Situating general practice training in the general practice context

Postgraduate training for general practice has a relatively recent history. Compulsory training was first introduced in 1982. It required doctors to train for a minimum of 3 years after full General Medical Council registration with 12 months in the general practice setting. The Tooke report,[1] which has yet to be implemented, has recommended increasing the length of training to 5 years. It proposes a 3 year core, most of which is to take place in the hospital setting, although it may include short general practice attachments, with the final 2 years in the general practice setting. Future GPs are being predominantly trained outside the context where they are likely to spend the remainder of their careers, a situation that is set to continue.

The paradox is particularly apparent on examining the RCGP curriculum document[2] on postgraduate training for general practice. The curriculum has an outcome-based curricular design where the emphasis is on product, the type of doctor that will be produced, rather than the educational processes involved or the content of the curriculum. In outcome-based education the specified outcomes determine the curriculum content and its organisation; determine the teaching methods and strategies used; inform the assessment process; and influence the educational environment. On applying this approach to curriculum planning it is clear that, to achieve competency in all outcome groups, learning should be primarily situated in the general practice context.

The literature on professional expertise shows that this develops as a transition from a conceptually rich and rational knowledge base, acquired from educational experience, to a non-analytical ability to recognise and handle situations efficiently and effectively acquired from clinical experiences. This ability is context-specific and not easily transferred from one problem or situation to another.[3-6] Expertise is characterised by 'states' of development restricted to specific content areas. They are based on previous personal experience, they do not generalise across situations or tasks, and they change continuously as a result of new experiences.[6] To develop expertise as a GP requires the learner to be predominantly situated in the general practice setting. In addition, increasing specialisation outside general practice threatens to proleterianise doctors training for general practice who have to work in such posts. Furthermore some posts, such as in obstetrics, now have little relevance for general practice given the changes in how care is managed at the community/secondary care interface.

There are fundamental differences between education and occupational training. Occupational training involves learning role-specific new knowledge, skills, and behaviours to achieve competence in a specific practice. Education is about transformation of the self into new ways of thinking and relating, and involves deeper learning at the level of identity. The RCGP curriculum document on training for general practice is essentially a blueprint for training as most outcomes are framed in terms of achieving competencies. However, achieving learning outcomes such as those in 'Essential Feature 2', which involves professional values, ethics, and emotions, are unlikely to occur without a pedagogic approach which promotes deeper learning at the level of self-identity. Without formal approaches which combine experience and reflection to foster moral growth and deepening of values, this type of learning takes place mainly in the informal and hidden curricula, often through the process of socialisation — the results of which may not be what is intended.[7] Friedson[8,9] showed that the culture and values of institutions where doctors work are more important determinants of their behaviour than their experiences at medical school. During hospital posts, future GPs are likely to be socialised to the norms of the institution(s) they are working in. This can have adverse effects.[10–12] It is not unusual for registrars to enter general practice with negative attitudes as a result of socialisation during hospital- based posts which require challenging, for example, towards patients with drug or alcohol problems or toward GP referrals to hospitals.

The reasons for using doctors in training for general practice in service provision in hospital units are largely economic and political. The rationale, from an educational point of view, that doctors who wish to become GPs must spend time in hospital posts has its roots in the positivistic technical rationality model of professional practice. This views professional activity as consisting of instrumental problem solving made rigorous by the application of scientific theory and technique. This view of professional practice has been challenged by Knowles' andragogy,[13] constructivist and social learning theories.[14–16] These place learning in the context of lived experience of participation in everyday activities.

Situated Learning Theory (SLT)[14] provides effective models to assist in the design of curricula where learning is 'situated' in practice allowing learners to develop their knowledge, and skills in authentic contexts and absorb, and be absorbed into, the culture of the profession they desire to enter.[17] An implicit assumption is that the knowledge, skills and attitudes are 'situated' in the practice environment and the framework to understand them is inseparable from its context.

SLT is an elaboration of the apprenticeship model. The basic tenet of this is that learners learn from participating in, and being gradually absorbed into, 'communities of practice'.[14] A key concept is 'legitimate peripheral participation'. Learners enter the community of practice at the periphery and, as they move towards fuller participation, they learn and are absorbed into, the culture of practice. Participation in communities of practice is often dependent on the trajectory of the learner. In the general practice setting, the learner is on an inbound trajectory towards full participation. In hospital units, where full participation is not a goal, GP trainees remain peripheral and in some units can be marginalised.[18]

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A key element is having the opportunity to observe and take part in the framing of problems and understand how knowledge is structured. As a result learners' existing schemas, which guide their thinking and actions, are revised and over time become more elaborate, complex, and integrated.[19] Legitimate peripheral participation provides role models who are the basis of, and also help motivate, learners' activities. By observing these role models, students learn what to observe, what interpretations to link to observations, and what words and actions to use when conveying these to both patients and colleagues. It demonstrates how behaviours and knowledge are affected by the context in which they are applied.[20] Learning is viewed as more than achieving competence in specific practices, but also involves identity negotiation and formation. Learners' recognition of their education needs, and their desire to become full practitioners, motivate learning and participation. Learning is seen as a dynamic process. While learners are building and revising their schemas, the community of practice is simultaneously changing. Each learner adds to the community and learning extends beyond the development of cognitive structures to reflect the larger changes in society and the work of the community. This reflects the post-modern view that coherence of an organisation's culture derives from the partial and mutually dependent knowledge of each individual involved in the process and develops out of the work they do together. Meaning is created rather than transmitted and culture is constantly being re-created.[21]

A major criticism of the SLT perspective has been the underestimation of the role of reflection on experience.[17] Schon's theories[22,23] are the most widely recognised in this area. Experienced professionals, he advocates, develop 'zones of mastery' around areas of competence. They practice within these zones as if automatic; termed 'knowing-in-action'. Occasionally professionals encounter an unexpected outcome or surprise. Two types of reflection are triggered at this time, 'reflection-in-action', which occurs during the activity and consists of three components:

- re-framing and reworking the problem from different perspectives;
- establishing where the problem fits into existing schemas; and
- understanding the elements and implications present in the problem, its solution, and consequences.

Reflection-on-action follows the experience and involves revisiting the event to consider what occurred, what was learned, and how to incorporate new learning into 'knowing-in-action'. However, reflective practice does not account for circumstances where decisions have to be rapid and the scope for reflection is extremely limited. In this case reflection is best seen as an intuitive, metacognitive process drawing on previous experience with little deliberation.

Reflective practice is the process of intentionally turning thoughtful practice into a potential learning situation. Moreover, reflective practice also goes beyond examining knowledge components to include the affective aspects of a situation. Boud *et al*[24] have described three essential components in the reflective process:

- returning to experience, where the learner recalls the salient events or recounts the key features of the events to others;
- attending to feelings, this includes utilising positive and removing negative feelings, both of which are required for learning to occur; and
- re-evaluating the experience, where the learner re-examines the original experience in light of their goals, associating new knowledge with prior knowledge and integrating new knowledge into prior schemas.

Roth's[25] perspective emphasises learning occurring through questioning, investigating, evaluating, analysing, theorising, seeking feedback, and incorporating the ideas and viewpoints of team members.

The current structure of training, where the majority of time spent in the practice setting is in the final year of training when the registrars' focus is predominantly on the assessment process of the MRCGP, is detrimental to the reflective process. Situating the entire period of training in general practice would help alleviate this situation.

It is time for the RCGP to stand up for our junior colleagues and ensure they are provided with an appropriate educational experience to enable them to become full participants in the community of practice that is general practice. It would mean learning being situated in the general practice setting after completion of foundation programmes. This would promote learners' progression to the higher levels of Dreyfus and Dreyfus's[3] model of expertise, which is less likely under the current system. It would also help socialise them to the culture of general practice enabling them to become insiders.

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