Strengthening general practice by extending specialty training?

DURATION OF TRAINING PROGRAMMES IN EUROPE

European legislation obligates member states to have a full-time postgraduate GP specialty training for ≥ 3 years, with a minimum of 6 months spent in general practice. Across Europe, GP specialty training varies from 3 years (for example, in the UK and the Netherlands) to 6 years (Finland), with training time in general practices varying between 6 months (Austria) and 4 years (Norway). Recently, across Europe a strong movement in favour of extending the minimum duration of GP specialty training from the current 3 years to 4 or even 5 years has developed.^{1,2} Supporters of this measure state that this will 'build the same level as specialty as other disciplines' and therefore strengthen GPs' standing across Europe.^{3,4} This is important because a strong primary care is needed to have a high-quality healthcare system accessible for all citizens, in which GPs function as key stakeholders.^{5,6} However, not every country values GPs in this way. Across Europe GPs' positions vary from being a strong gatekeeper with free access for patients to easily accessible secondary care and paid GP visits. Another argument for extending the duration is that more time spent in training will give trainees 'greater exposure to real world setting', and therefore better developed competencies important for future GPs.² Recently, extension of GP training programmes in Scotland and the West of Ireland reported positive results, whereby trainees from these programmes felt better prepared for independent practice.^{7,8} The extended period of general practice training in particular (2 years instead of 1) was valued by the trainees. Although we recognise that becoming a GP takes time and requires the mastery of a broad range of competencies,^{2,4} in this editorial we will argue that merely extending GP specialty training might not be the right measure to better prepare trainees or to enhance GPs' standing.

DIFFERENCES IN TRAINEES' COMPETENCIES

Individual competency development, rather than time spent in a training scheme, should determine the duration of a training programme. We have the following reasons to support this argument.

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First, trainees differ with regard to obtained competencies prior to residency. For example, they may have gained previous experience as a junior doctor not in training, in a PhD programme, or in transferable work experience outside the medical field. These competencies can be developed further during their training, and this may even lead to a shortening of their time in training.

Second, trainees' capability to master competencies depends on context.⁹ Most postgraduate learning occurs in the workplace, where trainees learn 'by doing'. Clinical experiences are the foundation of trainees' learning: trainees depend on the availability of relevant experiences to master competencies. However, workplaces are chaotic environments and therefore do not guarantee that all necessary experiences are encountered.¹⁰ It is questionable whether mere exposure will truly lead to more successful learning. Therefore, it would be better to increase the educational value of these workplaces by critically looking at the relevance of the workplace for learning primary care skills. For example, the duration of training in a GP setting could be increased at the expense of hospital training. Alternatively, self-directed learning (SDL) could be promoted or faculty development programmes organised.

A third reason is that trainees differ in their ability to learn.¹¹ To reach the full potential a workplace offers, trainees need to engage with their learning. This engagement depends, at least partly, on trainees' motivation and self-regulation abilities.¹² Self-regulated learning focuses on setting learning goals, identifying and employing learning strategies to fulfil those goals, and reflecting on this process. Motivated trainees with well-developed self-regulation skills will learn faster and more deeply; however, not every trainee has the same motivation or abilities to regulate their learning.¹³ Hence, the time to learn the same competence differs between trainees and training settings.

These factors call into question the

logic behind extending the GP specialty training to enhance the quality of GPs or better prepare trainees. Quality of time in practice should take priority over quantity, as the time it takes trainees to master competencies is variable.¹²

CUSTOMISING THE CURRICULUM

Duration of training should be based on educational needs; however, in recent history most decisions regarding time spent in training have been political in nature.¹⁴ For example, recent governmental regulations in the Netherlands forced medical specialty training to shorten their programmes by an average of 6 months in order to save costs. Of course, changing to a competence-based, time-variable GP specialty training is easier said than done, and will require time and funding.¹⁵ To fully equip future GPs with the competencies needed in our modern, fast-changing healthcare systems a more personal, customisable curriculum is needed.¹⁶ Moreover, we have to acknowledge that learning does not stop at the end of specialty training. In our view, competency-based, time-variable training may help to create GPs who are lifelong learners, deliver high-quality care, and have a high standing in their healthcare systems.

As stated before, we believe that it is time to improve GPs' standing across Europe. Next to improving GP specialty training, this can be achieved with other measures, of which there are four components. First, it is important that students get acquainted with general practice at an early stage of their medical training. Therefore it is important to have a strong position in the pre-graduate curricula and this contributes to the positive view students have of GPs.¹⁷ Unfortunately, in some countries it is still possible to become a medical doctor without experience in a primary care setting.¹⁷ Second, as in many other specialty programmes, GP trainees should be educated in academic skills. A strong academic base and development of evidence-based guidelines will improve the quality of primary care. Third, GPs should be encouraged to keep up their knowledge

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and skills by continuous professional development. This can be part of a revalidation system. Finally, strengthening the GP workforce can be accomplished by creating special fields of interest to extend primary care knowledge and organisation of care. Dutch GPs, for example, can develop themselves in a specific area (for example, emergency care) and become 'a GP with a special interest'. These GPs can support other GPs by consultation, lecturing, and contributing to the organisation of care in their field of specialisation.

CONCLUSION

In summary, we believe that imposing an extended GP programme will not automatically or necessarily lead to a better-qualified GP workforce. Quality should be prioritised over quantity. Deliberate use of time in training, with good-quality workplaces and coaching of trainees' SDL skills, can enhance the quality of a specialty training programme. Sometimes an extension or shortening is warranted, which should always be informed by GP trainees' educational needs. To strengthen the position of GPs, other measures, such as enhancing quality through revalidation, ensuring a strong academic standing, and developing reliable, high-quality guidelines, can be taken without changing European legislation regarding the minimum duration of GP specialty training.

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