Life & Times
The great training robbery

I chose to train in general practice for a multitude of powerful and positive reasons but increasingly feel the victim of a great training robbery. Many problems have beset the programme, with the recent House of Lords report calling it unfit for purpose.[1] There is however nothing more illustrative of the depth of despair than the lived experiences of ambitious generalists who are used as cannon fodder for an under-staffed, flailing secondary care system.

A FLAWED SYSTEM

General practice is the shortest specialty training for the broadest of all fields. To become a generalist today, half of my training is spent in subspecialised secondary and tertiary care settings, honing skills, accumulating knowledge, and reflecting on the experiences of service delivery in these particular institutions. The nature and purview of hospital care are fundamentally different, such as, its pathology-centred approach, over-reliance on investigations, and the proclivity for short-termism.

The scheme in its current form is ill-conceived and profoundly flawed. The first error is the notion that one can train in one specialty by doing a similar one in a contrasting environment. Imagine someone who will be flying a Boeing aeroplane spending their time learning to fly a hot air balloon just because both involve flying. The second issue is the allocation of posts with a free-for-all, anything-goes approach. It is as if someone has looked at the hospital rota and found some gaps in various places, which are then filled with GP trainees.

THE HOSPITAL MILIEU

The honest truth is that, within this cultural milieu of the hospital, we are treated as a general dogsbody, a mere paper-pusher, by some physicians and managers. There is no doubt that one can find not only a tenuous educational value in mundane clerical work but also meaning and purpose, especially if it leads to better patient satisfaction. As George Herbert once said:

'A servant with this clause
Makes drudgery divine:
Who sweeps a room as for Thy laws,
Makes that and th' action fine.'[2]

But pedagogically this attitude is a stretch too far and falls significantly short of the standard and rigour expected of an educational programme. It also manifestly lacks the ambition, philosophy, and scope to train outstanding future primary care consultants.

AN INTELLECTUAL VOID

Permanent gaps in hospital staff rotas and the pressure to focus on service delivery have meant real learning space and time, dubiously termed as 'educational opportunities', are few and far between. The Workplace-Based Assessments add very little to overall learning and development, so they are used merely for box-ticking. The clinical supervision I had consisted of a 5-minute conversation, at the end of 4 months, with an exasperated neurosurgeon who saw neither the utility nor the point of commenting on my consultation skills or whether I practised holistically.

Most hospital supervisors are in fact either entirely ignorant of the GP curriculum or wholly dismissive of its objectives. Scornful of our career choice, it is inexplicable that they are tasked to train us as competent community physicians. With this robbed training, the curriculum is learned and passed — on top of a largely irrelevant full-time job — by spending a disproportionate amount of time and resources on additional courses and teaching.

The issues of training are indeed symptomatic of a greater existential malaise. General practice is not certain what it is and what purpose it ought to serve. With this intellectual void, it is inevitable that other forces shape its structure and define its role.

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The prevailing intellectual poverty is also manifested in the public and academic discourse in the field. These are mainly what other players demand of general practice: better access and efficient patient flow between various parts of the health service.

WE MUST NO LONGER SUBJUGATE AND SUBSUME PRIMARY CARE TRAINING

A fundamental shift is needed to save the specialty and ameliorate some of the deep-seated disillusionment and frustration. To begin with, general practice needs to be placed on more solid scientific and philosophical foundations. There has to be more investment in primary care research and scholarship. The educational programme needs a complete overhaul with training entirely based in primary care in a fertile and nourishing environment, where learning and reflection are not subjugated and subsumed into service provision.

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