Training for change

General practice professional training has evolved over several decades. Currently it is well established that both recruitment to GP Specialty training and Certification of Completion of Training (CCT) require the doctor to demonstrate specified competencies respective to his career stage.[1–3] The competencies are partially based around expectations of the working GP: the pressures he faces within the range of situations it can be expected he would normally find himself in, and the attributes needed to overcome these successfully and calmly.

It is argued in this paper that the competencies have been defined on the grounds of the traditional expectations of GPs and general practice and that these competencies are in need of evaluation, revision and directed evolution in view of those changes which are imminently upon general practice. The validity of the current competencies is targeted at the generic GP and is in the main restricted to core competencies. However, a variety of different characteristics are needed by general practice to deliver its duties to the public. It is impossible for either the trainee or the established GP to be universally strong in all of these. These characteristics are a long list and include: the basic delivery of medicine, advocacy of general practice within the medical profession and to the wider public, leadership within both clinical units and across the profession, representation, academic and journalistic writing, teaching and training trainee GPs, junior doctors and potentially doctors from other specialties, advising professional bodies including governmental and scientific and research. Currently no account is taken, when recruiting or training GPs for any variation in the desired skill set. There appears to be an un-evidenced and un-vocalised assumption that individuals will emerge from those people recruited and trained to take up these roles.

Despite a gathering momentum towards a 5 year training programme,[4] there is no visible move to alter the competencies expected at the end of training. There are initiatives with an academic ST4 year but beyond this the additional 2 years of training appear to remain unformed.

Change has been an integral part of general practice for the past 20 years. The changes currently on the horizon and beginning to be effected will create a level of reorganisation of delivery of health care that will impinge a paradigm impact onto the role of the GP in UK society. Much of the current change has been led by politicians rather than practitioners. Despite widespread acrimony[5] there is little visible in the way of vocal political opposition[6] to these planned changes and it is reasonable to assume that whichever government is in place at the end of this year will have little effect on the current direction or the pace of travel. Changes include the accelerated introduction of the polysystem model and increased privatisation of healthcare management and provision. There are additional pressures for all NHS primary care units to improve their immediate patient access. Against all these plans is the serious threat of underfunding of health care in forthcoming years.[7]

The RCGP Roadmap[8] document in 2007 spells out a vision most GPs would subscribe to unequivocally and universally, however, the training requirements to deliver these aspirations are supported yet not defined.

Trainees emerging with MRCGP will be involved in health service care and delivery for up to a further 40 years and need to be prepared for the make up and constitution of practice over at least the first 5 of those years. They must be prepared for the initial change they will face, of graduating from being a student and supervised employee to an independent clinical leader and potential employer.

Where training fits into this model is uncertain. Contracts may be prepared obliging the provider to provide training facilities and resources across disciplines but for many commissioners the priority is always frontline clinical services. There are many anecdotes where training has a lower priority within the health provider organisation and penalties for failing to deliver this can be minimal compared to other areas perceived by managers as being of a greater importance.

It is a reasonable assumption that most professionals wish to work to high standards and the delivery of high quality health care is a longstanding aspiration of doctors, politicians, and managers. The difficulty comes with identifying quality. Many of the parameters we are familiar with are led by processes that can be measured and turned into accessible statistics. This does not always facilitate good general practice much of which is immeasurable and is evocatively elaborated by Sweeney.[9] There is a danger that GPs will develop into a new breed of clinician, effectively an out-patient services clinician. However in this organisation, will the holistic, relational practitioner remain and what needs to be done to retain this characteristic?

The skill set, the set of competencies the GP will need in this new practice are wider than the current set used to assess trainee entrants and their graduates. Indeed it may well be impossible to provide a generic GP at the end of training. Wider activities of GPs on a local and national level have come about historically by chance but now need to be directed by the profession rather than run the risk of falling behind the demands and expectations of practitioners.

It is suggested that besides core competencies, the profession defines its needs in terms of skill types for general practice and the numbers anticipated as being needed in each group. It is suggested that competencies defined and assessments against each prepared to deliberately select into general practice the range of skill needed.

It is suggested that work is undertaken to define the range of competencies needed for each of these skill types and assessment exercises are designed for candidates to demonstrate the competencies each skill type requires. This will now thus facilitate the deliberate

selection of each skill set needed into a career within general practice.

This may either be carried out at the beginning of training or, should the 5-year programme actually appear, then at the beginning of the additional 2 years with the appointee spending this time in a mix of practice and specific placements reflecting the programme the trainee has been appointed to. Further competency-based assessments will need to be designed and put in place at the end of the programme.

With any change there will be risks. The risks one can identify here include the actuarial risks of defining the numbers needed. Flexibility will need to be retained and mechanisms must be in place to allow doctors to change direction in mid-career.

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Mike Fitzpatrick

Motivation in question

'There are signs that today's young adults may be the first generation in modern history to be less healthy than their parents. Respiratory diseases and cancers, diabetes and obesity, heart and liver disease, and some psychological problems, such as depression, are all strongly linked to health behaviours and lifestyle. A majority of the maladies that now cause people to consult health care professionals … are largely preventable or remediable through health behaviour change.'[1]

In that spirit of commitment to continuing professional development which is expected of today's GP, I recently attended a 2-day course in Motivational Interviewing (MI) to empower me to implement the new 'NHS Health Check' currently being 'rolled out' around the country. This stimulating experience led me to look up the work of the pioneers of MI in the UK. The opening sentences of their introductory handbook for healthcare practitioners are quoted above. While the course provided helpful tips to improve consultation skills (notably in favouring an 'asking, listening, informing' approach rather than a 'lecturing, arguing, warning' style), these three sentences reinforced my determination to resist any inclination to attempt to change my patients' behaviour.

The first sentence sounds a familiar note of apocalyptic gloom. In the prevailing culture of pessimism and despair, this preposterous foundational assumption of the campaign to extend MI in primary health care is so widely accepted that it requires no elaboration or supporting evidence. It is evidently contradicted by that other great contemporary panic about the burden on society that is anticipated as more and more members of this generation become centenarians.

The second sentence affirms another familiar prejudice: if you get ill, it's your own fault. But it is simply not true that even most of the diseases mentioned are the result of individual behaviour. Apart from the link between smoking and lung cancer (the incidence of which has been declining for decades), lifestyle factors are of negligible significance in most common cancers and this is also true of most cases of respiratory, heart, and liver disease. What about neurological and rheumatological problems, such as Parkinson's disease, Alzheimer's, multiple sclerosis, rheumatoid arthritis, connective tissue disorders? Why not focus on chronic mental illnesses, such as schizophrenia and bipolar affective disorder? It seems that promoters of MI, like politicians and public health authorities, are only interested in conditions that offer scope for victim-blaming and moralising.

The third sentence asserts the dubious proposition that virtuous living can prevent or cure most illness. Apart from the well substantiated benefits of stopping smoking, the evidence that other lifestyle changes — notably in relation to diet and exercise — make a significant difference to health is poor. The evidence is even weaker that any of the methods used to promote such changes in lifestyle consistently achieves the desired outcomes.

The MI handbook and the same authors' recent promotional feature in the *BMJ* claim that MI 'outperformed traditional advice giving in 80% of studies'.[2] Given that 'traditional advice giving' is well known to be useless if not counterproductive, this is not as impressive a claim as it appears on first glance.

The fact that MI originated in the development of counselling techniques for dealing with problems of addiction to alcohol and drugs in the 1980s gives little grounds for optimism for its expansion into the world of primary care and chronic disease management. My experience of attempting to treat addiction in general practice led me to the conclusion that the way forward lay through doctors concentrating on the diagnosis and treatment of disease and leaving questions of lifestyle and behaviour to the only people who can resolve them — our patients.

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