PRHOs in primary care: what is happening out there?

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Preregistration house officer (PRHO) placements in general practice were introduced throughout Britain in August 1998. This paper describes an evaluation of PRHOs in primary care rotations in South Thames during 1998–99. There are important messages for both educational supervisors and undergraduates considering a PRHO in primary care rotation.

One of the last legislative initiatives of the previous Conservative government was to amend the Medical Act shortly before their election defeat in May 1997. The amendment made it possible for preregistration house officers (PRHOs) to be trained in centres other than those owned by the state (Oswald, 1998). Up to that point there had been very few PRHO rotations which included a training attachment in general practice. The NHS Executive (NHSE) responded by funding over forty new pilot PRHO in primary care rotations throughout the UK in August 1998.

There had been few evaluations of PRHO rotations in general practice before the commencement of the pilot rotations in August 1998 and the majority of these report small scale projects. The longest running scheme at St Mary's Hospital Medical School in London began in September 1981. The St Mary's scheme was evaluated in 1985 (Harris et al, 1985) and again in 1995 (Wilton, 1995).

The general practice attachments were found to offer worthwhile and useful experience for PRHOs, which included the management of chronic conditions, the investigation and management of clinical problems and an improved understanding of the interface between primary and secondary care. The reports also emphasized the not inconsiderable supervisory and administrative workload associated with the scheme.

More recently, Parsons and Gregg (1998) reported on the experiences of 12 PRHOs who undertook general practice rotations in North Thames Region during 1997–8. All of the PRHOs interviewed found learning about general practice useful and enjoyable, and they believed that all junior doctors would benefit from the experience. All of the PRHOs felt that they had gained experience in a wide variety of both acute and chronic conditions.

Cohen (1998) provided a fascinating personal insight into the experiences of a PRHO doing a 4-month attachment in primary care. He demonstrated that a PRHO could derive a lot of benefit from an excellent educational environment while providing a significant service input.

Between August 1998 and August 1999 a predominantly qualitative evaluation of four NHSE funded pilot rotations established in the South Thames region was carried out, exploring the perceptions of the key stakeholders: PRHOs, hospital consultants, and general practitioners (GPs). This paper summarizes the evaluation findings pertaining to the views of the PRHOs involved in the study, and the impact of placements in primary care on the nature of their work and learning. These findings are discussed more fully elsewhere (Williams et al, 1999), as are the experiences of GP trainers (Williams et al, 1999) and consultants (Williams et al, 1999, 2000a).

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PROJECT DESIGN

The evaluation used a before/after qualitative design. The twelve PRHOs doing the pilot general practice rotations were matched with twelve control PRHOs who, although they were working in similar posts, were undergoing hospital-based training only.

Semi-structured interviews were conducted with participating PRHOs, GP trainers and nominated partners during August and September 1998. They were re-interviewed in June 1999. The PRHOs' hospital consultants were interviewed at the start of the project. The PRHOs kept learning diaries at fixed points throughout their PRHO year in which they recorded what they were learning and how the learning was delivered. Participating PRHOs underwent an objective structured clinical examination (OSCE) in July 1999. The OSCE examined differences between control and GP PRHOs in problem solving and communication skills.

KEY FINDINGS

Why choose a general practice rotation?

PRHOs justified their choice of a general practice rotation under three categories:

- General practice offered a wide variety of clinical experience
- General practice was viewed as offering a unique learning opportunity
- The new rotation offered a secure job in one place for a year.

The PRHOs' initial concerns included:

- Net loss of hospital experience while in general practice

- A belief that hospital consultants would have a negative attitude to general practice placements.

Does the order in which a PRHO does a general practice rotation matter?

There were advantages and disadvantages to doing general practice first, second or third. Undertaking general practice first often meant a more relaxed start to professional life, but the PRHOs felt they were behind their colleagues when they returned to the hospital setting. While PRHOs doing the GP attachment second felt more confident starting general practice, they also felt more isolated from their hospital peer group. PRHOs doing general practice third felt they had the best order of rotation, but some found the different doctor–patient relationship in primary care difficult to adjust to. They were also anxious about starting senior house officer (SHO) posts having spent the previous 4 months in general practice.

Were skills learned in general practice applicable in a hospital setting?

Many of the skills PRHOs gained in hospital were applicable in general practice. This was particularly true if the PRHOs had done their medicine attachments before doing a GP attachment. PRHOs found it more difficult to apply skills learned in general practice within the hospital setting. This was blamed in part on the heavy service workload in hospital, which made it difficult for PRHOs to spend any significant time talking to patients.

What was different about the learning environment in general practice?

The PRHOs were entirely supernumerary in general practice, whereas in hospitals PRHOs were essential to the efficient functioning of consultant firms, and had large service workloads. Education in general practice was based on one-to-one teaching and self-directed learning. Generally PRHOs found it easier to discuss their learning needs with their GP trainers than with their consultant educational supervisors.

In hospital the PRHOs found that their learning was largely opportunistic and was supervised by their SHOs and specialist registrars. In general practice there was regular feedback on performance and learning was often driven by the PRHOs' personal responsibility for patients. Educational and clinical supervision were generally viewed as better in general practice. However, some PRHOs thought that the style of one-to-one supervision and feedback they experienced in general practice was too intense.

Responsibility
Most of the PRHOs felt they had more responsibility for individual patient care in general practice. However, some found that the General Medical Council regulation (1998) which prevented from signing their own prescriptions made them feel less capable in general practice than in hospital. There were also instances where PRHOs felt that trainers were too cautious about allowing them to see patients alone.

Were PRHOs adequately supported in general practice?
While all the PRHOs said they felt well supported in general practice, many of them missed having regular contact with their peer group, which resulted in feelings of isolation. The teams in general practice did not include staff at the same level of training as a PRHO, although they often found support in the presence of a GP registrar. Many practices had organized successful joint tutorials with the GP registrars and encouraged the PRHO to attend the local vocational training scheme's half-day release schemes.

How were the GP PRHOs viewed by their hospital colleagues?
At the outset of the scheme in particular, PRHOs found the negative attitudes of hospital-based colleagues difficult to deal with. They were labelled as 'GP trainees'. PRHOs found returning to hospital after a general practice attachment stressful, as they worried about being behind colleagues in terms of clinical and organizational skills. Some PRHOs were concerned that they might not have gained adequate hospital experience, particularly in medicine. This aspect of the scheme needs careful monitoring and long-term follow-up.

What did PRHOs learn in primary care?
Many of the General Medical Council's (1998) aims for PRHO general clinical training in general practice were met. There were a number of key areas of learning during the GP PRHO attachments:

Communication skills: The PRHOs felt they had learned about psychological and social antecedents to illness, and the importance of involving patients in decision making about treatment. However, many PRHOs were frustrated by their inability to use consultation styles learned in general practice on their return to the hospital setting.
Clinical skills: The GP PRHOs had exposure to a very wide variety of patients in general practice. They learned how to take responsibility for the management of patients' clinical problems from presentation to resolution. Individual responsibility for patient care meant that they learned about safe and effective prescribing and the appropriate use of investigations.
Teamwork: The PRHOs learned how to work within multiprofessional teams. The model of teamwork was very different to the hierarchical structures they were used to in hospitals. Although the PRHOs enjoyed the experience of multidisciplinary teamwork in the community, they missed the support of their uni-professional hospital-based teams.
The interface between primary and secondary care: All of the PRHOs learned about the process of hospital referral and the many factors which influence this. They developed a greater appreciation of the wide range of acute and chronic diseases dealt with in primary care which never reach hospital. PRHOs returning to hospital were also much more appreciative of the importance of communicating with GPs and other members of the primary health-care team on matters such as patient discharge.
Informatics in clinical practice: Many of the PRHOs in general practice made regular use of Internet resources for evidence-based practice, e.g. Bandolier or Medline. They also became familiar with the concept of electronic patient records. Despite the fact that PRHOs had access to similar electronic sources of evidence in hospitals there were few recorded instances in which they actually used these resources as external sources of evidence in the hospital setting.
The findings of the end-point OSCE: Our evaluation did not set out to measure specific educational outcomes of the PRHO GP rotations. However, there was a commonly held belief before the project's commencement that an attachment in general practice would make a significant difference to the participating PRHOs' communication skills. In addition, many of the PRHOs and some of the consultants were concerned about the potential loss of opportunities to learn clinical skills when placed for 4 months in general practice. We therefore examined two educational outcomes which were of particular interest to the stakeholders in this project, namely:

1. Does a placement in primary care make a significant difference to the communication skills of PRHOs?
2. Does the net loss of training time in a hospital setting lead to a diminution in clinical and problem solving skills?

Eighteen of the 24 house officers who participated in the evaluation were available to undergo an OSCE examination. Nine of the eighteen PRHOs assessed were control PRHOs and nine were GP PRHOs.

There were no significant differences in performance in either communication skills or clinical/problem solving skills between GP PRHOs and control PRHOs. The highest score in communication was achieved by a GP PRHO and the highest score in clinical skills and problem/solving was achieved by a hospital PRHO.

CONCLUSIONS

This evaluation found both benefits and problems for PRHOs undertaking a GP rotation. The key issue is whether or not the experience was useful to this small sample of PRHOs. In terms of the General Medical Council's aims (1998), most of these were fulfilled for the majority of the participants. Working with, rather than observing GPs, allowed the PRHOs to learn at first hand about the multiple roles of a GP and to experience a very different relationship with patients. For many of

the PRHOs it was their only opportunity to really understand medicine as practised in the community before embarking on hospital-based careers. With the rapid changes taking place in the organization of health care, and the growing awareness of the importance of primary care, it seems important that as many junior doctors as possible have experience of working in general practice.

Almost all of the PRHOs enjoyed the experience of having time to learn, and most were able to use the opportunities offered to take some responsibility for directing their own learning. The model of learning in general practice was essentially the same as that which applies in GP registrar training. Thus the PRHOs left their hospital-based 'institutional apprenticeship' (Sinclair, 1997) behind for a more adult learning environment. Clearly this suited some PRHOs more than others.

In order that all PRHOs placed in general practice gain maximum benefit from the learning opportunities on offer, it is essential that adequate time and information is provided for fourth and final year undergraduate students to explore the GP PRHO option (Williams et al, 2000b). The rotation may be more suitable for PRHOs who have demonstrated a previous aptitude for self-directed learning.

The experience of working in general practice offers great opportunities in terms of experiential learning and personal development. However, the skills and attitudes gained in general practice must be relevant to the hospital setting if PRHO placements in general practice are to fully benefit junior doctors, and arguably, patients. This can only happen if there is effective coordination of educational activity and communication between GP trainers and hospital consultants. We recommend that closer collaboration between primary and secondary care supervisors would be facilitated by:

1. Agreement between GP and hospital-based educational supervisors on a fundamental set of learning objectives for the PRHO year based on the 'New Doctor'
2. The use of shared educational tools such as log books and portfolios, in which PRHOs and supervisors can view a joint record of educational goals and achievement
3. A joint training contract between the clinical tutor/dean and the primary and/or secondary care based supervisor specifying supervisory roles and standards
4. The establishment of a mutually agreed system for early reporting of PRHO problems by supervisors to clinical tutors/deans
5. An end of attachment training report drafted by the supervisor and PRHO to inform the next educational supervisor/clinical tutor about areas of achievement and highlighting new learning needs.

An educational continuum between primary and secondary care will in our view address many of the problems associated with PRHO placements in general practice and may ultimately lead to changes in how hospital-based 'on the job' learning is delivered. **HM**

Conflict of interest: none.

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KEY POINTS

- A preregistration attachment in general practice offers a unique opportunity for future consultants and those considering a career in general practice to experience general practice at first hand.
- Doing an attachment in general practice as the first, second or third rotation had distinct advantages and disadvantages in each case.
- Many preregistration house officers (PRHOs) feel isolated from their hospital-based peer group when in general practice.
- The PRHOs in general practice valued the one-to-one supervision and the sense of control over their learning that they experienced in the pilot scheme. Can similar models be adapted to suit a hospital setting?
- Responsibility for individual patient care proved to be an important motivator for PRHOs' learning in general practice. Are there ways in which individual responsibility for patient care could be facilitated in hospitals?