Measuring satisfaction with hospital training: why we need a standardized national questionnaire

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Trusts, deaneries and Royal colleges use different questionnaires to measure satisfaction with hospital training. A case is made for a standardized national questionnaire. This could be the first step towards a more coordinated system of training evaluation and approval.

BACKGROUND

Feedback from teachers to learners about their performance is an important part of the training process. Likewise, feedback from learners to teachers about their experiences can be used constructively to improve the training of others. Obtaining feedback from senior house officers (SHOs) on a regular basis has been emphasized in two reports (Committee of Postgraduate Medical Deans (COPMED), 1995; Academy of Royal Colleges (ARC), 1997).

WHAT IS BEING DONE NOW?

At present, there are several levels at which the training in hospitals is evaluated. Individual departments may use formal (usually written) and/or informal (usually verbal) feedback. While feedback at this level may be considered ideal in adult education, anonymity is almost impossible to secure, and some junior doctors may be reluctant to express their true feelings, possibly because they are concerned about the reference they will receive.

Alternatively, feedback can be done at trust level with the clinical tutor taking responsibility for the process. Both questionnaires and interviews are used. Anonymity for the junior doctors can be guaranteed, but the consultants may need to put the feedback into an individual context to understand what went right or what went wrong. Not surprisingly, the perceptions of consultants and junior doctors about the training do not always agree (Baker and Sprackling, 1994).

The responsibility for monitoring education and training was originally that of the Royal colleges, and the system of joint hospital visiting with speciality colleges joining forces with the Royal College of General Practitioners (RCGP) is well established. Many of the Royal colleges have their own questionnaires; the RCGP uses one that was developed specifically for the purpose (Hand and Adams, 1998).

The criteria used by the RCGP for judging standards of hospital training are similar to those laid down by the General Medical Council for preregistration house officers (PRHOs) (GMC, 1997) and by the ARC (1997) for the training of SHOs. On some joint hospital visits, junior doctors may receive more than one questionnaire and on others no questionnaire at all.

The Joint Committee on Postgraduate Training for General Practice (JCPTGP) conducts its own monitoring of the hospital component of general practice training on behalf of the RCGP and the General Practice Council (previously the General Medical Services Council). Each region in the UK is visited every 3 years and one or more vocational training schemes are selected for inspection. SHOs training to be GPs are usually interviewed as a group by the visitors and the consultants are interviewed individually. Questionnaires are occasionally used.

At deanery level, postgraduate deans are responsible for monitoring the standard of training of junior doctors against the educational contract they have with the NHS trust from whom they have commissioned training. This is usually done by a system of annual or biennial visits to individual trusts, and many deaneries use questionnaires to inform the process. In some cases, exit questionnaires are used for PRHOs and/or SHOs. In the North Thames Deanery, for example, surveys of trainees in all grades and specialities have been carried out for several years and improvements in training demonstrated (Paice et al, 1997; Paice and Aitken, 1999). At present, there is no standard questionnaire that is used by all the deaneries.

Finally, what about outcomes? The evaluation of the training can be judged by the results of higher specialist examinations although, in some circumstances, these may reflect more the individual doctor's ability than the training they receive. Ultimately, the quality of training should be reflected in the quality of care and clinical outcomes for patients. This is much more difficult to demonstrate as there are so many other confounding variables.

PROBLEMS WITH THE CURRENT SYSTEM

Variation and duplication

In preparation for writing a chapter on the hospital component of general practice training (Hand, 1999), the author contacted several institutions and collected a number of their questionnaires. The questionnaires received varied in content from 32 to 83 items and from two to eight pages in length (Hand and Adams, 1998). Grant et al's (1989) original study of SHO training used a questionnaire of 282 closed and open-ended questions.

Under the present system, it is possible for an SHO to complete four questionnaires during one post:

1. Departmental
2. Joint hospital visit

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3. Postgraduate dean's
4. JCPTGP visit.

It is hardly surprising that the response rates vary considerably: from 59% to 97% in published studies and from 37% to 100% in unpublished individual surveys (Hand and Adams, 1998).

Validity and reliability

There is a general consensus on the areas that should be covered by a questionnaire (face validity):

- Induction process
- Contractual issues
- Duty arrangements
- Clinical experience (including support from seniors)
- Educational experience (including study leave)
- Speciality issues
- Career guidance
- Domestic arrangements
- General satisfaction.

Content validity varies considerably as some questionnaires use only single items to explore different areas. The relationship between sub-scales and their relationship with other important variables has rarely been examined (construct validity). Discriminant validity has, however, been shown by the ability of some questionnaires to distinguish between different groups of doctors (Paice, 1998; Hand and Adams, 1998).

Predictive validity will be difficult to test as satisfaction with training may not be directly related to the outcome of training. As there is currently no 'gold standard' questionnaire, concurrent validity has not been tested. Comparing the ability of different questionnaires to measure satisfaction will be an important step in the development of a national questionnaire.

Ideally, such a questionnaire would have two sections: one of generic questions, common to all specialities, and another of speciality specific questions. Including questions of relevance to individual Royal colleges will increase the face validity of the questionnaire and the sense of ownership.

A questionnaire is valid if it measures what it claims to measure and is useful. However, a questionnaire must also be reliable and this aspect of questionnaire development has rarely been examined. Heyworth et al (1993), who looked at predictors of work satisfaction in accident and emergency SHOs, reported high levels of internal reliability in the questionnaires that they used. Hand and Adams (1998) examined the internal reliability of their questionnaire and reported Cronbach alpha coefficients of 0.75 or more in all but one of the seven multi-item scales. Test retest reliability (reproducibility) was greater than 0.78 for six of the scales. Some items that had high face validity (e.g. 'The teaching is of a high standard') had relatively poor reproducibility.

COULD WE DO BETTER?

Raising standards nationally and reducing inequality

The continued use of questionnaires that are specific to geographical areas or Royal colleges makes it very difficult to make comparisons between regions or deaneries or between specialities. There are two reasons why it might be important to be able to do so. First, it would be useful to learn from centres of excellence and to disseminate good training practice. Second, where satisfaction with training is low, it might be possible to direct resources to these centres to raise standards and reduce inequality.

Economic necessity and reducing inefficiency

Visiting is an expensive business. The costs of joint hospital visiting are borne by individual trusts. The direct costs of travel and subsistence for the speciality college visitors, and the additional locum expenses for the RCGP visitor, are easily identified. They amount to several hundred pounds a day. The indirect costs of consultant time, both visitors and those being visited, must run into thousands of pounds if junior doctor and management time are also included. The effects on services to patients are likely to be substantial.

The author telephoned two Royal colleges and they were unable to give an estimate of what a day of visiting costs. The JCPTGP (S Robinson, personal communication, 1999) estimate that a 3-day visit with three visitors inspecting one vocational training scheme costs between £4000 and £5000. This accords with a cost of £4792 which one deanery paid for four people visiting two schemes this year. The costs of deanery visits are more difficult to quantify as expenses are claimed individually from employers.

As standards are raised by Royal colleges, increasing numbers of departments are being granted restricted periods of approval (RCGP Hospital Recognition Committee, personal communication, 1999). The effect of this action results in either more frequent follow-up visits or the submission of interim reports. The amount of extra work involved will test the visiting system to its limit.

To improve efficiency, it would seem logical for the different systems of monitoring to share information about training. The amount of visiting could be reduced and the visits redirected to where they are needed most. Some deaneries are already combining their visits with those of Royal colleges. A common system of paperwork would seem a prerequisite for this to happen easily, and one area where this could be achieved initially is in measuring satisfaction with training.

KEY POINTS

- There is duplication in the systems for evaluating the training of junior doctors.
- Trusts, deaneries and royal colleges use different questionnaires to measure satisfaction with hospital training.
- Validity and reliability of the questionnaires has not been adequately addressed.
- A standardized national questionnaire would enable information about training to be shared and compared.
- A more coordinated system of training evaluation and approval could have important economic consequences.

HOW DO WE DO IT?

Cooperation and coordination

Clearly, there needs to be a will among the deaneries and Royal colleges to develop a common system for collecting information and this needs to be discussed at a national level by COPMED and the ARC. If these two institutions feel that the task is too difficult, or that there are more pressing priorities, then it will be up to enthusiastic individuals to join forces. This is already beginning to happen.

Collecting the data

Completing questionnaires by hand and manually entering the data into databases is a time-consuming process Some deaneries already use optical scanning to handle large quantities of data and, in others, junior doctors enter their own data into dedicated computers that are brought to the postgraduate centres. Processing the data and writing individual reports is relatively easy once programs have been written. This whole process could be handled by a single centre.

CONCLUSION

An argument has been proposed for the introduction of a single questionnaire for measuring junior doctor's satisfaction with hospital training. This is might be the first step towards a more coordinated system of training evaluation and approval. It would require the cooperation of both COPMED and the ARC, but has the potential for making the process more efficient. The long-term aim is to raise the standards of training of junior doctors. Their views on training should be measured with a valid and reliable instrument. HM

Conflict of interest: none.

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