

The Curriculum for General Practice

A Guide for Learners and Teachers

About this guide

This guide is derived from the RCGP Core Curriculum Statement *Being a General Practitioner* (Principal authors: Dr Justin Allen, Professor Jan Heyrman, Professor Bernard Gay, Professor Harry Crebolder, Professor Igor Svab, Dr Paul Ram, Dr Mike Deighan, Professor Steve Field, Dr Adam Fraser, Professor Hywel Thomas and Dr Arthur Hibble) and *The RCGP Training Curriculum; Part One: A statement on the eight standards* a submission to PMETB. (Principal authors: Professor Hywel Thomas, Professor Steve Field, Dr Arthur Hibble and Dr Tim Swanwick)

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How to Use This Curriculum

This curriculum is for doctors training for general practice and their trainers and educational supervisors. It covers the period known as Specialist Training for General Practice: from the end of the Foundation Programme to the award of a Certificate of Completion of Training (CCT). It assumes trainees have already attained the core competences of the Foundation Programme.

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Overview

In this document we describe the competences needed to be a primary care physician in the UK. The aim of specialist training for general practice is to produce a doctor able to care for patients with equal regard for science and caring.

The Competences of Good Medical Practice

The GP curriculum described here addresses all sections of the General Medical Council's key document *Good Medical Practice*. It deals with the generic professional competences of *Good Medical Practice* which GPs share with other physicians as well as those competences that are distinctive to general practice. *Good Medical Practice* is familiar to all doctors completing foundation programmes and will continue to form the basis of annual appraisal. The curriculum emphasises the six competences which are essential to becoming a General Practitioner. These are described in the next section Curriculum Content on page 5. *Appendix 1: Good Medical Practice* on page 34 demonstrates how closely they are integrated with *Good Medical Practice*.

Plans are in hand to produce an electronic portfolio which will allow automatic cross-referencing of *Good Medical Practice* and the six core competences for General Practitioners, allowing the trainee to become more familiar with the close integration between them.

How this curriculum was developed

Curriculum working groups were created by the Education Department of the Royal College of General Practitioners. One dealt with Teaching and Learning and the other with Assessment. Each group had lay and GP trainee representation.

A literature review was commissioned from the Centre for Research into Medical and Dental Education at the University of Birmingham. At the same time, an extensive consultation exercise was carried out and involved:

- i) A national questionnaire survey of the views of trainees and GP educators on training for general practice
- ii) Meetings with lay representatives and GP trainees
- iii) Focus groups and presentations at national and international conferences to share findings and explore perspectives on them

Following consultation, the main curriculum statement was written, together with more detailed supplementary statements. The statements were circulated in draft form to lay and trainee representatives as well as specialist interest groups within the RCGP and posted on the RCGP web. There followed a period of formal consultation which led to this submission to PMETB.

Curriculum Content

The RCGP domains of competence: Six core competences for general practitioners

The first three competences have as their focal point the primary care consultation. They are:

1. Primary care management
2. Person-centred care
3. Problem solving skills, specific to General Practice

The remaining competences are more complex and take a wider perspective, going beyond the consulting room GP-patient interaction:

4. A comprehensive approach
5. Community orientation
6. A holistic approach

Each of these core competences is explained in more detail below.

Knowledge skills and attitudes

The learning outcomes are competences expected from the learner at the end of specialist training for general practice. They can be categorised as Knowledge, Skills or Attitudes and are indicated by K, S or A as appropriate.

Domain 1 — Primary care management

In caring for patients, general practitioners work with an extended team of other professionals in primary care within their own practice and in the local community, as well as with specialists in secondary care. Primary care trainee physicians must learn the importance of supporting patients' decisions about the management of their health problems and communicating how that care will be delivered by the NHS team as a whole.

Primary care management is concerned with the ability:

- **To manage primary contact with patients dealing with unselected problems**
- **To cover the full range of health conditions**
- **To co-ordinate care with other professionals in primary care and with other specialists**
- **To master effective and appropriate care provision and health service utilisation**
- **To make available to the patient the appropriate services within the healthcare system**
- **To act as an advocate for the patient**

Links with other domains

Primary care management links with:

- Specific problem-solving skills: in diagnosis and in the use of the epidemiology of problems presenting in primary care
- A comprehensive approach: prioritising among multiple problems
- Community orientation: in making effective use of resources
- Person-centred care: in the importance given to supporting patients decisions and skills needed to communicate management options

Learning outcomes for primary care management

Managing primary contact with patients, dealing with unselected problems requires:

- K Knowledge of the epidemiology of problems presenting in primary care
- S Mastering an approach which allows easy access for patients with unselected problems
- S An organizational approach to the management of chronic conditions
- K Knowledge of conditions encountered in primary care and their treatment

Covering the full range of health conditions requires:

- K Knowledge of preventative activities required in the practice of primary care
- S Skills in acute, chronic, preventative, palliative and emergency care
- S Clinical skills in history-taking, physical examination and use of ancillary tests to diagnose conditions presented by patients in primary care
- S Skills in therapeutics, including drug and non-drug approaches to treatment of these conditions
- S The ability to prioritise problems

Co-ordinating care with other professionals in primary care and with other specialists requires:

- K Knowing how NHS primary care is organised
- K Understanding the importance of excellent communication with patients and staff
- S Skills in effective teamwork

Mastering effective and appropriate care provision and health service utilisation requires:

- K Knowledge of the structure of the healthcare system and the function of primary care within the wider NHS
- K Understanding the processes of referral into secondary care and other care pathways
- S Skills in managing the interface between primary and secondary care

Making available to the patient the appropriate services within the healthcare system requires:

- S Communications skills for counselling, teaching and treating patients and their families/carers
- S Organizational skills for record-keeping, information management, teamwork, running a practice and auditing the quality of care

Acting as an advocate for the patient requires:

- A Developing and maintaining a relationship, and a style of communication that treats the patient as an equal and does not patronise the patient.
- S Skills in effective leadership, negotiation and compromise

Domain 2 — Person-centred care

McWhinney identified three core principles of patient-centred care:¹

1. Committing to the person rather than to a particular body of knowledge
2. Seeking to understand the context of the illness
3. Attaching importance to the subjective aspects of medicine.

A person-centred approach is more than just a way of acting; it is a way of thinking. It means always seeing the patient as a unique person in a unique context, and taking into account patient preferences and expectations at every step in a patient-centred consultation.² Sharing the management of problems with the patient and disagreement over how to use limited resources in a fair manner may raise ethical issues which challenge the doctor; the ability to resolve these issues without damaging the doctor–patient relationship is important.

Person-centred care places great emphasis on the continuity of the relationship process. McWhinney stresses that the key word is responsibility, not personal availability at all times.¹³

Person-centred care is concerned with the ability:

- **To adopt a person-centred approach in dealing with patients and their problems, both in the context of patient’s circumstances**
- **To use the general practice consultation to bring about an effective doctor–patient relationship, always respecting the patient’s autonomy**
- **To communicate, to set priorities and to act in partnership**
- **To provide long-term continuity of care as determined by the needs of the patient, referring to continuing and co-ordinated care management**

Links with other domains

Person-centred care links with:

- Primary care management: in offering patients true autonomy
- A holistic approach (See Holism and patient-centredness on page 16)

Learning outcomes for person-centred care

Adopting a person-centred approach in dealing with patients and their problems in the context of patient's circumstances requires:

- K The basic scientific knowledge and understanding of the individual, together with their aims and expectations in life
- K The development of a frame of reference to understand and deal with the family, community, social and cultural dimensions in a person's attitudes, values and beliefs
- K Mastering patient illness and disease concepts
- S Skills and attitudes to apply these in practice

Using the general practice consultation to bring about an effective doctor-patient relationship whilst respecting the patient's autonomy requires:

- S Adopting a patient-centred consultation model that explores the patient's ideas, concerns and expectations, integrates the doctor's agenda, finds common ground and negotiates a mutual plan for the future
- S Communicating findings in an understandable comprehensible way, helping patients to reflect on their own concepts and finding common ground for further decision-making
- A Making decisions that respect the patient's autonomy
- A Being aware of subjectivity in the medical relationship, from both the patient's side (feelings, values and preferences) and from the doctor's side (self-awareness of values, attitudes and feelings)

Communicating to set priorities and to act in partnership requires:

- A The skills and attitude to establish a partnership
- S The skills and attitude to achieve a balance between emotional distance and proximity to the patient

Providing long-term continuity of care and co-ordinated care management as determined by the needs of the patient requires:

- K Understanding and mastering the three aspects of continuity: personal continuity; episodic continuity (making the appropriate medical information available for each patient contact); and continuity of care (24 hours a day and 365 days a year)
- S The ability to help the patient understand and achieve an appropriate work-life balance
- S The ability to utilise disease registers and data recording templates effectively for opportunistic and planned monitoring of problems to ensure continuity of care between different health care providers

Domain 3 — Specific problem-solving skills

Problem solving in general practice is highly context-specific. The skills required relate to the context in which the problems are encountered, the natural history of the problems themselves, the personal characteristics of patients, the personal characteristics of the doctors who manage them, and the resources they have at their disposal.

Focusing on problem solving is a crucial part of GP training because family doctors need to adopt a problem-based approach rather than a disease-based approach. Because most learning occurs in secondary care environments, trainees need to adjust to the differences in problem solving between general practice and hospital work. These differences were described by Marinker³ in the following terms:

general practitioner approach	hospital specialist approach
tolerate uncertainty	reduce uncertainty
explore probability	explore possibility
marginalize danger	marginalize error

Although this model polarizes these two situations, it provides some useful pointers, and each learner will need to work out how differences occur in specific clinical contexts.

Certain models of general practice problem solving should be considered: the hypothetic-deductive model was described by Marinker⁴ and Sackett et al. Another approach is to use pattern recognition or learning scripts, which clarify the problem-solving strategy of the doctor and can be employed in teaching about specific cases.⁵ Other consultation frameworks may assist learners in understanding this topic (Pendleton,⁶ Stott and Davis,⁷ Neighbour,⁸ Cambridge Calgary⁹).

Use of time as part of the diagnostic process, incremental investigation and coping with uncertainty are each part of the skill of general practice. There is a growing body of literature on these topics to support teachers and learners.¹⁰

Specific problem-solving skills are concerned with the ability:

- **To relate specific decision-making processes to the prevalence and incidence of illness in the community**
- **To selectively gather and interpret information from history taking, physical examination and investigations, and apply it to an appropriate management plan in collaboration with the patient**
- **To adopt appropriate working principles (e.g. incremental investigation, using time as a tool), and to tolerate uncertainty**
- **To intervene urgently when necessary**
- **To manage conditions which may present early and in an undifferentiated way**
- **To make effective and efficient use of diagnostic and therapeutic interventions**

Links with other domains

The specific problem-solving skills domain links with:

- Primary care management: because it involves tolerating uncertainty and this often affects the decision to refer.

Learning outcomes for specific problem-solving skills

Relating specific decision-making processes to the prevalence and incidence of illness in the community requires:

- K Knowledge of the prevalence and incidence of disease
- K Knowledge of the practice community (age–sex distribution, prevalence of chronic diseases)
- S Skills to apply specific decision-making (using tools such as clinical reasoning and decision rules)

Selectively gathering and interpreting information from history-taking, physical examination and investigations, and applying it to an appropriate management plan in collaboration with the patient requires:

- K Knowledge of relevant questions in the history and items in the physical examination relevant to the problem presented
- K Knowledge of the patient's relevant context, including family and social factors
- K Knowledge of available investigations and treatment resources
- S History-taking and physical examination skills, and skills in interpreting data
- A A willingness to involve the patient in the management plan

Adopting appropriate working principles (e.g. incremental investigation, using time as a tool), and to tolerating uncertainty requires:

- A Adopting skills and attitudes to demonstrate curiosity, diligence and caring
- S Adopting stepwise procedures in medical decision-making, using time as a diagnostic and therapeutic tool
- A Understanding and acceptance of the inevitability of uncertainty in primary care problem-solving and development of strategies that demonstrate this

Intervening urgently when necessary requires:

- S Specific decision-making skills for emergency situations
- S Specific skills in emergency procedures that may occur in primary care situations

Managing conditions which may present early and in an undifferentiated way requires:

- S Knowledge of when to wait and reassure, and when to initiate additional diagnostic and therapeutic action

Making effective and efficient use of diagnostic and therapeutic interventions requires:

- K Knowledge that symptoms and signs vary in their predictive value, as do findings from ancillary tests
- K An understanding of the cost-efficiency and cost-benefit of tests and treatments

Domain 4 — A comprehensive approach

General practitioners need to be able to address multiple complaints and co-morbidity in the patients for whom they care. When patients seek medical assistance, they have become ill as a person and may not be able to differentiate between different diseases they may have. The challenge of addressing the multiple health issues in each individual is important, and it requires family doctors to develop the skill of interpreting the issues and prioritising them in consultation with the patient.

The family doctor should also use an evidence-based approach to the care of patients. The family doctor should aim at a holistic approach to the patient where the main focus would be in promoting their health and general well-being. An important task for the general practitioner is to reduce risk factors by promoting self-care and empowering patients. The family doctor should aim to minimise the impact of patient's symptoms on their well-being by taking into account the patient's personality, family, daily life, and physical and social surroundings.

Co-ordination of care also means that the general practitioner is skilled not only in managing disease and prevention but also in caring for the patient, providing rehabilitation and providing palliative care in the final stages of a patient's life. The physician must be able to co-ordinate patient care provided by other healthcare professionals and care provided by other agencies.

A comprehensive approach is concerned with the ability:

- **To simultaneously manage multiple complaints and pathologies, both acute and chronic health problems.**
- **To promote health and well-being by applying health promotion and disease prevention strategies appropriately.**
- **To manage and co-ordinate health promotion, prevention, cure, care, rehabilitation and palliation**

Links with other domains

A comprehensive approach links with:

- Primary care management and person-centred care: e.g. when individual patients exercise their autonomy not to pursue a healthy lifestyle and consequently need a greater share of health care resources
- A holistic approach: in promoting health and general well-being

Learning outcomes for the comprehensive approach domain

Simultaneously managing multiple complaints and pathologies, both acute and chronic health problems requires:

- K An understanding of the concept of co-morbidity in a patient
- S The skill to manage the concurrent health problems experienced by a patient through identification, exploration, negotiation, acceptance and prioritisation
- S Skill in using the medical record and other information
- S The skill to seek, and the attitude to use, the best evidence in practice

Promoting health and well-being by applying health promotion and disease prevention strategies appropriately requires:

- K The ability to understand the concept of health
- S The ability to promote health on an individual basis as part of the consultation
- S The ability to promote health through a health-promotion or disease-prevention programme within the primary care setting
- K Understanding the role of the general practitioner in health-promotion activities in the community
- A Understanding and recognising the importance of ethical tensions between the needs of the individual and the community, and acting appropriately

Managing and co-ordinating health promotion, prevention, cure, care, rehabilitation and palliation requires:

- K Understanding the complex nature of health problems in general practice
- K Understanding the variety of possible approaches
- S The ability to use different approaches in an individual patient and to modify these according to an individual's needs
- S The ability to co-ordinate teamwork in primary care

Domain 5 — Community orientation

General practitioners have a responsibility for the community in which they work which extends beyond the consultation with an individual patient. The work of family doctors is determined by the makeup of the community. They must understand the potential and limitations of the community in which they work and its character in terms of socio-economic and health features. The general practitioner is in a position to consider many of the issues and how they interrelate - and the importance of this within the community. In all societies healthcare systems are rationed, and doctors are involved in rationing decisions; they have an ethical and moral duty to influence health policy in the community.

Community orientation is concerned with the ability:

- **To reconcile the health needs of individual patients and the health needs of the community in which they live, balancing these with available resources.**

Links with other domains

Community orientation links with:

- Person-centred care: ethical tensions between autonomy of individual patients and communities

Learning outcomes for community orientation

Reconciling the health needs of individual patients and the health needs of the community in which they live, and balancing these with available resources requires:

- K An understanding of the health needs of communities through the epidemiological characteristics of their population
- K An understanding of the interrelationships between health and social care
- K An understanding of the impact of poverty, ethnicity and local epidemiology on a local community's health
- K An awareness of inequalities in healthcare provision
- K An understanding of the structure of the healthcare system and its economic limitations
- K An understanding of the roles of the other professionals involved in community policy relating to health
- K An understanding of the importance of practice- and community-based information in the quality assurance of each doctor's practice
- K An understanding of how healthcare system can be used by the patient and the doctor (referral procedure, co-payments, sick leave, legal issues, etc) in their own context
- S The ability to reconcile the needs of the individual with the needs of the community in which they live
- K An understanding of GPs role in the commissioning of health care

Domain 6 — holistic approach

Medicine, like any cultural practice, is based on a set of shared beliefs and values, and is an intrinsic part of the wider culture of society.

Perspectives on holism

Kemper's definition of holism entails: "caring for the whole person in the context of the person's values, their family beliefs, their family system, and their culture in the larger community, and considering a range of therapies based on the evidence of their benefits and cost".¹¹

For Pietroni, holism involves a "willingness to use a wide range of interventions ... an emphasis on a more participatory relationship between doctor and patient; and an awareness of the impact of the 'health' of the practitioner on the patient."¹²

The holistic view acknowledges objective scientific explanations of physiology but also admits that people have inner experiences that are subjective, mystical, spiritual or religious, which may affect their health and health beliefs.¹³

Holism and patient-centredness

Holism and patient-centredness are core values of general practice. Holism, described by Howie¹⁴ as the integration of physical, psychological and social components of health problems in making diagnoses and planning management, is well established as a central issue of good consulting practice^{15,16}. There is good evidence that this is promoted by longer consultations^{17,18,19} and by greater continuity of care^{20,21,22}. Howie and colleagues built on that evidence to develop their 'Consultation Quality Index' (CQI) for use in general practice. It reflects the core values of general practice using, as proxies, 'consultation length' and how well patients 'know the doctor', as process measures and 'patient enablement' as an outcome measure^{23,24}.

Our limitations as doctors

It is also important to stress that a basic understanding of our own limitations as doctors is crucial.

A holistic approach is concerned with the ability:

- **To use bio-psycho-social models, taking into account cultural and existential dimensions**

Links with other domains

A holistic approach links with:

- Primary care management: there are many more options available to patients than medical
- Person-centred care: (see above)
- Community orientation: doctors are not the only sources of health and healing

Learning outcomes for a holistic approach

Using bio-psycho-social models, taking into account cultural and existential dimensions requires:

- K Knowledge of the holistic concept and its implications for the patient's care
- A The ability to understand a patient as a bio-psycho-social "whole"
- S The skills to transform holistic understanding into practical measures
- K Knowledge of the cultural background and beliefs of the patient, in so far as they are relevant to healthcare
- A Tolerance and understanding towards patients' experiences, beliefs, values and expectations, as they affect healthcare delivery

Essential features of the discipline of general practice

Three features are essential for a person-centred scientific discipline such as general practice: **context**, **attitude** and **science**.^{29 30 31 32 33} They are concerned with doctors and determine their ability to apply the core competences in real life in the work setting.

These three features relate to some extent to all doctors – but they are particularly important in general practice because of the close relationship between the family doctor and the people with whom they work.

Links with other domains

Contextual, attitudinal and scientific aspects each link closely with the six domains

Essential Feature 1 — Contextual aspects

Understanding the context of doctors themselves and the environment in which they work, including their working conditions, community, culture, financial and regulatory frameworks

Learning outcomes for contextual aspects

- K Having an understanding of the impact of the local community, including socio-economic factors, geography and culture, on the workplace and patient care.
- K Being aware of the impact of overall workload on the care given to the individual patient, and the facilities (e.g. staff, equipment) available to deliver that care.
- K Having an understanding of the financial and legal frameworks in which health care is given at practice level
- K Having an understanding of the impact of the doctor's home and work environment on the care that they provide

Essential Feature 2 — Attitudinal aspects

Based on the doctor's professional capabilities, values, feelings and ethics

Learning outcomes for attitudinal aspects

- A Being aware of their own capabilities and values
- K Identifying ethical aspects of clinical practice (prevention, diagnostics, therapy, factors that influence lifestyles)
- A Having an awareness of self: an understanding that their own attitudes, and feelings are important determinants of how they practice
- A Justifying and clarifying personal ethics
- S Being aware of the interaction of work and private life and striving for a good balance between them

Essential Feature 3 — Scientific aspects

Adopting a critical and research based approach to practice and maintaining this through continuing learning and quality improvement

Learning outcomes for scientific aspects

- K Being familiar with the general principles, methods and concepts of scientific research, and the fundamentals of statistics (incidence, prevalence, predicted value, etc)
- K Having a thorough knowledge of: the scientific backgrounds of pathology; symptoms and diagnosis; therapy and prognosis; epidemiology; decision theory; theories about the forming of hypotheses and problem-solving; preventative healthcare
- S Being able to access read and assess medical literature critically
- S Being able to develop and maintain continuing learning and quality improvement

Extended Curriculum Statements

The Curriculum Group have produced further statements (Appendix 3: Core and Extended Statements, Page 39) to detail how the six core competences can be applied in a variety of different contexts and what learning resources are available.

There are statements on the professional and managerial aspects of general practice; a series of statements on the care of special groups (acutely ill, children, elderly, women's & men's health, sexual health, cancer & palliative care, learning disabilities) and statements on clinical areas (cardiovascular, neurological, skin, metabolic, respiratory, musculoskeletal, trauma, ENT, eyes, digestive problems, mental health, minor surgery).

The Extended Curriculum Statements: The learning outcomes and their assessment

Each of these statements has a number of learning outcomes where the six core competences are interpreted according to the focus of the statement. These help learners and assessors know how core competences will be assessed in each of the domains and all of the possible contexts. There are over a thousand examples of these learning outcomes. Learners do not have to demonstrate that they have been assessed in all of the learning outcomes. Rather, they need to demonstrate their mastery of all six core competences and the three essential features within a (representative) variety of contexts.

Learning and Teaching

The process of learning

The proposed model of learning combines three aspects:

1. It recognises the importance of balance and diversity in the learning situations that trainees experience
2. It places emphasis on clarity and transparency of learning outcomes as professional, adult learners expect
3. The pedagogy of learning recognises the distinctive requirements of adults as learners.

Balance and diversity

Teaching and learning in relation to a curriculum for general practice occurs primarily at work. A substantial proportion of this will take place in general practice itself although it is recognised that a wider training experience, incorporating time spent and competences gained in secondary care, will form an important contribution to the development of the future general practitioner.

In addition to training in the workplace, the learner will also participate in the formal learning opportunities provided through departmental teaching sessions and general practice specialist training seminars and day release activities. It is proposed to continue the well-established approach of regular release from practice, typically through a weekly half-day release programme, an approach that was assessed positively in the national survey.

Teaching and learning in all these contexts will be underpinned by clarity on expected outcomes that are specified in terms of competences.

Competences as outcomes

In the curriculum, competence is used to define steps on the way to expertise, specifically the ability to use knowledge, understanding, and practical and thinking skills to perform effectively to the national standards required for independent practice. An individual who is competent has general attributes incorporating understanding and judgement, 'a complex structuring of attributes needed for intelligent performance in specific situations'²⁵. They are also components of a whole; at once building blocks of professional competence and also inter-related parts of an integrated - holistic - whole.

Key principles of adult learning

The primary pedagogical relationship in the training programme is between the trainer (educator) and the learner, a relationship that is embedded in active, professional practice. The general principles of adult learning underpin the way teaching and learning is organised and delivered. A brief summary of these principles is set out below:

- *Self direction* There is a deep seated need for adults to be self-directed and in charge of their own learning, although there are times when adult learners will want and need to be told what to do rather than find out for themselves
- *Experiential* Experience provides the principal resource for adult learning. Experiential learning is iterative with situations revisited and something being gained each time

- *Needs-based* An adult's readiness to learn is strongly related to the tasks required for the performance of their evolving role
- *Problem centred* Adults want to apply tomorrow what they learn today. Therefore the appropriate units for teaching and learning are situations, not subjects.

The apprenticeship model

The apprenticeship model can be defined as education and service blended together for professional growth through “legitimate peripheral participation in a community of practice”²⁶.

The apprenticeship model has been valued highly in general practice education and training for many years and this will continue. Its strength is the opportunity it offers for modelling not only skills but also values. A great deal of transfer of learning takes place visually or subconsciously through watching good practice. Such modelling is important and the learner may not be aware of what they have learned until they move to a situation where they see things done less well.

The apprenticeship model sits well with adult and experiential learning, especially if provision is made for reflection with the use of personal reflective diaries and case-based discussions. Because of the need to provide a first response to any symptom a patient may present, general practice involves a different balance of skills and knowledge to other specialties within medicine. It requires:

- A relatively greater use of generic diagnostic and management skills
- ‘Useful’ knowledge rather than detailed knowledge
- Relatively fewer specific or procedural skills.

The development of generic skills and the honing of ‘useful’ knowledge are well supported by the apprenticeship model. The key is experience combined with reflection; the learner must be exposed to high number of patient contacts

There are disadvantages with the apprenticeship model in that the curriculum is, to an extent, ‘hidden’. Unconscious competence may be less useful to the learner than conscious competence and bad practice can be modelled as well as good practice.

Unlike the ordered spiral curriculum, the apprenticeship model is more organic – yet it does involve revisiting topics and themes, each time expanding the learner’s ability to recognise patterns, become aware of decision nodes and have command of a greater range of options, enabling them to respond to their patients and offering them a greater degree of choice. The approach leads to reinforcement of basic principles, the integration of topics, and the achievement of higher levels of complexity.

Training programmes

A three year curriculum

Until now, most trainees have been able to spend only twelve months in general practice itself. Research has demonstrated that this is not sufficient.²⁷

Of course, general practice takes longer than three years to learn; Higher Professional Education (HPE) needs to be developed beyond the award of CCT

GP-based experience

This is the most appropriate form of training for general practice. It is valued more highly than hospital experience by current trainees, recently qualified GPs and educators.²⁸

Learning opportunities within primary care

Work-based experiential learning

- Observing established GPs and other primary care practitioners
- Supervised surgeries followed by unsupervised surgeries
- Joint surgeries with a GP trainer
- Reflection on learning
- Problem case analysis and random case analysis

Formal tutorials

Formal tutorials have a role although they are often less useful than problem-based teaching or problem and random case analysis.

Courses

Courses may be local, as part of half-day release course, regional or national.

Half-day release course

Half-day release course teaching for general practice has a long history and remains popular with trainees. What is valued most by trainees is the meeting with peers, partly because they can feel isolated within practice (as a consequence of a regulation, only recently relaxed, of one GP registrar per practice).

Individual journeys through the curriculum

In the past, half-day release courses have been criticised for offering too little choice. To deliver education in line with adult learning principles (and PMETB requirements) programme directors need to offer GP trainees more choice so they can plan individualised programmes according to their needs

Opportunities for reflection are important. Through reflection 'on practice' and reflection 'in practice' learners have the opportunity to remodel their professional behaviours. GP educators should ensure that learners are provided with opportunities to reflect through diaries, feedback, debriefing sessions and peer discussion groups.

Independent Self-Directed Learning

Trainees will use this time in a variety of ways depending on their needs: for reading, e-learning, research projects, exam preparation, preparation of their portfolio for assessment, medical humanities

Inter-professional and multi-professional learning

Primary care is a multi-disciplinary activity and this should be reflected in the training programmes for future general practitioners. Practice based education is of increasing importance and Registrars should be involved, both as learners and teachers

Short attachments to other primary health care team workers and other professionals such as community pharmacist are helpful

Learning opportunities outside primary care

Secondary care learning opportunities

Outpatient clinics are valuable, either sitting in or seeing patients under supervision.

Consultant ward-rounds provide good opportunities for bedside teaching and for trainees to obtain feedback on their clinical and decision-making skills. Although useful, they are now significantly reduced in value because of lack of individual continuity of responsibility for patients (as a consequence of changes to junior doctors working patterns resulting from the European Working Time Directive).

In the past, hospital attachments used to provide good opportunities for continuity of clinical care. This allowed the natural history of a patient's illness to be followed through, linking the initial admission assessment, investigation, the evolving diagnosis and treatment. However, changes to hospital practice mean that this opportunity continuity is becoming less common.

Hospital attachments provide exposure to higher numbers of more seriously ill patients.²⁹ Although this does have advantages in offering a high concentration of experience, it should not be overstated. A key GP skill is not so much how to deal with a patient who is obviously seriously ill, but in separating the small number of patients who *may be* seriously ill from the larger number of patients who feel ill but do not need secondary care. This skill is best learned in the community.

Hospitals also provide opportunities for trainees to attend multi-disciplinary team meetings to gain perspectives on integrated care and team working.

Learning with peers

The half-day release course allows trainees from different years to come together for small group sessions and can have a powerful influence on shaping of attitudes. Self-help groups for preparation for assessments have a long tradition and are useful.

Although many educators still believe trainees need facilitation for effective learning in groups and doubt a group's ability to form a self directed learning sets, there are many examples of trainees learning to learn with their peers without the need for facilitation.

Assessment

Teaching and learning demand assessment. It is well recognised that monitoring what has been learnt is a good way of providing feedback on what has been learnt.

Formative *assessment for learning* and summative *assessment of learning* are both parts of the approach recommended for GP training. Some of the new workplace-based assessment tools will provide a dual role, making an assessment of learning and generating structured feedback for trainees on how they may improve.

Selection into Basic Specialist Training for General Practice

For entry into specialist training for general practice, doctors need to have successfully completed a Foundation Programme and passed the selection assessments. Selection into programmes for specialist training for general practice will comply with equal opportunities best practice (Equality and Diversity, Page 32).

Assessment for Learning

There are number of ways GP Trainees can become aware of their learning needs:

- Learner self-assessment
 - The explicit documentation of learning outcomes in the new curriculum will allow better self assessment by trainees
 - In addition there are traditional methods: informal subjective self-awareness of performance in the workplace; and more formal methods such as PUNs and DENs³⁰ and confidence rating scales
- Informal and formal feedback from trainers, clinical and educational supervisors
- Informal and formal feedback from patients
- The new workplace-based assessment methodologies. These will be familiar to learners who have completed foundation programmes; they perform a dual summative and formative role.

Appraisal

The annual appraisal is where the learning needs assessment is brought together and translated into an explicit learning agreement which contains a number of educational objectives for the following year.

Feedback to trainees

Formative assessment has always been a regular part of GP training. The classic tools have been random and problem case analysis. These will continue to be important. The use of the workplace-based assessment tool of case-based discussion (CBD) is a formalisation of this process using a small number of the many cases discussed by learner and trainer.

A wide variety of other techniques are available to support formative assessment and feedback and include learning portfolios, logbooks, reflective diaries, use of video and audio consultations as well as sessions when the trainee and trainer consult jointly.

Assessment of competence

Assessment of competence uses an integrated package of workplace-based assessments and examination of both knowledge and clinical skills.

An assessment blueprint has been developed which maps the assessment methods on to the curriculum in an integrated way. The blueprint ensures that there is appropriate sampling across all six domains of the curriculum.

Workplace-based assessment

Workplace assessment will take place throughout the three years, in primary care and during other learning. The tools for workplace-based assessment are being piloted. It is likely they will include tools familiar from foundation programmes:

- Consulting skills assessment (mini-CEX)
- Case-based discussion (CBD)
- Direct observation of procedural skills (DOPS)
- Multi-source or 360° feedback (MSF).

Annual Review

The summative annual review is based on a sufficiency of robust evidence from workplace-based assessment. It includes:

- A review of evidence: goals and objectives and their achievement
- A RITA judgment
- Educational planning (when the review is not the final review)

The process involves feedback to the trainee and educational planning as well as providing useful information to trainers. It ensures that the training and experience lead appropriately to the next phase of training.

Examinations

The examination component will comprise:

- An assessment of applied knowledge (AKT) which is similar in format and difficulty to the current examination for MRCGP multiple choice paper (MCP)
- A clinical skills assessment (CSA) which is a type of OSCE, using simulated patients. The CSA has been described as "... a means of assessing a doctor's ability to 'synthesise and assimilate' information from various sources and then to 'integrate and apply' this with the concerns and aspirations of individual patients, in a variety of contexts ..."³¹

Supervision

Each trainee will have one person nominated as a mentor. This will be a GP who will be responsible for overseeing the educational progress of the learner, delivering the learning outcomes defined in the curriculum and maintaining the learning environment or training practice to a standard of quality defined by the deanery.

The mentor is also responsible for the assessment of the learner, both formative and summative, although the judgment of the trainer will form only one part of the overall assessment strategy. It is through this process that curriculum coverage will be monitored and gaps identified.

Responding to such gaps will depend on their nature. Many will be resolved by the local team working within one programme while an additional attachment may require the involvement of a programme director or an associate director.

The local team will support the mentor in contributing to each programme. Members of the team will include: a GP trainer from a different practice to the main GP attachment; educational supervisors, such as hospital consultants, with responsibility for specific attachments in secondary care; and other GPs who will supervise aspects of a trainee's practice, such as out-of-hours training and family planning clinics.

It is this local team which will be central to ensuring coverage of the curriculum. That this is achieved will be monitored through of formative and summative assessment and the maintenance and completion of portfolios.

Resources

The curriculum statements provide guidance on approaches to teaching and learning. They are a resource for learning materials for all educators in the local team as well as trainees. In relation to hospital attachments, for example, the statements offer guidance to hospital consultants and trainees on the learning outcomes associated with specific specialties.

Responsibility for successful completion of training

Trainees themselves bear the greatest responsibility for their learning, not only because this reflects their professional responsibilities and their position as adult learners, but also because of the importance of securing a long-term commitment to their personal and professional development. Success as a general practitioner depends upon becoming a lifelong learner.

Responsibility for their own learning is supported by the design of the curriculum and the related assessments. The explicit definition of learning outcomes and competences gives clarity to the goals of trainees as learners and assists them in assessing their own progress.

Qualities of educational supervisors

The relationship between GP trainees and their educational supervisors is at the heart of the teaching and learning process whereby trainees acquire and develop the knowledge, skills and attitudes required to become an effective GP. It is the responsibility of the educational supervisor to oversee and support the trainees' progress. As such they must have appropriate professional attributes, personal qualities and training to equip them for this role.

Most of a GP registrar's learning will derive from seeing and contributing to good quality patient care and the greatest influence on them is the example presented by their trainer as doctor. For this reason trainers must be enthusiastic, competent and

caring general practitioners, working in well-organised practices. They must also be expected to know and accept the responsibilities of the role. The content of teaching throughout a GP registrar's attachment will relate to individual needs and aims identified by the trainer and registrar and these form the basis upon which the teaching programme is planned and weekly timetable arranged.

Enthusiasm for general practice should also apply to learning and the trainer's willingness to develop further as a clinical teacher. They require additional knowledge and new skills over and above those of non-teaching colleagues. Contribution to specialist training for general practice activities outside the practice illustrates their commitment to teaching. GP trainers must prepare carefully for their teaching responsibilities and may benefit from other teaching experience, for example with medical students or other health professionals. They should be willing to be appraised by their peers as this encourages trainees to adopt a similar critical approach to their work.

The trainer and assessment

The trainer role in assessment for learning and feedback

Formative assessment and feedback will take much the same form as now. Trainees will probably take greater notice of the results of their (summative) workplace assessments and this may mean less work in formal documentation of formative assessment.

The trainer and assessment of competence

Traditionally, the GP trainer makes two important decisions regarding a trainee's competence: the first usually comes early in the GP attachment when a decision is made on whether a registrar is able to see patients safely without the need for continuous direct supervision or supervision on a case-by-case basis; the second is the signing of a VTR1 which is itself informed by the data collected in the trainer's report.

Patient safety

Deciding when it is appropriate to let the trainee see patients without direct supervision will continue to be a matter of judgement for the training practice. The decision will be helped by direct observations or videos of consultations. Often these observations will, in themselves, have documentation using workplace based assessment tools.

This formative use of summative assessments will allow honesty between learner and trainer which should provide high quality feedback, helpful to both overconfident and under-confident registrars

Trainer's Report

An enhanced version of the trainer's report will be used each year in the annual review. Clearly, the training practices have the clearest insights into a registrar's actual performance and the trainer's role in workplace-based assessment will be crucial.

The trainer's role in the final assessment of competence is altered significantly. The final decision for the award of CCT will no longer be left entirely to the trainer.

Management

The RCGP curriculum will be delivered through schools of general practice (or similar) in each of the UK deaneries. Each school will be led by a Director of postgraduate general practice education who will manage a network of GP educators and trainers.

Scheme management

A director of postgraduate GP education has overall responsibility for the delivery and quality assurance of all the programmes and supervision provided within the deanery's scheme. This includes responsibility for ensuring that on the scheme and its component programmes, the learning outcomes of the RCGP curriculum are secured.

Principal responsibilities are to:

- Deliver and quality assure the specialist training scheme for the specialty of general practice
- Increase flexibility within training schemes for general practice
- Ensure the most appropriate training programme for each individual
- Connect the recruitment, appointment and workforce planning of all GP training grades in the NHS across the four countries of the UK
- Provide careers advice for aspiring GPs including doctors who wish to change career

Programme management

Within each geographical area, programme directors will be responsible for a set of individual programmes. Programme directors will be responsible for designing and maintaining fit-for-purpose educational experiences for trainees, including a variety of general practice, hospital and innovative posts and programmes of seminars and courses matched to the needs of learners and the agreed curriculum.

Support for learning and teaching

The individual programme for a trainee will be the responsibility of a single trainer or mentor who will work with others – the local faculty team in monitoring and supporting the progress of a trainee throughout the three years of a programme or, subject to individual circumstances, any variant of that time.

Structure of training programmes

See Appendix 2: Illustrative training programmes (Page 38)

Equality and Diversity

The general practice commitment to equality and diversity is expressed in *Education and training for general practice: a joint statement from the RCGP and COGPED*:

“Selection for general practice training will be conducted in accordance with best equal opportunities practice and a programme of continuous monitoring will be established to ensure that this policy is adhered to.

In delivering the curriculum, educationalists and educational managers must be mindful of the diverse needs of learners and the multi-cultural, multi-ethnic and multi-faith nature of the NHS workforce. All reasonable steps should be taken to ensure that the broadest possible curriculum is delivered flexibly to all learners and that no individual or group is disadvantaged. A policy of inclusion will be adopted by deaneries that values diversity, ensuring that all learners, irrespective of age, ability, gender, ethnicity, language and social background have access to learning and participatory practices appropriate to their needs.”

It is further illustrated by:

- The selection process for specialist training for general practice³²
- A separate curriculum statement on equality and diversity, *Promoting Equality and Valuing Diversity*, which includes a definition of the terms, an outline of the legal context, the significance of the issues for health inequalities and the knowledge, skills and attitudes that are necessary for ensuring competency in this area.
- Research studies to check selection processes are non-discriminatory

A Living Curriculum

Review, evaluation and monitoring of curriculum

- Each statement in the curriculum will be reviewed annually and re-written every five years
- Quality assurance: deanery and national
- Commissioned research

Review of curriculum materials

Each statement in the curriculum has a named 'guardian'. Guardians will be responsible for the annual monitoring of their statement and to propose any necessary changes to the RCGP's Education Network.

There are thirty curriculum statements. Each year six will be the subject of a review, their sequencing a product of views and outcomes from the deanery and national reviews. A major review after six years will enable the RCGP to undertake a root and branch revision that can address all aspects of the curriculum.

Regularly generated data

In every deanery, a range of data will be generated each year. These include:

- Quality assurance reports
- GP registrar performance - RITA and summative assessment;
- National exit survey data
- Expert views of educators in the deanery.

Commissioned research

At any time, a deanery, a group of deaneries, COGPED on behalf of all deaneries or the RCGP may decide to commission research on an aspect of the curriculum that, in their view, requires consideration. Results from such projects would be included into appropriate parts of the review processes outlined here.

Role of trainees and lay persons in review and monitoring

Trainees, lay people and others will be involved in review and monitoring in several ways:

- The exit survey completed by GP registrars
- As members of the schools of postgraduate GP education, trainees, lay people and members of other health professional groups will be part of each deanery's annual review process
- Trainees will be included in the five-year cycle of reviewing statements. Patient groups will also be consulted in this review process
- The root and branch review in 2012 and 2013 will draw upon the views of trainees, patients, health professionals and other lay persons.

Changing contexts

The review and monitoring plan drawn up here must be sensitive to changing circumstances and contexts such as changes in government policy or other unanticipated circumstances.

Appendix 1: Good Medical Practice

Mapping of the RCGP Curriculum against the General Medical Council's Good Medical Practice (2002)

Good Medical Practice	Corresponding paragraphs in the Curriculum
<p><i>Good Clinical Care</i> Clinical care</p>	<p><i>Domain 1: Primary care management</i></p> <p>1.1 To manage primary contact with patients, dealing with unselected problems</p> <p>1.2 To cover the full range of health conditions</p> <p>1.3 To co-ordinate care with other professionals in primary care and with other specialists</p> <p>1.4 To master effective and appropriate care provision and health service utilisation</p> <p>1.5 To make available to the patient the appropriate services within the healthcare system</p> <p><i>Domain 2: Person-centred care</i></p> <p>2.1 To adopt a person-centred approach in dealing with patients and problems in the context of patient's circumstances</p> <p>2.2 To use the general practice consultation to bring about an effective doctor–patient relationship, always respecting the patient's autonomy</p> <p>2.3 To communicate, to set priorities and to act in partnership</p> <p><i>Domain 3: Specific problem-solving skills</i></p> <p>3.1 To relate specific decision-making processes to the prevalence and incidence of illness in the community</p> <p>3.2 To selectively gather and interpret information from history-taking, physical examination and investigations, and apply it to an appropriate management plan in collaboration with the patient</p> <p>3.3 To adopt appropriate working principles (e.g. incremental investigation, using time as a tool), and to tolerate uncertainty</p> <p>3.4 To intervene urgently when necessary</p> <p>3.5 To manage conditions which may present early and in an undifferentiated way</p> <p><i>Domain 4: A comprehensive approach</i></p> <p>4.1 To simultaneously manage multiple complaints and pathologies, both acute and chronic health problems</p> <p>4.2 To promote health and well-being by applying health promotion and disease prevention strategies appropriately</p> <p><i>Domain 5: Community orientation</i></p> <p>5.1 To reconcile the health needs of individual patients and the health needs of the community in which they live, balancing these with available resources.</p> <p><i>Domain 6: A holistic approach</i></p> <p>6.1 To use bio-psycho-social models, taking into account cultural and existential dimensions</p>

<p><i>Good Clinical Care</i> Keeping records, writing reports and keeping your colleagues informed</p>	<p><i>Domain 1: Primary care management</i> 1.3 To co-ordinate care with other professionals in primary care, and with other specialists</p> <p><i>Domain 2: Person-centred care</i> 2.3 To communicate, to set priorities and to act in partnership</p>
<p><i>Good Clinical Care</i> Access, availability and providing care out of hours</p>	<p><i>Domain 2: Person-centred care</i> 2.4 To provide long-term continuity of care as determined by the needs of the patient, referring to continuing and co-ordinated care management</p>
<p><i>Good Clinical Care</i> Treatment in emergencies</p>	<p><i>Domain 3: Specific problem-solving skills</i> 3.4 To intervene urgently when necessary</p>
<p><i>Good Clinical Care</i> Making effective use of resources</p>	<p><i>Domain 3: Specific problem-solving skills</i> 3.3 To adopt appropriate working principles (e.g. incremental investigation, using time as a tool), and to tolerate uncertainty 3.6 To make effective and efficient use of diagnostic and therapeutic interventions</p> <p><i>Domain 4: A comprehensive approach</i> 4.3 To manage and co-ordinate health promotion, prevention, cure, care, rehabilitation and palliation</p> <p><i>Domain 5: Community orientation</i> 5.1 To reconcile the health needs of individual patients and the health needs of the community in which they live, balancing these with available resources</p>
<p><i>Maintaining Good Medical Practice</i> Keeping up to date, and maintaining your performance</p>	<p><i>Essential feature 3: Scientific aspects</i> 4 Being able to develop and maintain continuing learning and quality improvement</p>
<p><i>Relationships with Patients</i> Providing information about your services</p>	<p><i>Domain 2: Person-centred care</i> 2.3 To communicate, to set priorities and to act in partnership</p>
<p><i>Relationships with Patients</i> Maintaining trust</p>	<p><i>Domain 2: Person-centred care</i> 2.1 To adopt a person-centred approach in dealing with patients and their problems, both in the context of patient's circumstances 2.2 To use the general practice consultation to bring about an effective doctor–patient relationship, always respecting the patient's autonomy 2.3 To communicate, to set priorities and to act in partnership</p> <p><i>Essential feature 2: Attitudinal aspects</i> 1 Being aware of one's own capabilities and values 2 Identifying ethical aspects of clinical practice (prevention, diagnostics, therapy, factors that influence lifestyles) 3 Justifying and clarifying personal ethics</p>
<p><i>Relationships with Patients</i> Avoiding discrimination and prejudice against patients</p>	<p><i>Domain 6: A holistic approach</i> 6.1 To use bio-psycho-social models, taking into account cultural and existential dimensions</p>

<p><i>Relationships with Patients</i> If things go wrong</p>	<p><i>Essential feature 1: Contextual aspects</i></p> <ol style="list-style-type: none"> 1. Having an understanding of the impact of the local community, including socio-economic factors, geography and culture, on the workplace and patient care. 2. Being aware of the impact of overall workload on the care given to the individual patient, and the facilities (e.g. staff, equipment) available to deliver that care. 3. Having an understanding of the financial and legal frameworks in which health care is given at practice level 4. Having an understanding of the impact of the doctor's personal housing and working environment on the care that s/he provides
<p><i>Working with Colleagues</i> Working with colleagues and working in teams</p>	<p><i>Essential feature 2: Attitudinal aspects</i></p> <ol style="list-style-type: none"> 1 Being aware of one's own capabilities and values 2 Identifying ethical aspects of clinical practice (prevention, diagnostics, therapy, factors that influence lifestyles) 3 Having an awareness of self: an understanding that their own attitudes, and feelings are important determinants of how they practice 4 Justifying and clarifying personal ethics <p><i>Domain 1: Primary care management</i></p> <p>1.3 To co-ordinate care with other professionals in primary care, and with other specialists</p> <p>1.5 To make available to the patient the appropriate services within the healthcare system</p>
<p><i>Working with Colleagues</i> Referring patients</p>	<p><i>Domain 4: A comprehensive approach</i></p> <p>4.3 To manage and co-ordinate health promotion, prevention, cure, care, rehabilitation and palliation</p> <p><i>Domain 1: Primary care management</i></p> <p>1.3 To co-ordinate care with other professionals in primary care, and with other specialists</p> <p>1.5 To make available to the patient the appropriate services within the healthcare system</p>
<p><i>Working with Colleagues</i> Accepting posts</p>	<p><i>Essential feature 2: Attitudinal aspects</i></p> <ol style="list-style-type: none"> 1 Being aware of one's own capabilities and values 4 Justifying and clarifying personal ethics
<p><i>Teaching and Training, Appraising and Assessing</i> Teaching and training, appraising and assessing</p>	<p><i>Not explicitly covered in this statement but covered in a supplementary RCGP Curriculum Statements</i></p>
<p><i>Probity</i> Research Financial and commercial dealings Providing references</p>	<p><i>Essential feature 2: Attitudinal aspects</i></p> <ol style="list-style-type: none"> 1 Being aware of one's own capabilities and values 2 Identifying ethical aspects of clinical practice (prevention, diagnostics, therapy, factors that influence lifestyles) 3 Justifying and clarifying personal ethics

*Health and the Performance
of Other Doctors*

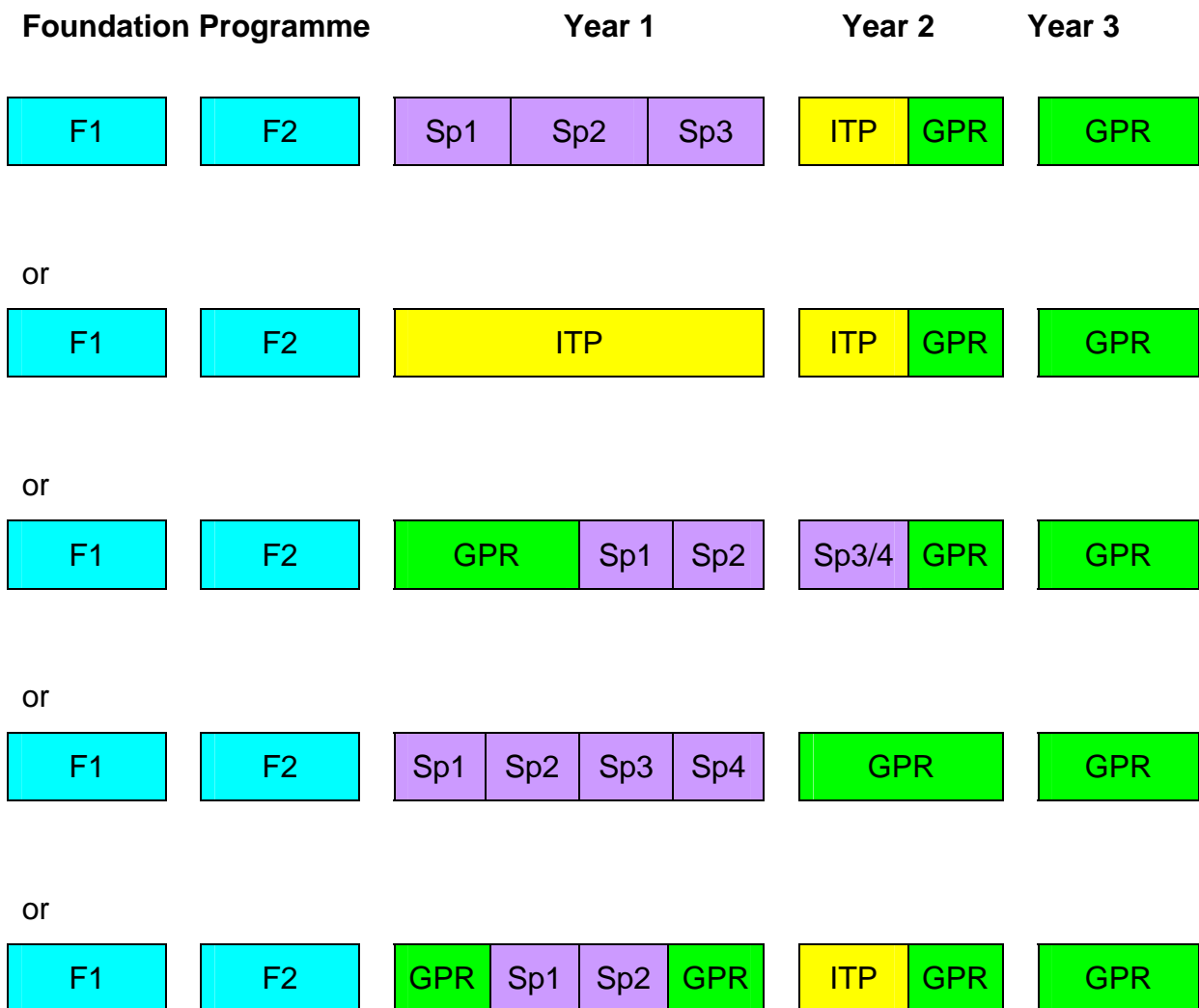
Protecting patients when
your own health or the
health, conduct or conduct,
or performance of other
doctors puts patients at risk

Essential feature 2: Attitudinal aspects

- 1 Being aware of one's own capabilities and values
- 3 Having an awareness of self: an understanding that their own attitudes, and feelings are important determinants of how they practice
- 5 Being aware of the interaction of work and doctor's own private life and striving for a good balance between them

Appendix 2: Illustrative training programmes

Illustrative training programmes in general practice training



F1= first year of foundation programme

F2 = second year of foundation programme

Sp = hospital specialty post

ITP= innovative training post

GPR = GP registrar post

Appendix 3: Core and Extended Statements

The GP training curriculum is composed of a set of 32 curriculum statements organised into 15 groups:

1. ***The 'Core Statement' - Being a general practitioner***
2. **The general practice consultation**
3. **Personal and professional responsibilities**
 - 3.1 **Clinical governance**
 - 3.2 **Patient safety**
 - 3.3 **Ethics and values based medicine**
 - 3.4 **Promoting equality and valuing diversity**
 - 3.5 **Evidence based health care**
 - 3.6 **Research and academic activity**
 - 3.7 **Teaching, mentoring and clinical supervision**
4. **Management in primary care**
 - 4.1 **Management in primary care**
 - 4.2 **Information management and technology**
5. **Healthy people: promoting health and preventing disease**
6. **Genetics in primary care**
7. **Care of acutely ill people**
8. **Care of children and young people**
9. **Care of older adults**
10. **Gender-specific health issues**
 - 10.1 **Women's health**
 - 10.2 **Men's health**
11. **Sexual health**
12. **Care of people with cancer & palliative care**
13. **Care of people with mental health problems**
14. **Care of people with learning disabilities**
15. **Clinical management**
 - 15.1 **Cardiovascular problems**
 - 15.2 **Digestive problems**
 - 15.3 **Drug using adults**
 - 15.4 **ENT and facial problems**
 - 15.5 **Eye problems**
 - 15.6 **Metabolic problems**
 - 15.7 **Neurological problems**
 - 15.8 **Respiratory problems**
 - 15.9 **Rheumatology and conditions of the musculoskeletal system (including trauma)**
 - 15.10 **Skin problems**

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