Vocational training and beyond — listening to voices from a void

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SUMMARY

This paper is written from the viewpoint of a doctor who has recently undergone general practice vocational training, and has first-hand experience of some of the opportunities, difficulties, and uncertainties facing doctors at this stage of their careers. The literature on vocational training and the issues concerning young doctors are explored in the light of concerns that recruitment into general practice is falling, that registrars may feel lost in a 'void' at the end of training, and that the 'new world' of post-training work brings problems for many new general practitioners (GPs). Instead of a traditional partnership, one of the authors (RB) chose a salaried, educationally oriented introduction to inner-city general practice. Some innovative, educational schemes, which are aiming to improve the appeal of general practice, are discussed.

Keywords: general practice; general practitioners, continuing education.

Introduction

IN the changing National Health Service (NHS), the role of primary care continues to develop and with the white paper *Choice and opportunity*[1] it could be argued that there are more opportunities for young doctors than before. For many, however, the transition from registrar to principal is less of a step and more of a quantum leap, and may leave doctors struggling to recognize and develop the skills required to perform successfully in today's NHS.

The locally developed, three-year vocational training schemes[2] are considered one of the successes of general practice,[3] but are too short.[4] Three years was a compromise from the outset, when regular reviews of training were also recommended.[5,6] No formal review has yet occurred. Has training for general practice 'reached the end of the first phase of its development'?[3]

What's on the training agenda?

The GP registrar year uses progressive educational methods and the mentor relationship with a trainer[7] and course organizer. These relationships, when they work well, are greatly valued by the registrar. This may be the first time since qualification that they feel professionally supported, and the transformation from hospital doctor to GP can begin.

Registrars have different agendas from principals and their trainers: they are adjusting to a different clinical emphasis, the MRCGP examination is looming, and they have little financial interest in the practice. Priority is given to subjects of immediate clinical relevance. There is so much to learn in this year, although under *Choice and opportunity* guidelines[1] registrars on schemes will be able to work in practice for 18 months. There are few opportunities for research,[8] chronic disease management,[9] or training in business skills. When management is explored during training, the emphasis and skills learned in a well-organized training practice may be very different from those required in a less developed practice. It could therefore be said that at the end of training the registrar functions well as a registrar in a *particular* training practice.

Training for the ideal?

Training practices make up 23% of all general practices, and include 37% of all GPs (personal communication, General Medical Statistics, NHSE, 1997). But how representative of the 'real world' of general practice are training practices? How aware are trainers and course organizers of the diversity and problems of less organized or dysfunctional practices? How good a position are they in to prepare registrars to face the issues that may arise for new principals? Are there ways to share experiences of potential difficulties within a protected environment?

At the end of training, the Joint Committee of Postgraduate Training for General Practice (JCPTGP) certificate represents professional judgements of a 'satisfactory level of competence in the field of medicine to which the statement relates'.[10] Exactly what this 'level of competence' means is controversial.[11] Summative assessment addresses issues of competence for the role of principal, but the lengthy assessment process may further reduce exposure to other issues, such as management. Additional requirements include accreditation for child health surveillance and resuscitation, with pressure to become adept at obstetrics, family planning, and minor surgery. Should all trainees pass the MRCGP examination at the end of training,[14-16] or is this still seen as the flag of excellence?[12]

Why think about reviewing general practice now?

The appeal of general practice has waned since the 1980s, but why? Is it because of uncertainties in career prospects, or is it fear of a changing ethos?[13] Undergraduate intake remains stable, but recruitment into general practice is falling. Applicants for registrar posts are reduced, and fewer registrars intend to become principals straight after training.[14-16]

Increasing numbers of women are completing vocational training[17,18] but are less likely than men to become principals, teachers, and trainers.[19,20] Fifty-six per cent of men recently surveyed were interested in part-time work,[21] and, as women's participation may be lower,[22] this has implications for recruitment.[23] Many GPs are also looking to take early retirement.[22] Reasons given by GPs for not working as principals were the out-of-hours commitment and the difficulties of combining work and family.[24] Burnout (even in young doctors) stress, and depression may also play a part.[25-28]

Failing to meet the expectations of registrars?

At the end of training, registrars may have fixed ideas about part-

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nerships (wishing for a 'carbon copy' of their training practice). Box 1 shows the features of a practice that they see as desirable.

- Good working relationships with patients, staff, and local hospitals
- A practice manager, nurse, and attached health authority staff
- Opportunities for postgraduate education.[16]

Box 1. Features considered desirable in a practice.

GP registrars enjoy the continuity of care, the holistic approach, and the professional autonomy offered by general practice work; they worry about workload, out-of-hours work, litigation, and the increasing demands of patients and government.[21]

Special problems in the inner city?

The inverse care law states that care is worst where the need is greatest.[29] Primary health care needs are greatest in the inner cities. In inner London there is a lower proportion of training practices,[30-33] and inner-city registrars have described the need to improve remuneration and safety.[15,34] In the London Initiative Zone (LIZ), 74% of practices are single- or two-handed. Some of these have poor premises, low incomes, and a shortage of attached staff — and so may differ from registrars' ideals. In one study only 28% would consider working in inner London, while 48% would definitely not.[16] Registrars may feel ill-prepared to join a practice they perceive as 'sub-standard'. They may need substantial support or some additional feature in their contract that they regard as 'compensatory'. There is possibly a perverse incentive in that the hardest pressed posts may be the worst paid. These problems are likely to be typical of other inner cities. If registrars were exposed to the challenges and opportunities that inner-city practices pose, might they be more willing to stay?

Voices from a void

Training often ends in uncertainties for registrars, who may feel that they have landed in a 'void'. Exposure to other styles of practice may occur during locum work or through the experience of peers. This can be quite a shock, and it has been suggested that this transition is inadequately addressed during training.[35] Eighty per cent thought that deficiencies in their training and continuing education had contributed to their difficulties by not preparing them adequately for their changing role.[36] Questions posed include: 'What will real general practice be like?', 'How do I avoid partnership problems?', 'What sort of practice do I want?', 'Will I have to stay for 40 years?' These uncertainties may contribute to the finding that 10% of male and 13% of female registrars found following a general practice career difficult or very difficult.[19]

Voices from a new world

Faced with partnership, possibly in a practice with a different organizational set-up, young GPs may feel as if they have landed in a 'new world'. Another move, from 'unconsciously incompetent' (unawareness of lack of necessary skills) to 'consciously incompetent' (awareness of deficiencies), may take place (Box 2).

Certain coping strategies are used: discussion with colleagues, partners, friends, young principals' groups, and spouses; management training; trial and error; patience and compromise; changing or leaving the partnership. Serious consequences of this move into practice may include marital break up or excessive drinking.[37]

'I have been fortunate enough to join a good successful practice in an area I know well. Even then I feel thrown into the deep end of a pool – barely swimming. A lot of the skills I require, I feel I have never been taught.'

'I'm new to general practice, and feel isolated sometimes. It's difficult to explain this to my partners as they've both been GPs for years and are heavily involved in other commitments.'

'Peer education and support is the thing I miss most since becoming a principal.'

Box 2. Comments from young principals about their experiences, taken from Woodward R, Shridhar S. *Survey of young principals in Merseyside.* Liverpool: Primary Care Initiative, 1996.

Other GPs have voiced similar concerns; for example:

- Training is too short and is not representative of real general practice.
- How should GPs select partners and partnerships, negotiate, and manage change, staff, and workload?[37]
- There is pressure to accept long-term contracts with large financial commitments prematurely.[19]

Young GPs are requesting:

- Flexible working hours
- Opportunities to move to other practices
- Involvement with health commissions, and
- Help with non-clinical communication skills and in dealing with the 'hidden hierarchy' within practices. (Woodward R. *Report of primary care initiative.* Liverpool: Primary Care Initiative, 1996.)

Future training: what criteria do doctors need to meet?

Trends towards responsiveness and accountability may make general practice the true foundation of the NHS, but to cope with these opportunities and challenges, doctors need broad-based skills,[38] covering areas such as computing, teamwork, understanding the purchaser–provider split,[39] community medicine, epidemiology, business skills, and delegation.[40]

Meeting the challenge: where do we go from here?

Many alterations to current training schemes have been proposed, either by increasing the general practice component,[41,42] or by reworking the hospital component of training.[43-46] Perhaps we need a flexible career structure, providing an educational continuum (academic, clinical, and managerial). Fifty-five per cent of doctors would like a salaried option, with 11% favouring it for all;[11] most of the doctors supporting this option are working in deprived areas with high demands and poor facilities.[47] The needs of women who wish to combine work with a family should be addressed,[48] and re-entry courses should be available.[20]

Alternative career pathways

Innovative schemes have developed recently to try to address these challenges. It is beyond the scope of this paper to describe all the current schemes, but we give some examples. The North West Region's Primary Care Initiative aims to recruit and retain practitioners, while supporting young doctors and practices in the

difficult inner-city environment. It offers the flexibility to define and address learning needs and organizational issues, and gives funding for optional study to masters level. It also provides mentoring and an active learning set. Eleven of the 16 salaried doctors are women.[49]

In Lambeth, Southwark and Lewisham (LSL) Health Authority, the South London Organization of Vocational Training Schemes (SLOVTS) are developing their training programme specifically to address the needs of inner-city registrars. In addition, they run a post-vocational training scheme whereby salaried, vocational training associates (VTAs) work between two inner-city practices[50] for one year, with protected time for educational and peer-group support, and professional development (personal communication, Rebecca Scott, associate director for Provider Development, LSL Health Authority, 1997). Both the North West and the LSL schemes have resulted in young GPs staying to work in the inner cities. In the Durham GP Career Start Scheme, doctors work for one year as a fully-qualified GP in two self-chosen practices, with on-going professional education as a particular focus (personal communication, Dr Jamie Harrison, Career Start, 1996).

The London Academic Training Scheme (LATS) enables young GPs to develop academic skills and to work three sessions a week in an inner-city practice with group and individual support. LATS concentrates on research rather than teaching, as it is felt that these academic skills are in most need of development in general practice (personal communication, Professor George Freeman, LATS Annual Report, 1995–1996).

One innovative practice offers what is loosely referred to as a 'senior registrar' post — a salaried, two-year position — as a transition that includes study leave and does not require the full commitment of partnership (personal communication, Dr Gillian Plant, GP tutor in Macclesfield, 1996).

Continuing and higher education

Continuing medical education has to be relevant. We may learn best by solving practical problems — self-directed learning (andragogy).[51] Training may need to change from being content-driven to being about the the learning process itself.[25] Most registrars probably do not master self-directed learning in one year, and dependent learning may continue during PGEA lectures.[52] Should all doctors have a personal, professional development plan?

There are only a few academic posts available: in 1988 there were 0.006 academic posts per GP, compared with 0.49 per consultant.[53] Few doctors take higher degrees, and practice arrangements are often too inflexible to accommodate this. If funding for academic practice were more equitable,[54] and practices more flexible, service GPs could be involved in research, possibly through integrated departments.[7,55] King's College School of Medicine and Dentistry have developed a scheme called Mid-Career Break, which offers GP principals who are in the middle of their careers a range of learning opportunities (personal communication, Virginia Morley, senior lecturer, Mid Career Break).

It has been said that the gap between medical education and the delivery of health care is widening. Styles stressed that 'reflection, pursuit of special interests, and promotion of personal and professional development lie at the heart of any educational process', and discussed the importance of recognizing when change is needed and how to initiate it.[35] As Peter White observed: 'GPs bolt on bits to their career, but it might be better if progression were built in and changing practice not viewed so negatively. We aren't trained to manage change.'[56] Denis Pereira Gray added, 'Outside jobs or study give a chance to look from a different perspective, broaden the horizon. Without them a doctor's outlook may be too limited for the complexity of the job.'[56]

Conclusion

Several common themes emerge from the literature concerning training, recruitment, and retention for general practice:

- The transition from registrar to principal is often a difficult process.
- Three years is too short to address these difficulties.
- Trainees may need exposure to the 'real world' of general practice in order to appreciate the skills that they will require (for example, in management, change management, communication, and partnership negotiation).
- New GPs should be supported by young principals' groups and mentors.
- Flexibility and protected time are required to address personal and professional development needs, especially for women.
- Reasonable financial arrangements should be made until long-term commitments feel right.
- Continuing and higher professional education should provide the flexibility to pursue educational needs and develop a personal education plan.
- Mid-career breaks and re-entry courses should be encouraged.
- An appreciation of the special needs of the inner cities should be encouraged.

These issues are not new, but the crisis in recruitment has brought them to the fore. The alternative programmes for vocational and post-vocational training need evaluation. Should there be opportunities for more practices to become involved in teaching, training, and research? Will these approaches reap long-term benefits in terms of recruitment, retention, and education? Perhaps the outcomes will be considered in the future planning of general practice careers.

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