

# Annex 1

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## Annex 2

### Training general practitioners: literature as a guide to action

While debate on the training of General Practitioners (GP) in the United Kingdom is not new, it has been given added urgency and impetus with the establishment of the Postgraduate Medical Education and Training Board (PMETB, 2005). The Board's responsibility for validating all post-graduate medical training in the UK has stimulated reviews of existing training in all the Royal Colleges so as to ensure that, in the context of available resources, training contributes to achieving the highest standards and quality of learning. In the case of general practice, the Royal College of General Practitioners (RCGP) has remitted this task to its Education Network who will make recommendations to the College Council for its approval before the College submits revised training proposals to the PMETB.

An early step in the Network's review was to seek a review of the existing literature on GP training both as a source to inform its immediate task and as reference for future work in this area. This paper is a product of that work and assists in providing perspectives on current progress with the Network's larger review of training and signalling areas where further work is required.

The review seeks to address the range of factors that might be expected to contribute, within available resources, to high standards and quality in training. The approach is represented in *Figure 1, Linking resources to learning* and the first section of the paper explains its main features. Subsequent sections identify from the literature key issues for each of the components in the Figure.

#### CURRICULUM

There is a large volume of literature on the appropriate curriculum for training GPs so that they have the skills, qualities and competencies necessary for their role. In 1995 the RCGP quantified its literature alone as 'sixty-five RCGP occasional papers, nine classic texts, twenty-five reports from general practice, seventeen texts in the clinical series and three policy statements' (RCGP, 1995:24). Later additions include other RCGP publications (RCGP, 1988 and RCGP, 2001), the GMC's *Good Medical Practice* (GMC, 1998; 2001; 2003) and *The European Definition of General Practice / Family Medicine* (WONCA, 2002). Whilst this list could be extended (for example: WONCA (1991); WGMSC & WCRCGP (1994); Ferguson *et al* (1998); and Oleson (2000)), it is appropriate to recognise a high degree of consensus across these documents.<sup>1</sup> Nonetheless, there are issues over which debate and we group these issues, one on the amount of time and the second on how it is used.

Current regulations prescribe three years for vocational training, though this has long been viewed as inappropriate and a compromise. In their recommendations to the Royal Commission reviewing medical education in 1966, the RCGP proposed four years for post-registration training (RCGP, 1966) and, though the subsequent Todd Report recommended five years post-graduate training, the Regulations legislated for a three-year minimum (HMSO, 1978). However, an approach that emphasised time and 'apprenticeship', whereby skills are gained through modelling on experienced professionals (Samuel 1990), has been superseded by a competency-based approach. Concerns about effectiveness and increased accountability have led to a more structured approach to educational provision and quality assurance (RCGP 1997, JCPTGP 2002). In 2002, the JCPTGP recommended 'an outcome-based approach to general practice training in which objectives are clearly defined' and the 'variable pace of learning of those undertaking vocational education recognised' (2002). It leads to recommendations that training should be flexible in terms of time with the focus on ensuring that educational needs are met. Paradoxically, this does not appear to mean less time but 'an agreed minimum duration....A three year training period would therefore be a

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<sup>1</sup> A consensus illustrated by a read-across of WONCA (2002) against *Good Medical Practice* (2003) by members of the RCGP's Education Network as part of its current review.

minimum and there could be extensions to a maximum of five years in line with an individual's educational need and progress" (JCPTGP 2002:7). It is an approach that enables a re-casting of 'equivalent experience' from one where experience gained and posts held for less than the prescribed time can count towards completion of training to one where skills are formally assessed (Allen 2001:77).

A minimum of twelve months gaining practice-based experience and twelve months gaining hospital-based experience in specialties from a prescribed list (DoH, 2000: 10) No less contentious is the distribution between experience in hospital and general practice, the College recommending in 1994 that the three years should be divided equally between general practice and hospital posts (RCGP, 1994), bringing UK training in line with recommendations made by UEMO (1995) and the Advisory Committee on Medical Training (ACMT, 1995), all at variance from an EU directive that requires only a minimum of six months in general practice (Council Directive 1993). Until recently, funding arrangements have prevented an even distribution between hospital and general practice, though there have been exceptions, as in parts of London through the Educational Incentive Programme (LIZEI) (Toon et al. 1999). Yet, surveys indicate that the majority of registrars, echoing expert views, consider more than three years is necessary to provide the skills of a GP principal with a minimum of 18 months practice-based experience (Smail, 2001; RCGP, 1985; RCGP 1994; RCGP, 1997c; and JCPTGP 2002).

How time is used is the second area of debate. In addition to the criticism that GP trainees spend a disproportionate amount of time in hospital posts, this element has also been criticised for poor quality and irrelevance (Ronalds et al. 1981, Evans 1987, Reeve and Bowman 1989, Styles 1990, Crawley & Levin 1990, Kearley 1990, RCGP 1994, RCGP 1997, Hand & Adams 1998, 2001), an issue that is not confined to UK GP training (Smith 1991, Polanay & Pringle 1989, Ogg et al. 1997).

The RCGP has formed working groups with several specialities to agree curricula relevant for GP training and the published guidance 'form the basis for the educational approval and selection of posts for vocational training purposes' (RCGP, 1993; RCGP 1997b: iv). However, some observers suggest this guidance has not been fully implemented (Styles, 1990) and McEvoy (1998) identifies continuing tensions between education and service needs. Hand *et al* (2001) show GP trainers and course organisers assessing hospital training as inappropriate because of the priority given to service needs and often not relevant and important for future GPs. Whilst there is some limited evidence that some posts for GP training are improving, hospitals seem generally resistant to adapt educational provision for SHOs training for general practice (Rickenbach *et al.*, 1997; Hand, 2000). A recent JCPTGP report highlights how current educational arrangements are 'flawed because they place greater emphasis on meeting demands of the service at the expense of the needs of the learner and, in the longer term, the NHS (2002).

Advancing the argument for reducing time spent in hospital posts, the RCGP has recommended shorter placements and placements in outpatients from a GP base. They also consider that training bases in the community, for example, community hospitals, Health Authorities, commissioning agencies and local authorities could equip the trainee GP with valuable experience of primary care and 'provide opportunities.. to acquire skills in... needs assessment of populations, the application of epidemiology, reviewing prescribing and team building' (RCGP 1994:6). The College has also (1997a) identified other specialties where experience could be gained in community settings, including: family planning clinics; well women clinics; community clinics; community health services; domiciliary visits; hospices; day hospitals; and outpatient clinics.

In addition to these areas of experience, a number of skills have been identified as requiring more attention. One set is management skills, including practice management, financial and organisation management and the use of Information Technology (IT) within the practice (WONCA, 2002; RCGP, 1994; 1997c). Patient surveys also show concerns about aspects of

practice management and organisation.<sup>2</sup> For example, on reported waiting times, in 1998, 63% said they usually had to wait two or more days for an appointment and this increased to 72% in 2002. The proportion reporting that their last appointment had not been on the day they wanted increased from 34% to 39% and the proportion who felt they should have been seen sooner increased from 19% to 23%. On surgery hours, 16% of respondents in 2002 said that inconvenient hours had put off going to see their GP at least once in the past 12 months. Twenty one per cent reported that in the previous 12 months, the receptionist had made it difficult to see or speak to the doctor and, although the great majority of respondents reported receptionists as helpful, 22% disagreed. On out-of-hours care respondents felt it was more difficult to persuade a doctor to make a home visit (20% in 2002 compared with 16%) and more likely to wait an hour or more for the doctor to arrive (55% compared with 47%). Patients were less satisfied that the out-of-hours response was correct (73% compared with 77%).

A related set of organisational skills highlighted by WONCA concern teamwork and the need for more multi-professional training. The need for the latter has been emphasised by the Victoria Climbié Enquiry and subsequent Green Paper proposals for 'improving skills and collaborative working' with 'a common core of training for those who work solely with children and families and those who have wider roles (such as GPs and the police)' (HMSO 2003: 86). The need for better team working to improve primary care also 'extends to the development of partnership with secondary care professionals through, for example, shared care protocols' (DOH 1996: 4).

Medical audit is now recognised as an essential component of GP training with registrars required to develop competency in conducting them and is one of the quality criteria used in the selection of hospital training posts (JCPTGP, 1997; 2001). It is seen as a way of promoting 'a self critical and enquiring approach to learning and to practice', improving standards of patient care and develops motivation for continued learning' (RCGP & RCOG 1997:3). These benefits can also assist the personal education planning seen as necessary by the RCGP (1997c). The College has also highlighted a need for protected time to develop research skills on a voluntary basis and has advocated 12 research training fellowships in each region (RCGP 1990a).

Issues that have received much attention are communication and consulting skills for interacting with 'patients and colleagues'. The traditional relationship between knowledgeable doctor and supplicant patient has been challenged (Coulter, 1997) and Roberts (1999) notes a shift in the USA, where patients have become more actively involved in their health care decisions, using the internet and other sources for information. In the UK, the GMC and RCGP have responded, placing greater emphasis on patient autonomy and the need to re-conceptualise the doctor-patient relationship (GMC, 2002: 2; RCGP, 1994).

The importance of these skills and wider interpersonal skills are recognised as having an effect on patient satisfaction, compliance, and health outcomes (Simpson *et al.*, 1991; Van Dalen *et al.*, 2001; Law and Britten, 1995). However, patient expectations are far from uniform:

Many patients now demand a more egalitarian relationship with their physicians and expect to take a more active part in decisions about their health care. But many people, notably the elderly, still value the conventional model of the doctor who 'always knows best' (Stewart *et al.* 1995: xvii).

Moreover, the communication needs of the same patient differ over time. Whilst these are appropriate concerns, the 1998 and 2002 patient surveys show high levels of satisfaction with their consultation (Airey *et al.*, 1999; Boreham *et al.*, 2002). In 2002, 95% of patients felt their GP treated them as they would wish all or most of the time; 83% reported that their GP knew enough about their condition or treatment; 95% felt that the action by the GP was appropriate; 90% said that their GP knew what was best most or all of the time; and 91% felt the doctor

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<sup>2</sup> Data from surveys in England in 1998 and 2002 by the National Centre for Social Research (Airey *et al.*, 1999; Boreham *et al.*, 2002). Surveys were stratified random samples to 100,000 individuals in 1998 (61.4% response) and 263,100 in 2002 (55.4%).

made the right diagnosis most or all of the time. Patients were satisfied with the length of their last consultation, only 14% in 2002 and 13% in 1998 reporting that it should have been longer. Most (88%) felt that they were able to ask as many questions as they wanted (89% in 1998).

Among those who did ask questions, however, in 2002 19% said not all their questions had been answered (18% in 1998). Yet, 91% reported that their GP listened to them most of the time or always and 89% reported that their GP took their opinions seriously most or all of the time. As in 1998, in 2002 87% said the GP gave them enough information about their condition or treatment most of all the time. Nearly all respondents (95%) found their GP easy to understand. However, these results contrast with findings from a range of other studies which suggest that patients want more information from their doctors (Ong *et al.*, 1995) and that patients often misunderstand doctors' instructions (Ley, 1988), possibly highlighting the problematic nature of self-reported comprehension in surveys and suggesting such findings should be viewed cautiously. When asked about referrals, in 2002, 36% of those referred to a hospital specialist in the last twelve months, 11% thought they should have been referred earlier.

**Taken together, these issues and complexities provide challenges to the pedagogy of training.**

## **PEDAGOGY**

In responding to these challenges, the literature on the pedagogy of GP training shows a clear philosophical and practical response based on theories of professional learning (Knowles, 1980; Brookfield, 1986; Schon, 1987; Neighbour, 1992; Coles, 1994; Burns, 1995; Havelock *et al.*, 1995; Tennant, 1998; Kaufman *et al.*, 2000). This has assisted in developing an 'understanding of what makes for effective postgraduate education' (RCGP, 1997:11), based on principles of adult learning and making training relevant to the adult professional learner (SCOPME, 1990; RCGP, 1997). It gives priority to meeting the needs of learners, enabling them to play an active part in identifying educational objectives and methods for achieving them (JCPTGP, 1997; JCPTGP, 2001; RCGP, 1997). There is emphasis on promoting a reflective practitioner, defined by Schon (1987) 'as the process of internally examining and exploring an issue of concern, triggered by an experience, which creates and clarifies meaning in terms of self, and which results in a changed conceptual perspective' (Schon, 1987). It means programmes promoting reflection based on personal experiences (Brookfield, 1986; Boud and Walker, 1993). The approach is evident in the JCPTGP's recommendations on the principles that that should underpin GP training and its objectives (2002: 6).

A practical response to this philosophical position is the importance attached to small group work, described as 'the backbone of many GP training schemes and a highly valued source of personal support for young practitioners' (Edwards *et al.*, 1988: 6). Small group teaching has been described as "the backbone of many general practitioner training schemes and a highly valued source of personal support for young practitioners in their early years in practice" (Samuel 1990:6). It also allows exploration of topics such as ethics and, by fostering mutual support, supporting morale among trainees (JCPTGP 1984). Individualised learning programmes are another way of fulfilling the educational philosophy of GP training, Samuel advocating that more effective training can be achieved through a 'personalised approach to curriculum with formative assessment' (1990: 28). However, he also notes that the success of this approach requires greater co-ordination between the course organisers and trainers to plan the educational programme of training, a task he regards as 'widely neglected'.

Individualised learning and small group work is supported by a commitment to protected time for learning, particularly day-release programmes. Whilst not a statutory requirement they represent a core constituent of GP training, seeking to ensure coverage of topics not dealt with adequately in hospital posts or practice, providing integration of the training programme with an orientation towards general practice and contributing to an understanding of concepts

such as normal human development, doctor-patient behaviour, the sociology of medical care and epidemiology (JCTPGP, 1984). This commitment has been echoed by the GMC (1987) who have made recommendations for SHOs to protect time for learning. However, the service demands of SHO training posts prevent participation in release programmes, 'compromised by the pressures of the service' (JCPTGP 2001: 3).

The pedagogic core of Registrar training, however, is the opportunity to engage with patients, so their attitudes are an important ingredient in the quality of learning. A study of patients' views in Dublin showed many have reservations (Murphy *et al.*, 1995). Whilst 91% of respondents considered it advantageous for a practice to have a trainee, a third considered home visits by trainees less satisfactory than those by the usual doctor, a third would not feel as comfortable with the trainee as with their usual doctor and 41% would prefer to see their usual doctor after seeing the trainee. Negative attitudes towards trainees were significantly increased in urban practices, among patients over 40 and those who had not previously encountered a trainee. More positive attitudes by those who had previously encountered a trainee suggested that a planned and structured introduction of a trainee to its patients may contribute to decreasing anxieties.

In Bain and Mackay's (1995) study, 15% of patients surveyed had experienced a trainee sitting in on a consultation and nine per cent had experienced a consultation with a trainee alone (a further 11% did not know). When asked about a trainee attending a consultation with their GP only four per cent said they would object, 54% had no objection, 35% thought it depended on the reason for the consultation and eight per cent. Asked how they would feel about consulting a trainee on his or her own, a third had no objection, 28% had no objection but would prefer their GP, seven per cent would object, 27% thought it would depend on the reason for the consultation and 14% did not know.

Approaches to teaching and learning that emphasise one-to-one learning, small group work and the goal of developing reflective lifelong learners are often in contrast with the earlier experiences of doctors:

Doctors need to develop a strong sense of professional autonomy both in clinical work and in their continuing education. Yet they are taught as students in passive hierarchical way that discourages thinking (Samuel 1990:).

These differences extend beyond undergraduate experiences. The hospital experiences of GP trainees often reflect the continuing preferences of some consultants for the apprenticeship approach to learning and, where this is in contrast to the expectations of trainees, can contribute to differences in their perception of the quality of training compared with their trainers (Grant *et al.* 1989, Baker & Sprackling 1994). The perceived limitations of the apprenticeship model may also have been exacerbated by the impact of *The New Deal* in reducing the hours worked by junior doctors (DoH, 1994). This disjuncture may be eased as a result of the increasing use of problem-based learning (PBL) in undergraduate training, an approach to teaching and learning that has many similarities with the philosophy informing GP training and recognised as having a useful contribution to GP education (Lowry 1993, Robinson *et al.* 1994, Downey and O'Brien 2001).

The principles and methods of PBL can also assist within the multi-professional context of a Primary Health Care Team (Downey and O'Brien, 2001). There is considerable recognition that the changing nature of primary care requires increased competency from the GP in multi-professional teamwork (RCGP, 1993; RCGP, 1994; RCGP, 1977c; DoH, 1996; JCPTGP, 1997; JCPTGP, 2002). The RCGP consider

The effective working of teams demands an understanding by each team member of his/her own role, as well as the role of those other professional groups with whom they work. Only through such knowledge can their combined efforts be effectively integrated (RCGP Connection, 1993).

Despite these aspirations, it is an area where time constraints and other priorities have meant that suitable provision has not occurred (RCGP 1994).

Belief in the value of multi-professional training is in contrast to the state of evidence on its impact on collaborative working where two systematic reviews on inter-professional learning showed no evidence of its benefit – or otherwise (Barr *et al.*, 1999). This is part of a wider issue where, despite a general consensus on what constitutes effective adult education, there is a need for a more rigorous approach towards evidence. Too often evidence-based practice is absent both because teachers can forget principles or because of insufficient evaluation of initiatives (Peile 2001, Wall 2001).

That increasing use of PBL in undergraduate training may correspond with similar methods in GP training leads to wider consideration of the nature and extent of continuity in different phases of training.

## **ASSESSMENT**

Methods of formative and summative assessment and the place of competencies in assessment have been central to developments in the assessment of trainee GPs.

The value of formative assessment during vocational training has become increasingly recognised (JCPTGP 1992, JCPTGP 1997, JCPTGP 2002, RCGP 1993, RCGP 1997c). Seen as a means of providing increased structure both within practice based and hospital based posts it allows progress to be monitored and provides increased focus to meetings between the trainee and trainer, enabling areas of weakness to be identified and addressed. Available methods include structured logbooks and evidence based portfolios, the latter increasingly recognised as valuable (Pitts *et al.*, 1999; Pitts, 2001; UKCC, 1994; Snadden *et al.*, 1996; Challis *et al.*, 1997; Mathers *et al.*, 1999; Driessen *et al.*, 2003). Their value has also been recognised within vocational training for general dental practitioners (Firmstone *et al.*, 2003). Trainees report valuing feedback on their performance but often consider the amount is insufficient (Reeves and Bowman, 1989; Crawley and Levin, 1990; Kearley, 1990) and there have been regional developments in this field, such *The West Midlands Formative Assessment Package* (2000).

Concerns about quality assurance within GP training contributed to the introduction of summative assessment in 1998. Well before then, existing arrangements were a cause for concern:

To date, such assessments have been undertaken by trainers using informal and unproven methods of imprecise reliability and variable application. Some trainers and consultants have expressed concern about this lack of objectivity and consistency (JCPTGP 1992:15).

Whilst there is now a consensus that summative assessment should remain, debate about its methods and the need for reliability and validity continue (Evans *et al.*, 1996; Skelton *et al.*, 1999; Bahrami *et al.*, 2001; RCGP 2002b). An increasingly prominent part of that debate is the place of the Membership of the Royal College of General Practitioners (MRCGP) examination. Introduced in 1965, it was the first examination of its kind in Europe and 'demanded the definition of the discipline of general practice' (RCGP, 1990:2). Before summative assessment was introduced, the advocated the MRCGP for this but this did not occur (RCGP 1995). Its content has been regularly revised and up-dated and the introduction of the PMETB has created a new context where the exam may become the basis for summative assessment (RCGP, 1990; RCGP, 1994; RCGP; 2002; RCGP, 2003).

Debate about formative and summative assessment has had to take account of moves towards a competency-based approach to training, influenced by the need for increased accountability and effectiveness. It has led to the need for a more structured approach to both educational provision and quality assurance (RCGP 1997, JCPTGP 2002). Also, rather than time being the determinant for the development of the skills and competencies required for general practice, a more structured approach focusing on the development and assessment of these competencies has evolved. However, the RCGP warns against reductionism in the current drive for assessment, the actual outcome remaining uncertain as proposals emerge for the PMETB to consider (RCGP1997c).

If new arrangements include patients in the assessment process, what is their view? The 2002 national survey showed 78% of respondents were comfortable with the idea of being involved in training and assessment of GPs (Boreham *et al*, 2002). When asked how they would feel about participating in different modes of assessment (e.g. joint consultation, audiotape, videotape and feedback), 87% chose joint consultation. Audiotape and feedback were also acceptable, with 65% and 75%, respectively, reporting that they would feel comfortable with those methods, and 56% and 69%, respectively, feeling they would be able to discuss their problems fully. The least preferred form was videotape, for which only 13% would feel comfortable.

Matching the curriculum with its pedagogy and modes of assessment can present challenges. Toon (1992) questioned whether there was sufficient agreement on what constitutes a model of general practice because, without it, there is:

a particular problem for summative assessment...in any re-accreditation scheme which might be introduced and of course for the MRCGP examination. Without an agreed concept of good practice there can be no consensus on what is valid assessment. Validity implies that the method measures what we think we are measuring, which in turn requires us to know what this is.

To this can be added a concern for validity that is based on anxiety about litigation but its consequence can be to base assessment on a narrower range of methods than might otherwise be the case. It is a concern that also applies to discussions about formative as well as summative assessment.

## **CONTINUITY**

In training GPs, there are issues of co-ordination in five main areas: an overall perspective from undergraduate to CPD; the place of GP experience in undergraduate programmes; links between undergraduate years and the Pre-registration house officer (PRHO) year; co-ordination within the VTS programme; between VTS and Higher Professional Education (HPE); and between HPE and CPD.

A framework for the overall co-ordination of medical education is provided by the GMC's *Good Medical Practice*, (1998, 2001, 2003), which identifies the duties and responsibilities of doctors and defines good standards of practice and care. With *Tomorrow's Doctors* (GMC, 1993; GMC, 2002) and *The New Doctor* (GMC, 1997) they provide the basis for the GMC's recommendations for undergraduate and pre-registration education and training (GMC 1993, GMC 1997). Provides guidance and makes recommendations to medical schools on undergraduate medical education. The knowledge, skills, attitudes and behaviours set out in these documents provide a basis for the design of 'detailed curricula and schemes of assessment' (GMC 2002: 2). Whilst, in principle, this should assist the process of linking the GP VTS with 'the educational continuum of the undergraduate and PRHO years as well as higher professional education', practice presents some problems (JCPTGP 2002:3).

The case for undergraduate medical training to provide experience of general practice has long been made and seen as a means of improving co-ordination with post-graduate education and promoting increased interest in general practice as a career choice (Morrison & Murray 1996, Hilton & Smail 2001). It has also grown significantly in recent years and is now a significant component of many undergraduate programmes.

Since 1978 it has also been possible for part of the PRHO year to be spent in a general practice setting (HMSO, 1978). The GMC has encouraged this and has provided guidance on how experience in a community setting should be gained (GMC; 1987; GMC 1998). Until recently, however, funding has limited the scale of activity (Harris *et al.*, 1985; Illing *et al.*, 1999; Carter and Parsons, 2000; Kelly, 2001).

A major issue on training schemes is the co-ordination between hospital training, practice-based training and the release courses. It is argued that improved co-ordination will maximise

educational opportunities, help limit the pressures to meet service commitments and make the experience more relevant to general practice (RCGP 1997b). This is seen as assisting in overcoming the danger of a series of disjointed SHO posts, as would having a GP trainer with oversight for the whole of the VTS programme which, according to the JCPTGP:

should be based in general practice supervised throughout by an educational facilitator (GP trainer) with carefully planned attachments in secondary and community care (JCPTGP:2000:2).

Ensuring the relevance of the hospital posts is a chronic problem and the RCGP has provided guidance to other Colleges 'to give a clearer idea of what should be learnt from working in various hospital specialties' (RCGP 1993; 1997). It has also advocated national core curricula on what needs to be taught and learned by hospital specialities (RCGP 1997b). Used in conjunction with structured logbooks and evidence based portfolios, these are seen as means of enhancing the value of hospital posts (Snadden *et al.*, 1996; Hand *et al.*, 2001). Nonetheless, a decade after the initial guidance, the JCPTGP considered the value of hospital posts impeded by 'lack of a coherent view about optimal educational arrangements from specialist and general practice representatives' (JCPTGP 2002:3).

Continuity from the VTS into principalship has also been identified as a problem. In 1997, the RCGP highlighted a need for increased structure in the educational provision for newly qualified general practitioners (RCGP1997c) and, more recently, studies of newly qualified GPs have raised concerns over the effectiveness of vocational training as preparation for becoming a principal (Grant 1998, Smail 1998). In 1985, the College proposed higher specialist training for general practice and, despite other proposals, it was almost twenty years before a formal and more structured two-year scheme was introduced (RCGP, 1990a; 1994; 2001; Hibble, 2001).

Following the HPE programme, GPs enter the CPD phase of lifelong learning. Before 1990, this was based on an 'inadequate system' of seniority awards and payments to attend Section 63 courses (Field 2001). In 1990, the Postgraduate Education Allowance (PGEA) was introduced, available only to principals and based on credits for attendance at courses and meetings:

This had the unintended effect of rewarding attendance at events (often of dubious educational quality), rather than recognising the importance of personal study and reflective learning (Field 2001: page ref required).

It has also been criticised for failing to demonstrate benefits to patient care (DOH 1998b) and failure to integrate with medical audit systems (Houghton 1996) with most PGEA activity unplanned and not based on an individual's learning needs (Field 2001). Advocacy for an improved system of CPD has been extensive in recent years (RCGP 1994, DOH 1997, DOH 1998b, SCOPME 1998a, SCOPME 1998b, DOH 2000b). Recommendations include more CPD within primary care settings with a focus on the educational needs of a multiprofessional team, also providing opportunity for a more integrated approach with the use of personal development plans (PDPs), practice development plans (PPDPs) and increased co-ordination with clinical governance and clinical audit (Field, 2001).

## **SUPPORT**

The role of educational supervisors and GP trainers as sources of support for trainees is recognised and, for the RCGP, an essential requirement for hospital posts to gain educational approval is that there is a designated educational supervisor available to the SHO, in regular contact with him or her and accountable for the overall educational experience offered by the job (RCGP, 1994). Other desirable aspects of this support include: an 'educational contract' describing the educational experience and expectations of the post; that the educational supervisor should have undertaken training in educational theory and methodology; and the SHOs given guidance as to the providers of their educational and pastoral support. The role of educational supervisors and trainers as mentors has also been linked to the use of evidence-based portfolios and formative assessment. By facilitating structured reflection they

assist 'deep learning' rather than 'surface learning', promote autonomy in the learner by enabling needs to be identified and planning to meet learning objectives and their use with mentor support has proved to be effective in achieving relevant continuing medical education for general practitioners (Mathers *et al.*, 1999).

"They use group learning approaches to encourage autonomy in the learners and sensitivity to patients' needs. They support formative assessment and summative assessment processes and help the GP Registrars prepare for the MRCGP examination. They also have an important role in the pastoral care of their learners" (DOH 2000:29).

## **TRAINERS**

GP trainees are dependent on three key groups of personnel for providing their education, training and support: course organisers, GP trainers and educational supervisors. More recently, recognition is also being given to the role of other health professionals.

In England, Wales and Northern Ireland course organisers are responsible for working with GP trainers and educational supervisors 'to support a coherent programme of learning for doctors on their VT scheme' (DoH 2000:29). They organise the half-day/day-release courses for SHOs and GP Registrars, support trainers' workshops, are involved in the recruitment of SHOs and GP registrars and provide career advice (DOH 2000). In Scotland, Associate Advisers perform broadly the same set of duties. Whilst they do not have to be medically qualified, typically they are experienced GPs, often principals with the MRCGP and experienced as a trainer. As training develops further, course organisers are likely to be responsible for the management of a more complex programme of placements (JCPTGP 2002).

Trainers have principal responsibility for GP Registrars. Their role includes reviewing the performance and monitoring the development of the Registrar, implementing formative assessment and preparing the registrar for summative assessment. As part of summative assessment, trainers are required to provide a report on the Registrar based on the time spent with the trainer. All trainers have to be fully registered with the GMC and approved by the JCPTGP who must be satisfied that 'the characteristics and qualities of both potential trainer and training practice are such that the experience required by the VT Regulations can be provided' (DoH 2000:24). Trainers are also 'expected to observe the highest standards in all aspects of their professional practice and be able to communicate and teach these standards effectively to GP Registrars' (DoH 2000:25). In England and Wales, approval is based on the advice of the regional Director as to whether these criteria have been met. In Scotland a quota system is used. Designed to promote competition, evidence of excellence is often required to secure appointment. Trainers are appointed by Directors, advised by the Regional GP Education Committees, acting on behalf of the Scottish Council for Postgraduate Medical and Dental Education (SCPMDE) (DOH 2000). In Northern Ireland, where the pool of approved trainers exceeds the number of GP Registrars, trainers must demonstrate their merit in a selection process organised by the Northern Ireland Council for Postgraduate Medical and Dental Education (NICPMDE).

During the hospital phase of the VTS, consultants have a role as the educational supervisors of trainees. In their requirements for recognised SHO posts, the JCPTGP recommend that a named educational supervisor should be available to carry out formative assessment during the placement and help draw up and periodically review an individual educational plan (2001). They also stress that time must be made available for consultants to develop skills in teaching, conducting assessment and providing the required teaching.

Whilst the JCPTGP are clear that the trainer/trainee relationship is paramount, others have a valuable contribution to make (1997). These include other partners as well as members of the primary health care team. Within hospital-based training, the relevant expertise of nurses, social workers, midwives and paramedical staff is also seen as relevant for training general practitioner SHOs (RCGP, 1997a; 1997b).

Ensuring that those with training responsibilities have appropriate expertise has been recognised by the GMC. In its guidance on *The doctor as teacher*, the professional attributes of the doctor with responsibility for clinical training are identified and formal training is recommended for all new appointees, who should demonstrate competence as part of before probationary. The GMC also notes the training needs of staff in post:

Those who accept special responsibilities for teaching should take steps to ensure they develop and maintain the skills of a competent teacher (1999:2).

For GP training, in particular, the satisfaction often expressed about it is partly attributed to the recognition that teaching skills have to be learnt and developed (Byrne and Long 1976, Hall 1983, Pendleton et al. 1986, JCPTGP 1998, GMC 1999). Specifically in the GP-based component of training, there is a requirement for regional schemes to develop the teaching skills of trainers and have systems for assessing these skills (JCPTGP 1997). These include workshops to facilitate 'understanding of the processes of teaching and learning' and allow the trainer 'to explore their teaching responsibilities with peers and to appreciate the wide range of local resources that can contribute' (JCPTGP 1998:17).

The increasing emphasis on non-medical staff contributing to GP training (RCGP 1997b, JCPTGP 1997) creates challenge greater than skill acquisition:

Society rates doctors highly and when lay men and women are invited to teach trainees, I have noticed medical awe (or is it suppressed phobia?) can sometimes interfere. Conversely some doctors find it hard to accept that they can gain skills from those outside their discipline. In an age of multidisciplinary teams in medical and social care (Samuel 1990:7).

Claims about the high quality of training have been challenged. Fifteen years ago, Samuel observed that trainers were rarely held directly accountable for their teaching: 'No one seems to require evidence that their essential work of assessment and training ... is done either consistently or well' (1990:3). Commenting on the JCPTGP advice in 1987 that the certificate of completion of vocational training should only be issued if training was 'satisfactory', he observed that it was:

According to Allen (2001) "the challenge of the new training is to produce a framework which satisfies both the desire of the discipline to facilitate development and that of society and the government, who will look for cost-effectiveness and the security of patient safety and service delivery" (Allen 2001:76). To achieve this, co-operation is required within the whole discipline of general practice. That is, between the RCGP, the GPC, Directors of postgraduate education, associate directors and the JCPTGP (Allen 2001).

It may that criticism such as these led the GMC and JCPTGP to recommend formal arrangements for reviewing the performance of supervisors and clinical teachers with mechanisms being set in place to provide feedback and for addressing any problems that are identified (GMC, 1999; JCPTGP, 1997). Whilst acknowledging the difficulties of assessing the teaching ability of trainers, the Joint Committee considers these assessments as vital and 'deaneries should state their expectations of trainers in terms that can be assessed' (JCPTGP 1997:18).

There is a general consensus that accreditation and re-accreditation of the GP Registrar component of training has contributed towards its educational value. However, whilst the approval and re-approval of hospital posts for GP training is a means of monitoring the quality of teaching provided, dissatisfaction with their educational value continues (RCGP 1997b).

## **MATERIALS**

A training practice is required to have suitable resources to support trainees, specifically: a library with relevant books and journals; Internet access; video recorders; and consulting room for the registrar (JCPTGP 2001). Hospitals are required to have an adequate

postgraduate library, education facilities and information sources relevant to general practice and the specialty (JCPTGP 1998). Information Technology (IT) resources are now widespread in health care provision and 'can improve communication between professionals, enable research and reinforce training, education and agreed protocols' (DoH, 1996:4).

## **FINANCE**

GP training is expensive and publicly funded, placing an expectation that it be cost effective and accountable for the quality of 'the end product (Allen, 2001:79). An aspect of effectiveness, however, is not the amount of money available but how it is distributed. Securing extended placements in training practices, for example, is associated with the amount spent in SHO posts (RCGP, 1994; Hand and McKee, 2001). The funding systems for HPE and CPD have also been criticised as inefficient (Field, 2001). However, providing pre-registration experience in general practice is seen as threatened by inadequate levels of funding (Harris *et al.*, 1985; Illing *et al.*, 1999; Carter and Parsons, 2000; Kelly, 2001).

Different sources of funds for different components of training have been viewed as 'obstacles to the freeing up of the system of vocational training that the College would wish to see' (RCGP 1995). From April 2000, however, deaneries were given increased control and flexibility over funds, enabling reforms to vocational training, including implementing extended placements in GP (DoH, 2000a; JCPTGP 2002). Lane and Patterson (2001) go further, observing that the change 'could improve the co-ordination of recruitment, appointment and workforce planning of all training grades in NHS into a unified management scheme. If this leads to better selection and less wastage, it will make vocational training more cost effective and efficient (JCPTGP 2002).

## **LEADERSHIP AND MANAGEMENT**

Through its vocational training sub-committee, the RCGP provided national oversight for GP training until, in 1974, it joined with the General Medical Services Committee of the BMA to form a separate committee for GP training that, in 1975, became the JCPTGP (JCPTGP, 1984). Within the legal framework of the VT Regulations, this committee supervised training until 1998 when hospital posts used for GP training required approval by the Specialist Training Authority (STA)(DOH, 1998). This meant that postgraduate medical deans could not fund training posts unless approved by the STA, a change seen by some as impairing effective management and preventing innovation (Allen, 2001; JCPTGP. 2002).

The JCPTGP fulfils its quality assurance role through its accreditation of regional postgraduate organisations and VT schemes (JCPTGP 1997). Until 1989, accreditation was based on external reviews through team visits and, since, through a 'comprehensive organisational audit' based on guidance on what was required for accreditation. Dialogue based on these audits is seen as a way of promoting improvements (JCPTGP, 1997:2). With the Deaneries, the JCPTGP also monitors and gives approval to the selection and re-selection of trainers, initially appointed for two years and then subject to re-selection; assessment involves practice visits by the deanery with the JCPTGP conducting visits every three years (JCPTGP, 1998; JCPTGP, 2001).

Notwithstanding the merits of these arrangements, the last decade has seen increased emphasis on accountability and the need for more transparent processes of assessment and quality assurance of individual clinical and medical practitioners. This has resulted in more emphasis on clinical governance (DoH, 1996) with concerns further fuelled by the Bristol case (HMSO 2001b), viewed by Smith as likely to have 'greater impact on future health care in Britain than the reforms suggested in the White Papers' (2002:1917). The most recent development has been the establishment of the Postgraduate Medical Education and Training Board (PMETB) as proposed in *The NHS Plan, 2000* (DoH, 2000b) and enacted by the UK Parliament in the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003 (HMSO, 2003).

As the Board must approve and validate the curriculum and assessment for all medical specialties and for GP training, it further reduces the traditional autonomy of vocational training. Nonetheless, the change is seen as potentially positive by some if it allows a more co-ordinated approach to training and greater opportunity for innovation, such as more posts which 'are appropriate for GP training' (JCPTGP 2002:4).

Greater accountability and transparency is also reflected in changes designed to give patients and the public a greater voice in the NHS. The *Patient's Charter* (DoH 1991), *Local Voices* (NHS Management Executive, 1992), NHS league tables from 1994 are all designed to encourage greater awareness of patients' rights and the standards they might expect from services. *Patient partnership: building a collaborative strategy* (DoH, 1996) and *The New NHS: Modern, Dependable* (DoH, 1997) looked strategically at promoting user involvement in their own care and building partnerships between the service and its users.

*The NHS Plan* (DoH 2000b) set out new powers for patients, including greater choice, and surveys and forums to help services become more patient-centred whilst there is greater emphasis on lay involvement on bodies such as: health authorities; trusts and primary care groups; maternity services liaison committees; research ethics committees and audit committees; as convenors and chairs of review panels for NHS complaints; and as members of community health councils (Hogg and Williamson 2001; Robinson 1991). Whilst these changes may have raised expectations, led to greater patient demand and possibly increased stress for GPs (Gaskin 1997), their impact on the quality of care is difficult to establish.

## **CONCLUSION: DIRECTIONS FOR RESEARCH**

Anticipating the changes that can be expected as a result of the creation of the PMETB and the changes to the initial training of junior doctors arising from *Modernising Medical Careers* (DoH, 2004) Allen argued that 'the challenge of the new training is to produce a framework which satisfies both the desire of the discipline to facilitate development and that of society and the government, who will look for cost-effectiveness and the security of patient safety and service delivery' (2001:76). To achieve this, he argued, co-operation is required within the whole discipline of general practice, between the RCGP, the GPC, Directors of Postgraduate General Practice Education, associate directors and the JCPTGP. It might be added that the discipline would also benefit from less advocacy and more research and evidence on training.

On the GP curriculum: how will revised hospital and general practice experiences compare; what impact will shorter placements have on what trainees learn; will existing areas of concern over skills be remedied; will clearer statements of expected learning outcomes lead to improvement in continuity between the phases of under-graduate, post-graduate and continuing education; and will patients views of the quality of care alter?

On pedagogy: how good is the match between a philosophy of adult learning and the daily experience of trainers and trainees; how different is teaching in hospital compared with general practice; might the differences within hospitals and within general practice be as significant as those between the two; how effective are the different models of protected time; and does the pedagogy lead to GPs becoming lifelong learners?

On trainers: how will course organisers, educational supervisors and trainers co-ordinate more complex training programmes; what is the nature and quality of their training; what will be the impact of the expected move towards trainers having more than one trainee; and how can trainees best learn from other health professionals.

Added to these questions could be a set related areas where the literature has little to say: on the management and organisation of training from national level to the individual hospital specialty and GP practice; the nature and scope of different funding mechanisms; and the range and quality of learning resources.

Contemporary changes in training reflect several concerns. Arising from high-profile cases over the last decade, there is concern about the quality of existing training. Related to this is the pressure for greater transparency and accountability. Increased effectiveness in training

can also be a means of increasing the rate of output of trained doctors. A re-thinking of training is also needed as a consequence of the European Working Time Directive. These factors are leading to changes, some designed to meet concerns identified by experts in the discipline and supported, in varying degrees, by studies of existing practice. While expert views are rightly a key component of policy debates and policy decisions, a more substantial body of research evidence on training can also assist in meeting Allen's challenge of a training framework that is cost-effective, facilitates development and meets legitimate expectations about patient safety and service delivery.

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## Annex 3

Research paper '**Reviewing general practitioner training in the United Kingdom: key themes**' submitted for publication in December 2005

### **REVIEWING GENERAL PRACTITIONER TRAINING IN THE UNITED KINGDOM: KEY THEMES**

#### Discussion paper

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#### **Key words:**

General practice  
Curriculum  
Teaching  
Learning  
Trainers  
Continuing medical education

Ethical approval was not sought as it was not appropriate for a discussion paper of this type.

## **REVIEWING GENERAL PRACTITIONER TRAINING IN THE UNITED KINGDOM: KEY THEMES**

Debate on the nature and quality of training of General Practitioners (GP) in the United Kingdom has been given added urgency and impetus with the establishment of the Post-graduate Medical Education and Training Board (PMETB) <sup>(1)</sup>, the new standard setting body for post-graduate training for all specialties and for general practice. Its establishment has stimulated reviews in all the Royal Colleges and, as part of its response, The Royal College of General Practitioners (RCGP) initiated a survey of the existing literature on GP training. The potential scope of such a review is wide and we focus on the curriculum, its pedagogy and the role of educators and trainers. We end by examining potential areas for research arising from the review.

### **CURRICULUM: TIME, CONTENT AND CONTINUITY**

There is a large volume of literature on the appropriate curriculum for training GPs. In 1995 the RCGP quantified its literature alone as 'sixty-five RCGP occasional papers, nine classic texts, twenty-five reports from general practice, seventeen texts in the clinical series and three policy statements' <sup>(2)</sup>. Later additions include other RCGP publications <sup>(3) (4)</sup>, the GMC's *Good Medical Practice* <sup>(5) (6)</sup> and the *European Definition of General Practice / Family Medicine* <sup>(7)</sup>. Whilst this list could be extended (for example: WONCA (1991); WGMSC & WCRCGP (1994) <sup>(8, 9)</sup>, it is appropriate to recognise a high degree of consensus across these documents.<sup>3</sup> Nonetheless, there are issues over which there is debate and we group these around three themes: time, content and continuity.

#### **TIME**

Current regulations prescribe 'not less than 36 months whole time or equivalent part time' (NHS, 1979). Long viewed as inappropriate and a compromise, the RCGP proposed four years for post-registration training to the Royal Commission reviewing medical education with the subsequent Todd Report recommending five years training <sup>(11)</sup>.

However, an approach that emphasised time and ‘apprenticeship’ with skills gained through modelling on experienced professionals <sup>(12)</sup>, is now being superseded by a competency-based approach with pressures for greater accountability leading to a more structured approach to training and quality assurance <sup>(13, 14)</sup>. In 2002, the JCPTGP recommended ‘an outcome-based approach to general practice training in which objectives are clearly defined’ and the ‘variable pace of learning of those undertaking vocational education recognised’. It leads to recommendations that training should be flexible in terms of time with the focus on ensuring that educational needs are met. Paradoxically, this does not appear to mean less time but ‘A three year training period would therefore be a minimum and there could be extensions to a maximum of five years in line with an individual’s educational need and progress’ <sup>(14)</sup>. It is an approach, however, that enables a re-casting of ‘equivalent experience’ to one where skills are formally assessed from one where experience gained and posts held for less than the prescribed time can count towards completion of training <sup>(15)</sup>.

## CONTENT

A key debate is the distribution between experience in hospital and general practice. Regulations require a minimum of twelve months gaining practice-based experience and twelve months gaining hospital-based experience from a prescribed list of specialties <sup>(16)</sup>. In 1994, the RCGP recommended that the three years should be divided equally between general practice and hospital posts <sup>(17)</sup>, bringing UK training in line with recommendations made by UEMO <sup>(18)</sup> and the Advisory Committee on Medical Training <sup>(19)</sup>, all at variance from an EU directive that requires a minimum of six months in general practice (Council Directive 1993)<sup>(20)</sup>. Until recently, funding arrangements have prevented an even distribution between hospital and general practice, though there have been exceptions <sup>(21)</sup>. Yet, surveys indicate that the majority of registrars, echoing expert views, consider more than three years is necessary to provide the skills of a GP principal with a minimum of 18 months practice-based experience <sup>(22)</sup>, <sup>(17, 23)</sup>, <sup>(13)</sup>, <sup>(14)</sup>.

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<sup>3</sup> A consensus illustrated by a read-across of WONCA against *Good Medical Practice* by members of the RCGP’s Education Network as part of its current review.

The RCGP has also recommended shorter placements and placements in outpatients from a GP base. They consider that training bases in the community, in a variety of settings, could equip the trainee GP with valuable experience of primary care and 'provide opportunities... to acquire skills in... needs assessment of populations, the application of epidemiology, reviewing prescribing and team building' <sup>(17)</sup>. The College has also identified other specialties where experience could be gained in a range of community settings <sup>(24)</sup>.

Some skills have been identified as requiring more attention. One set is management skills, including practice management, financial and organisation management and the use of Information Technology <sup>(7, 17), (17), (24)</sup>. Concern about aspects of practice management and organisation occurs in surveys of patients in England in 1998 and 2003.<sup>4</sup> These show increasing concern on reported waiting times, securing an appointment on the day of choice, inconvenient surgery hours, the attitudes of receptionists, securing home visits and waiting time and satisfaction for such visits.

The need for better teamwork and multi-disciplinary working has been emphasised by the Victoria Climbié Enquiry with subsequent proposals for 'improving skills and collaborative working' with 'a common core of training for those who work solely with children and families and those who have wider roles (such as GPs and the police)' <sup>(27)</sup>. The need for better team working also 'extends to the development of partnership with secondary care professionals through, for example, shared care protocols' <sup>(28)</sup>.

Medical audit is now recognised as an essential component of GP training <sup>(29, 30)</sup>. It is seen as a way of promoting 'a self critical and enquiring approach to learning and to practice', improving standards of patient care and developing motivation for continued learning and personal education planning <sup>(24)</sup>. The College has also highlighted a need for protected time to develop research skills on a voluntary basis and has advocated research training fellowships in each region <sup>(31)</sup>.

Issues that have received much attention are communication and consulting skills for interacting with 'patients and colleagues'. The traditional relationship between knowledgeable doctor and supplicant patient has been challenged <sup>(32)</sup> and Roberts <sup>(33)</sup> notes a shift in the USA, where patients have become more actively involved in their health care decisions. In the UK, the GMC and RCGP are placing greater emphasis on patient autonomy and the need to re-conceptualise the doctor-patient relationship <sup>(5)</sup>, <sup>(17)</sup>.

The importance of these skills and wider interpersonal skills are recognised as having an effect on patient satisfaction, compliance, and health outcomes <sup>(34-36)</sup>. However, patient expectations are far from uniform and, moreover, can change over time:

Many patients now demand a more egalitarian relationship with their physicians and expect to take a more active part in decisions about their health care. But many people, notably the elderly, still value the conventional model of the doctor who 'always knows best' <sup>(37)</sup>.

Despite these concerns, national patient surveys show high levels of satisfaction with their consultation <sup>(25, 26)</sup>. In 2002, 90% or more agreed with statements that their GP: treated them as they would wish; made the right diagnosis; knew what was best; took the right action; listened; and was easy to understand. Agreement rates were slightly lower on statements that their GP: took their views seriously (89%); allowed them to ask as many questions as they wanted (88%); gave them enough information (87%); knew enough about their condition (83%); and provided suitable time for the consultation (83%). However, these results contrast with findings from other studies which suggest that patients want more information from their doctors <sup>(38)</sup> and often misunderstand doctors' instructions <sup>(39)</sup>, highlighting the problematic nature of self-reported comprehension in surveys and suggesting such findings should be viewed cautiously.

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<sup>4</sup> Data from surveys in England in 1998 and 2002 by the National Centre for Social Research . Surveys

## CONTINUITY

Issues of co-ordination arise in five main areas: the range from undergraduate to CPD; GP experience in undergraduate programmes; links between undergraduate years and the Pre-registration house officer (PRHO) year; co-ordination within the VTS programme; between VTS and Higher Professional Education (HPE); and between HPE and CPD.

A framework for the overall co-ordination of medical education is provided by the GMC's *Good Medical Practice*<sup>(6, 10, 40)</sup>. With *Tomorrow's Doctors*<sup>(41, 42)</sup> and *The New Doctor*<sup>(43)</sup> they provide the basis for the GMC's recommendations for undergraduate and pre-registration education and training<sup>(41, 43)</sup>. The knowledge, skills, attitudes and behaviours set out in these documents provide a basis for the design of 'detailed curricula and schemes of assessment'<sup>(42)</sup>. Whilst this should assist the linkage of GP VTS with 'the educational continuum of the undergraduate and PRHO years as well as higher professional education', practice presents some problems<sup>(14)</sup>.

Seen as a means of improving co-ordination with post-graduate education and promoting general practice as a career choice<sup>(44, 45)</sup>, experience of general practice in undergraduate programmes has grown substantially and is now a significant component of many programmes.

Whilst it has been possible since 1978 to spend part of the PRHO year in a general practice setting<sup>(46)</sup> and the GMC has provided guidance on how experience in a community setting should be gained<sup>(47, 48)</sup>, funding has limited this activity<sup>(49-52)</sup>.

A major issue on training schemes is the co-ordination between hospital training, practice-based training and the day-release courses. In addition to the criticism that GP trainees spend a disproportionate amount of time in hospital posts, this element has been criticised for poor quality and relevance<sup>(36, 53-56)</sup>, an issue that is not confined to UK GP training<sup>(57-59)</sup>. Improved co-ordination is seen as a means of maximising educational opportunities, limiting pressures

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were stratified random samples to 100,000 individuals in 1998 (61.4% response) and 263,100 in 2002 (55.4%).

to meet service commitments, assisting in overcoming the danger of disjointed SHO posts and making the experience more relevant to general practice <sup>(13)</sup>. The JCPTGP has also proposed having a GP trainer for the whole of the VTS programme, providing co-ordination and continuity of carefully planned attachments in secondary and community care <sup>(60)</sup>.

In order to ensure greater relevance of hospital posts for GP trainees, the RCGP has worked with several specialties to agree curricula 'to give a clearer idea of what should be learnt from working in various hospital specialties' <sup>(24, 61)</sup> and 'form the basis for the educational approval and selection of posts for vocational training purposes <sup>(61)</sup>'. However, some observers suggest this guidance has not been fully implemented <sup>(62)</sup> and <sup>(63)</sup> identifies continuing tensions between education and service needs. <sup>(56)</sup> show trainers and course organisers assessing hospital training as inappropriate because of the priority given to service needs and work that is often not relevant for future GPs. Whilst there is evidence that some posts for GP training are improving, hospitals seem generally resistant to adapt educational provision for SHO training to general practice <sup>(64, 65)</sup>. A more recent JCPTGP report highlighted how current arrangements are flawed because of their lack of coherence and emphasis on service demands 'at the expense of the needs of the learner and, in the longer term, the NHS' <sup>(14)</sup>.

Recent studies of newly qualified GPs have raised concerns over the effectiveness of vocational training as a preparation for becoming a principal <sup>(22, 24, 66, 67)</sup>, contributing to a formal and structured two-year scheme in higher specialist training (HPE) introduced in 2002.

After the HPE programme, GPs enter the CPD phase of lifelong learning. Before 1990, this was based on an 'inadequate system' of seniority awards and payments to attend Section 63 courses <sup>(68)</sup>. In 1990, the Postgraduate Education Allowance (PGEA) was introduced. Available only to principals and based on credits for attendance at courses and meetings, it 'had the unintended effect of rewarding attendance at events (often of dubious educational quality), rather than recognising the importance of personal study and reflective learning <sup>(68)</sup>'. It has also been criticised for failing to demonstrate benefits to patient care <sup>(69)</sup> and failure to integrate with medical audit systems <sup>(70)</sup>, with most PGEA activity unplanned and not based on an individual's learning needs <sup>(68)</sup>. Advocacy for an improved system of CPD has been

extensive in recent years <sup>(17, 71-73) (74, 75)</sup>. Recommendations include a focus on the educational needs of multi-professional teams, a more integrated approach using personal development plans (PDPs), practice development plans (PPDPs) and increased co-ordination with clinical governance and clinical audit <sup>(68)</sup>.

## **PEDAGOGY**

The literature on the pedagogy of GP training shows a clear philosophical and practical response based on theories of professional learning <sup>(76-84)</sup>. This has assisted in developing a practical response based on an 'understanding of what makes for effective postgraduate education' <sup>(24)</sup>, particularly making training relevant to the adult professional learner <sup>(24, 85)</sup>. It gives priority to meeting the needs of learners, enabling them to play an active part in identifying educational objectives and methods for achieving them <sup>(24, 29, 30)</sup>. There is emphasis on promoting a reflective practitioner, a 'process of internally examining and exploring an issue of concern, triggered by an experience, which creates and clarifies meaning in terms of self, and which results in a changed conceptual perspective' <sup>(78)</sup>. It means promoting reflection based on personal experiences <sup>(77, 86)</sup>.

The approach gives emphasis to small group work, described as 'the backbone of many GP training schemes and a highly valued source of personal support for young practitioners' <sup>(87)</sup>, providing pastoral support and for formative and summative assessment. It also allows exploration of topics such as ethics and, by fostering mutual support, morale among trainees <sup>(88)</sup>.

Individualised learning is another way of fulfilling the philosophy of GP training, Samuel advocating that more effective training can be achieved through a 'personalised approach to curriculum with formative assessment' <sup>(12)</sup>. However, he also notes that success requires greater co-ordination between course organisers and trainers to plan training, a task he regards as 'widely neglected' <sup>(12)</sup>.

Individualised learning and small group work is supported by a commitment to protected time for learning, particularly day-release programmes. They seek coverage of topics not dealt with adequately in hospital posts or practice, providing an orientation towards general practice and contributing to an understanding of concepts such as normal human development, doctor-patient behaviour, the sociology of medical care and epidemiology<sup>(88)</sup>. However, GMC<sup>(89)</sup> recommends that SHOs have protected time for learning are often 'compromised by the pressures of the service'<sup>(30)</sup>.

The pedagogic core of Registrar training, however, is engaging with patients, so their attitudes are an important ingredient in the quality of learning. A study of patients' views in Dublin showed reservations<sup>(90)</sup>. Whilst 91% of respondents considered it advantageous for a practice to have a trainee, a significant minority considered expressed concern about the quality of home visits by trainees, discomfort consulting a trainee and a wish to see their usual doctor after the trainee consultation. More positive attitudes among those who had previously encountered a trainee suggested that a planned and structured introduction of a trainee may contribute to reducing anxieties. In Bain and Mackay's<sup>(91)</sup> study, only four per cent said they would object to a trainee attending a consultation but there were significant minorities whose views on attendance depended on the reason for the consultation.

Approaches that emphasise one-to-one learning, small group work and the goal of developing reflective lifelong learners are, however, often in contrast with the earlier experiences of doctors who, as students, are typically taught in a passive hierarchical way that discourages thinking<sup>(12)</sup>.

These differences extend beyond undergraduate experiences as the hospital experiences of GP trainees often reflect the preferences of some consultants for the apprenticeship approach to learning. Where these contrast with the expectations of trainees, it can contribute to differences in their perception of the quality of training compared with their trainers<sup>(92, 93)</sup>. This disjuncture may be eased with the increasing use of problem-based learning (PBL) in undergraduate training, an approach that has similarities with the philosophy informing GP training<sup>(94), (95), (96)</sup>.

The principles and methods of PBL can also assist within a multi-professional context <sup>(96)</sup>. There is considerable recognition that the changing nature of primary care requires increased competency from the GP in multi-professional teamwork <sup>(17, 61), (61) (14, 28, 29)</sup>. Despite these aspirations, it is an area where other priorities have meant that suitable provision has not occurred <sup>(17)</sup>. Moreover, belief in the value of multi-professional training contrasts with evidence on its impact, two systematic reviews showing no evidence of its benefit – or otherwise <sup>(97)</sup>. This is part of a wider issue where, despite a general consensus on what constitutes effective adult education, there is a need for a more rigorous approach towards evidence. Too often evidence-based practice is absent both because teachers can forget principles or because of insufficient evaluation of initiatives <sup>(98, 99)</sup>.

## **TRAINERS**

GP trainees are principally dependent on course organisers, hospital-based educational supervisors and GP trainers for their training and support with more recent recognition for the role of other health professionals.

In England, Wales and Northern Ireland course organisers are responsible for working with GP trainers and educational supervisors 'to support a coherent programme of learning for doctors on their VT scheme' <sup>(16)</sup>. They organise the half-day/day-release courses for SHOs and GP Registrars, support trainers' workshops, are involved in the recruitment of SHOs and GP registrars and provide career advice <sup>(16)</sup>. In Scotland, Associate Advisers perform broadly the same set of duties. Whilst course organisers do not have to be medically qualified, typically they are experienced GPs, often principals with the MRCGP and experienced as a trainer.

During the hospital phase of the VTS, consultants are the educational supervisors of trainees. In approving SHO posts, the JCPTGP recommend that a named educational supervisor should carry out formative assessment during the placement and help draw up and periodically review an individual's educational plan <sup>(30)</sup>. They also stress that time must be made available for consultants to develop skills in teaching, assessment and pastoral support.

In its guidance, the GMC identifies the professional attributes of the doctor as a clinical trainer and recommend formal training for all new appointees, who should demonstrate competence as part of meeting the requirements of probation <sup>(100)</sup>.

With principal responsibility for GP registrars, the role of trainers includes reviewing the performance and monitoring the development of the registrar, implementing formative assessment and preparing the registrar for summative assessment. As part of summative assessment, trainers provide a report based on the time the registrar has spent with the trainer. The value of formative assessment during vocational training has become increasingly recognised <sup>(14, 29, 61)</sup>. Seen as a means of providing increased structure within practice based and hospital based posts it allows progress to be monitored and provides a clearer focus for meetings between trainee and trainer. Methods include structured logbooks and evidence based portfolios, the latter increasingly recognised as valuable <sup>(101-107)</sup>. By facilitating structured reflection they assist 'deep learning' rather than 'surface learning', promoting autonomy in the learner through needs identification and planning to meet learning objectives. Their use with mentor support has also proved effective in achieving relevant continuing medical education for general practitioners <sup>(105)</sup>. Trainees report valuing feedback on their performance but often consider the amount is insufficient <sup>(54, 108, 109)</sup>.

The satisfaction often expressed about GP training is partly attributed to the importance attached to teaching skills <sup>(100, 110-113)</sup>. In the GP-based component of training, there is a requirement for schemes to develop the teaching skills of trainers and have systems for their assessment <sup>(29)</sup>. Skills are developed in workshops to facilitate 'understanding of the processes of teaching and learning' allowing trainers 'to explore their teaching responsibilities with peers and to appreciate the wide range of local resources that can contribute' <sup>(113)</sup>.

Whilst the trainer/trainee relationship is paramount, others have valuable contributions to make. These include practice partners and members of the primary health care team. Within hospital-based training, the relevant expertise of nurses, social workers, midwives and paramedical staff is also relevant for training general practitioner SHOs, though their contribution can create personal challenges <sup>(13, 29)</sup>.

Society rates doctors highly and when lay men and women are invited to teach trainees, I have noticed medical awe (or is it suppressed phobia?) can sometimes interfere. Conversely some doctors find it hard to accept that they can gain skills from those outside their discipline <sup>(12)</sup>.

Claims about the high quality of training have been challenged. Fifteen years ago, Samuel observed that trainers were rarely held directly accountable for their teaching: 'No one seems to require evidence that their essential work of assessment and training ... is done either consistently or well' <sup>(12)</sup>. It may be that criticism such as this led the GMC and the JCPTGP to recommend formal arrangements for reviewing the performance of supervisors and clinical teachers with mechanisms being set in place to provide feedback and for addressing any problems identified <sup>(29, 100)</sup>. Whilst acknowledging difficulties in assessing the teaching ability of trainers, it was considered vital and 'deaneries should state their expectations of trainers in terms that can be assessed' <sup>(29)</sup>.

## **CONCLUSION: DIRECTIONS FOR RESEARCH**

Anticipating the changes that can be expected as a result of the creation of the PMETB and the changes to the initial training of junior doctors arising from *Modernising Medical Careers* <sup>(114)</sup>, Allen argued that 'the challenge of the new training is to produce a framework which satisfies both the desire of the discipline to facilitate development and that of society and the government, who will look for cost-effectiveness and the security of patient safety and service delivery' <sup>(15)</sup>. To achieve this, he argued, co-operation is required within the whole discipline of general practice, between the RCGP, the GPC, Directors of Postgraduate General Practice Education, associate directors and the JCPTGP. It might be added that the discipline would also benefit from less advocacy and more research and evidence on training.

On the GP curriculum: how will revised hospital and general practice experiences compare; what impact will shorter placements have on what trainees learn; will existing areas of concern over skills be remedied; will clearer statements of expected learning outcomes lead

to improvement in continuity between the phases of under-graduate, post-graduate and continuing education; and will patients views of the quality of care alter?

On pedagogy: how good is the match between a philosophy of adult learning and the daily experience of trainers and trainees; how different is teaching in hospital compared with general practice; might the differences within hospitals and within general practice be as significant as those between the two; how effective are the different models of protected time; and does the pedagogy lead to GPs becoming lifelong learners?

On trainers: how will course organisers, educational supervisors and trainers co-ordinate more complex training programmes; what is the nature and quality of their training; what will be the impact of the expected move towards trainers having more than one trainee; and how can trainees best learn from other health professionals?

Added to these questions could be a set of related areas where the literature has little to say: on the management and organisation of training from national level to the individual hospital specialty and GP practice; the nature and scope of different funding mechanisms; and the range and quality of learning resources.

Contemporary changes in training reflect several concerns. Arising from high-profile cases over the last decade, there is concern about the quality of existing training. Related to this is the pressure for greater transparency and accountability. Increased effectiveness in training can also be a means of increasing the rate of output of trained doctors. A re-thinking of training is also needed as a consequence of the European Working Time Directive. These factors are leading to changes, some designed to meet concerns identified by experts in the discipline and supported, in varying degrees, by studies of existing practice. While expert views are rightly a key component of policy debates and policy decisions, a more substantial body of research evidence on training can also assist in meeting Allen's challenge of a training framework that is cost-effective, facilitates development and meets legitimate expectations about patient safety and service delivery.

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## **Annex 4**

Research paper '**Training for General Practice in the United Kingdom: A National Survey**' submitted for publication in December 2005

### **Training for General Practice in the United Kingdom: A National Survey.**

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**Keywords: graduate medical education, general practice, curriculum, and survey.**

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Competing interests: Adam Fraser, Hywel Thomas, Mike Deighan and Steve Field have received reimbursement from the Royal College of General Practitioners for attending meetings and conferences to discuss this work. Adam Fraser, Mike Deighan, Steve Field and Stephen Kelly are members of the Royal College of General Practitioners.

Details of contributors: Adam Fraser, Hywel Thomas and Mike Deighan are lead authors and guarantors. Adam Fraser, Hywel Thomas, Mike Deighan, Steve Field and Stephen Kelly were involved in study design, organisation, data analysis and writing up. Ian Davison completed the majority of data analysis. Julie Bedward completed the literature review and was involved in data analysis. Nick Freemantle and Mel Calvert provided statistical advice.

Ethics Approval: Ethics approval was not necessary for this study. We took advice regarding this from the West Midlands multi-centre research ethics committee.

Funding: This study was funded by the West Midlands Deanery, who have no financial interest in the outcome of the study. Several authors were involved in the study as part of their work for the West Midlands Deanery.

## **ABSTRACT**

**Objectives** To examine the experiences and opinions of learners and educators about the content and structure of GP training in the UK.

**Design** National postal questionnaire survey.

**Setting** Eight post-graduate Deaneries in the UK.

**Participants** 817 General Practice Registrars (GPRs), 521 General Practitioners within 2 years of qualification registered on the higher professional education scheme (HPEs) and 1559 Primary Care Medical Educators (PCEs).

**Results** The response rate was 61.2%. Respondents expressed a preference for a three-year training programme distributed equally between general practice and hospital placements. Currently, GPRs and HPEs typically spend the majority of their training in relatively few specialties for at least 6 months. GPRs, HPEs and PCEs all prefer a model where training involves experience in a greater number of specialties for a shorter time in each.

**Conclusions** There is a considerable consensus amongst GP trainees and educators that a greater proportion of time should be based in general practice with shorter placements in a wider variety of specialties. This will have important implications for current service provision and training arrangements.

### **What is already known on this subject**

- General practice training in the United Kingdom has remained relatively unchanged for over 25 years
- Recent regulatory changes will lead to major changes in all postgraduate medical training programmes in the UK
- There is little research evidence to inform these changes

### **What this study adds**

- There is considerable consensus of opinion among learners and educators
- GP training should be three years in duration after the foundation years
- An increased proportion of training should be based in general practice
- Specialty training should consist of shorter placements in a wider variety of specialties

## INTRODUCTION

General practice training varies considerably around the world. There is no international consensus on the ideal length of GP training and proportion of training spent in hospital to prepare doctors for working in modern general practice. The length of training varies from two years in Albania, Russia and Canada<sup>1,2</sup> up to six years in Finland,<sup>1</sup> with the majority of countries opting for three years training.<sup>1,3-5</sup> The proportion of training spent in hospital also varies widely, from 100% in Turkey<sup>1</sup> to 0% in Bosnia / Herzegovina,<sup>1</sup> with the majority of countries dividing training posts equally between hospitals and general practice.

General practice training in the United Kingdom was formally established in 1979, when a minimum period of three years post-registration experience was introduced.<sup>6</sup> As a country with a well developed primary care based healthcare system, the system for training GPs in the UK has influenced curricula for general practice around the world. However, training in the UK has remained relatively unchanged for over 25 years, and has become outdated compared with training curricula in other countries.<sup>1,3</sup> The Royal College of General Practitioners (RCGP) and the Joint Committee on Postgraduate Training for General Practice (JCPTGP) have both advocated that UK training is in urgent need of reform.<sup>7,8</sup>

A major concern about current GP training in the UK is that it does not adequately prepare GP registrars (GPRs) with the necessary confidence and competencies for independent practice.<sup>7,9</sup> This is reflected in the delayed transition from registrar to GP principal and reluctance to pursue a career in general practice upon completion of training.<sup>10,11</sup> Another problem is that hospital based training posts have been criticised for their poor quality and irrelevance, an issue also recognised in training in other countries.<sup>7,9,12-24</sup> Reasons for this include their lack of orientation towards primary care and tensions between service delivery and training.<sup>21</sup>

The majority of UK training still takes place in hospitals, and is typically two out of the three years. Various organisations have recommended that a greater proportion of training needs to be based in general practice to develop the increasing set of skills demanded as a GP principal.<sup>7,9,25-27</sup> However, the European Commission, which determines the statutory minimum training time based in general practice in the UK, has not yet acted on this advice.<sup>28</sup> In addition, UK funding arrangements and the need to fulfil service provision requirements within hospitals have generally prevented a reduction in hospital based training.<sup>8,29,30</sup>

The establishment of the Postgraduate Medical Education and Training Board (PMETB) in 2005<sup>31,32</sup> and the Department of Health's 'Modernising Medical Careers' proposals<sup>33,34</sup> will lead to major changes in the curriculum and assessment of all postgraduate medical training programmes in the UK. These changes represent a rare opportunity for a radical reorganisation of current training to improve standards and address some of the existing problems with training for general practice. The RCGP, working in collaboration with other stakeholders, has developed proposals for a new curriculum and assessment procedures to submit to the PMETB.

There is little research evidence to inform the RCGP recommendations for GP training, with much of the literature citing expert opinion. Two national surveys of GPRs have been conducted in 1980<sup>13</sup> and 1989.<sup>17</sup> These asked GPRs about the availability of hospital posts, teaching sessions received (including study release courses), and satisfaction with general practice placements. They did not ask whether GPRs wished to spend longer in hospital to incorporate additional posts or whether they would have preferred a different combination of posts over the same period. The Committee of General Practice Education Directors (COGPED) has completed a national exit survey of GPRs{personal communication}, but this is predominantly concerned with future career intentions to enable workforce planning. GPRs in the Eastern Deanery were surveyed about hospital posts they had experienced, and their ideal hospital training.<sup>35</sup> However, there has been no national survey about the experience and aspirations of GPRs. In addition, the views of recently qualified GPs and primary care educators have not been sought.

## **METHOD**

We conducted a postal survey of every learner and educator in eight of the seventeen Post-graduate Deaneries in the UK. The Deaneries were chosen to be representative of rural, suburban and urban areas, and of the four countries within the UK. Within each Deanery, postal questionnaires were sent to GPRs who were undergoing training, general practitioners registered on the higher professional education scheme (HPEs), and trainers and course organisers – referred to here as Primary Care Educators (PCEs). The HPE scheme is a voluntary programme of continuing medical education for GPs within 2 years of qualification.

A questionnaire was developed for each group surveyed – GPRs, HPEs and PCEs. Items were identified from national and international literature reviews on GP training. Comments on the items were elicited from members of the RCGP education network and revisions made. The wording and format of the questionnaires were modified to conform to good practice and enhance response rates.<sup>36,37</sup> The questionnaires were piloted in each of the three groups and revised into the final version.

Numbered questionnaires were sent to every individual registered in each Deanery's databases for GPRs, HPEs and PCEs in April 2004. A covering letter stating how the survey would influence future GP training and freepost envelope were included to enhance response rates. A second mailing was sent to non-responders in July 2004. All questionnaires were collected and analysed centrally. Separation of the mailing (by each Deanery) and analysis (centrally) ensured that responses were handled anonymously.

## RESULTS

### Response Rate

2897 out of 4734 replies were received, an overall response rate of 61.2%. This comprised 817 GPRs (56.9%), 521 HPEs (50.6%) and 1559 PCEs (68.7%). Response rates above 60% are generally considered acceptable for postal surveys.<sup>36</sup> Amongst clinicians the average response rate tends to be only 54%<sup>38</sup> and there is evidence that response rates among GPs are declining,<sup>39</sup> indicating the response rate of this survey is reasonable. These responses represent a large proportion of all those involved in GP education in the UK. For England alone, the replies from 730 GPRs represent 31.6% of all GPRs in England in June 2004.<sup>40</sup>

### Demography

Sixty per cent of respondents were female and forty per cent were male. This was identical to national data on the gender profile of GPRs<sup>40</sup> and the COGPED survey undertaken by Deaneries in England. The age profile in this survey (F: 32 years and M: 35 years) was comparable with the COGPED survey (F: 31 years and M: 34 years). The place of qualification (UK: 65%, EU: 6%, non-EU: 29%) was also similar to the COGPED survey profile (UK: 70%, EU: 6%, non-EU: 24%).

### Preferred length of training

All three groups of doctors showed a strong preference for a three-year training programme after the completion of the new two-year foundation programme (Figure 1). Overall 58% expressed a preference for three years of training, a response that is consistent across all three groups (57% for GPRs and 58% for both HPEs and PCEs). The remainder were distributed between 25% wanting less than three years and 17% more than three years.

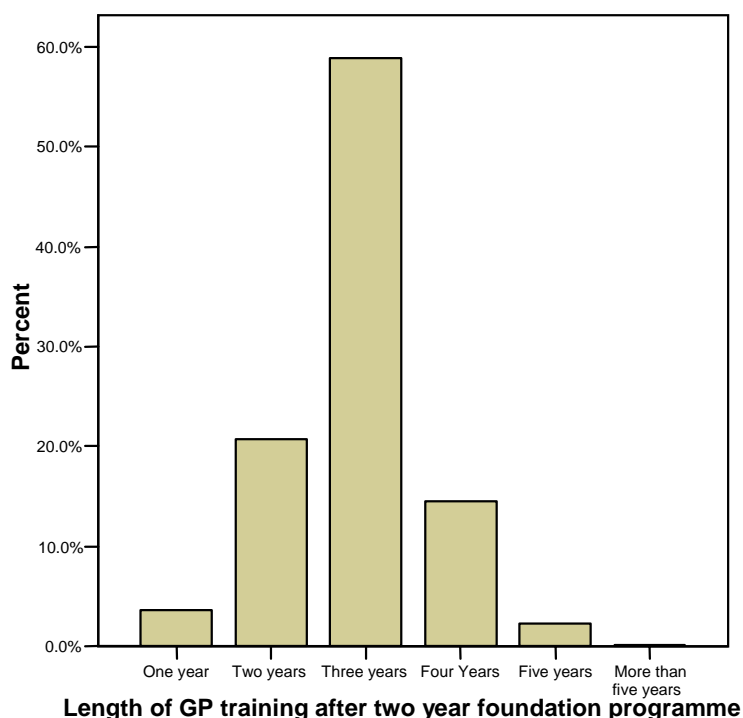


Figure 1: Preferred length of general practice training after the two year foundation programme amongst 2897 General Practice Registrars (GPRs), general practitioners on the Higher Professional Education scheme (HPEs), and Primary Care Educators (PCE).

When asked 'Out of three years, what is the ideal length of time that training should be based in general practice?' 62% of respondents selected 18 months (GPRs: 57%, HPEs: 62%, PCEs: 65%). While 20% selected the current length of 12 months, 18% opted for more than 18 months (Figure 2). These responses indicate an overall preference for three years in GP training distributed equally between general practice and hospital experience.

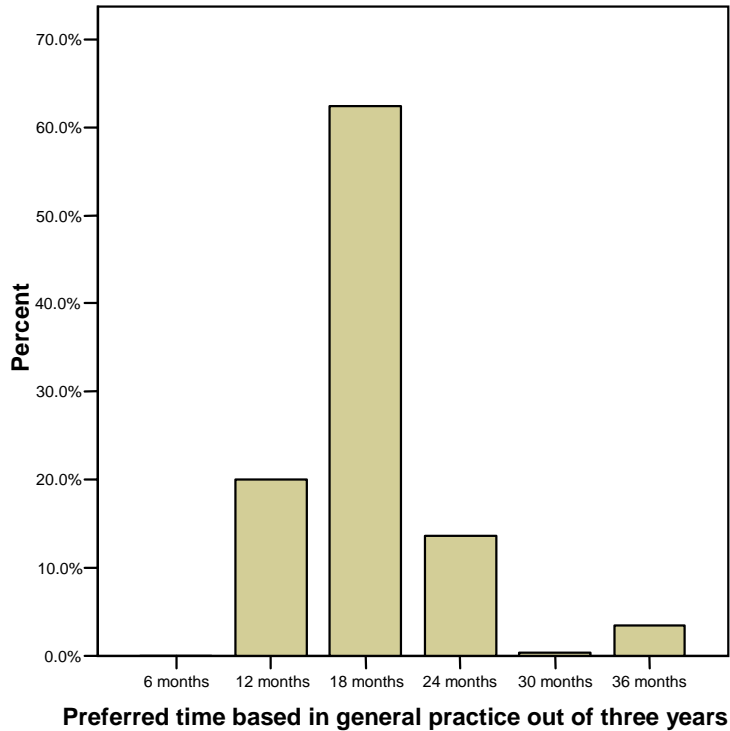


Figure 2: Preferred length of time that training should be based in general practice out of three years amongst 2897 General Practice Registrars (GPRs), general practitioners on the Higher Professional Education scheme (HPEs), and Primary Care Educators (PCE).

### The hospital experience

We examined which hospital specialty posts GPRs and HPEs had experienced and for how long. For each specialty in which they worked, GPRs and HPEs were asked to report on their preferred duration in those posts as preparation for general practice.

#### Actual hospital specialty experience

Table 1 shows the hospital specialty posts reported by the 1338 GPRs and HPEs in the survey. The first eight are 'major' specialties recommended by the JCPTGP regulations as being suitable for general practice training.<sup>6</sup> The five 'minor' specialties are commonly encountered in general practice but training in these subjects was not recommended by the JCPTGP. Specialties listed as 'other' have little relevance for general practice, such as intensive care and anaesthetics. Participants who reported completing a post in gynaecology, obstetrics, or both obstetrics and gynaecology were grouped together.

A large proportion of GPRs and HPEs had experience in the 'major' specialties, whereas experience in the 'minor' specialties was much less common. For example, around three quarters of all respondents had experience in obstetrics and gynaecology, accident and emergency, or paediatrics, whereas less than one in six had experience in the minor specialties. In addition, the duration of time spent in major specialties tended to be longer. Over 70% of posts in all the major specialties were for 6 months or longer, whereas the majority of minor specialty posts tended to be less than 6 months. Current training for general practice is focused on the major specialties to such an extent that the minor specialties are excluded from most GPRs and HPEs training.

	N (% of total) who did the specialty	N (% of those who did specialty) 6 months or more	N (% of those who did specialty) 3 months to < 6 months	N (% of those who did specialty) < 3 months
<b>Major specialties</b>				
O&/orG	1078 (81)	1030 (96)	41 (4)	7 (1)
Paediatrics	984 (74)	908 (92)	64 (7)	12 (1)
Medicine	710 (53)	562 (79)	133 (19)	15 (2)
A&E	992 (74)	904 (91)	69 (7)	19 (2)
Psychiatry	569 (43)	493 (87)	65 (11)	11 (2)
Care of the Elderly	644 (48)	456 (71)	160 (25)	28 (4)
Surgery	212 (16)	178 (84)	29 (14)	5 (2)
Orthopaedics and trauma	183 (14)	141 (77)	30 (16)	12 (7)
<b>Minor specialties</b>				
ENT	197 (15)	86 (44)	88 (45)	23 (12)
Palliative care	173 (13)	78 (45)	64 (37)	31 (18)
Dermatology	160 (12)	50 (31)	61 (38)	49 (31)
Sexual Health	106 (8)	57 (54)	16 (15)	33 (31)
Ophthalmology	92 (7)	20 (22)	47 (51)	25 (27)
Other	176 (13)	128 (73)	37 (21)	11 (6)

*Table 1: Actual hospital specialty experience of 1338 General Practice Registrars (GPRs) and general practitioners on the Higher Professional Education scheme (HPEs).*

### Comparison between actual and preferred hospital experience

GPRs and HPEs who had experience of a specialty during their training were asked to state their preferred duration for that specialty as preparation for general practice. We then compared the actual and preferred length of training in each specialty using a paired t test. Figure 3 shows the average difference in months between actual and preferred length of training for each specialty.

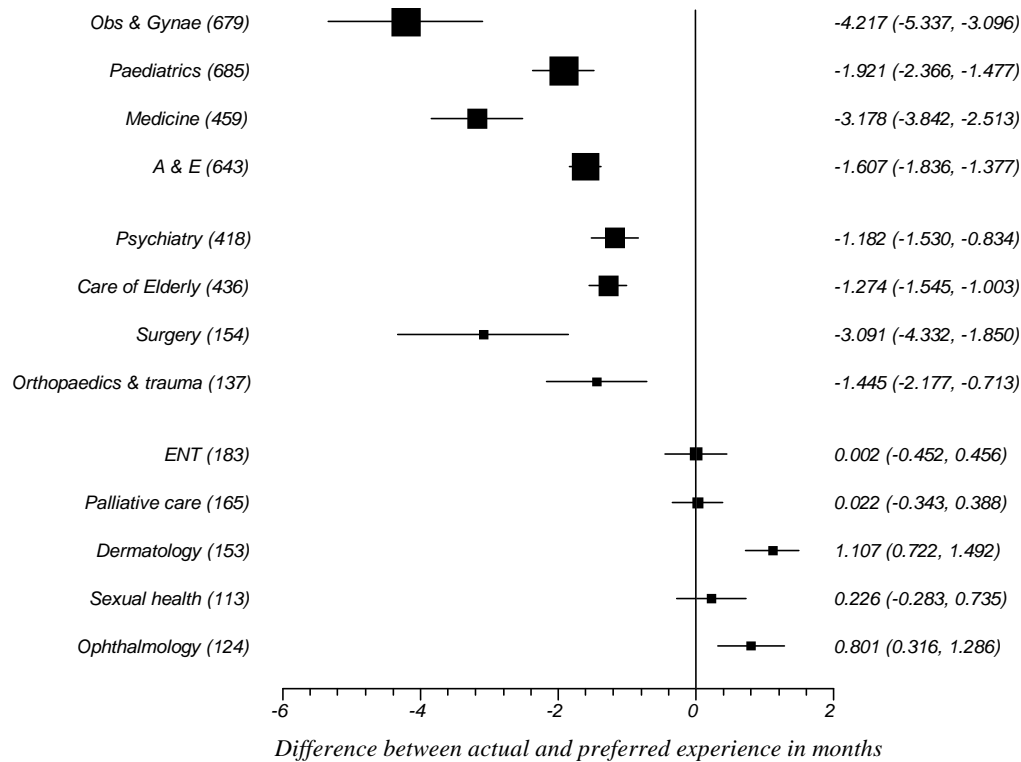


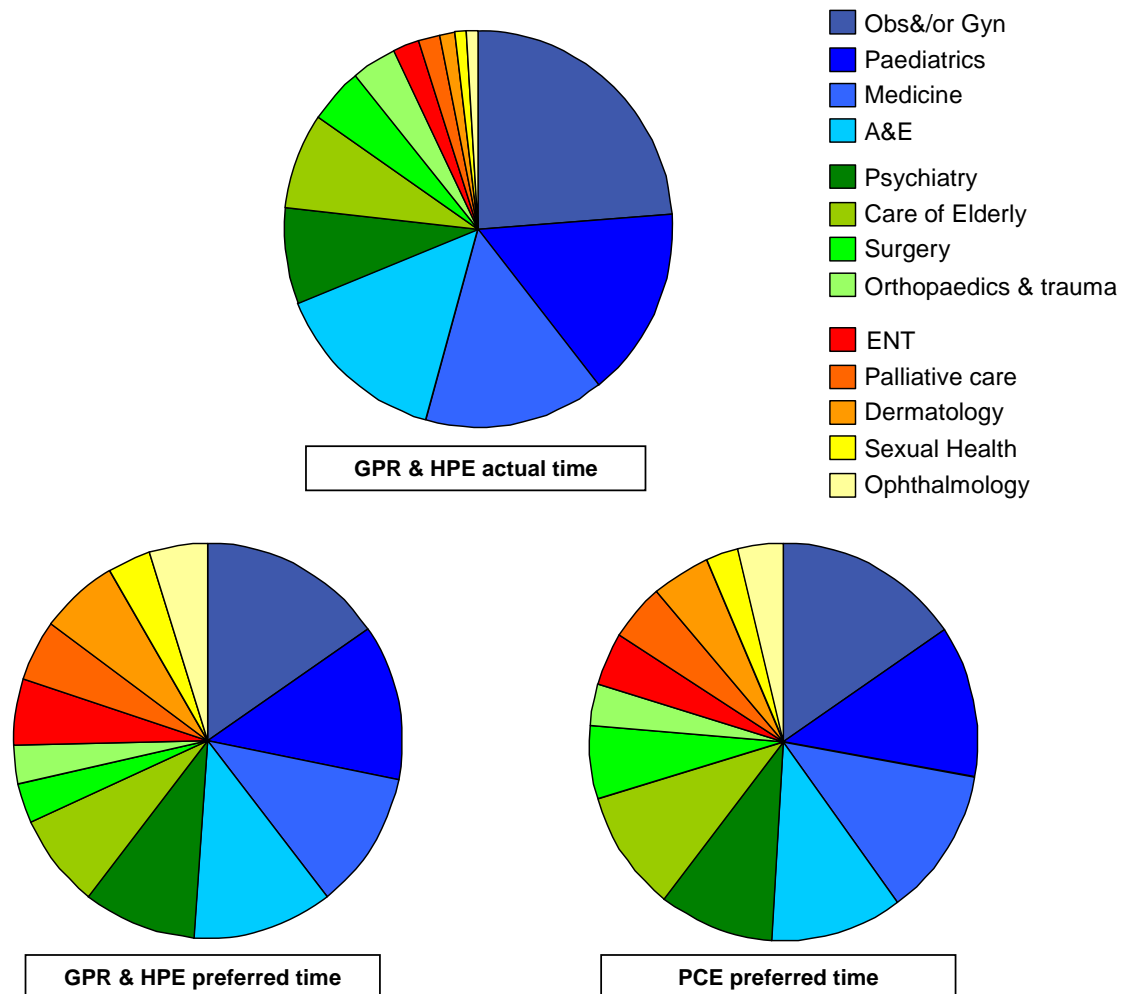
Figure 3: Forest plot of the difference between actual and preferred experience in major and minor hospital specialties. The vertical axis represents no difference between actual and preferred length of training, and the number of months difference is shown on the horizontal axis. A negative number of months means that GPRs and HPEs would have preferred to have less time in the specialty than they actually had, a positive number means that they would have preferred more time in that specialty. The horizontal bars represent the 95% confidence intervals for each specialty. The size of the black square represents the number of GPRs and HPEs who had done that specialty during their training. The major specialties are the eight ones at the top of the plot; the minor specialties are the five at the bottom.

For every 'major' specialty, respondents reported a preferred duration of training less than they had experienced themselves. This difference was particularly marked for obstetrics and gynaecology where preferred duration was 4.2 months less than actual experience, medicine (3.2 months less) and surgery (3.1 months less). For every 'minor' specialty, respondents thought the length of their training was either appropriate (ENT, palliative care and sexual health) or not long enough (dermatology and ophthalmology).

In specialties where training posts were typically six months or more, the difference between actual and preferred duration tended to be greatest. This was due to a preference for three or four month posts instead of the actual six months. Conversely, in specialties where training posts were typically two to four months long, there was a preference for an equal or greater length of training. In summary, three or four months of specialty training tended to be the most popular duration. Overall, the preference was for a greater number of specialties with less time in each.

Distribution of time between specialties

The data were analysed to identify the actual and preferred distribution of time between specialties for GPRs, HPEs and PCEs. This is shown in Figure 4.



*Figure 4: Pie charts showing the actual and preferred distribution of time between specialties. The first pie chart shows the distribution of 'actual time' in different specialties for all the GPRs and HPEs. The second pie chart shows the preferred time reported by GPRs and HPEs as suitable preparation for general practice and the final pie chart is based on the times preferred by PCEs. Time was calculated by summing the total number of months respondents worked in each specialty; for example, total months worked in Paediatrics by all respondents was 7,518, 15% of the sum of 50,064 months across all specialties.*

The actual time GPRs and HPEs spent in four of the 'major' specialties (obstetrics and gynaecology, paediatrics, medicine and accident and emergency) accounted for two-thirds of all time in hospital posts. This fell to half of all time preferred by GPRs, HPEs and PCEs in these specialties. In the remaining four 'major' specialties (psychiatry, care of the elderly, surgery and orthopaedics and trauma), actual and preferred times were approximately equal.

By contrast, in the five 'minor' specialties, preferred time was considerably greater than actual experience. These specialties accounted for seven per cent of the actual time spent in training, but this rose to 25% of the time preferred by GPRs and HPEs, and 20% of the time recommended by PCEs.

### Overall time in specialties

In addition to changes in emphasis between specialties, the overall time spent in specialty training was examined. The GPRs and HPEs in the survey had worked in hospital specialties for an average of 39 months. When their preferred experience for each specialty was added together the sum came to 34 months.

## **DISCUSSION**

This national survey of learners and educators demonstrates considerable consensus across important issues for general practice training in the UK: there should be a three-year training programme with time equally distributed between hospital and general practice; there should be training in more specialties with less time in 'major' specialties and more time in 'minor' ones. This survey demonstrates that current GPs have no specific training in several specialties by the end of their training.

Support for a three-year training programme is very strong, a period that is also the most common length of training around the world.<sup>1-5</sup> The preference for three years may simply support the *status quo*, reflecting a tendency to defend one's own experience as being appropriate. Equally, it might reflect a pragmatic need not to extend training, as it is expensive for the doctor and the health service. Training in the UK has already been extended by one year due to the two-year foundation programme replacing the single pre-registration year. However, three years after the foundation programme may not be long enough, since we found a preference for a total of 34 months specialty experience and an equal distribution of time between hospital and general practice.

Postgraduate medical education has traditionally been based on the apprenticeship model of learning, which depends on the accumulation of experience by practicing. In contrast, future medical curricula in the UK will be based on the acquisition of competencies rather than actual time served.<sup>31,32</sup> However, the competencies for general practice are likely to take at least three years to achieve, and extensions to this training will inevitably be required for some.

Spending a larger proportion of time in general practice is a clear preference for 80% of respondents. This is consistent with other surveys of GPRs<sup>17,35</sup> and recommendations by professional bodies.<sup>7,8</sup> It also reflects the majority of schemes outside the UK.<sup>1-5</sup> However, it is a significant challenge to the *status quo* in the NHS. There are implications for training required by primary care educators, the resources to support training in primary care settings, and not least staffing in the hospital sector. The European working time directive has already reduced the number of hours worked by junior hospital doctors, and training programmes for secondary care specialties are likely to be shortened. This could result in real difficulties with service provision in many hospital specialties.

Conversely, more time spent in the general practice environment places greater demands on primary care educators and their facilities. Teaching activity in general practice has already been increased due to more undergraduate training<sup>41</sup> and the establishment of foundation year posts in general practice.<sup>42,43</sup> Additional primary care resources will be needed if an increased proportion of GP training is going to be based in general practice. Yet, if training is to meet the declared needs of learners and the views of their educators, this change of emphasis is needed.

There is a clear preference in favour of shorter hospital placements. Even in the major specialties where there was a majority view that six months was the appropriate length of training as preparation for general practice, there were substantial minorities who believed four months was more appropriate. By contrast, for the minor specialties, three to four months was the preferred length though there were significant numbers who believed less than three months was appropriate. These may be specialties where relevant experience might be obtained through attachments in outpatient clinics whilst the trainee is based in general practice.

Reducing the time spent in each specialty post will impact on service provision and educational support. Greater use of three or four-month posts will reduce the service contribution provided by trainees, since time is needed for induction and learning enough about the specialty to practice competently. Reducing the length of posts also affects educational support in the specialties. If prospective general practitioners spend less time in each specialty and experience a greater range, their time in learning must be managed effectively. At a minimum this must require greater clarity on the learning outcomes for each specialty, but it also requires educational supervisors in hospital to be more aware of the needs of GP trainees.

Current experience in specialties differs markedly from the training that both learners and educators want. The preference for less time in major specialties relative to increased time in minor specialties is clear evidence of the desire for a wider range of experience. There is evidence that current specialty experience is not adequately preparing doctors for general practice. Many newly qualified GPs do not feel confident and competent enough for independent practice<sup>9</sup> and are reluctant to enter principals' posts.<sup>10,11</sup> Savage reported that registrars are usually willing to undertake an extension to the current three years of training provided it is relevant to their learning needs.<sup>44,45</sup> Experience of a greater variety of specialties may go some way to ensuring GPRs have the necessary competencies to enter independent general practice.

The cumulative preferred time for every specialty was 34 months, which is considerably longer than the 18 months preferred for hospital-based training. This paradox may simply be the result of adding the preferred duration of time in each specialty, rather than asking respondents to divide a set amount of time between specialties. However, it suggests the need for some placements which are shorter in duration than three months. This difficulty could be resolved by creating more opportunities for attachments to outpatient and community clinics so that specialty experience can be gained whilst the trainee is based in general practice. The Department of Health has advocated this option.<sup>34</sup>

Whilst this survey shows significant consensus about GP training, responding to this presents substantial educational and organisational challenges to the NHS. Reducing the length of posts and more emphasis on attachments to outpatient and community clinics will add to the complexity of managing training. However, if UK training is to produce generalists who are competent to practice in a modern health service, these challenges must be met and it is needed to evaluate innovative GP training schemes to determine how best these changes can be implemented in the UK.

Some countries have already introduced GP training programmes that allow an increased proportion of time based in general practice and shorter placements in a greater variety of specialities, notably Denmark, Australia and Ireland.<sup>1,4,5</sup> Now would seem to be the appropriate time for the UK to implement similar changes.

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## Annex 5

### Mapping of the core RCGP Curriculum Statement 1 – Being a General Practitioner against the General Medical Council’s Good Medical Practice (2002)

Good Medical Practice	Corresponding paragraphs in this Core Curriculum Statement (Statement 1 – Being a General Practitioner)
<p><i>Good Clinical Care</i></p> <p>1 Clinical care</p>	<p><i>Domain 1: Primary care management</i></p> <p>1.1 To manage primary contact with patients, dealing with unselected problems</p> <p>1.2 To cover the full range of health conditions</p> <p>1.3 To co-ordinate care with other professionals in primary care and with other specialists</p> <p>1.4 To master effective and appropriate care provision and health service utilisation</p> <p>1.5 To make available to the patient the appropriate services within the healthcare system</p> <p><i>Domain 2: Person-centred care</i></p> <p>2.1 To adopt a person-centred approach in dealing with patients and problems in the context of patient’s circumstances</p> <p>2.2 To use the general practice consultation to bring about an effective doctor-patient relationship, always respecting the patient’s autonomy</p> <p>2.3 To communicate, to set priorities and to act in partnership</p> <p><i>Domain 3: Specific problem-solving skills</i></p> <p>3.1 To relate specific decision-making processes to the prevalence and incidence of illness in the community</p> <p>3.2 To selectively gather and interpret information from history-taking, physical examination and investigations, and apply it to an appropriate management plan in collaboration with the patient</p> <p>3.3 To adopt appropriate working principles (e.g. incremental investigation, using time as a tool), and to tolerate uncertainty</p> <p>3.4 To intervene urgently when necessary</p> <p>3.5 To manage conditions which may present early and in an undifferentiated way</p> <p><i>Domain 4: A comprehensive approach</i></p> <p>4.1 To simultaneously manage multiple complaints and pathologies, both acute and chronic health problems</p> <p>4.2 To promote health and well-being by applying health promotion and disease prevention strategies appropriately</p> <p><i>Domain 5: Community orientation</i></p> <p>5.1 To reconcile the health needs of individual patients and the health needs of the community in which they live, balancing these with available resources.</p> <p><i>Domain 6: A holistic approach</i></p> <p>6.1 To use bio-psycho-social models, taking into account cultural and existential dimensions</p>

<p><i>Good Clinical Care</i></p> <p>2 Keeping records, writing reports and keeping your colleagues informed</p>	<p><i>Domain 1: Primary care management</i></p> <p>1.3 To co-ordinate care with other professionals in primary care, and with other specialists</p> <p><i>Domain 2: Person-centred care</i></p> <p>2.3 To communicate, to set priorities and to act in partnership</p>
<p><i>Good Clinical Care</i></p> <p>3 Access, availability and providing care out of hours</p>	<p><i>Domain 2: Person-centred care</i></p> <p>2.4 To provide long-term continuity of care as determined by the needs of the patient, referring to continuing and co-ordinated care management</p>
<p><i>Good Clinical Care</i></p> <p>4 Treatment in emergencies</p>	<p><i>Domain 3: Specific problem-solving skills</i></p> <p>3.4 To intervene urgently when necessary</p>
<p><i>Good Clinical Care</i></p> <p>5 Making effective use of resources</p>	<p><i>Domain 3: Specific problem-solving skills</i></p> <p>3.3 To adopt appropriate working principles (e.g. incremental investigation, using time as a tool), and to tolerate uncertainty</p> <p>3.6 To make effective and efficient use of diagnostic and therapeutic interventions</p> <p><i>Domain 4: A comprehensive approach</i></p> <p>4.3 To manage and co-ordinate health promotion, prevention, cure, care, rehabilitation and palliation</p> <p><i>Domain 5: Community orientation</i></p> <p>5.1 To reconcile the health needs of individual patients and the health needs of the community in which they live, balancing these with available resources</p>
<p><i>Maintaining Good Medical Practice</i></p> <p>6 Keeping up to date, and maintaining your performance</p>	<p><i>Essential feature 3: Scientific aspects</i></p> <p>4 Being able to develop and maintain continuing learning and quality improvement</p>
<p><i>Relationships with Patients</i></p> <p>10 Providing information about your services</p>	<p><i>Domain 2: Person-centred care</i></p> <p>2.3 To communicate, to set priorities and to act in partnership</p>
<p><i>Relationships with Patients</i></p> <p>10 Maintaining trust</p>	<p><i>Domain 2: Person-centred care</i></p> <p>2.1 To adopt a person-centred approach in dealing with patients and their problems, both in the context of patient's circumstances</p> <p>2.2 To use the general practice consultation to bring about an effective doctor-patient relationship, always respecting the patient's autonomy</p> <p>2.3 To communicate, to set priorities and to act in partnership</p> <p><i>Essential feature 2: Attitudinal aspects</i></p> <p>1 Being aware of one's own capabilities and values</p> <p>2 Identifying ethical aspects of clinical practice (prevention, diagnostics, therapy, factors that influence lifestyles)</p> <p>3 Justifying and clarifying personal ethics</p>

<p><i>Relationships with Patients</i> 10 Avoiding discrimination and prejudice against patients</p>	<p><i>Domain 6: A holistic approach</i> 6.1 To use bio-psycho-social models, taking into account cultural and existential dimensions</p>
<p><i>Relationships with Patients</i> 10 If things go wrong</p>	<p><i>Essential feature 1: Contextual aspects</i></p> <ol style="list-style-type: none"> <li>1 Having an understanding of the impact of the local community, including socio-economic factors, geography and culture, on the workplace and patient care.</li> <li>2 Being aware of the impact of overall workload on the care given to the individual patient, and the facilities (e.g. staff, equipment) available to deliver that care.</li> <li>3 Having an understanding of the financial and legal frameworks in which health care is given at practice level</li> <li>4 Having an understanding of the impact of the doctor's personal housing and working environment on the care that s/he provides</li> </ol> <p><i>Essential feature 2: Attitudinal aspects</i></p> <ol style="list-style-type: none"> <li>1 Being aware of one's own capabilities and values</li> <li>2 Identifying ethical aspects of clinical practice (prevention, diagnostics, therapy, factors that influence lifestyles)</li> <li>3 Having an awareness of self: an understanding that their own attitudes, and feelings are important determinants of how they practice</li> <li>4 Justifying and clarifying personal ethics</li> </ol>
<p><i>Working with Colleagues</i> 11 Working with colleagues and working in teams</p>	<p><i>Domain 1: Primary care management</i> 1.3 To co-ordinate care with other professionals in primary care, and with other specialists 1.5 To make available to the patient the appropriate services within the healthcare system</p> <p><i>Domain 4: A comprehensive approach</i> 4.3 To manage and co-ordinate health promotion, prevention, cure, care, rehabilitation and palliation</p>
<p><i>Working with Colleagues</i> 12 Referring patients</p>	<p><i>Domain 1: Primary care management</i> 1.3 To co-ordinate care with other professionals in primary care, and with other specialists 1.5 To make available to the patient the appropriate services within the healthcare system</p>
<p><i>Working with Colleagues</i> 13 Accepting posts</p>	<p><i>Essential feature 2: Attitudinal aspects</i></p> <ol style="list-style-type: none"> <li>1 Being aware of one's own capabilities and values</li> <li>4 Justifying and clarifying personal ethics</li> </ol>
<p><i>Teaching and Training, Appraising and Assessing</i> 14 Teaching and training, appraising and assessing</p>	<p><i>Not explicitly covered in this statement but covered in other RCGP Curriculum Statements</i></p>

<p><i>Probity</i></p> <p>15 Research</p> <p>16 Financial and commercial dealings</p> <p>17 Providing references</p>	<p><i>Essential feature 2: Attitudinal aspects</i></p> <ol style="list-style-type: none"> <li>1 Being aware of one's own capabilities and values</li> <li>2 Identifying ethical aspects of clinical practice (prevention, diagnostics, therapy, factors that influence lifestyles)</li> <li>3 Justifying and clarifying personal ethics</li> </ol>
<p><i>Health and the Performance of Other Doctors</i></p> <p>18 Protecting patients when your own health or the health, conduct or conduct, or performance of other doctors puts patients at risk</p>	<p><i>Essential feature 2: Attitudinal aspects</i></p> <ol style="list-style-type: none"> <li>1 Being aware of one's own capabilities and values</li> <li>3 Having an awareness of self: an understanding that their own attitudes, and feelings are important determinants of how they practice</li> <li>5 Being aware of the interaction of work and doctor's own private life and striving for a good balance between them</li> </ol>

# Annex 6

## The second stage of the national consultation on the proposed RCGP Training Curriculum, November 2005

<http://www.rcgp.org.uk/corporate/responses/curriculum/index.asp>

### Online Response Form

Step 1: Read consultation [documents](#)

Step 2: Complete the fields below.

### Background

The RCGP is consulting widely but in addition would welcome comments from current General Practitioners and registrars on the new curriculum for General Practice which will come into force from August 2007. The curriculum has been designed to inform the period of postgraduate medical education and training for general practice leading to the award of a Certificate of Completion of Training. This in turn will give the successful doctor eligibility for entry on to the General Medical Council's General Practitioner Register.

The curriculum, specified within a framework for a structured education programme, is designed to address the wide-ranging knowledge, competences, clinical and communication skills and professional attitudes considered appropriate for a doctor intending to undertake practice in the contemporary UK National Health Service.

### Timescale

All comments on the Draft Curriculum must be received at RCGP by 6th January 2006 in order that amended documents may be presented for consideration at the Council Executive Committee meeting on 19th January 2006 and then for approval by Council on 24th February 2006.

### Questions

The following questions are posed, and text boxes are provided for a response.

All compulsory fields are marked with an \*

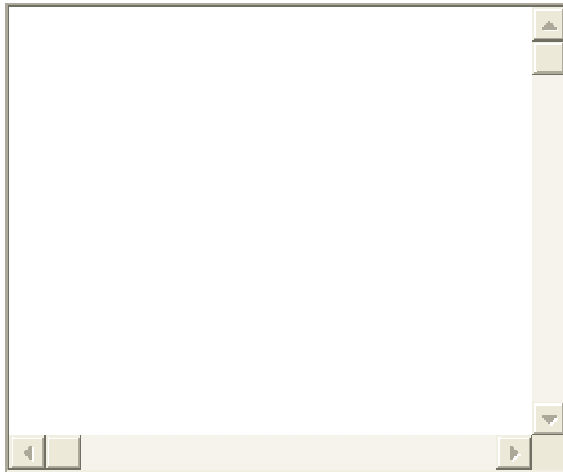
Please enter your name: \*:

Please enter your email address\*:

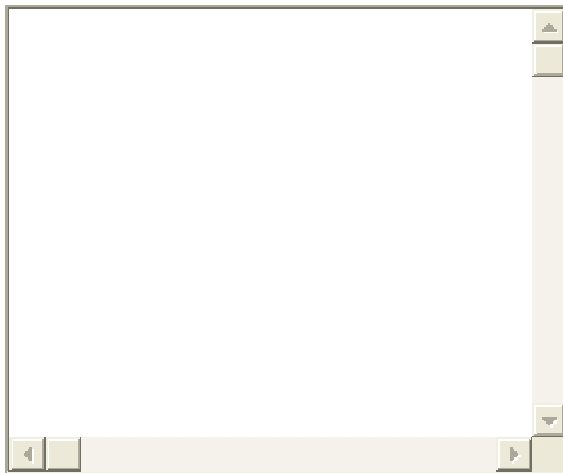
Please enter the organisation you represent for this response (if relevant):

### Appraisal and Assessment

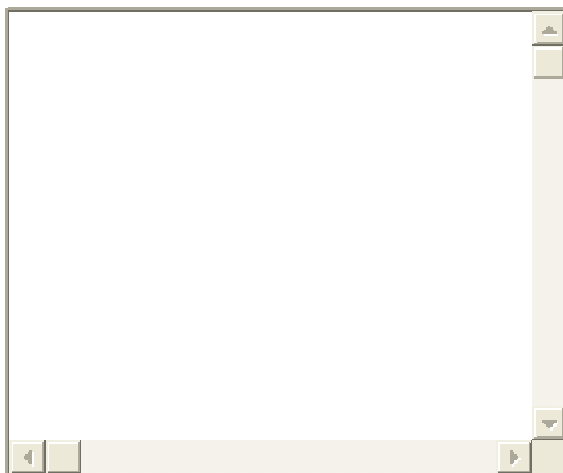
1. Do you agree with the philosophy of, and the approach behind the curriculum?



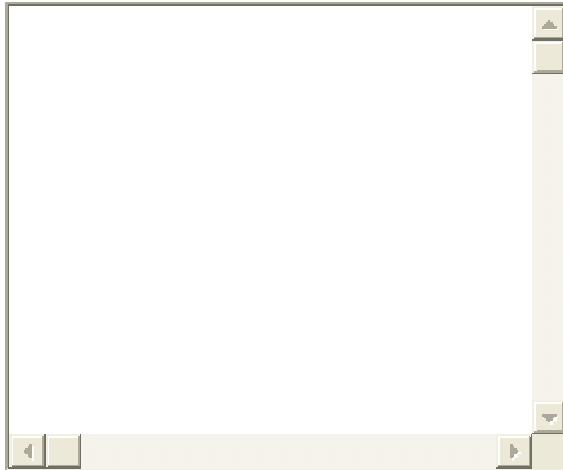
2. Assuming it is correctly implemented, will it lead to better standards of patient care or not?



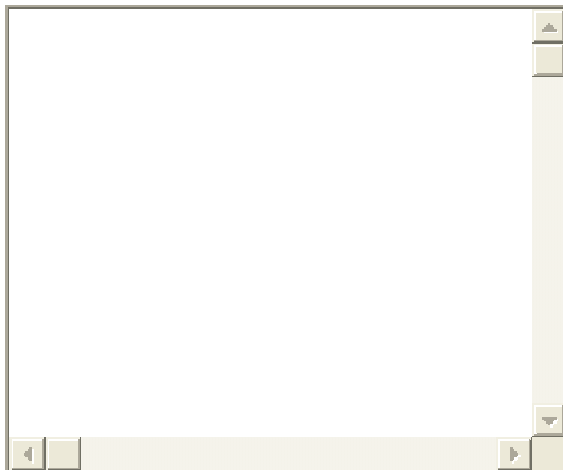
3. Is the level pitched correctly for GP Registrars? Will it produce GPs who are fit for purpose to meet the needs of patients?



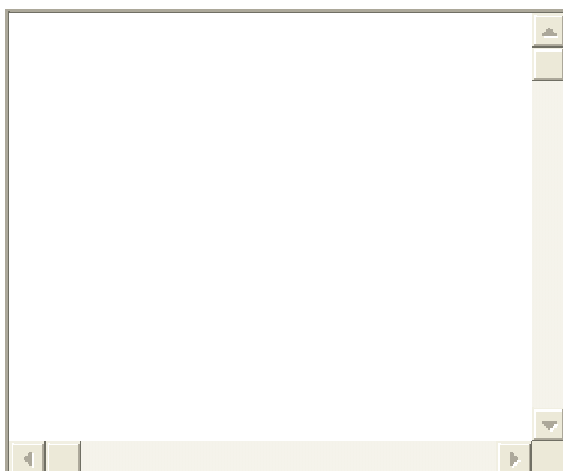
4. Is there anything that you feel has been omitted that should have been included?

A large, empty rectangular text box with a light beige background and a thin grey border. It is positioned at the top of the page and is intended for the respondent's answer to question 5. The box has small navigation icons in the corners: a left arrow and a right arrow on the bottom edge, and a top arrow and a bottom arrow on the right edge.

5. Do you think it will add value to education and learning over and above current approaches for GP registrars? For example, will it produce GPs with a higher level of knowledge and clinical skills?

A large, empty rectangular text box with a light beige background and a thin grey border. It is positioned below question 5 and is intended for the respondent's answer to question 6. The box has small navigation icons in the corners: a left arrow and a right arrow on the bottom edge, and a top arrow and a bottom arrow on the right edge.

6. Do you think the curriculum is teachable?

A large, empty rectangular text box with a light beige background and a thin grey border. It is positioned below question 6 and is intended for the respondent's answer to question 7. The box has small navigation icons in the corners: a left arrow and a right arrow on the bottom edge, and a top arrow and a bottom arrow on the right edge.

7. What do you think the process should be for the maintenance and review of the new curriculum?

A large empty text area with a scroll bar on the right and navigation buttons at the bottom.

8. Any further comments you feel would be helpful?

A large empty text area with a scroll bar on the right and navigation buttons at the bottom.

The Curriculum Statements and the draft PMETB submission documents were posted on the RCGP website in September 2005 to enable anyone who logged on to the website to comment. Reference to the website was given to the press and articles were written to draw attention to the consultation. Presentations were delivered to many organisations and reference to the website was made at many meetings with over 330 stakeholders contacted by post and email. These include:

The Royal College of General Practitioners: UK Council, Scotland, Northern Ireland and Wales Councils, Faculty Boards, Patient Partnership Group, Postgraduate Training Committee, Education Network, Panel of Examiners, Assessment Group, International Committee, Innovation Unit, Research Network, Clinical Networks, Examination Board, GP Trainer and GP Registrar representatives, and relevant experts in quality, education and patient care e.g. Martin Roland, Martin Marshall, Richard Baker, Tim Wilson)

Representatives of service and other national organisations including primary care organisations, the Departments of Health, the Healthcare Commission and the NHS Confederation. The General Medical Council, the Postgraduate Medical Education and Training Board, the Academy of Medical Royal Colleges, the Conference of

Postgraduate Medical Deans of the United Kingdom (COPMeD), the Committee of General Practice Education Directors (COGPED), The British International Doctors Association, the Small Practices Association, the General Practitioners Committee of the British Medical Association (GPC) and their education committee.

The National Primary Care Research and Development Centre, the NHS National Genetics Education and Development Centre, the United Kingdom Conference of Postgraduate Education Advisers in General Practice (UKCEA), the Association of Course Organisers (ACO), the National Association of Primary Care Educators (NAPCE), the Society for Academic Primary Care (SAPC), WONCA Europe and EURACT.

