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**THE DENTAL VOCATIONAL
TRAINING EXPERIENCE:
A TRANSITION FROM NOVICE DENTIST TO
COMPETENT PRACTITIONER**

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DOCTOR OF EDUCATION (Ed D)

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ABSTRACT

Immediate postgraduate dental training is compulsory. To practise within the General Dental Services (GDS) the newly qualified must undertake a twelve-month period of vocational training (VT) as a Vocational Dental Practitioner (VDP) in an appropriate training practice under the immediate supervision of a vocational trainer. VT advisors manage schemes of 12 practices and arrange 30 VDP Study Days. This is a crucial period of transition for the new graduate. There is little evidence to support Seward's claim (2000) that VT has been the profession's success story, particularly in terms of patient care or educational worth.

Taking an interpretive approach the aim of this study was to provide an insight into the educational value of VT and provide answers to the following:

- How is a typical trainer/VDP partnership manifest?**
- What if the partnership is not successful? Are there unforeseen consequences of VT?**
- Is the selection process successful?**
- What is the influence of trainer expertise?**

The participants were two successive cohorts of 13 and 22 GKT Dental Institute graduates and their trainers. I established success criteria for defined aspects of VT; evidence was then sought to determine if the criteria had been met. I interviewed the VDPs and trainers at six months and again at year-end.

An account of the most likely or typical experience and an example of failure to successfully implement VT form the core of this thesis.

Asian women appeared to have difficulty securing a VT place, but they wanted to remain in the South East where competition for VT places is fierce.

VT is a success story. Stated aims were achieved; with very few exceptions VT produced practitioners capable of independent practice. Novice dentists became competent practitioners.

Progression in VT is a complex issue. As an expansion of the models of Eraut (1994) and Dreyfus and Dreyfus (1986), VT advances a relational model of progression. Trainers have developed a well-grounded notion of VDP progression, but they are themselves, in parallel, undergoing their own skills progression. One cannot be considered without the other.

This study suggests VT could be better. The Professional Development Portfolio was not valued despite its potential. Training expertise seeped away from VT and was lost forever. Rested expert trainers could/want to act as mentors for less expert colleagues. That said VT as a 'community of practice' (Lave and Wenger, 1991) provided a supportive and effective environment for VDPs and trainers to develop professional practice.

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GLOSSARY OF TERMS AND ABBREVIATIONS

Associate	A post vocational training, general dental practitioner.
BDS	Batchelor of Dental Surgery. The qualifying degree of dentists in the UK.
BDA	British Dental Association. The educational and professional support organisation for UK dentists. The dentists' 'union.'
BDJ	British Dental Journal. The Journal of the British Dental Association. A widely read refereed dental journal.
CPD	Continuing Professional Development. Verifiable evidence of continuing professional development is mandatory for all dentists practising in the UK.
CVT	The Committee on Vocational Training for England and Wales. The official monitoring body of vocational training up until March 31 2003.
DVTA	The Dental Vocational Training Authority. This organisation is responsible for issuing vocational training numbers. A practitioner cannot practise in the General Dental Services without a vocational training number. From April 1 2003, the DVTA also has responsibility for the roles previously undertaken by the CVT.
Endo	Endodontic Dental Treatment.
GDC	General Dental Council. The governing body of the dental profession. A dentist cannot practise in the UK without having his/her name placed on the Dentists' Register.
GDS	General Dental Services. National Health Service Dentistry.
GKT	The Guy's, King's and St Thomas' Dental Institute, London.
HA	Health Authority.
KM	Knowledge Management.
MFDS	The Diploma of Membership of the Faculty of Dental Surgery of one of the Royal Colleges. The dental postgraduate qualification that is essential for those who wish to pursue an academic or hospital career.
MFGDP	The Diploma of Membership of the Faculty of General Dental Practitioners of one of the Royal Colleges. A practice based postgraduate qualification.

MGDS	The Diploma of Membership in General Dental Surgery of one of the Royal Colleges. A practice based postgraduate qualification.
MOS	Minor Oral Surgery. A term that includes the whole range of surgical procedures from simple extractions to the surgical removal of buried roots and impacted third molars.
NHS	The National Health Service.
PCT	Primary Care Trust.
PCD	Professions Complimentary to Dentistry. The members of the dental team working under the direction or prescription of a dentist. These are the dental nurse, hygienist, dental therapist and dental technician.
Portfolio	The Professional Development Portfolio. A reflective log and the primary assessment tool in vocational training in England and Wales.
Prosthetics	In vocational training, complete and partial dentures.
UCCA	University Central Council for Admissions, now UCAS.
Regional Advisor	Usually a Vocational Training Advisor. He/she manages each of the schemes in a vocational training region.
Scheme	A unit of twelve vocational trainers and their vocational dental practitioners, managed by a vocational training advisor.
Study Day	The day release formal teaching component of vocational training, managed by the vocational training scheme advisor.
VDP	Vocational Dental Practitioner. The graduate undertaking vocational training.
VT	Vocational Training. The twelve-month period of immediate postgraduate dental education. VT is compulsory for those wishing to practise within the General Dental Services.
VT Advisor	The Vocational Training Advisor manages a 'scheme' of twelve vocational trainers and vocational dental practitioners. He/she is usually a vocational trainer, but not on the same scheme.
Vocational Trainer	The dental practitioner charged with the education of of the vocational dental practitioner at the general practice level.

1 DENTAL VOCTIONAL TRAINING IN ENGLAND AND WALES: AN OVERVIEW

Some form of immediate post-qualification training is now compulsory for dental graduates. Most of the newly qualified will take the path to general practice. If they wish to practise within the General Dental Services (GDS) they must undertake a 12 month period of Vocational Training (VT) as a Vocational Dental Practitioner (VDP) in an 'appropriate' dental practice or community clinic under the immediate supervision of a Vocational Trainer. The Dental Defence Agency has a parallel arrangement for new graduates wishing to enter the armed forces. For those who intend to pursue a hospital or university career, it is not necessary to follow this path. However, because of the competition for hospital /university posts and recent changes to career pathways, virtually all graduates do their VT at some stage, even if a career in practice is not their preferred path.

VT pilot schemes started in 1977. VT was developed into a nationally funded scheme in 1988 and became mandatory in 1993. It is wholly funded by the GDS. The Dental Vocational Training Authority (DVTA) is the central statutory body that adjudicates applications for VT numbers from dentists who are applying to join a Health Authority (HA) or Primary Care Trust (PCT). Dentists cannot be included on an HA/PCT list until they have a VT number. The Committee on Vocational Training for England and Wales (CVT) was the central non-statutory body that until April 2003 managed and monitored VT. It has now been merged with the DVTA. It was however the managing organisation for VT personnel throughout the period of this study. The aims and objectives of VT as presented by the DVTA (2003) are presented in Fig 1.1.

There are around 750 training places nation-wide. Administratively, VT is divided into 15 regional deaneries. A regional advisor co-ordinates and monitors each of the schemes in that region. Each scheme which consists of 12 training practices is organised and similarly monitored by a VT advisor.

Fig 1.1

The Aims and Objectives of Vocational Training

Aims:

To enhance clinical and administrative competence and promote high standards through relevant postgraduate training to meet the needs of unsupervised general dental practice and in particular:

- a) To enable trainees to practise and improve their skills
- b) To introduce trainees to all aspects of general dental practice
- c) To identify a trainee's personal strengths and weaknesses and balance them through a planned programme of training
- d) To promote oral health of, and quality dental care for patients
- e) To develop further and implement peer and self review, and promote awareness of the need for professional education, training and audit as a continuous process

Objectives:

To enable the trainee to:

- a) Make competent and confident professional decisions including decisions for referrals to other services
- b) To demonstrate that s/he is working within the guidelines regarding the ethics and confidentiality of general dental practice
- c) To implement regulations and guidelines for the delivery of safe practice
- d) To know how to obtain appropriate advice on, and practical experience of, legal and financial aspects of practice
- e) To demonstrate that s/he has acquired skill and knowledge in the psychology and care of patients and can work successfully as a member of the practice team
- f) To demonstrate the necessary knowledge and skills to organise and manage a practice (dvta.org.uk/aims 2003)

The schemes can effectively be viewed as the functional units of VT. The regional advisor is usually one of the senior VT advisors in that region. Until very recently, the CVT was committed to provide enough training places for all new graduates. Recently there have been suggestions that there are now occasions when there are insufficient VT places for the new graduates.

Trainer selection

The CVT produces a person specification for trainers; this is presented as essential and ideal attributes. Significant for the purposes of this study are the following points:

20% of notional annual target gross income must come from the GDS. The dentist who supervises the VDP must have been a general dental practitioner for at least four years and he/she must be able to prove a commitment to postgraduate education, ideally by the possession of a relevant postgraduate qualification. Selection is by competitive interview with an accompanying practice visit to ensure all aspects of the practice are appropriate for VT training. The trainer is acting in lieu of the university teacher. He/she closely monitors the clinical management of the VDP's patients.

The Study Day course

The VDP has to attend a scheme course of Study Days. These provide the formal educational component of VT and they are designed to complement the practice teaching. These are usually held at a postgraduate centre within that scheme's region. VDPs are required to attend 30 Study Days, usually one a week. The year is divided into three terms that can be of variable length. Many advisors load the front of the year; this results in a short final term. As well as an opportunity for formal teaching on all aspects of general dental practice, the Study Days are seen as an opportunity for VDPs to get together, share experiences and learn from each other.

Trainers are expected to attend 14 of the study sessions during the year. They also have trainer meetings. These are considered to be of paramount importance and they are arranged and facilitated by the advisor. The aim of these sessions is to monitor and review progress through the training year. These are normally held once each term. These meetings provide a

supportive framework for trainers, an opportunity to exchange views and ideas, help plan future course content and review feedback on VDP progress and curriculum content (Rattan, 2002).

The practice tutorial

As well as managing practice aspects of the VDPs professional development, the trainer is expected to devote at least one hour each week to tutorial tuition and the VDP keeps a record of these discussions in the Professional Development Portfolio (Portfolio). The tutorial must take place during the working day and in protected time. This requirement remains in force for the entire duration of the training year. The aims of the session are as follows (Rattan, 2002):

- to discuss specific case histories and treatment planning issues
- to solve problems that may have arisen
- to impart knowledge about the rationale for treatment techniques
- to learn about practice management and related subjects
- to develop existing skills and acquire new ones
- to support the VDP in his/her personal and professional development (p 61).

The tutorial is seen as backbone of in-practice teaching.

The Professional Development Portfolio

This is the primary assessment tool in VT. The Portfolio grew out of and superseded the VT Record Book that was used in the early days of VT to monitor progress. Rattan (2002) notes that the Portfolio reflects the shift in postgraduate education towards outcome based assessments and this process of ongoing monitoring of VDP performance has the following features:

- It takes place during the learning process
- It takes place in real-life everyday conditions
- It is used to help the learner and the learning process
- It enables trainers to use any planned learning experience (in tutorials for example) to assess achievements and progress (p 101).

2 BACKGROUND TO PRESENT STUDY

VT is a relatively new initiative. It isn't perfect. It continues to develop and there are issues in VT that need to be addressed. VT grew out of a profession-wide concern to provide a period of transition between student and professional life. Levine (1992), working when VT was still optional, considered that this cushioned period of transitional education was essential for those entering general practice. Although VT takes place post qualification and the graduates receive an income, this process is so much more than a period of sheltered employment.

Dental schools have no influence over VDP placements. Graduates apply for VT positions as they would full time employment; the trainer is free to choose whomever he/she wants. In fact, some trainers see themselves as employers rather than teachers (Cabot and Radford, 1999), despite the fact that they receive a training grant. The trainers often further blur the education-employment distinction, as it appears that rather than consider VT as a fixed period of involvement with the VDP, some use the VT scheme as a way of finding someone that they want to keep on in the practice, post VT. That said, fewer VDPs appear to be staying on in the last few years. An advisor colleague suggested this was perhaps due to changes in career pathways for new graduates beyond VT. In the South East, VT is vastly oversubscribed. Many trainers receive in excess of 100 applications.

Dating from the same period as Levine's pre-compulsory VT work, we have the personal accounts of D'Cruz. He has eloquently chronicled his experiences at the time of qualification, with finals and the traumas of the VT interviews (D'Cruz, 1991a) and the continuing problems he faced trying to get used to a very different learning regime in those first few months post qualification (D'Cruz, 1991b). However, it must be remembered that then VT was optional; associate positions were waiting for those who didn't secure a VT place.

Isaacs (1997) highlighted what is an ongoing concern regarding the over-subscription of VT, yet he suggested that VT seems to work well. However

we only have the anecdotal evidence of those running VT to support that statement, although the mandatory practice inspections are likely to maintain a defined level of quality in participating practices. Isaacs also pointed out that although (at that time) there were enough VT places for graduates, the movement necessary to find a place could be very significant.

The gender and racial profile of dental graduates has changed dramatically in recent years. Once a profession overwhelmingly populated by men, now few, if any schools have less than a 50% female intake. In our School, The Guy's, King's, and St Thomas' Dental Institute (GKT), 60% of the intake is female and more than 80% have an ethnic minority background, the vast majority being South Asian. However, this is in line with Siraj-Blatchford's analysis of UCCA admissions as long ago as 1995, which revealed that in higher education subjects are highly racialized, and that 16% of all South Asian students who apply for university courses seek to enter medicine and dentistry, compared to 4% of all ethnic majority students.

Gender and race may well be significant issues in the VDP selection process. Bartlett et al (1997) reported that VDPs considered that gender and race influenced London-based trainers when awarding a VT position. This questionnaire-based study tended to ask leading questions of its participants, so these conclusions must be interpreted with care. That said, if trainers are ignoring advice on interviewing, it is not unreasonable to surmise that other aspects of VT policy might be ignored or re-interpreted.

We do not know if race and gender were influencing the VDP movement witnessed by Isaacs as he was not considering these issues at that time, but Bartlett and Woolford (2000) have again criticized the management of the selection process, highlighting issues of sexism and racism. I am unsure of the status of their comments, but anecdote does suggest that Asian women encounter difficulty finding a VT placement.

Anees et al (2001) commented specifically on the 1997 Bartlett study noting that neither the extent nor the nature of the disadvantage was investigated. They therefore explored perceived and experienced disadvantage in the same

region. It was their conclusion that the perception of disadvantage is greater than the reality within the experience of most trainees (VDPs).

There is also a perception from trainers and VT advisors that Asian women are reluctant to apply for VT places distant from their homes:

With the fierce competition for places in the South East, if Asian women don't get a job, what can they expect?

(personal communication, senior Asian male VT Regional advisor).

Anecdotal evidence suggests that most of our Asian female students want to stay in the South East, as do the majority of our students regardless of race or gender. Certainly, those who immediately apply to the provincial VT schemes are far more likely to be successful in securing a place, but with fewer applicants, the chance of success is higher for everyone, or it should be.

The relationship between university teachers and dentists in NHS practice is sometimes uneasy. There has been gathering, again anecdotal evidence from trainers that, graduates are not as good as they used to be (Grace, 1998). As a teacher this concerns me, as does the rather haphazard manner in which these uncorroborated allegations regarding the newly qualifieds' competence have been delivered. And it appears that some trainers see themselves less as teachers and more as consumers of dental schools. For example, in response to the submission of a paper discussing this issue (Cabot and Radford, 1999), one of the referees (herself a trainer) suggested that:

It is not the position of trainers to teach, and dental schools should not graduate the incompetent! (personal communication).

Comments such as this, and that of Grace (1998) seem symptomatic of a system of transitional education that is anything but the seamless process it could and should be. Gareth Morgan (1989) stresses the need for leaders to

provide an overarching sense of vision and to communicate that vision in an actionable form. It would seem appropriate for teachers, advisors and trainers to develop a shared vision concerning the role of VT in dental education.

This is the crucial period of transition for the new graduate. At present there is little evidence to support Seward's claim (2000) that VT has been the profession's success story. Indeed, Baldwin et al (1998) commented:

It is remarkable that no formal independent assessment of the value of VT [has ever been] carried out in terms of educational worth or... patient care (p 591).

The research questions

It is important, in fact essential to be able to appreciate what is actually going on in VT. Aspinwall et al (1997) pick up this very point and stress that it is essential to the question, how are we doing? (p 54).

Is VT achieving what it sets out to achieve? The General Dental Council (GDC), universities and VT personnel must have access to this information. Programmes of continuing professional development must be appropriate. VT aims to transform the novice dentist into a competent practitioner, but VT is a profound change for the new VDP. The expanded and overt environment of the university, and the compact, perhaps clandestine world of general practice are very different learning environments. Does it work?

VT policy must be appropriate, but the CVT website (discontinued as of April 2003) presented policy in quite general terms. The Trainers' Handbook (Rattan, 1994) and the more recent Handbook for Trainers (Rattan, 2002) are more prescriptive, but even with the trainer training days, policy is bound to be open to varied interpretation by those charged with the care of the new graduate. If there is an 'implementation gap' concerning aspects of intended policy, it is important to determine why this is the case and identify any unforeseen consequences of this. Individual trainers for example, are bound to have differing views and opinions as to how they should fulfil their role in the professional development of their VDPs.

Essentially the aim of this study is to address these concerns and in particular those of Baldwin et al (1998) and provide an independent assessment of at least some aspects of the management and educational worth of VT. The VT experience for both VDP and trainer must be laid bare. The following questions must be addressed:

- How is a typical trainer/VDP partnership set forth?
- What if the partnership is not successful?
- Are there unforeseen consequences of VT?
- Is the selection process successful?
- In this one to one teaching environment, what is the influence of the experience/expertise of the trainer?
- Is it possible to put together a pro-forma setting out attributes of the trainer and/or VDP performance that point to a successful outcome? Such guidance could be most valuable for VDP and trainer alike.

3 A CONSIDERATION OF THE LITERATURE

Professional knowledge and competence

The development of professional knowledge and competence in the GDS is perhaps VT's reason to be. The problem is to determine how this can be achieved. Ryle (1963) distinguished 'knowing how' and 'knowing that' and he suggested that in normal everyday life, we are more concerned with people's competences than their cognitive repertoires. In this, Jarvis (1997) maintains, Ryle was aiming his attack on the emphasis on cognitive knowledge. He further maintains that Ryle implies that 'knowing how' and 'being able to' are synonymous, which is incorrect. My own reading of Ryle does not support this conclusion. However Ryle is clear with his statement that when people perform an action they cannot always articulate the theory underlying that action. Nyri (1988) suggests that through continuous experimentation new knowledge is gradually absorbed from experience which might never have been articulated. Practical knowledge is therefore 'hidden in the practitioner,' or in Polanyi's words (1967), it has become 'tacit knowledge,' it cannot be expressed in words.

Jarvis (1997) sees practical knowledge as having two dimensions, knowledge how and tacit knowledge and posits that there are two processes of acquiring tacit knowledge, forgetting it and learning it. The former is that process stressed by Ryle; as expertise is developed, original rules tend to be forgotten. The latter is the learning from experience without being conscious of the learning that is occurring, what Marsick and Watkins (1990) call incidental learning. Dreyfus and Dreyfus (1986) trace five stages in the transition from novice to expert. Jarvis points out, that this seems to be a natural progression, but if it were, every practitioner would, given sufficient time, become expert. This is obviously not the case, people do not always learn from experience. In the words of a retired colleague:

You can get very good at getting it wrong.

Those who are expert have gained knowledge how and tacit knowledge from their practice. Jarvis maintains that only those who are in practice can be

expert, leave that practice and it is not possible to enhance knowledge how, nor specifically tacit knowledge. To understand something you must do it.

Eraut (1994) distinguishes two basic forms of knowledge relevant to professional practice. Public propositional knowledge, is necessarily explicit and is transmitted openly. Personal knowledge can be explicit or tacit. If it is possible to articulate what is known, then this is personal propositional knowledge. When a person is not fully aware of what they know, the knowledge is tacit. This echoes Ryle and his comment that rules are forgotten. Much of what is termed skilled or professional behaviour falls into this latter category. The crucial significance of tacit knowledge in professional practice is that it poses problems in learning how to perform skilfully. If the expert practitioner is him/herself not aware of how they are expert, as a teacher/trainer it will be difficult to pass this knowledge of how to practice on to the student/trainee. Tacit knowledge may well be *the* issue with this study. If trainers are going to succeed in teaching professional skills, they must themselves know how they are performing particular skills. They must be aware of the rules that they have forgotten. They must be able or enabled to make their tacit knowledge explicit.

Argyris and Schon (1974) noted how the divergence between comment and action persists when commentator and actor are the same person. They argue that professional actions are based on implicit 'theories in use' that are different from the 'espoused theories' used to explain these to external audiences, or even to the actor him/herself. They suggest that making these theories explicit and therefore open to criticism is the key to professional learning. The key here is the quest for good feedback, which may well be adverse. Good use must be made of it by being open to interpretations that challenge one's own assumptions.

Professional competence

Short (1984) argues that competence is a normative, not a descriptive concept. Before a person can be judged competent, there must be agreement on the scope of any statement of competence, what criteria will be used and what will be considered as sufficient evidence of that competence. However,

many professions do not effectively communicate their occupational standards. It can be difficult for those unfamiliar with often unwritten traditions of a profession to determine what newly qualified professionals are actually expected to be competent in, and the situations where the guidance of a senior will still be necessary. This is particularly relevant to VT. Those involved in dental education have differing ideas as to what new graduates should be capable of undertaking on qualification. Grace (1998) has presented evidence, based on conversations with trainers and experienced practitioners, that graduates are not competent in certain tasks. It must be remembered that VT was introduced to provide a sheltered introduction into professional life. Perhaps some of us recall our novice days with the aid of rose coloured spectacles. What does the trainer expect of the VDP on qualification? What should the trainer expect?

Criteria for assessment of competence

It may well be that we as a profession cannot agree on the levels of competence we expect on qualification, but what of assessment? The issue of assessment criteria is necessarily linked to that of standards. For Eraut (1994) assessment procedures start with the collection of evidence about performance and capability and an indication about the standards of competence about which judgements have to be made, cross referencing to indicate which pieces of evidence should be used for each distinct judgement of competence. Judgements of competence have to rest on separate decisions about each element of competence, taking into account all sources of evidence. Thus assessment criteria belong to the elements of competence, not to pieces of evidence. Even the most detailed criteria leave scope for variation and interpretation. Eraut suggests that it is easy for standards to slip if communication and training are not regularly maintained. Assessment criteria should be limited in number and easy to use. They should focus on areas where differences in interpretation are most likely to arise; they simply get in the way if they state the obvious. Vocational trainers are teaching and assessing the developing competence of VDPs. In England and Wales the primary assessment tool is the Portfolio that encourages reflective self-assessment. Trainers have limited guidance in the management of the Portfolio, and the degree to which this guidance is reinforced may vary

greatly from VT scheme to scheme. Therefore, quite apart from the conflict as to what competences should be in place on qualification, trainers are being asked to teach professional competences without necessarily being able to make their tacit knowledge explicit, and to assess that developing competence without the tools necessary for the task.

Qualified people must be competent to perform the roles undertaken by members of that profession. The final examination is the main assurance that we have, but no such end of VT assessment exists, nor is there any formal in-course assessment. The Portfolio must be completed, but essentially VT is time served. However trainers and advisors have an ethical obligation to report a VDP who is not considered safe to practice. In the context of continuity of learning there is the additional quality assurance provided by the organisation in which the professional starts his/her career. This can remediate weaknesses in the qualification system itself. The danger is when the newly-qualified is either self-employed or where there are barely competent or non-professional supervisors (Eraut, 1994). Baldwin et al (1998) noted that one third of 183 Scottish graduates stated that their trainers did not form a positive role model. Ralph et al (2000) similarly found that of 154 Leeds graduates, over 30% had difficulties with the team, in particular their trainers, who failed to provide support, encouragement or help. These studies may cast doubt on the ability of some trainers to provide quality assurance.

Eraut (1994) challenges the notion that time spent on further learning, after the assessment of competence, is wasted, as is often claimed by advocates of competency-based training. He has considerable problems with the competent/not competent binary concept. The formal training period should be considered as a learning contract with the following aims: ensure necessary minimum competences; take advantage beyond this of learning opportunities; be responsive to the qualities and preferences of individual learners. He further presents his model for progression during the period before and after qualification:

- Extending competence over a wide range of situations
- Becoming more independent of support

- Routinization of tasks
- Coping with a harder workload
- Becoming more competent in further activities
- Extending professional capability
- Improving the quality of some aspects of one's work

(p 218).

Here the critical issue is progression. Could this model act as a template to guide/ monitor progression through VT? Eraut is presenting a template that:

Offers an opportunity to work with an agreed model of progression which begins before qualification and continues after qualification and to develop habits of self-assessment, target setting and planned learning which are important in continuing professional development (p 218).

Binary systems of assessing competence do not allow for progression. If we want practitioners to develop professional practice; if we want to develop a generation who do not just accept continuing professional development, but demand it; we must look at progression, we must examine how practitioners develop clinical expertise. What are the attributes of expert?

In competence-based systems of education the implication is that underpinning knowledge can be acquired independently from the contexts of professional practice (Miller 1988). Competent professionals integrate separate strands and there is no reason to assume that professional skills and knowledge develop concurrently. Wilson and Pirrie (1999) note Eraut's concerns over assessing competence on a binary rather than a progressive scale. Their respondents demonstrated that becoming competent did not happen at one point in time. For many the qualifying examination was seen as the beginning rather than the end of becoming a competent professional. That said, there are many who favour competence-based systems of assessment. Bullock et al (2002) for example, have put forward recommendations for competence-based assessment in postgraduate dental

education. It can be argued that the more transparent statement of standards that such systems provide is essential in the clinical environment.

In fact there are many in VT who would like to see a more formal assessment of competence along the lines of the Scottish model (Grieveson, 2002) as discussed on page 156. However reflective self-assessment centred on the Portfolio is the primary assessment method in England and Wales and I shall not consider the literature on competence-based systems of assessment any further at this point. That is, apart from being mindful that Oliver and Bourne (1998) suggest that there are challenges that need to be addressed when working with a competence-based assessment system. One lies in determining the mechanisms to assess the value base that informs ethical and reflective practice. The second is assessing a practitioner's ability to remain competent (Eraut's concept of capability). Both these are crucial to professional competence. In their assessment plan for post traumatic stress counsellors they seek evidence of the ability to reflect, critically evaluate and develop ongoing practice. This they maintain is more important than an unflawed demonstration of skill. They pick up on the point made by Eraut, and Wilson and Pirrie (1999), noting that the point at which someone becomes competent is not easily defined. These comments, and those of Miller, have implications for the assessment of VDPs in VT, particularly if trainers have a rigid notion of progression.

There are many models of skills progression and that of Dreyfus and Dreyfus (1986) mentioned earlier (page 18) is well known and would appear to be entirely appropriate in charting the progression of our VDPs. This model posits that as a practitioner develops a skill, he/she passes through five levels of proficiency. These are novice, advanced beginner, competent, proficient and expert. These changing levels reflect changes in three aspects of skilled performance. The first is a movement from relying on abstract principles to using past concrete experiences as paradigms. The second is a changing view in the practitioners' perception of the situation, which is seen less as a compilation of equally relevant parts and more as a complete whole in which only certain parts are relevant. The third is the passage from 'detached' observer to 'involved performer.' The performer is now engaged in the

situation (Manley and Garbett, 2000). The significant attributes of each level are outlined below:

Novice

Rigid adherence to taught rules; little situational perception; no discretionary judgement.

Advanced beginner

Guidelines for action based on attributes or aspects; situational perception still limited; all attributes and aspects are treated separately, with equal importance.

Competent

Coping with crowdedness; actions seen at least partially in terms of long-term goals; conscious deliberate planning; standardised and routinized tasks.

Proficient

Sees situations holistically, rather than in terms of aspects; sees what is most important in a situation; perceives deviations from normal patterns; decision making less laboured. Uses maxims for guidance, whose meaning varies according to the situation.

Expert

No longer relies on rules or guidelines; intuitive grasp of situations based on a deep tacit understanding; analytic approaches used only in novel situations or where problems occur; vision of what is possible.

(summary from Eraut 1994, p 124).

This model, as befits its philosophical underpinning, has an emphasis on learning from experience, but as Eraut points out, Dreyfus and Dreyfus do not really explain how this actually occurs. There are only occasional references to theoretical learning or the development of fluency on standard tasks. Identifying where a practitioner is on this model will therefore be difficult, but the attributes provide a clear path for progression. The strength of the Dreyfus model lies in the case it makes for tacit knowledge and intuition as critical features of professional expertise. I see significant

similarities in Eraut's and the Dreyfus and Dreyfus concept of professional expertise and with the earlier work of Ryle. The expert no longer relies on rules or guidelines; the rules are in fact forgotten. There is instead an intuitive grasp of situations based on a deep tacit understanding. Eraut's model of progression would appear to be particularly appropriate for VT and when assessing the data, I shall look for this pattern of progression. On the Dreyfus scale I suggest that VT should enable the VDPs to reach competent and perhaps by the end of the year some will be moving to proficient.

If I cannot specifically locate a VDP at a particular position on this scale of progression, it should be possible to identify attributes that suggest a particular stage of progression. The Competent VDPs should I suggest be able to cope with the stressful and pressurised world of general practice. They should be able to consciously plan. They can begin to use that plan to deal with the crowdedness that they experience and they now have a standardised approach to routine procedures. Towards the end of the year it could be that some will be beginning to develop a far less laboured decision making process. Indeed they should be able to rapidly identify problems and deviations from the norm.

If VDPs are approaching proficient, they will be taking a more holistic approach to their work and see what is important in a situation. From Dreyfus and Dreyfus (1986), we hear of the proficient practitioner:

Because of the performer's perspective, certain features will stand out as salient and others will recede into the background and be ignored. As events modify the salient features, plans, expectations and even the relative salience of features will gradually change. No detached choice or deliberation occurs. It just happens, apparently because the proficient performer has experienced similar situations in the past and memories of them trigger plans similar to those that worked in the past (p 28).

We must note that for the proficient practitioner there is still an analytical approach to decision making. The progression to expert requires that decision-making and indeed an understanding of the particular situation is intuitive. This perhaps takes longer to reach than any of the intermediate stages, if it is ever reached at all.

Returning to Dreyfus and Dreyfus:

The proficient performer, while intuitively organising and understanding his task, will still find himself thinking analytically about what to do. Elements that present themselves as important, thanks to the performer's experience will be assessed and combined by rule to produce decisions about how best to manipulate the environment (p 29).

But the expert has reached a completely different level. Most of the performance of the expert is automatic, and non-reflective:

An expert's skill has become so much a part of him that he need be no more aware of it than he is of his own body....
When things are proceeding normally, experts don't solve problems, and don't make decisions; they do what normally works (p 30).

The expert will only move out of this mode on the occasions that the task in hand is particularly difficult or critical, or because they have critically reflected on their own intuition and are reconsidering the initial action.

I feel the strength of this model, as with the guidance provided by Eraut (1994, p 218) is that the practitioner can identify the attributes that indicate developing expertise. It provides a path for the practitioner to follow on the road to expert. This, I suggest, is far more important than being able to place a practitioner at a certain point on the skills acquisition model. Throughout

this study I aim to identify the attributes of expertise and highlight these as a template to guide trainers and VDPs on their path to expertise.

Identifying expert practice is, in any event a difficult task. Manley and Garbett (2000) suggest that in selecting expert practitioners, two assumptions seem to be made: expertise can be recognised in others by colleagues and significant practical experience is required as a prerequisite for expertise. Both these assumptions can be challenged. These authors reveal that in an analysis of studies in which expert practitioners were selected, a range of criteria were used to identify expertise. These included identification by peers and/or senior colleagues, experience, educational attainment, personal qualities and status. They noted that there appeared to be little consistency between studies in the criteria that were employed and there were only a few examples of attempts, Conway (1996) is one, to account for the rationale behind the identification and/or selection of participants. Probably the most striking finding was that the identification of experts was not seen as being intrinsically problematic, although the obvious effort taken to select appropriate participants suggested that selection was an important issue.

Against this background, trainers and advisors are bound to value attributes of expertise differently. Perhaps for the consummate expert, the practitioner completely at ease with his/her professional practice, the disparate criteria considered above can locate this obvious expertise. But what of the vast majority of practitioners who are hopefully on a course to expert? Locating a position on the Dreyfus model will be very difficult, but the attributes at each stage have the potential to sign the path to expert very effectively. And for the observer, and indeed the practitioner, it is far easier to identify defined attributes than it is to know what form the whole should take.

Interestingly Benner (1984) avoids defining the expert clinical practitioner; she does however provide a comprehensive account of the term in the context of a nurse demonstrating her/his expertise in clinical practice. She describes the expert nurse in terms of the Dreyfus model. The expert nurse has an intuitive grasp of situations and immediately focuses on a problem without the wasteful consideration of a large range of unfruitful diagnoses

and solutions. In contrast, a competent or proficient nurse faced with a novel situation must rely on conscious deliberate analytical problem solving.

Benner et al (1996) have developed the earlier work on expert practice and describe the characteristics of the expert clinical practitioner. These are outlined below:

- Expert practice is characterised by increased intuitive links between seeing the salient issues in a situation and ways of responding to them
- The links between patient condition and action are sufficiently strong that the focus shifts to actions taken rather than problems recognised
- Practice is characterised by engaged practical reasoning, which relies on mature and practised understanding, and a perceptual grasp of distinctions and commonalities in particular situations
- Expert practitioners are open to whatever the situation presents
- Actions reflect an attunement to the situation in that they are shaped by patient responses and do not rely on conscious deliberation
- Performance is fluid and seamless
- Emotional involvement is matured to the extent that it varies according to the needs and openness of the patient and family
- Moral agency -a concern for responding to patients as persons, respecting their dignity, protecting their personhood in times of vulnerability, helping them feel safe, providing comfort and maintaining integrity in the relationship
(cited in Manley and Garbett, 2000, pp 352-353).

Manley and Garbett (2000) note that a key insight into identifying and judging expertise is that experts require facilitation to demonstrate their expertise and help them highlight the knowledge embedded in their practice:

It is not the 'know-that' that is difficult for experts to articulate, but the 'know-how,' practical knowledge used spontaneously which is tacit and intuitive (p 355).

Central to developing their recognition process of expertise, these authors consider the notion of critical companionship; a notion that seems to encapsulate the advice given to us on page 19 by Argyris and Schon (1974) for the development of professional practice. Through their relationship with practitioners, critical companions operationalize four core facilitation concepts: consciousness raising, problematization, self-reflection and critique. These concepts are achieved through the facilitation strategies of:

- Articulation of craft knowledge
- Observing, listening and questioning
- Feedback on performance
- High challenge/high support
- Critical dialogue (p 355).

Manley and Garbett stress that critical companionship is primarily a developmental process that can facilitate life-long learning at any level of practice. It enables continuous professional development. Additionally, it enables practitioners to provide the evidence necessary, not only to demonstrate their expertise in the practice of nursing but also for other purposes such as practice development, increased effectiveness and career progression.

The critical companion will enable the practitioners through the facilitation processes to critique their practice and build a Portfolio of evidence to include structured reflections, annotated observations and audiotaped evidence, together with evidence drawn from peers and colleagues in other professions.

The trainer and advisor are effectively acting as critical companions for the VDP, but the notion of the critical companion is just as appropriate in the context of enabling the expert trainer to make his/her expertise explicit. This

could well have a dramatic influence on a practitioner's professional development and individual progression.

Wilson and Pirrie (1999) explore how novice clinicians become part of a community of practice, the notion first proposed by Lave and Wenger (1991), Wilson and Pirrie suggest that learning from experience implies learning from colleagues. They warn that when working with experienced colleagues, close scrutiny of practice can lead to uncertainty and an increasing awareness of knowledge and skill deficiencies. The trainer, the critical companion must be aware of this; juniors must be comfortable asking for help/advice. Vision and models of good practice are the issues here and there are links with Peters and Waterman (1982) who identified that successful organisations develop a shared vision of that organisation's future. Where a strong sense of vision was evident Wilson and Pirrie's respondents (1999) noted increased confidence and inspiration to learn. 'Hands on' senior clinicians were an important element in creating that culture. These authors also confirmed the notion that professionals learn from others besides members of their own profession, e.g. junior doctors from experienced nurses. The notion that seniors can learn from juniors was much in evidence. Juniors bring recently acquired and up-to-date theoretical knowledge to the team, which is valued by their seniors. This sounds very positive but we have on page 21, evidence from Baldwin et al (1998) and Ralph et al (2000) that the VT experience may be very different.

Feedback is critical for reflection on practice. Wilson and Pirrie noted how this could take place, but specifically they commented that a number of junior staff claimed to know almost intuitively when things were going right or going wrong. Our own juniors echoed this. It is well known amongst VDPs that the barometer of performance is how well their nurse or practice manager behaves towards them. They ignore this often unspoken feedback at their peril.

The problem of selection in VT

We have seen that the acquisition of competence can be difficult to determine. We have also seen that the notion that competence is achieved at

a particular point in time is flawed. This makes the task of choosing the 'best' candidate difficult for a trainer. The guidance provided by the CVT, The Trainers' Handbook (Rattan, 1994) and the Handbook for Trainers, (Rattan, 2002) is clear and comprehensive, but are trainers following that advice? Are they basing decisions on valid selection evidence? Morgan (1989) analysed decisions made in interviews for head teachers. Five criteria dominated decisions: personality; experience; answers to questions; qualifications; appearance/presence. If personality and appearance are combined, they are after all aspects personality variously defined, this category accounted for 39% of all criteria used. It could therefore be argued that selection under these circumstances is more a test of social acceptance than future job performance.

More recently Morgan (1997) has presented a format for predicting effective performance. He states that job selection should be about evidence tied to occupational performance, past and expected. He presents four stages to link rational selection procedures to job performance. These are:

- There is a good and clear job description
- The job criteria or person specification... are known by the selectors
- There is planned provision for the assessment of the required competencies
- There is a clear policy on how the final decision is to be arrived at (p 157).

Morgan presents evidence for the weakness of the interview as a selection method. It gives the illusion of validity but has a very poor predictive record. He suggests it has poor reliability and studies comparing subsequent performance with interview success show very low correlation, so the interview has low validity. Other selection tools must be used with the interview to enhance this. In assessing latent ability, form/developed ability is not sufficient. It is essential to create task/job simulations.

If we look at the situation in which the trainer finds him/herself, this advice may be difficult to follow. Trainers will receive around 100 applications per

placement. CV templates are available that VDPs are encouraged to follow. A trainer who guided me in the early stages of this study suggested that this resulted in 'clone' CVs. If trainers assume that on task competence is provided by the dental degree, then personality/interests or 'something different' in the CV can become attracting features. Furthermore, training practices are usually quite small; fitting in, being part of the family, the community of practice, may well be considered more important than a demonstration of competence. If the VT interview process is less than satisfactory (Bartlett et al 1997), then there is a need to determine if trainers are following selection policy, and if not, why not?

It is essential to identify how VDPs view success in their search for a placement. This is a difficult area; each potential VDP will assign different criteria in their assessment of success. Weitz (1961) has pointed out that the choice of criteria has a major effect on the results attributed to predictors. The primary intuitive criterion for search success is who has found a job. Rosenfield (1975) presents the alternative of determining a fixed point in time for job finders to have found a position. Implicit in this is the notion that all employed persons are equally successful in having a job by a certain time. Brasher and Chen (1999) suggest that this is not tenable as job quality is not considered. For a number of reasons job seekers may accept a less than desirable job in a very brief period of time. Search duration as suggested by Dyer (1973) does not take job quality into account. Granovetter (1974) suggests that in general employees will be more satisfied with a better job. In VT a better job could include features such as preferred practice location or facilities provided within the practice.

Stumpf et al (1984) have used the number of interviews achieved as a success criterion; job offers have been used by Steffy et al (1989). The assumption here is that all job seekers aim to maximize their interviews and offers, although Steffy et al suggest that some may focus on a narrow range of jobs in a particular locale. In VT, students frequently limit the search area and try to maximize the interviews/offers in that area, and that area for our students is the South East. Brasher and Chen (1999) simultaneously analysed nine separate criteria. Many of the presumably relevant criteria for success

were not significantly related to each another, and where there were significant correlations the magnitudes were small. They concluded that job search success is a complex and multi-dimensional construct. Focusing on a narrow range of variables will only capture part of the picture. They suggest that, rather than emphasising a set of criteria at a certain point in time, more attention should be paid to the process of search success. In the context of VT this would appear to be entirely appropriate; the analysis of process could be based around a framework of applications, interviews obtained, offers forthcoming and the preferred location to undertake VT. This framework will form the basis of the job-search supporting questionnaire.

Defining effectiveness in VT

VT policy is presented as statements of how VT is expected to take place and how the trainers and VDPs are expected to conduct themselves. Implicit in this policy guidance is the notion that for VT to be effective, policy must be faithfully implemented. This begs the question, how does an effective implementation of VT policy manifest itself? Or what are the characteristics of an effective training practice? The assumption that faithful implementation of policy will result in an effective practice is a notion which may itself be flawed.

Scott (1997) reminds us that in the examination of effectiveness there is a challenge to the notion that organizations exhibit a unified or consistent set of performances. Varying goals will be held by different participating groups. There are many different bases from which the generation of criteria for effectiveness can be made, and many different value positions from which the criteria can be generated. Different groups may well have difficulty agreeing on a basic definition of effectiveness. This point is particularly relevant. I am aware that my values result in a particular view of an effective training practice that may be at variance with the views of the practice trainers. I suggested on page 16 that trainers may well have varying views on what an effective training practice is. In this context, effectiveness is intimately linked to trainer expectation of VDP performance. So the question is, effective for whom?

Measuring effectiveness

Bennett et al (1996) suggest that effectiveness refers to the degree to which educational means and processes result in the attainment of educational goals and outcomes or the transition of Inputs, by means of Processes, into Outputs. Like Eraut (1994), Scott (1997) highlights the importance of criteria generation as an essential dimension of measuring organisational effectiveness. For an evaluation of performance to occur, criteria must be selected, standards set, the work sampled and a decision made on which indicators to employ. Sample values must then be compared with selected standards. Selecting the criteria is of course critical. Scott suggests that outcomes are the quintessential indicators of effectiveness. Yet we have been instructed by Simon (1957) to view even simple output goals as complex and multi-faceted. From Schuman (1967), we have a definition of process indicators:

[They] represent an assessment of input or energy regardless of output. It is intended to answer the question, what did you do? And not, how well did you do it? (p 61).

Process measures assess effort rather than effect. There are difficulties with process measures; for example, observations of performance are expensive and reactive. Routine inspection of work can be difficult to achieve, workers can create barriers and self-reports can be biased or incomplete. In VT I must determine whether or not the typical is effective. I am likely to focus on process indicators. However, to make sensible use of process indicators, there must be a robust model of organisational effectiveness (Scott, 1997), i.e. if we do 'this' well the organization will be effective. In fact questioning organizational effectiveness suggests a comparison against a predetermined set of standards.

Aspinwall et al (1997) suggest that good professionals are invariably looking for evidence of success and indicators of their level of performance. Like Scott, they maintain that asking how are we doing, implies:

A need for clarity about what we are trying to achieve and about how we shall know whether we have achieved it (p 52).

They likewise see evaluation as comparative. In their design of success criteria and indicators, gathered information will incorporate ideas about the standards or criteria against which performance is judged, and about the kinds of information that represent evidence of success or otherwise in achieving these standards. They maintain that the development of success criteria need not necessarily be a complex task, but for maximum benefit they must be developed in a systematic way. These elements are as follows:

- Identification of performance areas, with one or more focusing questions for each
- Identification of a number of success criteria for each area
- Determination of the kinds of data which need to be collected and analysed to present evidence in relation to those chosen criteria
- Determination of the basis on which the level of performance is to be judged (the basis for comparison)
- Consideration of any particular circumstances which may need to be taken into account when interpreting performance (p 59).

At this stage conclusions should be emerging. The gathered data must be relevant. There must be an adequate response; it must be valid and reliable. This model would appear to be entirely appropriate for the development of success criteria in VT.

If performance information is to be of value it must be attention-directing and it must be supplemented by processes which ensure a problem-solving approach to identified areas of concern. Aspinwall et al (1997) have us remember that this philosophy is not a cosy one. It challenges and it may threaten. It is essential therefore to consider the behavioural implications of

information management. Echoing Eraut (1994), they suggest performance criteria must be simple and clear. The best success criteria are those developed in partnership with those who work in the area where the performance is to be assessed, or who have an interest in that area. It is essential that all stakeholders have a shared understanding about the kinds of information being gathered and the purposes for which it will be used. It is highly desirable that success indicators are viewed from a development perspective. They must be kept under review and modified where and when appropriate. Herein there are lessons for this work, not only in the design of the success criteria, but also in how to manage the information and those participating.

Elliott (1990) has issued warnings regarding the use of performance indicators. He questions the idea that skills can be specified as a set of standardised techniques irrespective of the context and the persons displaying those skills. He maintains that the notion of performance indicators is one that cannot accommodate the personal and the idiosyncratic aspects of human performance. While many may disagree with Elliott, it seems to me that it is crucial to take on board his concerns and devise indicators that allow for them.

The Review of Vocational Training in Dentistry for the Chief Dental Officers, England and Wales (2002)

In an attempt to answer the very question 'How are we doing?' posed by Aspinwall et al (1997), in January 2001 a review of VT was commissioned by the CVT (2002):

In order to take stock of VT in the light of change occurring in education, healthcare and public accountability within today's society (p 4).

It describes research, discussion and consultation about the future needs of the dental service, which were carried out by external researchers and internal committees with a view to driving up standards, improving patient care and providing increased accountability.

The study had numerous strands, both qualitative and quantitative; it was published in March 2002 and it is by far the most comprehensive work of its type. It will have, not least because of its commissioning body, a significant influence on the future of VT. It is therefore worthy of detailed consideration here.

The review recommended:

- *Mandatory VT for every dentist entering permanent employment in any area of clinical practice*
- *Improved interface between undergraduate and postgraduate education.* Collaboration should occur within the continuum of dental education to ensure that lifelong career planning by dentists is supported
- *Requirements for clearer standards.* Research work-based assessment systems to determine completion of VT that is robust enough to stand legal challenge. Establish training and support for those VDPs unable to complete VT on time. Establish option of flexible training. Develop teacher education pathways for advisors and trainers. Analyse VT's management infrastructure and strengthen it where necessary
- *Review funding arrangements.* Revise financial estimates to provide mandatory VT. Examine where savings may be achieved, without loss of quality, through pooling of resources. Investigate possibility of extending VT to encompass other areas of training need, particularly issues affecting retention and recruitment, and issues regarding overseas dentists
- *Review management arrangements in some areas.* Continue to provide central monitoring and

accountability, as an essential role of the CVT, using improved standards where appropriate.

Provide central coordination of training of advisors, as an essential role of the CVT. Assess the roles of the CVT and the DVTA. Review the constitution of the CVT and consider re-establishment in a form more appropriate to the future roles it must undertake

- *Further research and development into improvement in standards.* Continue to research the benefits and outcomes of VT so that it is responsive to the changing healthcare environment. Fund and publish research into VT. Encourage and commission research to inform the next review of VT, the CVT's responses to consultation processes of other organisations and the dental profession
- *Inform patients of the work being undertaken to ensure high standards of healthcare (p 5).*

In the discussion of the findings and recommendations there are a number of points that are worthy of note for further discussion. The first is:

Our enquiry showed that VT was necessary for the safety of patients and for the high level of dental treatment offered to them. ...We conclude therefore, that since safety and care of patients is of paramount importance ...VT should be mandatory (p 15).

The report quotes the Quality Assurance Agency (2000):

Students reported that they felt well prepared for their professional careers. Vocational trainers who met with the reviewers praised the skills and knowledge of the students and reported that they made a swift transition to general

practice. Recent graduates from the school [Queen Mary and Westfield College] felt that they had been well prepared for the transition to employment and had acquired skills and knowledge to succeed in their profession (p 16).

Yet immediately following this QAA quote the report continues:

Whilst it is outside the scope of this Report and the remit of the CVT, our enquiry suggested that there is considerable concern, at the committee level of regulatory bodies, that the current undergraduate curriculum cannot produce graduates who are fit to practice unsupervised (p 16).

The research component (Annexure 1) informing the review was published as an annexure to the main report entitled, '*Vocational Training: Value for Money?*' The research question for this inquiry was, what is the value-added of the VT year in dentistry to the health of the nation?

The Inquiry had three elements:

A questionnaire circulated to all General Dental Practitioners in England and Wales working within the GDS. This is reproduced in Appendix 1. The overall response rate was 5.6%. For non-training principals it was 1%; former VDPs, 8%; current trainers, 60% and VT/Regional advisors 60%.

Three focus groups of participants in the VT year running concurrently, with former VDPs, trainers and advisors. Participants were first asked to focus on critical incidents in VT amenable to resolution. This information was then shared in a plenary session and the information used to focus on the costs and benefits of VT.

Three in-depth practice interviews in Wales, Yorkshire and Hertfordshire. The emerging themes from the questionnaire and focus groups were used as a basis of the interviews.

The conclusions of the study

The conclusions relevant to this present study were as follows:

The profession holds a cohesive and coherent view that the VT year provides substantial cost benefits (p 58).

From the questionnaire three statements were in high agreement,

The VT year tends to fill in gaps in the undergraduate curriculum; All new graduates would benefit from VT; Central monitoring to maintain quality ... is important (p 58).

Responses from the focus groups and in-depth interviews suggested that the quality of patient care and the quality of professional life were both improved and that all stakeholders benefited from the structured support from undergraduate to independent practitioner.

The author notes that:

Underpinning professional standards of care was the process of transition from dental school to general dental practice, the movement from theory to practice. ...VDPs experienced a change of focus, from treating the tooth as an academic exercise in dental school to treating the whole patient in practice. In particular this meant learning to develop treatment plans appropriate to particular individuals. ... VT also provided a 'safety net' which protected patients from inadequate levels of competence. ...These processes of professional self-regulation and lifelong learning are fundamental to the provision of a high quality health service (pp 58-59).

It was clear that an important objective achieved by VT was that of making best practice in one part of NHS dentistry, the norm in all dental practices in England and Wales:

[The in-depth interviews] confirmed that VT made a major contribution to patient care. [They] also provided information about the measurable differences between undergraduate dentistry and general dental practice ...identified in terms of the volume of work undertaken and the number of patients seen (p 61).

The recommendations of the CVT review presented here will be revisited and reviewed later, against a background of the work undertaken in this present study.

Knowledge management

Previously, I considered the development of professional knowledge and expertise and outlined the potential significance of tacit knowledge in VT. A further section reviewed organisational effectiveness, addressing the question that is at the heart of this present work. How is VT doing? The knowledge theme is now taken a stage further to determine how this is best managed in a successful and effective organisation.

In the last few years, knowledge management (KM) as a concept has come very much to the fore. The business community and government agencies are showing interest in KM. Kinney (1998) suggests that:

KM is the process by which an organisation creates, captures, acquires and uses knowledge to support and improve that organisation (p 2).

In other words, KM is the application of management to knowledge.

Most authors stress the distinction between knowledge and information. Information is part of knowledge, but knowledge is a much more all-

encompassing term which incorporates the concept of beliefs that are based on information (Dretske 1981). It also depends on the commitment and understanding of the individual holding those beliefs that are affected by people interactions, and the development of judgement, behaviour and attitude (Berger and Luckman, 1996).

Knowledge is therefore associated with a perspective that underlines actions. Throughout the management world there is now a general view that knowledge is of central importance to an organisation. Drucker (1993) argues that in the modern economy, knowledge is the most important resource; in fact it has become the only meaningful resource. He suggests that one of the most important challenges in the knowledge society is to build systematic practices for managing knowledge. Organisations have to be prepared to abandon obsolete knowledge and learn to create from a knowledge base. KM must therefore enable the process of destructive creation to take place. The organisation that wishes to cope dynamically with the changing environment needs to be one that creates information and knowledge, and not merely one that handles them efficiently. Drucker's words are appropriate to VT. The structure of VT, the community of VT need to ensure that it has such a knowledge culture.

The first step in ensuring that KM is a process for enhancing change and effectiveness is to identify the different types of knowledge discussed in the literature (Smith, 2001):

Explicit knowledge: Most explicit knowledge is technical or academic data or information; it requires a level of academic knowledge that is gained by formal education or training. Explicit knowledge can be codified, stored and accessed from databases and fast information retrieval systems. Explicit knowledge can be reused to solve similar problems or connect people with valuable reusable knowledge.

Tacit knowledge: Tacit knowledge was introduced earlier (page 18). Polanyi (1967) describes tacit knowledge as knowing more than we can tell; or knowing how to do something without thinking about it. Tacit knowledge is

highly personal, local and informal. It is not found in manuals, databases, or other forms of explicit knowledge forms. Tacit knowledge can be technical or cognitive. Technical tacit knowledge is demonstrated when a practitioner masters a specific body of knowledge or performs a particular skill to a high standard. Cognitive tacit knowledge has implicit mental models and perceptions that are so ingrained that they are taken for granted (Sternberg 1997). Stewart (1997) says that people use metaphors, analogies, demonstrations and stories to convey their tacit knowledge to others, who evaluate the story content and actions and then apply useful tacit knowledge to their own practice. Wah (1999) considers that tacit knowledge is often easier to remember and talk about than explicit knowledge. 'One of a kind,' spontaneous, creative conversations often occur when people exchange ideas and practicalities in an open and free environment.

While accepting the inherent difficulty in the process, Smith (2001) feels that tacit knowledge can be taught indirectly by providing answers to the following questions:

- What do you know about your strengths, weaknesses, values and ambitions?
- What are the strengths, weaknesses and ambitions of those with whom you work?
- How would you approach a similar job differently in the future? (p 317).

These questions seem entirely appropriate for unlocking and teaching tacit knowledge in the context of VT. The key is to enable trainers to make their tacit knowledge explicit and empower VDPs to develop it.

Smith says that 'communities of practice,' people with a vested interest in learning and sharing knowledge, capture and share knowledge and complement existing organisational structures. They galvanise knowledge sharing, learning and change. There is and always has been a tension between the explicit process and the tacit nature of practice. Brown and Duguid (2000) suggest that those who deal successfully with this dilemma use the various types of explicit and tacit knowledge to their advantage. Tacit

knowledge is used to foster creativity and innovation; explicit knowledge is used to make the working environment predictable and to guide the way tasks are organised. That said we must remember that knowledge is ever changing. Morrissey (1998) quotes the dean of Harvard Medical School:

In five years, half of what you have learnt will either be obsolete or downright wrong (p 42).

This comment instructs us to put knowledge in perspective. Whilst knowledge is in Drucker's words (1993), 'the resource,' it will; it has to change. This is what continuing professional development is all about.

In terms of health care provision, Burns (2001) suggests that in the United States, many health care providers still do not understand how to apply KM to healthcare. From a logistical perspective, it has to be possible to tap into some of that wisdom and at least share the information between departments, and reflect upon it before applying it.

Many within healthcare are unfamiliar with the processes used to collect, categorise, and share knowledge. However as management processes filter down, more and more health care providers are becoming aware that that instigating KM strategies drives performance improvements and organisational effectiveness. Conservative learning practices, or using traditional hierarchies to access knowledge have become obsolete but crucially, many who open the door to change don't know what to do with the knowledge once they have it. Burns (2001) underlines the notion that when health care professionals discover improved or better practices, these must be shared throughout the institution. All new players should be contributing to the new culture resulting in shared knowledge.

Busy people often have little opportunity to share their knowledge/expertise beyond the confines of their department. Some health care organisations are realising that collaborative groups or 'communities of practice,' are a way forward to achieve gains in effectiveness. Crucially, these communities of practice provide a forum for personal interaction and serve to create new

points of view by discussion. Gore and Gore (1999) suggest that the sharing and development of knowledge within the team is not just of explicit knowledge, but an individual can also acquire tacit knowledge from others by experience or by a hidden awareness of such factors as group norms. This work links to the notion of the community of practice proposed by Lave and Wenger (1991) and Bleakley (2002) which is considered further in the analysis and discussion.

The NHS has, from its inception, been the subject of many measures to enhance quality and accountability, and since 1982 managers have been accountable for output measures (Honnigsbaum, 1994). In more recent times, quality has become the issue of primary concern and Clinical Governance is now a term on every health professional's lips. Nicholls et al (2000) of the National Clinical Governance Support Team, suggest that:

Clinical Governance can be viewed as a whole system culture change which provides the means of developing organisational capability to deliver sustainable, accountable, patient focused, quality assured health care (p 174).

This concept forces people to move out of a comfortable status quo and move to a challenging culture, where there is 'active learning' and questions are asked in the spirit of learning and development. Nicholls et al again:

Clinical governance is a [way of] changing the way things are done, so that we move towards a reflective non-blame culture where, 'What went wrong?' and not 'Who went wrong?' is the first response to a problem, and where the same mistakes are not repeated by different people on a regular basis (p 174).

Clinical Governance is knowledge management in the NHS. Clinical Governance sees health care professionals working in teams to review their own service; professionals who are empowered to ask, 'Where do we want

to go?' And, 'How are we going to get there?' It must be remembered that health care decisions are always the product of teamwork. These teams, communities of practice, have the potential to be the prime movers for change.

In the context of VT, everything that has been discussed above, stresses the value of knowledge and how this should be used throughout the organisation. I have previously argued that knowledge/expertise should be valued and novice trainers should be able to tap into the valuable resource of expert trainers. VDPs come into VT with extensive and 'up to date' explicit knowledge; this must be recognised and valued by their trainers and shared, at least at local level.

Practical knowledge is a different issue. Substantially tacit in nature, this necessarily presents practitioners with difficulties in unlocking their knowledge so it can be shared. The structures in VT are in place. Reflective self-assessment underpins VT, but does this reach the level of the trainer and advisor? Do advisors recognise and value the expertise embedded in their trainers or do they perhaps, mistakenly, feel that it is not possible to pass this knowledge/skill on to VDPs or to less experienced trainers.

Trainers have invaluable expertise and with appropriate and effective procedures this can benefit everyone. Argyris and Schon (1974) remind us that seeking feedback on performance is a critical skill. Smith's questions (page 43) must be at the heart of this reflective self-assessment. As Drucker (1993) demands, comfortable, but obsolete knowledge must be abandoned. A well managed community of practice of trainers, both expert and novice, and VDPs with their 'up to date' knowledge has the potential to produce dramatic results.

A mentoring system of expert and novice trainers with an atmosphere of feedback and open discussion and reflection could be a very valuable aspect of VT. With such an arrangement regional/VT advisors will recognise the value of trainers' tacit knowledge and see that this can become a major factor in trainer selection alongside explicit examples such as extra qualifications

and a demonstrable commitment to continuing professional development. Without question the latter two are important, but they are achieved with relative ease, expertise is not.

The issue of task transfer

We have seen that there are many in the profession that question the competence of the new graduate. The CVT sponsored review of VT suggests that new graduates are not safe to practise without supervision, and implicit in this statement is the notion that dental schools are indeed qualifying barely competent or incompetent graduates.

This doesn't quite tie up with the evidence provided by the General Dental Council (GDC). To maintain appropriate standards, the GDC regularly visits and assesses each UK dental school. In the Visitation of Examiners Report 1999-2000 (GDC, 2001) there is the following quote:

All the Final Examinations visited were found to provide a sufficient guarantee that those passing the examination possessed the requisite knowledge, skills and attitudes necessary for the practice of dentistry and so would be suitable to apply for entry on to the Dentists Register (p 7).

And in the following paragraphs:

The Visitors were of the opinion that, overall, a great deal of thought and planning had gone into quality control and assessment since the last visitation of examination...

The Visitors were of the opinion that the candidates were generally of a high standard, and that some showed outstanding ability (p 7).

With these discrepancies of opinion, it may be appropriate to consider the transition from educational environment to work place a little more closely.

Bennett et al (2000) suggest that there has been, there is an assumption that the transfer of skills from the educational environment to the work context is easy to achieve and it is indeed automatic. Those who view learning from a cognitive perspective assume that knowledge and skills are embedded in the person. Now the more widely held view is that much of what is learnt is specific to the situation and that situation can and will influence the subsequent deployment of skills.

So the learning environment is a crucial factor and it is dangerous to have the view that skills can be transported whole from one context to another. We should really be thinking of how learning and performing in one setting prepares one to learn the rules limitations, habits and knowledge of the new setting.

Salomon and Perkins (1989) have looked at the literature on transfer and tried to identify the 'when' of transfer. They have developed the concepts of low road and high road transfer and it might be useful to look at these a little more closely. Low road transfer occurs when conditions in the workplace are similar to the learning environment. Well-learned automatic responses are achieved in the new setting. There is little reflective thinking. And the distance of transfer depends on the amount of practice. The more practice and the closer the learning environment parallels the workplace, the better.

High road transfer occurs when a practitioner needs to abstract his/her knowledge from the learning environment to the workplace. There has to be a deliberate search for connections; they have to look for common patterns, general principles and procedures.

I suggest that both these forms of transfer strike chords with the transition from dental school to life beyond. We aim to achieve low road transfer for many tasks. But much of what a new VDP finds him/herself doing is characteristic of high road transfer. The tasks have not yet become routine and non-reflective. And it might be inappropriate for them be considered as such. For example, in putting a complex treatment plan for a patient, there has to be a need for the deeper consideration of high road transfer. The VDP

must search for and make connections. And even when they become proficient or expert practitioners, such tasks are never automatic and non-reflective.

Bennett et al (2000) warn us that unless we plan for transfer, it is unlikely to occur, at least in the way we expect. They argue that the assumption that new graduates can just go into vocational training and perform is untenable. They reject the 'Bo-Peep theories of transfer' i.e. leave them alone and they'll come home. The evidence is that they don't.

This evidence suggests that it would be entirely appropriate to have a close liaison between the dental and vocational training. Dental school personnel need to have close contact with those managing vocational training. At some stage in the undergraduate curriculum, certainly after there has been an appropriate clinical grounding with a sound theoretical underpinning, rotating students out to community or general practice based clinics could be an appropriate way to go.

Some schools are developing these 'outreach clinics' to aid the transition into general practice, but I have yet to identify any recognition on the part of those developing these clinics that that this path could help dramatically with task transfer.

Poor transfer could explain poor performance in VT. Is it a skills problem that trainers are identifying in their VDPs or is it simply a problem of inadequate transfer? This is very difficult indeed to determine. Perhaps if the notion of transfer was more widely recognised, unfavourable trainer opinion regarding the performance of the new graduate would be moderated.

4 RESEARCH METHODOLOGY AND STRATEGY

The research questions at the centre of this study were:

- How is a typical trainer/VDP partnership set forth?
- What if the partnership is unsuccessful?
- Are there unforeseen consequences of VT?
- Is the selection process successful?
- What is the influence of the experience/expertise of the trainer?
- Is it possible to design a pro-forma setting out attributes of trainer and/or VDP performance that point to a successful outcome?

Most of the published data on the VT experience, the CVT Review of VT (2002) apart, has come from closed questionnaire-based studies. I am not convinced that this is an area of enquiry that is best researched in this manner. This work is located firmly in the interpretivist paradigm. The VT experience is just that –an experience; it is not one of givens or absolutes and the methods of data gathering must be appropriate to capture that experience. The whole *raison d'être* of this study is to determine how understandings are formed and relationships negotiated? Why do relationships develop and flourish? Why do they fail? This is a qualitative study. I want to present a thick description that Denzin (1989) describes as follows:

It goes beyond mere fact and surface appearances. It presents detail, context, emotion and the webs of social relationships that join persons to one another. Thick description evokes emotionality and self-feelings. ... It establishes the significance of an experience. ... In thick description, the voices, feelings, actions and meanings of interacting individuals are heard (p 83).

Rationale for the Methodology

There are many ways in which I could undertake my research to gain an insight into the experiences of the VDPs and their trainers. However, a collaborative enquiry approach, where I spend time with my participants as VT progresses, will provide a richer source of data than a more conventional large-scale survey could offer.

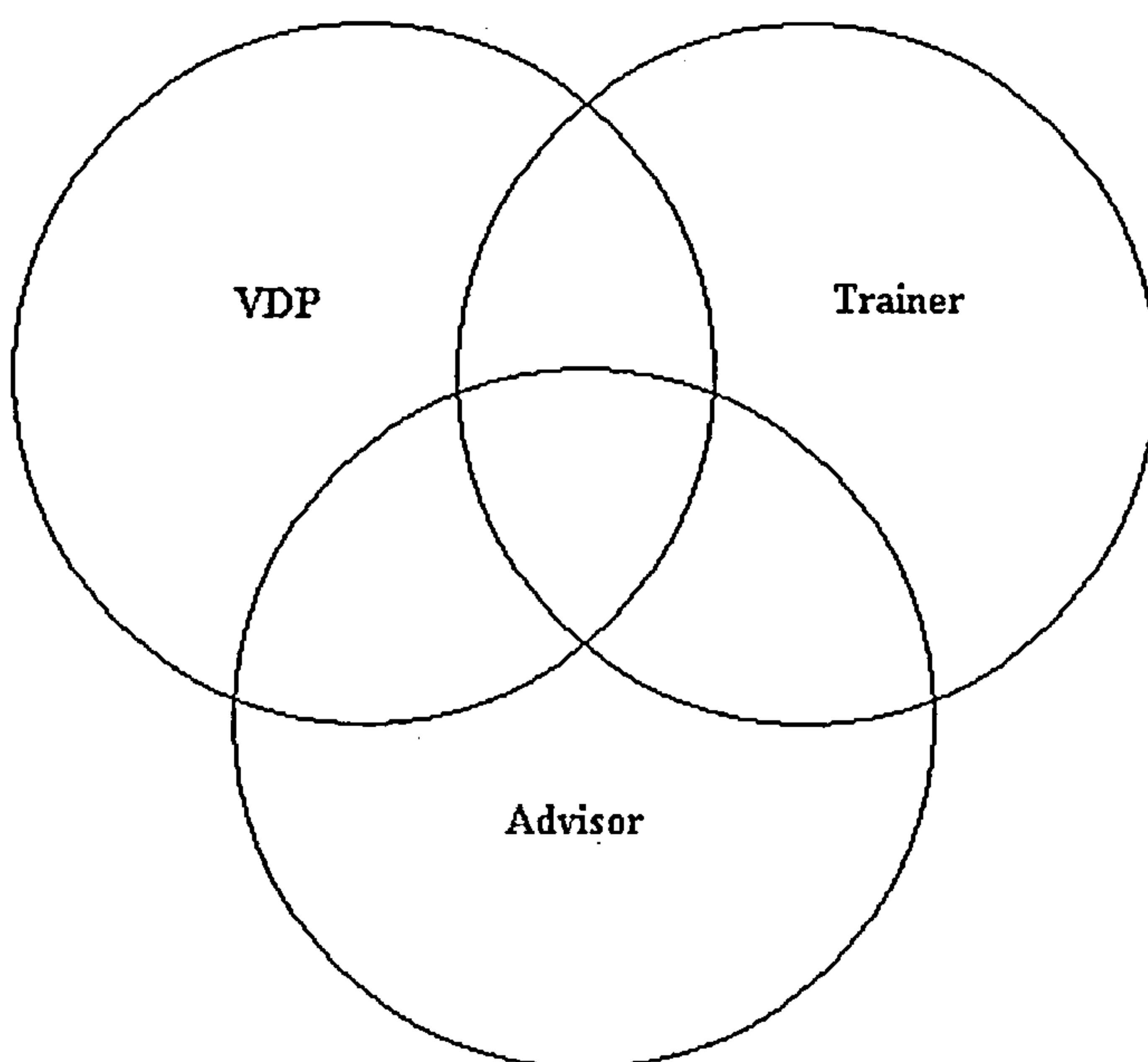
To achieve this I must go into the VT practices and interview my participants. But I must keep in contact with them throughout the 12 months of VT; a one-off interview will not suffice. I must capture the VT experience and my data gathering and analysis will revolve around this quest. Anything less than a truly interpretive approach will not be appropriate; it will not provide the nature or quality of data essential to this study.

Researching VT

Success in defined areas of VT may well take many different forms. I suggest that the VT experience is located as a function of three shifting forces, the trainer, the VDP and VT management in the guise of VT advisor. The three forces of advisor, trainer and VDP are presented diagrammatically in Fig 4.1. As I suggested earlier, each trainer will bring to VT his/her own perspective of what the VT experience should be. Trainers' expectations of their VDPs in terms of knowledge and skill will vary, perhaps significantly. Yet each trainer could be faithfully following VT policy.

Fig 4.1

The participating force in VT: VDP, trainer and advisor



And what of the VDPs? They enter VT with predetermined opinions and ideas of VT, of trainer performance and behaviour, in fact what life in VT is likely to be like. Then as VDPs, they meet regularly as a group and compare

notes. As a consequence they may have a stylised notion of what a 'good' VT practice is, and then expect their own to fit this impossible perfection.

My own position as researcher is one about which I have considerable concern. I am an 'interested researcher,' an academic from a university institution. I am interested, but this is not insider research. I have insider knowledge, but I am not an insider. I am not part of VT. In fact for many in VT I am very much an outsider; an outsider with an agenda.

I desperately want to research the trainers' experience as well as that of the VDPs. I want the whole picture. VT is a partnership. I need both partners to be involved. Historically university teachers and VT personnel have been wary of each other, not least because of the criticisms of the competence of new dental graduates, many of which come from general practice and VT. I have absolutely no doubt that new graduates no longer possess the same level of experience that their trainers had, but trainer expectations of the new graduate may be unreasonable. We all think that we were better when we qualified. We were different, but were we better? My contemporaries went into general practice without VT, that is true. But it was a traumatic transition and it was this trauma that was the driving force behind the introduction of VT (Levine 1992).

Berger (1996) suggest that:

Social reality has many layers of meaning and the discovery of each new layer changes the perception of the whole (p 34).

Blumer (1976) talks of: Lifting veils (p 15).

VT has a public face. I have to lift the veils and see behind the public face. In fact I want more than that. I want to become a part of VT. However, Bird and Hammersley (1996) suggest that a long stay is needed and much work is necessary to develop the knowledge, skill and trust that will permit entry into innermost arenas and confidences. I am prepared for a long stay. I want my

participants to see this as collaborative research, but I shall only achieve this if my commitment to an interpretive approach is absolute.

Each trainer and VDP has a particular and vested interest in the outcome of this study. Rather than provide absolute answers, I hope that this work will enable VT personnel to see at least some of the situations and problems that need to be addressed and/or developed to enhance the VT experience, possibly in a new light. Bird and Hammersley note that in taking this view, although the impact of the research is less direct, it is potentially persuasive, perhaps even shaping practitioners' whole orientation and approach to their practice.

However for this to happen I must develop the trust. Every participant must have confidence in me as a researcher; a researcher who genuinely wants to move vocational education forward in a positive and appropriate way. There can be nothing covert about this research. What my background says about me shouts louder than anything I can say.

I am not happy with some of the comments I hear regarding the new graduates' competence. These comments reflect ultimately on me as a teacher. Yet, if I'm honest, I am concerned about the 'quality' of the new graduates that we are qualifying. Whatever my position, I cannot suspend my beliefs and prejudices, but I can make sure that I never forget that they inform my every thought and action. Bell (1993, 2nd edn) discussing the potential for bias on the part of the researcher suggests that it is easier to acknowledge the fact that bias can creep in, than to unsuccessfully try to eliminate it.

The world of VT is a small one. I hope that this will work to my advantage in gaining access to the trainers, but I can also lose the goodwill of my participants very quickly. The terms of that access have to be sacrosanct. My own ethical standards and concept of and commitment to confidentiality have to be beyond reproach. I decided that it should be possible within the timescale of the study to follow two successive cohorts of VDPs and their trainers through VT. The most appropriate data gathering techniques would

be one to one interviews.

Participants in the study

The VDPs were all graduates from GKT. They were recruited into the study around eight months before they entered VT. The vast majority were at that stage, still six months away from qualifying. The others were well into house officer posts.

The initial cohort consisted of 13 VDPs and their trainers who undertook VT during the academic year 2000-2001. The main cohort consisted of 22 VDPs and their trainers who participated in VT during the academic year 2001-2002. All the participants undertook VT in Southern England. Most were in the South East, but I did visit training partnerships as far west as Poole in Dorset and as far north as Northampton.

This sample of VDPs cannot be considered representative of graduates entering VT nationally. GKT is a very large central London School and our undergraduate profile is very different from other UK schools. This is in fact an 'Opportunity Sample' (Bird and Hamersley, 1996); a sample that will essentially limit any direct extrapolation of the results to GKT graduates undertaking VT in the South and South East of England. Even then it must be appreciated that the outcome is still a construction. It is not value free.

However there were fortuitous aspects to the initial geographical location of my sample. During the course of the data gathering, I conducted a large number of interviews, the overwhelming majority of which were face to face in a location chosen by the VDP or trainer. This would not have been logistically possible had I not myself, been located at London Bridge, the hub of the rail and underground network in the South East.

The VDPs

The recruitment of the VDPs was far more difficult than I had anticipated. It was not an option to choose a random sample of the final year students. I was likely to ask a great deal of the participants during their time in VT and I felt that if I was going to have the level of co-operation and gather the quality of

data that I wanted, I would have to include students that I knew well.

Therefore, for the majority (11) of the first cohort, I chose students from my own tutorial group; a group taken from the 84 who qualified in June 2000. I was aware that as Drever (1995) warns, bias can be a significant issue if people are asked to volunteer to be interviewed; interviewees may hold an entrenched position with regard to the research questions. The decision to be included in the study was entirely that of each student. I hoped that my reputation was such that no student would feel obliged to participate and this would in part address Drever's concerns. However, I was aware that power relations could not be ignored, particularly as finals were on the horizon. I therefore stood down as an examiner for the duration of the study.

Most (19) of the VDPs in the main cohort were a group taken from the 80 who qualified in June 2001. They were those who had shown an interest in being part of this study and I was a little more comfortable that they were a self-selecting group; although in this case there were some that I didn't know that well.

I decided to include some house officers in each cohort. Discussions with colleagues confirmed that house officers moving into VT could bring an added dimension to the work. Two of the first cohort VDPs were house officers, as were three of the second. Each had been a member of the year group preceding that of the newly qualified in his/her cohort. They were therefore 12 months qualified when they entered VT. VT was the chosen path of the house officers and not a forced change of career direction.

In summary therefore:

1st Cohort of 13: 11 newly qualified (13% of year) + 2 House Officers.

2nd Cohort of 22: 19 newly qualified (24% of year) + 3 House Officers.

In the initial cohort there were 11 female and two male VDPs and in the second, 16 and six respectively. Both the cohorts had higher female to male ratios than their respective intake years that were close to 60:40. The initial cohort was drawn from a predominately female group; the gender bias in the second was not specifically intentional. In terms of ethnicity the majority of

both VDP cohorts were British of Asian origin. This profile is very different from that of other UK schools. For example on page 133 we hear of the profile of Dundee Students (Chadwick and Newton, 2003).

The trainers/advisors

The trainers of both cohorts were effectively selected by the VDPs. I was aware that gaining access to the trainers could be difficult and I was very concerned about this. Whereas I could involve VDPs that I knew would be willing to participate in the study. I had no control over the trainers. I had to follow the VDPs to the trainers who selected them. Mindful of my dental school background and that trainer participation was vital to the success of this study, in my introductory letter to the trainers I noted that that this work was being conducted under the auspices of The Open University, School of Education and not GKT. The introductory letter is presented in Appendix 2.

Prior to this I had asked each of the VDPs to let his/her trainer know that I was following them through VT and as part of the study I wanted to speak to the trainers. This would obviously be at a date and time to suit the trainer. I hoped that this two-way introductory approach would ease my problems of access. In the event, every trainer agreed to participate in the study. Three of the trainers were also VT advisors. Their additional management responsibility would bring an extra dimension to the work.

Although around 60% of new graduates are women, this has yet to manifest itself in VT and training is still a male dominated preserve. Three of the 13 trainers in the initial cohort and five of the 22 in the second cohort were female. Seven trainers in each of the cohorts were of Asian origin. One of the female trainers in the second cohort shared the training of her VDP with a male colleague; there were two other training practices where training was shared. There was no shared training in the initial cohort.

The strategy

This strategy of this work had two distinct phases. In advance of the main VT phase, I followed the cohorts through their search for VT placements.

The selection process/search for VT placements

In this initial phase, multiple short meetings were used. I had intended to use focus group interviews with a supporting questionnaire. I have used focus group interviews before; indeed a pilot for this work was designed specifically to determine whether this would be a sound data-gathering technique in my hands. Hess (1968) highlights the advantages of focus group interviews as compared to individual in-depth interviews. Synergism, security and snowballing are features that attract me to the technique. In the event, I had far closer contact with the cohort than I had anticipated, so I carried out interviews on an individual basis and in groups of two and three. Where small groups were present, I found the snowballing to be dramatic. I kept a detailed diary with the aim of building a comprehensive picture of the interview experiences.

Some students in the initial cohort came to see me four or five times; they caught me in corridors and clinics to keep me up to date with their progress. No structure was present at these meetings and each was prefaced by the question, 'How is the job hunting?' As the meetings progressed I was able to build a picture of that individual's interview experiences.

The VT experience

While the initial phase of the study was progressing, following the advice given by Aspinwall et al (1997) for the development of success criteria, VT performance areas at both practice and regional level were identified for criteria development. These were based on a consideration of CVT documentation, the Trainer's Handbook (Rattan, 1994) and Handbook for Trainers (Rattan, 2002), together with discussions with VT personnel on what could be considered 'accepted practice.' Whilst it was my intention to identify the typical, I needed to determine whether or not the typical was a success.

The performance areas and developed success criteria are presented in Appendix 3 and following Eraut's advice (1994) these were kept simple. The success criteria were developed with the help of an experienced trainer not involved in this study, and piloted on recent graduates who had recently

completed VT. These criteria were considered in particular detail, bearing in mind the various notions of professional competence discussed on page 20. Aspinwall et al suggest that the best success criteria are those developed in partnership with those who work in the area and this liaison proved to be invaluable.

My aim was to search for evidence to determine if success criteria had been met in defined aspects of VT. This involved a number of strands of data gathering, but interviews with VDPs and their practice trainers/advisors were the primary source of evidence. Focusing questions for each of the performance areas were devised and semi-structured interviews schedules developed for the VDPs and trainers. Included, were appropriately modified schedules for trainers who were also VT advisors.

Once the cohort was settled in VT, i.e. after approximately five to six months, I individually interviewed each of the VDPs. A further interview was conducted once they had completed the VT year. The first cohort, initial and end of VT interview schedules appear in Appendices 4 and 5. The main cohort interview schedules (Appendices 6 and 7) differ in some respects from those used with the initial cohort. These changes reflect the way the initial cohort informed the developing methodology.

I interviewed each vocational trainer involved in the training of the VDPs. These interviews took place immediately or shortly after the VDP interviews. As with the VDPs, the trainers were re-interviewed at the end of the VT year. And again, interviews with the initial cohort trainers informed the main cohort and the interview schedules underwent appropriate modification. The initial trainer schedules appear in Appendices 8 and 9, and the main cohort in 10 and 11. With the permission of each of the participants, each of the interviews was recorded. After transcription each of the VDPs and trainers was offered the opportunity of reviewing and editing the transcripts.

The data gathering techniques

Interviews had to form the backbone of my data gathering. To collect the quality of data that I required, these had to be in-depth and individual. They

also had to have a semi-structured format to ensure that I covered the appropriate ground.

The timing of the interviews was critical. To get a feel for an overall experience, a snapshot was not appropriate. I had to see progression through the year. The initial interviews were undertaken at around six months into VT because at this stage the VDPs should be settled and the initial traumas, for VDPs and trainers, should be well behind them. I had to see the participants again at the end of the year. Here the trainer mentioned in the previous section was most helpful. He suggested that I let the dust settle and to delay the end of VT interviews for at least two months after VT had finished.

This advice came as a direct result of his own training experiences. Ask a VDP what they think of VT after a particular difficult week, or even a trying episode with their trainer or a patient and their comments are not likely to be positive. The same is likely to be true with the trainers' view of the VDPs. Let a little time pass and VT ceases to be a series of positive and/or negative episodes; the participant can reflect on the experience as a whole.

Although I was using interviews with a degree of structure, I was aware that it is very easy to steer an interview in a favoured direction. Gebhardt (1982) says that:

What we want to collect data for decides what we collect.

(p 405).

This awareness stayed with me throughout all phases of this study.

Chance encounters with interested personnel, phone calls and formal meetings also added to the data, particularly with the main cohort. In fact a project diary rapidly became an essential research tool; it wasn't possible to separate formal data collection from the multitude of opportunities that arose to collect valuable, if informal data. Although I was primarily using

qualitative data gathering methods, I had the words of Stanley and Wise (1983) with me:

Methods in themselves aren't innately anything (p 159).

It is how I handle, reflect upon, analyse and represent my data that are the critical issues. Jayaratne and Stewart (1995) pick up this point:

[It is] the way in which the research participants are treated and the care with which the researchers attempt to represent the lived experience of the research participants [that] are of central concern (p 221).

Validation

Triangulation is essential in validating qualitative work. Attempting to set forth an experience of VT is necessarily problematic. Methodological triangulation was achieved by interviewing both VDPs and trainers and including other data gathering such as email communication and the numerous planned and ad hoc meetings. The selection part of the study also included a questionnaire (page 63).

The idea of interviewing successive cohorts of significant number half way through, and at the end of VT was to achieve data triangulation and reveal the unfolding experience. Thus I was able to discuss VDP and trainer expectations and plans for the year. I could then revisit these once VT had finished and determine the degree to which these had been achieved and or modified as the year progressed.

Approach to data analysis

Bennett (1994) suggests that analysis frequently takes place at the same time and in interaction with data collection and Bird and Hammersley (1996) note that many see it as a mistake to go on collecting data without examining it from time to time. The analysis of the initial cohort data informed my whole approach to data gathering and the management of the second larger cohort, but more than that the plan for this study allowed for ongoing analysis to take

place as the data gathering progressed. This is the process of progressive focusing. Lacey (1993) talks of 'escalating insights;' the process of moving backwards and forwards between observation, analysis and understanding.

Bird and Hammersley (1996) suggest that a principled analysis helps to organise data and generate insights that aid its understanding. This is an ongoing progressive process and the analysis of this study effectively passed through the following stages:

- *Preliminary and primary analysis* This is the initial analysis and during this phase important emerging themes were identified within the defined performance areas; what were the significant themes and what were not. There was a certain untidiness in this process, but the identification of performance areas did help structure this early phase of analysis.
- *Category and concept foundation* This is the stage at which categories are identified and grouped. This involved a great deal of reading, and rereading of the interview transcripts over a considerable period of time. This was a laborious, but vital procedure. It was at this stage that the data started to take shape and the legitimacy or otherwise of my defined performance areas was confirmed.
- *Generation of theory* My primary research question was to identify how a typical VT experience was set forth. At this stage I was beginning to appreciate events from the point of view of the participants and to understand how and why events were shaping the way they were and what in fact was likely to happen.

I conducted the analysis of the interview transcripts from three different perspectives. First, I linked the VDPs together to tease out the 'VDP

experience' and identify what could be considered typical for this group. I then carried out a similar process for the trainers. That completed, I linked the individual VDPs with their trainers with the aim of presenting the VDP/trainer partnership. It was during this phase, attempting to design a meaningful method of presentation that I took the step of using the combined data of the 35 partnerships to present one typical VT experience which appears on page 75.

In this stage of theory generation Bird and Hammersley suggest that the researcher becomes steeped in the data but employs devices to insure breadth and depth of vision, e.g. keeping a field diary -an ongoing reflective commentary. They also note how important it is to consult colleagues for their knowledge and as a 'sounding board.' I was most fortunate in this regard as I had two senior VT colleagues who acted in this capacity. The trainer mentioned earlier helped during the initial theoretical formulation of the study. The other, an advisor and a participant in the study, became an invaluable 'critical companion' who literally did act as a sounding board throughout the entire data gathering and analysis process. I was able to periodically feed back my findings and analyses to him and achieve a degree respondent validation. Lincoln and Guba (1985) maintain that such validation is *the* standard for work such as this where the objective is to reconstruct events and the perspectives of the participants.

Methodological changes as the study progressed

I asked each of the initial cohort to keep a diary of significant events in their VT year. This was essentially what Burgess (1994) terms an 'informants diary.' The letter to VDPs asking them to do this is included in Appendix 13. I wanted the VDPs to use the diaries as a reflective tool. In such circumstances Burgess suggests that guidance is necessary in making diary entries. Burgess (1985) and Griffiths (1985) also note that the time needed to keep such an account can be a problem. I did not include any suggested format or guidance in my letter to the VDPs and as a consequence of this and perhaps the time factor, only two VDPs kept a truly reflective diary.

Even so, I did see enough to realise that close and regular contact was

essential and if I could achieve this it would significantly enhance the quality of my data. I therefore asked each of the main cohort to keep in regular email contact with me, with eight to ten weeks as a suggested contact interval. Email had the potential to be an excellent contact medium. For example, if VDPs are going through a bad patch, making contact by phone may not necessarily be appropriate. With email, the VDP can contact if and when they want to.

It was always going to be difficult to find time to undertake all the second cohort interviews in the relatively narrow time frame that I had available. In order to complete all the end of VT interviews in a reasonable time, while all the trainer interviews were conducted as planned, nine of the VDP interviews were conducted by telephone. Here email contact proved to be invaluable. Those chosen were those whose ongoing email contact with me suggested that there would not be anything surprising in the end of VT interviews.

The selection process questionnaire

As a direct result of my preliminary analysis of the data, I did introduce quantitative data gathering into the study. Earlier I noted that other authors had reported racial and gender bias in the selection process (Bartlett et al, 1997 and Bartlett and Woolford, 2000). I did not come across any evidence of untoward behaviour during my work with the initial cohort despite this and other anecdotal evidence. However, this is an issue of concern. Therefore armed with data on the race and sex of our students and their trainers, I devised a questionnaire to determine if any particular new graduates were finding it difficult to gain a VT place and whether that was in a preferred location. 53 out of the 60 new graduates who entered VT in August 2001 or February 2002, which included the second cohort in its entirety, completed the questionnaire.

If race and gender are indeed issues in VT selection, then the evidence has to be placed in the public domain, but any such evidence must be valid. The numbers here were limited. The questionnaire was effectively a pilot; but if the analysis revealed significant issues in the selection process, it was my

intention to develop this aspect of the work further. The questionnaire used is included in Appendix 13; the questions were as follows:

- 1) How many CVs did you send off?
- 2
 - a) Did you include a photograph?
 - b) Why did you make this decision?
- 3) Where was your preferred location to do VT?
- 4
 - a) How many practices asked you for interview?
 - b) How many did you attend?
 - c) Which of these were in your preferred location?
- 5
 - a) How many offers did you receive?
 - b) Which of these were in your preferred location?
- 6
 - a) Are you completely happy with your place?
 - b) If not, can you tell me why?
- 7
 - a) How long did it take you to find a VT place?
 - b) What are your views on the 'interview experience'?
 - c) What was your impression of the practices you visited?
 - d) Do you have any other comments?

The timetable of the study

The timetable of the fieldwork of the study is presented in Fig 4.2. The fieldwork began in April 2000 with the recruitment of the initial cohort VDPs and the last of the second cohort interviews were undertaken at the beginning of 2003. The significant point about this time schedule was that it had to fit into the programme of the VT year. This meant that I had to keep up to date with the data gathering. If I fell behind, VT would continue on and my opportunity for data gathering would be lost. This necessity effectively gave structure to the study and urgency to the data gathering process.

Fig 4.2 Timetable of fieldwork for Cohorts 1 and 2

	COHORT 1	COHORT 2
April 2000	Cohort recruited (13 VDPs and their trainers)	--
May-July 2000	Follow job search (interviews)	--
Dec 2000- March 2001	'Initial interviews' (VDPs and trainers)	--
April-June 2001	--	Cohort recruited (22 VDPs and their trainers)
May-July 2001	--	Follow job search (as Cohort 1)
Aug 2001	--	'Whole Year Questionnaire'
Sept 2001	Interim scheme 'Initial interviews'	--
Sept-Nov 2001	'End of VT Interviews'	
Dec 2001- March 2002	--	'Initial interviews' (VDPs and trainers)
March-April 2002	Interim scheme 'End VT interviews'	--
Oct 2002- Jan 2003	--	'End VT interviews'

*Contact with advisors to arrange interviews and
observation of Study Days –throughout VT*

5 THE VOCATIONAL TRAINING EXPERIENCE

Introduction

I was reasonably confident that my VDPs would see the study through to its conclusion and each of them did, but I could not be certain that I would achieve the same commitment from the trainers. Dental practitioners are busy people. There was bound to be variation in the co-operation that I received in my quest to interview the trainers. Access was likely to be worse with those who were VT advisors, most of whom are trainers with this additional responsibility. Therefore, not only was it going to be difficult to recruit the trainers in the first place, but also once recruited, it was going to be far from easy to gather data of the quality that I needed.

As it turned out, the trainers were simply superb. Not only did every one of them agree to participate in the study, but each also saw the study through to its conclusion. Every trainer was most hospitable and I was never once made to feel that my presence was an imposition. Some insisted on providing lunch; one came in to see me while on holiday so that I would have enough time to carry out the end of VT interview. I had designed both initial and end of VT interview schedules so that if necessary I could complete them in around 25 minutes as lunchtimes and early evenings were my main opportunities to undertake the interviews. Some were completed in 25 minutes; others took in excess of two hours.

In terms of gaining access to the trainers, the sound working relationship I had developed with my advisor/mentor proved to be invaluable. He happened to be the first trainer I interviewed. Having introduced myself through his VDP and my introductory letter, he agreed to be interviewed, but initially he was wary of me. This was a timely reminder of what my university teaching position said about me.

In the event my interviews with him formed the basic template for my subsequent trainer interviews. He invited me to attend his Study Days and later his trainer training days. Through these meetings I met other trainers and advisors on other schemes. He continued to act as a sounding board and a critical friend throughout the study. I cannot overemphasise the value of his

counsel. The deeper I entered into the world of VT, the more I realised that I had become a part of what I was researching.

At the beginning of each interview I reminded each participant that the contents were confidential and nothing in the interview would be attributable to them. Despite my offer of reviewing the transcripts of the interviews, only one, a VDP took me up on this offer, after the initial interview. He declined the same offer after his 'end of VT' interview.

Ongoing contact with the cohort VDPs and trainers

The upheaval of the move to a new job/home meant that quite a few of the cohort were without email for the first few months. I managed to establish email contact with 20 of the cohort. 15 of them emailed me with a detailed account of their initial experiences in VT; another two wrote to me, again with a detailed account. Five VDPs, not in the cohort, made contact to let me know how they were getting on. In the event I was able to maintain regular contact with around half the cohort. Most of the others, however, continued to let me know of significant issues arising in their VT experience.

Email proved to be an excellent communication medium. It provided a continuing dialogue with the VDPs in the first weeks and months of VT and thereafter it effectively linked the initial and end of VT interviews. I could therefore see the VT experience as it developed.

The email contact showed that the VDPs were all experiencing similar traumas in the first half of the year. Appendix 14 presents a typical early email communication. Email also revealed that by and large, as Christmas approached, around five months into VT, they were feeling more confident. They were feeling part of VT.

But email also warned that while this was the general pattern of progression, there were problems. Danger signs in one relationship (page 113) were clear to see as early as the beginning of September. And while this particular VDP emailed me with an account of her progressively worsening experience (in

October), I had already received warnings of her predicament from two of her peers.

While for the most part the email contact charted a predictable path, there were occasions when it revealed unexpected changes in the pattern of particular relationships that I could not have predicted. In this way I was forewarned in advance of carrying out the final interviews. One consequence of this contact was that many of the cohort continued to email me for advice or just to let me know how they are doing.

The cohorts in VT

I had wanted follow the same trainers through both cohorts if possible. In the event, only one of the initial cohort trainers carried on with a main cohort VDP. One training practice was common to both cohorts, the partners alternating as trainers. Despite this, I did manage to maintain contact with over half of the initial cohort trainers. The advisors I met and interviewed gave me unrivalled access to their schemes and I now teach on three schemes. Although the numbers for this essentially qualitative study are quite large, to present the typical, I had to reach a point where I could predict what was likely to happen.

Time constraints meant that six of the 44 main cohort initial interviews were undertaken in April which was a bit later than I had planned. I do not think that this has had a deleterious effect on my data gathering. However VT moves relentlessly on. By April, decisions as to whether the trainers are going to keep the incumbent VDP, post VT, or train again, have been made, so the background to the interviews had changed. I noted which of the interviews took place at this time and the analysis took place with this in mind.

The selection process questionnaire

Perceived or otherwise, the main aim of this questionnaire was to ascertain whether there were issues of gender and race in the selection process. The idea was to ignore the comment and anecdote that seemed to pervade the process and attempt to determine if any identified group of new graduates

were finding it difficult to gain a VT place, particularly in their preferred location. The questionnaire used appears in on page 63 and in Appendix 12.

53 participants completed the questionnaire (a 7.5% sample of VDPs entering VT in England and Wales in 2001). For each question, data for specific participant groups based on gender and/or ethnicity was determined. The data was analysed using Fisher's Exact and Pearson's χ^2 and two sample t tests with unequal variance (STATA Version 7, Statistical Data Analysis System, Stata Corporation, College Station, Texas, USA).

The white male group was small and was therefore omitted as a specific group from the analysis. Therefore where ethnicity and gender are considered, the data for Asian females was compared to that of their white female peers and Asian males. In the summary that follows, significant differences between the compared groups are noted.

Summary of questionnaire data

Table 5.1 presents the numerical data for groupings based on gender and ethnicity for the questions that are considered below:

Question 1

This revealed that the mean number of CVs sent to trainers was 31 (SD = 22.10) with a range from 2, to in excess of 100. White candidates applied for a mean of 19.16 (SD = 11.62), whereas Asian candidates applied for a mean number of 33.13 (SD = 20.47) [t test, $p > 0.0095$].

Within the female group, those who are white applied for a mean of 19.21 (SD = 12.88), while their Asian peers applied to far more with a mean of 40.17 (SD = 22.23) [t test, $p > 0.024$].

Asian females also applied for more places than their Asian male colleagues, with means of 40.17 (SD = 22.23) and 22.58 (SD = 11.77) respectively [t test, $p > 0.0090$].

Asian female candidates therefore applied for more places than either Asian males or white females.

Question 2

Overall 68% (36) of the applicants included a photograph on their CV. 74% of females did so, as did 58% of males. The most oft heard reason for including a photograph was that it added a personal touch and acted as an aide memoir. Some applicants were advised to include a photograph by their tutors or lecturers and others followed a lead set by their peers.

Table 5.1

QUESTIONNAIRE: NUMERICAL RESULTS
Absolute values for Q3; mean values for other questions

Grouping (number in group)	Q1 No. of Applica tions	Q 3 Prefer London/ SE	Q4a No. of Offers of interview	Q4b No. of interviews attended	Q4c No. in preferred location	Q5a No. of Offers received	Q5b No. in Preferred location	Q7a Weeks to find position
Male (19)	26.89	14	7.42	4.10	2.74	1.84	1.16	3.71
Female (34)	33.29	22	7.50	4.32	3.09	1.88	1.15	5.06
White (19)	19.16	9	6.63	3.63	2.00	2.05	0.94	3.21
Asian (30)	33.13	23	7.90	4.70	3.73	1.73	1.30	5.62
White Male (5)	19.00	3	6.60	4.80	2.20	2.60	1.00	3.00
Asian Male (12)	22.58	9	7.00	3.92	3.16	1.58	1.25	3.87
White Female (14)	19.21	6	6.65	3.21	1.92	1.85	0.93	3.29
Asian Female (18)	40.17	14	8.50	5.22	4.11	1.83	1.33	6.85

Question 3

81% (43) wanted to stay in London and the South East, but interestingly just under a fifth of the group specifically wanted to move away from London.

There was an association between the ethnicity of the applicants and their preferred location to undertake VT. 23 of the 30 Asian applicants favoured London or the South East but only 9 out of the 19 white applicants did likewise χ^2 [Pearson $p > 0.036$; Fisher Exact $p > 0.063$].

And Asian females were more likely to favour the South East than were white females χ^2 , [Pearson $p > 0.043$; Fisher Exact $p > 0.068$].

Asian applicants, female and male favour London and the South East.

Question 4

a) The mean number of offers of interview was 7.45 (SD = 4.65). There was no significant association across any of the parameters for this question.

b) This question asked respondents how many interviews they attended. The overall mean was 4.25 (SD = 2.49). White females attended a mean of 3.21 (SD = 1.93); Asian females a mean of 5.22 (SD = 2.84) [t test, $p > 0.024$].

Asian females attend more interviews than white females.

c) This question determined whether these interviews were in a preferred location. The overall mean was 2.96 (SD = 2.97). White applicants noted 2.00 (SD = 1.45) in such a location; Asian applicants 3.73 (SD = 2.52) [t test, $p > 0.0037$].

Asian candidates, female and male secure more interviews in their preferred location than white candidates.

Question 5

a) This identified the number of offers of a VT place. The mean number was 1.87 (SD = 1.11). There were no significant differences across the groups.

b) This identified the number of offers received in a preferred location. The mean was 1.15 (SD = 0.77). There were no significant differences across the groups.

Question 6

This question noted that 81% (43) were completely satisfied with their VT position. If an applicant was not happy, the main reason was the travelling time to get to the practice.

Question 7

a) The time taken to find a VT place was in a range from three days to 20 weeks. The overall mean was 4.7 weeks (SD = 3.58).

White applicants took on average 3.21 weeks (SD = 1.99) and Asian applicants 5.62 weeks (SD = 4.12) [t test, $p > 0.0097$].

Furthermore, white and Asian females took 3.29 (SD = 2.27) and 6.85 (SD = 4.69) weeks respectively [t test, $p > 0.0107$].

Asian females take longer to secure a place than any other group.

b) The comments on the interview/selection procedure were very varied but these tended to be at the positive end of the spectrum. Of the 53, 32% (17) thought that the practitioners were friendly during the selections process. 26% (14) specifically commented on the informality of the interviews, another 15% (8) of the VDPs thought the process was pleasant, one going as far as to describe his experience as fun.

15% (8) thought that the process was particularly daunting, although this did not necessarily mean that they thought the training staff were unfriendly or formal in their approach to selection. Only 8% (4) of the group had specifically negative comments about their experience and these all noted stress and pressure. There were no comments of untoward experiences with the trainers.

c) As far as the VDPs' impression of the practices was concerned, the entire range of descriptive terms was used. Most practices were well presented (they are regularly inspected), but the applicants thought some were scruffy and uninspiring and these practices were invariably rejected. Some trainers were considered highly professional; others definitely not so. Most of the staff in the practices were friendly and positive toward the VDPs but that was

not a universal experience. Again, overall the comments tended to be positive.

d) In this final section just under half the respondents took the opportunity to make comments and these centred on the problems of applying for VT in London, particularly the competition for places. The timing of the selection process, so close to finals also featured strongly and the almost complete absence of support and advice in this period was also a major concern

Three participants specifically noted that they were aware that trainers were interviewing after they had made the offer of a place. Three Asian females commented on the success that males seemed to have in their quest to secure a VT place.

There were only 53 questionnaire participants; the individual group sizes were therefore quite small. The white male group was of a size that any ethnicity differences would be largely due to the effect of the white female group. Therefore I am cautious about interpreting the various analyses as causal or in suggesting that a particular phenomenon exists. That said a pattern did appear to be emerging that suggested a difference between the experiences of Asian and white applicants and Asian and white females in particular.

The Asian females tended to bias the picture from the Asian applicants point of view. Asian males and white females seemed to have very similar experiences. Asian males did attend more interviews in their preferred location, but the differences were not significant.

The experiences of white and Asian females appeared to be very different. Asian females were more likely to want to stay in the South East. They made more applications; they attended more interviews, and more in their preferred location than their white female peers. This effort did not translate into more offers of a VT position, preferred location or otherwise. Asian females also took longer to secure a position.

The VT relationships

The vocational training experience is just that –an experience, and it is not really feasible to separate the experience of the VDP from that of the trainer; each has such an influence on the other. In the following I shall present an account of a typical vocational training experience in the South East of England. This is immediately problematic as there is no such thing. But to understand the varying issues that arise and to have some understanding of how these fit into the general scheme of things, it is essential to have some idea of what is most likely to happen. My primary research question asked how a typical training partnership was manifest? What would a disinterested observer see if he/she observed the year?

To answer this I developed the notion of the typical; the most likely or usual outcome for all the performance areas considered in the individual interviews with the VDPs and their trainers. Thus I was able to build a picture of a fictitious ‘typical’ vocational training relationship; a relationship that was unfortunately lifeless and sterile. It did however provide a template and I have brought this to life by identifying the VT partnership that best fits this template. It is therefore this experience that is presented. Obviously the ‘fit’ is not perfect and each of the identified performance areas for this partnership will be considered and then compared with the rest of the cohort. In this way it should be apparent whether a particular issue or emerging theme is what is likely to be expected and if not, just how far from the typical it is. One VDP’s experience was so atypical and unsuccessful that it is not included in the account that follows. Her experience of VT is presented as separately at the end of this report. The names of the participants have been changed.

Although presenting the VT experience in this manner provides an idea of what is likely to take place, it does not indicate how each of the participants responded to each issue. At the conclusion of the presentation of the relationships, I have therefore included a summary of the participant comments (page 122 and Appendix 15).

The typical VT relationship

The choice of practice

Miss Patel, a VDP in the main cohort had placed the location of the training practice at the top of her list of decision criteria. It had to be close to her home. She applied to over 70 practices in waves of increasing distance from her South East London home. She included a photograph on her CV as she had been advised to do so by a VT advisor who had come to talk to the final year about life in vocational training. 15 training practices asked her to attend for interview; she attended eight, five of these being in her preferred location. These interviews were translated into two offers of a VT place, both close to her home.

How did she choose her practice?

It was close. I had a good vibe. The staff were pleasant and it felt like a nice practice to work in. Mr Smith (her trainer) had some nice ideas. He didn't seem...in other interviews they asked how quick are you? I was a bit wary of them, they saw training as a way of getting money out of you. I didn't get that feeling with Mr Smith.

There had been an initial short interview and Miss Patel was then invited back to visit the practice for a longer session and meet the staff. This second session lasted in excess of two hours.

Like Miss Patel, the overwhelming majority of the VDPs favoured a practice close to their homes, and close to their homes meant London and the South East, but only just over half were successful in finding a VT practice in such a location. Knowing or speaking to the outgoing VDP was considered important; most tried to do this and everyone including Miss Patel suggested that they would advise others to do likewise. Miss Patel did in fact speak to the outgoing VDP and received a most negative report on the practice and the trainer, but the manner and nature of the criticism suggested to her that he, and not the trainer, was at fault.

The mean number of VT applications for Miss Patel's entire qualifying year was 31, somewhat less than Miss Patel's 70, but very few of the VDPs had her degree of success. A VDP was more likely to receive seven invitations for interview, attend four and receive two offers, only one of which was in a favoured location.

Of particular concern was the conduct in some of the interviews. Again Miss Patel's experience was at the positive end of the spectrum; there were examples of inappropriate management. One trainer interviewed the applicants in the practice waiting room, with the patients taking part in the interview process! Post interview, one applicant was phoned by a trainer, who begged:

Please don't attend any more interviews. We really want you.

The post was then given to someone else.

The perception of disadvantage in the selection process was significant. Whilst Miss Patel had no complaints about her treatment, others were less happy with their experience. Time and time again female students commented that they hadn't had any problem themselves, but:

The boys just seem to walk into the jobs.

It's just not fair. There doesn't seem to be any obvious racism of sexism. But look who gets the jobs.

This perception of disadvantage in VT is widespread and not just restricted to the applicants. As had happened with the initial cohort, one Asian girl in the second cohort reported that a teacher had advised her not to apply to any Asian male trainers because they only ever employ males. She ignored this advice and secured a place with an Asian male trainer, as did almost half of her Asian female peers.

Choosing the VDP

At the time of this training year Mr Smith had been qualified for seventeen years and Miss Patel was his fifth VDP. This placed him exactly at the mean of training experience. The range of trainer experience varied from those who were in their first year of training to two who had been in VT since the pilot schemes of the late eighties, one now in his eleventh year. Mr Smith had trained for two years; he then had a two-year gap. He was now in his third consecutive year of training. This pattern of training, moving in and out of VT, was common amongst his fellow trainers although this trend seems to be changing. Competition for training places is increasing and three trainers reported that they would like to take a year out but felt that they might have difficulty regaining their place thereafter. Mr Smith had received well in excess of eighty applications for his VT place and he commented that most of the CVs were very similar and each school seemed to have a particular style.

And Mr Smith's selection criteria?

We go on location to a degree. It is a massive change for them. So if someone is stayingif they are local, it is one less issue to consider. We interview about ten, and then we invite about five of these to sit in with us -for about two to three hours. The whole practice makes the decision...at the end of the day it is teamwork, they have to fit in.

Mr Smith's two-hour interview was not the norm with his peers, but it was with the most experienced trainers. They saw this as time well spent; a worthwhile investment if it meant that the training year was going to be a success. I suggested on page 52 that VT was a partnership; one very experienced trainer commented wryly, but seriously, that he spent more waking hours with his VDP than with his wife. The relationship had to work.

As with Mr Smith most of the trainers saw location as important. They wanted the VDPs to be close at hand and although many VDPs were prepared to relocate, trainers saw this as another major change in their lives

and starting VT was more than enough. But the overwhelming issue was that VDPs had to fit in; they had to get on with the staff. Like Mr Smith, trainers are looking for someone to join a team –to join a family. Personality was therefore a critical criterion. As one commented:

They have to fit in. It's personality. I have to have a happy working environment.

And in common with Mr Smith, many of the other trainers thought the CVs were all the same; they were clones of each other. Too many of the applicants had copied the format suggested by the British Dental Association, including the wording. Therefore something different in the CV would invariably result in an offer of an interview. As one trainer noted:

It's not surprising really [that all the CVs are the same]. They've all done the same thing, but you can tell which school they come from. I look behind the CVs. What are their interests? What do they do?

My advisor mentor had suggested to me that I advise my students to have something different, something that stood out in their CVs or they would be ignored. He used the example of once interviewing a candidate because he kept ferrets. I help with many CVs and I suggested to one student that she make more of her piano teaching and asked if there was anything else she could put in? She replied, 'I'm a Charlton season ticket holder.' It was very reassuring to hear her trainer specifically mention these points as a reason for calling her for interview.

Miss Patel had not targeted the practices. Trainers considered this an important tactic to gain an interview; this showed that the VDP had done some homework. The Dear Sir/Madam approach was common and unlikely to succeed. A well-written and directed letter would almost certainly result in an interview, but so many letters were not well put together. One trainer from Rye had received an application from a student saying that he had always wanted to work in Wales! However there were difficulties that the VDPs

could never overcome. In common with Mr Smith most trainers did not like applicants phoning them. Yet a few trainers expected it. One trainer prioritised those who did so.

The role of the trainer

Mr Smith saw his own role thus:

I'm a mentor, a guide, a confidence builder.

His comments very succinctly summed up the sentiment of the other trainers. The quest was to settle the new graduates into VT and ease their transition into general practice, providing an environment for the VDPs to develop as practitioners. As one trainer put it:

[My role is] to make the transition easier and less painful than it was in the pre-VT days.

One very experienced trainer reiterated this, but added:

Above all else, my job is to make sure that they keep their enthusiasm. Your first job can have a dramatic influence on the rest of your career!

Another with similar training experience:

I give them the freedom to try what is right in the right environment. I'm there; they can push their own boundaries. My role is to ensure that they maintain their enthusiasm. If the NHS allows it, they can do it here.

This trainer noted that he was unlikely to continue next year. He, unlike Mr Smith, had not undertaken any postgraduate qualifications; something that now seemed to be required to continue as a trainer. He was aware that others were keen to take his place, but he questioned, as did others, in the same

position, whether additional qualifications should be a factor in trainer selection.

Another trainer, in his tenth year of training:

I'm here to problem solve –at any time. I'm not here to hold their hand. They know what to do. They are good. They are competent. Yes, I'm 'hands off'. Whatever anyone says, they are so much better than we were, but many forget what they were like.

Another with similar experience:

I'm a facilitator. We all got there without VT. The aim is to get them where they are going a bit quicker and with less pain.

He continued:

The idea is to try and get them to lead the year themselves. Hand them control. But in the first few months they don't want it. They want you to be prescriptive. The key is to read the VDP and know when to modify your approach.

Some were a lot more 'hands on'. A trainer in his sixth year:

I'm really a teacher. I want to see everything, every few minutes.

Another, five years into VT:

It's fire fighting! I'm sorting out basic clinical problems.

One in her first year, although hardly a novice trainer judging by these comments:

I stand back. I'm there if I'm needed. They'll speed up when the time is right. I'm young –or new! I was a VDP not so long ago and I do what worked very well with me. I wasn't rushed. I was given the time.

The trainer who wanted to see everything noted that he was very 'hawk-eyed'. In fact the risk of litigation is now a major concern with many in VT. But for the trainer who was unlikely to carry on because of his failure to undertake extra qualifications, this was just not an issue and he echoed the sentiments of Mr Smith:

Oh no, look after people properly and you rarely have a problem.

For a trainer/advisor in the second cohort, litigation was becoming an issue of increasing concern. He suggested that because of this many trainers were frightened let go of the reins. He similarly suggested that VT was a confidence building exercise; yet his VDP thought his VT commitments elsewhere meant he was too 'hands off'. He could also be patronising and sarcastic. This particular VDP was not at all confident and expected a very high level of support; a level that her advisor could not, or would not provide. Because of the nature of the job, other advisors suggested to me that they favour applicants who have undertaken a house officer post because they need less support.

While there were varying ideas on the role of the trainer, the approach to the actual day-to-day teaching carried far greater consensus; it was having an open door and being there. Building confidence was the primary aim.

The first five to six months of VT was a phase of extending competence in an increasing range of tasks and situations. The level of support had been decreasing and the type of support needed was changing, from definite help with tasks and situations to advice and guidance. Routinization of the more general clinical and management situations was occurring and the skill level

on complex procedures was enhanced. And within this framework, the VDP was able to cope with an enhanced workload. Most trainers felt that by January the 'basics were in place and the quest was now to enhance speed and workload without compromising quality. On the Dreyfus and Dreyfus (1986) model of skills progression they were now perhaps advanced beginner. All the trainers, to some degree at least, kept an eye on his/her VDP's monthly gross income. The prevailing view was that by the end of VT, the VDP should be grossing around £6,000 per month (this incidentally had been closer to £7,000 with the trainers in the first cohort), if they are going to perform satisfactorily as an associate thereafter. Not one trainer was able to articulate how these improvements were affected. However, in conversation two particular experienced trainers did recognise that they were trying to teach skills that were second nature to them. I felt that they were aware that they had tacit knowledge, but they could not make this explicit.

Practice facilities

Invariably the initial interviews were conducted in the VDP's surgery, so I was able to observe the equipment and general facilities first hand. Miss Patel was quite satisfied with her working environment. Surveying her domain:

This is nice. You get problems, but everything is working. I don't have the same range of materials that we had at university, but I feel able to ask if I want it. Mr Smith encourages me to try different materials, its fine.

Interestingly, the common perception of the VDPs' surgery was nothing as positive. This was summed up very well by the comment of another VDP:

I really like my surgery...you can spot most VDPs' surgeries a mile off. It's the cupboard at the end of the corridor.

The reality was in fact very different and Miss Patel's comments could well have come from anyone of eighteen of the second cohort VDPs. And those

who were unhappy, always had the basic requirements; unreliable equipment and slow maintenance were often the issues here. Two of the VDPs had facilities that were way beyond those of Miss Patel and were best described as palatial. Only one VDP was not happy and continued not to be happy with the practice facilities.

Patient load

After a quiet first week, the workload steadily increased until at the halfway point Miss Patel was feeling part of general practice. She was seeing around 15-20 patients a day, and although the absolute number of patients hadn't changed significantly as the months passed, she felt she was working with far greater efficiency and increasing amounts of work were being undertaken on each patient. Most of the work was routine 'NHS stuff,' a bit of everything. The NHS regulations had initially seemed to be an unfathomable and unnecessarily complex set of rules, but these were falling into place.

At this stage, Miss Patel's comments were representative of almost all the VDPs. They were safely settled into VT and it was pleasing to see that confidence levels were rising, something best summed up by the comment of one VDP:

Now I just do the surgical extractions. I used to lose sleep the night before, just thinking of doing them.

Now I suggest that the VDPs were beginning to show evidence of passing through advanced beginner just as the trainers in their proposed model of progression suggested they would at this point in time.

Virtually every VDP had a patient load that mirrored that of Miss Patel, and as time went on, they similarly had a quest to achieve more on each patient and not necessarily see more patients. The VDPs soon came to appreciate that patients rate dentists who are quick, and lengthy courses of treatment did not go down well.

One point Miss Patel hadn't mentioned in our interview was treatment planning, but this was something that Mr Smith was particularly concerned about. Well over half of the VDPs had been worried about being able to treatment plan a patient successfully. At the halfway stage this was getting easier and prioritising procedures was becoming a less laboured process. But the apparently simple act of putting together a sensible, manageable treatment plan had caused far more problems than any of the VDPs had anticipated. Indeed as far as the trainers were concerned treatment planning was an ongoing concern, even with the VDPs who appeared to be skilled in the usual weak areas of the oral surgery, endo and complete dentures.

The support staff

In Miss Patel's practice the nursing staff were good, but she noted how different they were to those in dental school. In practice many of the nurses joined as unqualified youngsters and they were then trained up. All the staff in her practice functioned well as a team and everyone got on well together. As far as the professional staff was concerned, as well as Mr Smith and Miss Patel, there was a full time associate, who had previously been a VDP in the practice.

Sixteen of the second cohort described their nursing support in broadly positive terms, but only a handful were given the level of support that Mr Smith had afforded Miss Patel. Pleasingly, only four had not been and continued not to be impressed with their nursing support as the year progressed. Here, an unwillingness to adapt or enhance speed and efficiency in parallel with that of the VDP were the major issues. As one VDP commented:

It's better to adapt to the nurse. I find that I am doing many nursing tasks myself in order to speed up. They are usually school leavers; their heart isn't in it. But it is better not to say anything.

The problem was most acute when the VDP was given a new and untrained nurse, particularly in this first six months. Later on they were able to cope

with training a nurse, but they had to feel confident in their own role first. Paradoxically, for two VDPs this had not been an issue; one revelled in the responsibility of training up a new nurse and considered it a hugely valuable experience. The other suggested that it was an opportunity to train up the nurse to your way of working and almost from day one, he held regular tutorials for his nurse which were well received and much appreciated. This VDP's trainer mentioned that his nurse had learnt so much from being with him. Some nurses were considered to be 'life savers,' and it was very common to find a VDP noting how much he/she had learnt from the nurse. Some nurses possessed an encyclopaedic knowledge of the NHS regulations and they were seen as a priceless asset; so many VDPs were completely baffled by the 'dos and don'ts' of NHS dentistry.

About one quarter of the trainers, usually but not always the most senior ensured that the VDP had the best or most senior nurse, just as Mr Smith had done. And if a nurse left the practice these trainers took on the task of training up the new recruit themselves, and she/he was not allowed to work with the VDP until the trainer considered them competent. As one experienced trainer commented:

They've got more than enough to be getting on with.

They've got to have good support. It's essential.

Another trainer of similar training experience, admonished himself for not placing his VDP with the practice manager. Although his VDP had had an experienced nurse, there were some problems that arose that the trainer thought would have been more effectively managed by the practice manager. She had the knowledge and experience to intervene early in a developing problem.

The teaching

Moving to the teaching within the practice, Miss Patel's initial concerns at the prospect of starting VT were:

Just being on my own. Being responsible for a patient and making the correct diagnosis. I know he was always there, but in university I was used to having a safety net.

And Mr Smith *was* always there and completely approachable, Miss Patel pointed out that unlike many of her peers, whose trainers were often elsewhere and doing other things, she had a trainer who was always in the practice:

He doesn't work in other places. Yes, he has the odd day off, but he's here and he always is, whenever I want him. It was like that on day one and it hasn't changed.

Miss Patel's concerns and worries about the first few days were common to all the VDPs. It was pleasing to see that they appreciated the support provided by Mr Smith and his peers –support that was invariably unconditional and ever present. The following VDP says it all:

She is always there.

And although as the year progressed the support was no longer needed to anything like the same degree, it was still there and this was much appreciated. A few trainers specifically demonstrated that they had faith in their VDPs. One VDP commented:

He trusted me. He said I'd be fine and let me get on with it.

Another VDP had identical comments and for the most part the trainers and staff followed Mr Smith and his staff in making the VDPs feel at home and part of the team. At this halfway point, in the entire second cohort there was only one dissenting voice; the VDP whose trainer was also an advisor on a neighbouring scheme. He was just not available when he was needed.

Miss Patel had learnt very quickly that dentistry in the real world was very different from that in dental school. She was beginning to fathom the workings of the NHS, but in common with her peers, she was at a loss to identify one advantage in the system, but there were many disadvantages. At this stage she thought that:

I'll always work in the NHS, but the constraints are far too great. All the paperwork... You can't do this or you have to do that. Its silly and very often you can't offer patients the best treatment.

Six months into the year and Miss Patel enjoyed the tutorials and Mr Smith's chairside teaching was of high quality. A regular tutorial slot was always blocked off during the week, and she invariably chose the topic. So often this protected time was used to discuss clinical cases or issues of the day. She commented that there was a backup list of theoretical areas for discussion topics, but this was not what she wanted. Mr Smith would occasionally use the tutorial session to undertake a difficult procedure with Miss Patel. He was particularly good at explaining complex issues involved in procedures such as molar endodontics, crown preparation and surgical dentistry. His approach was very effective and much appreciated. As she noted:

We could go through the topics, but I find the practical side far more useful.

These comments confirmed those of Mr Smith:

They lead the tutorials in the first weeks. We get patient case notes, radiographs and study models, we do cases, etc... It is amazing what spins off from that. I try to keep NHS management and the regulations to the final term. To begin they have to get used to treatment planning and doing the work. It seems to be working very well.

With this comment Mr Smith was demonstrating his understanding of VDP progression. He went on to note that it wasn't always easy to teach VDPs how to carry out some of the more complex clinical procedures. Four other trainers, all of whom had been in VT longer than Mr Smith, made similar comments. Every trainer reported that they held a regular weekly tutorial, although many of the VDPs reported that this regularity tailed off after the first few months. In the first few weeks and months, these covered the basics -practice rules, health and safety and how the NHS works. Then it tended to be a case of let the VDP decide or it was an issue of the day or week. Many of these sessions were used for 'hands on' practical teaching and as with Miss Patel they were well received

Mr Smith confirmed that by January the fundamentals were in place. The correct sequencing of clinical procedures was now understood. The next six months would essentially revolve around enhanced efficiency and speed, so that the VDP was able to survive in the real world, post vocational training. This model of VDP progression was a common thread running through virtually every trainer's teaching plan for the year. Mr Smith continued:

The speed will, it is coming... if you get it in the right order. You have to have the nuts and bolts in place. We've started to look at the schedules [the VDP's monthly returns from the Dental Practice Board]. You must do this... They talk amongst themselves. They all know who is earning what, so it is an issue.

A few of the trainers had a rather less hierarchical relationship than had been the case with Miss Patel and Mr Smith. One VDP, who had previously undertaken an Oral Surgery house officer post, did all the trainer's surgical extractions and all the impacted wisdom teeth. She and three others reported that their trainers regularly asked them for advice and the positive effect that this had was dramatic. It was a manifestation of the trainers demonstrating that they valued the VDPs. While this didn't necessarily happen with Miss Patel, the ongoing feedback on her performance (which was not that

common a practice) was exceptional and more than compensated for the differences outlined here.

The issue of gross monthly income

NHS dentists are paid on a fee per item basis. At the end of each course of treatment the completed work schedule is forwarded to the Dental Practice Board (DPB) who then reimburse the dentist each month. These are the schedules of gross income. At this point it is worth remembering that the VDP is salaried and this is sourced from central funds. The trainer receives a training grant and keeps the VDP's 'patient treatment' income. Advisors seem to be divided as to whether a VDP's monthly gross income should be a factor in measuring performance. Most trainers think that it should.

Aware that the VDP's monthly gross income is a sensitive issue, Mr Smith continued:

You've got to [discuss the gross]. They must be prepared. Even then, when they become associates [and are self employed] they shift up several gears. Many argue that that is when the real learning curve begins. VT is a cushion, but they are better dentists for it.

Working with enhanced efficiency meant that the monthly gross was increasing. Mr Smith was more than content with a relatively low, end of VT monthly gross figure in the region of £5,000; yet paradoxically he felt that the volume of work done was an important measure of performance.

Even as early as January two VDPs were concerned that their trainers were expecting too much. One with a schedule of £5,250 had ascertained that this was higher than anyone else on her scheme; yet her trainer had suggested that she was not working hard enough –indeed in the end of VT interview he suggested to me that she was lazy. The other VDP had a January schedule of £4,500, yet she was constantly reminded that she lacked speed and expertise.

Most trainers would like to see £6,000, perhaps £7,000 at the end of VT; few would be unhappy with £5,000 five to six months into the year. Mr Smith admitted that from a personal and practice point of view, he did not have any need to see a high gross. Advisors are responsible for their entire scheme and they monitor the gross income of all their VDPs. The advisor in the second cohort noted that his own VDP had never approached £5000 and she was one of the lowest earners on his scheme.

Initial reflections

At the halfway stage, Miss Patel commented:

It's hard work, but I'm glad I'm doing it. I'd do it even if it wasn't compulsory

In this Miss Patel was speaking for the entire cohort of VDPs. It is easy to dwell on problems and failures; they are newsworthy. But at the halfway stage VT was going well and it did seem to be a positive experience for the overwhelming majority of the participants.

And the future? Bearing in mind that any decision to stay on in the practice post VT, was going to have to be made less than a month after this mid term interview:

There are things that attract me to stay and others that don't. I think Mr Smith wants me to stay. If you stay on after being a trainee [VDP], I think I'd always feel like a trainee. I needed a lot of help at the start and I think I'd always feel that... I think I probably will stay on. I'd really like to follow up my patients.

This was a common problem. The VDPs were settled in; they were comfortable. For those whose trainer intended to continue in that role, the future was certain; they had to move on. But for the others, would they be invited to stay on? If they were, should they take up the offer? This was only

six months into the year, yet the selection timescale dictated that a decision would have to be made soon.

And for Mr Smith? He was very happy with Miss Patel's performance at this stage. Despite his time consuming efforts to choose an appropriate VDP, he didn't always get it right. He had had a disaster the previous year and he was still trying to deal with the fall out:

We had a disastrous time last year. It coloured my view of vocational training. We are still picking up the pieces. Cases are failing very quickly. We calculated that 5% of his [the previous VDP's] crowns have been successful. And it's so difficult to sort many of these problems out. It is a great learning curve, to see what you've done and to see how your cases are going. All my other VDPs have been fantastic; my associate used to be a VDP here. Oh Miss Patel is doing fine.

Bearing in mind that comments abound about the newly-qualifieds' competence, it was pleasing to see that at this point the VDPs were performing well. A few of the trainers had had initial concerns, but these were now more positive. The advisor in the second cohort:

I was horrified to begin with. She swerved things, but she is much better now.

The comments of three of the most experienced trainers:

Brilliant. She fitted in from day one; I never had one single problem or issue. And clinically she is very good.

Pretty good. He'll be fine. And:

Fine, always a smile and works very hard.

But the comments of two trainers in their first year were equally positive:

Oh he's good, and when I compare him with some of the stories I hear from trainers on my scheme. And:

Excellent, we don't want her to leave and she's not going to. Her surgery is very good -better than mine!

This last trainer suggested that although he felt fortunate, a careful and thorough selection process seemed to be the key to success. In the initial cohort it was only the most experienced (possibly expert) trainers who viewed the selection process in this way.

The conversation with Mr Smith moved to a discussion of the modern graduate, significant perhaps in view of his recent untoward experience:

We all think we were better, taught better. It's difficult; they don't have as much clinical experience, and for most, I don't think that it makes much difference. But there are some who do need extra experience in a protected environment. And VT hopefully identifies those who need that extra help. I'm not sure you can pick this up at interview or from references.

Two trainers, the most and least experienced developed this theme:

Oh, they are good. They know so much more. It's their repertoire of skills. But it is the trainer expectations; they forget what they were like. And:

Some of the [more experienced] trainers say that they are awful clinically, but we're happy. It's nice to be asked. You question what you are doing. You no longer do it on automatic. I ask, how am I doing this?

I suggest that in this last comment the trainer is aware that that he has tacit knowledge and that a critical training skill is to be able to make this explicit.

Another experienced trainer:

Everyone comments about endo, but we all had difficulty with endo –I still have difficulty with endo! We think we were better. Perhaps, but they know so much more than we did.

And echoing Mr Smith's sentiment:

They don't have the same clinical experience, but that doesn't matter.

But these comments were not universal, some trainers, admittedly a small minority, were not so complementary. One commented:

So many are not as good as they used to be. They need to do more.

And another:

VT is a remedial year. Some say it is the clinical part of the degree course.

Interestingly the last trainer was more than happy with the skills of his own VDP on arrival in the practice.

The Study Days

Moving to the regional Study Days Miss Patel felt that for the most part they were useful:

But every now and then, the lecturers go on a bit. Some are good, when they give you tips for general practice. Things that inform [your practice].

As far as the VDPs were concerned the social aspect of the study day was its reason to be. Like Miss Patel, every VDP enjoyed the social contact, but just as important was the sharing of experiences; the knowledge that you were not alone and others were facing the same problems. As one said:

VT can be very scary and it's really comforting to know that everyone is having the same problems.

Most of the advisors held or had previously held an initial hour of 'Moan and Groan.' This was a session facilitated by the advisor where the VDPs could talk candidly about their concerns and disasters. The success of these sessions depended entirely on the way they were managed. VDPs on one central London scheme thought that this session was:

Fantastic, These were fantastic. They were so helpful.

But other VDPs were not so impressed including Miss Patel who commented on her scheme advisor:

He's quite ... he's dedicated, but sometimes he can be quite ...he says come to me [with your problems], but we've found that if we do bring things up, he makes us feel quite small. So none of us bring up anything anymore. You just get, 'didn't you know that? Don't you know what you're doing?' And the point is, we don't quite know. He's not the way he would like to be, but he doesn't realize it. I'm good friends with another scheme advisor's VDP and I know he is just as dedicated, but he's good, he's approachable and they have a good time. It's not an easy time for us.

Mr Smith also had mixed feelings about the Study Days:

The social aspect...It's a complete change. It's good that they get together on a regular basis. They all have the same problems and they discuss them. Yes, that seems to work well.

As far as academic part is concerned, it's alright, but it is geared toward private practice. The sessions are interesting, but when you get back to it, you can't do that on the NHS. It tends to be geared towards high cost dentistry. And when you look at the fees the NHS give you!

In fact, no more than a third of the trainers in this study were grounded in NHS dentistry. To participate in VT, 20% of practice income must come from the GDS and for many practices the VDP is the major contributor to this income. One very experienced, wholly NHS trainer echoed Mr Smith's feelings, only more passionately:

They come out [of dental school] with the idea that you can't do anything [on the NHS] and you have to compromise on everything. The idea is to excite them. It can be fulfilling. The number of practices who are over 90% private!

As far as Miss Patel was concerned, as the year progressed into the second half, the Study Days continued very much as they had started. She enjoyed the days and the interaction with her group, but if anything her adverse opinion regarding her advisor strengthened:

He didn't like our group. He was unprofessional. He continued to intimidate our group and always made us look stupid. He made it so we didn't want to

participate. We learnt from each other, but not from him.

Despite this rather unfortunate remark, Miss Patel was able to separate this from the main thrust of VT, and this was seen as an unfortunate blot on an otherwise really enjoyable year.

That said, her experience with her scheme advisor was echoed, to an admittedly lesser extent by many of her peers on other schemes. They felt that they were treated like school children. As Miss Patel noted earlier, they knew that they were junior colleagues, but they were colleagues none the less. Miss Patel could have been speaking for many of her peers in expressing her concern about the private bias of so many of the study day lectures. Others picked up this theme:

On Friday [study day] I want something that is useful on Monday, not next year or when I have my own practice.

Another:

Many speakers only work in the private sector and what they bring is hardly relevant. One [lecturer] suggested that we should charge £95 for a failed appointment. I mean!

Assessment and the Portfolio

As far as the Portfolio was concerned Miss Patel suggested that it was OK, but:

It's really a bit of a drag. I think it can be useful if you've got lots of problems and you want to highlight them. But otherwise it can be quite hard going. Our advisor is pretty strict. I guess it's quite a good log. It monitors your progression.

With these comments Miss Patel was more generous than most. The majority of VDPs reported that maintaining the Portfolio was a most tedious procedure –and tedious was the word they used. It was common to find the VDPs acknowledge that the Portfolio was a valuable record to see how far they had come. But that wasn't the point:

But I don't look back. I don't want to look back.

The enthusiasm and rigour with which the Portfolio was completed was directly proportional to the advisors', and to a lesser extent the trainers', attitude towards it. When an advisor looked at it twice in the year and admitted to his group that he thought it is a pointless exercise, this attitude filtered down and as one VDP put it:

I know that it is meant to be an ongoing reflective account of your time in VT, but we all do it together the night before we have to hand it in. If they looked at it properly, we'd do it.

Another went straight to the heart of the problem of VT as she and many others see it:

They should have set objectives for the VT year. We must know what we have to achieve.

And Mr Smith had his concerns regarding the Portfolio:

It's difficult to do. We get through it, but whether it serves any real purpose.... I feel there should be more [formal] assessment and one component should be the amount of work. We should really have an idea of what they have done throughout the year. At the end of the day, the more work they do, the more experience they get and the more they learn.

Mr Smith's comments regarding the value of the Portfolio were typical of a trainer of his experience. He like most of his peers agreed that as a record of achievement it had value. But was that the purpose of it? The initial needs analysis was considered important, but thereafter many including Mr Smith questioned where they were meant to go with it.

The most junior trainers tended to be guarded with their comments:

'We are finding our way around it. Its OK...But they know what they can do.'

Another:

It's good but it could be far more effective. There is no appraisal. And no appraisal of trainers.

Three most experienced were starting to see the Portfolio in a different light:

It's good, but you need to look after it. The advisors must stress the importance of it.

It's difficult, but it adds some much needed structure to the year. It should be the framework on which you can hang things. And:

It does what it is meant to do. It's good.

The advisor in the second cohort summed up this progression of opinions:

I used to see it as a chore, but my view has changed. As an advisor? It is essential.

As time went on the Portfolio seemed to become more and more irrelevant. Miss Patel reiterated her earlier feelings that the Portfolio had been at its

most useful in the early stages. But she went on to comment that she, like her peers mentioned above, had ended up hurriedly making up weeks and months of supposedly ongoing reflection, the night before the advisor was due to check it.

Mr Smith was aware that many in VT had concerns about the Portfolio as the primary assessment tool. His scheme advisor had asked the trainers for their opinions regarding assessment, but he found it difficult to put into words how he carried out his own assessment:

It's difficult. You get a feel for a person; you know when they are good [with patients]. If they are good communicators...but...the Portfolio has its limitations and I think it should be more formal. Essentially you should be able to fail the year.

In this, Mr Smith was aware that if the year goes well as this one had done, issues of sanction are an irrelevance, but the events of his previous year were still fresh in his mind:

I know he [last year's VDP] has been a disaster wherever he has gone. I've been phoned twice by people who have employed him, and he hasn't changed. The advisor should have accepted more input from me. For example, the case presentation, he was very computer literate and he had jazzed up the report. He passed, but we know most of it was made up and the case failed very quickly.

This is where something formal would be useful. On the other hand if that meant he was staying on ... You get to a point where you don't want them with you in the practice any longer than absolutely necessary!

We discussed the far more formal path that assessment in vocational training is taking in Scotland (Grieverson, 2002) and Mr Smith pointed out that testing basic skills in VT is not what it is all about. It was about honing the relevant parts of their training to enable them to manage patients in a general practice environment. It was about going back to basics and being able to build up a comprehensive and definitive treatment plan. He also pointed out that it was obvious that on occasions not all the basics were in place and then there could be problems.

Another career trainer who couldn't remember how many years she had been in VT:

Testing isn't the way to go; they are qualified. I thought the whole idea of VT ...was its somewhere a VDP can make mistakes. If he knows he is going to be judged, he isn't going to ask questions that might appear silly.

It's about self-assessment. I remember wanting to ask really silly questions and some haven't been answered to this day.

She continued:

A lot of trainers who are keen on [a more formal] system of assessment, seem to see that there is only one way of doing things –and it is their way. And that is even more dangerous.

And then perhaps a predictable comment from someone with her level of expertise:

I have to say, maybe I've been lucky, but they've all been very competent.

This trainer went on to discuss how important it was for the VDP to develop his/her own professional expertise. They were graduates. This was not an apprenticeship; or it shouldn't be. She also noted that there had been times throughout her long time in VT when she would have liked to take a year out and recharge her batteries, but she hadn't done so because there was always the chance that she might not be able to get back in.

The second six months: consolidation

Reflecting on her progress throughout the year, Miss Patel noted that she had been pleased with the range of procedures she had been able to undertake, particularly in the second six months. Once she felt comfortable and the basics were in place, she just 'took off'. The one area where she would have liked to do more was orthodontics, and although she had the opportunity to do some cases, she had avoided doing them and she now regretted this.

This was a period where the VDPs were able to consolidate and enhance their efficiency. Miss Patel's comment about avoiding certain areas, is pertinent. Endo and MOS are areas that cause problems for the new graduate and it is critical for the VDP to break through what is a 'confidence barrier.' This is why using the tutorial session to tackle clinical problems such as these with the trainer was so effective. But some VDPs never break through this barrier; some avoid going near it! In a busy practice it is quite possible to avoid certain procedures rather than ask for help. And later on when reflecting on their progress, those that had taken this path regretted it, as did those who by their own admission, had cruised through the year. One particular VT who admitted that she was initially not at all confident commented:

I don't understand those who do the minimum... and try and get away. The more experience you get.... It is the only chance you have with a sort of safety net.

One VDP in the second cohort undertook her VT in the Community Service rather than general practice. And while she and her very experienced trainer were happy with her progress throughout the year, she was aware that the

community service exposed her to a very limited patient base. As these were mainly children or patients with special needs, she hadn't had the opportunity to undertake any advanced treatment plans that included endodontics and crown and bridge. She therefore felt ill equipped to proceed to general practice. In the event however, she did move to general practice, a practice with a principal committed to the professional development of his juniors and he helped her get up to speed in the areas VT had missed.

The support staff

For Miss Patel the nursing support continued as it started; she always had a nurse and Mr Smith would go without one rather than leave her in that position. The situation was the same with the equipment. If she had equipment problems that couldn't be fixed immediately, Mr Smith gave her his surgery until hers was fully functional again.

For most, the facilities continued as they had started, but the nursing support went downhill. It was in the second six months that VDPs were more likely to work with an untrained nurse or not have one at all. One VDP's view of his trainer and practice did change dramatically however. In January he was very happy and was almost certain that he was going to take up an offer to stay on in the practice. Then there were major staff changes and he was without nursing or reception support for long periods. Because of this and other issues, his opinion of and relationship with his trainer worsened and never really recovered. Yet this trainer seemed totally unaware that the relationship had gone downhill. He acknowledged that there had been problems with the support staff, but he was genuinely surprised his VDP decided to move on.

The teaching

Moving to the support afforded by Mr Smith in the second half of the year, Miss Patel was most complementary:

Oh the support was always there, most definitely. I never had a problem, he was always willing to help and always available. Moreover he never made me feel that I was an

inconvenience, and as with the earlier part of the year he was always on site.

Pleasingly this trainer support was there for just about everyone. Not necessarily quite as available and effective as that received by Miss Patel. But only Miss Shah (page 113) felt alone. Even the VDP mentioned in the previous section, noted that the problem was never one of a lack of support. A possible exception was the VDP in the second cohort with the advisor trainer. She didn't receive the support she would have liked, but she was never alone.

As far as the teaching was concerned, Miss Patel continued to be more than content:

He always wanted to hear what I had to say. He had high expectations of me, but he never put me under pressure.

He brought the schedules in [for discussion], but this was done in a positive way.

Miss Patel reported that the tutorial sessions continued regularly right to the end. Later in the year Mr Smith introduced her to a mix of complex cases and procedures to undertake, and more formal issues such as the NHS regulations and practice finance were covered. These sessions continued to be of high quality.

Here Miss Patel was speaking for only around a half of her peers. Tutorial sessions tended to fade out towards the end of the year. Where they did continue the sessions they usually became far less formal, particularly in the hands of experienced, perhaps expert trainers. This was an opportunity for reflection, which seems entirely appropriate for this stage. One such trainer talking of the need to continue the tutorials noted:

This is important, when you are busy and under pressure, the teaching is the first thing to go.

Without doubt there were trainers who felt uncomfortable teaching theory in the practice environment. One from the initial cohort hadn't conducted any tutorials at all in the first three to four months. In his first year of training, he suggested that his VDP knew so much more than he did. But as time progressed he felt more confident in his role and the tutorials started and they were well received. Perhaps for this novice trainer it was only once he was approaching advanced beginner that he felt he had something to offer. It is important to recognise that inexperienced trainers may feel uncomfortable moving into a teaching role.

Miss Patel was quite happy with her monthly schedules. At between £5,000 and £6,000 in the last months of VT, while not high, these figures were entirely respectable. The staff continued to be friendly, knowledgeable and very helpful:

They taught me a lot; they were so helpful. I don't understand the attitude of some. There was a nice atmosphere and it was a great place to work.

£5,000-6,000 as an end of VT schedule placed Miss Patel in the middle ground; most VDPs were in this region. The VDPs' reaction to their trainer introducing the notion of monthly gross income was mixed. Some accepted this as important as it was necessary to develop speed and efficiency. Others thought that they were being pushed and took longer to accept this. But deep into the second half of VT, gross income was an accepted fact of life. One trainer reported that in the final six months his VDP fretted constantly about enhancing his gross income:

Oh he fretted. He was always worried about it. But he was fine.

The trainer as a role model

Miss Patel's view of Mr Smith as a role model was very positive:

Oh very, very good. He stands out. He enjoys it. He's not the best model as a businessman. He's not very good at selling. But that's not what it is about. I would certainly recommend him, absolutely. You would be very lucky to have him.

We heard previously, Ralph et al (2000) and Baldwin et al (1998), that many VDPs did not view their trainers as positive role model. Here the outcome was very different. The vast majority of the trainers were seen as very positive role models and Miss Patel's feelings about Mr Smith were broadly representative of her peers. Although there were a few comments such as:

Not my ideal, but I admire him. And:

Not for me, but others would be fine (from the VDP with the advisor/trainer).

The comments from the following three VDPs were the more likely responses:

I had the best deal.

Very good. He's motivated to teach and does the right thing for the right reason. And:

I really look up to them (two trainers sharing the training). I am always trying to get my work up to the standard of theirs.

Of all the VDP partnerships in the study, only one (from the first cohort) ended in a situation where the VDP and trainer didn't talk to each other! Here the trainer was inexperienced and her expectations were perhaps a little high, but the VDP didn't help the situation. He had little regard for his trainer or any of her staff (I did have the opportunity to interview the practice manager in this practice). His attendance and punctuality were poor and he

made it clear that he felt that his trainer had nothing to contribute to his education. His trainer has left VT. He initially suggested to me that VT was a complete waste of time. However, having had time to reflect on the year as a whole, he admitted that he had indeed learnt a lot from the year. He enjoyed VT as a complete experience and was pleased he had undertaken the year. And so was every other VDP. VT was scary, often traumatic and definitely stressful, but it prepared VDPs well for the next stage of their professional life.

Trainer reflections

Mr Smith's reflections on the year were equally positive:

Oh the year went very well. A breath of fresh air [after last year]. She was good from the word go.

And her performance:

A bit slow with the paperwork, but fine clinically. Molar endo and oral surgery were initial concerns, but she was good. We had very few problems; very few people came back. I would have liked her to have stayed on as an associate, but it didn't happen.

Here Mr Smith was speaking for the vast majority of his peers. VDPs were slow with the paperwork and endo and MOS were recurring areas of concern. But as time went on, confidence levels were rising and skills were developing and these were less of an issue. Crucially, with very few reservations, the VDPs were considered capable of working independently as associates, post VT. Only four in the second cohort stayed on full time in the training practice, but if they didn't stay on, this was usually because the trainer was continuing in VT and a surgery was not available, or personal reasons dictated a move.

The next step

Miss Patel confirmed that she saw her future in general practice, so I was surprised to find she had moved on to a local, wholly private practice. Miss Patel explains:

I thought I might be going to the USA [to work] when he asked me to stay on. But [in the event] I didn't go.

She also commented again about the concern of staying on in the VT practice and always feeling like a student. In fact this was a major reason VDPs gave for moving on. They also wanted to see what life was like elsewhere.

Mr Smith thought that the reasons were situated elsewhere and yet again we heard of his concern about the influence of the private sector:

We had the facilities. The real reason is that this practice is mainly NHS. The VDPs are taught that private is the way to go. It's quite difficult. The Study Days are geared towards private dentistry. I can see it makes it more interesting, but VT is funded by the NHS and directs the VDPs to the private sector. There has been a big change in the last five years. They [VDPs] want to go into private practice or they want to be salaried. No one wants to run an NHS practice.

Other trainers noted that in the recent past VT was a good way of finding an associate, but now this wasn't necessarily the case. Recent changes in specialist training pathways meant that if a new graduate wanted to specialise, they have to complete a year in hospital and the best time to do this is immediately after VT. As one said:

No they don't stay on. If they want to specialise, they have to do a house job. They do VT because they have to!

While this was indeed the case there was another issue. Without exception the patient base for VDPs was more than adequate, but some VDPs noted that this was only just so. The patient list had been light to begin with and the load built up with time. This increase was usually initiated by the trainer, but once the VDPs were comfortable in their environment, close on half were conscious of the volume and nature of their patient base. They were keen to ensure that there was an adequate 'book' to support themselves as associates, but they were also keen to develop their repertoire of skills and if they worked in areas where patients preferred basic treatment this was a concern. Mr Smith may well be right with his comments regarding private dentistry, even if he is wrong about Miss Patel. The private sector frees the practitioner from both the treatment limitations of the NHS and much of its attendant paperwork.

The end of the year

Mr Smith was pleased to have a VDP who came in, did the job, got on with the patients and worked well with the staff. Punctuality was an issue of significant concern. Almost half of the trainers specifically commented on this, but Miss Patel had always been punctual and she was rarely ill. Mr Smith had to be pressed to think of a low point in the year and this concerned the management of his scheme. VT ends at the beginning of August, but it appeared that the VDPs were receiving their practising certificates earlier and earlier each year. This year it was June. Receipt of the certificate coincides with the end of the Study Days and this sends the tacit message that VT is coming to a close and the VDPs tend to ease off.

Unlike Miss Patel, four of the second cohort admitted that they eased off at the end of the year. Two of these stepped down a gear shortly after Christmas, but there appeared to be very specific motives. As one very experienced and I would suggest expert trainer noted:

VT did what it was meant to do. She doesn't like general practice. She created her own boundaries and wouldn't /couldn't step outside them, no matter how hard I tried to encourage her.

Returning to Mr Smith:

June to August could be a time for the VDPs to earn a bit of money for the practices. [It could be] an opportunity to give something back. Even if they are staying on, they still shift up a gear when they become associates. It's amazing how much they change.

Mr Smith took great care with the organisation of the year's teaching and attempted to tailor the tutorial programme to the individual VDP. However, he now felt it appropriate to be a little more prescriptive:

I used to let them decide what they wanted to discuss, but now I give them a selection of topics and they go away and prepare and then we have a tutorial. We ask the VDPs for feedback and we make sure that we take this on board.

Interestingly, his quest to add a little more structure to the year was something that some of the more expert trainers tended to do. They seemed to be concerned that perhaps they were a bit too hands off. They were constantly monitoring and modifying their programmes of study, aware that the need of each VDP was different.

Parting company

Mr Smith was aware that the VDPs give detailed feedback to the advisor at the end of VT:

I can only assume that there are no major problems as nothing is ever fed back to me. But the feedback has to be ongoing. I ask them how it is going. You want to know and you want to keep a happy relationship too.

Despite having to go through trainer selection each year, Mr Smith's comments regarding the lack of feedback on his performance, was something that was echoed by trainers throughout both cohorts. They wanted to know, not only the positive, but the negative too. If there were problems, even small ones, they wanted to address them. They wanted to develop as trainers.

Mr Smith returned to the issue of Miss Patel not staying on:

She sees a better reward in the private sector. Having said that, we still get on well. She stayed on for six weeks at the end of VT while she job-hunted. Generally, I think that the vocational commitment is diminishing. Maybe I'm getting older...They are at a different stage of need. They need to get on a career pathway, buy a car, etc. I don't have the same need, I can do things I enjoy doing.

Despite leaving the practice, it was pleasing to see that Miss Patel had similarly positive feelings about the training year:

I didn't stay on, but it was a very positive separation. He was good. I still see him and we go to continuing education days together.

Mr Smith returned to the issue of how important it was for VDPs to see the results of their work; to see their patients return on recall. The big cases tend to get finished just as the VDPs leave VT and they never see the patients again and learn very little from the experience. And the amount of work had to be considered. That said, he saw an end schedule above £4,000 as entirely acceptable, but his was not a high grossing practice. As he had suggested in the first interview (page 89), Mr Smith was happy with £5,000 and delighted with £6,000, but he was aware that others considered £7,000+ a more reasonable target. He returned to this issue:

Gross is now a big issue, certainly on our scheme and many feel that progress should be measured at least in

part by the VDPs' gross. It is a concrete measure of work done. Not stressing this issue is the number one reason why many find the transition from VDP to associate a huge jump.

Here he could be speaking for the entire group, although there were a few trainers who never mentioned gross to their VDPs and didn't push. The most experienced (expert) trainers maintained that above all else it was essential to maintain enthusiasm:

Concentrate on the skills and the money will come.

But without exception the trainers agreed with Mr Smith that once VDPs became associates and therefore self employed, the monthly gross increased dramatically.

Although I did not have planned questions on the subject, Mr Smith and four other trainers in the main cohort wanted to discuss the mechanisms of becoming or continuing to be a trainer. This had not been an issue in the initial study, yet it was something over which there appeared to be considerable unease/concern. The issue was that experience (perhaps expertise) in training did not seem to count in trainer selection, a process that trainers have to go through every year. Or at least the trainers have a perception that it doesn't count. It was suggested to me that regional and VT advisors were attracted by extra professional qualifications as evidence of commitment to continuing professional development.

Although Mr Smith possessed a postgraduate qualification, he had not felt any pressure to follow this path, but he was aware that others felt differently. One trainer (of seven years experience) with an absolute commitment to continuing education, but without a postgraduate qualification, noted that his regional advisor had told him that soon all trainers would need to have an appropriate post graduate qualification. Although this particular trainer enjoyed every minute of VT, he revealed that each year he expected his application to be rejected. He noted that extra qualifications are easily

identifiable indicators of performance, even though they are not necessarily valid indicators of a trainer's training knowledge and expertise. Another trainer who adored every moment of training noted that at interview it had been suggested to her that some of the experienced trainers should step aside for those who wanted to have a go at training. Such suggestions had not come Mr Smith's way, but two others had had similar experiences, one feeling that, as much as he enjoyed training (no one in the cohort had trained more VDPs), he felt his days were numbered. He only held a basic dental degree and wistfully noted:

There are now many youngsters with all the right badges.

However, there were three younger trainers who considered continuing professional development essential and gaining appropriate postgraduate qualifications was a crucial part of that process.

The outcome

The trainer who stressed the need to maintain enthusiasm throughout the year went on to note how much your first job could influence the rest of your career. As with Miss Patel and Mr Smith the vast majority of the VDP/trainer relationships were not only successful, but they developed into strong and lasting friendships. So many of the new graduates kept in contact with their old trainer. One trainer was pleased to report:

She's enjoying her new practice, but she still feels able to phone me for advice at any time. She does, and that's very special.

The VDPs or rather former VDPs confirmed this. While many didn't have a problem asking their new boss for help and guidance, the relationship with their trainer was different. Help and advice had been and continued to be unconditional. On numerous occasions I heard that VDPs of three, four and five years ago would still phone for advice. But now the advice could be on buying a partnership or a practice. One VDP moved on to a high grossing practice and within months she noticed the quality of her work deteriorating.

Her old trainer found space for her return part time and restock. He was still there for her.

The atypical VT relationship

The relationship between Miss Shah and her trainer is the least representative of any of those in this study. It is perhaps the ultimate response to my second research question: What if the partnership is not successful? It is covered here in some depth as it highlights issues and problems that interested parties must be aware of. It is perhaps the worst example of what can happen, but many of the problems visible here are present elsewhere in VT, albeit to a lesser extent.

It was particularly pleasing to arrange the mid VT interview with Miss Shah; her VT advisor was uncomfortable about her discussing the events of the previous six months with anyone outside scheme. But she had promised to speak to me and intended to keep that promise. This was fine, but immediately I found myself in a very sensitive ethical position.

Choosing the practice

Miss Shah applied to twenty practices and was invited to four interviews. She attended two, both in her preferred location, but these did not result in an offer. At that point she decided to delay her entry into VT until the following February and enter one of the interim schemes. She had a late change of mind when she saw a position advertised through clearing in the South of England:

They sold it to me as a prevention orientated practice and I liked the ideas that the trainer had. To be fair I wasn't giving myself all the options. As you know I wasn't going to take a VT place initially. Why were they in clearing? They said they hadn't found the right dentist for the practice. But later on, I heard about everyone who went there, were offered the job and declined it. So there were other reasons.

Miss Shah felt that the interview had gone well. Questions were based around how much clinical work she had done and how long she usually took to do particular clinical procedures. The trainer, his wife -the practice manager and the VDP nurse were present in the interview:

I should have picked up on it then. The practice manager had a large hold on things. She ran the interview. I didn't think about it at the time. They offered me the job then and there and I took it. There was no outgoing VDP to speak to. I was their first.

Clinical facilities

The surgery hadn't been fitted out at the time of the interview. It had all that was necessary, but it was small, windowless and it felt very claustrophobic:

It would have helped if my handpieces had worked in the first two weeks –which they didn't. That was a bit of a problem (she laughs).... Then the chair didn't work, but it got sorted eventually.

At this point in the interview Miss Shah informed me that she was on holiday and that her scheme advisor was looking into how long she was allowed to be off. There was a pause:

I'm not happy and I don't want to go back. I'm not going to go back!

Progress during the first six months

We continued the interview and discussed her clinical practice:

When I started I wasn't worried. I always get on with everyone. I was excited; I wanted to fit in and get on and see my patients. But... I've lost a lot of confidence in my own clinical decisions. I've moved backwards. My drive to do things better, to read up about things, has

completely dried up. I wasn't in an environment where I could try things out. I couldn't do things on my own and I didn't have support if I asked for it.

I asked of her trainer?

Oh he did lots of things, but I'm not sure that there was anything helpful. We did a lot of things like role-play; how to bring a patient in and speak to them. I had to role-play an initial examination in front of every member of the practice! I found this extremely undermining. I thought we were meant to be a team.

Tutorials and teaching

Miss Shah reported that she had received regular tutorials and she had hoped that these would be orientated towards learning new techniques, practice administration and areas of specific concern. But they revolved around behaviour management. As far as the NHS administration was concerned, Miss Shah was not allowed any help at all:

The practice manager and the trainer warned that I would be fired if anyone helped me -even if they wrote a name or address on the NHS forms.

Miss Shah continued:

I don't know what is expected of me any more. I was wrong to ask for help with the NHS forms. It was wrong to take five minutes more than I should to do something. It was everything. I began to feel suppressed after the first month. They were comparing me with an experienced associate. I thought ... Oh God! You don't know what to expect of a new graduate... I've just come out of dental school.

I asked what she has learnt in VT:

What have I learnt? I've learnt that I can be very professional in a very unprofessional environment.

At this point in the interview Miss Shah asked if we could continue the discussion without the recorder. Before we did however, she told me about her scheme advisor:

My advisor has been very supportive throughout the whole thing and he always gives me good advice. The only reason I've been able to take it for this long is because of him.

He had a word with the trainer and things got better for a while –for about a month. And in that month I was even asked to stay on as an associate!! I was shocked. I said I'd think about it over Christmas, I did and said I had other plans.

No, my advisor has been really good and he is doing all he can to make things better for me from now on.

It was after the recording had been suspended that Miss Shah revealed that she had been asked not to speak to anyone outside of her scheme. This was a difficult moment. Miss Shah did however confirm that I could use her comments provided that they could not be attributed to her.

She had been 'picked on' by the staff and the trainer. The walls of her surgery were covered with red lettered laminates giving the times allowed for each clinical procedure and she would receive a reprimand if she exceeded these by even five minutes. She reported that she was undermined at every opportunity. Despite the warnings, on one occasion, her nurse did enter the name and address of a patient on an NHS claim form. The practice manager screamed at Miss Shah and told her she would be sacked if that happened again!

It is interesting to note that despite all this, at the time of this interview Miss Shah had just received her January schedule, and at £4,800 this was a figure most trainers would be more than happy with.

Some of the reported incidents were difficult to comprehend. For example, on one occasion Miss Shah recalled that she had made herself and her nurse a cup of tea during a quiet time in the surgery. The receptionist phoned the practice manager at home to report that Miss Shah hadn't made tea for the other staff. A staff meeting was then arranged to discuss this incident and she was reprimanded.

Miss Shah reported that by the beginning of February, she had reached the stage where she was shaking and waiting for the next criticism. At that point she phoned her father; he said enough was enough and told her she was not to go back to the practice.

The second six months of VT

Because of the circumstances of this separation, I was not in a position to speak to her trainer, so I can only report Miss Shah's account of events. However her advisor was able to find a trainer who was willing to take her into his care for the second half of the year. I was able to make contact with him and he agreed to speak to me. The following account is from the end of VT interviews of Miss Shah and her 'new' trainer, Mr Jones. Miss Shah continued:

Oh, in the second six months my surgery was gorgeous. The practice was in a thirteenth century building. Timber ceilings. It was lovely. Mr Jones was lots of fun; he was young, about 33 and he could remember what it was like to be a student. He could relate to the problems that I was having. And he was really good with me, because he knew I'd lost a lot of confidence.

Fortunately, the scheme advisor worked in the same practice as Mr Jones and he had kept him up to date with events as they unfolded. Mr Jones took up the story:

I'd been appointed as a trainer on the scheme. In this area we don't get many applications, so trainers usually take the first [VDP] they see. I interviewed as many as I could in a two-week period, but they were all getting offers elsewhere and I missed them. I entered clearing, but I didn't want to take just anyone, so I didn't appoint. Six months in, the advisor asked me if I could take Miss Shah on.

Mr Jones reported that Miss Shah had settled in well. In fact he was surprised how keen she was to get on with her clinical work but there were some instances when he felt she should have asked for advice, rather than carry on. Despite his advice to the contrary, Miss Shah seemed to want to show him how much she could do, almost certainly so she could demonstrate that she was far more able than he might have been led to believe.

As time went on Mr Jones reported that he still felt that Miss Shah wasn't taking as much time with some of the procedures that she should have done and her standards were dropping off a touch. And he had stressed that he wanted quality, not quantity.

He felt quite strongly that because of what had happened in the first six months and the fact that Miss Shah had been ill for a period in the second six months, she should have had twelve months with him. She just hadn't had sufficient experience of VT to develop as a general practitioner. He continued:

I discussed this with my advisor and we agreed that if the trainer, advisor and dean feel that a further six months is needed, the funding should be made available.

And the positive side?

Oh her personality, she just gets on so well with everyone. Her communication skills are excellent. And at her best, her clinical skills are excellent.

Miss Shah was happy to be able to undertake the complete range of procedures, although as the practice hadn't been expecting a VDP, her patient list had had to grow from scratch. The staff in the practice were friendly and helpful. It was very different from her experience of the first six months.

The teaching

Miss Shah always had the help and support that she wanted. She reported that Mr Jones would always come to help whenever he was needed. When asked about the tutorials, Miss Shah gave a big smile and this broke into a laugh:

They didn't really happen, for a number of reasons. But in a week we'd discuss more than enough to count as a tutorial.

Mr Jones, aware that Miss Shah had not progressed in those first six months, suggested that he had had to be very careful when managing her in those first few weeks:

She gained absolutely nothing from that first six months. It could so have easily ended her career. She could have got so much more [from VT].

Miss Shah noted that with Mr Jones she had consistently received positive and encouraging feedback on her performance. This was very pleasing and something that was not that common an experience amongst her peers. She noted that he made a point of seeing what she could do well. And she again suggested that because of his relative youth, he seemed able to explain and/or

demonstrate a procedure in a way she could understand. He could tell exactly how and where she was likely to go wrong. I suggest his inexperience meant he was still able to make his tacit knowledge explicit.

Trainer expectations

Not surprisingly Miss Shah was concerned in this respect, as she knew that Mr Jones had heard so much from the previous trainer and her advisor. She noted:

He was in an awkward position. If the problem had been with me, then he was going to be in a fix. He said he didn't want speed, just good work. To be fair, I was very tired and things were still playing on my mind. I knew that Mr Jones felt I would benefit from an extra six months. Towards the end I wondered if I had let him down, but the feedback was always positive.

Mr Jones was tight on assessment; not only did he ensure that the Portfolio was adhered to rigidly, but he was keen for Miss Shah to show him what she had done. He confirmed that he wanted to see what she could do and not just come in and help when things went wrong. He reported that although the Portfolio was valuable, his scheme was developing an assessment protocol that went beyond that of the Portfolio, particularly in the areas of administration and clinical and social skills. He suggested that it was difficult to have a formal end of VT assessment, but more formal assessment was definitely necessary.

The Study Days

Miss Shah reported that these were brilliant. Her group gelled well right from the start and they had provided her with a great deal of support in those first few months. In fact one friend on her scheme (and a member of this cohort) phoned me on a number of occasions to let me know of Miss Shah's problems. And uncertain that Miss Shah would actually come and see me, she arranged to come with her and then left immediately.

While Miss Shah appreciated the academic component of the Study Days, it was for her advisor that she had the most praise:

He was a pillar of strength throughout the whole thing.

He wouldn't dwell on things. He just went out and solved the problems.

The year as a whole

For Mr Jones, who himself had only trained once before:

It was difficult, but I learned from it too. Was there something going on? In cases like this there should be the opportunity to extend VT for another six months.

I asked why he thought the previous relationship had failed so catastrophically:

The area she was in. Her ethnic background. I think the patients might have found it difficult. I know that the trainer...and certainly the staff did. [The trainer] would phone me and have a gripe. It did seem to be a personal attack on her. The advisor was aware of what was going on from an early stage and in retrospect I think he moved her too late. But advisors want –they need VT to work. He did try.

For Miss Shah:

I learnt a lot. The politics of a practice. I was very naïve. I should have made a judgement on my situation much earlier. I learnt a lot from Mr Jones and VT finished on a happy note.

I did a two-month practice locum at the end of VT and I was asked to stay on as an associate. That was really

positive. I thought I can do this. I had begun to hate dentistry. I'm a totally different person. Yes, I'm happy now.

Interestingly, in this interview and in later discussions, we tried to determine why events had taken such a turbulent initial path. Miss Shah did not feel that her ethnicity had been a problem, at least not the major problem. Jealousy was a more likely reason.

Summary of the VT experience

As I noted at the beginning of this chapter although I have presented the typical VT partnership, it does not indicate how each of the participants responded to each issue. This section is therefore designed to quantify the responses or observations that occurred. Essentially what follows is an explanation of the summary data table presented in Appendix 15.

The 35 trainers who participated in this study had been qualified for a mean of just over 21 years; the individual cohort means being remarkably similar at 21.3 and 21.7 years for the first and second cohorts respectively.

The trainers had taught on average 5 VDPs, again the mean for the second cohort was slightly higher than the first at 5.1 and 4.8 respectively. In both cohorts the range of training varied from the VDP in this study being the trainer's first, to trainers who had seen in excess of 10 VDPs. Some had been in VT since the early non-mandatory days.

When selecting a VDP, 17 of the trainers suggested that it was essential that the VDP fitted into the team and that personality was the factor that enabled them to make that decision. 12 trainers specifically mentioned the locality, where the VDP lived; ideally this was close to the practice. The most experienced of the trainers spent considerable time selecting their VDP. Selection was far more than just an interview.

For the VDPs, when they looked for a practice, two issues dominated. 26 noted the practice atmosphere; this had to be relaxed, friendly and informal. 24 of the VDPs wanted the practice to be close to their homes.

As far as their role in VT was concerned, 30 trainers saw this as providing guidance, easing the transition into general practice and being a mentor. One trainer suggested his task was to teach basic skills.

Into VT and there was only one VDP who wasn't satisfied with the clinical facilities that were made available. The VDPs' patient load once they were settled in, ranged from 15-25 patients a day, with a mean closer to 15 than 25. As time went on and they became more efficient, 18 noted that the number of patients seen didn't necessarily increase, but the amount of work carried out on each patient did.

The VDPs' opinion on the quality of their nursing support depended on which cohort they were in. In the first cohort there were 6 (out of 13) negative and only 4 positive views. In the second cohort there were 4 negative (out of 22) and 14 positive views. Throughout both cohorts, the most experienced trainers were more likely to ensure that the VDP had a good nurse, even if that meant that the trainer went without one him/herself.

On starting VT, 15 of the VDPs were concerned about the workload they were likely to face and running late. 12 were worried about living up to expectations. In those early days 32 of the VDPs reported that their trainer was supportive and always there when he/she was needed. 2 VDPs suggested that their trainer was no help at all at this time.

In the first six months 21 of the VDPs reported that they had regular one-hour tutorials that took place in protected time. Apart from the early housekeeping sessions, the tutorials almost always had a clinical bias. 9 of the VDPs reported that it was quite common for the trainer to use this session as an opportunity to carry out a clinical procedure on a patient together with his/her VDP.

As far as the trainers were concerned 14 suggested that the tutorial session was used to discuss issues of the day/week. Those who made this comment had taught a mean number of 4.6 VDPs, with a range of 1-10.

8 trainers suggested that they tried to make the VDP take the lead in the tutorial; in fact take responsibility for their own education. Those that made this comment had taught a mean number of 7.9 VDPs, with a range of 5-11.

Using the tutorial session to treat a patient with the VDP was suggested by 8 trainers. Interestingly these trainers had taught a mean of just 2.5 VDPs with a range of 1-5.

Trainers had a view that as far the first half of the year was concerned, in the first 3 months the VDPs needed a lot of help. The second 3 months was a settling in period. From the halfway point onwards, 15 of the trainers suggested that it was essential to stand back and give the VDP space. The mean number of training years possessed by this group was 6.1 with a range from 1-11.

At the end of 6 months 25 trainers suggested the basics should be place; 4 specifically noted that they would expect the VDPs to have a working knowledge of the NHS regulations. 24 of the trainers noted that it was now that the VDPs could start to work more efficiently

In those first 6 months, 33 of the VDPs reported that they were getting quicker, and performing a broader range of tasks. They confirmed that they were not necessarily seeing more patients, but doing more on each. 13 of the VDPs specifically noted that their treatment planning had improved and confirming the expectation of their trainers, they were able to manage patients with enhanced efficiently.

As far as the Study Days were concerned, 18 VDPs commented favourably, 13 had mixed feelings and 6 thought them a waste of time. 5 VDPs spoke positively with regard to their advisor; 7 others were very negative with their comments.

Fewer trainers specifically addressed the issue of the Study Day. Overall 4 were very positive and thought the Study Days very worthwhile. 6 were a little more cautious with their remarks; 2 were very uncomplimentary. 8 trainers thought the Study Days were an excellent opportunity for the VDPs to meet their peers and share their experiences; a sentiment echoed by 18 of the VDPs. 5 trainers volunteered that they were unhappy with the private bias of the Study Day lecturers and indeed the private bias of VT generally.

The Portfolio did not fare particularly well. An issue discussed only with the second cohort, only one of the 22 VDPs thought it useful. 17 suggested it was either not useful or a waste of time. The adjective most often used to describe the Portfolio was 'tedious.' 3 VDPs reported that their trainers and advisors checked it regularly. The trainers and advisors belonging to 7 of the VDPs hadn't looked at it at all in the first six months of training.

As far as the trainers were concerned, 12 thought the Portfolio served a purpose, but there were problems with it. 4 suggested that it was a good assessment tool if used properly. Interestingly these four trainers had a very high mean of 8.25 training years, the range from 6-10. 5 trainers did not consider the Portfolio at all useful.

At the end of the year, reflecting on their nursing support, if anything the VDPs' comments were less favourable than at the half way stage. 6 of the first cohort and 14 of the second cohort were satisfied. Unfortunately 7 of the first and 8 of second cohort were particularly unhappy with the support that they had received. Not having a nurse in this period or having to train up an inexperienced nurse were major reasons for this downward trend. Another was a nurse's inability to support the VDP when he/she felt able to speed up and increase workload.

In the second half of the year, 8 of the first cohort reported that the tutorial continued to the end, but 8 of them also noted that the tutorials tended to become far less regular than they had been in the first half of the year. 12 of the second cohort had tutorials that continued to the end of the year, but 10

of this cohort noted a reduction in the regularity of the tutorials. One VDP did not have any tutorials in the first 3 months, but thereafter they continued to the end of the year.

27 of the VDPs viewed their trainers as a positive role model. 4 had mixed feelings and for 4 others their trainer was not a positive role model.

Reflecting on the year as a whole, 9 of the VDPs had some, usually relatively minor reservations; 26 VDPs thought the year had gone well. None would have wanted to enter practice without VT. And for the trainers, 28 thought that the year had been a success. 6 still harboured reservations either about their VDPs or how the year had progressed. One trainer was particularly unhappy with the conduct of her VDP.

As for the process of trainer selection, 5 of the second cohort trainers voiced their concern that possessing additional qualifications was becoming ever more important, even though this did not necessarily indicate how good a trainer, a practitioner was.

At the end of VT, 4 of the first cohort stayed on as an associate in the training practice, one part time. 5 of the second cohort stayed, one in a part time capacity. In 2 partnerships in the first cohort and 5 in the second cohort, both VDP and trainer regretted that they did not continue working together at the end of VT.

Observations on VT

Skills progression, Experience/expertise

The atypical relationship was the only one in the main cohort that could be considered poor. While some were better than others they all worked, that is, they all reached a conclusion. There were many aspects of a relationship that influenced the outcome and the expertise of the trainer was an obvious one. Returning to the Dreyfus and Dreyfus (1986) model of progression presented on page 24, trainers who viewed VT holistically, and could see what was important in a situation (attributes of proficient) and those who had a clear vision of what was possible (expert), were able to create an atmosphere

conducive to professional development. It is perhaps significant that in their approach to teaching, the trainers who made the VDPs take the lead and/or assume responsibility for their own teaching, had taught for a mean of 7.9 years, with a range of 5-11.

Although I came across quite a few trainers in the first or second year of training, apart from Miss Shah's trainer, there were only two, both from the initial cohort that I would have placed at the novice end of the model. Neither of these partnerships ran smoothly, but one did develop into a successful partnership after a shaky first four or five months. The VDP in this case kept a detailed reflective diary for me and through that I was able to chart the trainer's progress. To begin with, he was rigid; he stuck to his rules, and saw no other way do things other than his way. And he ridiculed his VDP every time she suggested something different or pointed out problems such as flaws in his infection control procedures. A necessary theme underpinning these features is confidence. As his skills developed as a trainer, so did his confidence as a trainer. The relationship developed and trainer and VDP worked together to develop their respective skills.

I suggest that for the clinical teacher one attribute that needs to be added to the skills model is confidence. This is an attribute underpinning the behaviour of so many of the trainers at the expert end of the progression. It is impossible to separate the role of trainer from that of clinician. Part of the ability to step back, and not interfere is the knowledge that you are able to handle any clinical problem that may arise as a result of the actions of the VDP. The following is an example from one (relatively inexperienced) trainer handling the perennial problem of minor oral surgery.

This trainer was aware that his VDP was weak in oral surgery and she had tried to avoid doing any. Like other trainers he booked patients, so they could do a case together. She did the second case with his assistance and for the third, he let her get on with it. She knew that he was just next door. She also knew that whatever happened, whatever problems she caused, he could handle it and handle it in a manner that did not undermine her. In fact she specifically commented that he was particularly good in this respect.

When a relationship develops along these lines it is likely to be a very positive one. From my observations and discussions I became convinced that the danger time is a trainer's first year. I saw first year trainers who were showing attributes that placed them way beyond novice, but there were others. Miss Shah's trainer was in his first year as were the two barely successful initial cohort trainers mentioned above. At this stage the trainer is new, unsure of what to expect of VT. He/she may dislike it and never train again, but some VDP had to go through that experience with the trainer.

I specifically outlined this concern to my advisor/mentor. He agreed absolutely and noted that he actively kept a close eye on new trainers. We discussed the notion of a senior VT mentor for new trainers and he is attempting to determine how he could put this in place. He recognised that some who had become 'serial' trainers were not the best in the world, but they were safe. They could be trusted with the care of the new VDP, even if their expertise did not parallel their experience.

The proficient or expert trainer therefore develops an atmosphere that is likely to enhance the relationship. It is worth remembering that the trainers with the attributes of expert also took time to select a VDP who could fit in. We have a mix of the personal and the professional, and unlike dental school this is primarily a one on one relationship, so the personal is a major issue. Part of the skills progression for the VDP, is working on and developing the personal relationship, and we must not forget that it isn't just the trainer; the practice staff are part of that community and they must be courted too.

The community of VT

VDPs have regular weekly meetings where they are encouraged to share their problems and experiences with their advisor and each other. And there are of course the trainer days. I attended one of these on a scheme whose advisor is desperately keen to develop a transparent, knowledge sharing community of practice, but the commitment of the advisor does not guarantee the commitment of the rest of the team. Trainers, particularly those of novice status, were rather reluctant to enter into the reflective spirit of

examining practice, and discussed issues tended to revolve around structure and process. They felt vulnerable about being open about their concerns and failings. Furthermore, even this advisor did not allow trainers into, or let them have access to the feedback from, the VDP discussion sessions. He had yet to take the critical leap of faith and develop the open community of trainers and VDPs, where the question is not, 'who went wrong?' But, 'what went wrong?' (page 45). And, 'Where do we go from here?' This community could have a dramatic impact on knowledge sharing, and the development of professional expertise.

Staff relationships

The practice staff are not bound by the same code of practice as is the trainer. In the first cohort, two VDPs had problems with the wives of trainers. One felt pressurised by the dentist wife of her trainer to work longer than her contracted hours. She managed the practice alone while her trainer and his wife went on holiday, only to have her management heavily criticised by the trainer's wife on their return. This relationship did eventually resolve and the VDP stayed on in the practice post VT.

The other VDP had difficulty with her trainer's wife, who as practice manager had a significant degree of control in the practice. Always cold, distant and unhelpful, the wife took it upon herself to cancel any tutorials her husband arranged. The advisor visited the practice and instructed the manager to book off protected time for tutorials; these were cancelled immediately the advisor left the practice. Neither of the two male successors in this practice have had any problems.

Similar anecdotal evidence came from the main cohort. One male VDP noted that his nurse had told him that the practice manager, the wife of the trainer, would never allow her husband to employ a female VDP.

Overall though, my concerns over the one to one relationship of VT (page 17) were unfounded. With few exceptions both parties endeavoured to make the relationship work. Of course making sure that the VDP fitted into the team –into the community, was a primary selection criterion.

The VDPs' relationships with their advisors were rather different and not necessarily as successful as those with their trainers. All advisors were trainers (on different schemes to their own) but less than half of the advisors involved in the management of the VDPs in this study were liked. One was regarded most highly by successive groups. This advisor is the one that has acted as my VT mentor.

Where there were problems, the recurring comment was that the VDPs were spoken down to and treated like children. Confidentiality was also a problem. It appeared that some of the advisors thought it entirely acceptable to discuss the problems of one VDP with others. However the advantages of the Study Days far outweighed the disadvantages. The social gathering –the chance to share stories and experiences and realise that others were in the same boat, was invaluable to the VDPs.

A model of progression

I noted that trainers have come up with a model of progression through VT. The model appears to be sound and closely parallels Eraut's model of progression (page 21). This is essentially Eraut's model modified in the clinical environment of VT. Fig 5.1 summarises the progress through the year. After a period of trepidation, anticipating the start, the students begin VT and enter the honeymoon period. This lasts about four to eight weeks. They then enter the blue period; a time when they are likely to need encouragement. The reality of practice hits home. The VDPs then start to fret about their novice status. Into the New Year (five to six months in) it gets better. 25 of the trainers specifically noted that the basics are now in place and the VDPs are more positive about the experience. They are perhaps now moving out of novice and into advanced beginner. They are beginning to cope with crowdedness; they are engaged in standardised and routinized tasks. The final six months is a period for gaining confidence, speed and efficiency. And conscious deliberate planning is the aim of VT that they are starting to achieve. They are showing signs of becoming competent.

Fig 5.1 The model of VDP progression through VT

THE NOVICE

Rigid adherence to taught rules

<i>The Honeymoon Period</i> August to end September	A gentle introduction. VDPs realise they can survive in VT
--	--



<i>The Blue Period</i> November to December	Increased work load/responsibility. It is that bad. VDP is acutely aware of his/her novice status. This is the low point of the year
--	--



<i>The Comfort Period</i> Late January to February	Its OK. The Basics are in place. 'I think I can do this.' But there is a long way to go!
---	--

Coping with extended workload
Routinization of tasks



ADVANCED BEGINNER (perhaps)

Period of Consolidation March to May	'I can do this.' A period to develop skills and enhance efficiency
--	--

Extending competence over wide range of tasks
Becoming independent of support



A difficult time June to July	The end is in sight. 'Can be a time to throttle back and cruise.' Even those who do work to end, 'shift up a gear' when they become associates
---	--



COMPETENT

Can visualize long term goals
Conscious deliberate treatment planning

The end August	The VDP is capable of independent practice. Trainer likely to act as mentor for some time to come
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VDP is keen to become competent in further activities

PROFICIENT

6 ANALYSIS AND DISCUSSION

In the previous chapter, I presented the results of the selection questionnaire for the main cohort. Thereafter, I gave an account of the typical VT partnership and compared this with the rest of those in this study. I also included an account of one particularly unsuccessful partnership. These followed a format developed by merging the interview schedules to follow the chronology of the year. From the accounts, significant and recurring themes emerged and these, together with the data from the questionnaire are now the focus of the following analysis and discussion. The emerging notion of the typical VT experience and my findings regarding the defined performance areas were discussed with my advisor mentor and the emphasis in some areas was modified as a consequence.

The process of selection

The VDP perspective

The search for a VT place was a difficult one. Most new graduates wanted to stay in the South East where the competition for places is fierce and the timing couldn't be worse. When most of the applicants were attending interviews, they were aware that finals were a matter of weeks, sometimes days away. Everyone in VT knows that there are problems with selection and that many applicants feel under immense pressure at this time. Bartlett et al (1997) pick up on this point:

Although it has been demonstrated that the geographical location of a practice is considered vital in job selection, the financial and social pressures to gain employment are likely to persuade all but the most determined, to accept the first post that is offered (p 284).

It is little consolation for the applicants to realise that the system is not really any better for the trainers. The trainer lists for the August schemes are published in late March or early April. If a trainer is thinking of moving out of VT and offering the incumbent a chance to stay on for a year, a decision must be made by early March at the latest. A difficult time to make such a

decision for both VDP and trainer. There is always the spectre of the trainer not being able to regain the training place the following year, if he/she does take a year out. This does seem to explain, at least in part, the reducing numbers of VDPs staying on in their training practices.

We heard reports of gender and racial bias in the selection process from Bartlett et al (1997) and Bartlett and Woolford (2000) and certainly the perception of disadvantage is significant. The evidence from the interviews tends to suggest that it is perhaps more perception rather than actual bias. Those in this study did not experience overt prejudice nor did they sense that this was acting covertly. We heard from Anees et al (2001) that perhaps the perception of disadvantage in VT is greater than the reality and this would appear to be the case here.

Recent work by Chadwick and Newton (2003) highlights this issue and that care that must be taken when interpreting data. They asked 36 qualifying students from Dundee Dental School to fill in a questionnaire regarding their application experiences. 20 were recorded as female, 15 male and three were non-white. The mean number of applications and interviews attended were 14.2 and 8.6, and 16.6 and 10.7 for males and females respectively. The authors comment that:

In the light of our findings that gender has no influence upon the number of job interviews attended, there is insufficient evidence to say that discrimination according to gender is in operation, but suffice to say that applications lodged by women are treated differently from those of men...

Anecdotal reports indicate that genderism in VT has either been explicitly expressed by denying female applicants an interview (Grace, 2001) or considered by candidates to have influenced a trainer's selection of a VDP (Bartlett et al, 1997) (p147).

These comment are based on the finding that for males, the number of applications and the number of interviews attended correlated linearly, whereas for females they did not. But as with the participants in this present study, there could be a number of reasons for this. For example, female applicants could be reluctant to move a great distance, despite the suggestion by Bartlett et al on page 132. The geographical location of Dundee is one reason why, for Chadwick and Newton's students, the mean distance travelled in the placement search was 465 miles, the highest being 1808.

However, perception can be very real and we cannot ignore the data from the main cohort questionnaire. In the introduction I noted that Asian women seemed to have difficulty gaining a VT place. I also recorded that there is a perception from trainers and advisors (page 15) that Asian women are reluctant to apply for VT places distant from their homes. At the beginning of the study, I thought that these comments were perhaps a convenient way of explaining away a major problem in the selection process, but perhaps these comments are not so far off the mark as I thought.

The results of the questionnaire revealed that Asian females applied for more places than their white female or Asian male peers and they spent longer finding a satisfactory VT position. The fruits of this extra effort were more interviews, and more interviews in their preferred location. And that preferred location was London and the South East. What they did not achieve was any more offers of a position in their preferred location.

Bearing in mind that the numbers in the questionnaire are relatively small, care must be exercised in inferring that these phenomena exist in the broader environment. It does however appear that Asian women have to put in more effort into their job search to achieve the same end result as their peers. It could be that they are facing disadvantage, but it could also be that they are more selective; they want to stay in the South East. With the fierce competition for places in this location, it is entirely reasonable that they need to put in that extra effort. This could explain why the extra interviews they gain (in the South East) do not translate into firm offers.

Whatever else, Asian females took a mean of seven weeks to find a VT place; twice as long as their white female peers. When finals are imminent and you are still desperately looking for a VT place, it is disconcerting to see others gaining places and settling down to the important business of getting qualified. And of course those who are taking that extra time to find a place have no idea that they might have been more selective in their job-search. They think they are comparing like with like and that might not be the case. This could account, in part at least, for a perception of disadvantage that is greater than the reality. On page 32 we heard Brasher and Chen (1999) warn that job-search success was a complex and multi-dimensional construct.

The trainer perspective

Trainers in the South East were likely to receive in excess of 100 applications for their VT place and selection was a critical factor in determining the success of the year. I suggest that those who spent considerable time getting to know the short-listed applicants were more likely to have a predictably successful year. In essence these trainers, who were demonstrating attributes of expertise were better able to select an appropriate candidate; a candidate that could be part of the team. We must not forget that on page 31 we saw Morgan (1997) present us with evidence to demonstrate how weak the interview is as a selection method. But with the expert trainers this selection process was so much more than an interview. It was the novice or perhaps advanced beginner trainers who relied simply on an interview and perhaps luck for a successful outcome. Therefore the expert trainers were more likely to choose a 'good' VDP, when in point of fact it is the experts who were better able to deal with difficult issues such as poor performing VDPs. There could be an argument here for relieving trainers of selection duties and having a central organising body placing candidates instead.

There is another issue. Not unreasonably, the CVT (now DVTA) provided a format to help the trainer choose the 'best' candidate. But this was not necessarily what the trainers wanted. What is best? Trainers were looking for different things; their notion of the competent professional seemed to be different from that of the CVT. One of the most experienced (expert) and

popular trainers chose a candidate whose references suggested that she was good with patients, but 'nothing special' in terms of her academic record. Another experienced trainer specifically avoided 'high flyers.' He was consciously avoiding the 'best' and looking for something else. Trainers appeared to be using criteria to assess candidates that were somewhat different from those either the CVT or indeed the universities expected. I suggest that expert trainers were choosing VDPs who fitted into the community of practice.

The role of the trainer

The facilities available to each VDP and the management of their actual VT experience were obviously different, reflecting the individual values and perspectives of the trainers. They did however meet the defined criteria outlined in this study for these areas. It is fair therefore to suggest that the typical VT experience is likely to be a success. The role of the trainer as defined by the CVT, was in general terms, echoed by the trainers themselves. This was to provide mentoring, support and guidance to enable VDPs to work competently as independent practitioners. The more experienced, I suggest expert trainers tended to be far less prescriptive in their approach than were their less experienced colleagues. They were confident to let go of the reins. They were able to stand back and give a VDP room to develop his/her professional practice. They were also more likely to maintain a tutorial slot throughout the year. However, the nature of the tutorial changed as the year went on. Later on, these tended to become a session for discussion and reflection, at a time when this would seem to be entirely appropriate.

In terms of VDP progression, the trainers saw the first five to six months of VT, as a phase of extending competence in an increasing range of tasks. At six months the 'basics' should be in place. Perhaps they are now moving towards advanced beginner on the Dreyfus model?' The quest in the second half of the year was to enhance efficiency. This is a time for consolidation and enhancing workload translating to a monthly gross of £6,000. With some very minor reservations, the entire cohort was considered capable of independent practice at the end of VT. I suggest most were now competent.

Most of the trainers noted how VDPs shifted up a gear once they became associates and self employed. At this stage some are perhaps proficient.

Earlier (page 21), I presented Eraut's model for progression before and after qualification (1994) and I suggested that this would be entirely appropriate for VT. This proved to be the case (Fig 5.1 outlines this progression). Almost every trainer had developed, or was following a model of progression that was very similar to that suggested by Eraut. Not surprisingly, there were differences of opinion on how quickly VDPs should reach points on the model of progression, but this model seemed to provide the year with a degree of structure, a path for VDP and trainer to follow.

The VDPs' patient base

The VDPs' concern over the limited patient base was unexpected. Once settled in VT, as part of their own model of progression, as well as enhancing their 'gross', they also wanted to develop their repertoire of skills, using techniques seen in the Study Days. Their patient base did not necessarily allow this. Continuing professional education is now mandatory for all practitioners and these VDPs have qualified in an environment where this is the norm. A common reason given for leaving the practice, post VT, despite having an offer to stay on, was to move to an area where these skills could be developed. That could include a change to the private sector.

Staff/nursing support

The need for reliable nursing support and the fact that many nurses were inexperienced became an issue when the VDP looked to work with enhanced efficiency. When the support was poor, this only deteriorated as the year progressed. Problems outlined in the initial interviews were magnified once the VDPs were moving through advanced beginner into competent. Now some of them were required to train up new nurses and/or work without one. Some accepted, even revelled in this teaching role, but if a VDP was feeling pressured to enhance his/her income, this did not go down at all well.

Trainers could do well to recognise this problem. Only once in the first cohort did a trainer suggest that the nurse could have an effect on VDP performance. The second cohort was different. The majority of the trainers

were explicit in their acknowledgement of the role a VDP's nurse had to play, but this didn't necessarily translate into ensuring that support was there. Again it was those demonstrating the attributes of expert who took that extra step. They ensured that a VDP always had a nurse and the best nurse, an expert nurse who could perform as an in-surgery teacher/mentor. The nurse, of course is the only person who can legitimately monitor the VDPs clinical work without overtly undermining his/her confidence –or indeed the confidence of the patient in the VDP. She/he is in a unique position to identify and possibly defuse problems almost before they arise. This arrangement could sometimes be problematic. The VDP had to recognise his/her initially subordinate position in the community and both needed to appreciate that the necessary change in the relationship as VT progressed (page 148).

Benner (1984) in fact talks of the diagnostic and monitoring function of the expert nurse, a nurse who can provide an early warning of a deteriorating situation for, for example, a junior hospital doctor. The critical point here is that the expert nurse is picking up on subtle signs or changes that an inexperienced practitioner (VDP) may fail to recognise.

Teaching and skills acquisition

Developing expertise

Specific guidance is given on education in VT and in spite of this, the mandatory tutorial was often forgotten or ignored, particularly by the inexperienced trainers. I am convinced that at least some of the novice trainers did not feel that they had the academic background to tackle theory-based issues. They might not have had the latest up to date information, but these trainers were expert clinicians. They had so much to give. The problem was making the wealth of knowledge underpinning their practice explicit.

One trainer in the first cohort seemed almost in awe of his VDP's knowledge and to begin with, he suggested he had nothing to contribute to her education. For the first four months he didn't hold tutorials. I suggest that the status of his training skills was a critical issue here. VT was a learning process for him. At the beginning, conscious of his novice trainer status, this

expert clinician felt he had little to contribute. But as the year progressed, in parallel with his VDP, he was undergoing a progression in his own training skills and was approaching perhaps advanced beginner; his confidence and attitude changed, the tutorials started and were well received. Trainer and VDP were developing their skills together.

Some trainers were frustrated by not being able, 'to find a way to explain it.' Essentially, as Ryle (1963) says, they had forgotten the original rules, and they (usually the most experienced) were having difficulty making their tacit knowledge explicit. They were expert clinicians, but critically their status as trainers had not yet reached this level. The expert trainers were using the tutorial sessions to good effect, but not necessarily as they were meant/expected to. But should the VT practice be the forum for theory-based teaching? VT as an organisation suggests it should, but trainers did not necessarily share this view.

Time and time again it was quite clear that in the context of training, expertise and experience were not synonymous. Jarvis (1997) reminds us not to view the transition from novice to expert as a natural progression. If it were, every practitioner would become expert, given sufficient time and this is not the case. However, so often it was clear that the converse is also true. Two inexperienced but hardly novice trainers had many of the hallmarks of expert and others were demonstrating at least some of these attributes.

Benner (1984) sees experience as an essential prerequisite for the development of expertise, but for her:

Experience....does not refer to the mere passing of time or longevity. Rather it is the refinement of preconceived notions and theory through encounters with many actual practical situations, that add nuances or shades of differences to theory (p 36).

I suggest that some practitioners/trainers who seem to progress rapidly, are making full use of and critically reflecting upon the (limited) situations that

they have actually encountered.

In the discussion so far I have suggested that particular management/training attributes point to a trainer as being at a particular stage on the Dreyfus model of skills acquisition. Trainers are indeed undergoing a skills progression in parallel with their VDPs. And in a development of the models of progression of Eraut (1994) and Dreyfus and Dreyfus (1986), VT advances a relational model of skills progression; a model in which the progression of a VDP is intimately linked to that of his/her trainer. Benner (1984) recognises the link between the expertise of the instructor and the instructed. But she doesn't necessarily draw the distinction between the clinical and the teaching expertise of the instructor.

It was quite dramatic to witness the range of expertise within the trainer group. The expert, often but not always experienced, trainers were demonstrably more at ease in their role than were those of novice, advanced beginner, or even competent status. They were far less likely to maintain tight control of the year. They were able to stand back and give the VDP space; not an easy task when the trainer is personally responsible for the VDP's clinical practice. They had a complete picture of VT and what is meant and likely to happen. The degree and rate of reduction in a trainer's clinical support as the year progresses is dependent on many factors, the most important being the respective clinical and training expertise of the VDP and trainer. A critical attribute of training expertise was the ability to skilfully judge the degree and rate of that reduction.

They might not have been able to make their tacit knowledge explicit in their teaching, but it was those who were demonstrating the attributes of expert who were more aware that that they had expertise that was difficult to articulate. One inexperienced trainer specifically noted that because he was still developing his own clinical skills, he felt this helped his teaching:

It's nice to be asked. You question what you are doing.

You no longer do it on automatic. I ask myself, how am I doing this?

This novice practitioner had yet to progress as a clinician to the stage where the original rules had been forgotten, or if he had, he was aware that to teach effectively he had to go back and search for those original rules. His inexperience as a clinician was a major factor in his ability to make his tacit knowledge explicit, but I would suggest that this evidence places him well beyond novice in his training status.

One area that tends to get ignored in the debate on expertise is that of teaching skills. We have noted how poor subject knowledge might explain why a trainer is reticent about tackling theory based teaching, and in the trainer training days this issue is acknowledged and attempts are made to address it. But the actual skill of teaching is something that tends to be ignored. It is often just assumed that the trainer can teach. Some guidance is provided, but essentially if trainers are experienced clinicians, with a relevant postgraduate qualification and a commitment to continuing professional development, they are likely to succeed. Yet teaching skills are not necessarily easy to acquire.

Recognising, valuing and harnessing expertise

Trainers become a self-selecting group and those managing VT must be aware of this. A new trainer is appointed and undergoes a short introductory programme. He/she is unlikely to have previously had the opportunity of working with a newly qualified practitioner, so expectations of performance are bound to be very variable. The trainer has the new experience of having constant interruptions and requests for help, while trying to manage his/her own practice of patients. Add to that the increased administration and a mandatory commitment to attend 14 trainer days and the world of general practice has changed dramatically. The new trainer is no longer completely in control. Some love every second of it, they learn to let go; they will stay in VT for good and they see it as a valuable aspect of their own professional development. And they appreciate that they are working with novices. As one trainer remarked:

Some of the [more experienced] trainers say that they

[VDPs] are awful clinically, but we're very happy.

This trainer couldn't wait to do it all again, but others quickly realise that training is not for them and their first year is their last. This is the danger time. We saw that Miss Shah didn't get past the halfway stage in her first training practice, but neither did her trainer. Accepting that at least in part it appears that there was a personal attack on her; there were other issues. She was constantly criticised for her lack of speed, yet her January schedule was as high as any other VDP on her scheme. She quickly realised that she was being compared with a high grossing associate. This trainer's expectations of the likely performance of a new graduate were way off the mark. It appears that with the intervention of the advisor the situation improved for a while. Miss Shah never had an organised tutorial programme and became afraid to ask for help; she knew what the outcome would be. I outlined my concerns on page 52 that unreasonable expectation could be an issue and this indeed appears to be the case. The expectation of the trainer is bound to influence his/her view of how effective VT is manifest. Unlike most of the partnerships this one was not successful, but the 'community of VT' ensured a successful final outcome. On page 33, I noted Scott's (1997) comment that we must have a robust model of organisational effectiveness. The model is there. It just needs to be enforced. In this case, to begin with at least, it wasn't.

This relationship has been covered in depth. It was extreme and my time in VT suggests to me that relationships rarely deteriorate to this extent, but it was important to document what can happen. The odd thing in all this is that Miss Shah was offered the opportunity of staying on in the practice as an associate, despite the steadily worsening problems. There are two possible reasons. The trainer, having established that VT was not for him, was keen to continue with an associate. In a semi-rural area it might be difficult to attract candidates. More likely, he was unaware of the magnitude of the problem in which case he really needed close support. We saw this problem to a far less serious extent with two other partnerships and in one of these the trainer was totally unaware that the year was going steadily downhill. An expert mentor in each of these cases could have provided valuable guidance.

Advisors are aware that those in the first year are new and need support and the expert advisors provide significant and appropriate support at this time. This level of support and/or intervention is critical to the level of success of the new trainer in VT. Earlier I noted that the VT experience was a result of three shifting forces; those of trainer, VDP and advisor. The critical skill is for the advisor to read the situation as training skill develops and adjust his/her intervention accordingly. This is shown diagrammatically in Fig 6.1 and 6.2.

Fig 6.1

**Significant advisor intervention during a trainer's first year,
Or when there is a need for that intervention**

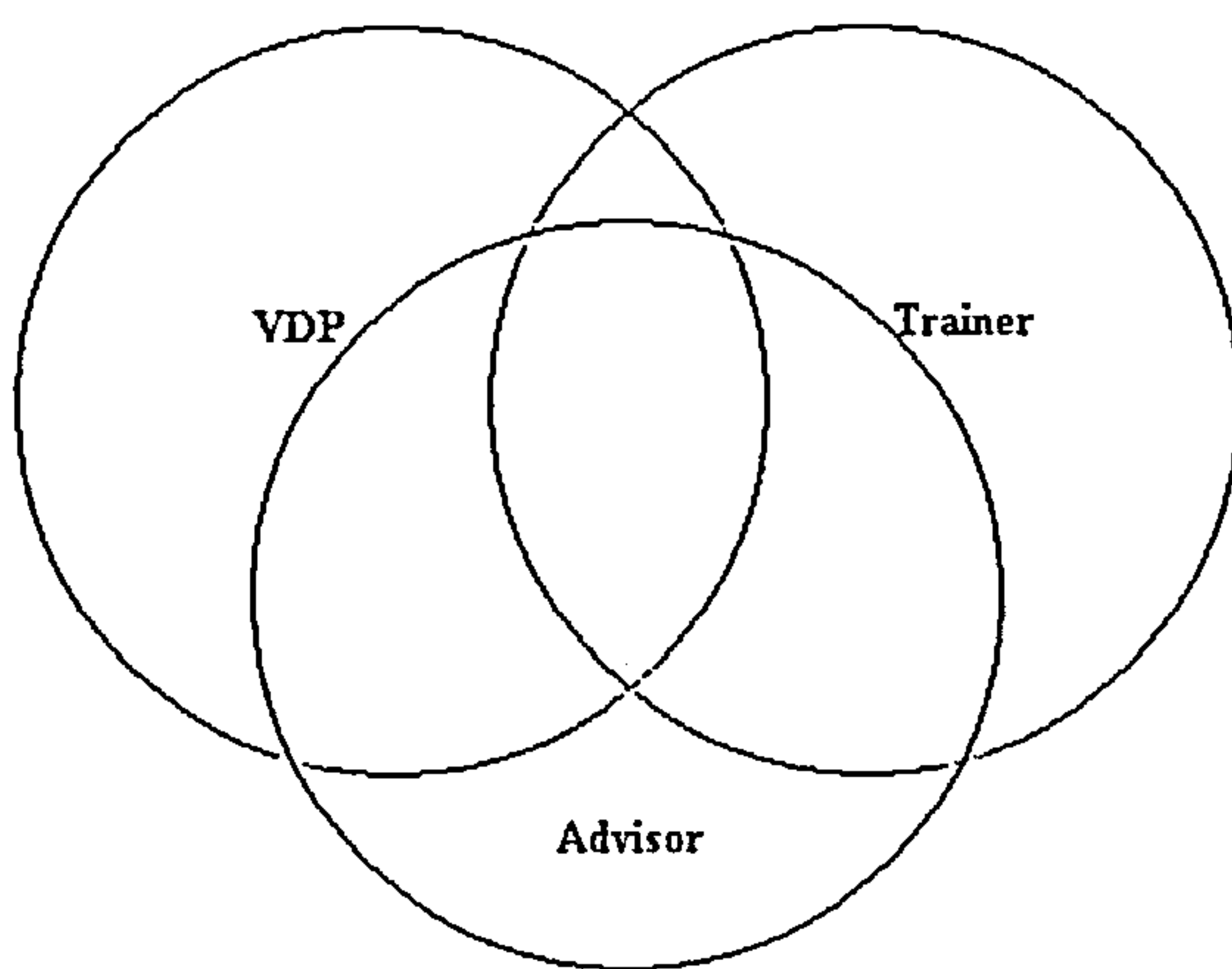
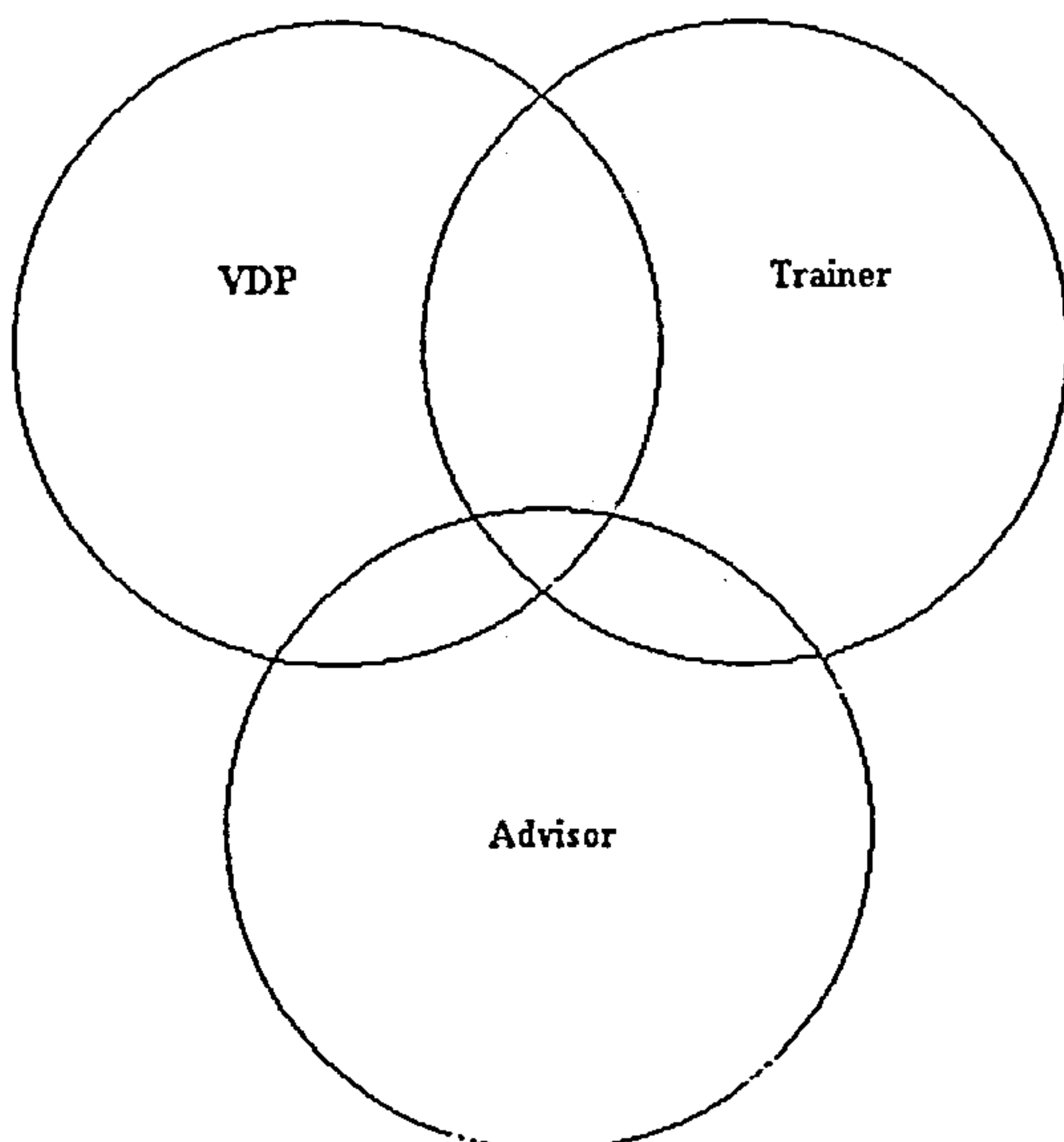


Fig 6.2

**Reduced level of advisor intervention with the more
expert trainers.**



VT is missing out on a golden opportunity. We saw that some trainers would like to take a year out after a while, but they fear that if they do so, they will be unable to return. I suggest that such sabbaticals should be encouraged, and the trainer made aware that return to the scheme will not be a problem. But during that year out, as one trainer, perhaps the most expert of them all suggested, if appropriate, they can keep the trainer on a retainer. He/she would have to attend the training days and act as a mentor/consultant to more junior or less expert trainers and advise. Surely there is an opportunity here to embrace the concept of the critical companion (Manley and Garbett, 2000). It seems to me that these committed trainers are tailor made for this role. On page 43 we heard Wah (1999) suggest that tacit knowledge is often easier to remember and talk about than explicit knowledge. The critical companion can facilitate the 'spontaneous and creative conversations' that Wah talks about and answering the questions that Smith (2001) on page 43 suggests can unlock tacit knowledge. My advisor/mentor noted how he kept an eye on inexperienced trainers, but he cannot be with them all the time. This is an opportunity to move professional development to a higher level.

For some time one trainer had in effect played the role of critical companion. His expertise was widely recognised by his peers. He noted:

When they phone you and say that their VDP is useless and can't do molar endo, you say, that's normal; that doesn't matter. Now how are you going to sort that out? Ask them, what was your molar endo like when you qualified? And above all else, be there on the end of the phone.

At this point it is worth remembering Taylor and Glascoff (1998) who demanded that knowledge sharing become one of the critical competencies of any organisation. And a little closer to home, Nicholls et al (2000) talking of the critical importance of Clinical Governance (knowledge management in the NHS):

Clinical governance is a chance to harness and value the talents of our staff and to recognise the need to mobilise knowledge from the front line (p 175).

I noted on page 128 how an advisor was trying to develop an atmosphere on his scheme that was conducive to open discussion and reflection. He was attempting to mobilise knowledge from the front line.

Hindsight is a wonderful thing, but if Miss Shah had had appropriate support the situation could have been so different for both parties. Yet the expert trainer quoted above knew, because he had been told (page 111), that because he hadn't undertaken appropriate post-graduate qualifications, his training days were numbered. Yet his record in supporting others in their post-graduate professional development was significant.

There have to be defined criteria in trainer selection and as competition for training places increases these become ever more important, but what form should they take? The possession of an appropriate post-graduate qualification is one way forward. This shows commitment to the profession and a commitment to one's own professional development, but it is not a measure of expertise in training.

Expertise as we have seen (Manley and Garbett, 2000) can be notoriously difficult to determine. The assumptions, that expertise can be recognised in others by colleagues and significant practical experience is a prerequisite for expertise, can be challenged. We think we know who is expert. But do we? A qualification is easy to recognise; it is there to see.

The system of trainer selection has to be completely transparent, it therefore easy to understand why the situation is the way it is. The issue here is not whether trainers are undertaking professional development; they are. It is the manner in which this takes place. Because the knowledge/expertise base of the trainers might be difficult to determine, structures should/must be in place not only to assess this, but also to tap into it, and having done so, use this as a resource through the scheme and beyond to enhance the

effectiveness of VT. A starting point could be an analysis of the year on year VDP feedback on their VT experience, and observations and feedback on the interaction of trainers and others in VT. Here the critical companion could be invaluable. As Manley and Garbett (2000) point out this approach facilitates continuing professional development within the changing context of healthcare, focusing on practice-based learning.

Identifying expertise is not easy, but it must be done. Throughout this discussion I have identified attributes that suggest expert behaviour. We heard that Benner (1984) specifically avoids identifying 'the expert.' Rather she focuses on the attributes of expertise. I suggested on page 26 that rather than attempt to place a practitioner at a particular position on the scale of skills acquisition, it could be easier and indeed more informative to search for a demonstration of the attributes of expertise.

VT as a community of practice

VT can be viewed as a 'community of practice' (Lave and Wenger, 1991), a community that we heard Smith (2001) on page 43, and Wilson and Pirrie (1999) on page 30, speak of. The critical companion or VT mentor could galvanise knowledge sharing, learning and change within that community. In some VT schemes these communities of practice are working well, even if that isn't always recognised. Clinical Governance demands that this good practice is signposted and placed in the public domain, to provide an example for others to follow, reflect upon and develop.

There is another dimension to this community. As I reflected upon the many VT experiences I became involved with, there were some issues that didn't fit squarely with the simple notion of the expert trainer facilitating the professional development of the VDP. Despite what many might say, trainers, particularly those who are expert, are not that concerned about the new graduate's level of experience. These expert trainers are the ones who are most likely to give the VDP space, and limit their close support teaching. The other issue, and a far less tangible one, was that a VDP's view of what they had learnt during VT, often seemed to be at odds with his/her view of the trainer's expertise. The traditional notion of a psychological model of

learning that centres on the transmission of knowledge and skill from one to the other didn't seem sufficient to explain what was going on. In particular it didn't explain the dramatic and rapid professional development that seems to take place in VT.

In Lave and Wenger's (1991) analysis of apprenticeship in its broadest definition, the apprentice (the VDP) is seen as being a 'legitimate peripheral participant' within a community of practice:

Peripheral participation is about being located in the social world. Changing locations and perspectives are part of actors' learning trajectories, developing identities and forms of membership. ...Furthermore legitimate peripherality ... is a place in which one moves toward more intensive participation, peripherality is an empowering position (p 36).

Viewed as a community of practice, VT is so much more than a forum to learn the skills involved in becoming a competent practitioner:

A community of practice is a set of relations among persons, activity and world. A community of practice is an intrinsic condition for the existence of knowledge, not least because it provides the interpretive support necessary for making sense of its heritage (p 98).

Bleakley (2002) picks up on the ideas of Lave and Wenger and sees the learning process for junior doctors as:

A socialisation into varying 'communities of practice,' through work based experience that serves to construct an identity (p 9).

Bleakley has concerns regarding expertise. He suggest that in a complex profession such as medicine, mastery is never achieved, even as a specialist:

Expertise is not simply what an individual holds, but is seen as a collaborative definition within a working group of what is valued and beneficial at a certain moment in time. Socialisation into expert practice is ...not only accruing knowledge and skills, ...but also acquiring an identity and a particular attitude to continuing professional development (p 11).

I accept his comments, but I'm not sure he gives due credit to the influence of expertise in shaping the whole culture of the working group. That said, in response to my concern regarding the learning that seems to be at odds with a trainer's expertise, Bleakley notes that junior doctors do not simply learn from the consultants they like and respect, they learn to be like them. They also learn not to be like those they do not respect. VDPs construct their professional identity by selecting particular aspects of their trainer's identity and discarding what isn't appropriate. They learn not to do it like that or not to be like that. Interestingly, in this study the overwhelming majority of the VDPs considered their trainers a very positive role model. They want to use their trainers' professional identity to shape their own. Significantly this finding runs contrary to the earlier work of Baldwin et al (1998) and Ralph et al (2000). It is however more in line with Bartlett et al's (2001) more recent finding. They noted that 89% of VDPs would recommend their trainers to future VDPs.

Bleakley (2002) reminds us that we must be aware of how knowledge is held within members of a community of practice. He highlights the example of a junior doctor wondering why a nurse will not readily share information when asked for it. Is the nurse being difficult, or has the doctor not yet gained legitimate participation into the community of which the nurse is a part? Like the junior doctor, the VDP has to learn the specific rules and regulations of the community in order successfully negotiate its rites of passage. Bleakley warns that failure to do so is often misread as a failure of knowledge or skills.

The VDP must learn how to achieve this balance and managing the changing relationship with his/her nurse is a critical skill. Ultimately selection for the expert trainer is trying to identify a VDP who can achieve this balance. They are not looking for experience; they are looking for someone who will successfully negotiate the rite of passage to general practitioner and all that represents in the community of practice; someone who will know where his/her legitimate position is and how and when it is appropriate to change that position. However on page 102 we saw a partnership go down hill in the second six months. I suggest that here the trainer failed to ensure the staff maintained their position; he therefore failed to maintain his.

And what of the expert trainer, standing back, with limited close support?

Again returning to Lave and Wenger (1991):

In apprenticeship, opportunities for learning are more often than not given structure by work practices instead of by strongly asymmetrical master apprentice relations. Under these circumstances learners may have a space of 'benign community neglect' in which to configure their own working relations with other apprentices (p 93).

Perhaps training expertise in VT should be viewed from a perspective of preparing the appropriate environment to allow the VDP to gain access to and become part of the culture of VT. Access that will encourage the VDP to develop appropriate attitudes and values that inform professional practice. It was significant that the expert trainers abandoned formal theory based tutorials in the second half of the VT. But they continued the tutorials; they were not abandoned all together. I suggest that the more reflective nature of these tutorials is a part of facilitating the VDP's successful rite of passage and can be seen as an attribute of trainer expertise.

That said, perhaps it is unfair to centre on expertise. There are problems in VT; not all practices are managed expertly and success in the Study Days seems to be variable. But that is not the point. From this perspective, VT is a successful community of practice. The VDP has, and recognises his/her

legitimate position in that community. In terms of Lave and Wenger's notion of situated learning, everything is in place to rapidly facilitate the VDP's transition; his/her rite of passage to general practitioner. Lave and Wenger note that there is anecdotal evidence to suggest that where the circulation of knowledge among peers and near peers is possible, it spreads exceedingly rapidly and effectively. The message here is that by accident or design, the structure of VT works, and it works well. Miss Shah is an example of the community of VT addressing a major problem with some degree of success.

The competence of the modern graduate

The more expert trainers seemed to be less critical of the newly qualified's competence than their less expert colleagues. Comments such as:

Oh, they can develop their skills, it's not a problem. And:

We all think we were better. ... They don't have as much clinical experience, but that doesn't make much difference.

seem to fly in the face of the anecdotal evidence of Grace (1998). Although it is not difficult to imagine that one accusation of graduate incompetence is far more newsworthy than ten comments to the contrary. Again those trainers at the expert end of the spectrum specifically noted the modern graduate's impressive 'raft of skills.' Every trainer was impressed with the theoretical knowledge possessed by the graduates. And reduced expectation of the new graduates clinical experience seemed to run parallel with other attributes that suggested a trainer was expert. But there was more to it than just expectation. Expert trainers were not overly concerned about the VDPs' level of clinical experience. They could teach that. But how a VDP gelled with the rest of the team and treated his/her patients were different matters.

However some are still wary as Mr Smith commented:

Some do need the extra experience in a protected environment and VT hopefully identifies those who do need that help.

He and others had questioned whether these candidates could be identified at interview, after all it had all gone completely wrong for Mr Smith the year before. I have suggested that being able to identify a 'good VDP' is one characteristic of the expert trainer, but even experts don't always get it right.

We must not forget the negative comments; suggesting that VT is perhaps the remedial part of the degree course is hardly complimentary, but again the trainer who made this comment had never had problems himself. This is what others had said! It did appear to be the novice trainers who were most likely to comment adversely regarding the VDPs' limited clinical experience. Some VDPs are indeed better than others, but we must remember that the skills level of the VDP was never the primary selection issue for any of the trainers, expert or otherwise. In fact, this criterion almost always followed an ability to fit into the practice, and the location of the VDP's home. I suggest that this would not have been the case if the VDPs were that bad. The VDP must fit into the community of practice and if they do, perhaps the skills level as an issue becomes diluted. But if there are problems with fitting in, as Bleakley (2002) warns, this can itself be interpreted as a skill or knowledge deficit.

Returning to expectation and the notion that we (experienced practitioners) think we were all better. There is evidence to suggest that this is just not the case. Bartlett et al (2001) in a large questionnaire based study, noted that when asked to reflect on how their VDP's overall confidence compared with their own on qualification, 70% of 455 trainers thought the VDPs compared well.

But myth is one thing that is easily perpetuated. In the CVT Review of VT (2002) there is a quote from a trainer in one of the three practices visited in that study. Speaking of undergraduate experience, he suggests that:

In my day you didn't qualify only having made two or three set of dentures for somebody. We might have made 30 sets of dentures. I got quite a lot of applicants this year

whose experience...was quite limited because they'd only made a couple of sets of dentures (Annexure 1, p 40).

This is perception; it is not reality. Few if any students can graduate from a UK school with such meagre Prosthetic Dentistry experience. The figure of 30 is also suspect. It could be true, if the trainer qualified in excess of 40 years ago, but then they would have been skilled in oral surgery, dentures and little else. What is disappointing about some aspects of the Review is that sufficient recognition is not given to the fact that undergraduate dental education has moved on, it has developed and so has the 'raft of skills' possessed by the modern graduate.

Bartlett et al (2001) noted that 60% of the trainers rated the undergraduate curriculum as satisfactory or good in preparing VDPs for general practice. But 40% rated the preparation as poor and 40% is a cause for concern.

The transfer of skills

The issue of task transfer is significant. VDPs noted how different things were in practice and they took sometime to come to terms with this. We have heard from Bennett et al (2000) that there has been an assumption that skills transfer easily or indeed automatically from educational to work contexts. Perkins and Salomon (1994, 2nd edn) provide us with abundant evidence to show that very often, anticipated transfer of skills does not occur. No account is taken in VT of the fact that many developed skills are situation specific and are not necessarily embedded in the person. It is therefore essential to take account of the social and technical context in which the learning takes place. These comments echo those of Lave and Wenger (1991) and Bleakley (2002).

I suggest that many in dental education may perceive the transition into vocational practice in terms of 'low road' transfer of skills.' The reality is perhaps very different and 'high road' is a more likely model for many dental skills (page 48). Even if the new graduate is well practised in a technique, he/she is faced with a situation where transfer depends on a mindful

abstraction of knowledge from the context and there is a need to search for connections. This may partly explain the varying opinions on the new graduates competence and why for example they have immense difficulty treatment planning in VT, when this doesn't seem to be an issue of concern in dental schools. This certainly has implications for how and where specific techniques are taught.

The Study Day and NHS practice

A primary objective of the Study Day is to enable the VDPs to get together and share experiences. They must know that they are not alone and that others are having similar problems. Social events are arranged to facilitate bonding of the group, to develop the community of VT and this seems to work exceptionally well. It was rare to find a VDP who didn't value the social contact and support afforded by their peer group. Miss Shah had commented that she would not have survived without it.

The success of the lecture programme was very variable. Some scheme advisors seemed to be able to put on a relevant and useful programme, but many of the scheme days were not so successful. This seems to contrast with the findings of Bartlett et al (2001). They noted that most of the 435 VDPs in their study thought the structure of the postgraduate days, and their control of the course and the preparation of 'hands on' teaching was good or satisfactory. But 17% of the VDPs thought that the Study Days were not at all useful and 30% claimed that they had either poor or no control over the structure of the days. These findings are perhaps more significant than they first appear. In this present study the highly positive social component of the Study Days often seemed to compensate opinion on the academic aspects of the day. So it is possible that Bartlett et al's participants were similarly influenced. The variable quality apart, the issue was really the significant bias of Study Day lecturers towards the private sector. This does seem inappropriate for a system designed to develop practitioners for the GDS that is wholly funded by the GDS (NHS).

The problem actually goes further than the Study Days; around half of the trainers in this study were working primarily in the private sector. So in

effect the GDS is funding private sector practitioners to teach NHS practice. Some haven't worked within the GDS for some time and while they may be sound trainers, they may perhaps lack that extra dimension that is needed to teach effectively under the strict limitations of the GDS. Trainers grounded in NHS practice resent this arrangement. As one said:

[VDPs] have the idea that they can't do anything on the NHS. The idea is to excite them. It [NHS practice] can be fulfilling.

But VT personnel are not the only culprits. I heard so often, from even privately based trainers, that new graduates leave dental school with a negative impression of NHS dentistry. It appeared that they have the attitude that working within the GDS is something that they have to avoid. So instilling enthusiasm for it is an uphill struggle.

In the introduction I suggested that it was essential that the GDC and other stakeholders in VT were informed of how it is performing. This is an issue of particular significance. The CVT Review of VT (2002) concluded that VT provided value for money. VT may well provide immediate value for money, but what of next year or the year after. At no point was it my intention to consider the financial aspect of VT. Yet I suggest that if we have a system that drives new graduates away from the GDS into the private sector, VT is not providing the NHS value for its money.

But should this be an issue? There were very good trainers who were likely to be lost to VT because of their increasing commitment to private dentistry. Can VT afford to lose their expertise? And this is not just an issue specific to the South East. Grieveson (2000) working in the Northern Deanery noted:

The effect of practices becoming private cannot be ignored. ...The system is losing potentially very good training practices, only because they are not treating NHS patients.

Some advisors were well liked and respected, but others seemed less able to manage the Study Days and their VT group. It was disappointing to hear comments suggesting that trainers could be unprofessional, but so many of the VDPs felt that they were treated like children. The advisor has a difficult task. He, in this study all advisors were men, has a major organisational role; there are management and teaching components too. And, as with my concern regarding the trainers in their teaching role, while the advisor may well have had significant training experience, it is unlikely that a similar level of management training has been forthcoming. It must be appreciated that even expert trainers do not automatically become expert advisors. They must acquire advisor skills, and the comments here may indicate that many are still at the novice stage in their development as advisors. On the positive side, the advisor comes into his own when there are problems between VDP and trainer and although these are not always handled as tactfully as they could be, Miss Shah is evidence of an advisor faced with a very difficult situation, bringing it to a successful conclusion.

The Professional Development Portfolio: Assessment

The Portfolio is, or should be the primary assessment tool in VT, but it is a concern when an experienced trainer notes that few in VT knew what to look for in the Portfolio; particularly when he suggests that, it is hard for the VDP to see its value if the trainer and advisor are not convinced of its value.

Another advisor admitted that he had taken sometime to see the value of the Portfolio, but now he too saw it as central to the assessment procedure. He also noted that many trainers and advisors did not value it, and in fact, the less experienced trainers tended to view it as something that had to be done. These comments confirm my initial concerns (page 20) regarding the limited guidance that trainers receive with the Portfolio.

I suggested previously that VT was about inputs and processes. The Portfolio has to be completed, but it is virtually impossible not to pass VT. There are no defined outcome indicators in VT. This is not necessarily wrong but as Schuman (1967) tells us, under such circumstances those responsible can only see what happened, and not how well it was done. Assessment in VT is

under review. Is a more formal assessment procedure appropriate? This is the one area where my advisor mentor and I differed in our opinions concerning the way forward. He felt that a more formal approach to assessment was needed, and I am mindful that there is evidence for the value of outcome-based approaches to assessment where the emphasis is on the product rather than the process (Harden et al, 2002). But I am convinced this is not the way forward in VT.

We have seen that in Scotland the more formal path is seen as the way forward (Grieverson 2002). Competencies are defined for the domains of clinical; communication; managerial and professional. For each of these, core key skills have been developed that define the 'appropriate standard.' The VDP can receive feedback and any weaknesses can be addressed with remedial training. This system is small and manageable; it also has its flaws. Prescott et al (2002) point out that reliability in this context depends on using a number of different evaluators over a number of clinical scenarios, but in VT there is just the trainer and perhaps the advisor. This system also relies on a significant commitment from the trainers and advisors and further assumes that they are competent in the assessment process. It does however apply structure to the VT year and a degree of rigour to its assessment.

Grieverson accepts that the Portfolio, used properly as a reflective learning tool, is useful, but it requires the VDP to fully embrace the notion of reflective practice. I suggest that this requirement includes the trainer and the advisor. But the Portfolio also needs to be developed in the light of changing practices. It has remained essentially unchanged for ten years; and not to embrace change is to move backwards. I am convinced that an appropriately updated Portfolio, approached in the right way is all that is needed. On page 103 we saw that the expert trainers, including my mentor, used the later tutorial sessions as an opportunity for reflective self-assessment. I suggest that they are doing exactly what the Portfolio guidance suggests, even though this is sometimes without the framework of the Portfolio.

Despite my mentors feelings to the contrary, I am convinced that testing skills has no place in VT. Put examinations into the system and VDP and

trainer will concentrate on these and not on the core business of developing professional practice. We heard an expert trainer pick up on this point (page 100). To quote her again:

I thought the whole idea of VT ...was it's somewhere to make mistakes. If he knows he is going to be judged, he isn't going to ask questions that might appear silly. It's about self-assessment. I remember wanting to ask really silly questions and some haven't been answered to this day.

In fact, accepting the alternative notion of learning provided by Lave and Wenger (1991), introducing tests of competence in the VDPs path could be a retrograde step in their professional development. They are registered dentists, they are not students, nor do they have the intermediate status of pre-registration doctors. They have moved on from their participative role they had as undergraduates. As part of their rite of passage to general practitioner, they have earned the right to embrace the reflective self-assessment of the Portfolio.

This doesn't mean that we ignore performance. Aspinwall et al (1997) remind us that good professionals are invariably looking for evidence of success and indicators of their level of performance. But this can be achieved using the Portfolio. On page 44 we heard that Drucker (1993) demands that we recognise that knowledge will change. Obsolete knowledge must be abandoned. VT as a well-managed community centring on reflective self-assessment is tailor-made to enhance the flow of relevant and up to date knowledge through VT. Perhaps it is time to re-establish the professional educational advice with the Portfolio that I understand was available in the early days of mandatory VT. Eraut (1994) reminds us that, it is easy for standardisation within assessors to slip if training and communication are not regularly maintained. A commitment to the Portfolio must pervade all levels of VT.

One concern about the structure of VT that I had from the very beginning

was of the possible consequences of the one on one teaching relationship. If there were problems, VDP and trainer were stuck with each other. There were no others in the immediate equation. There were problems, but they were in the minority and were effectively moderated by the broader community. For the most part these partnerships worked and worked well. And as we saw, when they did work well, the relationship between VDP and trainer was a close and lasting one and the commitment of so many of the trainers to their VDPs did not end with the conclusion of the VT year. It was ongoing and unconditional.

The Schedule (monthly gross income)

The issue of the VDPs' gross monthly income is all pervading and as this work has progressed the attitudes of those managing VT have shown signs of changing. At the beginning, gross income was not and could not be an issue. I recall a trainer asking an advisor if this could be a factor in measuring performance. His request was politely but firmly dismissed out of hand. Yet the reality is that most trainers use it to monitor their VDP's progress and many scheme advisors are now actively canvassing trainer opinion on this issue.

Should gross income be a factor in measuring performance? So many trainers think it should. And they have a strong argument. If we accept that the role of VT is to develop practitioners who are capable of independent practice, then one major issue has to be the ability of the practitioner to survive financially working within the GDS. We know that most trainers are happy with an end VT gross monthly income of around £6,000; we also know that they wryly comment that the VDPs shift up a gear once they become an associate and are no longer salaried. As the former advisor in the first cohort stressed:

To make a living, being competent is not enough. They have to be competent and quick.

As an associate, £10,000 is a more realistic monthly target. Armed with this information it can be argued that if a trainer does not ensure that his/her VDP

reaches a reasonable final income, then they are failing the VDP. I know of VDPs who were grossing just over £2,000 at the end of VT; they may have difficulty surviving in practice and are perhaps more likely to find employment in a less stressful branch of the profession.

The counter argument is that this is a forum to develop professional practice in a sheltered environment and performance related assessment has no place in VT. Through their position in the community of VT, VDPs have earned the right not to be assessed in this way. Some VDPs accept monitoring of their progress in this way as a necessary fact of life. We saw that one VDP fretted about his gross, even though his relatively experienced trainer noted that he was working very well. But the sensible trainer treads very carefully. In the early days the VDPs are just trying to survive with a daunting daily patient list. In months to come they will wonder what they were worried about, but that is in the months to come. Trainers wisely avoid mentioning gross income at this stage and they wait until the VDP has gained confidence. But it must be done carefully. At this stage the VDP's are still novices and I did find four or five who admitted that their world temporarily fell apart when their trainer handed them their monthly schedule with its implicit implications. Others take offence and interpret this as a trainer wanting them to earn money for the practice (The trainer keeps all the VDP's income). This is where encouraging the VDP to take responsibility for their own learning experience (an attribute of expertise) can pay dividends. If a trainer can develop a climate where, as in the example above, the gross is more of an issue for the VDP than for the trainer, success is assured.

Mr Smith could hardly be accused of being motivated by money, but he wistfully noted that the last few months of VT was a time when the VDP could give something back to the practice. Other trainers have similar views, but again the issue is really one of expectation. The two VDPs who came in for particular criticism at the half way stage were in fact grossing as high as anyone in their particular schemes. One who had grossed £5,250 in January was considered lazy by her trainer. Their trainers were inexperienced; they still had to be inculcated into the culture of VT. They had to recognise their legitimate position in the community of VT. I suggest they were still in

associate mode. They were not yet thinking as trainers.

Around this time the trainer has to decide if they are going to offer the VDP a post as an associate after VT, or continue in VT with a new VDP in August. If the VDP stays on, then encouragement to speed up is seen as a positive move to help them. However, if the VDP either chooses not to stay on, or is not given the opportunity to, then similar encouragement may again be perceived as the trainer wanting to make money.

Whether gross income should be a factor in measuring performance is an issue for those managing VT. If it is going to be, as soon as the VDP is settled in, it would make sense to ensure that he/she knows that this is part of their assessment process. And trainers should be looking for defined rates of VDP progression regarding gross income.

Comment on the recommendations of the CVT Review of VT

Earlier I considered this review in some detail and at this point it is pertinent to analyse the relevant recommendations that were discussed earlier, in the light of this work and other available data. Each recommendation is noted in sections as there appear in the Review; my comment follows each recommendation.

Mandatory Vocational Training

1. VT should be mandatory for every dentist entering permanent employment in any area of clinical practice.

Comment: This recommendation is difficult to comment on. Implicit in this statement is the notion that new graduates are unsafe to practise without participating in VT.

There are many inputs into this review, but the research evidence provided by the Review to support this recommendation is not particularly strong. In the text of the Review we have the quote from the QAA commenting on the Teaching Quality Assessment of Queen Mary & Westfield College (2000):

Students reported that they felt well prepared for their professional careers. Vocational trainers who met with the reviewers praised the skills and knowledge of the students and reported that they made a swift transition to general practice. Recent graduates from the school felt that they had been well prepared for the transition to employment and had acquired skills and knowledge to succeed in their profession (p 16).

This comment supports the findings of the present study, certainly those of the expert trainers who noted the impressive raft of skills that the new graduates possessed. There is also the rather positive comment of the GDC Visitation of Examinations (GDC, 2001), noted on page 47.

Most new graduates will do VT in any event, but the evidence to support this recommendation is not strong.

Interface between undergraduate and postgraduate education

2. Collaboration should occur within the continuum of dental education to ensure that the life long career planning of dentists is supported.

Comment: This recommendation was not considered in the present study. It seems entirely appropriate.

3. The CVT should continue to work with the Council of Deans of dental schools to ensure that established two way channels of communication are further developed between universities and trainers.

Comment: This recommendation was not considered in the present study. It seems entirely appropriate.

Standards

4. Research work-based assessment systems to determine completion of VT that is robust enough to withstand legal challenge.

Comment: This recommendation is not relevant to the present study.

5. Establish training and support facilities for graduates unable to complete VT on time.

Comment: This recommendation is entirely appropriate. This is an ongoing issue of concern and must be addressed as a matter of urgency.

6. Establish flexible training facilities for graduates whose participation in VT is constrained by external factors beyond their control.

Comment: This recommendation is entirely appropriate and should be addressed as soon as possible.

7. Develop a teacher education pathway for advisors and trainers.

Comment: This recommendation is entirely appropriate and can only enhance the experience of VDP, trainer and advisor.

8. Analyse VT's management infrastructure and strengthen it when necessary.

Comment: This recommendation is entirely appropriate but those managing VT must recognise what is good about VT.

Funding

9. Revise financial estimate to provide mandatory vocational training.

Comment: This study and other evidence discussed under Recommendation 1 provides evidence to suggest that this recommendation is not necessarily appropriate.

10. Examine where savings may be achieved, without loss of quality through pooling of resources currently available through CVT, the Dental Vocational Training Authority: England and Wales (DVTVA), the National Advice Centre for Postgraduate Dental Education and the National Centre for Continuing Professional Education of Dentists, in the light of current funding changes.

Comment: This recommendation is not relevant to the present study.

11. Investigate the possibility of extending VT to encompass other areas of training need, particularly issues affecting retention and recruitment, and issues concerning overseas dentists.

Comment: This recommendation is not relevant to the present study.

Policy and management

12. Continue to provide central accountability for VT and the monitoring, required to achieve that, as an essential rôle for CVT, using improved systems where appropriate.

Comment: This is particularly appropriate in view of the fact that the CVT has been disbanded as an organisation and its rôle taken on by the DVTA.

13. Provide central coordination of training of advisors to establish a cohesive national standard as an essential rôle of CVT.

Comment: This is entirely appropriate in view of the recent demise of the CVT.

14. Assess the rôles of CVT and the DVTA with particular regard to efficiency, accountability and relevance to *Modernising NHS Dentistry* and *Improving Health in Wales*.

Comment: No longer relevant.

15. Review CVT's constitution and consider re-establishment in a form more appropriate to the future rôles it must undertake, for example, as a statutory body or other legal entity.

Comment: No longer relevant.

Research

Recommendations 16 – 19 discuss the need for future research to inform the profession and future reviews.

Comment: This seems entirely appropriate.

In summary therefore the only area of disagreement is in Recommendation 1. The CVT could be accused of making a recommendation that maintains its reason to be. The contrary accusation could be aimed at the author in that as a university teacher this recommendation aims criticism directly at the heart of undergraduate education. I suggest that the evidence available does not support a recommendation that vocational training should be mandatory.

7 CONCLUSIONS

This was a study that aimed to present an independent assessment of VT in terms of aspects of its management and educational worth. This study took place in the South East and any conclusions apply to training partnerships in that area. The accounts of the typical (successful) and unsuccessful partnerships on pages 75 and 113 address the initial research questions. The format of the conclusions that follow was designed to specifically address the research questions. Essentially this study has shown that:

VT is a success story

It is worth recalling that despite the remarks of Baldwin et al (1998) who suggested that it is remarkable that no formal independent assessment of the value of VT has ever been carried out in terms of educational worth or patient care, Seward (2000) claimed that VT has been the profession's success story.

The aim of VT is to facilitate the transition of new graduates into general dental practitioners and this study has considered defined aspects of the VT experience to determine the outcome of that aim. The typical partnership was a success. This and the evidence from the other partnerships in this study suggest that VT is a success story. VT is a success for trainers and it is a success for VDPs. For the most part trainers follow policy guidelines and they have a clear notion of VDP progression through VT. And while there wasn't and can never be unanimous trainer agreement as to how rapid or successful a VDP should be in his/her progression throughout the year, the trainers have a plan of progress and it does seem to work.

VT is a success for its participants, but does it achieve its aims? It does; the structure, the community of VT, ensures that trainer and VDP broadly follow a predetermined path. But there can be problems. The planned 'product' of VT, i.e. a practitioner capable of independent practice, is more abstract than tangible. We heard from one VDP (page 97) that she needed to know what she had to achieve.

Aspinwall et al (1997) remind us that there is a need for clarity about what

we are trying to achieve and how we know when we have achieved it. VT is first and foremost a time-served educational arrangement. If trainers are not clear about their objectives, they won't know whether or not they have been achieved. Not only must objectives be clear, they must be reinforced appropriately. In fact the guidance is there, in the guise of the training handbooks (Rattan, 1994 and 2002) and the Portfolio.

VDPs enjoy VT. It is hard work; it is scary and stressful, but they do enjoy it. None would have wanted to enter general practice without doing VT.

There are problems, but it is important to put these in perspective. Of the 35 partnerships analysed here, after a period of reflection, only two did not consider the year a success.

Miss Shah's initial experience is a manifestation of VT not being a success (my second research question). But the community of VT provides a safety net for just such eventualities and the safety net worked. So it might be appropriate to suggest that even in this case, VT was successful.

Trainers do a good job; the VDPs that they have in their care are good too, but VDPs are novice practitioners and we must remember that. Some are better than others and they have their weaknesses; but the trainers identified these weaknesses and more often than not remedial action was taken with a minimum of fuss. Formal assessment procedures are not necessary in VT. Contrary to what many of the trainers say, *they* don't need it.

Despite oft-heard anecdote, trainers are not in VT for the money. Some are in it because VT provides a regular person to undertake the practice's NHS commitment. Others are trying it out, to see what it is like. Most are in it because they enjoy it; they enjoy the teaching. They see it as a part of their own professional development, and for some seeing a novice VDP become a confident and skilled practitioner, who forever afterwards keeps in touch, and continues to ask for advice, is what VT is all about.

As far as Baldwin et al's concerns about patient care are concerned, with only a few reservations, trainers thought that the VDPs were capable of

independent practice, post VT. We need not be concerned about the educational worth of VT. Trainers assume the role of professional teachers and they carry out their duties very well. VT is a community of practice. And as we heard from Gore and Gore (1999) on page 45, by virtue of the structure and group norms of the community of VT, trainers and indeed VDPs are enabled to acquire tacit knowledge. As a loose coupled educational organisation it is very successful. Fine-tuning is necessary, but major change to the organisation, management and assessment process should be avoided. VT facilitates the transition of the novice dentist to competent practitioner.

There are unforeseen consequences of VT

Practice based academic teaching tends to drift away as the VT year progresses. Scott (1997) reminds us that, within an organisation varying goals will be held by participating groups. The purpose of VT is to produce general practitioners capable of sound independent practice. However, what is a 'general practitioner.' We are not seeing a 'drift' away from the notion of good practice; rather there is a re-interpretation of that notion. Trainers see clinical management as the key to success in VT; education is a subordinate issue. The absence of theory-based teaching should not be a concern. It is important that tutorials continue; the expert trainers maintained these throughout, but late on in VT, reflection is the key. This is a clinical environment. VDPs must have sufficient theory on which to base sound clinical practice. VT provides 30 Study Days during the year for academic development and I suggest that this is an entirely appropriate forum for theory-based teaching.

The Portfolio

As a tool for reflective self-assessment the Portfolio does not work –for most training partnerships.

Most VDPs find the Portfolio tedious to use and consider it a waste of time, certainly after the first few weeks; but this is not the fault of the Portfolio! I am absolutely convinced that this state of affairs is simply a consequence of inexpert use of the Portfolio as a tool for reflective self-assessment, at all levels of VT. The result of this is a lack of commitment to its use by virtually

all VDPs, most trainers and some advisors.

When it was used as intended, both trainer and VDP thought it an exceptionally useful tool to develop professional practice. Used properly the Portfolio is very effective, but few in VT know how to use it properly. This includes many of the trainers who demonstrate the hallmarks of expert. But interestingly these expert trainers see the value of, and develop alternative structures for, VDP reflective self-assessment in the later stages of VT.

The influence of the private sector

Earlier I suggested that a lack of clarity could result in unforeseen consequences and perhaps as important as any issue is the unforeseen influence of the private sector on an NHS funded educational system. Unforeseen is the wrong word as this influence seems to be well recognised by most in VT. Those managing VT not only tacitly accept the situation, but many contribute to it. NHS funds are indirectly driving the very people it needs out of the GDS and into the private sector and the influence is all pervading. Committed trainers feel convinced that VDPs come out of dental school with the attitude that it is only possible to provide an inferior service within the GDS. So many trainers work primarily in the private sector and the message from the Study Days is that NHS dentistry is not the way to go. So what chance does the VDP have of getting a sound and enthusiastic grounding in NHS dentistry?

There are still trainers in the South East who are wholly committed to the NHS; I saw some of them here and I was humbled by their clinical skills and their training expertise. Yet despite each of them being desperately keen to continue in VT, for various reasons, each was unlikely to continue and their expertise was going to be lost to VT. Perhaps an overt commitment to the GDS should be the primary criterion in trainer selection.

VT cannot afford to lose these trainers. But can it afford to lose the expertise of the privately based trainers? I'm not sure that it can, and we know that this is not just a problem in the South East (Grieveson, 2000).

Selection in VT is a problem

Trainers seem to be at variance with the CVT and the Training Handbooks (Rattan, 1994 and 2002) regarding the criteria they consider important in selecting a VDP. Specifically they appear to have little concern for clinical and/or academic prowess. Much has been written about selection in VT; this is a difficult period of time for those seeking a VT place and it is particularly difficult for Asian female applicants. They have to work harder and for longer to secure a VT place in a preferred location than either their Asian male or white female colleagues. However, despite anecdote and the perception that Asian females are disadvantaged in their job search as a consequence of their gender and ethnicity, I could not find any evidence of this. The experience of Asian female applicants can be explained, at least in part by the fact that they are keen to stay in the South East. Bearing in mind the dramatic competition for places in this part of the world, Asian females have significant success securing job offers in their preferred location.

Expertise is a critical issue in VT

There is a wealth of expertise in VT but so much of this seeps away and a precious resource is lost. Expert trainers who have the ability to act as critical companions (page 145) leave VT, never to return. VT is a very successful community of practice, but the potential is there to move the professional development of both VDPs and trainers to a higher level.

This is really the issue of trainer selection and whether post-graduate qualifications should be an issue. Postgraduate qualifications should not be on the essential list of requirements and care should be taken before including them on any preferred list. They do not function as indicators of expertise in training. VT does not overtly value its most precious asset, i.e. the expertise of its trainers. Or if it does this is not apparent in either word or deed. We have seen that advisors are not necessarily expert trainers. Perhaps this is because trainers tend to become advisors by following a path to promotion that does not consider training expertise. The advisors then perpetuate the situation when they become involved in trainer selection. I suggest that the loss of this expertise is lessened by the fact that the overall structure, the community of VT, provides a sound environment to develop

professional practice. In particular the opportunities that VDPs have to get together and share their problems and experiences, not just with each other, but also with others in VT. The value and success of this community must not be ignored.

Relational skills progression.

Trainers go through their own process of skills acquisition in parallel with their VDPs, but the pathway is less well signposted than that for the VDPs. We have seen qualities or attributes that can be considered to be the hallmark of training expertise, but we know from Jarvis (1997) that the transition from novice to expert is not automatic and some very junior trainers demonstrated many of the attributes of expert. Unfortunately other senior trainers could not necessarily be classed as expert. Progression in VT must be considered as relational. And within a training partnership, the level of expertise of both the VDP and the trainer is a critical factor in determining how that partnership is manifest.

Advisors are trainers, but they are also teachers and managers and it is in this latter role that there can be problems. As we have seen with trainers and teaching, it is assumed that the individual innately possesses the necessary skills. Managing is a skill, and the assumption that advisors are skilled managers is similarly flawed.

Success as a trainer, surviving as a VDP

The final research question asked if was possible to set out the attributes of the trainer/VDP partnership that point to a successful outcome? I suggest that it is and this question is addressed below in two parts: 'On becoming a successful trainer' and 'The VT year: a survival guide for VDPs.'

On becoming a successful trainer

Throughout the results and discussion I have suggested that trainers undergo a skills progression, just as VDPs do. I have also indicated that that there are particular features or attributes that place a trainer at the expert end of the skills acquisition model. Furthermore I suggested that it is easier to identify

the attributes of expertise than it is the expert. Dreyfus and Dreyfus (1986) remind us that:

An individual will be at the same time expert with respect to certain types of problems in his area of skill, but less skilled with respect to others (p 20).

The lists of recommendations/suggestions that follow are presented as a working model; a guiding path that any trainer can use to develop his/her expertise. These are the hallmarks of expertise in training:

- Spend time getting to know your short-listed candidates. Your VDP is joining your family –your community
- Be mindful of your VDP's level of experience/expertise and adjust your expectations of his/her performance accordingly
- Once the 'honeymoon' period is over, let the VDP know that you will be monitoring his/her gross income throughout the year
- Give the VDP ongoing feedback on his/her performance –good as well as bad. Always be constructive
- Encourage the VDP to show you the successes as well as the failures
- Show that you value your VDP's opinion. Ask them for advice
- Give your VDP space. You need the confidence to step back; they will get things wrong –accept this
- Be there to give help and/or advice when it is needed. This must be unconditional
- Ensure that the VDP receives good quality nursing and administrative support
- An experienced and knowledgeable nurse can teach the VDP a great deal. They are also in a unique position to identify and defuse developing problems
- Use the tutorials to work through difficult tasks together. Let the VDP do it. Watch and try to deconstruct the particular skill. Ask yourself, 'how am I doing this?'

- Keep a dedicated (tutorial) session to the end. Let this session become more reflective as the year progresses. Use it in conjunction with the Portfolio
- The Portfolio must be seen as an invaluable assessment tool. If you don't value it, your VDP won't
- Seek and reflect upon the feedback on your own performance as a trainer
- Maintain the VDP's enthusiasm. For the VDP to feel that NHS dentistry can be rewarding –you have to believe it is rewarding

The VT year: A survival guide for VDPs

For the VDP, the points outlined below can be considered to be a survival guide. As the VDP develops his/her professional practice in VT, the following will make the process easier:

- When choosing a VT place, the people are more important than the fabric of the practice or its immediate environment
- Listen and be receptive to advice. And remember trainers aren't perfect and they get things wrong
- Work hard to fit into the team. Show that you value the staff. Say thank you
- Be punctual and remember the effect of any absence you make take. A cold is a cold –you work through it
- This is a learning experience. Use this opportunity to learn and develop your clinical expertise
- Accept that your monthly gross income is an important factor in assessing your performance
- The more you earn the more the trainer gets; consider this as an opportunity to develop your clinical practice
- Share your concerns and problems with your peers. Discuss issues of concern with your trainer. Then approach your advisor if the problems are not resolved

8 RECOMMENDATIONS

The recommendations outlined below are presented in a similar format to those of the CVT Review of VT (2002) discussed on pages 36 and 160.

The undergraduate/postgraduate interface

- Those managing VT and the Council of Deans of the dental schools must develop a close collaboration to ensure the safe transfer of new graduates through this educational interface. Undergraduates could be introduced into the community of VT by visiting outreach practices in their final year.
- The huge enthusiasm and expertise of trainers and advisors must be seen as an asset that can and must be, exploited.

Education/standards

- The progress of trainers must be monitored, particularly those in their first or second year of training. A system should be developed that can tap into the wealth of expertise available in VT. A mentoring system using expert trainers as ‘critical companions’ should be developed.
- The facility must be available for ‘serial’ trainers to take a year out of VT without the worry of not being able to regain their training position. In fact expert trainers should be actively encouraged to do this. During this period trainers could still be involved as mentors to their junior colleagues.
- A programme of advisor training must be developed to ensure that there is a coherent and shared view of how VT should be managed at scheme level.

Assessment

- At present VT in England and Wales rejects competence-based systems of assessment in favour of Portfolio centred reflective self-assessment. This arrangement appears to work very well when

approached in an appropriate manner. A move to a more formal assessment procedure, as is taking place in Scotland, should be resisted. To aid this the Professional Development Portfolio should be reviewed and restructured to take into account the ever changing face of general practice and the rapid progress that VDPs make after their initial few weeks of VT.

- Training in the use of the Professional Development Portfolio must be given to trainers, and advisors.

Management

- VT should continue in its present form. The success of VT is such that regulatory bodies should think very carefully before any major change to the present format is considered.
- The formal general practice based period of VT training should not be increased beyond the current twelve-month period.
- For some VDPs a period of more than twelve months is necessary to ensure safe transfer to independent practice. There must be the facility to continue for a longer period if trainer, advisor and dean consider this appropriate.
- This flexibility must be extended to those who wish to undertake VT part time or for other reasons such as pregnancy or long-term illness.

Policy

- The CVT provided a sound policy monitoring system. The DVTA must ensure that this continues.

Funding

- Those managing VT must face the fact that many trainers are barely able to meet the NHS income requirements to remain in VT. I recommend that this requirement should be abandoned. Expertise in training is the key and if necessary VT should source this from the

private sector.

- VT must buy in the expertise that privately based trainers can provide; however, it must not buy in a private ethos.

9 THE CONTRIBUTION OF THIS STUDY

Introduction

This work has to make a contribution to both theory and practice. On page 53 I said I wanted this to be a collaborative project. I owe it to all those who gave so freely of their time to ensure that their participation has added to what is known about VT. This study broke with tradition in researching VT. I wanted to determine how understandings were formed and relationships negotiated. No other research in this area has focused so closely on the participants. The CVT Review of VT (2002) included in-depth interviews, but with personnel in only three practices; practices that were selected for the researcher. Admittedly this was but one strand of a larger study, but throughout the review, there is an impression that was at its most persuasive in the questionnaire (Appendix 1) that this was an inquiry looking for confirmation; confirmation that VT was sound, and it provided value for money. That approach was not appropriate for this work. The funding arrangements of VT did not concern me, and I was neither trying to confirm nor refute the validity of VT as an educational community. That would emerge from the study. This study lifted the veils of VT (Blumer 1976); the VT experience I presented was in the words of its participants. Yes the account was my construction, but it was one undertaken with an absolute commitment to tell *their* story.

This study has confirmed claims such as Seward's (2000) that VT is the profession's success story. But I suggest that its more meaningful and perhaps far-reaching contribution was to give an insight as to how that success was achieved.

VT is a community of practice

First and foremost VT is a success because of its structure as a community of practice (Lave and Wenger, 1991). The functional unit of VT can be seen as the VDP, trainer and advisor, but there are many more participants in this community. It also includes practice staff, regional VT personnel, other trainers, study day teachers, but probably most important of all, other VDPs. It is the functioning of this community that ensures success in VT. And this

community is very effective when things go wrong, as they always will do. VT could be better, it could be more effective, but I suggest the evidence presented in this thesis suggested that any major changes to the structure of VT should be considered very carefully. Significant changes could jeopardise the effectiveness of this community.

How does VT manage when things do go wrong? Miss Shah's experience gave us an insight into this. Just a month or so into VT, because the mechanisms were in place, her advisor was involved and the support from her VDP peers was immense. Because of this network, I knew of the situation within weeks. Perhaps the advisor should have taken action sooner than he did, but what we saw was the community of VT facing a major problem, and that community, it wasn't just the advisor, successfully managed that situation. Some may argue that this scenario was extreme and unrepresentative. It was extreme, but the point is, it was the community of VT that moderated and guided how matters were handled. It was this community that ensured that situations such as this were and are a rare occurrence.

Developing expertise in VT

Fig 5.1 lays forth in their own words, the trainers' plan for VDP progression through VT. It revealed that for the most part, VDPs were competent by the end of the year. That plan of progression closely followed that put forward by Eraut (1994) presented on page 21.

But progression in VT is a complex issue. I suggested (page 140) that as an expansion of the models of Eraut (1994) and Dreyfus and Dreyfus (1986), progression in VT must be considered as a relational model. Trainers were undergoing their own skills progression, as trainers, in parallel with their VDPs. And within a training partnership, where each partner was located on their own individual path to expertise was critical to how that particular training partnership was manifest.

This relational path of progression is not unique to VT, but its effect was particularly significant because of the intimate VDP/trainer partnership. But

encasing this partnership was the broader community of VT; a community that was not only able to moderate the effect of novice status, but it also provided an effective environment for the VDP and trainer to develop their expertise together.

This work highlighted the fact that expert practice in VT was not necessarily valued as a key resource. It was by listening to the trainers and identifying attributes that indicated expert performance (Dreyfus and Dreyfus, 1986) that I was able to put together guidance notes on becoming a successful trainer (page 169). This work was able to demonstrate how trainers showing the attributes of expertise managed the VT experience very differently to their less expert colleagues. They were able to give the VDP space. They had the confidence to step back and accept that the VDP would get things wrong. They were as I argued on page 149, providing an opportunity for learning. The trainers provided the space of 'benign community neglect' (Lave and Wenger, 1991) in which VDPs could configure their own working practices and relationships.

The trainer's ability to step back and give the VDP space when he/she is ultimately responsible for the clinical care of the VDP's patient is borne out of that trainer having absolute confidence in his/her own clinical skills. A confidence that says I can manage any clinical situation that the VDP may find him/her self in. When considering expertise in VT this notion of clinical confidence should perhaps be added to the Dreyfus and Dreyfus (1986) list of attributes that define the expert trainer.

The expert trainer ensured that the VDP had an experienced, perhaps expert nurse, who as Benner (1984) suggested can take a diagnostic and monitoring role and as a consequence, she/he can contribute to the VDPs learning experience. Most significantly of all perhaps, the expert trainers did not appear to be overly concerned about the initial clinical experience of their VDPs; neither did they let the tutorial session fade away in the second half of VT as so often happened. But the emphasis they placed on the tutorial changed; formal teaching gave way to reflective self-assessment. This was the key to success in VT.

Training in VT is becoming more popular, certainly in the South East, and trainers showing the hallmarks of expert, reported that it had been suggested to them that they should let new people have a go at training. This implies perhaps, that expertise is not valued. More likely, it highlights the problem of identifying expertise. Advisors can identify 'safe,' competent trainers, but the community doesn't have any structure in place to identify, or indeed enable trainers to develop and make explicit their expertise. This study revealed that for whatever reason there is training expertise that is allowed to drift away from VT.

The community of VT could be even more effective if this expertise was harnessed; if critical companions/mentors were introduced to aid the professional development of less expert trainers. We saw (page 144) that one trainer had already taken it upon himself to act unofficially in this capacity. And it was a role he thoroughly enjoyed. VT must develop the notion of the critical companion. A need to recognise, harness and develop expertise in VT was a persuasive theme that ran right through this study.

Experience and expertise in VT are not synonymous. Some trainers in their first year of training demonstrated attributes of the proficient, even expert trainer. It was with the novice trainers that problems were most likely to occur. My trainer advisor confirmed that he watched trainers in their first or second year very closely. I suggest that this work revealed that novice trainers were more likely to have an unreasonable expectation of their VDP's competence than their expert colleagues. This was probably the major reason for conflict. That said, the community of VT appeared to be very successful in moderating the effect of this novice status; Miss Shah is an excellent example of this. It is worth remembering that Bleakley (2002) doesn't see expertise necessarily as what an individual holds; he sees it more as a collaborative definition within a working group.

Assessment in VT

In England and Wales assessment in VT is at a crossroads. This work showed quite clearly that as an assessment tool the Portfolio doesn't work.

The reason for this is clear. For the VDP to see the Portfolio as valuable, the trainer has to see it as valuable, and so does the advisor. Unfortunately there is little commitment to the Portfolio at any level of VT, and most of the trainers in this study felt a more formal approach to assessment was the way forward, possibly with some form of formal end of VT assessment.

Tests of competence and outcome indicators are important in dental education. Dental practitioners must be competent to carry out the business of dentistry. But VDPs are qualified; they are registered dentists. I have suggested that as part of their rite of passage through the community of VT, VDPs have *earned* the right not to be subjected to formal assessment procedures. And this study demonstrated how valuable the Portfolio could be as a tool for reflective self-assessment if trainers knew how to use it. Again illustrating the influence of expertise in VT we heard from one trainer (page 100) troubled by the possibility of introducing testing of competences. VT was the place to make mistakes; it was about self-assessment and not being afraid to ask the silly questions. VT does not need to take the route to more formal assessment. It has what it needs in the Portfolio. The community just needs to recognise that, and learn to use it. Returning to Lave and Wenger (1991) and their notion of situated learning everything is in place to facilitate the VDPs' transition to general practitioner. In fact Lave and Wenger suggest that under circumstances such as are present in VT, introducing tests of competence could be a retrograde step in the VDPs' professional development.

Selection in VT

Problems in the selection process were well known before this work began. This is a difficult time for both VDP and trainer. This work did however reveal that trainers showing other attributes of expertise handled the interview process quite differently from their less expert colleagues. They were not trying to appoint 'high flyers.' They wanted to find someone who could fit in, who would recognise his/her legitimate negotiated position in that individual community of practice. This process was time consuming, but these trainers rarely had problems with their VDPs.

Issue of race and gender still hover over the selection process; there is a perception that Asian women in particular are disadvantaged in the selection process. The questionnaire attached to this study was small scale, but it suggested that GKT Asian female applicants applied for more places and took longer to secure a position in a favoured location than their white or Asian male peers. They were also more likely to want to stay in the South East where the competition for VDP places was fierce. On page 14, I noted that Anees et al (2001) have suggested that the perception of disadvantage in the selection process may well be greater than the reality.

Perception of disadvantage continues to be reinforced in the accessible dental literature. Anees et al (2001) have tried to address this. They noted that although Bartlett et al (1997) claimed that gender and race influenced London-based trainers in making their choice of VDP, neither the extent, nor the nature of the disadvantage was investigated. More recently, despite reporting that there was insufficient evidence to say that discrimination according to gender was in operation, Chadwick and Newton (2003) offer tacit support to the findings of Bartlett et al (1997) and Grace (2001). Maintaining the perception of disadvantage in this way is potentially very damaging.

The influence of the private sector

One final contribution that this work has made was to reveal the bias towards the private sector that seems to pervade VT in the South East. As far as the VDPs were concerned this could be annoying, but the influence on their educational experience was really minimal. This issue should perhaps, be more of a concern for policy makers. NHS funds seemed to be, indirectly, driving the very people it needed out of the GDS into the private sector.

The CVT Review of VT (2002) suggested that VT provided value for money. It probably does, it certainly provides a sound community of practice in which the transition of novice dentist to competent practitioner can take place. Whether that competent practitioner is willing to practise in the GDS is another matter.

10 REFLECTIONS ON THE METHODOLOGY

I cannot overstate the value of working with my advisor mentor. He facilitated my progression as a VT researcher. I noted on page 67 that the way I viewed VT changed as the study progressed and I effectively became part of what I was researching. I was humbled by the welcome I received and the openness of the trainers and advisors. Would my university colleagues - would I have been as welcoming had the situation been reversed?

This entire study relied on my achieving the cooperation of the trainers. My carefully planned introduction was certainly one reason I managed to achieve this, but perhaps there was another. I suggested on page 52 that although I had insider knowledge, as a university teacher I was very much an outsider. Now I'm not so sure that I was right. Perhaps this perception was more my prejudice coming through, rather than that of the trainers. In a recent conversation my trainer mentor noted that a non-dental researcher was having some difficulty gaining access to a group of trainers. He suggested that my open and reassuring approach had contributed to my success. But, he also noted that compared to this researcher, I was really 'one of them.' Despite my university position, I was still an insider and I should not underestimate that.

To determine how understandings were formed and relationships negotiated in VT an interpretive approach was essential. But I was very fortunate; my very first trainer interview was a difficult one and I didn't handle it well. This trainer/advisor was wary of me; I was nervous and the first ten minutes of the interview were awful. But as the interview progressed, we both became more at ease, and from that faulting beginning, this trainer/advisor eventually became *my* advisor/mentor. This experience was a salutary lesson. I was a novice; I had to develop my skills as an interviewer.

It was impossible to conduct this work without addressing issues of race and gender; to ignore these issues would be to devalue the research and fail those who participated in this study. I have considered the ethical responsibilities that researchers have to their research participants (page 53) and I was very aware that there are some (Davies, 1985) for example, who maintain that to

achieve reliable and valid data it is essential to match the sex and race of the researcher with the researched. Blair (1995) argues that race matching does not necessarily produce more reliable data, but I was always aware that I, a white male, was researching at least some issues that affected women and Asian women in particular.

Initially I didn't want to include Miss Shah in this account. As her former teacher, it was so difficult watching the early months unfold. But I rapidly realised that I was now part of the larger community of VT. Even if I had wanted to, I couldn't divorce myself from the situation, her peers –the community wouldn't allow me to. The support mechanism of the community was a powerful one, and a very humbling one to experience.

This and further work

There are so many aspects of this work that I would now do differently. I couldn't afford to fall behind the relentless onward progress of VT and I think I managed the fieldwork quite well. However, this study generated a huge amount of paperwork and to begin with at least, I was swamped, not so much in the data, but in the study itself. I took me a while to put a sound study management programme in place.

If I had my time over again I would not try to fit so much into so tight a timeframe. It was a difficult task; time was always a problem. I wanted to follow the VDPs beyond VT. I just didn't have the opportunity to do this, and I feel that I have in a way, let them down. They were my VDPs; indeed they were my trainers. It was difficult to let go.

The questionnaire in this study was small scale. It was an addition; effectively a pilot designed to determine whether or not in the South East, one particular group of VDPs, based on gender and ethnicity had less success in their job search, than others. This is an important area of investigation. It is my intention to continue with and develop this work by following successive qualifying years of graduates, possibly including graduates from Queen Mary and Westfield College (the other undergraduate dental school in

London). Anecdote has no place in informing such a sensitive issue such as race and gender in VT.

There are now increasing numbers of regional postgraduate deaneries who participate in two year general professional training programmes, where twelve months of VT is linked with an NHS hospital or community post and these can take various forms. There is an urgent need for work that identifies the impact of the two-year schemes. These schemes must enhance or at least complement the present community of VT.

The future

On page 35, I noted Aspinwall et al's comments (1997) that in work of this nature, all stakeholders should have a shared understanding how the gathered information will be used. Time and time again trainers asked if this work would appear in the accessible dental literature. They wanted the profession to know what goes on in VT; to hear their story. I have a commitment to place the findings of this work in the public domain.

Although it was not my intention to research the actual competence of the new graduates, it was an issue that hovered constantly over the entire project. It is an issue that must be addressed. In fact as a consequence of this work, I am now, together with the Dean of Dental Studies of GKT and my advisor mentor, developing a protocol to forge bonds and develop dialogue between our School and VT trainers. We aim to design a longitudinal study in which the opinion of the trainers is taken into account and fed into the design of a dynamic undergraduate curriculum. I see a potential role here for rested expert trainers.

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Appendix 2 Letter of introduction to trainers

Department of Prosthetic
Dentistry,
Floor 20, Guy's Tower,
London Bridge, SE1 9RT.

Tel: 020 7955 2144 /4026
Home: 01689 856679
Mobile: 07870 488989
E mail: cab.cabot@kcl.ac.uk

5.12.00

Dear Dr ,

As part of a long term, in depth study of the progress of graduates from the GKT Dental Institute, I am following new graduates through VT and beyond. Within this framework I interview our graduates once they have settled into VT and again on completion of the VT year.

I hope that has mentioned me to you and that I would also like to interview you in your practice for a short time. The trainers' views and opinions on the role of VT and the progress of the incumbent VDP are crucial to this study and I hope you will be willing to participate.

Although I am a clinical teacher at GKT, this work is taking place under the auspices of the Open University, School of Education. It is independent of, and has no formal link with GKT or King's College. All discussions will take place in the strictest confidence and no one apart from me is aware of the identity of those taking part.

I'll phone you next week, if I may, to arrange a convenient time to meet. If you prefer, please do not hesitate to contact me by telephone or E mail. I am more than happy to come and see you after work to minimise disruption to your practice.

Thank you and I look forward to meeting you.

Best wishes,

Yours sincerely,

Lyndon B Cabot
Senior Lecturer

Appendix 3 Developed criteria for defined performance areas in VT

VDP Selection

Performance Area

Developed Criteria

Application procedure:

Early publication of VT lists.
Information about practices.
Defined application procedure, same for all candidates.

Conduct of interviews:

Structured interview schedule.
Appropriate conduct.
See practice in action, meet staff. Care of interviewee, travel/timing of interviews/expenses. Management post interview.

Outcome notification:

Contact all applicants within reasonable time.

Practice facilities

Performance Area

Developed Criteria

Clinical facilities:

Adequate surgery and sound major equipment.

Clinical freedom/materials available: No limit on clinical freedom.

Appropriate range of materials.

Nursing/administration support:

Dedicated nurse. Appropriate staff for practice.

Patient Book:

Adequate. Look for gradual increase range of skills/patient load.

VT Management (practice)

Performance areas

Developed Criteria

Help/advice/support:

Early on: trainer available on demand.

Later: changing support, less frequent/advice/less involved.

Teaching, quality and commitment: Look for weekly tutorials.

Commitment, prearranged tutorial schedule.

Attitude/support of auxiliary staff:

Trained nurse, capable of handling increased work load. Friendly/efficient administrative backup.

Clinical demands:

Not excessive. Look for gradual increase in range of skills/patient load.

Monitoring of progress:

Feedback and encouragement from trainer.

VT Management (region)

Performance areas

Developed Criteria

Content/organisation of Study Days: Look for well organised sessions varied and relevant content.

Support by regional staff:

Monitoring of Portfolio/general progress by advisor. Mechanism if problems in VT.

Appendix 4 Cohort 1 VDP: Initial interview schedule

Performance areas and focusing questions

VDP SELECTION

Management of advertising/application procedure

How did you decide on the practices you applied to?

What information was made available to you?

Tell me about the application procedure.

Appropriate conduct in interviews/care of the interviewee

How about the interviews? Here must prompt to develop the interview experience, but do not lead. Did you see the practice working? Who did you meet?

Ask if VDP thought there was anything inappropriate in the conduct of the interviews.

Management post interview, outcome notification

What happened after the interview? How were you informed of the outcome?

Other comments?

PRACTICE FACILITIES

Adequacy of clinical facilities

Tell me about your surgery. And the other facilities? Examples?

Level of clinical freedom/materials available

And what are you actually doing? How has that changed over the first few months?

Auxiliary support

Tell me about your nurse. The admin staff? How about the lab facilities?

Examples?

Patient book

How about your patient book? Look for enhanced load /input with time.

Other comments?

VT MANAGEMENT (Practice)

Availability of help/advice/support

What were your main concerns when you joined the practice?

What did your trainer do in those early days which was most helpful/supportive?

And how about now, six months on?

What do you feel you have learnt?

Teaching –quality and commitment

What are the tutorials like? What do you cover? Examples?

Support of auxiliary staff

What facilities are there for the paperwork? What help do you get with the paperwork?

Other comments?

VT MANAGEMENT (Region)

Quality/organisation of teaching

Tell me about the Study days. And the lectures? Examples

Support by regional staff

How are you monitored by region? What contact do you have with the regional staff? Examples?

Other comments?

Appendix 5 Cohort 1 VDP: End of VT interview schedule

Performance areas and focusing questions

PRACTICE FACILITIES

Adequacy of clinical facilities

What was your surgery like? How about the other clinical facilities?

Examples?

Range of work undertaken

What range of procedures were you able to undertake? How did you feel about this? Examples?

Nursing support

Tell me about your nursing support throughout the year. And the other staff?

Patient Book

What did you think about your patient load during the last six months? Look for enhanced load. Probe.

Other comments?

PRACTICE MANAGEMENT

Trainer support

Looking back, what support /help/advice did your trainer provide?

Was there anything that you would have liked that you didn't have?

Examples?

Teaching-quality and commitment

What were trainer tutorials like? And the clinical teaching? Examples of good and not so good?

Demands of the trainer

What did you feel of your trainer's expectations of you? Did this change as time went on?

Role model of trainer

How would you consider your trainer as a role model?

Attitude and support of practice staff

What were the staff like? Did this change with time? Examples?

Are there any improvements that you would recommend to your trainer?

Would you recommend your trainer to another VDP? Other comments?

REGIONAL MANAGEMENT

Study day quality/organisation

What was your overall view of the study day? The lecture programme? The organisation?

Support of advisor

Tell me about your advisor. What level of support did you receive?

The case presentation

Tell me about your case presentation. What do you think about having this in VT? Other comments?

OUTCOMES OF VT

Feedback from trainer/advisor

What feedback did you get on your performance in VT? Trainer and advisor? Examples?

The assessment process

How were you assessed in VT? What did you think about the assessment process?

Career guidance

What did you receive in the way of career guidance?

[You didn't stay on post VT. Did this cause any problems in the second part of VT?]

Success in job applications

What are you doing now? How did you make your decision?

Overall what was the year like? Probe. The high points and the low points.

Other comments?

Appendix 6 Cohort 2 VDP: Initial interview schedule

Performance areas and focusing questions for main cohort

VDP SELECTION

Management of application procedure

Tell me about the application procedure.

How did you decide on your practice?

Appropriate conduct in interviews/care of the interviewee

How about the interviews? Prompt to develop the interview experience.

Did you see the practice working? Who did you meet?

Management post interview, outcome notification

How were you informed of the outcome?

Other comments?

PRACTICE FACILITIES

Adequacy of clinical facilities

Tell me about your surgery. And the other facilities? Examples?

Level of clinical freedom/materials available

And what are you actually doing? How has that changed over the first few months?

Auxiliary support

Tell me about your nurse. The admin staff? How about the lab facilities?
Examples?

Patient book

How about your patient book? Look for enhanced load/input with time.

Other comments?

VT MANAGEMENT (Practice)

Availability of help/advice/support

What were your main concerns when you joined the practice?

What did your trainer do in those early days which was most helpful/supportive? And how about now, six months on?

What do you feel you have learnt?

Teaching –quality and commitment

What are the tutorials like? What do you cover? Examples?

Support of auxiliary staff

Does the practice have a computer link with the Dental Practice Board?

What help do you get with your forms?

Other comments?

VT MANAGEMENT (Region)

Quality/organisation of teaching

Tell me about the Study Day. And the lectures? Examples?

Support from region

How is the Portfolio going?

What contact do you have with your advisor?

Examples?

Other comments?

Appendix 7 Cohort 2 VDP: End of VT interview schedule

Performance areas and focusing questions

PRACTICE FACILITIES

Adequacy of clinical facilities

What was your surgery like? How about the other clinical facilities?

Examples?

Range of work undertaken

What range of procedures were you able to undertake? How did you feel about this? Examples?

Nursing support

Tell me about your nursing support throughout the year. And the other staff?

Patient Book

What did you think about your patient load during the last six months? Look for enhanced load. Probe.

Other comments?

PRACTICE MANAGEMENT

Trainer support

Looking back, what support /help/advice did your trainer provide?

Examples?

Was there anything that you would have liked that you didn't have?

Teaching-quality and commitment

What were trainer tutorials like? And the clinical teaching? Examples of good and not so good?

Demands of the trainer

What did you feel of your trainer's expectations of you? Did this change as time went on?

Role model of trainer

How would you consider your trainer as a role model?

Attitude and support of practice staff

What were the staff like? Did this change with time? Examples?

Are there any improvements that you would recommend to your trainer?

Would you recommend your trainer to another VDP? Other comments?

REGIONAL MANAGEMENT

Study day quality/organisation

What was your overall view of the Study Day? The lecture programme? The organisation?

Support of advisor

Tell me about your advisor. What level of support did you receive?

OUTCOMES OF VT

Feedback from trainer/advisor

What feedback did you get on your performance in VT? Trainer and advisor. Examples?

The assessment process

How were you assessed in VT? How about the Portfolio?

Other examples of the assessment procedure?

Career guidance

What did you receive in the way of career guidance?

[You didn't stay on post VT. Did this cause any problems in the second part of VT?]

Success in job applications

What are you doing now? How did you make your decision?

Overall what was the year like? Probe. The high points and the low points.

Other comments?

Appendix 8 Cohort 1 trainer: Initial interview schedule

General: Age, sex, date qualified, no. of VDPs through practice.

How do you see your role as a trainer?

How do you select the VDP?

How much input should you have in?

a) practice b) theory.

How do you approach your teaching?

And the tutorials?

What do expect of a VDP at this stage? How will that change over the next six or seven months?

How much do you have to do with the VT advisor?

What do you think about the weekly Study Day?

How is progressing? How do you see your role as a VT assessor?

How competent is the modern graduate on qualification?

Other comments?

TRAINER ALSO ADVISOR

General: Age, sex, date qualified, no. of VDPs through practice.

How do you see your role as a trainer?

How much input should you have in?

a) practice b) theory.

How do you approach your teaching?

And the tutorials?

What do expect of a VDP at this stage? How will that change over the next six or seven months?

How is progressing?

Tell me about your role as an advisor

How do you handle the two roles? Tensions? Examples?

What do you think about the weekly Study Day? Examples?

How do you see your role as a VT assessor?

What are your views on the competence of the VDPs that come to you?

And those that you see on your scheme?

Other comments?

Appendix 9 Cohort 1 trainer: End of VT interview schedule

Identify if X is staying on post VT or not.

Focus on Student:

How did the VT year go?

In your view how did X perform?

Was this as you expected?

Were there any surprises? Examples?

What were the ups? What were the downs?

How do you feel that X felt the year went?

Focus on Trainer's role:

As far as you as a trainer are concerned, how did the year go?

If you could replay the year would you do anything differently?

Are there any changes that you would like to see in the management/
organisation of the VT year?

X is staying/didn't stay on post VT. How did you come to this decision?

What were the issues here? Probe here.

Focus on Assessment:

There is no formal end of VT assessment. How did you assess X's progress?
Examples?

Would you recommend any improvements to the method of VDP
assessment?

Trainer also an Advisor

How did the scheme go this year? Probe. Examples?

How does X compare with the other VDPs in your scheme?

Appendix 10 Cohort 2 trainers: Initial interview schedule

General: Age, sex, date qualified, no. of VDPs through practice.

How do you see your role as a trainer?

How did you choose

How do you approach your teaching? Examples?

And the tutorials?

What do expect of a VDP at this stage? How will that change over the next six months?*

How much do you have to do with the VT advisor?

What do you think about the Study Days?

How do you see your role as a VT assessor?

How do you find the Portfolio?

How is progressing?

How competent is the modern graduate on qualification?

Comments.....?

***Trainer also an advisor**

As above until * How will that change over the next six months?

How is progressing? Tel me about your role as an advisor.

How is the scheme going?

How do you see your role as an assessor?

What of the Portfolio?

How competent is the modern graduate on qualification?

Comments.....?

Appendix 11 Cohort 2 trainers: End of VT interview schedule

Identify if X is staying on post VT or not.

Focus on Student:

How did the VT year go?

In your view how did X perform?

Was this as you expected?

Were there any surprises? Examples?

What were the ups? What were the downs?

How do you feel that X felt the year went?

Focus on Trainer's role:

As far as you as a trainer are concerned, how did the year go?

If you could replay the year would you do anything differently?

Are there any changes that you would like to see in the management/
organisation of the VT year?

X is staying/didn't stay on post VT. How did you come to this decision?

What were the issues here? Probe here.

Focus on Assessment:

There is no formal end of VT assessment. Discuss Portfolio.

How did you assess X's progress? Examples?

Would you recommend any improvements to the method of VDP
assessment?

Trainer also an Advisor:

How did the scheme go this year? Probe. Examples?

How does X compare with the other VDPs in your scheme?

Appendix 12 Vocational Training interview experience questionnaire

Name:

Address and contact number:

As you know I am keen to find out about your VT placement finding experiences. Do you think you could answer the following questions for me?

Although this is not an anonymous questionnaire, your comments are confidential and only I shall know your identity.

- 1) How many CVs did you send off?**

- 2) a) Did you include a photograph?**
b) Why did you make this decision?

- 3) Where was your preferred location to undertake VT?**

- 4) a) How many practices asked you to attend for interview?**
b) How many did you attend?
c) Which of these were in your preferred location?

- 5 a) How many offers did you receive?**
b) Which of these were in your preferred location?

- 6) a) Are you completely satisfied with your VT place?**
b) If you aren't, can you tell me why?

7) Could you give me your views on the VT placement search experience?

a) How long it took you to find a VT place?

b) The interview experience.

c) Your impression of the practices that you visited.

d) Is there anything else you would like to comment on?

Can you give me your trainer's name and address?

Name:

Address:

Thank you very much. I shall stay in touch.

Lyndon B Cabot

Appendix 13 Letter asking VDPs to keep a reflective diary

Department of
Prosthetic Dentistry,
Floor 20,
Guy's Tower,
London Bridge,
SE1 9RT.

Tel: 020 7955 2144 /
020 7955 4026

Email: cab.cabot@kcl.ac.uk

18.07.00

Dear ,

Re: My research work following you through vocational training

I should have asked you this when I saw you last!

I have enclosed a small notebook. Do you think you could keep some notes on your first few months in VT? Not a day by day account, but a record of significant events –the good as well as the not so good. Although we can discuss these when we meet, it is so easy to forget issues which were important at the time.

I shall be the only person who will have access the note books. I can collect them when I see you, which be around Christmas or early in the new year.

Thanks again for your help and all the best in VT.

Take care.

Lyndon B Cabot
Senior Lecturer

Appendix 14 Email from VDP discussing early VT experience

Lyndon Cabot

From:
To: <cab.cabot@kcl.ac.uk>
Sent: 01 October 2001 23:43
Subject: VT Study

Hello! I hope you are well.

I am pleased to tell you that so far, I am really enjoying VT! My fears about practice seem to have been unfounded. My trainer is brilliant; very patient approachable and a good teacher. I am not afraid to ask for help, when required and he will always help me when I'm struggling.

During the first month, I think the most difficult aspects for me have been understanding the NHS regulations and clinically I have been struggling with extractions as neither of my rotations at Guy's involved a significant amount of surgical experience.

The first tutorial I had from my trainer was on the NHS regulations. It all did go a bit over my head at first, but as I've been treating patients, I've been learning as I go along. During the first month, and to a lesser degree now, I have for the most part been under claiming or failing to claim for some treatment carried out, as I did not know I could claim for it or claimed under the wrong code. We had a really good session on the SDR at our day release course two weeks ago with, which was very helpful and now things are beginning to make sense.

My confidence and skill with extractions is building up gradually, aided by a tutorial from my trainer and watching him do them when I get stuck. His tips on how to position the patient in the chair and use of children's forceps instead of adult forceps! (it really works) and luxators have really helped. Many of my patients have needed extractions, so I am getting enough practice, although I haven't done a surgical yet.

I am the first VDP in the practice, so I am building up my book from scratch. Many of my patients have not seen the dentist for years, so I am getting to see a wide range of clinical problems, and seem to be gaining experience in most fields. I spent the first three days observing my trainer, so I got to learn different techniques for e.g. taking impressions for crown and bridge work, jaw relations for dentures and for endodontic treatment (my trainer uses giromatic instruments, which I have had the opportunity to try out).

The day release course has been quite good so far, with 'lectures' on how to use the Professional Development Portfolio, clinical problem solving, the SDR, radiography, perio in practice and a talk from the Inland Revenue!

Therefore my experience of VT, so far has been very positive. I have so far found it to be an excellent way of introducing me into general dental practice and I am gradually building up my confidence and clinical skills.

I hope this is helpful to you,

Regards,

P.S. have bought my own car! Bought a lovely new VW Polo which takes me to work and very nicely! OK, not quite a Lotus Elise, but I'm happy with it!!!!!!

Appendix 15

The VT experience: Summary of comments
 (Number of responding participants in brackets)

Relevant group	Parameter	Outcome/Comment
Trainers	Years qualified	Cohort 1, mean = 21.3 yr Cohort 2, mean = 21.7 yr
Trainers	No. of VDPs taught	Cohort 1, mean = 4.8 Range 1-11 Cohort 2, mean = 5.1 Range 1-10
VDPs	Choosing a practice	Relaxed/friendly/informal (26) Location, Close to home (24)
Trainers	Selecting a VDP	Must fit into team/personality (17) Locality/where VDP lives (12) The most experienced trainers spent considerable time selecting VDPs
Trainers	Role of trainer	Mentor, provide guidance. Ease transition into practice (30) Teach basic skills (1)
VDPs	Surgery/facilities	One VDP not satisfied with clinical facilities available
VDPs	Patient load	All between 15-25 a day More work on each patient as efficiency increases (18)
VDPs	Nursing Support	Cohort 1 Positive (4), Negative (6) Cohort 2 Positive (14), Negative (4) Very experienced trainers ensured VDP had good nurse –even if they went without themselves
VDPs	Initial concerns	Workload/running late (15) Living up to expectations (12)
VDPs	What trainer did in early days	Trainer there when needed and supportive (32) Trainer no help whatsoever (2)
VDPs	The Tutorial session in first six months	Regular one hour of protected time (21) Almost universally clinically orientated Session used to treat patient together (9)
Trainers	The Tutorial session	Discuss problems of day/week (14) [Mean No. of VDPs taught 4.6. Range 1-10] Make VDP take the lead/responsibility for own education (8) [Mean No. of VDPs taught 7.9. Range 5-11] Book in patients and treat together (8) [Mean No. of VDPs taught 2.5. Range 1-5]
Trainers	Approach to teaching in first six months	A general view: 1 st three months VDPs need a lot of help. 2 nd settling in period Stand back and give the VDP space (15) [Mean No. of training years 6.1. Range 1-11]

VDPs	What doing at six months	Much quicker and performing a broad range of tasks (33) [Not necessarily seeing more patients, doing more on each]
VDPs	What learnt in first six months	Efficient patient management/treatment planning (13) [Emphasis is general and not on specific aspects of treatment]
Trainers	Expectations at six months	Workings of the NHS (4) The basics should be in place (25) The are now starting to work with enhanced efficiency (24)
VDPs	Study Days	Positive view (18), Variable (13), Waste of time (6) For meeting with peers/swap experiences (18)
	View of Advisor	Particularly positive (5) Very negative (7)
Trainers	Study days	Positive (4), Variable (6), Poor (2) Very good for VDPs to meet peers (8) Unhappy with private bias of lecturers (5)
VDPs (Cohort 2 only)	View of Portfolio	Useful (1), Not useful/waste of time (17) [Most oft used word –tedious] Trainer/Advisor checked it regularly (3) Trainer advisor never checked it (7)
Trainers (Cohort 2 only)	View of Portfolio	Good Assessment tool, if used properly (4) [Mean No. of VDPs taught 8.25, Range 6-10] OK, but there are problems with it (12) Not useful (5)
VDPs	Reflections on nursing support	Cohort 1 Satisfied (6), Very negative (7) Cohort 2 Satisfied (14), Very negative (8) Comments worse than at six months. Issues of having to train up a nurse/not having one/ or inefficiency
VDPs	The Tutorials in second six months	Cohort 1 Continued to end (8), Faded out (8) Cohort 2 Continued to end (12) Faded out (10) One VDP did not have tutorials in initial three months, thereafter they continued to end of VT
VDPs	Trainer as role model	Cohort 1 Positive (10), Mixed (1), Negative (2) Cohort 2 Positive (17), Mixed (3), Negative (2)
VDPs	Reflections on the year	The year had gone well (26), Reservations about year/trainer (9) None would have wanted to enter practice without doing VT

Trainers	Reflections on the year	The year had gone well (28), Reservations about year/ VDP (6) Particularly unhappy with VDP (1)
Trainers	Trainer selection process	Unhappy with emphasis on qualifications, not training expertise (5)
VDPs/ Trainers	The end of VT	Cohort 1 Staying on (3), Staying part time (1) Going elsewhere (9) Cohort 1 Both Trainer and VDP regret VDP not staying on (2) Cohort 2 Staying on (4), Staying part time (1) Going elsewhere (17) Cohort 2 Both Trainer and VDP regret VDP not staying on (5)
