The Review

Five-year training:

a radical rational approach to delivery

CONTEXT

The MRCGP as it stands. Acquisition of the MRCGP has evolved over the years and the most recent changes, introduced in 2008, incorporate both examination modules and satisfactory submission of work place based assessment evidence. One of the most significant steps in the recent change has been the requirement for the trainee to enter a GMC approved and Deanery delivered 3-year programme from the outset of their specialty training.

Parallel to the changes in the entry requirements for Royal College Membership has been discussion on how long the training programme should be. In 2008 the Tooke[1] report on postgraduate specialty training was published and shortly thereafter accepted by the then Secretary of State for Health. One of its key points being that general practice training should be extended to 5 years.

However, since then, adverse national economic factors have arisen and discussion on this change appears very low key.[2,3]

Simultaneous with the changing financial challenges, the NHS has been subject to further organisational and structural change.[4] Some of the key points include the dismantling of the current administrative structure of the PCTs, and the assumption of leadership by GPs in the commissioning of health care. This additional proposed responsibility has coincided with the ongoing development of an ever-growing body of health knowledge, the development and implementation of complex systems of delivery of health care, increasing expectations in the consultation style and manner of their GP by patients and increased delivery of healthcare needs within the practice, including diagnosis and chronic disease management. Further pressures for example, those on secondary care, such as earlier discharge and enforced limits to the number of outpatient attendances, require GPs to manage patients who are more sick than hitherto. GPs are now increasingly expected to undertake specialist outpatient level services either for their own patients or additionally for a geographical patch.

The GP must now deliver many differing services at multiple layers to their patient. More is expected in terms of the requirements of the position but nothing has been taken away. Other specialties (for example, surgeons: 8 years, paediatrics and psychiatry: 6 years) have longer training programmes to prepare their trainees for work in clinical fields which are narrower in breadth than primary care.

Supervised specialty training in practice has expanded from a single year to 18 months, within an unaltered 3-year programme, and a new role of 'Educational Supervisor' has emerged. There is little evidence of opposition to the idea of 5-year training but little evidence that this will be developed in the foreseeable future.

With the increasing expectations of the range and styles of services a GP should provide there is a need to make sure professionals have the right skills to request, manage and interpret what is needed to care for their patients. GPs collectively have these skills; individually, especially in the earlier years of their career, they may be more dependent on their colleagues in dedicated specialties for support.

General practice specialty trainees are increasingly talented but anecdotally are increasingly more fearful with an ever-expanding wealth of expectations, of being licensed to practice independently. Having clinical, patient-led skills, is only one aspect of an ever-larger range of duties.

In addition, new fields of responsibility are rapidly emerging, and with the new White Paper, confirmed as being incumbent on the GP to perform. These include:

- leadership;
- strategy and policy development, and implementation;
- commissioning;
- public health;
- teaching at all levels and all disciplines;
- management;
- research;
- public health; and
- specific clinical skills and interventions, not normally expected of GPs.

In the current situation, with the unlikelihood of a 5-year, supervised training programme being funded an alternate route to ensuring the competence of GPs to perform this new expanded role is proposed.

PROPOSAL

It is suggested that the 3-year training programme remains in its current position with different initiatives to explore the development of 4 and 5-year programmes.

Following acquisition of the MRCGP, all GPs should be invited to undertake a new higher level qualification which could for example be either a Masters or even a Fellowship. All GPs would have the right to choose whether to embark on this further career pathway, when they would commence this higher level training and at what pace they undertake this. Those who choose not to would remain predominantly clinically based within the expectations of performance of current general practice.

Those who were to choose this option would apply, competitively if demand was such, for the higher qualification. This would be a part time programme over a minimum period of perhaps 2 or 3 years with a range of super-specialist qualifications and accreditations. There would be generic entry level modules in topics such as small organisation leadership, team skills and negotiation skills, prior to the more detailed studies in the higher level trainee's chosen field. The course contents would naturally be obliged to demonstrate flexibility both in their content and range as both general practice and medicine itself change. Entry would be by demonstration of competencies deemed appropriate for the expectations, at entry level, of those proposing to develop their career within the respective fields. Success would require demonstration of evidence of learning, curriculum coverage, and competence expected of those completing the course.

PROGRESS

If this principle was accepted, the next

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steps would involve gaining acceptance, in principle, from by the RCGP and Department of Health and explore partnerships between universities and the RCGP to design and deliver training programmes. This would necessitate funding, though not at the level of a fully supervised 5-year programme. However, GPs completing this programme may rightfully expect a higher level of remuneration to reflect their higher level skills.

BENEFITS

Government aspirations for the model of health are outlined in the White Paper. Increasing decision making from within general practice will be delivered within a framework that would be sustainable in terms of GPs' competencies and training. One could predict, for example, a commissioning general practice, underpinned by those with higher level training in this field, providing a higher level of organisational decision making than those who choose or drift into doing so despite inadequacies.

RISKS

There are uncertainties that the infrastructure of current training is able to deliver such a model and a risk, that if accepted, the time needed to develop the modules may stall the initiative. There is a real risk that practice premises could not cope with the comprehensive clinical demands expected of this style of service regardless of training provision.

There is also a risk that with the increasing size of this model of practice and delegation within the team to specialist services, the relationship element of practice, one of its keenest strengths, will be lost, compounded by the increased withdrawal or partial withdrawal of clinicians from clinical duties.

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