Vocational Training in Greater London

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March, 2008. 7:45 am. I'm on a cosy train going from Ashford to East Sheen, in Greater London. The train is packed with passengers - sitting, standing. People of diverse ages, backgrounds and ethnicity. They are on their way to work or school. Most of them are reading papers or books; some stare somewhere out of focus, avoiding eye-contact. A few fiddle with their laptop, while others have their eyes closed. Nobody speaks - the only sounds are the du-dum, du-dum of the train on the rails, and the rustle of newspapers. Then a female voice on the microphone proclaims: "This station is Mortlake".

I alight from the train, together with others who are in a hurry. A biting wind greets me - temperature 7 °C. A strange smell hangs in the air (I'm told later that it's the smell of hops from the Old Brewery). I walk over to Sheenlane Medical Centre in East Sheen. This Centre is shared by two NHS GP practices: Dr Marek Jezierski & Partners and Dr Ian Johnson & Partners. I was given the honour of spending a week there observing how the first practice works and how GP training is implemented.

I was also fortunate to spend a second week in ***Studholme Medical Centre*** in Ashford, Surrey. These visits were made possible by a Leonardo da Vinci EU Fund Grant to our St James Group Practice, and this second phase of the project concentrated on specialist training in family medicine.

Dr Marek Jezierski has three other partners: Dr Sophie Jukes, Dr Darren Tymens and Dr Christine Grayson. The last three doctors are GP trainers, while Dr Jezierski is responsible for supervising vocational training in the Richmond and Twickenham Primary Care Trust. He is well known in Malta for his charisma and his sterling work in the training of all GP teachers in our country in his capacity as RCGP envoy. His practice has been involved in GP training for the last twenty-five years. Indeed, three out of four partners making up this practice had been themselves trained in the same.

Two registrars are attached to the above practice at present: Dr Pavithra Natarajan and Dr Kay Wang. The vocational training scheme is spread over three years, the first half is held in a hospital setting and the latter half in a community setting. The registrars have their own lists of patients, and are expected to stick to 10 minute appointments like all other doctors. Every week they have a tutorial with their trainer, a half-day release course with other trainees, a meeting with other trainees and trainers (more about these later) and a study day off work. These two registrars are both due to finish their training next April after their summative assessment.

Studholme Medical Centre has seven partners, but only Dr Sohail Butt is an official trainer. However, his partners are involved in training by providing support to the registrar whenever Dr Butt is absent. They are also involved in hosting Foundation doctors (ALL housemen have to be exposed to general practice for a short period during their training). The registrar, Dr Amie Church, has already passed through her summative assessment and has six months to go to finish her training to become a fully-fledged GP.

Tutorials

I was kindly invited to witness a two-hour-long tutorial between trainer Dr Ian Johnson and registrar Dr David Griffiths at Sheenlane Medical Centre. The registrar described several cases he had managed and he discussed them with his trainer. They talked about universal GP dilemmas such as when to refer for X-rays, how to live with uncertainty, how to allow a terminal patient to die at home, when to prescribe a statin and which one, etc... They also discussed time-management and organization of professional and personal life. I joined in the discussion and could see that the good trainer rarely provides answers, but often reframes the terms of reference of a question.

At Studholme Medical Centre I was honored to observe a very educational tutorial between Dr Butt and Dr Church. This tutorial lasted two and a half hours, and included debriefing about cases seen recently by the registrar and a focus on time-management. They also discussed how registrars are obliged to perform a certain amount of out-of-hours work with the local provider (Thames.Doc in this case).

Dr Butt then briefed his registrar on how to go about working as the Triage/ Duty doctor in the practice. Every day, during the week, one doctor takes all the telephone calls from patients asking to be seen on the same day. The aim of this exercise is to minimize the number of patients that have to be seen at the surgery or at home by giving telephone advice for minor conditions. As Dr Butt explained, these telephone consultations require prudence and a good knowledge of risk management when dealing with particular symptoms. He clearly explained that about 80% of patients phoning in have to be seen on the same day, the majority of them at the surgery. Hence, the triage doctor would either give telephone advice alone or give the patient an appointment at a set time. As this was going to be the first time that Dr Church was going to be the triage doctor, he showed readiness to help her at any stage by answering any queries and by seeing patients if she wasn't coping with the workload.

I was able to sit with Dr Church during her triage session. She received a phone call from an elderly male, previously known to suffer from ischemic heart disease, who complained of chest pain lasting two hours. Since he lived quite nearby, she considered telling the patient to drive to the local hospital himself, but after discussing with her trainer, she wisely decided to request an ambulance to take the elderly man to hospital. A clear example of risk-management in practice!

Half-Day Release Course

I was able to attend a three-hour-long session which is held weekly at Kingston hospital and caters for the nineteen trainees of the Richmond and Twickenham Primary Care Trust. Dr Jezierski was leading the session, with the active participation of Dr Tymens and Dr Johnson. The session was divided into three parts.

In the first hour, Mr. Toma, an ENT and Maxillofacial Surgeon, gave a very learner-friendly and GP-oriented presentation on "Common ENT Problems in General Practice". At the start of the presentation, Dr Jezierski specifically asked the trainees to come forward with their needs with regard to this topic, and he listed them down on a flip-chart. Mr. Toma then took it from there, and made it a point to tackle these queries one-by-one. He readily answered questions throughout his presentation, and one could see that he truly enjoys teaching. His PowerPoint presentation consisted entirely of photographs. Another obvious thing was that as a surgeon he treated GPs as esteemed colleagues, was ready to communicate with them freely and accept their feedback.

In the second part, registrars had been asked to look up words in relation to the current theme being discussed - evidence-based medicine. A registrar explained the term "triangulation" whilst another described what "metanalysis" means.

In the last section, Dr Jezierski asked the registrars to stand up and line themselves up according to their own perceived ability to understand evidence-based medicine. He was obviously in his element whenever he was teaching. He proceeded to divide the registrars into five groups and gave each group a vignette of a patient with atrial fibrillation. Their specific task was to discuss treatment options and risks with these patients. To the groups who perceived themselves to be weaker he also gave more material such as numbers-needed-to-treat to avoid stroke and some patient-friendly visual aids. Each group of registrars had to select a representative.

The four trainers present at the meeting then acted out the patient vignette with the chosen representative from each group. The latter had ten minutes to discuss the pros-and-cons of prescribing nothing, aspirin or warfarin to this particular patient. I played the role of Agnes - a difficult 78-yr old wheelchair and house-bound lady who had "no veins" and did not want any treatment. In fact, the registrar who was trying to explain complicated statistics to me did very well and kept her cool throughout. At the end of each ten minute "consultation", Dr Jezierski asked the pseudo-patient "What would you like to do?" and the registrar "What would you want the patient to do?" Dr Tymens is a born actor and he made us all laugh when he altered his voice to impersonate an old lady.

Trainees plus Trainers Meeting

Once a week, the registrars of Richmond and Twickenham Trust all meet together with their trainers at Mayfield Surgery. The aim of these meeting is primarily educational, but they also provide an opportunity for socializing. Every week, a different registrar researches a "hot topic" and presents it for discussion with the others.

When I was there, Dr Pavithra Natarajan discussed the rising incidence and prevalence of HIV infection in heterosexuals and children and the need for GPs to actively screen for this condition. Several doctors argued about the cost-effectiveness of such screening, acceptability to patients and the pick-up rate in the general population. Dr Natarajan had just attended a course on Family Planning and Genito-Urinary Medicine as part of her professional development.

Assessment Methods:

Formative Assessment

Formative assessment is based on an ***electronic portfolio*** which is accessible to both trainer and registrar, albeit the registrar may not have access to restricted information. This system has been in use since November 2007. The e-portfolio provides a highly structured way in which to collate data about the training carried out, and allows ongoing assessment of the registrar's progress. It includes a shared log, a skills log and a competence log.

Consultation Observation Tool (COT)

In the tutorial between Dr Butt and Dr Church, a video consultation was observed and assessed by the trainer. The video was 15 minutes long, and 5 minutes were dedicated to feedback. The trainer used written criteria for evaluation such as the use of communication skills; consideration of appropriate psychosocial contexts; making a diagnosis; appropriate examination; discussion of a management plan; use of resources, etc.. Then he entered his grading into the e-portfolio of the registrar.

Case-Based Discussion (CBD)

In the same tutorial, Dr Church brought a case she had seen for detailed analysis. She had forwarded the written case to her trainer one week before. She proceeded to describe the history, the clinical dynamics, all the correspondence and other data related to this case, followed by her management plan. Dr Butt asked a number of questions to clarify certain issues.

I was intrigued by the ethical framework surrounding this case and how important principles of consent, autonomy, beneficence, non-maleficence and justice were all addressed by the registrar and her trainer. Dr Butt also made an interesting reflection on how GPs vary in how much responsibility they are willing to shoulder for their patients and their role as advocates for the patient even when the latter is in secondary care. The trainer's feedback was again entered into the e-portfolio.

Appraisal

Every six months, multi-source feedback for the registrar is entered into the e-portfolio by all the staff of the practice. The feedback is quite detailed and includes sections on communicative and clinical skills. I had the privilege of observing a tutorial between trainer Dr Sophie Jukes and registrar Dr Pavithra Natarajan, where this feedback was used to appraise the trainee.

The trainer showed respect towards her trainee while she gave feedback in a sensitive way about skills and attitudes such as time-management, self-confidence, efficiency and professional boundaries. It was clear to me that the trainee was comfortable with discussing these issues with her trainer (despite my interference!). Together they worked out a plan of action. This included sitting-in with the other GPs in the practice while they saw patients so as to observe their different styles of consulting and how they handled these issues in their daily work.

Other methods used for formative assessment are:

1. Directly Observed Procedures (DOPS)
2. Mini Clinical Evaluation Exercise (mini-CEX)
3. Patient Satisfaction Questionnaire held 6-monthly
4. Clinical Supervisor Report (CSR) held 6-monthly

All these are reported on the e-portfolio by the trainee and/or trainer, so that this is built up as the training proceeds.

Summative Assessment

The registrars have to sit for an Applied Knowledge Test which consists of Multiple Choice Questions over three hours.

Later on in the course they have to sit for a Clinical Skills Analysis where a registrar has to go through thirteen Objective

Structured Clinical Examination (OSCE) stations with simulated patients. The registrars are given a defined clinical objective to be achieved in (strictly) ten minutes while they are observed by a trainer. I learnt that the pass mark for this test is 60%, the pass rate around 93%, and that it's very expensive to sit for! It is undoubtedly a very complicated exam to organize and carry through. However, it probably is THE exam that most closely emulates a normal primary care consultation.

Training the Trainers

Trainers' meetings

Trainers in VT attend a day-long seminar every three months in order to keep up-to-date. Most practices also give study leave to a trainer partner, for his personal development.

Refresher Courses

I was invited to attend a refresher course on Cardio-Pulmonary Resuscitation at Studholme Medical Centre. The doctors, nurses and nurse practitioners attached to the practice attended. The course lasted three hours, was hands-on with the use of dummies, and dealt with adult, infant and child Basic Life Support and how to use an Automatic External Defibrillator. It was ably delivered by a trained nurse who is contracted by the NHS to visit GP practices every 18 months, giving out certificates of attendance.

Training Practice Visit

Every three years, the local Deanery sends a delegation of three doctors to visit the training practice. This visit lasts three hours and includes interviews with the trainer and his/her trainee and possibly other staff. A structured checklist allows the visitors to assess the following areas:

1. The physical environment in the practice
2. The working atmosphere (teamwork; practice meetings; workload; variety of patients)
3. The use of IT and regular audit
4. The availability of educational facilities (video; internet; library)
5. The trainer (qualifications; organization of training; skills; personal development plan)

At the end, the delegation writes a report with general feedback for the trainer and recommendations for improvement.

GP Appraisal

UK GPs are obliged to undergo an appraisal exercise every year. This is done by an experienced colleague who, together with the GP, would explore the GPs performance, his health, his personal development plan, feedback from staff and patients, etc... The appraiser would then make recommendations to the local Primary Care Trust on fitness to practice, and to the appraisee on areas for further development. I think that this exercise, when performed in the correct spirit and in a tactful way, leads to a culture of lifelong learning and better doctors.

Conclusion

The study visits to Sheenlane and Studholme Medical Centers have been tremendous learning experiences for me as a GP, practice partner and trainer. I have seen the cardinal principles of training being applied effortlessly before my own eyes, and have become more of a believer.

Vocational training in Malta is still in its infancy, and it needs to develop along the lines of what I have described above. All current trainers and trainees have to make a concerted effort to improve their input into this programme by setting higher standards for themselves as GPs, by identifying their relevant needs better and by dedicating more time and effort to meet needs.

The Malta College of Family Doctors should work to provide protocols for best practice for all GPs, and work hand-in-hand with the GP trainers. The National Coordinator needs to feel the pulse of the VT, and intervene when necessary. The Department of Primary Health Care should support all good initiatives.

Investing energy in vocational training will spark off a chain reaction and lead to improved quality in general practice. This chain reaction will greatly benefit family doctors, their patients, the entire health care system and, ultimately, the Maltese community as a whole.

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