

EDUCATION IN GENERAL PRACTICE: A MODEL FOR HOSPITAL TRAINING?

Andy Craven, General Practitioner, Lancaster
VTS course organiser (hospital component)

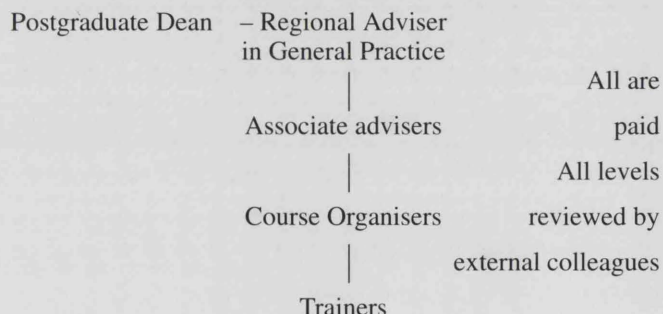
Yes, GPs are educated! In fact, we feel that general practice education is quite advanced compared to other areas of medicine. When I was asked to write this article I thought, who will be interested, who will read it, and what relevance does it have to those outside general practice? Now, having spent some time thinking about the subject, I realise it is very important indeed because we are probably all involved in learning, teaching or both. I hope there is something in here for everyone and that it will be useful.

General practice education is a huge subject. I intend, therefore, to sketch an outline of the major developments and probable future direction of general practice training.

THE NATIONAL SCENE⁽¹⁾

Education in general practice has made great advances in the last 30 years. The establishment of vocational training has led to the formation of a group of experienced teachers with skills in the teaching of trainees (GP registrars) and trainers. Over the same time, but almost entirely separately, university departments of general practice have also developed. Their priority has been to support the increasing undergraduate curriculum and to promote research. This article concentrates on vocational training.

Vocational training was established in the 1970s and expanded rapidly, so that by the time mandatory training was introduced in 1981, a postgraduate establishment had been developed. Teaching was practice-based and centred round postgraduate centres of local district general hospitals. Half-day and day release schemes had been established, run by a course organiser with practice-based trainers.



The standard of teaching has improved greatly and is well regarded by other disciplines. General practice is the only branch of medicine in which teachers have to meet regionally agreed educational criteria and attend courses in teaching methods before they are allowed to teach. Course organisers have to develop teaching skills in a wide range of one-to-one or small group methods which is applicable to teaching trainers and GP registrars. Trainers undergo a rigorous process of training to be teachers and in the preparation of their practice.

VOCATIONAL TRAINING IN LANCASTER

Much of the progress locally has been due to a pioneer from our area – the late Professor Patrick Byrne. He was on the founding committee of the Lancaster Postgraduate Centre and was appointed to the first Chair in General Practice in Manchester. Pioneer training schemes in the UK were set up by him in 1966. These started as an 18 month rotation between hospital and general practice and developed into a three year scheme in the 1970s. The Lancaster scheme was the first outside the university department and was set up by Dr John Frankland in 1972. Since then many doctors in this area have passed from registration to fully approved status as GP principals.

The scheme is based round Lancaster Infirmary and associated hospitals, involving GP trainers from local practices. There has always been a day of training on a Wednesday for all those in the practice year and, more recently, some GP specific teaching introduced for those working in their hospital jobs.

THE TRAINERS⁽²⁾

A GP trainer will be an established principal in general practice and will have a registered list of patients to allow the trainee sufficient experience without excess workload. The trainer should be enthusiastic and willing to teach general practice. The trainer must attend a trainers' course to prepare for training. This is a very intensive course split into two modules of three days. The first module develops skills to teach clinical problem-solving/decision-making and then management of patients. The second module looks at a variety of teaching methods and how to use them.

"Undifferentiated doctor"	GP
DIAGNOSIS	
Poor use of massive data base Full history Complete examination All investigations	Hypothesis formation Discriminating history Focused examination Selective investigation
MANAGEMENT (ACRONYM RAPRIOP)	
Reassurance Advice (doctor-based) Prescription Referral Investigation Observation Prevention	Reassurance/explanation Advice (Counselling) Prescription Referral Investigation Observation Prevention

Fig. 1 – Undifferentiated doctor vs GP

A great deal of time is spent looking at clinical problem-solving⁽³⁾. This is a major area of teaching, and developing this skill is one of the main tasks for the trainer in converting the "undifferentiated" doctor into a GP (see fig 1).

The training practice is also looked at very carefully and it often takes considerable time and effort to bring the practice up to standard and keep it there. The partners of the trainer should be supportive of the training role and allow the trainer time for teaching in the practice and time away to maintain teaching skills (see fig. 2).

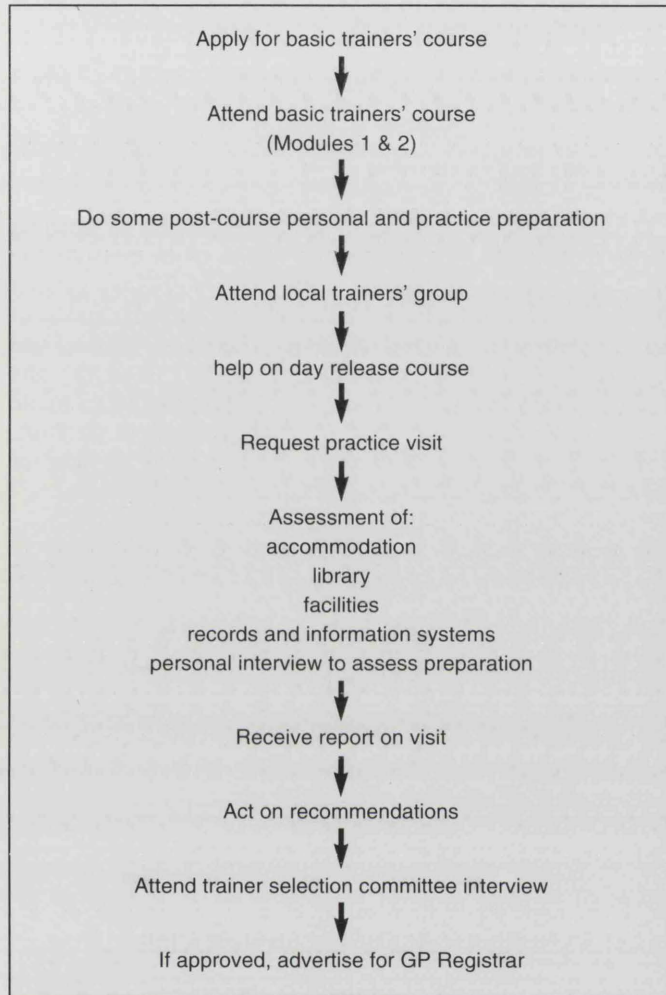


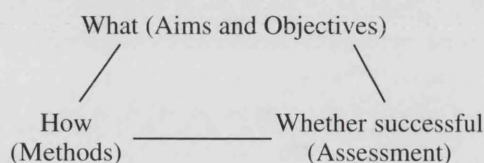
Fig. 2 - Becoming a trainer

TEACHING THE REGISTRARS

Three fundamental questions are asked about teaching:-

1. What is it that the learner needs to know and be able to do?
2. How can we best teach these things?
3. How successful has the teaching been?

THE TRIANGLE OF LEARNING



The triangle of learning can be entered at any point and we can proceed in any direction but each part is very important.

(a) The Learning Objectives

- Knowledge – this is overemphasized in undergraduate medical teaching. The facts are always changing and, although knowledge is important and needs to be tested, the GP trainer spends less time on this although it is often the registrar's priority.
- Skills – this is not only the skills of examination and procedures, but communication skills and decision-making which are often lacking in a new GP registrar.
- Attitudes – the predictor of what people will actually do. There is very little attention paid to this in undergraduate teaching.

The trainer will spend much time looking at skills and attitudes while encouraging the registrar to increase his knowledge.

Obviously, it is also important to learn management, business and financial skills.

(b) The Methods Used

Training methods are legion. Day by day constant supervision and availability is the hallmark. Particularly useful methods include:-

Random Care Analysis – this is a powerful method of teaching and demands a clear-thinking and imaginative trainer. It is possible to teach on many aspects from one case and this method is often used to assess the registrar's needs and plan future tutorials. Questioning needs to get away from "Did he/she do as I would have done?" and "Are his/her attitudes like mine?".

For example, look at decision-making skills:-

- Options – "What alternatives would you consider at this point?"
i.e. does the registrar consider reasonable alternatives within the context of general practice?
- Implications – "What are the advantages and disadvantages of the course of action you outline?"
i.e. does the registrar consider the implications?
- Choices – "Why would you do that?"
i.e. does the registrar justify the actions chosen?

Problem Case Analysis – In-depth discussion of the problems encountered by the registrar is invaluable. However, this is not about advice-giving but involves a process by which the trainer helps the registrar discover the true nature of the problems. This is often registrar-directed but, if well done, can be used to assess the registrar's needs. Cases not perceived as problems, but which contain learning opportunities can be valuable.

Other methods used for teaching are:-

- Formal tutorial
- Case discussion
- Joint surgeries and visits
- Videos of consultations and their analysis (discussed below)
- Project work
- Attachments outside the practice

TEACHING THE CONSULTATION

"The essential unit of medical practice is the occasion when in the intimacy of the consulting room a person who is ill or believes himself to be ill, seeks the advice of a doctor whom he trusts. This is the consultation and all else in the practice of medicine derives from it." Sir James Spence⁽³⁾.

Teaching the consultation is the most important task facing the trainer.

There are many models of the consultation and many books written on the subject. Most are useful and bring out different aspects of the consultation. I would like to mention two single models which I feel can be used from day to day and are very helpful in understanding what we do.

Stott and Davies describe four areas which could be systematically explored each time a patient consults⁽⁴⁾.

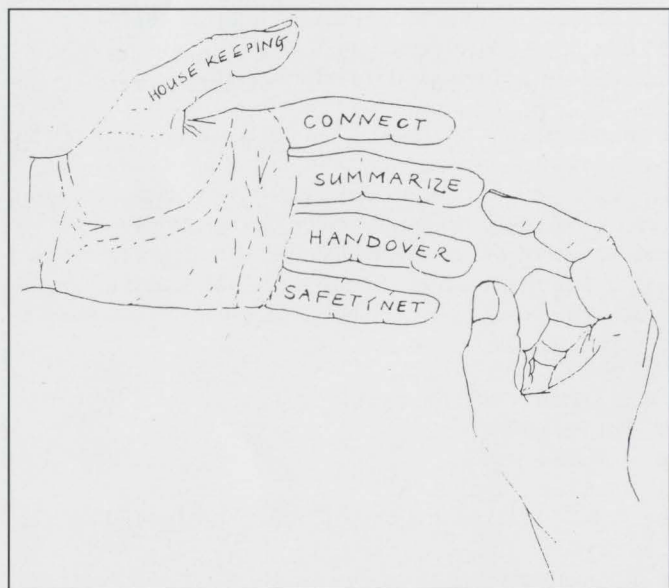
Management of presenting problem	Modification of help-seeking behaviour
Management of continuing problem	Opportunistic health promotion

Besides dealing with the presenting problem, the doctor could –

- modify the patient's help-seeking behaviour, e.g. by educating the patient about the natural history and self-medication of minor illness.
- review the patient's long-term problems by, for instance, checking blood pressure, asking about drinking habits or state of marital relations.
- take the opportunity to undertake health promotion, e.g. cervical screening, advice regarding smoking or vaccination.

In 1987, Roger Neighbour described the consultation as a journey, not a destination⁽⁵⁾. He describes five places/areas to visit during a consultation:-

- Checkpoint 1 – connecting
- Checkpoint 2 – summarizing
- Checkpoint 3 – handing over
- Checkpoint 4 – safety netting
- Checkpoint 5 – housekeeping



This is derived from many of the other consultation models and is described in his book "The Inner Consultation" which is an excellent book and will alter the way you deal with patients.

Very briefly, the points can be summarised as follows:-

CONNECT – this deals with the patient entering the room and starting the consultation. Why has the patient come? –

methods to find this out.

SUMMARISE – ideas, concerns and expectations. Exactly why has the patient come – do doctor and patient agree? The doctor summarises the consultation so far and sees if patient accepts this.

HAND OVER – the doctor hands over explanation/management of the situation – is the patient happy with this?

SAFETY NET – what should the patient expect to happen, e.g. they will recover in 10 days. If this doesn't happen, what must they do?

HOUSE KEEPING – taking care of yourself – stress prevention
A very simple example – after a bad consultation the doctor may go and make a cup of tea!

Video techniques are now standard practice for teaching and assessment of the consultation. Videos of the consultation are carried out with consent of the patient following strict ethical protocols promising confidentiality. Various aspects of the consultation can be discussed between trainer and registrar to develop consultation skills. Recently the consultation is being used more for assessment. An example of an assessment tool is the Leicester Assessment package. This looks at areas as shown in Fig 3 and gives a grade for each.

Physical Examination
Patient Management
Problem-solving
Behaviour/relationship with patient
Anticipatory care
Record keeping

Fig. 3 – Areas covered in Leicester assesment package

ASSESSMENT OF GP REGISTRARS

During the last few years there has been much discussion about how to assess future GPs. I will describe recent developments in assessment of registrars. This has met some ongoing resistance from registrars and trainers. Trainers in practice have, up until now, had to complete a VTR 1 (hospital consultants, a VTR 2) which is a certificate of satisfactory completion. This was often based on "gut" feelings about the registrar, and the forms were signed despite little written evidence of any teaching or assessment having taken place.

Assessment can be continual and formative. There must be proper recording of "gut" feelings, feedback to registrar, and agreement about actions to improve. Registrar and trainer must identify learning needs. This will be followed by some teaching, a summary of the registrar's performance, and then reassessment of needs. Recording of the process is part of assessment.

All the methods of teaching described above can be used as assessment tools and this can be added to various assessment scales such as the Manchester Rating Scale.

This scale looks at the following criteria

Criterion 1	Information Gathering
Criterion 2	Problem Solving
Criterion 3	Clinical Judgement
Criterion 4	Relationship to Patients
Criterion 5	Continuing Responsibility
Criterion 6	Emergency Care
Criterion 7	Relationships to Colleagues
Criterion 8	Professional Values
Criterion 9	Overall Competence

Each of these is graded poor, marginal, good or excellent. Fig 4 shows an example of Criterion 4-Relationship to Patients.

Recently there have been demands for those completing vocational training to demonstrate their competence for independent practice through an objective assessment that operates to a national standard⁽⁶⁾. This is Summative Assessment. Reasons given for the introduction of Summative Assessment are:-

- to assess the competence of those joining the profession
- to reassure the public and protect patients from doctors whose performance is not adequate
- to reassure doctors they have achieved the minimum standard
- to identify those not ready for independent practice and who require further training or need to reconsider career options

The Royal College of General Practitioners, in a policy statement⁽⁷⁾, says that upon completion of vocational training, all doctors should sit the MRCGP. They suggest that all new principals should hold this qualification. As pointed out by Bahrami⁽⁸⁾, this is difficult to reconcile with the college's support for the Joint Committee's separate package of summative assessment. It is intended that registrars completing vocational training after September 1996 will have to undertake the summative assessment package which includes:-

- - consultation assessment (videos)
- - MCQ
- - written project
- - trainer's report

There is still much discussion and argument about this but, at present, doctors will need to pass summative assessment to enter general practice and will not need the MRCGP. It is likely that the MRCGP will make registrars exempt from parts of summative assessment eg the MCQ.

CONCLUSION

I have outlined the training of general practitioners and introduced some of the concepts/methods that we use. It should be possible for there to be an increased use of such methods especially in hospital teaching. Many of these techniques do not require a reduction in service commitment as they can be used during normal daily work with thought and imagination and would not lead to an increased amount of "time off" for teaching or so-called protected time.

In general practice we are already encouraged to continue our education after becoming a principal! Currently this is achieved by paying GPs the postgraduate education allowance. Unfortunately this type of education is not always relevant and the RCGP is trying to encourage continuing education as a professional responsibility rather than a contractual obligation. In the future we are being encouraged to have personal education plans based on need. There has already been the introduction of fellowship by assessment and we are waiting for some form of GP re-accreditation⁽⁹⁾: lots to look forward to!

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MANCHESTER RATING SCALES

CRITERION 4: RELATIONSHIP TO PATIENTS

This criterion is concerned with the trainee's effectiveness in working with patients.

THE UNACCEPTABLE TRAINEE

does not relate well to patients either through aloofness, discourtesy, indifference or pressure of work. He has difficulty in understanding his patients' needs. He is unable to give patients confidence and may even unnecessarily alarm them. He reacts poorly to a patient's hostile or emotional behaviour. He does not exhibit sympathy or compassion in dealing with patients.

THE ACCEPTABLE TRAINEE

gives patients confidence, affords co-operation and relieves their anxiety. While patients appreciate his interest in their well-being he himself does not become emotionally involved. He is honest with the patient and his family. Patients like him and feel he is an easy person of whom to ask questions, or with whom they may discuss problems.

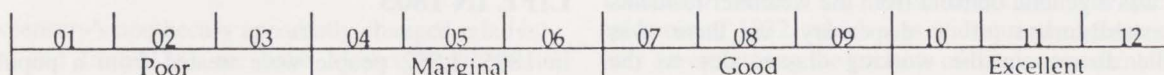


Fig. 4