



Royal College of
General Practitioners

The Learning and Teaching Guide

Version 3.3 (March 2009)



ACKNOWLEDGMENTS

This guide is derived from the RCGP core curriculum *Being a General Practitioner* (principal authors: Professor Justin Allen, Professor Jan Heyrman, Professor Bernard Gay, Professor Harry Crebolder, Professor Igor Svab, Dr Paul Ram, Dr Mike Deighan, Professor Steve Field, Dr Adam Fraser, Professor Hywel Thomas and Dr Arthur Hibble) and *The RCGP Training Curriculum; Part One: a statement on the eight PMETB standards for curricula*, a submission to the Postgraduate Medical Education and Training Board (PMETB) (principal authors: Professor Hywel Thomas, Professor Steve Field, Dr Arthur Hibble, Dr Tim Swanwick and Dr Bill Reith).

Being a General Practitioner was itself derived from *The European Definition of General Practice/Family Medicine*¹ and The EURACT Educational Agenda.²

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The ongoing support and work of the RCGP curriculum development group is gratefully acknowledged: Dr Les Ashton, Professor Justin Allen, Ms Julie Bedward, Dr Jill Edwards, Dr Dan Faller, Dr Arthur Hibble, Dr Christine Johnson, Dr Jane Mamelok, Dr Ben Riley, Dr Amar Rughani, and Professor Charlotte Tulinius.

Version 3.3: March 2009

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CONTENTS

About the RCGP Curriculum.....	5
Development.....	6
Curriculum Content.....	7
The Core Curriculum.....	7
The RCGP Domains of Competence.....	7
Domain 1 – Primary care management.....	9
Domain 2 – Person-centred care.....	12
Domain 3 – Specific problem-solving skills.....	14
Domain 4 – A comprehensive approach.....	17
Domain 5 – Community orientation.....	19
Domain 6 – A holistic approach.....	21
Essential features of the discipline of general practice.....	23
Essential feature 1 – Contextual aspects.....	24
Essential feature 2 – Attitudinal aspects.....	24
Essential feature 3 – Scientific aspects.....	25
The interpretive curriculum statements.....	26
Learning and Teaching.....	27
The process of learning.....	27
The apprenticeship model.....	28
Specialist training for general practice – programmes of learning.....	30
Learning opportunities within primary care.....	30
Individual journeys through the curriculum.....	31
Learning opportunities outside primary care.....	31
Curriculum Resources.....	33

A Living Curriculum.....	34
Review, evaluation and monitoring of the curriculum	34
Assessment.....	37
Assessment for learning	37
Assessment of competence	38
Supervision.....	41
Individual roles and responsibilities.....	41
The trainer’s role in assessment	43
Scheduled reviews during training.....	45
Equality and Diversity	47
Appendix 1: Core and Interpretive Statements.....	48
Appendix 2: The MRCGP Competence Framework	49
References	51

ABOUT THE RCGP CURRICULUM

The RCGP curriculum is for UK doctors training for general practice, their trainers and educational supervisors. It covers the period known as *Specialty Training for General Practice*: from the end of the Foundation Programme to the award of a Certificate of Completion of Training (CCT). It assumes that trainees have already attained the core competences of the Foundation Programme.

Set within a framework for a structured educational programme, the RCGP curriculum identifies the knowledge, skills, and professional attitudes required of a doctor intending to undertake independent practice in the contemporary UK National Health Service.

Since August 2007, all UK Specialty Training programmes for general practice have been based on the RCGP Curriculum, which has been unconditionally approved by the Postgraduate Medical Education and Training Board (PMETB). The curriculum is also the educational framework adopted by the RCGP for Continuing Professional Development (CPD) and revalidation.

DEVELOPMENT

In this document we describe the competences needed to be a general practitioner (GP) in the UK. The aim of specialty training for general practice is to produce a doctor able to care for patients with equal regard for science and caring.

The competences of Good Medical Practice

The GP curriculum described here addresses all sections of the General Medical Council's key document *Good Medical Practice* (2002). It deals with the generic professional competences of *Good Medical Practice* that GPs share with other physicians as well as those competences that are distinctive to general practice. *Good Medical Practice* is familiar to all doctors completing foundation programmes and will continue to form the basis of annual appraisal. The curriculum emphasises six domains of competence that are essential to becoming a GP. These are described in the next section, 'Curriculum content'. Appendix 1: *Good Medical Practice* demonstrates how these domains are integrated with *Good Medical Practice*.

How this curriculum was developed

Curriculum working groups were created by the Education Network of the Royal College of General Practitioners. One dealt with Teaching and Learning and the other with Assessment. Each group had lay and GP trainee representation.

A literature review was commissioned from the Centre for Research into Medical and Dental Education at the University of Birmingham. At the same time an extensive consultation exercise was carried out in partnership with the NHS West Midlands Workforce Deanery, which involved:

1. A national questionnaire survey of the views of trainees and GP educators on training for general practice
2. Meetings with lay representatives and GP trainees
3. Focus groups and presentations at national and international conferences to share findings and explore perspectives on them.

Following consultation, the core curriculum statement was written together with more detailed interpretive statements. The statements were circulated in draft form to lay and trainee representatives as well as specialist interest groups within the RCGP and posted on the RCGP website. There followed a period of formal consultation prior to formal submission to the Postgraduate Medical Education and Training Board (PMETB), which granted unconditional approval to the curriculum in 2007.

CURRICULUM CONTENT

The Core Curriculum

Being a General Practitioner is the core curriculum. This defines the learning outcomes for the discipline of general practice and describes the skills required to practise medicine as a general practitioner in the NHS. *Being a General Practitioner* is applicable to all aspects of general practice.

The RCGP Domains of Competence

Being a General Practitioner sets out six domains of competence that define general practice as a specialty.

The first three domains have as their focal point the primary care consultation:

1. Primary care management
2. Person-centred care
3. Specific problem-solving skills.

The remaining domains are more complex and take a wider perspective, extending beyond the immediate GP-patient interaction in the consulting room:

4. A comprehensive approach
5. Community orientation
6. A holistic approach.

These domains of competence have been drawn from the EURACT Educational Agenda² (Figure 1) and are explained in detail below.

Knowledge, skills and attitudes

The learning outcomes in *Being a General Practitioner* detail the competences expected from the learner at the end of specialist training for general practice. They can be categorised as Knowledge, Skills or Attitudes and are indicated by K, S or A as appropriate in the following pages.

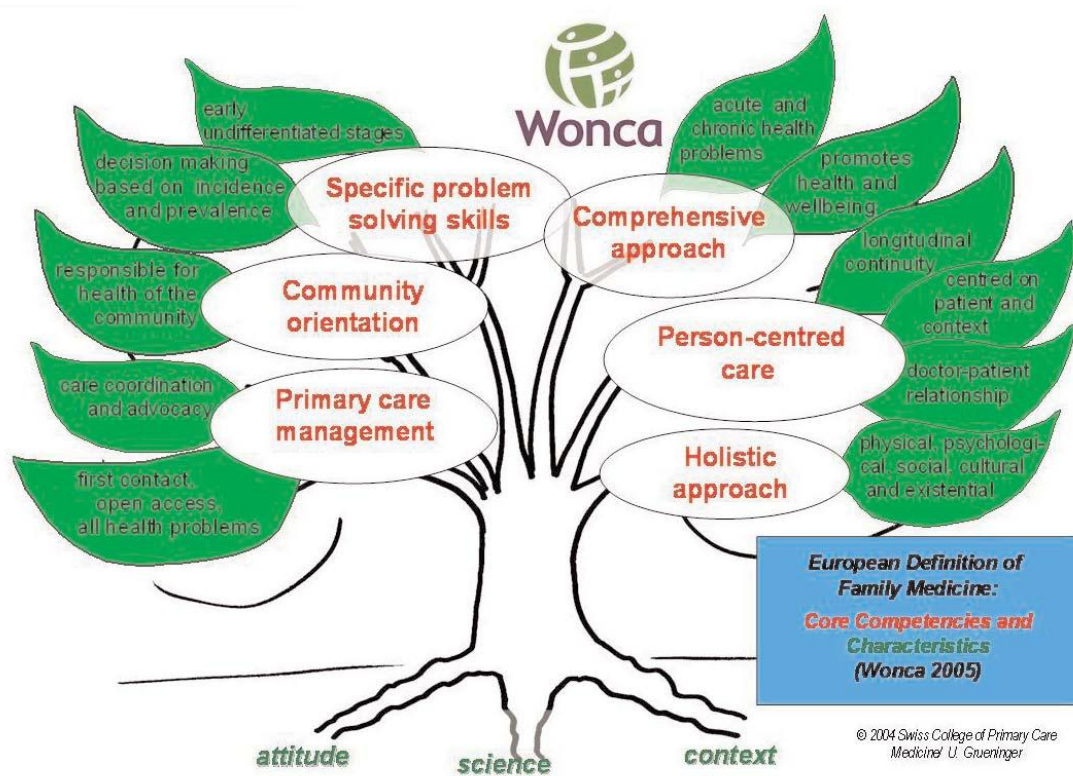


Figure 1: The Domains of Core Competence of General Practice

Domain 1 – Primary care management

In caring for patients, GPs work with an extended team of other professionals in primary care within their own practice and in the local community, as well as with specialists in secondary care. Doctors training for general practice must learn the importance of supporting patients' decisions about the management of their health problems and communicating how that care will be delivered by the NHS team as a whole.

Primary care management is concerned with the ability:

- *to manage primary contact with patients, dealing with unselected problems*
- *to cover the full range of health conditions*
- *to co-ordinate care with other professionals in primary care and with other specialists*
- *to master effective and appropriate care provision and health service utilisation*
- *to make available to the patient the appropriate services within the healthcare system*
- *to act as an advocate for the patient.*

Links with other domains

Primary care management links with:

- specific problem-solving skills: in diagnosis and in the use of the epidemiology of problems presenting in primary care
- a comprehensive approach: prioritising among multiple problems
- community orientation: in making effective use of resources
- person-centred care: in the importance given to supporting patients' decisions and the skills needed to communicate management options.

Learning outcomes for Primary Care Management

Managing primary contact with patients, dealing with unselected problems requires:

- K* Knowledge of the epidemiology of problems presenting in primary care
- S* Mastering an approach that allows easy access for patients with unselected problems
- S* An organisational approach to the management of chronic conditions
- K* Knowledge of conditions encountered in primary care and their treatment.

Covering the full range of health conditions requires:

- K* Knowledge of preventative activities required in the practice of primary care
- S* Skills in acute, chronic, preventative, palliative and emergency care
- S* Clinical skills in history-taking, physical examination and use of ancillary tests to diagnose conditions presented by patients in primary care
- S* Skills in therapeutics, including drug and non-drug approaches to treatment of these conditions
- S* The ability to prioritise problems.

Co-ordinating care with other professionals in primary care and with other specialists requires:

- K* Knowing how NHS primary care is organised
- K* Understanding the importance of excellent communication with patients and staff
- S* Skills in effective teamwork.

Mastering effective and appropriate care provision and health service utilisation requires:

- K* Knowledge of the structure of the healthcare system and the function of primary care within the wider NHS
- K* Understanding the processes of referral into secondary care and other care pathways
- S* Skills in managing the interface between primary and secondary care.

Making available to the patient the appropriate services within the healthcare system requires:

- S* Communications skills for counselling, teaching and treating patients and their families/carers
- S* Organisational skills for record-keeping, information management, teamwork, running a practice and auditing the quality of care.

Acting as an advocate for the patient requires:

- A* Developing and maintaining a relationship, and a style of communication that treats the patient as an equal and does not patronise the patient
- S* Skills in effective leadership, negotiation and compromise.

Domain 2 – Person-centred care

McWhinney identified three core principles of patient-centred care:³

1. Committing to the person rather than to a particular body of knowledge
2. Seeking to understand the context of the illness
3. Attaching importance to the subjective aspects of medicine.

A person-centred approach is more than just a way of acting; it is a way of thinking. It means always seeing the patient as a unique person in a unique context, and taking into account patient preferences and expectations at every step in a patient-centred consultation.⁴ Sharing the management of problems with the patient and disagreement over how to use limited resources in a fair manner may raise ethical issues that challenge the doctor; the ability to resolve these issues without damaging the doctor–patient relationship is important.

Person-centred care places great emphasis on the continuity of the relationship process. McWhinney stresses that the key word is responsibility, not personal availability at all times.³

Person-centred care is concerned with the ability:

- *to adopt a person-centred approach in dealing with patients and their problems, both in the context of patient's circumstances*
- *to use the general practice consultation to bring about an effective doctor–patient relationship, always respecting the patient's autonomy*
- *to communicate, to set priorities and to act in partnership*
- *to provide long-term continuity of care as determined by the needs of the patient, referring to continuing and co-ordinated care management.*

Links with other domains

Person-centred care links with:

- primary care management: in offering patients true autonomy
- a holistic approach (see 'Holism and patient-centredness').

Learning outcomes for person-centred care

Adopting a person-centred approach in dealing with patients and their problems in the context of patient's circumstances requires:

- K* The basic scientific knowledge and understanding of the individual, together with their aims and expectations in life
- K* The development of a frame of reference to understand and deal with the family, community, social & cultural dimensions in a person's attitudes, values & beliefs
- K* Mastering patient illness and disease concepts
- S* The skills and attitudes to apply these in practice.

Using the general practice consultation to bring about an effective doctor-patient relationship whilst respecting the patient's autonomy requires:

- S* Adopting a patient-centred consultation model that explores the patient's ideas, concerns and expectations, integrates the doctor's agenda, finds common ground and negotiates a mutual plan for the future
- S* Communicating findings in a comprehensible way, helping patients to reflect on their own concepts and finding common ground for further decision-making
- A* Making decisions that respect the patient's autonomy
- A* Being aware of subjectivity in the medical relationship, from both the patient's side (feelings, values and preferences) and from the doctor's side (self-awareness of values, attitudes and feelings).

Communicating to set priorities and to act in partnership requires:

- A* The skills and attitude to establish a partnership
- S* The skills and attitude to achieve a balance between emotional distance and proximity to the patient.

Providing long-term continuity of care and co-ordinated care management as determined by the needs of the patient requires:

- K* An understanding of and mastering of the three aspects of continuity: personal continuity; episodic continuity (making the appropriate medical information available for each patient contact); and continuity of care (24 hours a day and 365 days a year)
- S* The ability to help the patient understand and achieve an appropriate work-life balance
- S* The ability to utilise disease registers and data-recording templates effectively for opportunistic and planned monitoring of problems to ensure continuity of care between different healthcare providers.

Domain 3 – Specific problem-solving skills

Problem-solving in general practice is highly context-specific. The skills required relate to the context in which the problems are encountered, the natural history of the problems themselves, the personal characteristics of patients, the personal characteristics of the doctors who manage them and the resources they have at their disposal.

Focusing on problem-solving is a crucial part of specialty training for general practice because family doctors need to adopt a problem-based approach rather than a disease-based approach. Because most learning occurs in secondary care environments, trainees need to adjust to the differences in problem-solving between general practice and hospital work. These differences were described by Marinker⁵ in the following terms:

<i>General Practitioner's approach</i>	<i>Hospital specialist's approach</i>
Tolerate uncertainty	Reduce uncertainty
Explore probability	Explore possibility
Marginalise danger	Marginalise error

Although this model polarises these two situations, it provides some useful pointers, and each learner will need to work out how differences occur in specific clinical contexts.

Certain models of general practice problem-solving should be considered: the hypothetic–deductive model was described by Marinker⁶ and Sackett *et al.*⁷ Another approach is to use pattern recognition or learning scripts, which clarify the problem-solving strategy of the doctor and can be employed in teaching about specific cases.⁸ Other consultation frameworks may assist learners in understanding this topic (Pendleton,⁹ Stott and Davis,¹⁰ Neighbour,¹¹ Cambridge–Calgary¹²).

Use of time as part of the diagnostic process, incremental investigation and coping with uncertainty are each part of the skill of general practice. There is a growing body of literature on these topics to support teachers and learners.¹³

Specific problem-solving skills are concerned with the ability:

- *to relate specific decision-making processes to the prevalence and incidence of illness in the community*
- *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*
- *to adopt appropriate working principles (e.g. incremental investigation, using time as a tool), and to tolerate uncertainty*
- *to intervene urgently when necessary*

- *to manage conditions that may present early and in an undifferentiated way*
- *to make effective and efficient use of diagnostic and therapeutic interventions.*

Links with other domains

The specific problem-solving skills domain links with:

- primary care management: because it involves tolerating uncertainty and this often affects the decision to refer.

Learning outcomes for specific problem-solving skills

Relating specific decision-making processes to the prevalence and incidence of illness in the community requires:

- K* Knowledge of the prevalence and incidence of disease
- K* Knowledge of the practice community (age–sex distribution, prevalence of chronic diseases)
- S* Skills to apply specific decision-making (using tools such as clinical reasoning and decision rules).

Selectively gathering and interpreting information from history-taking, physical examination and investigations, and applying it to an appropriate management plan in collaboration with the patient requires:

- K* Knowledge of relevant questions in the history and items in the physical examination relevant to the problem presented
- K* Knowledge of the patient’s relevant context, including family and social factors
- K* Knowledge of available investigations and treatment resources
- S* History-taking and physical examination skills, and skills in interpreting data
- A* A willingness to involve the patient in the management plan.

Adopting appropriate working principles (e.g. incremental investigation, using time as a tool) and tolerating uncertainty requires:

- A* Adopting skills and attitudes to demonstrate curiosity, diligence and caring
- S* Adopting stepwise procedures in medical decision-making, using time as a diagnostic and therapeutic tool
- A* Understanding and acceptance of the inevitability of uncertainty in primary care problem-solving and development of strategies that demonstrate this.

Intervening urgently when necessary requires:

- S* Specific decision-making skills for emergency situations
- S* Specific skills in emergency procedures that may occur in primary care situations.

Managing conditions that may present early and in an undifferentiated way requires:

- S* Knowledge of when to wait and reassure, and when to initiate additional diagnostic and therapeutic action.

Making effective and efficient use of diagnostic and therapeutic interventions requires:

- K* Knowledge that symptoms and signs vary in their predictive value, as do findings from ancillary tests
- K* An understanding of the cost-efficiency and cost-benefit of tests and treatments.

Domain 4 – A comprehensive approach

GPs need to be able to address multiple complaints and co-morbidity in the patients for whom they care. When patients seek medical assistance, they have become ill as a person and may not be able to differentiate between different diseases they may have. The challenge of addressing the multiple health issues in each individual is important, and it requires GPs to develop the skill of interpreting the issues and prioritising them in consultation with the patient.

The GP should also use an evidence-based approach to the care of patients. They should aim at a holistic approach to the patient where the main focus should be in promoting their health and general wellbeing. An important task for the GP is to reduce risk factors by promoting self-care and empowering patients. They should aim to minimise the impact of patient's symptoms on their wellbeing by taking into account the patient's personality, family, daily life, and physical and social surroundings.

Co-ordination of care also means that the GP is skilled not only in managing disease and prevention but also in caring for the patient, providing rehabilitation and providing palliative care in the final stages of a patient's life. The GP must be able to co-ordinate patient care provided by other healthcare professionals and care provided by other agencies.

A comprehensive approach is concerned with the ability:

- *to simultaneously manage multiple complaints and pathologies, both acute and chronic health problems*
- *to promote health and wellbeing by applying health promotion and disease prevention strategies appropriately*
- *to manage and co-ordinate health promotion, prevention, cure, care, rehabilitation and palliation.*

Links with other domains

A comprehensive approach links with:

- primary care management and person-centred care: such as when individual patients exercise their autonomy not to pursue a healthy lifestyle and consequently need a greater share of healthcare resources
- a holistic approach: in promoting health and general wellbeing.

Learning outcomes for the comprehensive approach domain

Simultaneously managing multiple complaints and pathologies, both acute and chronic health problems requires:

- K* An understanding of the concept of co-morbidity in a patient
- S* The skill to manage the concurrent health problems experienced by a patient through identification, exploration, negotiation, acceptance and prioritisation
- S* Skill in using the medical record and other information
- S* The skill to seek, and the attitude to use, the best evidence in practice.

Promoting health and wellbeing by applying health promotion and disease prevention strategies appropriately requires:

- K* The ability to understand the concept of health
- S* The ability to promote health on an individual basis as part of the consultation
- S* The ability to promote health through a health promotion or disease prevention programme within the primary care setting
- K* Understanding the role of the GP in health promotion activities in the community
- A* Understanding and recognising the importance of ethical tensions between the needs of the individual and the community, and acting appropriately.

Managing and co-ordinating health promotion, prevention, cure, care, rehabilitation and palliation requires:

- K* Understanding the complex nature of health problems in general practice
- K* Understanding the variety of possible approaches
- S* The ability to use different approaches in an individual patient and to modify these according to an individual's needs
- S* The ability to co-ordinate teamwork in primary care.

Domain 5 – Community orientation

GPs have a responsibility for the community in which they work that extends beyond the consultation with an individual patient. The work of GPs is determined by the makeup of the community. They must understand the potential and limitations of the community in which they work and its character in terms of socioeconomic and health features. The GP is in a position to consider many of these issues and how they interrelate – and the importance of this within the community. In all societies health care is rationed, and doctors are involved in rationing decisions; they have an ethical and moral duty to influence health policy in the community.

Community orientation is concerned with the ability:

- *to reconcile the health needs of individual patients and the health needs of the community in which they live, balancing these with available resources.*

Links with other domains

Community orientation links with:

- person-centred care: ethical tensions between autonomy of individual patients and communities.

Learning outcomes for community orientation

Reconciling the health needs of individual patients and the health needs of the community in which they live, and balancing these with available resources requires:

- K* An understanding of the health needs of communities through the epidemiological characteristics of their population
- K* An understanding of the interrelationships between health and social care
- K* An understanding of the impact of poverty, ethnicity and local epidemiology on a local community's health
- K* An awareness of inequalities in healthcare provision
- K* An understanding of the structure of the healthcare system and its economic limitations
- K* An understanding of the roles of the other professionals involved in community policy relating to health

- K* An understanding of the importance of practice- and community-based information in the quality assurance of each doctor's practice
- K* An understanding of how the healthcare system can be used by the patient and the doctor (referral procedure, co-payments, sick leave, legal issues, etc.) in their own context
- S* The ability to reconcile the needs of the individual with the needs of the community in which they live
- K* An understanding of the GP's role in the commissioning of health care.

Domain 6 – A holistic approach

Medicine, like any cultural practice, is based on a set of shared beliefs and values, and is an intrinsic part of the wider culture of society.

Perspectives on holism

Kemper's definition of holism entails: 'caring for the whole person in the context of the person's values, their family beliefs, family system and culture in the larger community, and considering a range of therapies based on the evidence of their benefits and cost'.¹⁴ For Pietroni, holism involves a 'willingness to use a wide range of interventions ... an emphasis on a more participatory relationship between doctor and patient; and an awareness of the impact of the "health" of the practitioner on the patient.'¹⁵

The holistic view acknowledges objective scientific explanations of physiology but also admits that people have inner experiences that are subjective, mystical, spiritual or religious, which may affect their health and health beliefs.¹⁶

Holism and patient-centredness

Holism and patient-centredness are core values of general practice. Holism, described by Howie¹⁷ as the integration of physical, psychological and social components of health problems in making diagnoses and planning management, is well-established as a central issue of good consulting practice.^{9,17} There is good evidence that this is promoted by longer consultations and by greater continuity of care. Howie and colleagues built on that evidence to develop their 'Consultation Quality Index' (CQI) for use in general practice. It reflects the core values of general practice using, as proxies, 'consultation length' and how well patients 'know the doctor', as process measures and 'patient enablement' as an outcome measure.¹⁷

Our limitations as doctors

A basic understanding of our own limitations as doctors is crucial.

A holistic approach is concerned with the ability:

- *to use bio-psycho-social models, taking into account cultural and existential dimensions.*

Links with other domains

A holistic approach links with:

- primary care management: there are many more options available to patients than medical ones
- person-centred care (see above)
- community orientation: doctors are not the only sources of health and healing.

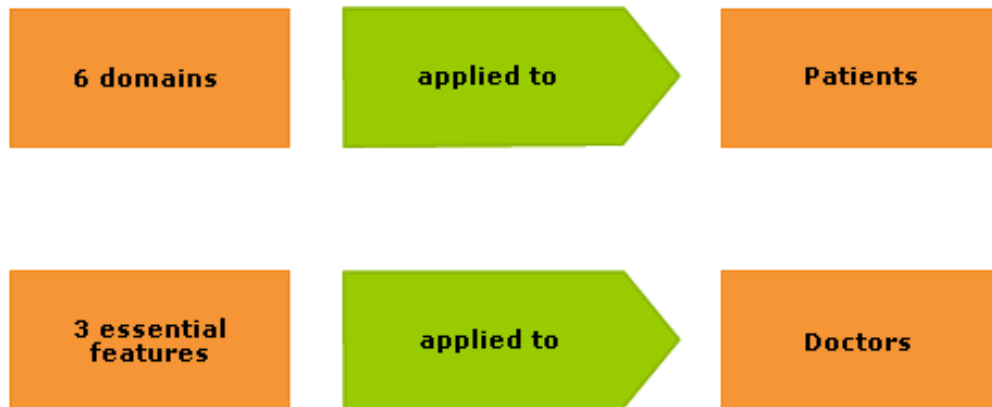
Learning outcomes for a holistic approach

Using bio-psycho-social models, taking into account cultural and existential dimensions requires:

- K* Knowledge of the holistic concept and its implications for the patient's care
- A* The ability to understand a patient as a bio-psycho-social 'whole'
- S* The skills to transform holistic understanding into practical measures
- K* Knowledge of the cultural background and beliefs of the patient, in so far as they are relevant to health care
- A* Tolerance and understanding towards patients' experiences, beliefs, values and expectations, as they affect healthcare delivery.

Essential features of the discipline of general practice

Three features are essential for a person-centred, scientific discipline such as general practice: *context*, *attitude* and *science*.^{1,2} They apply to doctors themselves, and determine their ability to apply the RCGP domains in the real-life work setting.



The three features relate to some extent to all doctors – but they are particularly important in general practice because of the close relationship between the family doctor and the people with whom they work.

Links with other domains

Contextual, attitudinal and scientific aspects each link closely with the six domains.

Essential feature 1 – Contextual aspects

Understanding the context of doctors themselves and the environment in which they work, including their working conditions, community, culture, financial and regulatory frameworks. The learning outcomes bear similarities to those in Domain 5 – Community Orientation, but Domain 5 applies to patients, whereas the essential features apply to the doctor.

Learning outcomes for contextual aspects

- K* Having an understanding of the impact of the local community, including socio-economic factors, geography and culture, on the workplace and patient care.
- K* 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.
- K* Having an understanding of the financial and legal frameworks in which health care is given at practice level
- K* Having an understanding of the impact of the doctor's home and work environment on the care that they provide.

Essential feature 2 – Attitudinal aspects

Based on the doctor's professional capabilities, values, feelings and ethics.

Learning outcomes for attitudinal aspects

- A* Being aware of their own capabilities and values
- K* Identifying ethical aspects of clinical practice (prevention, diagnostics, therapy, factors that influence lifestyles)
- A* Having an awareness of self: an understanding that their own attitudes and feelings are important determinants of how they practice
- A* Justifying and clarifying personal ethics
- S* Being aware of the interaction of work and private life, and striving for a good balance between them.

Essential feature 3 – Scientific aspects

Adopting a critical and research-based approach to practice and maintaining this through continuing learning and quality improvement.

Learning outcomes for scientific aspects

- K* Being familiar with the general principles, methods and concepts of scientific research, and the fundamentals of statistics (incidence, prevalence, predicted value, etc.).
- K* Having a thorough knowledge of: the scientific backgrounds of pathology; symptoms and diagnosis; therapy and prognosis; epidemiology; decision theory; theories about the forming of hypotheses and problem solving; preventative health care.
- S* Being able to access, read and assess medical literature critically.
- S* Being able to develop and maintain continuing learning and quality improvement.

The interpretive curriculum statements

In addition to the core curriculum, *Being a General Practitioner*, the complete curriculum contains a further 31 interpretive statements (Appendix 3: Core Curriculum and Interpretive Statements). These interpret the domains and essential features of general practice in relation to a wide range of different professional and clinical situations. The interpretive statements are intended to provide helpful, and complementary, additional information, but should not be regarded as the core curriculum.

There are interpretive statements on the professional and managerial aspects of general practice; statements on the care of special groups (acutely ill, children, elderly, women's and men's health, sexual health, cancer & palliative care, learning disabilities) and statements on clinical areas (cardiovascular, neurological, skin, metabolic, respiratory, musculoskeletal, trauma, ENT, eyes, digestive problems, mental health).

Each interpretive statement is constructed with the same sections:

- 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 and national guidelines
- A statement of learning outcomes in terms of the knowledge, skills and attitudes that are required to demonstrate a competency in that topic area
- Guidance on teaching and learning resources
- A reference section.

Approaching the interpretive curriculum statements

Each of these statements describes a number of learning outcomes, in which the six core domains of competence are interpreted according to the focus of the statement. These outcomes help learners and assessors to understand how the core domains of competence will be assessed in a wide variety of possible contexts. There are over a thousand examples of these learning outcomes. Learners do not have to demonstrate that they have been assessed in all of the learning outcomes. Rather, they need to demonstrate their mastery of all six core domains of competence and the three essential features within a (representative) variety of contexts.

The objective of the interpretive statements is to interpret the core curriculum in a range of contexts. Understandably, individuals or organisations with a particular area of interest may wish to see a curriculum statement explicitly focusing on that area. However, it is not possible to incorporate a comprehensive exposition of every possible context or problem that a GP might encounter.

The interpretive statements include guidance on approaches to teaching and learning and are educational resources in themselves. They can be used as source materials for all educators in the local team as well as for 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.

LEARNING AND TEACHING

The process of learning

The model of learning set out in the RCGP curriculum combines three aspects:

1. It recognises the importance of balance and diversity in the learning situations that trainees experience
2. It places emphasis on clarity and transparency of learning outcomes (as professional, adult learners expect)
3. The pedagogy of learning recognises the distinctive requirements of adults as learners.

Balance and diversity

Teaching and learning in relation to a curriculum for general practice occur primarily at work. A substantial proportion takes place in general practice itself although it is recognised that a wider training experience, incorporating the time spent and competences gained in secondary care, forms an important contribution to the development of the future GP.

In addition to training in the workplace, the trainee also participates in the formal learning opportunities provided through departmental teaching sessions, general practice specialty training seminars, and day release activities. The curriculum supports the well-established approach of regular release from practice, typically through a weekly half-day release programme, which is an approach that was assessed positively in the national survey.

Teaching and learning in all these contexts will be underpinned by clarity on expected outcomes (that are specified in terms of competences).

Competences as outcomes

In the curriculum, competence is used to define steps 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 for independent practice. An individual who is 'competent' has general attributes incorporating understanding and judgement, 'a complex structuring of attributes needed for intelligent performance in specific situations'. Competences are also components of a whole: at once building blocks of professional competence and also interrelated parts of an integrated, holistic whole.

Key principles of adult learning

The primary pedagogical relationship in the training programme is between the trainer (as both educational and clinical supervisor) and the learner, a relationship that is embedded in active, professional practice. The general principles of adult learning underpin the way teaching and learning is organised and delivered. A brief summary of these principles is set out below:

- *Self-direction.* There is a deep-seated need for adults to be self-directed and in charge of their own learning, although 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 is 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 role
- *Problem-centred.* Adults want to apply tomorrow what they learn today. Therefore the appropriate units for teaching and learning are situations, not subjects.

The apprenticeship model

The apprenticeship model can be defined as education and service blended together for professional growth, through 'legitimate peripheral participation in a community of practice'.

The apprenticeship model has been valued highly in general practice education and training for many years and this will continue. Its strength is the opportunity it offers for modelling not only skills but also values. A great deal of transfer of learning takes place visually or subconsciously through watching good practice. Such modelling is important and the learner may not be aware of what they have learned until they move to a situation where they see things done less well.

The apprenticeship model sits well with adult and experiential learning, especially if provision is made for reflection with the use of personal reflective diaries and case-based discussions. Because of the need to provide a first response to any symptom a patient may present general practice involves a different balance of skills and knowledge from other specialties within medicine. It requires:

- a relatively greater use of generic diagnostic and management skills
- 'useful' knowledge rather than detailed knowledge
- relatively fewer specific or procedural skills.

The development of generic skills and the honing of 'useful' knowledge are well supported by the apprenticeship model. The key is experience combined with reflection; the learner must be exposed to a high number of patient contacts.

There are disadvantages with the apprenticeship model, in that the curriculum is, to an extent, 'hidden'. Unconscious competence may be less useful to the learner than conscious competence and bad practice can be modelled as well as good practice.

Unlike the ordered spiral curriculum, the apprenticeship model is more organic – yet it does involve revisiting topics and themes, each time expanding the learner's ability to recognise patterns, become aware of decision nodes and have command of a greater range of options, enabling them to respond to their patients and offering them a greater degree of choice. The approach leads to reinforcement of basic principles, the integration of topics, and the achievement of higher levels of complexity.

Specialist training for general practice – programmes of learning

A three-year curriculum

Until recently, most trainees have been able to spend only 12 months in general practice itself. Research has demonstrated that this is not sufficient. Discussion is currently underway with a view to extending GP specialty training for up to five years.

Of course, general practice takes longer than three years to learn; professional education needs to be developed beyond the award of CCT.

GP-based experience

This is the most appropriate form of training for general practice. It is valued more highly than hospital experience by current trainees, recently qualified GPs and educators.

Learning opportunities within primary care

Work-based experiential learning:

- observing established GPs and other primary care practitioners
- supervised surgeries followed by unsupervised surgeries
- joint surgeries with a GP trainer
- reflection on learning
- problem case analysis and random case analysis.

Formal tutorials

Formal tutorials have a role although they are often less useful than problem-based teaching or problem and random case analysis.

Courses

Courses may be local, as part of a half-day release course, regional or national.

Half-day release course

Half-day release course teaching for general practice has a long history and remains popular with trainees. What is valued most by trainees is the meeting with peers, partly because they can feel isolated within a practice (as a consequence of a regulation, only recently relaxed, of one trainee per practice).

Individual journeys through the curriculum

In the past, half-day release courses were criticised for offering too little choice. To deliver education in line with adult learning principles (and PMETB requirements), programme directors must offer trainees choice to plan individualised programmes according to their needs.

Opportunities for reflection are important. Through reflection 'on practice' and reflection 'in practice', learners have the opportunity to 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.

Independent self-directed learning

Trainees use this time in a variety of ways depending on their needs: for reading, e-learning, research projects, exam preparation, preparation of their portfolio for assessment, medical humanities.

Interprofessional and multiprofessional learning

Primary care is a multidisciplinary activity and this should be reflected in the training programmes for future GPs. Practice-based education is of increasing importance and trainees should be involved, both as learners and teachers. Short attachments to other primary healthcare team workers and other professionals such as community pharmacists are helpful.

Learning opportunities outside primary care

Secondary care learning opportunities

Outpatient clinics can be valuable, either sitting in or seeing patients under supervision.

Consultant ward-rounds provide good opportunities for bedside teaching and for trainees to obtain feedback on their clinical and decision-making skills. Although useful, they are now significantly reduced in value because of lack of individual continuity of responsibility for patients (as a consequence of changes to junior doctors' working patterns resulting from the European Working Time Directive).

In the past, hospital attachments used to provide good opportunities for continuity of clinical care. This allowed the natural history of a patient's illness to be followed through, linking the initial admission assessment, investigation, the evolving diagnosis and treatment. However, changes to hospital practice mean that this opportunity to experience continuity is becoming less common.

Hospital attachments provide exposure to higher numbers of more seriously ill patients. Although this does have advantages in offering a high concentration of experience, it should not be overstated. A key GP skill lies not so much in how to deal with a patient

who is obviously seriously ill, but in separating the small number of patients who *may be* seriously ill from the larger number of patients who feel ill but do not need secondary care. This skill is best learned in the community.

Hospitals also provide opportunities for trainees to attend multidisciplinary team meetings to gain perspectives on integrated care and team working.

Learning with peers

The half-day release course allows trainees from different years to come together for small group sessions and can have a powerful influence on shaping of attitudes. Self-help groups for preparation for assessments have a long tradition and are useful.

Although many educators still believe trainees need facilitation for effective learning in groups and doubt a group's ability to form a self-directed learning set, there are many examples of trainees learning to learn with their peers without the need for facilitation.

CURRICULUM RESOURCES

The curriculum statements provide guidance on approaches to teaching and learning. They are a resource for learning materials for all educators in the local team as well as trainees. In relation to hospital attachments, for example, the statements offer guidance to hospital consultants and trainees on the learning outcomes associated with specific specialities.

The RCGP has developed a range of curriculum-based resources to support GP trainers and trainees:

e-GP: www.e-GP.org

The RCGP's e-learning resource to support GP specialty training, featuring interactive e-learning modules covering the RCGP curriculum. Available to all NHS GPs, the resource contains an e-learning module on *Being a General Practitioner* which introduces the core curriculum domains and essential application features. Register now at www.e-GP.org

RCGP InnovAiT: www.rcgp-innovait.oxfordjournals.org

The RCGP's monthly educational journal for Associates in Training, providing articles and AKT questions on GP topics and curriculum-based issues. The journal is available to trainers for a special subscription rate of just £35. Throughout 2009, *InnovAiT* will be featuring a series of articles on the nMRCGP competencies.

RCGP Curriculum & Assessment Website: www.rcgp-curriculum.org.uk

Offers the latest news and information on GP training and the nMRCGP. Visit the RCGP Curriculum Documents section to download the curriculum statements and the *Learning and Teaching Guide*.

RCGP Curriculum Map: www.rcgp-curriculum.org.uk/extras/curriculum

The navigable online RCGP curriculum linking to online educational resources, and featuring a curriculum search engine to quickly locate items in the curriculum.

RCGP Curriculum and nMRCGP Books: www.rcgp.org.uk/bookshop

Order online at the RCGP bookstore for a 10% membership discount:

The Condensed Curriculum Guide

The official users' guide to the new RCGP curriculum and the nMRCGP; for all GP specialty trainees, trainers and educators. It includes a condensed and indexed version of the official RCGP curriculum.

General Practice Specialty Training: Making it Happen

The RCGP guide for GP educators to the nMRCGP assessments.

A LIVING CURRICULUM

Review, evaluation and monitoring of the curriculum

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

1. Annual review of minor changes to curriculum and assessment
2. Continuous review of major changes to curriculum and assessment
3. Annual deanery review of regularly generated data
4. Annual national review of regularly generated data
5. Structured collection and analysis of feedback on the curriculum
6. Commissioned research

Annual review of curriculum and assessments

The annual reporting process to PMETB is divided into two parts. The first, the Annual College Summary, is a summary of the minor changes made to, or planned for, the curriculum and its associated assessments. The second, the Annual College Report, is submitted six months later and is a report of examinations data, including breakdowns of the data by deanery and ST year. The procedure for the approval of major changes to the curriculum or assessment is separate to this reporting process. After the first two years of annual review, the process will be repeated on a five yearly basis.

The strategy for changes in the first year will build upon the incoming data and comments from the stakeholders and resources described below. PMETB will receive documentation for the suggested changes for the curriculum and the assessments. A database has been set up to record and manage feedback on the curriculum.

The choice of statements to be adjusted in first round of review will be based on incoming data from:

- *The Curriculum Guardians*; each curriculum statement has a named 'Guardian', responsible for the annual monitoring of their statement and for proposing any necessary changes through the Curriculum Development Group to the RCGP Postgraduate Training Board.
- *The Curriculum Evaluation Team* (see below under 'Commissioned Research').
- *COGPED* comments on the curriculum based on feedback from the deaneries.
- *The Trainers Project* will provide data from *The Diary Project* as well as the feedback from the *Senior Educators Group*. The Diary Project invites all UK trainees and trainers to write a diary for a day about how it is to be training

within the RCGP curriculum. This is repeated each year, inviting all those involved in GP training to contribute to continuous feedback. The entries are analysed as qualitative research data. The Trainers Project also consists of a network of senior educators shared between deaneries and the RCGP working on solutions to problems with the implementation of the curriculum and its assessments.

- *The Blueprinting Group*, which includes the RCGP assessment group chairs and others with expertise on the curriculum or assessments.
- *Case Writers* from the CSA, the WPBA and AKT groups will collect feedback, as will others involved in the practical work of the assessments.
- *The ePortfolio* is an essential resource for understanding where the curriculum needs adjusting or strengthening through implementation initiatives
- *AiT and Trainee surveys*
- *Feedback from patient groups*
- *Developments within CPD and Revalidation*
- *The trainer surveys*
- *The RCGP's curriculum-based e-learning projects (e.g. e-GP)*
- *Feedback from the Curriculum Map feedback tools*
- *Other medical specialities*
- *The Quality Management and Training Standards Committee*
- *Informal feedback (stored on a database).*

The coordination and digestion of all the feedback received on the Curriculum is carried out by the Curriculum Development Group.

Continuous review of major changes

The procedure for the approval of major changes to the curriculum or assessments is separate to the annual reporting process. At any time, the RCGP can apply the PMETB to make a major change. These changes can only happen with PMETB approval.

Annual deanery review of regularly generated data

In every deanery, a range of data are generated each year. These include:

- Quality assurance and management reports, including the PMETB's annual survey of trainees and trainers
- A tracking protocol on aspects of performance
- ARCP Panel performance data and feedback from RCGP external assessors

- GP Specialty Registrar performance in the RCGP assessment programme:
 - Exit survey data that shows results for the deanery as compared with the national results
 - Reported expert views of educators in the deanery.

These data form the basis of an annual assessment within each deanery area and will form the basis of the data set fed to COGPED for national review.

Annual national review of regularly generated data

On behalf of the RCGP, the Committee of General Practice Education Directors (COGPED) will undertake an annual review of the curriculum, including:

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

COGPED's conclusions and recommendations for action will be reported to the RCGP who will act on these as appropriate. This will be a 2-way process; the RCGP will be comparing national data sets and feeding back to the deaneries.

Structured collection and analysis of feedback

The governance structure of the RCGP curriculum review process involves a number of internal groups. This includes the Curriculum Development Group, which is responsible for the structured analysis of all feedback on the curriculum; a group of 'Guardians', experts in different fields who monitor their statement and propose any necessary changes through the Curriculum Development Group; The Curriculum Steering Group, which overlooks the project management of initiatives related to curriculum development, maintenance and resources; and the Postgraduate Training Board, which authorises any developments of the curriculum and nMRCGP assessments.

Commissioned research

The RCGP has commissioned an evaluation research project on the implementation of the curriculum, which is being managed by the Centre for Research in Medical and Dental Education at the University of Birmingham. Results from this research are an important part of the continuous updating of the curriculum. The curriculum review process includes results from this research, which makes it possible to implement changes as soon as the need is discovered.

ASSESSMENT

Teaching and learning demand assessment. It is well recognised that monitoring what has been learned is a good way of providing feedback on what has been learned. Formative *assessment for learning* and summative *assessment of learning* are both parts of the approach recommended for GP training. Some of the new workplace-based assessment tools will provide a dual role, making an assessment of learning and generating structured feedback for trainees on how they may improve.

Assessment for learning

There are a number of ways that GP trainees can become aware of their learning needs:

- learner self-assessment
 - the explicit documentation of learning outcomes in the new curriculum will allow better self-assessment by trainees
 - in addition there are traditional methods: informal subjective self-awareness of performance in the workplace; and more formal methods such as PUNs and DENs and confidence-rating scales
- informal and formal feedback from trainers, clinical and educational supervisors, and other team members/practice staff
- informal and formal feedback from patients
- the new workplace-based assessment methodologies. These will be familiar to learners who have completed foundation programmes; they perform a dual summative and formative role.

Appraisal

The annual appraisal is where learning needs assessments are brought together and translated into an explicit learning agreement that contains a number of educational objectives for the following year.

Feedback to trainees

Formative assessment has always been a regular part of GP training. The classic tools have been random case analysis and problem case analysis. These will continue to be important. The use of the workplace-based assessment tool of case-based discussion (CBD) is a formalisation of this process using a small number of the many cases discussed by learner and trainer.

A wide variety of other 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 trainee and trainer consult jointly.

Assessment of competence

The assessment of competence uses an integrated package of workplace-based assessments and examination of both knowledge and clinical skills.

An assessment blueprint has been developed that maps the assessment methods on to the curriculum in an integrated way. The blueprint ensures that there is appropriate sampling across all six domains of the curriculum.

The Certificate of Completion of Training

The Certificate of Completion of Training (CCT) is awarded at the end of the training period only to those GP trainees who have completed their approved training posts and are also successful in the three components of the new Membership of the Royal College of General Practitioners (nMRCGP) assessment:

1. **Applied Knowledge Test (AKT):** a multiple-choice style assessment of the application of knowledge essential for independent general practice.
2. **Clinical Skills Assessment (CSA):** an OSCE-style assessment of a doctor's ability to integrate and apply clinical, professional, communication and practical skills appropriate for general practice.
3. **Workplace-based Assessment (WPBA):** the three-year evaluation of a doctor's progress in their performance, in those areas of professional practice best tested in the workplace. The evidence collected for Work-place Based Assessment is recorded in the RCGP ePortfolio, which is similar to the ePortfolio used widely in the Foundation Programme.

The ePortfolio and Workplace-based Assessment

At the start of specialty training, once a trainee registers with the RCGP, he or she is given access to the RCGP ePortfolio. The ePortfolio is a web-based learning tool that records details of achievement, documents all stages of training, and records evidence of Workplace-based Assessment (WPBA) and reviews with educational supervisors. It collates evidence that training has taken place and allows the GP trainee to reflect on a range of learning opportunities.

The ePortfolio contains the evidence that is considered at the interim and final reviews. Trainees who demonstrate they are competent (or exemplary) in the final review of WPBA, and also have a pass in the AKT and CSA, will be eligible to apply for certification of completion of training (CCT), inclusion in the General Medical Council's GP Register, and membership of the Royal College of General Practitioners.

The evidence recorded in the ePortfolio is based on performance and evaluation taking place in the real situations in which doctors work, including a section for the Clinical Supervisor to write a short structured report on the trainee at the end of each hospital post.

This covers:

- The trainee's knowledge base relevant to the post
- Practical skills relevant to the post
- Evidence of performance against the nMRCGP professional competence areas (see Appendix 5).

The ePortfolio as a learning tool

A key function of the ePortfolio is to act as a curriculum-focused learning tool to enable the GP trainee to collect evidence of learning and to reflect on it, either alone or with his or her trainer or colleagues. The ePortfolio is a record of learning with particular emphasis on clinical encounters.

The ePortfolio belongs to the trainee but key parts of it are accessible to the trainer, educational supervisor and deanery administrators through a permissions system. All personal records will be hidden to all except the trainee until they decide to share them. The ePortfolio includes places to record tutorials, formal educational sessions and a skills log. It has a diary and a mailbox. It also contains links to learning resources and has a personal area where individuals can save files, documents, certificates of learning and other digital materials.

Through the ePortfolio the trainee can book places on the AKT and CSA and the results will come back into the portfolio. The Certification Unit of the RCGP will also be linked into the membership data and will receive the indication from the trainee that they are ready for certification.

Evidence-gathering tools in the ePortfolio

The ePortfolio enables evidence of learning and performance to be gathered using designated and validated tools. The use of each tool serves as an episode of evidence collection. The WPBA tools ensure the evidence is collected in the same way for each trainee, and promote consistency among Trainers and across deaneries.

The use of the tools does not involve pass/fail assessments; the judgement may be one of insufficient or inadequate evidence, particularly in the early stages of training, but this simply points to the need for further training. At regular points during training all the evidence available from the trainee is reviewed and a judgement is made about progress through each of the 12 performance areas defined in WPBA (see Appendix 5).

WPBA involves making qualitative not quantitative judgments. As the trainee proceeds through training it would normally be expected that evidence of competence demonstrated and the degree of readiness to practise is gradually built up. The overall picture of the trainee becomes clearer as more evidence is gathered.

The WPBA tools include:

- Case-based Discussion Tool
- Consultation Observation Tool (in primary care only)
- Multi-Source Feedback Tool
- Patient Satisfaction Questionnaire (in primary care only)
- Direct Observation of Procedural Skills (in hospital posts)
- Clinical Evaluation Exercise (Mini-CEX) (in hospital posts)
- Clinical Supervisors Report (in hospital posts).

Many evidence-gathering tools can be completed on-line without the contributor having to enter the ePortfolio itself. Writing data to many parts of the ePortfolio is limited to the Trainer or educational supervisor. The personal section of the ePortfolio is hidden to all except the GP trainee.

Naturally-occurring evidence

The ePortfolio has been designed to record and validate naturally occurring evidence against the WPBA framework. For example, a trainee may undertake a journal review on a specific topic and present it to a practice meeting. This might be evidence of that individual's data gathering and interpretation, or communication skills. Evidence that a trainee is late for surgeries on a regular basis might be discussed with the trainee and recorded under teamwork skills. All naturally occurring evidence needs to be validated by the GP Trainer.

SUPERVISION

Individual roles and responsibilities

Training Programme Director

Programme Directors are 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 RCGP curriculum. They 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. They are accountable to the Director usually through a local associate director. Local administrators support the programme directors often based in postgraduate centres or large primary care centres.

Educational Supervisor

Each GP trainee has a nominated GP educational supervisor throughout their entire training programme. This role may be performed by a GP Trainer, Programme Director, or another nominated individual (local arrangements vary). The educational supervisor holds a structured review meeting with the trainee every six months, (regardless of the length of the trainee's individual training posts). The educational supervisor assesses progress on the basis of workplace-based evidence collected by the trainee and recorded in an ePortfolio. This generates a learning plan and can also be used to identify those trainees in difficulty. These regular reviews do not replace formative meetings with clinical supervisors. Educational supervision also meets the requirement for annual service appraisal for the GP trainee.

Clinical Supervisor

Clinical supervision involves overseeing the day-to-day work of the GP trainee during their posts outside their training practice. A consultant would normally perform this role during the training posts in secondary-care. The clinical supervisor is expected to hold formative meetings with their trainee at the beginning, middle and end of their placement. They will be the trainee's initial point of contact in issues relating to the specific post. Clinical supervisors will sign off workplace-based assessments, and write an end-of-placement clinical supervisors report to be recorded in the trainee's ePortfolio. Trainees and clinical supervisors should at all times be aware of their responsibilities for the safety of patients in their care.

GP Trainer

A GP Trainer is a specially trained and approved GP who is responsible for overseeing the educational progress of a GP Specialty Registrar within his or her training practice. During a GP Specialty Registrar's post in a training practice, the role of the GP Trainer encompasses that of both clinical and educational supervisor. The GP Trainer is also responsible for maintaining the learning environment within the training practice to national standards of quality, which are defined by the RCGP and regulated by PMETB with support from the local deanery.

The GP Trainer is also responsible for the ongoing assessment of the trainee, although the judgment of the GP Trainer will form only one part of the overall assessment strategy (the Workplace-based Assessment). It is through this process that curriculum coverage will be monitored and gaps identified. In some deaneries, some of the responsibilities of GP Trainers (such as the regular reviews) are shared with Programme Directors.

GP Specialty Registrar

GP trainees themselves, as adult learners, bear the greatest responsibility for their learning; this reflects their professional responsibilities and their position as adult learners, and the importance of securing a long-term commitment to their personal and professional development. Career success as a general practitioner depends upon becoming a lifelong learner. Responsibility for one's own learning is supported by the design of the curriculum and formative Workplace-based Assessment.

The curriculum's explicit definition of learning outcomes and competencies gives clarity to trainees as learners and assists them in assessing their own progress. Self-managed learning is supported by the inclusion in the curriculum of advice on approaches to learning and learning resources, not only placing responsibility for learning on the trainee but supporting the means for achieving it.

Other GP educators

A local team contributes to each Specialty Registrar's training programme. Members of the team include: a GP Trainer from a different practice; clinical supervisors (such as hospital consultants with responsibility for specific attachments in secondary care), and other doctors who supervise aspects of practice, such as out-of-hours training and attendance at clinics.

The local team is central to ensuring broad coverage of the curriculum. As they provide guidance on approaches to teaching and learning, curriculum statements are source materials for all educators in the local team as well as for trainees. In relation to hospital attachments, for example, the statements offer guidance to hospital consultants and trainees on the learning outcomes associated with specific topics areas, such as cardiovascular problems.

The trainer's role in assessment

Qualities of trainers

The relationship between GP trainees and their trainers 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 trainer to oversee and support the trainee's progress. As such they must have appropriate professional attributes, personal qualities and training to equip them for this role.

Most of a trainee'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 trainers must be enthusiastic, competent and caring GPs, 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 general practice attachment will relate to individual needs and aims identified by the trainer and trainee, and these form the basis upon which the teaching programme is planned and weekly timetable arranged.

Enthusiasm for general practice should also apply to learning and the trainer's willingness to develop further as a clinical teacher. They require additional knowledge and new skills over and above those of non-teaching colleagues. Contribution to specialty training for general practice outside the practice illustrates their commitment to teaching. GP trainers must prepare carefully for their teaching responsibilities and may benefit from other teaching experience, for example with medical students or other health professionals. They should be willing to be appraised by their peers as this encourages trainees to adopt a similar critical approach to their work.

The trainer's role in assessment for learning and feedback

Formative assessment and feedback will take much the same form as now. The Workplace Assessment tools will provide trainees and their trainers with valuable information on performance and suggestions for improvement. This will be a major contribution to formative assessment.

The trainer and assessment of competence

Traditionally, the GP trainer makes two important decisions regarding a trainee's competence: the first usually comes early in the GP attachment when a decision is made on whether a trainee (GP) is able to see patients safely without the need for continuous direct supervision or supervision on a case-by-case basis; the second is the signing of a VTR1, which is itself informed by the data collected in the trainer's report.

Patient safety

Deciding when it is appropriate to let the trainee see patients without direct supervision will continue to be a matter of judgement for the training practice. The decision will be helped by direct observations or videos of consultations. Often these observations will, in themselves, have documentation using workplace-based assessment tools.

The formative use of the summative workplace assessments will allow honesty between learner and trainer, which should provide high-quality feedback, helpful to both over-confident and under-confident trainees.

The trainer's report

An enhanced version of the trainer's report is completed each year by the educational supervisor in the annual review. Clearly, the training practices have the clearest insights into a trainee's actual performance and the trainer's role in workplace-based assessment will be crucial.

The trainer's role in the final assessment of competence is altered significantly. The final decision for the award of CCT will no longer be left entirely to the trainer.

Scheduled reviews during training

The evidence collected in the ePortfolio is reviewed at six monthly intervals by the educational supervisor and there is a final, holistic judgement made at the end of training.

Six monthly reviews

Before each of the six monthly reviews, the trainee conducts a self-assessment. Progress is assessed by the educational supervisor (who may be the trainer) against each of the twelve WPBA performance areas. Each review is informed by the evidence collected through the WPBA tools, augmented by any naturally occurring evidence. A learning plan will then be agreed. All this information will be recorded in a standardised format in the ePortfolio.

The reviews provide an opportunity to consider the breadth of coverage across the whole curriculum. The structured way of recording and reviewing evidence will highlight the areas where the trainee is doing well and those areas where more learning and support is needed.

The final review

The standard against which the trainee is judged is always the level of performance expected of a doctor who is certified to **practice independently as a general practitioner**. This standard is used throughout the three years of training. This means that the trainee is being judged against the standard they should have reached at the end of training. It is not expected that a GP trainee will reach this standard in the early stages of Specialty Training, and so further developmental needs *should* be identified. This is what the assessment system is designed to do, so that training experiences can be targeted at the developmental needs of the individual trainee.

Towards the end of Specialty Training a final summative review is conducted, this time without the self-assessment of the trainee. The trainer or educational supervisor will make a recommendation to the deanery regarding the overall competence of the trainee. This recommendation is subject to external moderation in the deanery by the ARCP Panel.

Annual Review of Competence Progression

The Annual Review of Competence Progression (ARCP) is a formal deanery process that scrutinises each GP trainee's suitability to progress to the next stage of, or to complete, the Specialty Training programme. It is conducted by an ARCP Panel which bases its recommendations on the evidence that has been gathered in the trainee's ePortfolio during the period between ARCP reviews and evidence from the trainee's educational supervisor. The ARCP records that the required curriculum competencies and experience are being acquired, and that this is occurring at an appropriate rate. It also provides a coherent record of a trainee's progress. The ARCP is an evaluation process and not in itself an assessment exercise of clinical or professional competence.

The ARCP process should normally be undertaken on at least an annual basis for all trainees. An ARCP Panel may be convened more frequently if there is a need to deal with progression issues outside the normal schedule. The RCGP uses the opportunity afforded by ARCP, through a representative on the panel, to monitor the quality of training being delivered by the local programme and its components. Further information on the ARCP process can be found in the *Guide to Postgraduate Specialty Training in the UK* ('The Gold Guide' available here: www.mmc.nhs.uk).

Preparation for the ARCP

The trainee's ePortfolio provides the evidence of progress. It is the trainee's responsibility to ensure that the documentary evidence is complete in good time for the ARCP. A minimal evidence requirement has been defined for each period of GP Specialty Training, which must be completed in time for the panel meeting.

EQUALITY AND DIVERSITY

The general practice commitment to equality and diversity is 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.

It is further illustrated by:

- the selection process for specialty training for general practice
- a separate curriculum statement on equality and diversity, *Promoting Equality and Valuing Diversity*, which includes a definition of the terms, an outline of the legal context, the significance of the issues for health inequalities and the knowledge, skills and attitudes that are necessary for ensuring competence in this area
- research studies to check selection processes are non-discriminatory.

APPENDIX 1: CORE AND INTERPRETIVE STATEMENTS

The GP training curriculum is composed of a core curriculum and 31 interpretive statements, organised into 15 groups:

THE CORE CURRICULUM:

- 1 Being a General Practitioner

THE INTERPRETIVE STATEMENTS:

- 2 The General Practice Consultation
- 3 *Personal and Professional Responsibilities*
 - 3.1 Clinical Governance
 - 3.2 Patient Safety
 - 3.3 Clinical Ethics and Values-Based Practice
 - 3.4 Promoting Equality and Valuing Diversity
 - 3.5 Evidence-Based Practice
 - 3.6 Research and Academic Activity
 - 3.7 Teaching, Mentoring and Clinical Supervision
- 4 *Management*
 - 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 and Alcohol Problems
 - 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 & Conditions of the Musculoskeletal System (inc. Trauma)
 - 15.10 Skin Problems

APPENDIX 2: THE MRCGP COMPETENCE FRAMEWORK

The MRCGP is the licensing exam for general practitioners and has been designed to test whether doctors in training are performing well enough to practice independently, i.e. without being continually supervised.

How do the assessors know what to test?

Firstly and most importantly, the knowledge skills and attitudes that GPs require are laid out in the RCGP curriculum. The curriculum can look overwhelming, but it isn't if we remember that the curriculum itself is described in the **core curriculum**, *Being a General Practitioner*. The core curriculum describes six domains and three essential features. The other curriculum statements are interpretations of the core curriculum, illustrating how the competencies in the core statement manifest themselves in different contexts.

For the MRCGP, the six domains and three essential features of the core curriculum have been translated into 12 competency areas which we call the **competence framework**. The relationship between this framework and the curriculum is demonstrated in the following table.

The RCGP core curriculum	The 12 MRCGP competency areas
Primary care management	Clinical management Working with colleagues and in teams Primary care administration and IM&T
Person-centred care	Communication & consulting skills
Specific problem-solving skills	Data gathering and interpretation Making a diagnosis/making decisions
A comprehensive approach	Managing medical complexity
Community orientation	Community orientation
A holistic approach	Practising holistically
Contextual features	Community orientation
Attitudinal features	Maintaining an ethical approach to practice Fitness to practise
Scientific features	Maintaining performance, learning and teaching

Why translate the curriculum?

The core curriculum was written in order to explain the essence of being a GP. It contains many ideas, but was not designed to specify the behaviours that doctors must have in order to pass the licensing exam. This is why a translation was needed. The competence framework doesn't represent the entirety of the curriculum and to understand each of the 12 assessment areas properly, you need to read about the area of the curriculum to which it is related, as shown in the table.

By having behaviours that are specified, trainees know what they are expected to do for the MRCGP and assessors to know what to look for.

What is the structure of the competence framework?

Each of the 12 assessment areas in the framework is further broken down into a number of themes which are separate from each other. For example, 'Managing medical complexity' contains themes on:

- Managing several problems together.
- Assessing and managing clinical risk
- Health promotion

Each theme is itself developed from a lower level in the 'needs further development' column to an 'excellent' level on the right-hand side. This has been done so that trainees can see the trajectory of learning and can see how to improve their performance over time. Don't be fooled by the terminology, though. The lower-level of 'needs further development' is taxing and we expect that most trainees will not be able to perform above this level until late on in training. It also carries with it the obligation on the trainer to offer feedback on how performance can be improved to reach the 'competent' level and beyond.

So what is good enough for licensing?

The standard required for licensing is described by the middle column labelled 'competent', which is short for 'competent for independent practice'. To achieve this licensing standard, trainees need to demonstrate the behaviours in the first column **and** the second column. Don't worry about the final column (excellent), which is simply there to show the trajectory of learning and to provide goals for those who are still in training but are already achieving the 'competent' standard in that area of performance.

Where are the 12 assessment areas tested in the MRCGP?

All 12 assessment areas are tested continually through workplace-based assessment. Most of them are also tested in the other two examination components. For example, clinical decision-making and interpersonal skills and attitudes are tested in CSA and the knowledge base of general practice and how it is applied this tested through the AKT.

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