GP non-principals' education: let's improve access for our flexible friends

THE Chief Medical officer's recent report on continuing professional development in general practice encompasses principal and non-principal general practitioners (GPs).[1] GP non-principals are an essential part of the GP workforce and the delivery of primary care. Locums, deputies, assistants, associates, and retainees probably make up about 20% of GP numbers,[2,3] providing additional services and relieving hard-pressed principals. GP non-principals are a disparate group in terms of age, stage of career, and time availability. One recent study[2] found that the non-principals were predominantly young, female graduates with a median of two postgraduate qualifications, were professionally isolated, had difficulty accessing appropriate education, and were in need of more support and information.

Principals and non-principals are highly qualified doctors and both groups are expected to deliver the same high standards of primary healthcare, but this is where their similarity ends and inequality begins. In many respects, non-principals are disadvantaged. Principals have financial incentives to take up continuing medical education or the newer version, continuing professional development (CPD), easy access to CPD, maternity and seniority benefits, tax free property investments, job security, and professional standing. The majority of non-principals, on the other hand, are not entitled to any of these benefits, except for some assistants and retainees who may qualify for limited education allowances.

Most non-principals work part-time, with retainees working for two sessions or less per week, and so have correspondingly low incomes. They may not have a free choice between passive models of CPD and active problem-based methods, which might be more suitable for their needs, because they are limited by time taken for travelling and the course fees they can afford. It cannot be assumed that part-time working automatically gives more time for CPD, because many non-principals care for dependents or have a portfolio of other work. The philosophy of care that centres on the continuity of the doctor-patient relationship is not the case for many non-principals, who may be in danger of losing the experience of managing chronic conditions.

There is a debate about whether education for general practitioner non-principals should be catered for separately. CPD needs to be tailored to the individual needs of all general practitioners, whether they are principals or non-principals. Although wanting to discourage the use of the patronizing and stigmatizing term 'special needs', it should be recognized that, while non-principals have similar requirements for CPD to any other GPs, the nature of their work and situations means that they have additional specific needs, which through a lack of funding and information are often not being provided.

There is an awakening interest in non-principals' CPD, but meeting non-principals' educational requirements is still a low priority in educational circles, because of the lack of new money to fund their required education. There are a variety of pilot schemes being trialled around the country that offer specialized educational opportunities for non-principals. These include in-depth regional interest in the career plans and educational needs of doctors on local retainer schemes, such as those in London and the North West,[3] a residential three-day returner course held in the Trent region[5] that encourages conversion to becoming a principal, re-entry initiatives offering regular education and support in Wessex and the West Midlands,[3,6] and an academic assistant scheme in London[3] where non-principals are employed to relieve principals on a part-time basis and have three sessions per week of protected academic time. An alternative scheme that has been piloted in Durham[3] and is being modelled elsewhere, offers a first year of placements in practices with a half-day workshop and another half-day for personal learning, followed by a choice of general practice related work and education in the second year. The establishment of many of these schemes was driven by the need to prepare for the predicted shortfall in GP principals, with Health Authorities and funds from the London Implementation Zone sponsoring the projects.[7] These schemes pilot seamless educational support for doctors at all stages in their careers from vocational trainee to non-principal to principal, a model which should be regarded as the norm rather than an ideal.

A recent national workshop[3] reviewed the types of education being offered to non-principals, and produced the following consensus from the educationalists attending that:

- There should be equal opportunities for access to, and funding of, continuing medical education for GP principals and non-principals.
- There should be no educational discrimination between principals and non-principals.
- GP tutors should be available to support all groups of doctors working in general practice to facilitate learner-centred personal education plans.
- Every region/deanery should employ at least one educational facilitator, whose responsibility includes non-principals' education, as a minimum.
- There should be opportunities for career variations for GP principals and non-principals, including transitional and salaried schemes as part of a GP career structure.
- A database of all non-principals is essential, based on regions or deaneries, to enable career tracking of doctors.
- Doctors employing non-principals for more than three months should include an entitlement to study leave in their contracts.

The National Association of Non-Principals[8] is a strong voice in urging that action be taken to provide GP non-principals with appropriate CPD. It has initiated a national database, facilitated the setting-up of many local support groups, and provided a forum for stimulating better working conditions for GP non-principals, with regard to rights, responsibilities, earnings, and education.

There have been calls for decisive action on the looming primary care workforce crisis,[9] and the pool of vocationally trained GPs who are not principals[10] is a potential way of addressing this crisis. However, the SCOPME report[2] describes flexibility and low levels of non-clinical responsibility as reasons why doctors with family commitments choose to work as non-principals rather than principals. With an increasing proportion of GP registrars being female,[11] choosing to be a non-principal is

likely to be increasingly common. It is important that a range of CPD is planned to accommodate the chosen career variations and preferences of the GP workforce, and provide young doctors with appropriate postgraduate education that consolidates the levels of skills and knowledge attained at the end of their training.

Any restructuring of CPD for GPs should not be exclusively practice-based, or else non-principals may continue to be excluded, especially locums and deputies who are not attached to any particular practices. We must create a system of equal educational opportunities for principals and non-principals, so that patients always see doctors who are maintaining their postgraduate education and are up to date. We need to ensure that there is equal access to support for continuing professional development – in terms of money, practical support (via educational tutors and facilitators, who are readily available to non-principals), and access to sources of information such as postgraduate centre mailing lists, British National Formularies, and health service news-sheets. Any new proposals for direct educational reimbursements for general practice should not be confined to principals, but be extended to *all* general practitioners.

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PRODIGY: implementing clinical guidance using computers

AS physicians today we are faced with the dual demands of an explosion in medical knowledge and an increasingly informed society.[1,2,3,4] These challenges should be embraced – by developing our clinical method,[1,2] engendering patient self-care, increasing team work, and improving utilization of up-to-date information in the management of the individual patient.[1] Information technology has a crucial role to play; several studies have indicated the potential benefits of computer decision support systems,[3,5,6,7] which use an underlying knowledge base of clinical information to present the general practitioner (GP) with advice relevant to clinical decisions.[3,5,6,7,8]

Over the past two years, over 900 GPs in more than 200 practices nationally have been involved in a project which aims to address these issues, through the development and evaluation of a computerized decision-support system for general practice in the UK: the PRODIGY project (Prescribing RatiOnally with Decision Support In General Practice StudY). The project, funded by the NHS Executive and based at the Sowerby Centre for Health Informatics at the University of Newcastle, set out in 1995 to research the acceptability of such a system to GPs and its impact on prescribing habits, as well as addressing a range of other questions pertinent to the future development of general practice.

GPs can use PRODIGY on existing clinical computer systems, during the consultation. When a diagnosis is entered, PRODIGY immediately offers decision support by presenting clinical advice and prescribing recommendations, as well as non-drug treatments and patient information leaflets. This support is offered across a wide range of clinical conditions commonly seen in general practice: 70% of primary care consultations are covered.[9]

There is no erosion of clinical freedom. GPs can continue to make both diagnosis and management decisions – use of PRODIGY is at the discretion of the practitioner, who can bypass or edit clinical recommendations and therapy choices. PRODIGY does not aim to supplant GPs, but to empower them by offering relevant information at the appropriate point in the decision-making process.

The involvement of GPs has been integral to the development of PRODIGY. The first prototype of the system was tested in 137 practices during the first three months of 1996, and findings from this research[9] were then used in the development of a second version of PRODIGY, which is being evaluated at the time of writing (autumn 1997). This rapid iterative methodology – with NHS Executive, academic project team, computer suppliers and GP users collaborating to develop and improve the product – is commonly applied in industry, but is untypical for Information Management and Technology (IM&T) initiatives.[10,11]

During both phases of the PRODIGY project, a comprehensive range of qualitative and quantitative evaluation methodologies have been employed by the project team. The main findings of PRODIGY Phase One were presented in an Interim Report in September 1996, and other results are currently being prepared for publication.

The Interim Report on Phase One included evidence that, in general, PRODIGY moved the GPs towards the selection of drugs it recommended.[9] Although the size of this effect could not be quantified, or statistical assurances given, the broad finding was reassuring. The Interim Report also revealed that 94% of GPs who had used the system considered PRODIGY to be a concept worth developing. Many of these GPs believed that the system needed further improvements, but the prototyping methodology applied by the project team meant that these developments could be incorporated into the next version of PRODIGY.

PRODIGY Phase One also found a high level of enthusiasm for a computerized decision support system within the GP community as a whole. Because the practices involved in the study were selected by the computer suppliers involved (AAH Meditel, EMIS, Genisyst [now Globalsoft], MCS, VAMP [now Reuters Health Information]), a national questionnaire of non-PRODIGY GPs was carried out to assess the typicality of the PRODIGY sites. This showed that 87% of GPs nationally would welcome a set of 'high quality prescribing guidelines', with 84% specifying that these should be presented by computer. There was high awareness of issues concerning control of the development and implementation process of these; 78% of GPs believe that clinical computers will enhance their ability to deliver best practice, as long as the professional bodies (including the RCGP) 'control' the agenda setting.

The issue of the quality and control of clinical content is clearly central to any decision support system. 73% of GPs using PRODIGY Phase One considered the clinical information to be of 'some use'. However there was criticism that the content was 'too basic', a finding which was not unexpected with a prototype system designed primarily to test the concept of decision support.

In recognition of the fundamental importance of the clinical content, the clinical authoring process has been substantially developed for the new clinical recommendations released as part of PRODIGY Phase Two. Recommendations are produced by a multidisciplinary team following a structured literature search and review of the evidence; they are rigorously validated by an eminent panel drawn from the RPSGP, RCP, RCGP and GMSC. The team at the Sowerby Centre are doing pioneering work towards developing a robust method for integrating evidence into rational, educational, and interventional computer-delivered guidance.

The structure of the clinical information presented has also been modified. Although laboratory testing and video analysis of Phase One showed that PRODIGY caused minimal disruption to the consultation,[12] questionnaire and facilitated group research found that users perceived that the system slowed the consultation. The qualitative research suggested that this was because users were overloaded with information, which was not adequately structured or sign-posted.

Clinical advice on PRODIGY is now structured into three decision levels. First, the clinician selects a problem heading, followed by a scenario, and then a therapy group – for example, a GP might enter 'dyspepsia', then select the scenario 'duodenal ulcer (confirmed)', then the therapy group '*H pylori* eradication'. The physician would then directly be able to issue a prescription for triple therapy.

Supporting texts and educational material are now presented only at the request of the user, while 'sign-posting' has been increased, with the objective of achieving consistency throughout the system. The evaluation of Phase Two will reveal the response of GP users to these changes.

No final decision will be made on the future of PRODIGY until Phase Two has been fully evaluated. At this juncture, however, it is possible to say that workshops held during Phase Two suggest that GPs have broadly welcomed the developments, and that the project methodology appears to have been vindicated by producing a second iteration of the system received more favourably by users than the first.

As for the future, research is set to continue into issues of chronic disease management and effective methods for authoring clinical knowledge, while a related trial, COGENT,[13] is evaluating the impact of computerized guidance on health outcomes. It is clear that considerable progress has been made towards the goal of a workable and professionally accepted prescribing decision support system.

> 'The solution is not to remove the decision-making power from physicians, but to improve the capacity of physicians to make better decisions. To achieve this solution, we must give physicians the information they need; we must build processes that support, not dictate, decisions'.
>
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