Making primary care placements a universal feature of postgraduate medical training

Ahmed Rashid[1], Nishma Manek[2]

[1.] Department of Public Health & Primary Care, University of Cambridge, UK
[2.] St Mary's Hospital GP Vocational Training Scheme, London, UK
**corresponding author (ahmed.rashid@doctors.org.uk)*

We know what you're thinking having read the title to this article: another desperate attempt to lure new doctors into general practice and then trap them to bolster numbers. In fact, this is not about recruitment at all. Rather, it is about uniting the profession and fundamentally improving the experiences of our patients.

The interface between primary and secondary care has long been recognised as problematic[1], with both patients[2] and doctors[3,4] frequently voicing their discontent at the care and communication that slips through the cracks. Many suggestions have been made to improve this, varying from shared educational events[3] to better use of technology to plug the gap. The most pertinent, however, is surely to improve the appreciation of the working environment of the other.

In the UK, all doctors are required to complete two years of foundation training after graduating from medical school and this is based predominantly (and sometimes exclusively) in hospital settings. Those training to be general practitioners (GPs) then typically complete a further 18-24 months of hospital placements before completing their training in the community. By the time GPs have qualified, they will therefore have completed a minimum of 3-4 years of hospital work, and often much more.

There are many reasons why this time is so valuable. Firstly and most obviously, the generalist nature of working in primary care means that experience of all clinical disciplines is necessary. Beyond this, however, these placements also offer an insight into the intricate workings of a hospital, from the emergency department triage, to the pre-operative assessment clinic, to the labour ward in the maternity unit. This intimate knowledge helps them to steer their patients towards the right services, strive to organise the most appropriate investigations, and send appropriate information across the interface. Moreover, although some aspects of these posts are geared more towards service provision than education, simply being part of the hospital team is useful in raising awareness of the culture, etiquette and stresses of the environment.

Yet in comparison, only a small proportion of specialty trainees will have set foot in a GP surgery as a doctor after qualifying. In 2012, 0% of foundation year 1 placements and 18% of foundation year 2 placements were in general practice[5]. Of note though, general practice placements were reported to receive the highest satisfaction ratings of all specialty placements in the Foundation Programme, with trainees valuing the ready access to senior support and regular, high-quality feedback that they received[5]. There is also a strong correlation between training placements in primary care and eventually choosing to work in

general practice[6]. Whilst more recent plans to reform the foundation programme to mandate community-based or integrated placements are laudable[7], this should not detract from the importance of increasing an understanding of primary care in the early years.

Hospital doctors may feel that their roles, and therefore their training, end in acute environments. We think otherwise. Firstly and most importantly, the system that their patients are navigating is built on a bedrock of primary care, with most of our patients' journeys starting and ending here. Indeed, 90% of all patient contact in the NHS takes place in primary care[8], and often in patients' own homes. Time spent on both sides of the fence helps to inform an understanding of how we can support our patients in their interface transitions.

In addition, almost all hospital doctors will work continuously in conjunction with primary care in the course of their work. Whether receiving referrals, sending discharge summaries or collaborating with joint prescribing and monitoring plans, these interactions can only be enhanced by gaining an insight into the primary care environment. Moreover, many of the conditions managed in hospitals, such as osteoarthritis and asthma, have a less severe course that it is almost exclusively managed in the community. For hospital doctors, a broader understanding of what lies beneath the 'tip of the iceberg' of their patients' conditions can lead to an enhanced appreciation of the support they need in the community.

Other notable features of primary care training include gaining independence in assessing undifferentiated sub-acute presentations, managing complex multi-morbidity over time, addressing lifestyle factors in brief interactions, and exposure to the complete spectrum of the patient demographic and their interdependent health problems, including mental health.

The NHS Five Year Forward View outlines new models of care that aim to reshape our healthcare landscape to address the changing patient demographic[9]. These models blur the boundaries between primary and secondary care even further than before, and focus on shifting the centre of gravity into the community. Ensuring these changes translate into an enhanced patient experience warrants a greater understanding of the complexities faced by doctors in different settings. It is essential that our postgraduate training rapidly evolves in parallel, to provide broader based beginnings which reflect where our patients spend most of their time in the system.

Primary care doctors continue to benefit from the training they receive in the hospital. As we move forwards, providing universal exposure to primary care for all trainees could inspire greater collaboration in designing services that look beyond our four-walled silos, and instead centre on the needs of individual patients as they navigate through our labyrinthine system.

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