Higher professional education for general practitioners: postal questionnaire survey

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SUMMARY

Background. *There is no consensus about whether higher professional education (HPE) is necessary for general practitioners (GPs) to complete their vocational training.*

Aim. *To investigate beliefs about the need for HPE, its funding, duration, curriculum, and whether new principals (NPs) are eligible to undertake it.*

Method. *A confidential postal questionnaire was sent to senior partners, GP registrars, NPs, GP trainers, and GP tutors, principally in the old South West region of England, and nationally to other 'academic' GPs.*

Results. *Of 1199 GPs, 750 (62.6%) replied; 561 (79.2%) responders agreed with the principle of HPE for NPs, especially members of the Royal College of General Practitioners and academic GPs; senior partners (SPs) were less likely to agree (all P<0.001). Of 700 GPs, 331 (50.3%) believed that HPE should last one or two years, 66.4% agreed that NPs should have a major input into the HPE curriculum, and 54.6% agreed that health authorities should be major sources of funding, together with the postgraduate deans (29.9%). GP tutors and trainers should have the main responsibility for teaching HPE. The principal barriers to setting up a HPE course are the financial cost, the time cost, difficulty in changing the status quo, and various practical problems. The facilitatory influences are: the enthusiasm of the NPs and of their clinical colleagues, an appropriate educational environment, a high quality clinical base, and recognition that NPs have specific needs. Of 668 GPs, 89.7% would release NPs if an HPE course were free and locums were paid, although SPs were less likely to agree (P<0.001); if the HPE course cost the practice money, then only 30.6% would release NPs.*

Conclusion. *If adequately externally funded, then there is widespread support for HPE with most GPs willing to release NPs. NPs and existing GP teachers should decide the curriculum. Its aim should be to provide educational support for NPs during the transition from GP registrar to fully-trained GP principal.*

Keywords: *higher professional education; vocational training; new principals;GP registrars; GP trainers; GP tutors.*

Introduction

HIGHER professional education (HPE), to enable general practitioners (GPs) to become fully independent, competent practitioners, was first proposed by the Royal College of General Practitioners (RCGP) in 1985,[1] being recently re-stated[2] and endorsed.[3] The theoretical arguments, first put forward over 30 years ago,[4] are reinforced by the increasing expansion of GPs' clinical and managerial responsibilities. Such HPE should provide protected educational time for GPs to complete their education once they are in practice. There has been a slow increase in HPE opportunities,[5] but there is no agreed national blueprint, and access to relevant courses is patchy and inequitable. This survey was thus executed, principally in the old South West region of England. Its aim was to obtain the beliefs of a wide range of GPs on the concept of HPE and how it could be organised.

Method

To obtain an overview of beliefs, we sought the views of those in training or recently appointed (registrars and new principals [NPs], via health authorities [HAs]), those involved in GP training (trainers, via regional advisors), those who were in a key position to release NPs to HPE courses (senior principals [SPs], via HAs), and, nationally, other GPs with an academic interest in the development of general practice (local medical committees [LMCs], RCGP faculties, medical audit advisory groups [MAAGs], undergraduate and postgraduate GP departments, and GP tutors). All lists were satisfactorily obtained, except for one of six HAs and the regional advisor for Cornwall and Devon who were unable to supply their lists. A postal questionnaire was sent to identified doctors in May 1997, with a covering letter and a freepost envelope for return. Non-responders were sent up to three reminders.

All replies were analysed using the SPSS PC statistical package. Likert scales were used to obtain GPs' beliefs in the questionnaire. These were treated as continuous variables and analysed using one-way analysis of variance with Student–Neuman–Keuls posterior tests as appropriate. The independent variables used for this were: sex (male/female), membership of the RCGP (yes/no), and type of GP (registrar or NP/trainer/SP/'academic' GP). Correlation (Spearman's rho) of beliefs was also investigated using age and hours of continuing medical education (CME) per year as independent variables. Because of multiple comparisons, the level of statistical significance was set at 1% ($P<0.01$). Simple descriptive statistics were used for demographic and background variables.

Results

Of 1199 questionnaires that were sent out, 750 were returned (breakdown of response rate: 119/237 registrars or NPs, 260/468 SPs, 208/293 trainers, and 159/266 'academic' GPs), of which 708 were usable. Of these, 627 (90.2%) had received their undergraduate training in the United Kingdom (missing values [mv] = 13). Most became principals in 1982 (standard deviation [SD] = 8.7 years, n = 652, mv = 56); were aged 44.4 years (SD = 8.5, n = 691, mv = 17); were male (n = 559, mv = 12); had done a formal vocational training scheme (n = 356, mv = 13); were members of the RCGP (n = 468, mv = 31); and had attended many hours of CME annually (fewer than 25 hours = 9.2%, 26 to 35 hours = 31.1%, 36 to 45 hours = 32.5%, 46 to 59 hours = 12.4%, more than 60 hours = 14.8%, n = 655, mv = 53).

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Of 708 responders, 79.2% agreed with the statement: 'new GPs need a further period of higher professional education after becoming a principal in general practice' (121 [17.1%] totally agreeing, 197 [27.8%] strongly agreeing, 243 [34.3%] agreeing, 70 [9.9%] neutral, 46 [6.5%] disagreeing, 31 [4.3%] strongly or totally disagreeing). Agreeing more strongly was associated with increasing hours of annual CME (Spearman's rho = 0.219, n = 651, P<0.001), possessing MRCGP (mean score of members = 2.58 versus 3.06 of non-members, F = 19.31, n = 671, P<0.001), and being an 'academic' GP (F = 17.25, degrees of freedom [df] = 3700, P<0.001). SPs were significantly less likely to agree compared with all other groups (registrars/NPs = 2.75, SPs = 3.20, GP trainers = 2.67, academic GPs = 2.22). Neither the GPs' ages nor their sex were related to this belief.

Most GPs favoured a one- or two-year course (27 [4.1%] favoured six months, 127 [19.3%] one year, 204 [31%] two years, 129 [19.6%] three years or more, 171 [26%] were not sure; mv = 50). There were no significant associations with any of the five independent variables tested. There was a range of beliefs about both the minimum and maximum period of time that NPs needed to be in practice to be eligible for a HPE course (for minimum period: 250 [37.5%] favoured no minimum period, 218 [29%] one year or less, 70 (9.3%) two years, and 102 [13.6%] were uncertain; for maximum period: 176 [27.6%] favoured no maximum period, 31 [4.9%] one year, 77 [12.1%] two years, 137 [21.5%] three years, and 158 [24.8%] were uncertain).

When asked about the content, funding, teaching, and administration of HPE (Tables 1 and 2), most GPs believed that the curriculum should be decided mainly by NPs themselves (66.4% agreed that they should have a major input), HPE teachers (45.1% agreed), and GP tutors/postgraduate deans (34.4% agreed); that HPE should be funded by health authorities (54.6% agreed) and GP tutors/postgraduate deans (29.9% agreed); and that HPE should be organised by HPE teachers (71.6% agreed), GP tutors/postgraduate deans (50.9% agreed) and NPs themselves (39.8% agreed). Most believed that HPE teachers should be GP tutors (35.7%) and GP trainers (27.7%).

When asked in three open questions about the objectives, barriers, and facilitators of local HPE (Table 3), responders stated a range of objectives in four general areas: personal development of NPs (41% of objectives), improving NPs' clinical care (24%), education (15%), and a supportive environment (12%); the four main 'barriers' were: financial cost (30%), time cost (21%), acceptance of the 'status quo' (27%), and practical problems (15%); the five facilitatory influences were: the enthusiasm of the NPs (13%) and of their clinical colleagues (22%), an appropriate educational environment (21%), a high-quality clinical base (13%), and recognition of specific needs (learning objectives) of NPs (15%).

For a one-year HPE course of 30 half-days' duration, 7.8% out of 564 GPs agreed that a cost of £500 would be reasonable, 20.9% agreed £1000, 25.9% agreed £1500, 24.5% agreed £2000, and 20.9% agreed more than £2000 (mv = 144). The more that such a course would cost the practice, the less likely it was for GPs to agree to release a NP (Table 4).

Senior partners were less likely to release their NPs if either HPE was free and locum costs were paid (F = 8.65, df = 3661, P<0.0001; mean scores were: registrars/NPs = 1.35, SPs = 1.80,

Table 1. Beliefs of GPs (as a percentage) about the extent to which various groups should decide the curriculum of, fund, and organise HPE courses for new principals.

	Decide curriculum of HPE[a]					Funding HPE[a]					Organising HPE[a]				
	Major input	Some input	Little input	No input	n[b]	Major input	Some input	Little input	No input	n[b]	Major input	Some input	Little input	No input	n[b]
New principals (NPs)	66.4	31.0	1.0	1.5	686	9.0	32.9	26.3	31.8	635	39.8	43.8	10.2	6.1	607
NPs' practices	17.6	53.8	21.3	7.4	677	7.3	28.0	24.5	40.2	629	NA	NA	NA	NA	NA
RCGP/Faculties	11.8	53.8	25.3	9.0	676	7.4	22.2	23.6	46.8	609	15.3	49.2	22.8	12.7	654
HPE course tutors	45.1	44.7	7.8	2.4	676	NA	NA	NA	NA	NA	71.6	23.1	3.0	2.3	662
GPC/LMC	3.7	35.9	44.1	16.2	671	3.8	11.1	22.3	63.0	605	4.2	30.0	38.9	26.9	647
Health authority	2.3	29.2	47.9	20.5	674	54.6	30.6	6.8	8.1	664	9.7	35.5	35.5	19.4	654
MAAG/PCAAG	8.0	46.5	33.6	11.9	666	4.2	15.0	27.1	53.8	602	7.9	39.6	31.9	20.6	646
GP tutors/postgraduate deans	34.4	53.0	9.9	2.7	677	29.9	28.1	14.3	27.8	616	50.9	35.9	9.1	4.2	674

[a]Responders were offered a choice of five options for these questions but so few ticked the 'total input' option that 'total input' and 'major input' have been grouped together; [b]n = number of GPs answering this question. Missing values for each question = 708-n. NA = GPs not asked this question.

Table 2. Beliefs of GPs (as a percentage) about the extent to which various groups should be involved in teaching HPE courses.

	Major input	Some input	Little input	No input	n[a]
GP trainers	27.7	60.4	7.9	4.0	675
GP tutors	35.7	55.8	6.5	2.1	676
Practice managers	5.5	58.7	31.7	4.0	669
Practice nurses	3.3	48.1	40.9	7.9	667
Other NPs	16.7	53.3	23.1	6.9	666
University departments of general practice	18.8	60.4	16.3	4.6	676
Health authorities	2.5	41.4	43.5	12.6	664
Hospital consultants	4.0	41.5	42.5	12.0	668
Patients	2.3	34.6	47.2	15.9	659
Non-medical specialists	1.8	46.3	41.5	10.4	663
Others	4.8	8.3	3.6	83.2	660

[a]Missing values for each question = 708-n.

Table 3. Summary (percentages of all suggestions) of GPs' beliefs about the objectives of, barriers to, and positive influences on, a local HPE course (n = 708).

GPs' beliefs	Percentage
Objectives (1579 suggestions)	
Improve clinical skills, knowledge	13.4
Develop coping/self-care mechanisms/reduce stress	12.9
Provide peer support/share ideas/'network'	11.5
Improve ongoing education (CME, CPD)	10.7
Improve management skills	7.9
Personal growth/development	7.5
Self-directed learning/lifelong learner	7.0
Ease transition to principal	6.2
Motivate, improve morale	5.6
Fill 'holes' in vocational training	4.5
Improve teamwork, communication	4.3
Career development	3.9
Improve quality of care	2.3
Improve research, teaching	1.8
Miscellaneous	3.3
Barriers (1505 suggestions)	
Cost (financial)	30.3
No time to participate/high workload	20.6
Lack of understanding of need	9.2
'Inertia', difficulty changing the 'status quo'	8.5
Lack of a local leader/teacher	6.1
Reluctance to release NPs from practice	5.7
Access problems (geography, venue)	5.0
Perceived lack of ownership	4.7
Lack of locums	3.8
NPs lack enthusiasm	1.5
Already have strong educational structures	1.2
Already high quality GP	1.2
Lack of NPs	1.2
Miscellaneous	0.9
Positive influences (1190 suggestions)	
Enthusiastic NPs	13.3
Local strong educational structure as base	11.3
Supportive general practice environment	9.5
Existing high quality clinical skills	8.3
Peer support	7.9
Enthusiastic educational structure/personnel	5.3
Existing high quality general practice	5.0
Recruitment/retention crisis	4.6
Recognition of need for HPE	4.5
Local university department	4.2
Need to help with stress, coping	3.8
Enthusiastic health authority	3.6
Need to encourage learning/personal growth	3.6
Need to develop teamwork, communication	3.5
Enthusiastic local medicopolitical bodies	3.3
Need to develop management skills	1.8
Need to develop research and teaching skills	2.7
Miscellaneous	3.9

trainers = 1.45, academics = 1.49, using a five-point Likert scale [1 = very likely to release a NP, 5 = very unlikely to release a NP), or if HPE was free but no locum costs were paid (F = 6.42, df = 3,661, P<0.001; mean scores were: registrars/NPs = 2.53, SPs = 2.81, trainers = 2.61, academics = 2.30, respectively). Responses were unrelated to GPs' sex, hours of annual CME, or to their membership of the RCGP (P was not significant).

General practitioners were asked to grade a range of potential benefits and disadvantages to new GPs undergoing a HPE course (Tables 5 and 6). NPs thought the potential benefits were likely to be in the areas of organisational skills, practice management, peer support, financial awareness, and personal growth. Overall, most responders felt that there would be clear benefits but were less certain about the disadvantages.

Discussion

We found that four out of five GPs who responded were in favour of the principle of HPE for NPs. Despite the response rate being less than 70%, our results may reflect the important views of those involved most intimately in GP education and training nationally. Even those SPs who replied were more likely to agree than disagree with the principle, although the non-response of their colleagues in the region might be interpreted as a lack of support for HPE. GPs believe that the four most important benefits of HPE are helping the personal growth and development of NPs, providing a supportive environment and peer support, providing relevant education and encouraging lifelong self-directed learning, and improving their clinical care; existing HPE projects[6-8] have shown that these objectives can be achieved in practice. The aim of HPE could thus be summarised as being to ease the transition from dependent GP registrar to independent GP principal.

There were a number of perceived barriers to setting up HPE, especially funding. HAs are viewed principally as sources of funding for HPE, in conjunction with deans, with little input into curriculum, teaching, or organisation. The cost to a practice of HPE is crucial. If it is free, and locum costs are paid, nearly 90% of responders were likely to release a NP; if it cost the practice money, only one in four would do so. The need for external funding from outside practices is therefore perhaps the crucial factor in the institution and uptake of HPE.

Other barriers that need to be overcome are NPs having the time to attend, changing the present working and educational arrangements (the 'status quo'), and various practical issues, such as a suitable venue. Pitts and Vincent[9] found similar barriers when they surveyed GPs who had expressed an interest in joining the Wessex HPE course but who ultimately did not. Non-participants' three major concerns were time commitment, their workload, and family pressures. Both the dormant Oxford HPE course[10] and the discontinued Wessex HPE course required attendance at meetings outside of a GP's usual working hours and also attendance at residential sessions; the successful Somerset[6] and South London[7,8] courses did neither. It may be

Table 4. Beliefs of GPs (as a percentage) about releasing a NP to undertake a HPE course.

Question	Very likely	Likely	Not sure	Unlikely	Very unlikely	n[a]
If a half-day release scheme for HPE were set up in your area and it was fully PGEA approved, would you be interested in joining (or permitting a new partner to join) if ...						
... it were free and locum fees for course attendance were paid for you?	63.5	26.2	4.9	2.8	2.5	668
... it were free but no locum costs were paid?	13.5	42.2	22.6	15.0	6.7	668
... it cost you/your practice about £500/year and no locum costs were paid?	6.2	24.4	23.3	25.5	20.6	664

[a] missing values for each question = 708-n.

Table 5. GPs' beliefs (as a percentage) about a range of statements on potential benefits of HPE.

Appropriate GP HPE would be of benefit in the following areas:	Definitely	Possibly	Minimum/none[a]	n[b]
New GPs				
Peer support	88.2	27.0	4.8	679
Practice	73.7	23.8	2.5	681
Organisational skills	71.5	25.7	2.8	681
Financial awareness	67.0	29.8	3.2	681
Personal growth	65.0	29.8	5.2	678
Dealing with stress	58.1	35.5	7.4	678
Problem-solving abilities	55.8	37.1	7.1	679
Managing problem patients	55.6	38.2	6.2	678
Partnership problems	54.6	38.9	6.5	681
Career development	54.6	38.1	7.4	678
Change strategies	54.2	37.4	8.3	674
Doctor–patient relationships	48.7	43.0	8.2	679
In specific clinical areas	46.2	41.2	12.6	678
Other	5.4	3.6	91.0	670
Practices				
Enhance new partners' competence	66.2	29.3	4.6	680
Bring new ideas to practice	64.5	31.1	4.4	679
Enhance overall practice care	55.7	38.1	6.2	679
Attract high quality new partners	34.0	48.4	17.5	677
Other	3.4	2.7	93.1	673
Patients				
Improved practice organisation	54.4	40.9	4.6	682
Improved clinical care	50.0	42.8	7.2	682
Less stressed new GP	52.9	37.5	9.5	682
Other	2.5	3.4	94.0	676
Health authority				
Attract better quality GPs to area	37.8	46.6	14.2	678
Improve relationship with profession	35.6	50.0	14.4	680
Increase new GPs familiarity with HA	33.9	46.7	19.4	681
Improve HA image	25.1	41.5	33.4	680
Other	3.3	2.4	94.4	675

[a]There were so few 'none' responses that 'minimum benefits' and 'none' were grouped together; [b]missing values for each question = 708-n.

Table 6. GPs' beliefs (as a percentage) about a range of statements concerning potential disadvantages of HPE.

Appropriate GP HPE might be a problem in the following areas:	Definitely	Possibly	Minimum/none[a]	n[b]
New GPs				
Would mean extra study	41.2	46.0	10.9	691
Cost of HPD	37.0	50.6	12.4	690
Conflict with practice responsibilities	23.3	59.2	17.5	691
Conflict with family/social life	19.1	52.2	30.8	692
Increase short-term stress	11.9	47.4	34.3	690
Other	2.0	2.2	95.8	684
Practices				
Reduced patient access to new GP	39.0	45.9	15.0	690
Increased locum use	38.7	55.2	6.0	692
Cost of HPD	29.9	52.9	17.1	692
Pressure to change	18.8	59.2	22.0	692
Other	0.7	2.3	96.9	686
Patients				
Difficulty seeing own GP	24.9	53.3	21.9	691
Other	1.3	1.9	96.8	685
Health authority				
Cost of HPD	46.1	45.6	8.3	688
Other	2.0	1.9	96.1	683

[a]There were so few 'none' responses that 'minimum benefits' and 'none' were grouped together; [b]missing values for each question = 708-n.

that HPE is a non-starter unless the majority of the education occurs within the GPs' working week.[11]

In contrast, GPs believe that there can be a number of facilitatory influences that lead to a good educational environment: enthusiastic NPs, partners, educationalists, regions, and HAs. It is important that all parties recognise the need for such HPE, which will not only help NPs but also their practices and patients. High quality local primary care and high quality clinical competency of NPs was seen as helpful, possibly because such NPs could complete their transition by achieving competency in those non-clinical areas that are crucial in facilitating and enabling the practice of high quality clinical care.

Interestingly, only around one-third of GPs stated that HPE should last two years, as recommended both by the RCGP[2] and the National Association of Health Authorities and Trusts.[3] Indeed, the only current HPE course for service NPs lasts one year and satisfies the objectives of its learners.[6] In contrast, the existing academic HPE courses, both in London[12] and in Scotland,[13] last two years. Perhaps such differences are appropriately reflecting the different needs of learners.

The views of the educational 'establishment' are crucial. NPs, their HPE teachers, GP tutors, and deans were seen as important in deciding the curriculum of HPE courses and in their administration and organisation. GP trainers and tutors are seen as the two groups to teach HPE. Other organisations that might have an input, such as LMCs, faculties of the RCGP, and MAAGs are not felt to have a large role to play in the mechanics of HPE. The best model might be a local steering group with representation from all relevant parties to put in place an appropriate educational and supportive framework for the HPE course. This might well vary from area to area depending upon the established and successful local educational structures.

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