consists of three segments: two years of hospital-based training, two years of community-based (C1, C2) training and two years of higher training. In the hospital-based segment, trainees rotate through a number of hospital specialties with medicine, surgery, paediatrics and obstetrics and gynaecology making up the core requirements. In the community-based segment, they either work in government facilities such as Integrated Clinics and Staff Clinics in government hospitals, General Out-Patient Clinics (GOPCs), other government training centres and university family medicine clinics, or in private hospital out-patient clinics and private offices. In the higher training segment, they either work in the same facilities as in the community-based segment or in their own offices as independent medical practitioners. Trainees are assigned trainers in the community-based and in the higher training segments. HA training posts are grouped into clusters and managed by cluster co-ordinators (supervisors) who are trainers as well.

Other trainers in the programme comprise senior family physicians in government service, private family physicians who train trainees part-time in government facilities (part-time consultants) and private family physicians who train in their own offices. The essential requirements of a trainer are that he/she possesses a higher qualification in family medicine/general practice and Fellowship of the Hong Kong Academy of Medicine in Family Medicine.

Training methods are mainly sit-in sessions in which the trainer observes how the trainee consults and vice versa, supplemented by review of video-taped consultations and weekly held seminars for trainees.

At present, there are many more trainees in community-based training than in higher training.

Methods

Forty seven trainers who trained doctors in the community-based segment of the vocational training programme were identified from the 2002-2003 Annual Report of the Hong Kong College of Family Physicians.[3] They were sent a letter inviting them to attend a discussion group to air their views on the vocational programme. Nineteen trainers did not reply and 11 declined the invitation. Of the remaining 17 trainers who responded positively, 13 attended and they were divided into two separate groups so that the numbers were kept small in order to facilitate the exchange of opinions. The discussion was held on two separate days. Six trainers attended the first session and seven the second session. In the first session, JC led the discussion while in the second session a senior family physician and trainer who had acted as an observer in the first meeting led the discussion. In both sessions, the discussion followed a pre-determined agenda, namely, the role of a trainer, the difference between a trainer and a supervisor, sit-in sessions, other training methods, difficulties encountered in training and difficult trainees.

The discussions were audio-taped (with the consent of the participants), transcribed and translated from Cantonese to English by trained research assistants in the Family Medicine Unit of The University of Hong Kong. The transcriptions were confirmed by the authors who individually analysed the transcripts under different headings. These headings were then compared. Differences were discussed. All the authors had agreed on the headings as well as the selected opinions.

Results

The response rate was 27.7% (13/47). The 13 trainers whō attended the sessions were from 12 centres. One worked in a government centre, one in academic family medicine, two in university primary care clinics and nine private practitioners as part-time consultants in HA training centres.

i. The role of a trainer

The trainers were clear about their role:

"The trainer-trainee relationship is like that of an apprenticeship".

"The trainer is like a "See Fu" (master)".

"The trainer is a role model".

"A trainer teaches what family medicine is about. He teaches concepts as well".

"A trainer teaches a trainee to pass the College Conjoint Fellowship Examination".

"A trainer has three main duties: (a) to help the trainee pass his exams, (b) to build up the trainee to be a good doctor, (c) to see that he does not get into trouble in his work".

"The trainer should share a vision with his trainee".

They did not see their role as a static one:

"The trainer has different roles for different trainees".

"Different trainees have different demands and expectations".

"There should be a learning contract with the trainee on what to learn".

They were unsure on how to do their job:

"There are no guidelines from the College on what to teach and how to teach".

"The Trainee's Handbook is too wide in scope and not possible to cover in all".

"The College should have a standard process on training".

"There are no guidelines from HA on what trainers do".

Some questioned the aim of training:

"What is the College's priority? To pass more Fellows?"

The trainers would like to have training on how to train:

"The standard of teaching is variable and the level of teaching can be standardised".

"There is no reason why we cannot have an annual workshop for the trainers".

ii. A trainer vs a supervisor

The trainers saw a difference between a trainer and a supervisor though some felt that there was an overlap in their functions:

"A supervisor determines how a practice is run. He has an administrative function".

"A supervisor has less contact with the trainees".

"A trainer has no say on the running of the HA clinic".

iii. Sit-in sessions

The trainers had similar concepts about sit-in sessions:

"The foremost function is to observe".

"The role is to assess, intervene, interact, discuss, plan and give feedback".

"Some newly starting C1 trainees think sit-ins are a luxury and a waste of time, but for them sit-ins are very useful for assessment".

They saw the limitations of sit-in sessions as a teaching method:

"If you rely totally on sitting-in, the value is not great".

"There is an ethical dilemma with sit-ins because you can make the trainee look incompetent in front of the patient".

"I do not do sit-ins because I think I am interrupting the trainee. I prefer one-way mirror or video-tape

observation. However, sit-ins are useful in the beginning of training".

The trainers had views about the frequency of sit-in sessions:

"The frequency of sit-in sessions would depend on what stage the trainee has reached".

"I spend one-third of training time sitting in, one-third with the trainee and one-third with a small group of trainees".

iv. Other training methods

All trainers agreed that there should be other training methods as well:

"Discussions have more value than sit-in sessions".

"There should be lectures, small group discussions and video taping".

"Trainers should cross over and change their trainees".

"You may have to use different methods at different stages of a trainee's training".

They saw the obstacles in using other training methods:

"It depends on the flexibility of Hospital Authority on trainees' service hours".

"You may have to ask trainees to stay behind after work or make extra time, like Saturday afternoons".

"If you put service first, then you have to compromise a lot. Maybe that is what HA limits us to do (sit-ins)".

"If training time is flexible, the trainee can come to the trainer's clinic to observe".

v. Difficulties encountered during training

All trainers experienced some difficulties during training. Trainees had too much to do:

"The service element is too heavy. Trainees see too many cases".

"There should be a message for HA. When there is a trainer, the trainee should not have so large a volume of cases".

Training centres posed hurdles to training:

"The computer gets in the way. The trainee spends a lot of time entering data and little time interacting with the patient".

"Some basic investigative resources are limited at GOPCs".

"Coping with limited resources can be a learning opportunity".

"The set-up at out-patient clinics makes it not possible for trainees to follow-up their own patients".

"Anticipatory care is a problem. Staff grumble if you do too much".

There was too much to teach:

"You don't have enough time to finish everything in the syllabus/logbook".

There was no effective channel of communication:

"The cluster co-ordinators should have more contact with the trainers".

"I think there should be more feedback, more co-ordination among HA, College and the trainers".

"Our grievances stop at the cluster co-ordinator level".

"The cluster co-ordinators are HA co-ordinators, but they are also HA employees and function as administrators. There is a conflict of roles".

Some trainers would like to see changes, yet felt powerless:

"The College should have a training co-ordinator, to whom the trainers are answerable. This person co-ordinates among HA, trainers and trainees to ensure quality and standards".

"Family medicine occupies a low priority among HA. There is little input in the clusters. That is the

difficulty. The College cannot intervene in the management because that is HA's business".

"I feel HA has already made many concessions to the College, but I would like to see more feedback and co-ordination on how to train".

vi. Difficulties with trainees

Some trainers experienced difficulties with their trainees:

"There is the personality problem, unwilling to accept advice".

"Some trainees are "sloppy", lazy, unmotivated and reluctant to learn. It is most painful to meet them everyday".

"Our trainees lack interest in research".

"I had a trainee who said he hated having someone sitting behind him when he worked".

Discussion

The response rate of 27.7% was lower than anticipated. The opinions expressed may not be construed as representative of the majority of trainers but still they offer a snapshot view of how the vocational training programme was perceived. This may be considered as one limitation of the study. There may have been a number of reasons for trainers not responding, such as lack of interest in the survey, lack of time to participate, having nothing to say, concern about conflict of roles and speaking out.

The trainers recognised and, at the same time, acknowledged the differences and similarities in the roles of a supervisor and a trainer. However, as some supervisors were also trainers, a conflict of roles existed which might affect the effectiveness and quality of training. It is interesting to note that some trainers felt that supervisors spent less time with their trainees, a consequence of the supervisors' administrative functions.

The trainers were generally clear about their functions, i.e. to teach family medicine, be a role model and keep the trainees out of trouble. Some took a holistic view and guided trainees to become better persons. However, a minority of trainers felt that getting trainees to pass examinations was a very important part of their job. It is debatable whether vocational training programmes exist purely to produce examination competent candidates, but any discussion cannot escape the notion that examinations serve as a test of the quality of the training. However, some established family physicians pass examinations without having gone through a vocational training programme, so the argument must be that vocational training should focus on producing doctors competent to practise in their community. Competence is then translated into success in examinations.

The trainers felt unsure about the scope of their work. They looked for guidelines from the College on what to teach and how to teach. Furthermore, they felt that they were left to their own devices to cope within the constraints of HA in terms of limited resources and the paucity of protected teaching time. They felt unhappy about the lack of channels to convey their concerns and grievances. In this respect, there is much the College can do by improving co-ordination between College and the trainers, providing training for trainers in the form of trainers workshops and producing a trainers handbook. It is useful if the College can enter into discussion with HA to improve trainees' service conditions so as to maximise their learning opportunities.

Training was largely limited to sit-in sessions, no doubt a consequence of limited teaching time. These sessions are not effective in the long run and cannot be relied upon as the mainstay of training. The College can do much by exploring other methods of training with HA within the constraints which HA experiences.

The Handbook on Vocational Training in Family Medicine,[3] a College publication, lists the syllabus to be covered in training. While this syllabus is covered in structured seminars which are mandatory for trainees to attend, trainers cannot expect to cover the same individually with their trainees. Such duplication will not be cost-effective. What trainers can do is to supplement the information given therein. The onus is hence on the supervisors to arrange seminars which are educationally stimulating and effective.

The vocational training programme at present seems to be disjointed in delivery, at least to the trainers surveyed. The College sets the requirements and the

Key messages

1. Trainers in the community-based segment of the College vocational training programme were unsure about what to teach and how to teach. They would like to see guidelines from the College and Hospital Authority (HA) which provides the most training posts.
2. They would like to make use of more training methods, relying less on sit-in sessions and hope to see flexibility in the trainees' service conditions.
3. To maximise training opportunities, trainers would also like to see more resources at training centres.
4. The trainers felt that their comments and suggestions could not reach policy makers. For better communication among themselves, the College and HA, they looked for a training co-ordinator.
5. All trainers saw the benefit of an annual trainers workshop.

content, and collaborates with HA (mainly) in its delivery while having little influence on how it is delivered. The full benefit of the programme is hence compromised because of various factors. However, it has to be recognised that the College vocational training programme has grown into maturity in the last 18 years. What has been achieved is a valuable and solid foundation upon which to refine and expand. It will rank as one of the most important medical training programmes in Hong Kong.

In summary, the trainers wished to have explicit definition of their role and description of teaching content and methods. While eager to teach, they did not find enough facilities and time for interaction with their trainees. They also felt that their suggestions and opinions had not been heard. It was their unanimous opinion that (a) better co-ordination and communication among trainers, the College and training organisations, and (b) training for trainers were required. A possible future study is to develop a questionnaire based on the findings of this project to survey all trainers.

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