The future of general practice education

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The current state of general practice education

Formal general practice education has been running for over 30 years in New Zealand. During the last 30 years the world has changed immensely, and so has the practice of medicine and general practice. However, there has been little change in the structure of general practice education during that time. The trainees who now enter postgraduate general practice training are different from those of 30 years ago. They are shaped from a different society, with different expectations, and their experiences prior to entering postgraduate training are very different from those of their predecessors. To meet the needs of current trainees and to provide them with the skills to practise in the future world of general practice, the model of general practice education also needs to change.

In hospital medicine today you cannot go far without bumping into an MPS Casebook, or mention of the Health and Disability Commissioner. The environment of perceived medico-legal risk can often result in the practice of good medicine being replaced by the practice of defensive medicine. One can split hairs on the differences between the two but defensive medicine does have downstream effects on the undergraduate and postgraduate junior doctors in the team. For example, there is a greater importance placed on documentable findings, so investigations gain weight over clinical acumen. Also there is less autonomy for junior staff. Although this defensive medical environment may result in greater patient safety, junior staff miss out on opportunities to develop the skills of decision-making and independent thought. There is less opportunity for inexperienced members of the team to attempt new procedures for fear of making mistakes. In addition, the role of the junior doctor in the hospital setting is becoming increasingly clerical. Less time is spent on consultation and clinical skills. Patients now spend very little time in hospital. Many conditions for which patients were previously admitted are now managed outside the hospital or through outpatient visits. Ultimately, all of these aspects lead to less experience for the junior doctor.

There has been a recent article in the *NZMJ*,[1] and comments from the Minister of Health, regarding the lack of skills in junior doctors. This lack of experience and confidence, and the fear of harsh judgments of any mistakes, will deter junior doctors from leaving the supervised safety of hospital-based training, unless they feel that the GP training scheme can give them what they need. In addition, we are not even encouraging people into general practice. Junior doctors are only exposed to a hospital environment and hospital education pathways. Even those with a genuine interest in general practice need to be almost brave in order to leave the familiarity of the hospital system and go into the unknown world of general practice.

Perhaps the hospital system can no longer be relied upon to provide all the necessary experience required for junior doctors. There has been debate in the medical media recently of developing a first year GP run for junior doctors as part of their registration process. I would argue that in their first year and certainly in their first six months, most junior doctors would need a lot of supervision and gain less from GP exposure than those who have already achieved general registration. However, I believe that second year GP experience would benefit all doctors – those intent on a GP career and those going into other specialty training, as it may well help towards greater understanding and better communication skills. There is already a GP house surgeon run set up for doctors in their second or third

postgraduate years to encourage them into rural general practice – it is a three-month attachment and at present has 24 places per year. I was one of the early participants in this programme. I can certainly vouch for its usefulness both educationally and as a chance to focus on what I wanted to achieve prior to the GP registrar year. So why not work on enhancing this structure that is already in place, rather than re-inventing the wheel – I certainly would not want to gain a first year GP run at the expense of the existing scheme.

There is little guidance for GP trainees on what sort of experience they should try to gain before entering the training scheme. One could argue that general practice is best learnt in general practice but I think that the hospital environment is still better placed to offer close supervision to junior doctors and the structure for this is already in place. GPs also need to understand hospital medicine. There are lists of preferred runs but no guidance as to the suitability of these in certain areas and often some of the positions are protected for those who wish to train in that field. It would not be a new thing to have a number of placements held for GP trainees in certain fields as this is already done for surgery and emergency medicine trainees. Potentially those who knew they wanted to be GPs could enter into a loose training structure within the hospital incorporating a house surgeon GP run once they had achieved general registration.

Most of our clinical medical education occurs in a situation in which an apprentice junior doctor learns under the supervision and guidance of a teacher. In postgraduate general practice education this model is used in the teaching practice component of the registrar programme and for the PGY2/3 house surgeon run. Trainees going through the seminar only programme may not ever be involved. Why is this apprenticeship important? I think it provides the support that most trainees need to make the transition from hospital medicine to general practice. It provides a relationship for dynamic learning in which the teacher can give feedback and appreciate the response. There is a chance for learning about the process of the consultation, the self of the doctor and collegiality. Learning medicine in isolation is to practise trial and error and we know how unforgiving the world has become of error.

The problem with the current model of GP training is that for most of the trainees there is only nine months of this apprenticeship. One can learn a lot in nine months of intensive work but not enough, I believe, for many modern trainees to feel secure. Trainees who do not feel secure are more likely to shy away from general practice and especially rural general practice where they do not have the security of a hospital and its specialist and emergency services just up the road. Our current Advanced Vocational Education programme provides little support for general practice trainees. Supervision is in the form of the Medical Council's oversight requirements for doctors without vocational registration and the guidance of the regional facilitator to keep momentum up through the hurdles.

I believe that the current registrar programme is an excellent model for training, albeit too short. I found it to be well run and full of superb and patient teachers. I learned far more about the consultation, the practice of medicine and myself as a doctor from my apprenticeship than I did from attending seminars.

I believe the Intensive Clinical Training Programme has one problem other than its length and that is the focus on the hurdle of the written Primex exam occurring in about the eighth month.

We all tend to be hurdle focused – half an eye on the ground under our feet and the rest looking towards the next rail we have to jump. This is the biggest problem around the Primex. I'm sure many GP registrar teachers will be familiar with the problems trying to teach general practice and the consultation process to trainees obsessed with answering multi-choice questions. I believe this takes the focus away from the apprenticeship and onto book-based learning. Yes, knowledge is important and yes, there needs to be some assessment of it. But surely, after seven months of general practice experience, trainees should be ripe to hone their skills and tackle the more complex issues of family medicine rather than have their noses in text books. The simulated patient exam is a more fitting assessment of the content of the registrar programme and should remain as it is. I believe that the registrar period should be longer and then the written exam could occur relatively earlier.

The fragmentation of general practice education

Present GP education is compartmentalised into a number of almost separate entities. What should be a continuous, seamless pathway is broken down into four quite separate stages: undergraduate, early postgraduate, Intensive Clinical Training Programme (ICTP) (seminar only attendees are a separate category again) and Advanced Vocational Education (AVE).

1. ***Undergraduate:*** There is a reasonable presence of general practice at most levels but I will not focus on this.
2. ***Early postgraduate:*** Under the present system, the aspiring GP loses all contact with general practice during the early post graduate years (except those who have an interest in rural practice and the good fortune to get a place on the PGY2/3 run.) Perhaps the ideal would be a house surgeon run late in the first or early in the second year for all junior doctors and a further advanced run for all those who want go on to GP training.
3. ***ICTP:*** In the current structure, other than those on the PGY2/3, everyone must leave the hospital system and join the ICTP. I think that the intensive nature of this apprentice model with GP teacher supervision and protected educa-

tion is the best way of learning general practice.

Some would look at the good outcomes of the seminar only group in exams and their progression to Fellowship and challenge the cost-effectiveness of the registrar programme. However, I argue that at present the seminar attendees represent a very different group from those who are registrars – they are often doctors with considerable experience in general practice and other fields before they decide to obtain GP qualifications. A change to this sort of model for all would certainly not be an investment in the future of general practice.

4. ***AVE:*** After Primex and gaining membership of the College, the trainee is really free to go and work as a GP provided they have 'oversight' and work in a practice with at least one doctor who has Fellowship. There is no mention of supervision. Some will go on to AVE; some will even complete it. The AVE programme seems so separate from the registrar year that in our year nobody even received the information pack until after having finished the year. It was almost like an invitation to join a secret society. By this time most had already finalised working arrangements, based around a variety of factors, but continuing education was not likely to be one of these factors. AVE is much like the seminar attendee programme – a self-funded series of hoops to jump through to reach Fellowship. You are expected to meet the appropriate standards and show that you are of Fellowship quality but the emphasis is entirely on self help. You are expected to develop reflective practice on your own, essentially with no guidance or support. There are plenty of stories of people struggling or failing to complete AVE with no protected learning time and little perceived benefit.

I think as a College we have an image problem. We are training Members but not Fellows – contrast this with the other colleges. Here am I, no longer a registrar but still a trainee of sorts, not a Fellow but effectively practising independently. I work as a locum, so the primary driver of what I do each day is really money, not educational benefit. At present I feel as though I'm being trained by my vocation, not for it. Vocational education: advanced chronologically but not educationally. If you set out with a pathway to train Fellows rather than Members then you will get them. Isn't that what we should really be aiming for as the standard of general practice in this country? It is certainly the standard for other specialties, and what one hopes that Fellowship of the College actually means. Why accept less?

Solutions?

I think we already have the elements of a very good training system – but there just isn't enough of it. There should be opportunities for fostering junior doctors through appropriate hospital runs into the formal training programme. Then the registrar experience should be longer and end with Fellowship. I think that the registrar programme should start with more seminars, which are progressively reduced, but the GP teaching apprenticeship should be retained for longer. As the trainee gains more knowledge and skill they gain greater autonomy and spend less time in seminars. Seminars may become more like a true group of peers where the group learns from sharing experiences gained at the same level. The written Primex should be earlier, within the time of increased seminar work and the simulated patient examination should be later, within the time of greater clinical work. In the advanced registrar years, trainees should be mostly independent but with regular mentoring and supervision, more in the sense of clinical psychology, rather than watching over your shoulder. It is important to retain elements of flexible delivery, understanding that we are training self-aware generalists, not carbon-copy surgeons. Perhaps the exams could be sat at varying times within the programme depending on the trainee's readiness; some may even sit the written exam before becoming a registrar. Even with flexibility I think we need to aim for quality – we want to produce the best GPs we can and I think that the registrar programme should be the gold standard. Alternative pathways should be reserved for those with prior GP qualifications gained overseas. I think we should aim for this and for this to be funded through the Clinical Training Agency, DHBs or otherwise. Perhaps with the CTA review underway, and DHBs slowly realising their responsibility for primary care, it is time to push forward for a better training scheme – one that will keep New Zealand general practice strong for the future.

In summary

The current system does not meet the needs of modern trainees who need more guidance and support to make up for less prior experience.

There should be an almost seamless pathway for GP trainees into Fellowship, starting from their early postgraduate years.

The apprentice model of registrar training should be expanded and the timetable of assessment modified to interfere less with learning opportunities.

We have excellent teachers within this system but they need to have more opportunity to teach effectively.

Competing interests

None declared

References

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