General practice

Is general practice in need of a career structure?

Glyn J Elwyn, Simon A Smail, Adrian G K Edwards

Department of
Postgraduate
Education for
General Practice
and Department of
General Practice,
University of Wales
College of
Medicine, Cardiff
CF4 4XN

Glyn J Elwyn,
senior lecturer
Simon A Smail,
*director of
postgraduate
education for general
practice in Wales*
Adrian G K
Edwards,
*lecturer in general
practice*

Correspondence to:
Dr Elwyn
elwynG@cf.ac.uk

BMJ 1998;317:730-3

With nearly 1000 vacancies for general practitioners in the United Kingdom in 1998,¹ the recruitment problem—exacerbated by early retirement by doctors keen to leave a discipline under pressure—is high on the professional agenda. Recruitment to general practice depends on acceptable and appropriate training. Bain has suggested that role models for the training of general practitioners in Britain are still stuck in a time warp of the 1970s, when the first training scheme started.² The government, however, has deemed that primary care is to become the steering force of the NHS again. An imbalance exists therefore between the strength needed to steer the NHS and the potential lack of structure in general practice training.

Current educational and career framework

Specific training for doctors to become general practitioners was first implemented in the 1970s. The scheme that was finally accepted (the vocational training scheme) comprised two years' experience in a variety of approved senior house officer posts in hospital, coupled with one year in general practice. Although the scheme was always a compromise (the Royal College of General Practitioners argued from the outset for five years' training), it has been tolerated, even applauded occasionally. Figure 1 illustrates the current training and educational system.

The consultation study on general practice training by Hayden and colleagues sounded the alarm bells, but their suggestions to reorganise vocational training³ have been ignored. The vocational training scheme, as currently conceptualised, is clearly out of date,² weighed down by the laudable but onerous requirements of "summative assessment"—a series of hoops at the end of training (trainer's report, multiple choice questions, video assessment, and audit project) and separate from the Royal College of General Practitioners' examination.^{4 5} The timescale is ridiculous. Once study leave and annual leave have been accounted for, the registrar is left with barely 46 weeks to metamorphose from senior house officer to potential principal. Senior house officer posts—even those approved for general practice training—are still primarily geared towards the educational needs of specialist training, even though all the posts are supposed to be approved for "general professional training."

Choosing general practice is not always a positive decision.⁶ Also, young doctors are increasingly aware of

Summary points

The training for general medical practice in Britain is outdated and based on a requirement to spend two years in hospital posts and one year in a training practice

All other disciplines require a professional college standard to be achieved either at entry or during training but general practice has no entry criteria

Training should occur in the context of general practice so that the generalist registrar becomes the equivalent of the specialist registrar, integrates with the multidisciplinary team, and has protected time for professional development and research

Flexibility to allow part time training or moving areas without incurring undue penalties would be important

Postgraduate directors should control the training resources and form contracts with training practices and hospital departments to deliver a practice based generalist registrar scheme

The career structure after training should be reorganised to allow development of educational, research, and managerial roles within practitioners' NHS responsibilities

the void facing them as they emerge from vocational training schemes.⁷ They can either enter the "hidden hierarchies" of partnerships or work as non-principals (retainees, assistants, and other part time practitioners), now estimated to represent a fifth of the generalist workforce.⁸

After the vocational training scheme no structured professional development (or career advisory service) exists for general practitioners, and no account is taken of general practitioners' needs as they enter the early, middle, and preretirement phases of their career. Those who join supportive partnerships are fortunate, but many doctors, both principals and non-principals, find themselves isolated, sometimes exploited, and for them the postgraduate education allowance system simply means collecting certificates of attendance at educational events. Young practitioners now prefer

Fig 1 Current educational and training system for general practitioners in Britain

Fig 2 Length of training periods for generalists in Europe (J Allen, personal communication)

flexible working arrangements.⁹ Aware that their secondary care colleagues have more varied roles, these younger practitioners want to acquire additional skills.

What happens in Europe?

Until specific training for general practice became a mandatory requirement in 1995 (as a result of the implementation of the EEC directive 93/16), professional preparation for family practice had developed at different rates in Europe. Although complex "acquired" rights exist for generalists who qualified before this date, a substantial variation still exists

across the general practice training schemes in the member states of the European Union, ranging from 2 years' training (the minimum allowed under article 31 of council directive 93/16/EEC) in Iceland, Belgium, and Italy to five years in Norway. The directive requires a minimum of 6 months' training in an approved general practice, but this is interpreted in different ways. Figure 2 illustrates how the training time is divided between hospital and general practice posts. Information on which to base a comparison of outcomes (clinical skills and competence) of the various training schemes in Europe, however, does not exist.

Comparison with specialist training

Comparisons with the specialist training arrangements for hospital doctors could not be starker.¹⁰ Doctors who choose a career in a specialty spend at least two to three years at senior house officer grade, and during these years work to meet the entry criteria for the training grade (now known as specialist registrars). In most specialties the entry criterion is membership of the requisite professional college. After competitive entry, successful candidates become specialist registrars, are allocated a national training number, and complete a prescribed period of in service training to obtain a certificate of completion of specialist training. This period usually lasts four to six years and includes protected sessions for research and study. The emerging specialist, if successful in obtaining a post, joins the consultant workforce, often having completed research projects and, increasingly, gained management experience.

By comparison, the current vocational training scheme is totally inadequate for preparing a young practitioner to manage a practice, let alone lead the NHS, as the government wants. Entry requirements are slack, almost invisible. When shortages exist, training schemes might be tempted to appoint registrars with inadequate language skills. Despite what many believe, employers may ask for evidence of language skills, even among doctors coming from the European Economic Area. Indeed, in a legal precedent in 1996 it was determined that language skills were not a racial characteristic.

Many senior house officers organise their own rotations and often remain undecided about their career direction. Although technically a three year programme, vocational training is no more than one year's training added on to a mix of senior house officer posts. Most of the so-called vocational period is in NHS trusts, filling senior house officer posts, where the training varies in quality, is often non-existent, and is certainly not oriented to general practice.¹¹ One year is then spent either in one general practice or in two (six months in each). This is when the summative assessment is crammed into a timetable that allows for little but the preparation of a video and an audit project. It certainly does not leave time to learn how to fit into a team or acquire business, research, educational, or commissioning expertise—all skills required for independent generalist practice.

Is a generalist registrar training a possibility?

Hasler and others argue that vocational training for general practice needs to be based not on senior house officer rotations but on general practice training programmes.¹² They argue that to improve the vocational training scheme the educational organisations need to control the corresponding budgets and shift the balance of time spent away from hospital jobs.^{12 13} It will be interesting to see whether their proposals achieve wide support. But why stop there? Why not accept that generalist training should take place in general practice,¹⁴ that it should be a practice based activity, except for the occasional sojourn to the technical world of specialists? It makes sense to provide elements of skills training for general practice in the context of hospital practice, but the current model of senior house officer posts, with their inevitable service demands, is hardly appropriate. A new model of intensive skills training in relevant hospital services is required—probably with a large element of learning in outpatient clinics, which is often completely lacking in current arrangements for senior house officers.

Why does general practice accept such an inferior training structure compared with the strict entry criteria and structured pathway laid out for specialist registrars? Is it any wonder that young clinicians shun a generalist career when it is clear that the real training takes place in the first five years as a principal? And in these five years, learning “on the job” is typically accompanied by the stress of taking on a large loan while contemplating the implications of a partnership agreement and wondering if this is truly the right choice for the next 30 years.

Should we not, therefore, acknowledge that the years as senior house officers mainly provide broad preparation for a range of careers?¹⁵ A clinician choosing to become a generalist should surely have to meet the entry criteria for general practice training after a period of broad based, supervised practice. This “entry gate” could be a more appropriate role for summative assessment. It would at least guarantee a basic level of communication skills.

Logically, from this point onwards the generalist registrar should be based for three to four years in a training practice, providing a service role while having protected educational input. Flexibility within this overall structure would be essential. Registrars will want to move areas or work part time, and this should be facilitated without their incurring penalties on the overall timescale of training. Other training from hospital specialties could still be included if it was relevant. The proposal is simple: aspiring generalists should be provided with a structure similar to that for specialist registrars in secondary care, without the financial burden and the commitment of a long term partnership agreement. From this practice base the necessary components of planned training could be purchased through brief attachments to outpatient departments.¹² The emphasis could then be directed at the requirements for generalist practice: funduscopy, indirect laryngoscopy, minor surgical procedures, joint injection techniques, and many other specific areas seldom addressed under the current arrangements.

Registrars should have protected time to develop their own professional interests (research, commissioning, or education) and study time to pass the examinations for the Membership of the Royal College of General Practitioners, which the college and others maintain should become the accepted exit point from training.¹⁶ Rotations to non-training practices could also be included—an opportunity perhaps for registrars in the final phase of training to have an attempt at managing change in less ideal circumstances, in the very areas where recruitment is hardest.¹⁷ There would be anxieties that this system would provide cheap labour—a problem that will need addressing. But paying salaries to generalist registrars on equivalent scales to other career registrars, rather than spending General Medical Services funds on restless junior partners, might even cost the NHS less. It certainly fits in with what young practitioners are calling out for in general practice.⁷

Entering the void after vocational training

The current vocational training scheme releases young practitioners into a buyers' marketplace, and consequently many are postponing their career decision by spending time abroad or working in long or short term locum posts or assistantships. They are wary of becoming principals and are increasingly sceptical about the void that they see before them: a “less valued clinical horizon” within a tightly controlled primary care service perceived to have few of the potential benefits of independent contractor status.⁶ A survey in 1996 of 107 general practice registrars and senior house officers in Wales showed that only 24% were intending to become principals immediately after completing training, 49% were likely to spend up to three years doing other things—often continuing to work as senior house officers, for lack of any other suitable employment—and 27% were undecided about their future career.¹⁸

It need not be like this. General practice can be a demanding and exciting career, but it takes determination to capitalise on the opportunities that exist in education, practice management, research, and health

Fig 3 Potential educational and training system for general practitioners in Britain

commissioning. These opportunities need to be more accessible, but numerous factors militate against generalists becoming involved in non-clinical activities, staffing shortages being one of the main obstacles. Many established principals are ambivalent about non-clinical work, and obtaining permission from partnerships to develop other interests or pursue further qualifications can often be a dispiriting activity.

Not only does general practice training need an overhaul, but general practitioners need a professional developmental framework and career guidance.¹⁹ General practice has always allowed a diversity of interests, but these have been regarded as “fillers,” done in spare sessions or between surgeries. But the systematic rigidity that promoted that dilettante approach is changing. Part time working, portfolio doctors, and salaried practitioner posts are the expected norm among those emerging from the vocational training scheme. Moreover, such posts are now regularly advertised. A training scheme such as that illustrated in figure 3 needs to be urgently developed. The announcement that practice and personal development plans are to be introduced is a crucial step in this direction.²⁰ The education, research, commissioning, and management organisations need to define and support these career development opportunities for generalists.

Avoiding a crash

If, as we keep hearing, primary care is to be the point of first access, the gateway to other services, and the “commissioner” for the NHS, then the generalist career structure needs attention, fast. A training system based on senior house officers serving time in secondary care is hopelessly outdated for a doctor who needs to meet both the demands of increasingly well informed patients and the complex requirements of a multidisciplinary organisation. Postgraduate directors need to control the training budgets and lay the career pathway where it logically belongs—in the generalist workplace. Established general practitioners then need the opportunities experienced by their colleagues in secondary care, who incorporate teaching, management, and other functions seamlessly into their NHS contracts. In reality, the years after vocational training are anything but a void. Yet it still seems that young doctors

mistakenly perceive general practice as an easy ride in a long dark tunnel. If we are to avoid what many fear is a crash ahead, general practice needs more than a bit of tinkering with the track—it needs a more purposeful journey in a different landscape.

We thank Drs David Wood, Keith Richards, Gareth Parry Jones, Alan Rogers, Sarah Matthews, Malcolm Lewis, Phil Mathews, and Trisha Greenhalgh for their help.

Funding: None.

Conflict of interest: None.

- 1 Medical Practices Committee. *Survey of general practice recruitment in England and Wales*. London: MPC, 1997.
- 2 Bain J. Vocational training: the end or the beginning? *Br J Gen Pract* 1996;46:328-33.
- 3 Hayden J, Styles WMcN, Grant J, Mountford B. Developing vocational training for British general practice: a system for the future. *Education for General Practice* 1996;7:1-7.
- 4 Tegner H. Summative assessment—a front line perspective. *Education for General Practice* 1997;8:95-9.
- 5 Rhodes M, Wolf A. The summative assessment package: a closer look. *Education for General Practice* 1997;8:1-7.
- 6 Petchey R, Williams J, Baker M. “Ending up a GP”: a qualitative study of junior doctors’ perception of general practice as a career. *Family Practice* 1997;14:194-8.
- 7 Bosnor R, Gibbs T, Woodward R. Vocational training and beyond—listening to voices from a void. *Br J Gen Pract* 1998;48:915-8.
- 8 Wall D, Campbell I. *The educational needs of general practitioner non-principals*. London: Standing Committee on Postgraduate Medical and Dental Education, 1997.
- 9 Taylor Jr DH, Leese B. Recruitment, retention, and time commitment change of general practitioners in England and Wales, 1990-4: a retrospective study. *BMJ* 1997;314:1806-10.
- 10 Department of Health. *A guide to specialist registrar training*. London: NHS Executive, 1996.
- 11 Paice E, West G, Cooper R, Orton V, Scotland A. Senior house officer training: is it getting better? A questionnaire survey. *BMJ* 1997;314:710-1.
- 12 Hasler J, Morando S, Percy D, Plant M, Smail S. *Vocational training for general practice: from SHO rotations to general practice training programmes*. London: Committee of Regional Advisers in General Practice in England, 1997.
- 13 Savage R, Torry R, Vaughan C, Horner B. Vocational training for general practice: course organiser controlled funding to construct innovative senior house officer posts. *Education for General Practice* 1997;8:280-7.
- 14 Murphy A. The hospital component of general practice vocational training: persistent preventable problems. *Education for General Practice* 1995;6:19-29.
- 15 Allen I. *Doctors and their careers*. London: Policy Studies Institute, 1994.
- 16 National Association of Health Authorities and Trusts. *Partners in learning: developing postgraduate training and continuing medical education for general practice*. London: NAHAT, 1994.
- 17 Carlise R, Johnstone S. Factors influencing the response to advertisements for general practice vacancies. *BMJ* 1996;313:468-71.
- 18 Smail SA. *Present state and future aspirations for vocational training in Wales*. Cardiff: Department of Postgraduate Education for General Practice, University of Wales College of Medicine, 1996.
- 19 Stanton F, Grant J. *The effectiveness of continuing professional development*. London: Joint Centre for Medical Education, Open University, 1997.
- 20 Elwyn GJ. Professional and practice development plans for primary care. *BMJ* 1998;316:1619-20.

(Accepted 6 July 1998)

One hundred years ago

The cycle and its medical foes

There are many persons who fail to distinguish between use and abuse, and their erroneous reasoning becomes especially conspicuous when they criticise a fashion like bicycling. The experience of the last few years has sufficiently proved that the bicycle is an excellent instrument for exercise. It has once more made familiar our old roads and the grass-grown streets of sleepy country towns. For the middle-aged it is less fatiguing than walking; in youth it is an admirable resource. In France the bicycle has done wonders, as those who remember Paris, Fontainebleau, and the intervening districts thirty years ago can bear witness if they once more revisit that pleasant part of the world. The native has given up sugared water, dominoes, and gudgeon fishing for the bicycle. Woman has profited greatly by

this invention, and as the race of Englishwomen is manifestly improving in strength and beauty, cycling cannot be doing them much harm. On the contrary, when properly used, it is probably of great benefit to them.

The bicycle, however, as was to be expected, has found its detractors. D'Alessandro, in the *Policlinico*, declares that it is a dangerous exercise for women. He believes that the only ladies who should stride the wheel are such as are obese, apathetic, or past the climacteric. Should his advice be followed the aspect of a West End thoroughfare or a road in the Thames Valley would at once undergo a very manifest modification, for the most picturesque element would be entirely obliterated. (*BMJ* 1898;ii:994)