

The training capacity of general practice

The demand for training places in general practice looks set to increase greatly in the next few years. The challenge is to increase training capacity without sacrificing quality. Our experience at The White House Surgery in Sheffield in multiple training may be of interest to others who are doing or contemplating doing similar things.

The demand for extra training places comes from three main sources. Modernising Medical Careers (MMC)¹⁻³ aims to give all senior house officers (SHOs) experience in primary care as part of their foundation training. This will mean that all hospital-based consultants will eventually have spent some time working in general practice. GP registrars will spend more of their time being trained in practices.^{4,5} Finally, the number of medical school places has substantially increased. With the extra student numbers and the increasing specialisation of hospital firms it is not surprising that general practice is being looked at to provide more undergraduate training as well as generic postgraduate experience.

The increase in numbers is such that, if the old model were to continue, of each training practice having one, or at most two, trainees, then the number of training practices would have to increase to such an extent that there would be a danger of sacrificing quality for quantity. One of the reasons general practice training has been successful is the high standard required for a training practice. This is particularly important when training SHOs and students who are going back into hospital medicine. If we give them a good experience of general practice, more of them may choose to work in the community or go back into hospital service with a greater understanding of and respect for the difficulties of family medicine. If they have a bad experience they return to hospital practice with the prejudices they may already have been

given by their hospital-based training reinforced.

When I went into general practice 19 years ago I wanted to be a trainer. I was not allowed then because our practice of 5500 patients already had one trainer. It was made very clear to me that our list size was considered too small to have enough clinical material to train more than one registrar. So I became a course organiser. As a course organiser, I spent many years listening to registrars describing the training they were receiving. What was striking was that the determinant of the quality of the training was not the number of patients per registrar or the number of registrars in a practice, but whether or not the practice was committed to and gave enough time for training.

The orthodoxy of 19 years ago was that to have two registrars, the list size had to be at least 12 000. That was based on the idea that what determined the educational experience the registrar received was the list size and that you needed 6000 patients to generate enough work to give the registrar adequate experience. We have shown that orthodoxy to be false. To train properly takes time — more time than the registrars save you by seeing patients. The more junior the learner, the less service work they do and the more time they take up.

The old orthodoxy assumed that registrars simply saw patients. There would be a weekly tutorial and, of course, some informal discussion of cases. But it did not emphasise enough that to get the most educational benefit from seeing those patients registrars need support, supervision, de-briefing and an educational experience based on formative assessment.

Now our list size is 5300. We have four partners, two of whom are full-time equivalent, one three-quarter time

equivalent and one half-time equivalent. Three of the partners are now GP trainers. Our fourth partner is an undergraduate medical student teacher and our senior district nurse is a nurse trainer. At the moment we are training a medical student, a preregistration house officer, a senior house officer, a GP registrar and an innovative training post registrar. In addition to this, at various times through the year our primary healthcare team colleagues will have attached to them nursing, midwifery, health visitor and physiotherapy students. We have evolved from a single registrar training practice to a multiple-learner teaching practice.

Rather than thinking that a big list size enables more training to take place, we believe that multiple training grants enable a small list size to be run to allow training to be done more effectively. The size of the trainers' grant needs to be big enough to let this happen.

List size must eventually set a limit on training capacity but we have found that space, trainer time, and support staff needs run out before the registrars run out of patients. Grants are at present available for capital projects but they need to be increased in size and made more accessible. An extra £73 million has just been announced for foundation placements under the MMC scheme. This will help fund attachments in general practice. Staff budgets have never reflected for the need for the support staff necessary for training and now that staff budgets are included in the practice global sum it would be difficult to change them. The easiest way to address the non-capital funding issues of training would be to greatly increase the size of the trainers grant.

The prerequisites for multiple training to work are commitment from the whole team and organisation.

Individual learning plans have to be

made. Where learning needs overlap, joint tutorials can be used. These can seem daunting to trainers who have only ever given teaching to individuals. However, the skills of giving tutorials to more than one learner can soon be picked up by willing trainers. All of the feedback we get from our registrars is that they prefer joint tutorials. Where learning needs don't overlap, there has to be time in the system either for individual tutorials or for learning needs to be met in other ways, such as during debriefings or by attending courses.

Supervision has to be carefully planned. Every trainer will be used to running his own surgery while simultaneously supervising a registrar. Supervising more than one surgery takes more planning. We have found that once you are supervising three learner surgeries it is no longer possible to satisfactorily run your own. At this point the trainer needs to become solely a supervisor and this can be a very intellectually stimulating role. The patients seem to be impressed that so much care and discussion is being directed towards their problem. Finding time for multiple debriefs can be challenging and they cannot always take place immediately after the surgery.

A balance needs to be achieved. While intellectually stimulating if done occasionally, supervision would be frustrating for the trainer if done too frequently, as his own clinical time would be reduced. There also needs to be enough surgery time for the patients to choose to see the family doctor they have come to know over the years if they wish. In attempting to train more family doctors we must not destroy that aspect of care that is central to family medicine; access to a known and trusted family physician.

Peer-group learning is a tool that can be used. There is a lot of evidence that doctors learn best from those closest to

them in experience.⁶ To ensure it is effective, peer-group learning needs careful supervision by an experienced educator. With this input it can be an efficient and popular method of learning and it also gives the doctors in training a supervised opportunity to improve their own teaching skills. The trainer does not always have to train but does have to make sure that the learners learn.

As well as day-to-day supervision of patient contacts, thought has to be given to the overall supervision of the learner's education. In our experience there is an advantage in day-to-day supervision being carried out by different partners. The learners are exposed to different approaches to problems and seem to value this. The individual supportive relationship between trainer and registrar has always been an important feature of general practice and care must be taken to protect this in a multiple-learner practice. We do this by retaining the attachment of each learner to a nominated trainer for formal and informal assessments, drawing up educational plans, administration, pastoral care and support.

Is the outcome as good as the traditional single-registrar training practice? I think so. I am sure we have had some learners who may have gained more and moved on more if they had had the undivided attention of their trainer. But I sense they are balanced by the well recognised gains of peer-group learning and support that our model allows. Certainly, we are a very popular training practice and have no problems attracting registrars and our results in the MRCGP exam, the most objective external measure we have, are as good as any. Our recent patient satisfaction survey found that the patients, too, were happy with the care they were receiving.

We have found that the greatest gain to the practice is to work in the intellectually

stimulating environment that is created when you are surrounded by young people all willing to learn. That is a huge gain for the partners. The patients also gain from the knowledge and enthusiasm of our younger colleagues.

Let us accept the challenge of training more of tomorrow's doctors in primary care, both GPs and consultants, but let us make sure we maintain the quality of our training practices while we do it. The multiple-learner teaching practice is one model that seems to work.

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