Royal College of General Practitioners

TRAINING CURRICULUM

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CONTENTS

Part One:
A statement on the eight PMETB standards for curricula 1

Acknowledgements 2

Contents – Standards 3

Contents – Standards continued, References and Annex documents 4

STANDARD 1: RATIONALE 5
The purpose and role of the curriculum
Developing the curriculum and securing consensus
Overall policy and management
Literature review and national survey
Review of existing curriculum models
Discussion and debate
Curriculum statements
The appropriateness of the curriculum
Linking the curriculum to previous and subsequent stages of training
The curriculum, training programme and training posts

STANDARD 2: CONTENT OF LEARNING 15
Content
Content and intended outcomes
Content and learning experiences

STANDARD 3: MODEL OF LEARNING 19
Balance
Key principles of adult learning

STANDARD 4: LEARNING EXPERIENCES 22
The principal relationship
Approaches to teaching and learning

STANDARD 5: SUPERVISION AND FEEDBACK 24
Mechanisms for supervision of practice and safety
Royal College of General Practitioners
COGPED and Deaneries
The Training Practice
The Trainer
Mechanisms for feedback on learning

STANDARD 6: MANAGING CURRICULUM IMPLEMENTATION 28
Management
Structure
Scheme management
Programme management
Implementation and coverage

STANDARD 7: CURRICULUM REVIEW AND UPDATING 32
Plans for review, evaluation and monitoring
Annual review of each curriculum statement
Annual Deanery review of regularly generated data
Annual national review regularly generated data
Cycle of major reviews of curriculum statements
Comprehensive review
Commissioned research

Schedule for updating
Role of trainees and lay persons
Changing contexts

STANDARD 8: EQUALITY AND DIVERSITY **36**
Selection process for specialist training for general practice
Curriculum Statements
Overall framework
Content statements
Equality and diversity
Research

References: **38**

Part 2 Annexes

Annex 1 **Members of the RCGP Education Network and its working groups on the RCGP Curriculum** **39**

Annex 2 **Training General Practitioners: Literature as a guide to action** **41**

Annex 3 **Research paper 'Reviewing general practitioner training in the United Kingdom: Key Themes'** **67**

Annex 4 **Research paper 'Training for General Practice in the United Kingdom: A National Survey'** **85**

Annex 5 **Mapping of the core RCGP Curriculum Statement 1 – *Being a General Practitioner* to the General Medical Council's Good Medical Practice (2002)** **103**

Annex 6 **The second stage of the national consultation on the proposed RCGP Training Curriculum, November 2005** **109**

Annex 7 **Education and training for general practice: a joint curriculum statement** **115**

Annex 8 **Specialist Training for General Practice: Implementation Strategy for August 2007** **145**

Annex 9 **The core RCGP Curriculum Statement – 1 *Being a General Practitioner*** **163**

Annex 10 **The RCGP Curriculum Statement *Promoting Equality and Valuing Diversity*** **191**

Annex 11 **The proposals for a new assessment programme (nMRCGP) to confirm satisfactory competition of specialist training for prospective general practitioners** **201**

STANDARD 1: RATIONALE

The purpose and role of the curriculum

The Royal College of General Practitioners Training Curriculum set out in the accompanying material has been designed to inform the period of postgraduate medical education and specialist training for general practice leading to award of a Certificate of Completion of Training which in turn gives the successful doctor eligibility for entry on to the General Medical Council's General Practitioner Register.[1]

The material is set out so as to meet a key requirement of a curriculum as a statement that communicates 'the essential features and principles of an educational proposal in such a form that it is open to critical scrutiny and capable of effective translation into practice'[2]. It does this by describing a journey of learning built from several components including its rationale, content, outcomes, strategies and resources. In broad terms, it also describes methods of assessment and the evaluative processes that will be applied to learning processes as they apply to individuals and, more generally, to ensure that the curriculum meets changing demands and expectations.

Specified within a framework for a structured educational programme, it 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. The framework draws explicitly upon *The European Definition of General Practice/Family Medicine* as set out by the European Academy of Teachers in General Practice (EURACT)[3] and has been mapped against *Good Medical Practice*[4], the General Medical Council's guidance on the duties of a doctor registered with the General Medical Council.

Using the domains of core competences and background features of the discipline described in the *European Definition of General Practice/Family Medicine*, the Royal College of General Practitioners (RCGP) has developed its own framework for the development of the curriculum for general practice both for the core competences of the general practitioner, and also for specific content areas in general practice.

These six domains are:

1. Primary care management
2. Person-centred care
3. Specific problem-solving skills
4. A comprehensive approach
5. Community orientation
6. A holistic approach

Attached to these are three essential features fundamental to a person-centred scientific discipline:

1. Contextual: *using the context of the person, the family, the community and their culture*
2. Attitudinal: *based on the doctor's professional capabilities, values and ethics*
3. Scientific: *adopting a critical and research based approach to practice and maintaining this through continuing learning and quality improvement*

The framework is set within a pedagogical approach that supports the preparation of lifelong learners as a necessary prerequisite for doctors to sustain their capacity to practice effectively in an environment of changing expectations about appropriate practice. It is an approach that also recognises that individuals learn at different rates using different styles and, typically, that learning is enhanced when individuals are actively involved in identifying their needs and contribute to planning, implementing and evaluating their programme of learning.

As set out, the curriculum has three principal audiences. Above all, it must meet the needs of its primary users, trainees (GP Registrars) and educators. For GP Registrars, it must contain the elements of knowledge, skills and attitudes that will assist them in reaching and demonstrating required competences. For educators with responsibilities as facilitators or managers of learning, it must be a resource that is a guide or framework and which, shaped by their professional practice, is a basis for their dialogue with trainees as learners. For educators with responsibilities as assessors, it must be a resource that enables them to interpret learning outcomes into valid and reliable tests of those competences.

No less important, the curriculum must meet the needs of the Postgraduate Medical Education and Training Board (PMETB), the regulatory authority with responsibility

for approving the curriculum. The transparency of this document and its suitability in meeting the requirements of the regulatory body is fundamental in giving legitimacy to the social contract and confidence in the relationship between the medical profession and the wider public.

Finally, the curriculum must serve the needs of the academic community of general practice and primary care whose partnership with practitioners is fundamental to the continuing development of the discipline. For them, the curriculum is a benchmark of contemporary practice and an evidence base for development as expectations of practice change.

Developing the curriculum and securing consensus

Overall policy and management

The approach to developing the curriculum and securing consensus was defined by the Council of the RCGP. Through its Education Network, working groups were established for the Curriculum and for Assessment, the former chaired by Professor Steve Field (Chair of the RCGP Education Network) and the latter chaired jointly by Professor Valerie Wass (Chair of the RCGP Examination Board) and Dr Agnes McKnight (Chair of the National Summative Assessment Board). These groups took forward the process for developing the curriculum and assessment procedures, reporting regularly to the Education Network and RCGP Council. Membership of the Education Network and its two working groups are shown in Annex 1. The work of the Curriculum Review Group is best described as having four main components: literature review and national survey; review of existing curriculum models; consultation on models and methods; and development of curriculum statements.

Literature review and national survey

An initial task set by the Curriculum Review Group (CRG) was to review the literature on the training of general practitioners. This was undertaken by a team led by Professor Hywel Thomas at the Centre for Research in Medical and Dental Education (CRMDE) at the University of Birmingham. Included as Annex 2 to this document, it is organised into nine sections - curriculum; pedagogy; assessment; continuity of learning; support; trainers; materials; finance; and leadership and management – that serve to demonstrate the extent of the literature in some areas and its limited scope elsewhere. Also included as Annex 3 is the academic paper that was formed from the literature review that was submitted for publication in December 2005)

The literature review provided the basis for a national survey on training issues to GP Registrars, GPs on Higher Professional Education (HPE) Programmes and GP Trainers and Course Organisers (also known in some deaneries as Primary Care Medical Educators). Undertaken by Dr Mike Deighan, Dr Adam Fraser and Professor Hywel Thomas, the survey was preceded by focus group meetings with representatives of these three groups of doctors and the questionnaires were also piloted in settings across the United Kingdom.

The national postal survey was sent to all GP Registrars, HPEs and Educators in eight of the 17 Post-graduate Deaneries and national regions in England (14 Deaneries), Scotland, Wales and Northern Ireland. 1559 replies were received, an overall response rate of 61.2%: 817 GP Registrars (56.9%), 521 HPEs (50.6%) and 1559 Educators (68.7%). There are no national data for comparing the profile of HPEs and Educators and only national data on the gender profile of GPRs. These show a distribution (F: 60% and M: 40%) comparable with the profile in this survey (60/40) and an annual exit survey undertaken by Deaneries in England (60/40). The age profile in this survey (F: 32 years and M: 35 years) is comparable with the annual survey (31/34) and place of qualification (UK: 65%, EU: 5.6%, non-EU: 29.4%) is similar to the exit survey profile of 70/6.3/23.6). For England alone, the replies from 730 GPRs represent 31.6% of all GP Registrars in England in June 2004 (Annex 4).

Results from the survey were reported through presentations and workshops at national and international meetings and conferences, further contributing to the process of consultation and feedback. The results also assisted discussion within the CRG and emergent views on the overall length of training, its location in hospitals and general practice and the length of posts in different hospital specialties.

Review of existing curriculum models

In parallel with the literature review and survey, curriculum models developed and applied elsewhere were also examined. Those considered by the CRG with its conclusions reported to the Education Network and RCGP Council included a UK model developed by the Oxford Region and those of nine countries: Australia, Canada, Denmark, Eire, the Netherlands, Norway, Portugal, Spain and the USA. It was concluded, however, that the most appropriate framework was that devised by the World Organisation of Family Doctors ((WONCA) Europe) both because of its international applicability and its acceptance by the national colleges and associations of family medicine in thirty countries in Europe. Moreover, as the UK is

subject to EU Directive 93/16, which promotes free movement of doctors through mutual recognition of training, it was argued that it would be desirable to use a framework familiar to other nations in the Union.

As part of this process, Dr Justin Allen mapped the content of the WONCA framework against the General Medical Council's *Good Medical Practice*. Once the core Curriculum Statement 1 – *Being a General Practitioner* was completed, an updated map was added as an appendix to the statement as an aid for trainees and their supervisors (Annex 5).

Discussion and debate

It will be apparent that the RCGP ensured that consultation on the development of the curriculum and teaching methods has been extensive through the use of literature, focus groups, surveys, conferences and workshops as well as debate in expert groups. To these should be added the opportunities taken to share ideas and proposals with RCGP faculties and meetings of GP Registrars, HPEs and Educators. The meetings provided opportunities to discuss proposals with representatives of service including many primary care trust professional executive committee chairs and members. There were also several meetings with the RCGP's Patient Partnership Group, representatives of other health professionals and representatives of other medical specialties.

Finally, the Council of the RCGP launched a further national consultation on the proposals by writing to stakeholders and posting the draft PMETB submission documents and the RCGP Curriculum Statements on the RCGP website (Annex 6).

RCGP Curriculum Statements

At the core of the curriculum is a set of statements that cover the range of professional responsibilities of general practitioners. Their mode of development further illustrates the participatory approach adopted by the CRG on behalf of the RCGP. Statements were drafted by groups of general practitioners across the UK and were subject to scrutiny and feedback from a wide spectrum of practitioners, a further aspect of a process designed to ensure that the curriculum matches the needs and requirements of doctors in daily practice. Once the initial consultation was completed, they were submitted to the RCGP Council for its formal approval and subsequently placed on the RCGP website as part of a wider consultation with key stakeholders, including the public, the service, UK Departments of Health, medical royal colleges, the British Medical Association, the PMETB, GMC and others.

The appropriateness of the curriculum

The learning journey of a general practitioner starts before medical school and finishes only when s/he stops practising. This curriculum, however, concentrates on the part that takes them from the beginning of specialist training for general practice until they are certificated as competent independent practitioners. It takes them through the 'home' territory of general practice together with content on specialties relevant to UK primary care.

Subsequent sections describe how that that journey will be managed, defining the principles that underpin both the teaching and learning that will take place, and the design of programmes that will support the achievement of the stated learning outcomes.

In the curriculum, the first statement on *Being a General Practitioner* describes the generic professional competences necessary for UK general practice. These are drawn from and steeped in the reality of European professional practice as developed by WONCA and EURACT. Based also upon the reviews and consultations described earlier, as well as analyses of earlier UK curricula models and those of other countries, the RCGP and the Committee of General Practice Education Directors (COGPED) are agreed that these generic competences form the core and foundation of the curriculum for postgraduate general practice education and training.

Linking the curriculum to previous and subsequent stages of training

From August 2005, a new training programme has been introduced across the UK for all doctors in their first two years after initial qualification. This Foundation Programme aims to provide a generic and broad-based education with core competences set out for each year in *Curriculum for the foundation years in postgraduate education and training*[5].

In line with decisions made by the UK MMC Strategy Group and PMETB, the RCGP and COGPED have agreed that the general practice specialty training programme will commence on successful completion of the Foundation Programme and should

remain a minimum of three years duration. Specialty training will build, therefore, on the base provided by demonstrating achievement of the core competences.

To ensure transparency and clarity in the linkages between the Foundation and subsequent years of training, the learning outcomes of the GP training curriculum are also defined in terms of three levels of competence: Novice GP (ST 1 level), Competent GP (CCT level) and Excellent GP (continuing practice). The linkage between the Novice GP level of the GP curriculum with the competences expected for the second Foundation Year is illustrated in Table 1 in relation to communication with patients. Including the Excellent GP category from the GP curriculum illustrates progress beyond competence and, in that respect, demonstrates the expectation that the education and training of general practitioners continues after the award of a certificate for independent practice.

After successful completion of the Foundation Programme and the three-year specialty training programme, the expectation will be of progression onto a two-year in-service Higher Professional Education leading onto a career of lifetime continuing professional development (CPD).

The creation of GPs with a special interest (GPwSI) will also build on the foundation of the GP training curriculum. Guidance from the Department of Health in England for Primary Care Trusts (PCTs) implementing a scheme for GPs with special interests[6] emphasises that primary care organisations will need to ensure that the GP is a competent and experienced generalist, as well as having the specific competences and experience for the special interest area.

CPD is all the more important in a rapidly changing health service. While the new GMS Contract for general practice retains the current broad clinical remit of the general practitioner, it encourages more explicit patient care pathways, integrated working across the system and better developed clinical relationships. As the contract also allows GPs more flexibility over their work arrangements, an increase in flexible portfolio careers may challenge the functions of general practice. While the application of quality standards, appraisal and revalidation may serve to consolidate recent developments, it is clear that CPD has a key role in supporting these developments.

Table 1: The linkage between the Novice GP level of the GP curriculum with the competences expected for the second Foundation Year and for practising (Excellent) GPs in relation to communication with patients.

Novice GP (ST 1 level)	Competent GP (CCT level)	Excellent GP (continuing practice)
3.0 Relationships with patients and communication: (i) Demonstrates appropriate communication skills	1 Communication and consulting skills	1 Communication and consulting skills
Frames all communication with patients in the context of taking decisions and acting with the patient and not for them Demonstrates an ability to anticipate patients' needs, explains clearly and checks understanding Chooses a suitable setting with necessary support to break bad news when it is appropriate to do so Provides or recommends relevant written/online information for patients Deals appropriately with angry or dissatisfied patients/relatives	Explores the patient's agenda, health beliefs and preferences Elicits psychological and social information to place the patient's problem in context Works in partnership with the patient, negotiating a mutually acceptable plan that respects the patient's agenda and preference for involvement Explores the patient's understanding of what has taken place Flexibly and efficiently achieves consultation tasks, responding to the consulting preferences of the patient	Incorporates the patient's perspective and context when negotiating the management plan Whenever possible, adopts plans that respect the patient's autonomy Uses a variety of communication techniques and materials to adapt explanations to the needs of the patient Appropriately uses advanced consulting skills such as confrontation or catharsis to achieve better patient outcomes

The curriculum, training programme and training posts

Training programmes for general practice will be a minimum of three years duration.

A trainee may commence a GP training programme on satisfactory completion of a two-year Foundation Programme in the UK or by being able to demonstrate the equivalent level of competence. Trainees will apply directly and in open competition

to be selected into a GP training programme through a nationally coordinated, fair and open recruitment system. The system is operated by COGPED and managed through their National Recruitment Office for General Practice Training. A national person specification has been developed to ensure that job opportunities correspond to the educational needs of Foundation Programme graduates and others at that level. Exit from, and subsequent entitlement to being awarded the Certificate of Completion of Training by the PMETB will be subject to satisfactory performance in the RCGP's assessment programme. (The proposals for a new assessment programme (nMRCGP) to confirm satisfactory competition of specialist training for prospective general practitioners are outlined in Annex 11.)

Programmes will usually comprise a *minimum* of eighteen months full time (or part-time *pro rata*) in a GP training practice under the supervision of a general practice trainer. The time spent in practice may be divided up, however, and will normally entail time spent in more than one practice.

Programmes will usually include placements in hospital and community based speciality posts selected on the basis of capacity to deliver the competences defined in the RCGP curriculum. In order to obtain the broadest possible training, it is desirable that experience in any one hospital based speciality will generally not exceed four months though a year in general medicine with specialty clinics may be suitable for others. A preference for posts of shorter duration and experience of more specialties was evident in the outcomes of the national survey of GP Registrars, HPEs and GP Educators[7]. The final 12 months of GP training programmes will normally be sited in general practice. Programmes should finish with time spent in the role for which the trainee is being prepared and dependent on learning needs.

In order to support new developments, innovative training placements will be encouraged to examine their benefits for a GP-relevant primary care experience. Some posts may be based in general practice with secondments to other primary care organisations, such as drug and alcohol teams and hospices; and to acute services, such as outpatients and day hospitals. Others may be based in secondary care but focussed on the needs of the general practice trainee, such as posts structured around out patients and chronic disease or exposure to general practice relevant sub-specialities such as dermatology, rheumatology, ophthalmology and ENT. The preference for greater experience in these sub-specialties was evident in the returns from the national survey.

The curriculum statements have been structured in order for trainers and educators to adapt their use to their stage of training and the post they occupy at a specific time. This is not a linear or chronological curriculum. The first statement on *Being a General Practitioner* (Annex 9) describes the generic professional competences necessary for UK general practice and will be drawn upon at all stages of the training programme. This will also apply to some of the later statements, such as that on *The General Practice Consultation* and *Management in Primary Care*. It can be expected that all others will also be drawn upon when relevant to learning needs but it might be expected that those on *Clinical Management* will be of particular value and greatest use when a trainee is working in a specific hospital specialty.

The use of the curriculum statements in terms of fitness-for-purpose places significant emphasis on the use of personal development plans. An individual trainee's programme will be built around a personal development plan and will be orientated to meeting the learning outcomes defined in the curriculum.

STANDARD 2: CONTENT OF LEARNING

Content

The GP training curriculum is composed of a set of 32 curriculum statements organised into 15 groups:

1. ***The 'Core Statement'*** **- Being a General Practitioner**
2. **The General Practice Consultation**
3. **Personal and Professional responsibilities**
   - **3.1 Clinical Governance**
   - **3.2 Patient Safety**
   - **3.3 Ethics and Values Based Medicine**
   - **3.4 Promoting equality and valuing diversity**
   - **3.5 Evidence Based Health Care**
   - **3.6 Research and Academic Activity**
   - **3.7 Teaching, Mentoring and Clinical Supervision**
4. **Management in Primary Care**
   - **4.1 Management in Primary Care**
   - **4.2 Information Management and Technology**
5. **Healthy People: promoting health and preventing disease**
6. **Genetics in Primary Care**
7. **Care of Acutely Ill People**
8. **Care of Children and Young People**
9. **Care of Older Adults**
10. **Gender-specific Health Issues**
    - **10.1 Women's health**
    - **10.2 Men's health**
11. **Sexual Health**
12. **Care of People with Cancer & Palliative Care**
13. **Care of People with Mental Health Problems**
14. **Care of people with Learning Disabilities**
15. **Clinical Management**
    - **15.1 Cardiovascular problems**
    - **15.2 Digestive problems**
    - **15.3 Drug Usering Adults**
    - **15.4 ENT and facial problems**
    - **15.5 Eye problems**
    - **15.6 Metabolic Problems**
    - **15.7 Neurological problems**
    - **15.8 Respiratory problems**
    - **15.9 Rheumatology and conditions of the musculoskeletal system (including trauma)**
    - **15.10 Skin problems**

The first and the 'Core Statement', *Being a General Practitioner*, describes the holistic competences required for UK general practice (Annex 9) Subsequent statements explore the major topic and disease areas and describe the knowledge, skills and attitudes that will enable a practitioner to demonstrate competence in these specific contexts. The statements are intended to be a resource that will facilitate conversations between teacher and learner and offer a route map, milestones and signposts along the learning journey. Each topic is constructed in the same way:

- the rationale for its inclusion;
- a section on the UK priorities describes the relevant imperatives that drive the service in the UK, such as National Service Frameworks, NICE guidelines etc.;
- a statement of learning outcomes in terms of the knowledge, skills and attitudes that are required to demonstrate the competence in that topic area;
- guidance on teaching and learning resources; and
- a reference section.

In terms of the relationship between the curriculum and *Good Medical Practice*, it was noted earlier that, as part of reviewing curricula models, Dr Justin Allen mapped the content of the WONCA framework to *Good Medical Practice*. Each of the statements contained in this new curriculum has been mapped to statements in these documents to ensure that coverage of the discipline is complete. An illustration of this mapping is provided in Annex 5.

Content and intended outcomes

With respect to learning outcomes, each includes a statement of competences in three groups from '*Needs further development'* to '*Competent*' and *'Excellent'*. The sequencing of learning along these competences will vary with the sequence of posts occupied by trainees. In the case of this specialty, therefore, it would be inappropriate to specify intended learning outcomes in terms of identifiable stages of training. The competence statements do, however, summarise what trainees will know, understand, recognise, be aware of and be able to do at the end of the training programme.

An example is shown in Table 2 on the following page.

Table 2: Making a diagnosis / making decisions

4	Making a diagnosis / making decisions	
This competency is about a conscious, structured approach to decision-making.		
Novice GP (ST 1 level)	Competent GP (CCT level)	Excellent GP (Continuing practice)
Taking relevant data into account, clarifies the problem and the nature of the decision required. Generates and tests an appropriate hypothesis. Makes decisions by applying rules or plans.	Addresses problems that present early and in an undifferentiated way by integrating information to aid pattern recognition. Uses time as a diagnostic tool. Uses an understanding of probability based on prevalence, incidence and natural history of illness to aid decision-making. Revises hypotheses in the light of additional information. Thinks flexibly around problems, generating functional solutions.	Uses methods such as models and scripts to identify patterns quickly and reliably. Uses an analytical approach to novel situations where probability cannot be readily applied. No longer relies on rules alone but is able to use and justify discretionary judgement in situations of uncertainty.

Content and learning experiences

In each curriculum statement, the section on teaching and learning resources includes examples of approaches to learning that are suitable for the particular topic. In the statement on *The General Practice Consultation*, these are:

Work-based learning – in primary care

- Video analysis of consultations
- Random case analysis of a selection of consultations
- Sitting in with GPs and other healthcare professionals in practice to observe different consulting styles
- GP trainer to sit in with the GP Registrar to give formative feedback
- Patients' feedback on consultations using satisfaction questionnaires or tools

Work-based learning – in secondary care

- Observation of consulting behaviour during outpatient clinics

- Reflection on a selection of consultations in different specialties (using log books)

Non-work-based learning

- Courses or teaching using role-played consultations with "standardised patients"
- Peer-group discussions, for example during general practice specialist training scheme half-day release programmes
- Balint groups

STANDARD 3: MODEL OF LEARNING

Taken as a whole, the proposed model of learning combines three aspects. First, it recognises the importance of balance and diversity in the learning contexts that trainees experience. Second, it places emphasis on clarity and transparency of learner outcomes. Professionals and adult learners welcome and often require clarity in relation to what is expected. Third, the pedagogy of learning must recognise the sometimes distinctive requirements of adults as learners. These aspects are briefly considered below and developed more fully in Annexes 7 and 8. Annex 7 is the joint statement produced by the RCGP and COPMED, in 2005, 'Education and training for general practice: a joint curriculum statement from the Royal College of General Practitioners and the Committee of GP Education Directors', which helped provide a framework for discussions about the new curriculum at deanery level. Annex 8 'Specialist training for general practice: Implementation strategy for August 2007' was produced in December 2005 building on the earlier paper to inform deaneries and the UK's Modernising Medical Careers committees[1] about the proposals to enable deaneries to begin preparing for transition and implementation of the proposed new system.

Balance

Teaching and learning in relation to a curriculum for general practice occurs primarily at work. A substantial proportion of this will take place in general practice itself, although it is recognised that a wider training experience, incorporating time spent and competences gained in learning environments outside general practice will form an important contribution to the development of the future general practitioner. In addition to training in the workplace, the learner will also participate in the formal learning opportunities provided through departmental teaching sessions and general practice specialist training seminars and day release activities. It is proposed to continue the well-established approach of regular release from practice, typically through a weekly half-day release programme, an approach that was assessed positively in the national survey of GP Registrars, HPEs and Educators. Teaching and learning in all these contexts will be underpinned by clarity on expected outcomes that are specified in terms of competences.

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[1] Specifically for the UK Modernising Medical Careers Strategy Group and the UK Modernising Medical Careers Advisory Board

Competences as outcomes

In the curriculum statements, competence is used to describe stated achievements on the way to expertise, specifically the ability to use knowledge, understanding, and practical and thinking skills to perform effectively to the national standards required in employment. An individual who is competent has, therefore and by definition, attained the defined standards. They are general attributes incorporating both understanding and judgement, 'a complex structuring of attributes needed for intelligent performance in specific situations'. They are also components of a whole, at once building blocks of professional competence and also inter-related parts of an integrated and holistic whole.

Specifying learning outcomes in these terms allows an overview of competences that relate to general practice and are presented in the curriculum statement *Being a General Practitioner.* It also allows the knowledge or skills unique to each topic or disease-specific area to be clearly specified in their particular context. Taken as a whole, the model of learning proposed combines three aspects. First, it recognises the importance of balance and diversity in the learning contexts that trainees experience. Second, it places emphasis on clarity and transparency of learner outcomes. Professionals and adult learners welcome and deserve clarity in relation to what is expected. Third, the pedagogy of learning must recognise the sometimes distinctive requirements of adults as learners.

Key principles of adult learning

The primary pedagogical relationship in the training programme will be between the trainer (educator) and the learner (GP Registrar), a relationship that will be embedded in active, professional practice. Given the nature of a teacher-learner relationship that is between mature and experienced adults, it would be inappropriate to specify precisely the nature of that relationship. It would be expected and recommended, therefore, that teaching and learning will be organised with attention to the general principles of adult learning. A brief summary of these principles are set out below and developed more fully in Annex 7.

- *Self direction* There is a deep seated need for adults to be self-directed and, typically, in charge of their own learning, though there are times when adult learners will want and need to be told what to do rather than find out for themselves.

- *Experiential* Experience provides the principal resource for adult learning. Experiential learning can be iterative with situations revisited and something being gained each time.

- *Needs-based* An adult's readiness to learn is strongly related to the tasks required for the performance of his or her evolving social role.

- *Problem centred* Adults want to apply tomorrow what they learn today. The appropriate units for teaching and learning, therefore, are situations not subjects.

STANDARD 4: LEARNING EXPERIENCES

The principal relationship

The primary pedagogical relationship in the training programme will be between the GP Trainer and the GP Registrar, a relationship that will be embedded in active, professional practice. Given the nature of the teacher-learner relationship, all the more between mature and experienced adults, it would be inappropriate to specify precisely the nature of that relationship but approaches to the relationship are recommended. Described briefly here, they are developed more fully in Annex 7 *Education and training for general practice: a joint statement from the Royal College of General Practitioners and the Committee of GP Education Directors.*

Approaches to teaching and learning

The principles of adult learning summarised earlier will be practiced and implemented through a variety of approaches

- ***Opportunities for reflection*** -Through reflection 'on practice' and reflection 'in practice' learners have the opportunity to continually remodel their professional behaviours. GP educators should ensure that learners are provided with opportunities to reflect through diaries, feedback, debriefing sessions and peer discussion groups.

- ***Formal learning*** - Formal learning includes planned tutorials, day-release on the specialist training for general practice scheme, departmental training activities and external courses.

- ***Informal learning*** - The greater proportion of learning is likely to take place informally in the workplace, where it may be *implicit*, *reactive* or *deliberative*.

- ***Education as apprenticeship*** - The programme will include an element of apprenticeship, historically understood as a pupil working alongside a master in the workplace in a bounded training relationship but here defined as education and service blended together for professional growth through "legitimate peripheral participation in a community of practice".

- ***Inter-professional and multi-professional learning*** - Primary care is a multi-disciplinary activity and this should be reflected in the training programmes for future general practitioners.

- ***Preparation for life-long learning*** - GP training is just the start of a career of life-long learning and must be alert to opportunities for developing the commitment and skills to be a lifelong leaner.

- ***Assessment*** - Teaching demands assessment. Monitoring what has been learnt is embedded in good teaching as a means of providing feedback on what has been learnt. Formative assessment *for* learning and summative assessment *of* learning are both parts of the approach recommended for GP training.

Each curriculum statement gives examples of approaches to learning that are suitable to that topic and are supported by possible resources that the learner and educator can draw upon. Further details on the proposals for a new assessment programme (nMRCGP) to confirm satisfactory competition of specialist training for prospective general practitioners are given in Annex 11.

STANDARD 5: SUPERVISION AND FEEDBACK

The PMETB is ultimately responsible for the approval and quality assurance of postgraduate medical education and training for all specialties, including general practice. Assuring that the standard of quality set out in this RCGP training curriculum is achieved is a shared responsibility between the PMETB, the RCGP, the COGPED, the Postgraduate Deaneries, the training sites and the GP Trainers. Their respective roles are summarised below.

Mechanisms for supervision of practice and safety

Royal College of General Practitioners

It is the responsibility of the RCGP to recommend quality standards for training to the PMETB and in partnership with COGPED propose a framework for ensuring these standards are achieved. Working through its Postgraduate Training Committee, the RCGP will undertake a regular review so that quality standards meet changing contexts and expectations. Its *Guidance* defines those for deaneries, training practices and trainers.

COGPED and deaneries

For deaneries, standards address the:

- quality assurance processes for monitoring training environments;
- clinical standards of trainers;
- quality of supervision;
- level of supervision;
- needs of patient safety; and
- hospital, mental health and other specialist placements for GP registrars.

A system of deanery-based quality assurance of training practices and trainers has been in place for many years built on standards defined by the Joint Committee on Postgraduate Training for General Practice (JCPTGP). These processes examine both the training practice as a suitable environment in which to learn but also the clinical standards of the doctor, level of supervision and regard for patient safety. Such quality assurance mechanisms will be built on and developed in accordance with direction from the PMETB.

In managing the selection of GP Trainers, formal application procedures are required, selection criteria must be transparent and practice visits undertaken. Initial

appointment will be for two years and, subject to continuing to meet deanery criteria that will reflect the national framework, re-selection will normally be for three years. Deaneries should state their expectations of trainers in terms that can be assessed.

In the secondary care environment, hospital placements are subject to monitoring by deaneries which themselves are subject to a national programme of quality assurance previously overseen by the JCPTGP. It is assumed that oversight of these quality assurance processes will be taken over and revised as appropriate by the PMETB working in partnership with the RCGP.

The GP Training Practice

For GP training practices, standards address:

- the characteristics of a training practice; and
- the resources available in the practice.

Each GP training practice must meet high clinical, organisational, professional and educational standards and be committed to specialist training for general practice. All GP Trainers and educational supervisors will be trained to be competent in teaching and assessment and the delivery of the curriculum will be monitored through regular quality assurance. Time spent in practice may be divided up within the three-year training experience and will normally entail time spent in more than one practice.

Each practice must have and use good quality resources and infrastructure in terms of premises, management and administrative systems, IT for management and consultations, access to hospital services and library and teaching aids.

The workload for a GP Registrar must ensure a balance between clinical experience and other learning opportunities.

The Trainer

For trainers, standards address:

- the attributes of the GP Trainer as a doctor;
- the qualities of the GP Trainer as a teacher;
- the personal qualities of the GP Trainer;
- how GP Trainers maintain their teaching skills;
- the time set aside for teaching; and
- how teaching abilities are monitored.

The relationship between GP Registrars and their educational supervisors is at the heart of the teaching and learning process whereby trainees acquire and develop the knowledge, skills and attitudes required to become an effective GP. It is the responsibility of the educational supervisor to oversee and support the GP Registrar's progress. As such they must have appropriate professional attributes, personal qualities and training to equip them for this role.

Most of a GP Registrar's learning will derive from seeing and contributing to good quality patient care and the greatest influence on them is the example presented by their trainer as doctor. For this reason, GP Trainers must be enthusiastic, competent and caring general practitioners working in well-organised practices. They must also be expected to know and accept the responsibilities of the role. The content of teaching throughout a GP Registrar's attachment will relate to individual needs and aims identified by the GP Trainer and GP Registrar and these form the basis upon which the teaching programme is planned and weekly timetable arranged.

Enthusiasm for general practice must also apply to learning and their willingness to develop further as clinical teachers. GP Trainers require additional knowledge and new skills over and above those of non-teaching colleagues and contributions to specialist training for general practice activities outside the practice also illustrates their commitment to teaching. GP Trainers must also prepare carefully for their teaching responsibilities and may have benefited from other teaching experience, for example with medical students or other health professionals. They should also be willing to be appraised by their peers and encourage trainees to adopt a similar critical approach to their work.

Mechanisms for feedback on learning

Formative assessment is at the core of feedback on learning. A variety of techniques are available to support formative assessment and feedback and include learning portfolios, logbooks, reflective diaries, use of video and audio consultations as well as sessions when the GP Registrar and GP Trainer consult jointly. While the JCPTGP expected deaneries to develop their own policies, methods and practices for formative assessment, the PMETB requires these to be in place and this will be assured through the mechanisms described above.

The GP Trainer must ensure that formative assessment is a regular and continuing part of the whole of the period of training. Training needs must be agreed at the start of the programme and regularly reviewed and reassessed through the training period with detailed reviews occurring at agreed intervals. How clinical and management problems have been handled must be discussed regularly with the GP Registrar and a contemporaneous written record of training and assessments maintained that shows that all important aspects of the training programme have been covered. Once identified, potential problems should be discussed with the local deanery's Director of Postgraduate GP Education and any necessary remedial training arranged.

Satisfactory completion of training will require formal processes of summative assessment. The RCGP's proposals for these are submitted to the PMETB Assessment Committee through a separate submission, but are outlined in Annex 11.

STANDARD 6: MANAGING CURRICIULUM IMPLEMENTATION

Management

The RCGP curriculum will be delivered through a 'School of Postgraduate General Practice Education' in each of the UK deaneries. Each school is led by a Director[2] of Postgraduate General Practice Education who manages a network of GP educators and GP Trainers. The overall structure of management is described below and includes a summary of the roles and responsibilities of members of that structure in relation to curriculum implementation.

Structure

Proposed deanery management of the GP training scheme is based on line management with responsibilities and accountabilities linked to individuals in placements not committees, and this will be set out in job descriptions. Overall responsibility will be with a Director of Postgraduate GP Education who will be accountable to the Postgraduate Dean. The Director will be advised by the deanery's Postgraduate General Practice Education Committee which will include representatives of the RCGP. While they may choose to work on the basis of majority view of that committee, responsibility for implementation of policy and accountability for their outcomes will rest with the Director. The Director will be supported by associate directors who will be responsible for activities in a geographical area within a deanery. Within each geographical area, programme directors will be responsible for a set of programmes and an individual programme will be overseen by a training mentor supported by the expertise and resources of a local team, further details of which are described below.

It should be noted that 'School' refers to all the GP training provided by a deanery, 'programme' to the training experience of an individual trainee and 'attachment' to a specific post or placement within a programme. The overall management of a school, programmes within schemes and of attachments within programmes is outlined below.

School management

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[2] Also known in some deaneries as the Dean of Postgraduate GP Education

A Director of Postgraduate GP Education has overall responsibility for the delivery and quality assurance of all the programmes and supervision provided within the deanery's school of postgraduate general practice education. This includes responsibility for ensuring that in the school and its component programmes, the learning outcomes of the RCGP curriculum are secured. Principal responsibilities are to:

- deliver and quality assure the specialist training for general practice;
- connect the recruitment, appointment and workforce planning of all GP training grades in the NHS across the four countries of the UK;
- increase flexibility within schools of postgraduate general practice education;
- ensure the most appropriate training programme for each individual; and
- provide careers advice for aspiring GPs including doctors who wish to change career.

Directors will be supported in this role by the School's Committee of Postgraduate General Practice Education whose membership will include: service representatives; RCGP representatives; GP trainers; GP registrars; associate directors; programme directors; and other stakeholders, such as representatives of patient groups.

The final structure will vary with the size of deanery and other local circumstances. As outlined here, associate directors will have overall responsibility for the training scheme for a substantial geographical area within a deanery and, working within the policies approved by the director as advised by the Committee of Postgraduate GP Education, will be responsible to the director for successful implementation of policy.

Programme management

Within each geographical area, programme directors will be responsible for a set of individual programmes. Programme directors will be responsible for designing and maintaining fit-for-purpose educational experiences for trainees, including a variety of general practice, hospital and innovative posts and programmes of seminars and courses matched to the needs of learners and the agreed curriculum. They will work with a team of educators who may have responsibilities across programmes, and trainers with specific responsibility for the progress of one or more trainees.

The individual programme for a trainee will be the responsibility of a single trainer or mentor who will work with others – the local faculty team - in monitoring and supporting the progress of a trainee throughout the three years of a programme or, subject to individual circumstances, any variant of that time.

Implementation and coverage

Each trainee will have one person nominated as their GP Trainer. This will be a GP who will be responsible for overseeing the educational progress of the learner, delivering the learning outcomes defined in the curriculum and maintaining the learning environment or training practice to a standard of quality defined by the deanery. The GP Trainer is also responsible for the assessment of the learner, both formative and summative, although the judgment of the trainer will form only one part of the overall assessment strategy. It is through this process that curriculum coverage will be monitored and gaps identified. Responding to such gaps will depend on their nature. Many will be resolved by the local team working within one programme while an additional attachment may require the involvement of a programme director or an associate director.

The local team will support the mentor in contributing to each programme. Members of the team will include: a GP trainer from a different practice to the main GP attachment; educational supervisors, such as hospital consultants, with responsibility for specific attachments in secondary care; and other GPs who will supervise aspects of a trainees' practice, such as out-of-hours training and family planning clinics.

It is this local team who will be central to ensuring coverage of the curriculum. That this is achieved will be monitored through processes of formative assessment against the competency statements in the curriculum and the maintenance and completion of portfolios. The curriculum statements as a set go well beyond statements of competences. As guidance on approaches to teaching and learning and as a resource for learning materials, they are source materials for all educators in the local team as well as for the trainees. In relation to hospital attachments, for example, the statements offer guidance to hospital consultants and trainees on the learning outcomes associated with specific specialties.

Responsibility for successful completion of the GP training programme does not only rest with GP Trainers and educators. Trainees themselves bear the greatest responsibility for their learning, not least because this reflects their professional responsibilities and their position as adult learners but also because of the importance of securing a long term commitment to their personal and professional development. Success as a general practitioner depends upon them becoming lifelong learners. Responsibility for their own learning is supported by the design of the curriculum and related documents on formative assessment. The curriculum's explicit definition of learning outcomes and competences gives clarity to the goals of

trainees as learners and assists them in assessing their own progress. No less important in supporting self-managed learning is the inclusion of advice on approaches to learning and learning resources, not only placing responsibilities for learning on the trainee but supporting the means for achieving them. Added to these are the techniques for supporting formative assessment set out in the section on 'Supervision and feedback'.

STANDARD 7: CURRICULUM REVIEW AND UPDATING

Plans for review, evaluation and monitoring

There are six parts to the process of curriculum review and updating.

- Annual review of each curriculum statement
- Annual deanery review of regularly generated data
- Annual national review of regularly generated data
- Five year cycle of major reviews of curriculum statements
- Comprehensive review every six years
- Commissioned research

Annual review of each curriculum statement

Each curriculum statement has a named 'Guardian'; Guardians will be responsible for an annual monitoring of their statement and to propose any necessary changes to the RCGP Postgraduate Training Committee. The aim here is for a light touch and modification only if necessary. For example, the outbreak of SARS might have required a modification to the relevant statement. During the year, a guardian might have identified a valuable new teaching resource and decides to include this but this would not be an expectation of a process where the emphasis will be on necessary changes. Any changes would be included in a single section of modifications placed at the end of the curriculum document.

Annual Deanery review of regularly generated data

In every Deanery, a range of data will be generated each year. These include:

- quality assurance reports, including the PMETB's annual survey of trainees,
- a tracking protocol on aspects of performance
- RITA performance data;
- GP Registrar performance in the RCGP assessment programme;
- Exit survey data that shows results for the deanery as compared with the national results; and
- reported expert views of educators in the deanery.

These data will be the basis of an annual assessment of how the curriculum is working within a deanery area and would be the basis of modifications to planned

programmes of teaching and learning. Clearly, the nature and scale of response to these reviews will be contingent to the nature of the evidence on performance.

In terms of management, the review will be the responsibility of the Director of Postgraduate GP Education working to their Postgraduate Dean, who will submit a report and supporting data to the deanery's postgraduate general practice education school committee. A major responsibility of the committee will be to review these data and make any necessary recommendations on change.

Annual national review of regularly generated data

On behalf of the RCGP, COGPED will undertake an annual review of the curriculum. Its data will include:

- The annual reports from each deanery as defined above
- National data on RITA performance
- National data on GP Registrar performance in summative assessment
- The national exit survey data

COGPED's consideration of these data, their conclusions and recommendations for action will be reported to the RCGP who will act on these as appropriate.

Cycle of major reviews of curriculum statements

There are 32 curriculum statements and, over a five-year cycle, at least six statements each year will be the subject of major reviews, their sequencing a product of views and outcomes from the deanery and national reviews described above.

A major review will follow the same format as the approach taken in preparing the original statements. A nominated 'Guardian' will have overall responsibility for coordinating the review process who will have a small team to work on the review, testing proposals with focus groups of general practitioners. Drafts of revised statements will be sent to the RCGP's patient group for consideration and draft statements will also be sent to each deanery so that their postgraduate GP education school committees have an opportunity to comment. Revised statements will go to COGPED before submission for final approval to the RCGP.

Comprehensive review

Whilst the cyclical review will work within the existing framework, a major review after six years will enable the RCGP to undertake a root and branch revision that can

address all aspects of the curriculum. Its outcome may well be a quite different document to that submitted here and, if so, we would expect the PMETB to require its submission for their approval.

Commissioned research

At any time, a deanery, a group of deaneries, COGPED on behalf of all deaneries or the RCGP may decide to commission research on an aspect of the curriculum that, in their view, requires consideration. Results from such projects would be included into appropriate parts of the review processes outlined here.

Nearer the time of its six-year major review, consideration will be given to the need for and likely benefits of commissioned research to support that process.

Schedule for updating

The time schedule represented in the review processes described above is summarised in Table3 below.

<table>
<tr><th>Year</th><th>Annual</th><th>Five year cycle</th><th>Six years</th><th>Research</th></tr>
<tr><td>2008</td><td rowspan="6">Every statement reviewed annually by its 'Guardian' who will recommend modifications. All modifications to be published together at the end of the curriculum statements</td><td>Six statements to be reviewed each year. With 30 statements, all statements will have been subject to a major review over five years, beginning in 2008 and completed by 2012.</td><td rowspan="4">By 2013, the curriculum will have been subject to a root and branch review.

The review will take two years, beginning in 2012 and completed in 2013.</td><td rowspan="6">Projects devised and undertaken as appropriate</td></tr>
<tr><td>2009</td><td>12 completed</td></tr>
<tr><td>2010</td><td>18 completed</td></tr>
<tr><td>2011</td><td>24 completed</td></tr>
<tr><td>2012</td><td>30 completed</td><td>Total review begins</td></tr>
<tr><td>2013</td><td>No statements reviewed</td><td>Total review completed</td></tr>
</table>

Role of trainees and lay persons

GP registrars, lay persons, the public and other health professional groups will be involved in review and monitoring in several ways.

- The annual review conducted by each deanery and by COGPED will draw upon data from the exit survey completed by GP Registrars.
- As members of the deanery's postgraduate general practice education school committee, trainees, lay persons are part of each Deanery's annual review process.
- GP Registrars will be included in the five-year cycle reviewing five statements annually. Patient groups will also be consulted through this review process.
- As with the current process, the root and branch review in 2012 and 2013 will draw upon the views of GP Registrars, patients, health professionals and other lay persons.
- Depending on the nature of the research, some projects will draw on the views of a wide range of people.

Changing contexts

The review and monitoring plan drawn up here must be sensitive to changing circumstances and contexts. For example, changes in government policy or other unanticipated circumstances may require modifications to these proposals.

STANDARD 8: EQUALITY AND DIVERSITY

The commitment to equality and diversity is succinctly expressed in *Education and training for general practice: a joint statement from the RCGP and COGPED*:

> Selection for general practice training will be conducted in accordance with best equal opportunities practice and a programme of continuous monitoring will be established to ensure that this policy is adhered to.
>
> In delivering the curriculum, educationalists and educational managers must be mindful of the diverse needs of learners and the multi-cultural, multi-ethnic and multi-faith nature of the NHS workforce. All reasonable steps should be taken to ensure that the broadest possible curriculum is delivered flexibly to all learners and that no individual or group is disadvantaged. A policy of inclusion will be adopted by deaneries that values diversity, ensuring that all learners, irrespective of age, ability, gender, ethnicity, language and social background have access to learning and participatory practices appropriate to their needs.

The commitment can be further illustrated by reference to:

- the selection process for specialist training for general practice;
- the RCGP Curriculum Statement on *Promoting equality and valuing diversity* (Annex 10) and
- research

Selection process for specialist training for general practice

The *joint statement* in Annex 7 sets out the approach to a national selection process for applicants for GP training and notes that 'all recruits to the workforce should be appointed with due regard to equal opportunities'. In the GP selection process this will be facilitated by training all those involved, is further supported by the nature of the person specification for applicants as well as by scrutiny of the data collected by each deanery on the demographic profile of applicants and those selected. These data are itemised in s. 6 of Annex 7, the *joint statement*.

Curriculum statements

The curriculum statements manifest the RCGP's commitment to equality and diversity in three distinct ways: overall framework; content of statements; and a statement on equality and diversity.

Overall framework

The nature of domains of competence based on *The European Definition of General Practice/Family Medicine* ensures prominence to issues of equality and diversity. Domain 2: Person-centred care', 'Domain 6: Holistic approach' and 'Essential feature 1: Contextual aspects' all include explicit reference to factors such as:

- the development of a frame of reference to understand and deal with the family, community, social and cultural dimensions in a person's attitudes, values and beliefs;
- knowledge of the cultural background and beliefs of the patient;
- tolerance and understanding towards patients' experiences, beliefs, values and expectations; and
- socio-economic factors; geography and culture

Their use as the framework for every curriculum statement means these factors have been taken into account in relation to the areas covered.

Content statements

An example of how the commitment to equality and diversity is manifest in individual statements is drawn from the statement on *The Consultation* where the first learning outcome involves demonstrating:

> an understanding of the context in which the consultation happens [and] with patients this means recognising that patients are diverse: that their behaviour and attitudes vary for example by age, gender, ethnicity, social background and as individuals

The statement goes on to recognise that a number of demonstrable competences follow from this first stage of recognition.

Equality and diversity

In order to ensure the importance of equality and diversity is apparent to all involved with the use of the curriculum, there is also a separate statement on *Equality and*

Diversity (3.4 Promoting equality and valuing diversity). (Annex 10) It includes a definition of the terms, an outline of the legal context, the significance of the issues for health inequalities and a set of 14 items of knowledge, skills and attitudes that are necessary for ensuring competency in this area.

Research

The commitment of the specialty of general practice to equality and diversity is also supported by some of the research projects undertaken in the field. Significant among these are recent studies underpinning changes in recruitment and selection where studies have been concerned to examine whether and, if so, to what extent existing selection processes have been discriminatory. Given its importance, this commitment will continue.

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[3] WONCA Europe (The European Society of General Practice / Family Medicine) The European Definition of General Practice/Family Medicine Barcelona: WONCA, 2002

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[5] Department of Health, Curriculum for the Foundation Years in Postgraduate Education and Training London: Department of Health, 2005

[6] Department of Health and the RCGP, Implementing a scheme for General Practitioners with Special Interests London: Department of Health, 2002

[7] Fraser A, Thomas H, Deighan D, Bedward J, Davison I, Field SJ, Kelly SD Training for General Practice in the United Kingdom: A National Survey (Submitted for publication November, 2005)