What do family medicine trainees say about their training?

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Summary

Objective: *To survey the vocational trainees' evaluation of their training.*

Design: *Questionnaire survey with quantitative and qualitative components.*

Setting: *All trainees, past and present, registered with the Hong Kong College of Family Physicians up to April 2002.*

Main outcome measure: *Quantitative analysis on trainees' agreement/disagreement on specific items of their training, and qualitative analysis of themes extracted from all the responses to open-ended questions.*

Results: *247 out of 355 present and past trainees responded. Overall, the trainees found the training useful and they learnt the knowledge and skill of family medicine. The Basic Hospital Trainees were more likely to have dissatisfaction than the other trainees; they perceived low esteem, were engaged more in service than in training, and were uncertain about what they were expected to learn. The Basic Community Trainees had diverse and balanced opinions on their training and were more concerned with the variable quality of supervision. The Higher Trainees would like to have a more structured and organised training program than the present one. The trainees suggested that the College of Family Physicians could do more to assure quality of training and to facilitate more communication among the trainers, trainees and the College.*

Conclusion: *The trainees have given a lot of useful and constructive information about their training.*

Keywords: *vocational training, family medicine, evaluation study, Hong Kong*

摘要

目的：調查家庭醫學學員對他們所受職業訓練評價。

設計：定量和定性的問卷調查。

對象：截至2002年4月曾在香港家庭醫學院登記接受職業訓練的所有的學員。

測量內容：定量分析學員對有關訓練的特定項目的意見，並就自開放性問題之回答進行定性分析。

結果：355位現任或以往登記的學員中有247位做了回應。整體上，學員們認為所學的家庭醫學的知識和技能對他們的職業有幫助。基礎醫院的學員有較多不滿，有些自卑感，大部份時間用在工作而不在培訓上，對學習的目標缺乏清晰的認識。基礎社區的學員有多種意見但較平衡，他們更關注導師的質素不一的問題。高級學員希望有更有組織、有系統的課程。學員們提議家庭醫學院做更多工作，以確保訓練的質量，促進學員、導師和學院之間的溝通。

結論：學員們提供了很多關於職業訓練的有用和有建設的意見。

主要詞彙：職業訓練，家庭醫學，評價，研讀，香港

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Introduction

The Hong Kong College of Family Physicians (HKCFP) has been organising vocational training for family medicine since 1985. In 1998 there was a surge in the number of trainees when the Hospital Authority introduced family medicine trainee posts for junior doctors. The training programme consists of two-year rotations in different hospital specialties (Basic Hospital Training), two-year community-based outpatient clinics (Basic Community Training), and

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then two-year Higher Training in community-based clinics (Higher Training). The trainees are assessed by examination after the basic training, leading to Fellowships in HKCFP and Royal Australian College of General Practitioners (RACGP). Successful trainees enter Higher Training, at the end of which they undertake the Exit Examination leading to the Fellowship of Hong Kong Academy of Medicine. Although the trainees are assessed by examinations, their evaluation of the training programme has never been analysed.

Some countries have evaluated their vocational training programmes after running for some years.[1,2] An essential step in such evaluation is getting feedback from trainees.[3] In May 2002, we conducted a questionnaire survey of all the trainees, present and past, for views on their training. Our aim was to collect their opinions and experience about their training, especially around the time when the first batch of trainees from the Hospital Authority were about to finish their four-year Basic Training. We hope that the results will provide impetus for further improvement of the training programme.

Method

We designed a questionnaire comprising three parts:

(1) data about the trainee (e.g., gender, year of completing training),

(2) a quantitative section in which the trainees rated specific items of training (e.g., content of handbook, usefulness of hospital training) on ordinal scale of "strongly agree", "agree", "neutral", "disagree", "strongly disagree", and

(3) a qualitative section with open questions on satisfaction, dissatisfaction, and suggestions. We pilot-tested and revised the questionnaire with a few trainees.

With the permission from the Board of Vocational Training and Standards, we obtained a list of trainees registered with HKCFP. To encourage response, the questionnaire was anonymous. The return-envelops were numbered and only the research assistant knew the number of each trainee on the master list.

Due to the small numbers of "strongly disagree" and "strongly agree" answers, we present our results after combining "strongly disagree" with "disagree" into "disagree", and "strongly agree" with "agree" into "agree".

For the qualitative section, the open responses were recorded verbatim into a computer file. For ease of reference in reporting the results, the research assistant randomly numbered each returned questionnaire. We read through the printouts independently and discussed the themes to be extracted. WYT then did the thematic analysis and circulated the results to the other authors for discussion.

Chi-squared test was used for quantitative analysis, with $p=0.05$ as type I error.

Result

The questionnaire was sent with an explanatory letter to 360 past and present trainees. One replied that he/she was not a trainee. Three were not trained in Hong Kong, and one could not be contacted due to the wrong address. There were 32 higher trainees, 162 hospital-based trainees, 101 community trainees, and 2 deferred training, making a total of 297 current trainees and 58 past trainees. After three rounds of invitation, 247 returned the questionnaires, a response rate of 70% (247/355). Response rates from hospital-based trainees were 92/162 = 56.8%, community-based trainees 93/101 = 92.1%, higher trainees 20/32 = 62.5%, and those who had completed training 28/58 = 48.3%.

Basic hospital training

Table 1 shows the responses from the trainees grouped by their current stage of training. Overall, 84% trainees found hospital training useful, and 75% thought two-year training was adequate. As to the content listed in the handbook, 41% considered it too much and 48% had covered only 60-70%. Only 49% trainees agreed that they had adequate supervision, 39% had adequate training in community-based clinics, 24% had adequate protected time, and 30% had been treated equally as other specialty-trainees.

Basic community training

Although 85% of all the trainees considered the content in the handbook adequate, 24% could cover only 60-70% (**Table 2**). Most considered two years to be adequate for the training. Only 50% of the trainees agreed that they had adequate supervision or protected time. (A quarter of trainees in basic training (hospital and community combined) regarded two-year to be too short but only 14% of the higher and past

Table 1: Basic Hospital Training: frequency of responses by different categories of trainees.

Item	Response	BHT (%)	BCT (%)	HVT (%)	Completed (%)	Total (%)
Content listed in handbook	Inadequate	2 (2.2)	4 (4.3)	1 (5.0)	0	7 (3.)
	Adequate	47 (51.1)	46 (49.5)	15 (75.0)	21 (75.0)	129 (55.4)
	Too much	43 (46.7)	43 (46.2)	4 (20.0)	7 (25.0)	97 (41.6)
	(Total)	92	93	20	28	233
Content in handbook covered	60-70%	50 (54.3)	45 (48.4)	4 (20.0)	11 (42.3)	110 (47.6)
	≥80%	40 (43.5)	46 (49.5)	13 (65.0)	14 (53.8)	113 (48.9)
	More *	2 (2.2)	2 (2.2)	3 (15.0)	1 (3.8)	8 (3.5)
	(Total)	90	93	20	26	231
Training duration	Too short	19 (26.7)	20 (21.5)	3 (14.3)	4 (14.3)	46 (19.5)
	Adequate	73 (79.3)	67 (72.0)	18 (85.7)	20 (71.4)	178 (75.4)
	Too long	0	8 (8.6)	0	4 (14.3)	12 (5.1)
	(Total)	92	93	21	28	236
Proposed duration	(Mean year±SD)	2.2±0.51	2.2±0.60	2.2±0.43	2.0±0.64	2.2±0.56
BHT useful	Disagree	7 (7.6)	6 (6.3)	3 (14.3)	2 (7.1)	18 (23.7)
	Neutral	6 (6.5)	10 (10.5)	2 (9.5)	1 (2.6)	19 (8.1)
	Agree	79 (85.9)	79 (83.2)	16 (76.2)	25 (89.3)	199 (84.3)
	(Total)	92	95	21	28	236
Enough hospital supervision	Disagree	17 (18.5)	18 (19.1)	4 (19.4)	7 (26.9)	46 (19.7)
	Neutral	22 (23.9)	37 (39.4)	8 (38.1)	5 (19.2)	72 (30.9)
	Agree	53 (57.6)	39 (41.5)	9 (42.9)	14 (53.8)	115 (49.4)
	(Total)	92	94	21	26	233
Enough community clinics	Disagree	38 (42.7)	28 (29.8)	4 (19.0)	4 (14.8)	74 (32.0)
	Neutral	27 (30.3)	31 (33.0)	4 (19.0)	4 (14.8)	66 (28.6)
	Agree	24 (27.6)	35 (37.2)	13 (61.9)	19 (70.4)	91 (39.4)
	(Total)	89	94	21	27	231
Enough protected time	Disagree	32 (35.2)	42 (44.2)	10 (47.6)	11 (40.7)	105 (44.9)
	Neutral	31 (34.1)	35 (36.8)	5 (23.8)	5 (18.5)	76 (32.5)
	Agree	18 (19.8)	18 (18.9)	6 (28.6)	11 (40.7)	55 (23.5)
	(Total)	91	95	21	27	234
Similar training as other trainees	Disagree	45 (50.0)	38 (40.4)	9 (42.9)	10 (41.7)	102 (44.5)
	Neutral	22 (24.4)	27 (28.7)	4 (19.0)	5 (20.8)	58 (25.3)
	Agree	22 (24.4)	29 (30.9)	8 (38.1)	9 (37.5)	69 (30.1)
	(Total)	90	94	21	24	229

BHT = Basic Hospital Training, BCT = Basic Community Training, HVT = Higher Vocational Training
*% = Percentage of total, SD = standard deviation, * = more than stated in the Handbook*

trainees thought so. The difference was not statistically significant ($\chi^2=2.05$, $p=0.36$)).

Higher vocational training

Only half of the trainees agreed that they had adequate protected time (**Table 3**). Regarding supervision and the structure of the training programme, they were equally divided into "agree", "neutral", and "disagree".

What supervision do they have?

Comments on the Basic Hospital Training unanimously voiced frustration. They felt neglected, their role misunderstood, and inadequately supervised.

> "They [hospital specialists] are all confused as to the relevance of F-med in their particular field. Their line of thinking have often been extremely narrowed". (#161)

Table 2: Basic Community Training: frequency of responses by different categories of trainees.

Item	Response	BCT (%)	HVT (%)	Completed (%)	Total (%)
Content listed in handbook	Inadequate	6 (6.2)	0	1 (3.3)	7 (4.7)
	Adequate	77 (79.4)	20 (90.9)	29 (96.7)	126 (84.6)
	Too much	14 (14.4)	2 (9.1)	0 (0.0)	16 (10.7)
	(Total)	97	22	30	149
Content in handbook covered	60-70%	26 (29.5)	3 (13.6)	4 (13.8)	33 (23.7)
	≥80%	60 (68.2)	17 (77.3)	23 (79.3)	100 (71.9)
	More *	2 (2.3)	2 (9.9)	2 (6.9)	6 (4.3)
	(Total)	88	22	29	139
Training duration	Too short	17 (18.1)	1 (4.8)	3 (10.0)	21 (14.5)
	Adequate	69 (73.4)	19 (90.5)	27 (90.0)	115 (79.3)
	Too long	8 (8.5)	1 (4.8)	0	9 (6.2)
	(Total)	94	21	30	145
Proposed duration	(Mean year±SD)	2.22±0.63	2.0±0.39	2.1±0.43	2.1±5.6
Enough supervision	Disagree	19 (20.2)	6 (27.3)	3 (10.0)	28 (19.2)
	Neutral	29 (30.9)	3 (13.6)	9 (30.0)	41 (28.1)
	Agree	46 (48.9)	13 (59.1)	18 (60.0)	77 (52.7)
	(Total)	94	22	30	146
Enough protected time	Disagree	22 (23.7)	9 (40.9)	6 (20.0)	37 (25.5)
	Neutral	24 (25.8)	5 (22.7)	8 (26.7)	37 (25.5)
	Agree	47 (50.5)	8 (36.4)	16 (53.3)	71 (49.0)
	(Total)	93	22	30	145

BCT = Basic Community Training, HVT = Higher Vocational Training, % = Percentage of total
*SD = standard deviation, * = more than stated in the Handbook*

Table 3: Higher Training: frequency of responses by different categories of trainees.

Item	Response	HVT (%)	Completed (%)	Total (%)
Enough supervision	All disagree	6 (25.0)	10 (35.7)	16 (30.8)
	Neutral	9 (37.5)	9 (32.1)	18 (34.6)
	All agree	9 (37.5)	9 (32.1)	18 (34.6)
	(Total)	24	28	52
Enough protected time	All disagree	11 (45.8)	14 (51.9)	25 (49.0)
	Neutral	7 (29.2)	6 (22.2)	13 (25.5)
	All agree	6 (25.0)	7 (25.9)	13 (25.5)
	(Total)	24	27	51
A structured programme	All disagree	8 (33.3)	10 (35.7)	18 (34.6)
	Neutral	9 (37.5)	8 (28.6)	17 (32.7)
	All agree	7 (29.2)	10 (35.7)	17 (32.7)
	(Total)	24	28	52

HVT = Higher Vocational Training, % = Percentage of total

"Some specialties teaching family medicine as cheap labour power. Not much teaching apart from enormous amount of work". (#37)

"Some specialists are obviously 'looking down' on family medicine, yet they are appointed to be the clinical supervisors". (#144)

"Lack of attention from specialist: feeling of being a burden". (#185)

Comments on the Basic Community Training are about equally positive and negative. It seemed that the quantity as well as quality of supervision varied. Some positive comments included:

"Dedicated trainers – giving extra time to other trainees (not attached to them)". (#4)

"The supervisors I encountered are all excellent and committed in training the juniors". (#34)

"Many sit-in consultations from supervisors and feedback". (#51)

But there were also negative and contradictory comments.

"Little interaction with trainers who are quite busy". (#5)

"Not enough sit-in section". (#168)

"A supervisor doesn't stand on your side, just looking for what are you doing wrong". (#192)

Similarly, the comments on supervision in Higher Training are conflicting, e.g.,

"Not adequately supervised in higher training". (#28)

"Not enough guidance on Audit". (#42)

"Not much feedback from mentors/supervisors or may be I am lazy". (#51)

"Good support from clinical supervisor". (#61)

"Good relationship with my supervisor. Mentor was great for guidance and helped me through different moments". (#147)

How did their colleagues treat them?

Comments from the Basic Hospital Trainees were unanimously bitter. They were the only category of trainees giving comments to this theme. Marked frustration was shown, e.g.,

"Other specialist trainees treat us as house officers. Also do the nurses and sisters". (#14)

"The COS [Chief of Service] doesn't like us, as well as some of the colleagues. Besides, COS once stopped me to go to integrated clinic as she wanted me to stay to listen to a meeting". (#19)

"Even if you perform well and is hard working/eager to learn, sometimes the training opportunities given is still inferior to that of the hospital specialist trainee". (#32)

"Discrimination, little respect, [I] need to work/call as houseman if houseman are on leave; e.g. they claimed have to protect HO [house officer] to avoid overload them. But not for their own junior trainees even I have more experience. That's too unfair. I don't mind having rotation with their junior MOs [medical officers] together". (#52)

What have they learnt?

Trainees in Basic Hospital Training expected also some training in family medicine but were generally disappointed.

"Exposure to ENT/Skin and Eye not adequate". (#65)

"Inadequate minor operation in surgical/orthopaedics training". (#81)

"Inadequate training on consultation skill". (#115)

"Not enough family clinics/integrated clinic section. Too much specialist clinics. I feel that [like] a pharmist [pharmacist] rather than a doctor. Also, the new case in the integrated clinic are old case from specialist clinic. I'd rather have a case of URTI". (#94)

"Non-specific manifestation in clinic base is more useful. Even do not know what is meant by 'time is a diagnostic tool' ". (#31)

Basic Community Trainees often found their expectation met, apparently with some hard effort.

"Insufficient exposure in 'office management' in my training center". (#49)

"Too much outside office hour 'training sessions' ". (#41)

"Not every trainee got equal chance for training. Some training center – well organised, some not". (#136)

"Learned a lot about consultation skills and comprehensive approach towards a patient". (#45)

"Improvement in consultation skills from supervisors' guidance and peers". (#63)

Having gone through with basic training, Higher Trainees generally found themselves not learning many new things. They also felt isolated.

"High trainee is a self help program which is a realistic". (#24)

"I really think there is no structure at all to the higher training. I felt I was on my own". (#43)

"Lack of opportunity to be involved in clinic management". (#63)

"Not a lot except my additional training had been delayed by 2 years because HKCFP did not know how to deal with additional trainee". (#163)

"Did not really gain much from higher training". (#92)

"None [satisfaction]. It was and it is still waste of time and manpower". (#55)

Comments on seminars

All the trainees have seminars; some had protected time for them but more did not. The trainees themselves ran these seminars and the comments were unfavourable.

The Basic Hospital Trainees had negative comments on the seminars.

"Teaching seminars not well organised". (#139)

"Lack of structured seminar/tutorial about Family Medicine (FM) principle". (#232)

"Content of weekly seminars are irrelevant to hospital based trainees". (#180)

"Not enough time to attend training seminar. Always spend the half-day (post-call) to attend lecture. Too tired". (#243)

"Trainee should not be held responsible to be the sole speaker in the Hospital Authority (HA) seminar: input from supervisor on FM practice viewpoint is more valuable". (#32)

But the other trainees were also dissatisfied with the seminars. The Basic Community Trainees commented:

"The training seminars are poorly organised". (#124)

"Seminar and group discussion provide us chance for discussion of hot topics and difficult case". (#173)

The same comment from the Higher Trainees:

"Learning is opportunistic, and the small group activity is a joke. Less than 50% of the group actually turn up for any of the meeting". (#43)

How useful is the training?

Despite much dissatisfaction and uncertainties, the overall comment of the training by the trainees was positive. Most thought that they had gained knowledge and skill. The comment "satisfactory" came from far more trainees than "disappointed".

"Very useful for a trainee to acquire knowledge, skill and experience for independent practice in Family Medicine". (#8)

"The basic vocational training programme is adequate. Of course the experience varies between clinic". (#24)

"The 4 years training is a precious learning experience. It is a well balanced program, has a lot of hand-on experience and adequate clinical exposure. The training has equipped me as a competent and confident family practitioner". (#40)

Dissatisfaction with the training came less from the content than the uncertainty of the future and self-esteem, especially for the basic trainees under contract. "No future", "Nowadays, in Hong Kong health policy, no one will really help the junior doctor for training/career" and "Have I made the wrong decision for choosing family medicine in my career" were examples of despair. These are also reflected by comments like:

"We are physically, psychosocially inferior? Lazy? Or FM trainee are slow to learn? Or we can enjoy life for 4 years before we fight for survival in long hours work in private sectors? In this sense, we feel we are very inferior in front of my classmates!" (#31)

"The so called 'FM vocational training' has a very bad image among the graduates who used to regard it as a dumping programme which just make use those cheap labour instead of training". (#41)

"I would grade the vocational training as satisfactory. My dissatisfaction during the training is nothing to do with our College. It is a matter of the belief of some sort of superiority by some other doctors in Hong Kong, despite the fact that I don't see their superiority in patient care except the very experience-based aspects". (#132)

"No respect to family medicine of Hospital Authority". (#205)

Constructive suggestions

Many trainees did not just tell their problems but also suggested solutions. They did not complain about the HKCFP, but suggested that the College should proactively promote communication between the College and the hospital specialists, the supervisors and the trainees. The College should have the obligation to monitor the quality of training. For example,

"Feedback from trainee from supervisors' performance is also important". (#34)

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"Inadequate communication/cooperation between College and specialist". (#210)

"The College need to monitor closely on the hospital training program offered by HA". (#92)

"I would suggest to set up a 'Joint committee on general practitioner training' consists of members from HA/ HKCFP + 2 universities to oversee and coordinate the hospital & community training. It 'must' have the power to allocate funding and assess the suitability of hospital unit for training". (#163)

"If College really wants to train good family physicians in Hong Kong, they should fight for a secure training for trainees/give a guidance for trainees". (#2)

Discussion

This study shows that the trainees are satisfied with the nature of their vocational training but not the process. Most grievances relate to the Basic Hospital Training. Their grievance may be due to misunderstanding the purpose of training family medicine in hospitals. The ward staff may have difficulty in adjusting to a trainee who will not stay long. The seniors who are mostly service-oriented are inexperienced in dealing with these trainees for short periods. Similar feelings were observed in the United Kingdom: "Education and training in hospital-based vocational training posts was widely perceived as being of poor quality, of little relevance to general practice careers and treated as being of secondary importance to meeting service commitments".[4]

The Basic Community trainees are satisfied with their training, probably because they are more accustomed to doing family medicine. Their comments are diverse but balanced. The important comment is on the supervisors. There are two problems: inadequate trainers and lack of quality control. Some trainers are obviously dedicated and capable, earning high appreciation from the trainees, while some may not understand their role. The expectations of trainers and trainees should be explicit and congruent.

Most Higher Trainees comment on the lack of a structured programme. While a structured programme is mandatory for Basic Training, it may not be so for Higher Training. With the FHKCFP and FRACGP qualifications, the Higher Trainees should be able to practice independent quality FM. But if the Higher Trainees cannot improve their knowledge and skill during their training, the objectives of Higher Training have to be reviewed. "The higher training should enable our trainees to process special skills on special interests rather than repetition of basic training and make up a programme". (#55) Audit, practice management, and consultation skills are not just "exam papers" but advanced skills for them to learn. These are also important life-long skills for continuous professional development. "More practical guidelines/information needed from experienced general practitioners as those information are difficult to obtain from textbooks" (#1) is very true.

The findings of this study repeat what have been observed a decade ago in the United Kingdom, Ireland, and New Zealand: lack of protected time for teaching, absence of structured programme, and no clear indication of what to teach in hospital rotations.[3-7] It is specifically pointed out that "The concept of protected time for teaching, which is a feature of the general practice component of training, is not one that is readily accepted by many hospital consultants", and that "An important difficulty ... is that of balancing the time needed to fulfill the service commitments of all hospital posts ... with the time needed for learning and teaching".

We are surprised by the good response from the trainees and the voluminous comments and suggestions written; some of which are so frank and opened. We cannot agree more that "Feedback from trainees very important" (#28). To evaluate training, the trainees should not only be assessed but should also have the opportunity to assess. Given the variable quality of seminars, supervisors and trainers as opined by the responding trainees, the College should have quality assurance on its vocational training: training programme, trainers and trainees. "Trainee does not know what they should learn. Trainer did not know what they should teach in the past but also prepare to change in the future". (#9)

We conclude that there is the urgent need for improved communication between the trainees and the College (to clarify the objectives of training and discuss the feedback on training itself), between the College and the supervisors (to clarify the supervisors' role and ensure quality of supervision), and between the trainees and the supervisors (to make training more fruitful). There are of course limitations on what we can do, e.g., employment opportunities for trainees. Although employment opportunity could affect immensely the motivation and perceived satisfaction of vocational training, we should evaluate training by the knowledge, skill and attitude in family medicine ultimately achieved.

Key messages

1. The vocational trainees on the whole are satisfied with the content, but not necessarily the process, of their training. They acquire some knowledge, skill and experience in Family Medicine.
2. The Basic Hospital Trainees are frustrated with uncertainty about their future career, unclear objectives of their training, workload more on service than training, and low self (possibly also peer) esteem.
3. The quality of training for Basic Community Trainees is probably variable, largely depending on the individual trainers.
4. The Higher Vocational Trainees are independent learners but would like to have structured programme and more guidance.
5. The trainees of different categories would like to have more communication among different parties involved in their vocational training.

Training and learning can be a painful process with falls and hurt. Success is not given but achieved with continuous evaluation and effort. We hope that this study can suggest directions for improvement and facilitate the relevant organisations in enhancing vocational training to be a greatly treasured experience.

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