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LEADING ARTICLE

Educational training requirements for general practice/family medicine specialty training: recommendations for trainees, trainers and training institutions

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ABSTRACT

High-quality training is a prerequisite to teaching future general practitioners. To inspire and guide all countries to implement General Practice (GP) specialist education and training and bring it to the highest standards, we aimed, within the European context, to produce a collaborative document entitled 'Educational Requirements for GP Specialty Training'. Through an iterative process existing documents from the European Academy of Teachers in GP and Family Medicine (EURACT) and the World Organization of Family Medicine Doctors (WONCA) were collated. Other reports, grey literature about specialty GP training and requirements for trainees, trainers and training institutions were included. State-of-the-art GP specialty training 'core' competences, characteristics and essential features of GP are described. General principles and specified tools for training and assessment are summarised. Recommendations on the duration and place(s) of training and selection of trainees are provided. Trainers should be accredited teachers and quality training institutions are essential. New insights, existing gaps and issues for debate have highlighted areas for further research. This document was produced in the specific context of Europe but its general principles are relevant to GP training in all countries.

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Introduction

Primary healthcare (PHC) is an essential, effective and efficient part of the healthcare system. Rawaf *et al.* state in their World Health Report on PHC, '*Now more than ever*'[1,2], that the 'evidence at macro-level is overwhelming: countries with a strong service for primary care have better health outcomes at low cost'[3]. The World Health Organisation (WHO) website[4] states that 'PHC is usually the first point of contact people have with the health care system. It provides comprehensive, accessible, community-based care that meets the health needs of individuals throughout their life'.

The general practitioner or family doctor (FD)[1] plays one of the key roles in PHC. This is acknowledged in Europe and worldwide. GP/Family Medicine (FM)[2] is an important discipline in its own right. The European definition of GP, issued by WONCA, states that 'GP is an academic and scientific discipline, with its own educational content, research, evidence base and clinical activity; a clinical specialty orientated to primary care'[5].

Mandatory, high-quality training is a prerequisite to teaching future FDs. In 1986, the European Union Directive 86/457/EEC first mentions specific training for GP and makes it mandatory for all member states [6]. Later on, more specifications on the duration and place of training were included (Directive 93/16/EEC and Directive 2005/36/CE)[7,8].

This legislation has contributed to the recognition and acceptance of GP as a medical specialty in many European countries but, unfortunately, not in all. Furthermore, there are countries where participation in specific GP specialist training before being accredited as an FD is not required. In those countries where GP specialist training is required and implemented, some common features exist but there is also great diversity of approach. Now is the time on a European level to register GP as a medical specialty equivalent to other recognised specialties and to set clear minimum standards for GP specialty training.

WONCA Europe pleas for a 'common undergraduate GP curriculum, postgraduate specialist training and continuous professional development for FDs in all European countries'[9]. WONCA Europe and its teaching organisation EURACT have produced over the years several important documents on a common definition and description of the GP specialty. The EURACT Specialty Training Committee (STC) set out to compile the many educational documents (from

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2006 to 2014) and add recommendations for specialist GP training in Europe. The aim of this project is to inspire and guide all countries to implement GP specialist training and bring it to the highest standards, warranting registration of GP as a medical specialty.

This article describes the development and content of this document. The document itself can be consulted via the websites of EURACT or WONCA Europe[10].

Methodology

In 2017, the European Union of General Practitioners (UEMO) decided to explore the recognition of GP as a specialty within the European Union members. UEMO requested from WONCA Europe a statement on GP training requirements. This task was delegated to WONCA Europe's education network, EURACT.

Through an iterative process former EURACT and WONCA documents were consulted, along with (grey) literature or other reports about GP specialty training. The new document describes requirements for trainees (chapter 1), for trainers (chapter 2) and for training institutions (chapter 3). The trainees' requirements were structured by using six different questions: (1) What do trainees have to learn/achieve? (2) How should trainees achieve this? (3) How are the competences assessed? (4) How long should training last? (5) Where should training be organised? (6) How should selection of trainees occur?

WONCA Europe Executive Board (EB) and UEMO approved a first draft, which was then reviewed by the EURACT STC members. In May 2018, WONCA Europe EB and WONCA Europe Council approved the final version which was sent to UEMO for further steps.

Results

Most answers to the first three questions for trainers, on the competences and how these should be achieved and assessed had already been defined in former important WONCA and EURACT documents: the WONCA Europe consensus document on the European definition of GP/FM (2002), revisions in 2005 & 2011)[5], the EURACT Educational Agenda [2005, 11], the EURACT Performance Agenda of GP/FM [2014, 12] and the EURACT statement on assessment in Specialty Training for GP/FM [2015, 13]. For the other questions, additional literature was used, including European legislation and two EURACT documents on hospital posts [14] and on trainee selection[15].

Requirements for trainees

What do trainees have to learn/achieve?

FDs should achieve six essential or 'core' competences; for a common understanding, they are divided into 12 central characteristics (see Table 1[10]).

As GP is a person-centred scientific discipline, three essential features could be added to the application of the core competences: contextual, attitudinal and scientific. All these – the 12 characteristics, the 6 core competences and the 3 additional features – are interrelated in the WONCA Tree produced by the Swiss College (2004) (Figure 1)[16].

How should trainees achieve these?

The EURACT Educational Agenda provides a framework to teach and learn the core competences[11]. Learning objectives, with possible educational methods for achieving them, are defined for each competence, covering knowledge, skills and attitudes. Teachers and training institutions can find inspiration in this framework. General principles should be taken into account.

Table 1. The 6 core competences and 12 central characteristics of the discipline of GP.

Six core competences:		Twelve central characteristics of the discipline of GP: it
(1) Primary care management	a	is normally the point of first medical contact within the healthcare system, providing open and unlimited access to its users, dealing with all health problems regardless of the age, sex or any other characteristic of the person concerned.
	b	makes efficient use of healthcare resources through co-ordinating care, working with other professionals in the primary care setting, and by managing the interface with other specialities taking an advocacy role for the patient when needed.
(2) Person-centred care	c	develops a person-centred approach, orientated to the individual, his/her family and their community.
	d	promotes patient empowerment.
	e	has a unique consultation process, which establishes a relationship over time, through effective communication between doctor and patient.
	f	is responsible for the provision of longitudinal continuity of care as determined by the needs of the patient.
(3) Specific problem solving skills	g	has a specific decision making process determined by the prevalence and incidence of illness in the community.
	h	manages simultaneously both acute and chronic health problems of individual patients.
(4) Comprehensive approach	i	manages illness which presents in an undifferentiated way at an early stage in its development, which may require urgent intervention.
	j	promotes health and well-being both by appropriate and effective intervention.
(5) Community orientation	k	has a specific responsibility for the health of the community.
(6) Holistic modelling	l	deals with health problems in their physical, psychological, social, cultural and existential dimensions.

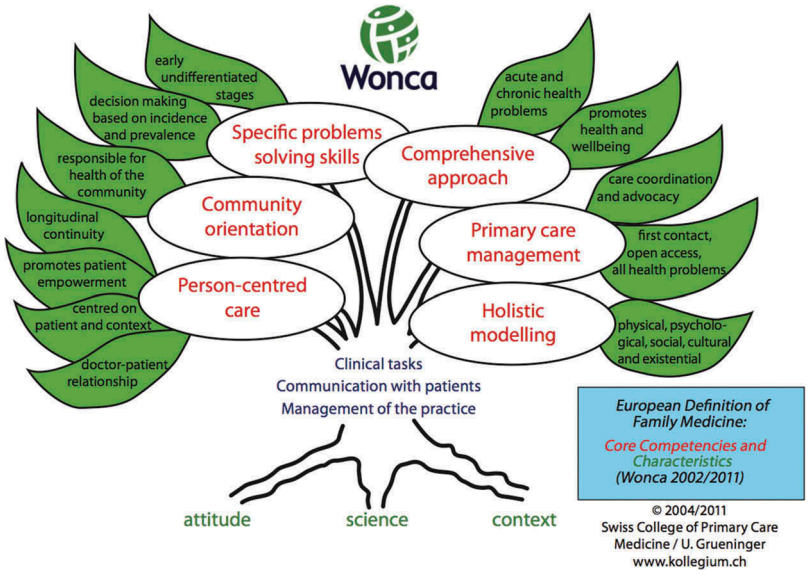

Figure 1. The WONCA Tree as produced by the Swiss College in 2004. It shows the interrelation between the 12 characteristics, the 6 core competences and the 3 additional features of GP.

The training should be outcome-based, learner-centred and mainly take place in the workplace itself. The learning environment should be safe and supportive. Important elements are constructive feedback and frequent interaction with trainers. Self-directed learning and reflective practice are intrinsic to GP specialty training. The 'doctor/trainee as a person' should be explicitly emphasised.

How should the competences be assessed?

'The assessment must ensure the development of a confident competent doctor who takes responsibility for patient care and functions as a safe, independent, professional FD'[13]. Whether formative or summative, it should be of high quality (i.e. reliable and valid) and programmatic, i.e. embedded in the whole programme of learning to support the trainees' learning process. Advance planning is essential to use a mix of assessment tools at different times, in different settings and undertaken by various assessors. Trainees should be mainly observed and assessed in the workplace across different practice contexts and use feedback and scores to develop and grow professionally.

The EURACT Educational Agenda and Performance Agenda has generated a toolbox relating core competencies with assessment methods [11,12]. This enables trainers to adjust assessment tools to the objectives, settings and organisation of their specialty training programme.

How long should training last?

European legislation has determined the minimum requirements for the duration and setting of GP training: (1) a full-time course of at least 3 years; (2) at least 6 months in an approved hospital or clinic and at least 6 months in an approved GP practice or centre where doctors provide primary care. Training must be more practical than theoretical and centred for at least 50% of the time in a GP practice [7,8]. However, significant variation exists across Europe in training times and settings[17]; the average GP training time varies between 2 and 6 years[18].

Where should training be organised?

At least 50% of the training should take place in a GP setting, where GP core competences can be learnt and trainees have patient encounters relevant to their future practice[14]. However, hospital-based training is of value too. Important and specific outcomes can be acquired for some essential key principles[14]. Most importantly though, the learning should be competence-driven and goal-oriented towards GP; the content of the training and the clinical work should be relevant to their future FD practice.

In addition to the workplace learning (on-the-job), some external curriculum-based training (off-the-job) can occur. Group learning, reflection, peer learning, seminars and workshops, visiting conferences, and learning specific skills can be a valuable addition to the trainees' learning plan.

How should selection of trainees occur?

Selection procedures should be credible, fair and publicly defensible. Across Europe, there is a great variety in selection procedures[19]. The central aim should be

to select the most suitable candidates but this is not as straightforward as it seems. It all depends on the predictive validity of the applied selection tools. We need an ongoing review of predictive validity against future performance to identify best selection practice.

Requirements for trainers

In 2002 (updated in 2012), the EURACT STC described criteria on selection of trainers and teaching practices for specific training in GP[20]. It is essential that trainers, both in GP practice and in hospital, are officially accredited as teachers and regularly participate in teach-the-teacher courses. Guidelines for appropriate practices and educational settings should cover infrastructure, governance and educational facilities. Practices should provide appropriate opportunities and working hours to consult with patients, maintain an educational environment with protected teaching and study time, and involve the whole healthcare team.

Requirements for training institutions

A 'competent authority' should organise the GP specialist training (Directive 2005)[8]. Although there are examples of good speciality training outside the realm of the universities, training institutions are preferably embedded in, or connected to universities or other academic institutions. A close relation with GP education in basic medical education is recommended.

Discussion

The WONCA Europe document on the definition of GP/FM, the EURACT Educational and Performance Agenda, and the EURACT statement on assessment were rich sources for this project [5,11–13]. For many years, this GP-oriented European framework has inspired and guided training institutions when developing GP specialty training. The common understanding and language supports collaboration between institutions and countries. It provides a platform for international teach-the-teacher programmes like the Leonardo Teachers Courses (EURACT)[21].

However, theories and insights on (medical) education change. GP training must stay up-to-date with new knowledge, frameworks and approaches. The CanMEDS framework, working with EPAs (Entrustable Professional Activities), inter-professional learning, peer-teaching and -learning, trainees' research, involvement in society, etc. are topics that could be investigated and implemented. Opinions of trainees and trainers should be involved.

Discussion about the minimal length of GP specialty training is ongoing. On the one hand, it is known that developing mastery in GP takes time, given the broad range of generic knowledge and clinical skills, the uncertainties and complexities of the workplace, and the practice management that is needed nowadays [17,22]. A survey among EURACT Council members showed the need to upgrade GP to at least the same level as other medical specialties[23]. On the other hand, the quality of GP specialty training per se to enable the trainee to reach the outcome competences is the main focus. A more trainee- and individual-centred approach in training could meet this objective.

In most of the European countries, GP specialty training takes place part in hospital posts and part in GP practice[17,18,24]. Often, trainees spend more than 50% of their training in the hospital setting, even though little is known about the quality of this training. Research on how to best organise GP-oriented training in a hospital post is lacking.

Selection procedures remain an issue for debate. We should aim to identify the most suitable candidates using methods that are credible and fair. Nevertheless, procedures are often shaped by local circumstances such as the number of vacancies versus candidates or the financial resources. A recent BEME review on selection procedures for all postgraduate specialty training offers evidence for the use of Multiple Mini Interviews, Situational Judgement Tests and Clinical Problem Solving tests. Cost-effectiveness has not been evaluated properly[25]. Further research on this topic is certainly needed.

The quality of training programmes relies on the (quality of) trainers and training practices. Thus, training and coaching of the trainers is of high importance [26]. Being a trained teacher alongside extensive clinical work is a challenge; trainers should be allocated sufficient time and resources to give and receive training. This should be resolved on the macro-level by faculty members and policymakers.

For this work, a systematic review with educational evidence was not performed and that is a limitation. However, it can be concluded that: (1) valuable and usable documents on GP specialty training exist; (2) this leading article contributes to a practical overview of those documents; and (3) some gaps, issues for debate and new insights identify important areas for future research. This document was produced in the specific context of Europe, but the general principles are relevant to GP training in all countries. After all, the patients in GP worldwide deserve highly trained FD specialists.

Notes

1. For the convenience of the reader, general practitioner/family doctor will be abbreviated by FD.
2. For the convenience of the reader, General Practice/Family Medicine will be abbreviated by GP.

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