GORD than thinking about doing serial endoscopies.

While effective acid suppression is likely to remain the cornerstone of therapy for GORD, non-pharmacological measures should always be considered, particularly as stopping smoking, reducing heavy drinking and addressing obesity have other self-evident health benefits. The role of non-drug factors in GORD has recently been reviewed and the evidence both for and against postural and dietary interventions is remarkably thin, although there is some support for raising the bedhead, avoiding post-prandial stooping, avoiding late evening meals and cutting out dietary provocants of various kinds. The most compelling evidence is that for the role of obesity, and of differences in the distribution of visceral and subcutaneous fat, which provides an obvious target for intervention. Finally, the role of psychological factors in the aetiology and exacerbation of reflux symptoms has not been extensively studied but in view of the health beliefs concerning heart disease and cancer held by many patients with upper gastrointestinal disorders probably deserves more attention.

GORD imposes a significant health burden, because of its high prevalence, and has substantial adverse effects on patients’ lives. It is associated with significant morbidity and is a risk factor for increased mortality because of its aetiological link with adenocarcinoma of the oesophagus. Prescription of proton pump inhibitors accounts for around 15% of prescribing costs in general practice in the UK, making accurate diagnosis and appropriate management of particular importance. The new global definition of GORD provides valuable information to improve diagnostic precision and complements existing guidance on best practice.

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General practice specialty training: an innovative programme

With the implementation of Modernising Medical Careers has come a radical change to the structure of postgraduate medical training in the UK. The first cohort of young doctors completing foundation programmes are now in their second year of foundation training and will be considering application to specialist training commencing August 2007. This major policy change took place in parallel with revision of the criteria within the regulatory framework of the Postgraduate Medical Education and Training Board for approval of specialist training in general practice, prompting UK deaneries to review current general practice vocational training schemes. It has been reported that around 60% of UK medical graduates have not decided their final career destination 18 months after graduation. Deaneries across the UK face the challenge of developing new general practice specialty training programmes, which not only fulfill the need to train doctors who are equipped with the competencies required for 21st century primary care, but also, by being attractive training programmes, encourage recruitment of high calibre doctors to general practice.

Since the inception of the original vocational training regulations in 1979, GP vocational training schemes have historically consisted of 2 years at senior house officer (SHO) grade in hospital and 1 year as a GP registrar in practice. It has long been recognised that there is a need to review GP training and there is sufficient evidence to challenge the value of these traditional schemes. The position statement of council of the European Academy of Teachers in General Practice supports a unified training programme for Europe but acknowledges that the minimum training period of 3 years, as
defined by Title IV of the EU Directive 93/16/EEC, is too short, in particular, the length of time spent in the general practice setting which inadequately prepares doctors for independent practice. There has been plenty of published evidence reflecting the concern surrounding the educational value of the SHO component of existing GP vocational training schemes, and the continuing problems surrounding SHO training in the UK resulted in a detailed review summarised in the 2002 Donaldson Report, Unfinished Business. In his report, the England Chief Medical Officer recommended 2 years of generic training after graduation that should include a period in general practice for all doctors irrespective of their career destination. He proposed that all SHO training should be programme based, tailored to need, time capped and flexible. The response of the Department of Health, Modernising Medical Careers, brought about the implementation of foundation training to be followed by run-through specialty training from 2007. Stand alone SHO posts will cease to exist and all GP training will be in predetermined programmes, thus creating the impetus to develop new improved schemes.

There is evidence of progress with general practice training in Europe and elsewhere. In 2005 in Denmark, general practice training was extended from 3.5 to 5 years comprising 2.5 years in general practice. Also in 2005, the Australian College of General Practitioners published new standards for General Practice Education and Training in the Requirements for Fellowship, the expected entry requirement for independent practice. This includes 3 years in training, of which two are spent in general practice. In the UK, there is published evidence indicating the value of innovative training posts and also the benefits of extended periods of training in general practice. To date there is little published evidence in the literature on the feasibility and more specifically the educational value of differently structured 3-year programmes.

As models of healthcare delivery change across the UK, different opportunities to place training doctors in appropriate and relevant training environments are evolving. One such example has been the formal review of the provision of healthcare services within Angus in Scotland and the development of an ambulatory diagnostic and treatment centre, which replaced the traditional district general hospital. This created an opportunity to redesign and implement a new model of training for general practice. In anticipation of the changes in postgraduate training, an innovative programme was negotiated with secondary care colleagues and implemented in Angus from August 2002. The full evaluation of the Angus programme is reported in a paper to be published in Education for Primary Care. The design of this new programme encompassed three main objectives: early contact with general practice; continuity of general practice and the GP trainer throughout the 3-year period of training; and broad spectrum clinical experience relevant to care in the general practice setting. The first year includes a 3-month attachment to general practice. Throughout year 2 trainees spend 1 day a week in general practice and the remainder working in the ambulatory diagnostic and treatment centre with regular attachments to a broad range of out-reach specialist clinics. Year 3 is the GP registrar year. The important question is whether this new model of training offers any tangible benefits over traditional schemes. The qualitative evidence is acquired through an in-depth analysis comparing semi-structured interview data from participants on the new model of training and those on the traditional schemes. The evidence is strengthened by triangulating learner perceptions with the impressions of GP trainers and educational supervisors and appears to support that this type of programme is highly valued. However, numbers in this innovative project are small and the significance attributed to the evidence lies in the quality of the interpretation of the data and the readers’ acceptance of the qualitative methodology applied.

There are now clear recommendations from the Royal College of General Practitioners (RCGP) and the Committee of GP Education Directors that GP specialty training programmes should be designed around their ability to deliver the competencies described in the new GP curriculum, Being a General Practitioner and subsequent curriculum statements. Such programmes will require to support the new MRCGP assessment schedule, which will include workplace-based assessments throughout the programme, the enhanced trainer’s report, a clinical skills test and a written exam, which if successfully achieved will result in a Certificate of Completion of Training for General Practice and eligibility for entry on to the General Medical Council’s General Practice Register and membership of RCGP. It seems logical, and is indeed recommended that programmes should be practice-based with an appropriate balance of the required clinical experience in secondary care supported by the GP trainer to facilitate relevant and focused learning. It is recognised that the innovative programme in Angus would not be suitable in all settings but the principles applied to it could be considered in different contexts to improve GP training. The evaluation confirms the feasibility of such programmes and exemplifies a programme that provides the infrastructure for a learning experience that could equip participants with the competencies defined within the framework of the new GP curriculum. The spectrum of knowledge, skills, application and attitude defined within this competency model provides a comprehensive set of learning goals, which it is anticipated will not inhibit flexibility in programmes and should encourage innovation.

In the current climate of change that surrounds implementation of Modernising Medical Careers, negotiation between GP programme directors and consultant colleagues around the placement of GP trainees in appropriate hospital-based training, in which trainees can provide some useful service delivery and thereby feel valued, remains a challenge. The funding of the full 3-year GP training programme is complex and another key barrier to the review of GP specialist training programmes. In particular, implementation of the recommendations that more training should take place in general practice includes the resource implications for funding of GP registrars in practice, GP trainer’ grants and the practice infrastructure required to support the training. Financial managers will argue...
that justification of any additional resource requires robust evidence of outcome benefit, however there is a real risk that such demands for more rigorous evaluations may stifle this kind of local and imaginative innovation.

There can be no doubt that training programmes need to equip GPs with the required level of competence and confidence to work effectively in modern healthcare systems. Important outcome measures of the success of future GP training programmes must also include both recruitment and retention of doctors into general practice which is, of course, crucial to the future survival of primary care as we know it. However, until the existing evidence base is strengthened, the consensus opinion of educational experts should remain pivotal in influencing such change.

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