General practice in the foundation programme: evaluation of a brief embedded experience

Modernising Medical Careers aims to provide an experience in general practice for all doctors in the foundation programme. Is this desirable, and what constitutes a meaningful experience in primary care? This evaluation of a brief embedded attachment reports on an alternative to the 4 months in general practice which will be on offer to the majority of trainees in 2006.

Introduction

The new medical training described in Modernising Medical Careers (Department of Health, 2003) launched in August 2005 with a 2-year foundation programme offering a broad base of experience built around a generic curriculum. One of the aims of the programme is that trainees should experience a wide range of specialties in order to provide them with a greater insight into the workings of the health service and to equip them to make appropriate career choices. One of those specialties is general practice, which in several respects is something of a special case. General practice accounts for 90% of all patient contacts in the NHS (Audit Commission, 2002), and is the preferred career option of 32% of medical graduates (Lambert et al, 2003).

Primary care is also the preferred sector of a modernizing government that, for patients with long-term conditions, aims to offer 'closer personal attention and support in the community and at home' (Department of Health, 2004) and to reduce emergency inpatient stay by 5% by 2008 (Department of Health, 2005).

Mindful of the above, at a British Medical Association conference in September 2004 the Minister for Health, John Hutton, reiterated the government's intention to offer all trainees in the foundation programme a meaningful experience in primary care. In April 2005, the Department of Health backed the minister's proclamation and announced new funding for substantive attachments to general practice in the second foundation year, sufficient for 55% of all doctors in 2006 – regardless of career destination – rising to 80% in 2007 with a commitment to GP for all by 2008. The bulk of training in the foundation programme will continue to take place in hospital but a general practice attachment offers trainees the opportunity to care for patients in a very different setting; arguably one more attuned to the needs of a modern NHS. What we do not yet know is what constitutes a 'meaningful experience' nor how it can best be delivered.

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The 'patient journey' pilot programme

The rationale for ring-fenced funding was based on the experience of pilot studies around the UK which had, almost exclusively, focussed on attachments of 4 months' duration (Grant et al, 2004). There were well-founded educational reasons for this approach; it is argued that only through sustained exposure the trainee can be immersed in both the content and context of primary care, and the nature of the relationship with secondary care fully understood. Experience with GP preregistration house officer attachments has shown that they require at least 3–4 months to orientate themselves to the organizational and clinical dimensions of general practice (Illing et al, 2003). Trainees need also to be able to manage their own clinical caseload in order to add value to the general practice experience they have already obtained in medical school. All this takes time.

In London, an alternative approach was developed: a brief semi-structured general practice experience entitled 'the patient journey'. The programme offered 13 sessions in primary care as an embedded experience. Trainees were seconded out to practices for a half a day each week where they received a mixture of case-based discussion, clinical experience and formal teaching. The emphasis of the programme was two-fold; on the journey of the patient from primary to secondary care and back again, and on the doctor's own personal career development. The programme curriculum was devised around the emerging national foundation programme curriculum and available published learning outcomes (Joint Committee on Postgraduate Training for General Practice, 2004), and was further honed at a meeting of the educational supervisors themselves resulting in the production of a programme handbook.

Ten acute trusts participated in the pilot and the programme was subject to an independent external evaluation.

Evaluation questions

The principal question that the evaluation wished to answer was whether or not the patient journey programme added value to the foundation training. This larger question included sub-questions:

- What does the patient journey add over and above medical student experience of primary care?
- How does its impact compare with the impact of 4 months full time in primary care?
- To what extent is its intended learning outcomes achievable in the time?
- Does the patient journey influence career intention?

Method

All the London foundation pilot trainees who participated in the patient journey programme from August 2004 to June 2005 were invited to complete a baseline questionnaire and to attend three focus groups held in November, February and May. One group was also held including the Northern Deanery's foundation pilot trainees who had experienced a 4-month full-time primary care attachment. In addition, a focus group of educational supervisors was held in London Deanery at the end of the programme. Those who were unable to attend the groups were contacted by telephone or e-mail with the same questions.

Data were analysed under the two main themes: what is added by a foundation year experience in general practice, and whether the very brief approach used by London is an suitable design for such an experience. The trainees' and trainers' responses were then analysed for content into categories (Radnor, 2002) and agreed by both authors. For validity purposes, the full results and all quotations for this study are contained in the original report which can be found at: http://www.mmc.nhs.uk/pages/foundation/pilot-results.

Results

A total of 34 trainees took part in the patient journey across ten acute trusts throughout London. Of those, 26 (76%) were interviewed either in a focus group, by telephone or by e-mail. Of those interviewed, baseline information was available through questionnaire on 19 (73%). The cohort ranged in age from 25–34 years with a mean age of 27 years and 58% were male. Of the cohort, 26% were totally certain about their intended specialty and 42% expressed a strong preference for general practice as a career. In the Northern Deanery six of the eight trainees who completed the first 4-month placement were interviewed within the group or by e-mail. In the educational supervisors' group seven of a possible 16 took part (44%).

Two thematic areas emerged from the analysis: what trainees took away from the programme and the design of the patient journey programme itself.

What trainees took away from the programme

Heightened awareness of primary care

An appreciation of the challenges faced by GPs:

'Having to take clinical decisions just based on the patient's history – clinical experience and examination was in some cases remarkable when compared to hospital work where no decisions are taken without blood results, X-rays etc.'

'You can't just test, so you have to send patients to A&E [accident and emergency] sometimes. It's much more scary without having all the tests available.'

An increased awareness of the different professionals and range of services involved in primary care:

'I had no idea how many different people were involved in care.'

'Having trained in Spain this was my first contact with a GP practice…It was very interesting and I saw how the practice was structured, the different roles of the nurse practitioner, district nurse, health visitor etc.'

The overall variety in primary care:

'Very varied role of GP. I especially enjoyed home visits and specialist clinics. I appreciated the role of GPs in providing continuing care after patient discharged from hospital, the role of the intermediate care team. There was so much more involved than I'd ever realised.'

Increased insight into issues at the primary–secondary care interface

Most trainees referred to their heightened awareness of issues at the primary–secondary care interface:

'You can now see it from both ends.'

'I understand better what "back to the community" means, especially from A&E.'

Discharge summaries were a major issue:

'Discharge summaries are really dreadful – they don't even say what the patient's in for!'

'My summaries are much better after my placement. I put in all the test results.'

Positive regard for general practice, including as a career option

Overall a more positive feeling towards general practice was engendered by the experience:

'I now have more respect for and understanding of general practice.'

'It has offered an alternative vocational direction.'

'I am even more determined to pursue a career in general practice.'

'I have been working to be a surgeon for 5 years and I haven't changed my mind, but it has been an extremely positive experience.'

Opportunity to take personal responsibility, and so build confidence

Many trainees valued the opportunity to take personal responsibility for decisions, and felt more confident as a result:

'It gave me the opportunity to get really involved.'

'I have begun to feel more confident, especially as general practice places more responsibility on the doctor.'

'Seeing patients on my own was one of the best things.'

Although one participant felt the opposite was true:

'There was much less responsibility than we're used to in hospital and a lot of waiting around between patients to discuss them with your GP.'

Acquisition of specific competencies

Trainees felt that they had acquired a number of specific competencies through the experience:

Communication skills:

'I appreciate the doctor/patient relationship more, especially with elderly people.'

'I take more time listening to my patients and their expectations before "making my move".'

Time management:

'I learnt a lot about time management – ways to steer the consultation faster to get what you want out of it.'

Stress management:

'I enjoyed speaking with the practice counsellor who taught me various relaxation techniques. I've since taught these to some of the teenagers I've seen at the hospital and found it a valuable way of supporting them through stressful events.'

Clinical management:

'I feel better now about dealing with depressed patients and also with some paediatrics and O&G [obstetrics and gynaecology].'

Appreciation of a whole person approach to patients

'I most appreciated home visits as a chance to evaluate patients in an environment in which they felt comfortable. This allowed me to observe cultural and domestic influences on symptoms and history.'

'It has opened my eyes a little more to make me see patients instead of disease.'

The design of the patient journey programme

Duration

There were mixed feelings about the duration of the placement. The majority of trainees and supervisors would have preferred a longer attachment:

'I would have preferred 4 months because there's so much to cover in just 12 morning sessions.'

'A longer period in general practice would have given me the chance to see a greater variety of cases, and the chance to follow patients up over time at four months they'll only just be up to speed in terms of making any sort of contribution to the practice.'

About one third of trainees interviewed were pleased not to have had a longer attachment.

'Four months is too long if you don't want to be a GP.'

'In some ways a short taster probably makes general practice more attractive than a longer stint.'

Most trainees who completed the patient journey programme felt that it would have been better structured as a block. The educational supervisors agreed with this:

'Four months is too much, but …a 2–4-week period would create the opportunity of being known by patients and staff.'

'It would be easier to do if it was a block. There wouldn't be the pressure from hospital, and you would become more part of the practice.'

Integration with other elements of the foundation programme

A minority of trainees felt that the patient journey was well integrated with the rest of the foundation programme pilot:

'It was good the sessions are close to the hospital – it meant there was already a relationship between the two.'

Most, however, had experienced problems and this was confirmed by the educational supervisors:

'I had to find someone to cover for me every single week.'

'At times the consultants in charge were unable to get a locum cover for me and I missed precious days of the experience.'

'I couldn't go to all the sessions because of the inflexibility of the O&G rota.'

Depth of the experience

About half the trainees felt that the attachment offered an adequate depth of experience:

'You hardly turned up at medical school. This feels much more realistic.'

'As a medical student you were not able to get as deeply involved in the practice. I think it gives you great insight and understanding of primary care even for those doctors not keen on it as a career.'

A similar number felt that the attachment was inadequate:

'The experience of continuity of care is more likely in a longer placement.'

'Greater value to the GP practice if I was there for longer than a few half-day sessions per week.'

'A full-time training [sic] would have made me feel more part of a team.'

'I missed understanding the whole structure and politics of primary care.'

'Personally I did not feel I gained from this experience. I trained at Manchester where 1 day a week was spent in general practice throughout the clinical years.'

All agreed that the experience was enriched by having previously practised as a doctor in secondary care:

'Having the opportunity to see GP patients with some knowledge now of hospital medicine, the attachment gave me an excellent insight into the responsibility placed on GPs.'

Practical administrative issues

There was some disapproval that the attachment was mandatory:

'I didn't like having to do GP placement as part of study leave.'

'The only thing that was not good about this experience was that it was not optional. For me I felt I was being forced to do something I wasn't interested in.'

There were doubts over future capacity:

'We're all with excellent practices. What will it be like when there's hundreds doing it.'

'Trainers need more time for FP2s.'

And for some trainees there was confusion over status:

'Initial teething problems such as other partners thinking I was a medical student.'

'I had no prescribing rights on the surgery premises.'

Additional themes from Northern Deanery trainees

The headline themes that emerged from the Northern Deanery group mirrored those from London. However, three additional specific competency areas were identified:

Administration and management:

'I am also aware of the managerial side of medicine that is not experienced at F2 level in hospital practice.'

Dealing with uncertainty:

'I have learnt to deal with uncertainty in a much more systematic way.'

Investigations:

'I've learned to cut down on investigations. In hospital medicine I would tick all the boxes, but in general practice you learn to ask for just what matters.'

In relation to integration, there was anxiety about return to secondary care after a prolonged attachment:

'I've done no on calls at all and I'm scared to bits about A&E and not remembering how to do a cannula.'

And three additional practical administrative issues arose relating to unfair pay and banding, professional indemnity and travel expenses.

Additional issues raised by educational supervisors

Again, similar topics were generated by the educational supervisors' group but an additional theme emerged in relation to teaching the patient journey programme:

Appreciation of individualized teaching:

'It seemed to be the first time that anyone had worked with them on their training and development.'

Supervisory load:

'I did no clinical work at all that day. The work with the trainee is so intense.'

'I always saw the patient too, either at the same time or afterwards.'

'Buy in the practice, not the GP. That way nurses can get involved too, which would be better.'

'Bring in more trainees at a time. That would make it more cost-effective, but also it's better for the trainees. It's certainly very good to share the time with a registrar.'

Failure of engagement: There was concern about the experience stretching to 3 or 4 months full-time as some felt they would be fighting a lack of enthusiasm for those who wanted to do hospital medicine.

Non-attendance was highlighted as a particular problem:

'It's awful if they don't come. They don't realise how much organisation is involved in having them there.'

There were also differences from vocational training:

'Be clear about what we want them to achieve. Remember they're not registrars.'

Discussion

The patient journey cohort appears representative in terms of the likely future age, sex and career preference of foundation trainees. The evaluation itself has limitations as numbers were small. However, response rates were good. In addition, the themes identified appear to be robust and were remarkably concordant across the two deaneries and between trainees and supervisors.

All trainees interviewed, both in London and Northern Deaneries, valued their experience, citing changed attitudes towards primary care, an enhanced understanding of the primary–secondary care interface, an insight into patient-centredness and improved confidence and competence in making management decisions. In London there were mixed feelings about the duration and depth of the attachment, some lack of understanding from hospital colleagues. No doctor completed the full 13 sessions because of on-call duties and leave.

The number (36) involved in the London general practice experience was relatively small. Nevertheless, the views of more than three-quarters of them were represented in these data. While some trainees may have spoken more positively than they felt, the use of an independent interviewer should have reduced this bias. Moreover, the views of the Northern Deanery group mirrored those of London, suggesting that the gains reported can be seen as valid.

So, is an embedded experience enough?

Given the brevity of the patient journey, it is extraordinary just how much the trainees reported gaining from the experience. Overall, while there is no doubt the 4-month experience was fuller and richer than London's 13 sessions, it needs to be asked how much better it was in terms of the cost of the longer placement and the opportunity costs of missing training elsewhere. This is especially pertinent to those destined for specialties such as surgery where other tasters, in addition to a briefer spell in general practice, might be more appropriate.

There were aspects that were lost to the London group. In particular, they had almost no continuity of patient care (although this was also low in the Northern group); they missed meeting some other members of the primary health-care team, and also taking part in the wider life of the practice. They had more difficulties with the computer and other practice systems because of the intermittent nature of the attachment, and there were problems for most in obtaining release from secondary care commitments. Nevertheless, most of these losses could be remedied by constructing a shorter experience around a block of 3 or 4 weeks, as many participants suggested.

Participants also raised the important issue of capacity. Indeed, the availability and quality of expanded placements is an immediate and real concern and highlights the importance of considering the most cost-effective way of delivering what are clearly major gains.

Conclusions

For foundation trainees in 2006, substantive attachments in general practice appear to be the order of the day. To what extent these will be possible for the majority may turn out to be a pragmatic rather than an educational decision. What this evaluation shows is that even a brief experience in general practice can add value to the training of doctors in the foundation programme and that the patient journey may yet provide a solution to 'GP for all'. **BJHM**

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KEY POINTS

- Modernising Medical Careers aims to provide an experience in general practice (GP) for all doctors in the foundation programme.
- Funding has been announced for substantive GP attachments for 55% of doctors in the second foundation year from 2006 rising to 80% in 2007.
- Concerns have been raised particularly in relation to training capacity and the mandatory nature of GP attachments.
- The 'patient journey' programme piloted a brief embedded experience as an alternative means of providing an exposure to primary care.
- Trainees valued their brief GP attachment citing changed attitudes towards primary care, an enhanced understanding of the primary–secondary care interface, increased patient-centredness and improved confidence and competence in making management decisions.
- Appropriately structured, brief attachments in GP add value to the training of doctors in the foundation programme and may provide a pragmatic alternative to 3–4-month placements.