

Here is another article from our very popular series:

### **People who Train People**

All the facts in the article were true at the time of writing but of course may have changed slightly over the last ten years. Penny Aeberhard runs a medical general practice with two other doctors in Stoke Poges, England. She has been a doctor for 30 years and regularly trains apprentices.

## **Training for general practice**

by *Penny Aeberhard*

### **General Background**

Medical school training in the U.K. is changing slowly. Over the last two decades departments of General Practice have been set up in Universities and there are now even a couple of professors of General Practice. There is a greater interest in psychology and behavioural sciences. But it is still quite possible for a newly qualified doctor to have only had two weeks experience in practice out of five years of undergraduate study. Most of those five years, focus on medicine as a science: strings of cause and effect, symptoms and signs, laboratory tests and prescriptive medication – the basis of hospital medicine. However, back in 1966, when the Charter of General Practice was produced, it was recognised that a good General Practitioner (GP) needed more than that. At that time General Practice was in the doldrums. Professional respect and job satisfaction was very low. Emigration of doctors peaked at this time too. But the Charter was a turning point and succeeded not just in encouraging good practice but also in winning professional respect over a time so that now the majority of newly qualified doctors aim to enter General Practice. Back in the 1960's too, Balint, a psychoanalyst at the Tavistock Clinic and his group of GP's were starting to analyse the doctor-patient relationship. This analysis continues to this day.

From the time of the Charter, the existing training scheme for GP's was expanded until in 1981 it became compulsory, by law, that all new GP principals\*(1) had to have undergone, after initial qualification and one year 'pre-Registration' work, three years of approved further experience. This is two years in hospital in four approved specialities such as paediatrics, psychiatry, gynaecology or geriatrics, plus one year in one or two approved practices. The scheme is overseen by a board of certification. At present, at any one time, there are around 2,000 trainee GP's in their General Practice year. They are organized into districts and regions to facilitate the group meetings and discussions that occur half to one day a week. For the rest of the time they work as an apprentice under their approved trainer.

### **The Selection of Trainers**

Trainers do not as yet have a nationally agreed approval board. In all areas, however, the applicant, an experienced general practitioner, has to provide evidence of some ability to teach, and to have a high standard of patient care and good consultation skills, 'bedside manner', if you like. In the Oxford region this selection is rigorous and three visiting doctors will spend a whole day interviewing nurses and receptionists who work in the practice; scrutinizing the patient notes that have to reflect a high standard of care and organisation; and, furthermore, assessing the trainer's suitability of attitudes and skills. The latter is done by discussion and analysis of a videoed consultation. Trainers are now well respected members of the profession. They no longer use trainees as just an extra pair of hands in a busy practice but give thorough teaching.

### **What is a Good GP?**

To select trainers, academic boards have had to start to define what they think 'good' General Practice is. 'Quality in practice' is a big debating point now and there are attempts to define too, exactly what a

trainer is trying to give to a trainee. The training year is not cheap, as a trainee doctor is paid the salary of her/his last post by the training practice and yet the training practice is only paid £2,400 p.a. Of course patients in the lucky practice get a good deal, but the practice and the profession must justify the expenditure.

What are these criteria at the present time, then, and how are they being taught? Criteria for a 'good' GP and curriculum for a trainee are one and the same.

Some years ago, vast curriculum checklists were produced of clinical illnesses, emergencies and procedures. Trainer and trainee would try and 'collect' cases to discuss at their two-hour tutorial. But it was clear that GP's were just emulating hospital doctors and trying to compete and be specialists in everything. It is not ever possible to see more than a sample of conditions in a year. The idea was bound to fail. But what is important for a generalist is to learn that the management of a chronic illness can be similar whether it is diabetes or arthritis. To be able to recognize that there are medical and social aspects to these diseases is what counts as well as the long term responsibility to these patients. In practice one sees illness in early, unformed stages. In hospital the disease process has crystallized into a more definitive diagnosis. GP's have to learn at times when to be patient and wait, for so much illness gets better spontaneously, and to tolerate their own anxiety because over diagnosis and treatment are not appreciated by patients. There are times, of course, when action has to be prompt and accurate to be safe. A trainee has to gain this discrimination by experience. A fruitful source of learning here is the discussion, often after a long day, of the trainer's surgery\*(2). Alternatively the trainee can sit in on the trainer's surgery or vice-versa or the two of them can share a surgery. This sharing of patient care means a greater spectrum of illnesses can be covered.

### **Can you teach Communication skills?**

Acknowledging, then, that lists of diseases are not necessarily the best curriculum, what should be covered? Back to the idea of what is 'good' General Practice. Communication has to be an important skill, until recently undervalued by the profession but instantly recognized by patients. How is it to be taught? Is it possible to teach a good bedside manner or is it simply intuitive? Analysis of consultation by different techniques, e.g., Balint-type discussion; listening to tape recordings; interviewing patients before and after seeing the doctor have all been used so that we now understand the processes better than ever. Psychologists have helped us analyse non-verbal and bodily communication too. One of the tools used in General Practice is now the frequent use of a video camera in consultations (with the patient's permission). Trainer and trainee can then look at different aspects of communication and different styles. One ten minute consultation can be viewed and then ensuing discussion can take an hour. An example here is observation of behaviour used by a GP to attempt to end a consultation, e.g., dropping of eye contact, pulling back from desk, writing out prescriptions, shuffling papers, standing up or helping the patient on with their coat. Trainees can be made aware of abrupt or rude behaviour. Though intuitive for some, good consultations can be taught and even the good can be bettered.

Another aspect in the curriculum for good practice is liaison with, and respect for, other professionals (such as district nurses and health visitors) working in the Primary Health Care Team.

The opportunity to accompany others in their jobs, and, hopefully, seeing a good team meeting and working together is the best education, and will lead to effective communication within a group.

### **Management Skills**

General practitioners are independent contractors to the Health Service and therefore the business administration side must also be covered in training. Patients appreciate efficient and kind receptionists, a good appointment system and pleasant, warm reception areas. The jungle of claim forms and regulations must mean that by the end of the year the trainee doctor should at least be equipped with a machete and map!

Some of this can best be taught by a traditional lecturing format in the Day Release scheme with others, but for the information to be meaningful, the trainee should be present at the partner's business meetings, meet the accountant and understand for example how sick pay is calculated when a receptionist is ill.

### One to One Training Methods

We are aware of how in a one-to-one situation we should be able to offer a training flexible enough to take into consideration the trainee's own perceived needs as well as the profession's thoughts on what is 'good'. Formal assessments are needed therefore to plan the individual curriculum, as well as to assess progress and avoid collusion between trainer and trainee to miss out a 'boring' or weak area. Assessments in General Practice training have developed, not just through the professional's skills, but have also been gleaned from psychologists working in businesses and hospitals, and from the wider teaching profession.

Teaching assessments often go hand in hand, for instance, with video analysis. To make the best out of video viewing and discussion there are now many tools available. One example is the "map", a form filled in while watching the video. If the video is of a GP/patient consultation for example the viewer can jot down notes under headings such as "Patient's concerns". "Patient's expectations". "Involvement of patient in management of illness". After the video watching and "mapping" comes the "rating" where the viewer ticks along a scale from, for example, "Patient involved in management adequately and appropriately" to "Involvement in management inadequate or inappropriate". The "Manchester rating scales" can be used following a direct observation (sitting-in, viewing through a one-way mirror or using audio or audio-visual techniques) or indirect observation (a report or later discussion of an observation) and again involve ticking along a scale as the following:

|  |   |   |   |   |   |   |   |   |    |
|--|---|---|---|---|---|---|---|---|----|
| 1  | 2 | 3 | 4 | 5 | 6   | 7 | 8 | 9 | 10 |
| Patients are treated with disdain, as little children or stupid with no opinions, or no right to voice them. |   |   |   |   | Doctor always tries to build an adult-adult relationship with patients.<br>Patients are encouraged to be more self-aware, more questioning and more self-reliant. |   |   |   |    |

Little boxes are also used:

|                                       | Never | Sometimes | Usually | Always |
|---------------------------------------|-------|-----------|---------|--------|
| Clean, neat and appropriately dressed |       |           |         |        |
| Non-authoritarian manner              |       |           |         |        |
| Shows respect for patients' ideas     |       |           |         |        |
| Etc.                                  |       |           |         |        |

Rating scales can look at simple parameters such as tidiness of the room or at more complex behaviours or attitudes. The aim is not to rank trainees but to teach them, to encourage them to develop or change a set of behaviours. In this the content of the rating scale is as important as the outcome of the assessment.

As well as maps and rating scales there are also quite sophisticated examinations that search for breadth of experience and lateral thinking and these are indeed part of the examination for the membership of the Royal College of General Practitioners. These, along with 'vivas' (oral examinations) and multiple choice questions, are assessments that may be carried out several times along the course of the year.

### The Apprenticeship

I have touched on some aspects of the history of training in General Practice in England and on some of the perceived priorities of curriculum and assessments as well as on the one to one apprenticeship relationship between trainer and trainee. Apprenticeship has a bad name in England unlike in the rest

of Europe where tradespeople in general are held in high esteem and the apprentice is also valued and paid appropriately. Apprentices are taught their craft by practice and example. The General Practice apprenticeship is a rare and good example of this system in the U.K. The relationship is a very close and bonds of friendship develop. The trainee can contribute to the ongoing development of the trainer and the practice. The trainer must, however, be aware of not 'cloning' the trainee! Individual strengths should be brought out – indeed, doing so is one criterion of a successful trainee-ship.

### **Variety of Training Methods**

The personal growth and knowledge of the trainee must be fostered by a variety of training methods. The two-hour weekly tutorial involving didactic teaching by the trainer (so often perceived as the only way to teach in hospital) works best if seen as sharing new discoveries with the trainee contributing and must be supplemented by self-criticism and "audit of work". "Audit of work" means not presuming you know what your behaviour in a certain area of work is but deciding to log it in some way and analyse it. An example would be looking at the giving of prescriptions to patients. This could be logged and then analysed for different features e.g. costs of what you prescribe or types of medication prescribed. Then you decide what you want to do. You may decide to prescribe lower cost medication. You then re-log and re-analyse to see if you have changed your behaviour. You can audit your own or the practice's work. Auditing is a tool to keep day to day work fresh. It forces isolated GP's, in the rather "God-like" roles they often have, to be down-to-earth and self critical.

It is important too that the personal stress that a GP may feel is recognised and shared and for GP's to have their own doctor! This way GP's have a better chance of knowing how to help others, allowing the patients to control their own lives and make independent choices.

### **Conclusions**

To be taught by example, to be stimulated by enthusiasm, and gain confidence in one's skills must be part of apprenticeship. Part of it too is the ongoing development of the trainer. We hope both trainees and trainers in the apprenticeship system will stay students for life.

\*(1) A principal is a GP partner sharing full responsibility for the running of a practice.

\*(2) "Surgery" in England is the time when people can come to the GP to discuss their symptoms and obtain advice and prescriptions for medicine which they then take to a chemist's.