1 Introduction: Seeing the big picture

Why take notice of what this book has to say?

There are lots of books that offer advice on getting to the exam and you might very reasonably ask: 'Why should I take any notice of what *you* have to say?' I could sell myself by telling you that I'm an experienced examiner and have helped develop the new MRCGP. I could tell you that I contribute to the development of the curriculum. However, the most important thing about me is that I am a family doctor who is passionate about general practice and that I have spent much of my career trying to be the best doctor I can for the patients who put their trust in me. That ongoing journey has also helped me to become a better person than I once was and continues to stimulate and reward me beyond my expectations.

In this respect, I'm no different from many of my colleagues and in this book, I hope to help the next generation of GPs develop the mindset and skills that will help them and their patients to live healthy and fulfilled lives.

Preparing for the MRCGP

In this book, my aim will be to help you to be successful in the MRCGP and to assist you in the best way, which is by helping you to understand generalism well enough to perform to a high standard in the workplace. Surely, you may be thinking, an examiner will give me the inside knowledge, the shortcuts to get me through the exam so that I can get on with real life? Unfortunately there are no shortcuts and the reason is that the MRCGP does not test your ability to take tests, which in any case would be difficult to achieve because the exam uses lots of different types of test. Instead, the MRCGP tests what is really important ,i.e. your ability to do the job.

What do we mean by this? The Clinical Skills Assessment (CSA) and Applied Knowledge Test (AKT) are important and provide additional evidence of your ability in the artificial conditions of an examination. However, they are not the full story. If you think you can pass by cramming for AKT, going on a course for CSA and keeping your nose clean in training, you're pretty likely to be found out. Whether you get through or not depends not just on examiners but on the continual assessments and feedback from the people you work with.

So the bottom line is: don't look for shortcuts. This might surprise you; surely a course on the AKT and lots of practice questions would be the best way of getting through? In fact, the AKT examiners recommend that you learn through day-to-day general practice rather than 'learning to the test' and it has been shown that doctors who are doing just that (i.e. practising GPs) do better in the AKT than many trainees. Incidentally, this is a good example of why the new MRCGP is such a valid test of general practice: real GPs can pass it.

Similarly, the CSA requires no special tricks. It is a reproducible test of what happens in the consultation and the best way to prepare is to consult- - - - lots.

To pass the licensing exam you have to demonstrate to many people over a long period, that you are continually learning, improving your performance and are able to reliably achieve a specified level of performance. It's impossible to do this consistently without understanding what you're doing. Therefore, the best way to *prepare* for the MRCGP is by *performing* and this book will show you how. It is fact-light but (I hope) insight-rich and will help you to improve your understanding of general practice and more specifically, of the standard of performance that you need to achieve to comfortably get through the MRCGP.

Understanding Generalism

Generalism is complicated, difficult to define and therefore easy to underestimate. Like the piano, it is the easiest of the medical instruments to play, but the hardest to play well, so don't be fooled into thinking it is a soft option! The payback is that few specialties provide the opportunity to do so much for so many people. And yes, general practice is a *specialty* in its own right and takes an expert to do well. Let's think about the nature of this specialty in more detail.

Defining general practice has always been a struggle. This in itself must tell us something. In early days, it suggested something unflattering, for example that Generalism was a low-challenge 'dustbin' for those without talent, energy, ambition or all three. The gradual understanding of 'patient-centredness' helped us to see our discipline in terms of a focus upon the *person* rather than the disease. Later, we came to understand how Generalists need to communicate in order to achieve effective consultation outcomes.

These advances have led to GPs suggesting that what makes our specialty different from others is a focus on relationships, the communication skills of the consultation (where General practice has provided the most significant literature on the subject) and the high-quality teaching with which GP training is associated. However, we could argue that none of these features are singular to Generalism. Indeed, one of the great contributions that our specialty can make to all others, is to make these features part of the experience and values of ***all*** doctors.

If we think about what it is to be a Generalist, or indeed any specialist, it is helpful to think in terms of our *context* (where, with whom and for whom we work and the problems we are asked to deal with) and our *behaviour* (our thinking and actions in a professional situation).

It is useful to separate the two facets in order to illustrate that context will and should change, possibly more so in primary care than most other medical specialties. On the other hand, the behavioural base of our discipline is likely to remain relatively stable. This book describes the behavioural base (what we call our 'competencies') in detail. Mastering these competencies will help you to perform well for the exam but more importantly, to continue to perform throughout independent life even when the context of general practice inevitably changes.

Although the environment will change, there are some contextual features that characterise our specialty and are worth trying to understand because they are likely to remain important. I've selected three (**C**omplexity, **U**ncertainty & **P**artnership) to examine in more detail.

Complexity

Complexity implies the presence of many interconnected parts. All initiates to Generalism become used to plurality or the presence of multiple components, which at one level may simply be the wide range of medical conditions with which the GP may be faced. However, complexity is not simply plurality but is the **connection, integration and interaction** between parts. Engaging with complexity is a high-order cognitive ability, requiring considerable attentiveness, perception and understanding. The GP curriculum (the first our specialty has had) at last gives us a framework for learning about connections. Here are some examples of complexity in action:

- GPs do not simply deal with medical conditions but also engage with broader notions of health (rather than illness), with problems rather than just diseases and with management options that are of greater scope than drug treatments or complementary therapies.
- By considering health more broadly, GPs don't think of the mind and body as being separate from each

other, but use the interconnectedness of both. This helps us to value and use thoughts and perceptions as well as information on bodily function when we explore problems, make professional judgements and facilitate improvement.

- In clinical terms, complexity may mean an appreciation of the implications of co-morbidity (how coexistent symptoms, diseases and possible treatments impact upon each other) and how this might be anticipated and addressed.

- Complexity also operates when GPs recognise and make use of the social connections that influence the patient's health. These include the patient, the other people within the patient's social and cultural grouping and more widely, the influences of society, which includes the influence of health professionals.

What are the implications for the learning journey? It means that we should never regard any experience, learning, situation or problem as being entirely simple or isolated. To do so is to miss important opportunities to make connections. As *students*, we should learn that the different sections of the curriculum do not stand in isolation but are integrated and have effects on each other. As *practitioners*, we should learn how seemingly innocent physical, psychological and social cues can be the early signs of more significant problems. We should also learn how connections between seemingly unrelated pieces of information can allow us to recognise important patterns at an early stage.

Uncertainty

It is said that nothing is certain except death & taxes….and perhaps in the future even death may become optional! It is interesting that as society moves away from traditional certainties such as faith in religion or trust in professionals, it takes refuge in proxies for certainty such as rights, accountability and the exercise of control. Medicine, in part reflecting this movement, has developed an evidence-base paradigm that we could argue is an attempt to control uncertainty.

Like all frameworks, EBM cannot represent the whole truth although it does provide an explicit structure that can be used to educate, inform, direct, ration and measure the application of healthcare. However, in general practice uncertainty is inherent in the work that we do and a full hospital diagnostic workup or EBM are not routinely available to rescue (some would say distract?) us. With patients, there may be uncertainty over the diagnosis and more broadly, how best to manage the problem given the particular circumstances. These crucial judgements are only partly assisted by evidence-based medicine and a large part of GP expertise lies in the ability to use a resource bank of experiences from medical and non-medical contexts. In situations of uncertainty, perhaps where the problem is evolving or has never been encountered before, we rely upon the bells of our prior experience and knowledge of probability to ring in order for patterns to be recognised or events to be anticipated in a sophisticated way that reduces the risk that uncertainty represents.

Although it seems strange, uncertainty can improve our capacity to make optimum judgements. How? By indicating the limits of certainty, signposting uncharted territory that may prompt us to learn and by giving appropriate weight to the available options. Also, uncertainty helps to improve our thinking by encouraging us to make connections between bits of information in an effort to come up with lower-risk strategies to deal with a problem than we might otherwise have thought of. As we can see, uncertainty and complexity (making connections) are thereby related.

In our learning journey, we should value uncertainty and sensitise ourselves to it, for example by recognising the discomfort that it causes and using it to prompt questions such as 'What did I feel unsure of and does this matter?' In this way, uncertainty should be a routine and lifelong spur to learning.

Partnership

Partnership is a relationship between individuals or groups that is characterized by cooperation and mutual responsibility in an effort to achieve a specified goal. In our age, we are moving from compliance, where doctors tell and others obey, to concordance where there is a meeting of minds and a sharing of understanding and responsibility. Communication skills have helped to undo the harm caused by the disease-orientated approach to patient encounters. However, we are still at an early stage in the appreciation of the implications of partnership. Let's consider two facets of this.

Firstly, within the consultation we are becoming more adept at probing the patient's health beliefs and sharing appropriate management options. However, by definition partnership has at least two parties and relatively little is done to empower the patient toward greater self-sufficiency or to discuss what shared responsibility might mean from the patient's perspective beyond the rather trite concordance with prescribed medication.

Secondly, partnership is a mindset as well as a contract. We work in partnership with colleagues as well as with patients and the intention is to collaborate. For this to happen there must be a mindset of mutual respect and understanding of each other's abilities and capacity to contribute, as well as a commitment to provide the *opportunity* to contribute. We might argue that there is no equality of opportunity without the *differences* between us being valued and harnessed. In other words, equality and diversity must progress hand in hand. In practical terms, we should ask ourselves questions such as:

- 'How can I encourage my patient to wish to be my partner for this problem and for future problems?'
- 'Who else might have a view or might legitimately wish to be involved in managing this problem?'
- 'What can others add to this enterprise, even (perhaps *especially*) those people whose views I disagree with and how can I get them involved?'

In terms of our learning journey, we can summarise CUP as follows:

- **C**omplexity: is an **opportunity** to make connections
- **U**ncertainty: is an **unsettled feeling** that we should not ignore but use as a prompt to learn and be creative with problem-solving.
- **P**artnership: is an **offer** that we should make far more often to the people we work for and with.

Who is this book for?

This book is intended to help the learning journey; performance assessment is a guest at the table of education and should enrich the conversation, not spoil the meal. By illustrating the GP competencies required for licensing, this book provides a common language that should help trainees and educators to have better-informed conversations that allow insight into performance to be improved. As a result, learning plans can be targeted to the most appropriate areas and pitched to the most appropriate level of difficulty. The latter is important, because many of the GP competencies cannot be achieved until late in training and it is counter-productive to suggest or assume that they can be mastered early on.

The book is also intended to help assessors, both those who have a responsibility for GP assessment and for trainees who wish to use their self-assessment skills to drive their learning. The book gives numerous examples of assessment tips but more importantly, it provides a basis for assessors in all components of the MRCGP to develop their understanding of the licensing standard that is being assessed (see page 8).

What is learning for?

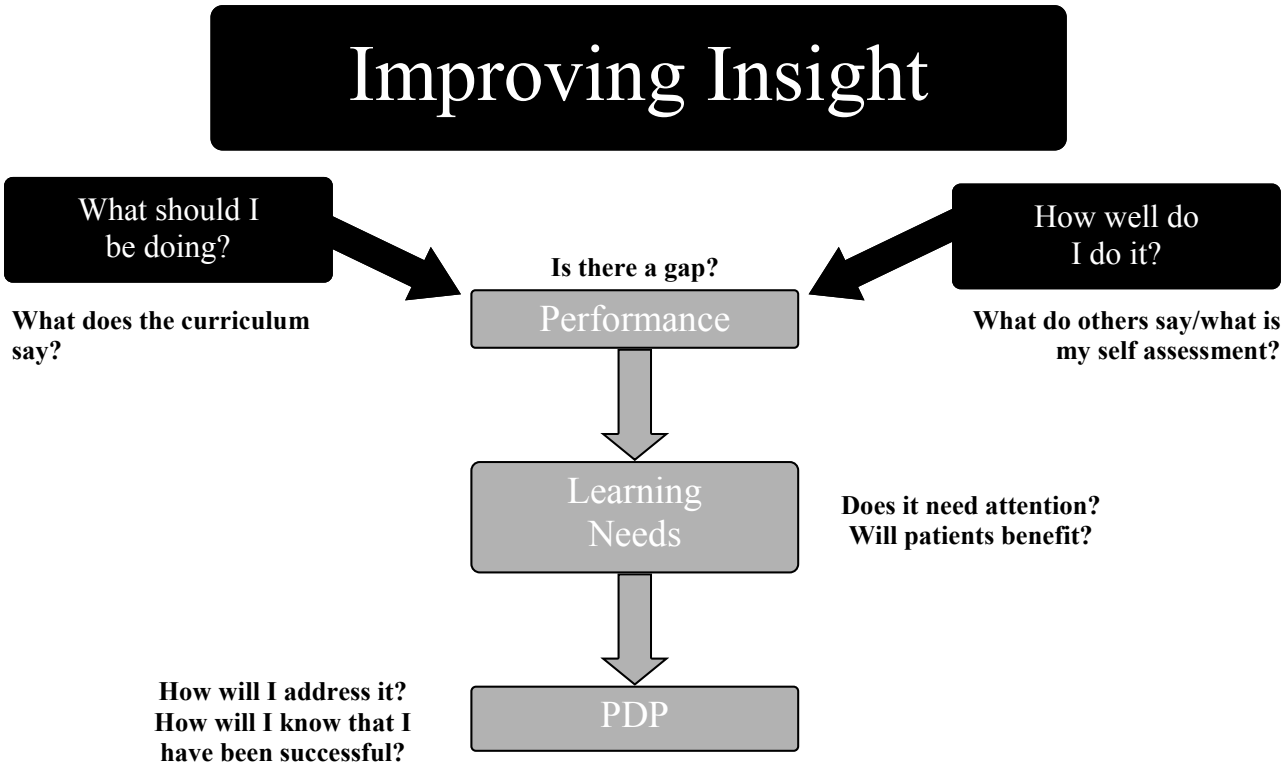
I've said that this book is intended to help us to learn, so it is worth asking what exactly learning is for. We all have our own response to this, but at one level the purpose of our learning (in our professional context) is in order to improve our professional performance.

The following equation, which is explored in greater depth in the chapter on 'Fitness to practise' (page 203), helps us to understand the factors underlying improvement in performance:

d performance = d (insight x motivation x application x opportunity)

d (delta) represents change.

Insight can be improved by the following mechanism:



The crucial stage is to recognise and to interpret the gap between current performance and the level of performance that is required. This book describes the competencies and the standards so that this gap can be made more explicit and therefore discussed more productively.

Motivation is mentioned and at this stage of your career, the motivation may simply be to get through the exam. However, what about when the exam is behind you? It's worth thinking about your deeper motives and again there are no rights and wrongs. Some doctors are motivated by vocation, others by status or income and many by a combination of the three. As the equation shows, if our motivation suffers then so will our performance. Deeper motivations can't be easily changed, but if we are aware of them, we can nurture what's important and change the balance if we need to. For example, we might maintain motivation by seeking to be inspired by those whose values we admire or we might undertake work that improves our status (e.g. self-esteem) but doesn't earn income.

Looking more broadly we might say that 'performing' isn't just about being a better medic, it's about being a better person. However, is that relevant to us as GPs?

I'd say 'yes' because our expertise lies in our ability to help others make choices that are right for them in situations that are important, but uncertain. We can't do that without caring about and trying to understand people and what distresses them. To that end, we need to be better people not just better technicians. It's worth remembering that competence is not a big issue for our patients. For them, competence is a given. However, what they hope for and what they really value is our human compassion. Compassion is not a 'competency' that can be faked to get through an exam. It is a fragile virtue, but one that we know is part of the doctor's make-up when they continue to care about their patients, despite the stresses of their working environment and own lives.

'Becoming a GP', is not simply about the destination of becoming a licensed general practitioner, but about a learning journey that continues throughout life. As the philosopher Alan Watts said, life is not about some distant goal (an exam, retirement or even enlightenment) but about enjoying and making the most of each day along the path. That, he says, is why composers write symphonies, not just final movements! In a similar way, the MRCGP looks at how trainees engage with the learning journey, continually engaging with life, reflecting on their experiences and applying their insights to practice.

What do patients need?

Patients have increasing access to high quality sources of information, so doctors are less important as content experts than they used to be. Paradoxically, far from reducing the need for a doctor's advice, GPs are needed more then ever to help the patient make sense of the information and to put it in the context of their lives so that the best choices can be made. This means that patients need *guidance*, not given paternalistically but offered in a way that respects the patients desire (or lack of desire) to share in decision-making.

What do trainees need?

In order to guide patients, GPs need to be good at evaluating situations and helping others to understand and act. Although GPs also have some practical skills, our main expertise is in the development and use of our intelligence. In broad terms, let's think about two manifestations of this. *Cognitive* intelligence is mainly concerned with our ability to interpret information and to reason. Just as importantly, *emotional* intelligence concerns our 'feeling' mind especially our self-awareness and motivations, our understanding of other people's emotions and of how to manage relationships. The thrust of GP training is directed at developing both forms of intelligence.

So where do we find out what needs to be learned?

First and most importantly, the knowledge skills and attitudes that GPs require are laid out in the RCGP curriculum. The curriculum can look overwhelming, but it isn't if we remember that the basis is described in the **core curriculum statement 'Being a General Practitioner'**. The core statement has 9 principal areas as shown in the table below. The first 6 are called 'domains' and the last 3 are called 'essential features'.

In addition to the core statement there are many other curriculum statements. However they should not be thought of as being separate stand-alone areas of general practice. Their purpose is really to illustrate the ideas within the core curriculum. For example, a 'holistic approach' from the core curriculum (such as the impact of a problem on the patient's life) will manifest itself differently in a young adult with earache compared to a mother with terminal ovarian cancer. These differences are illustrated by the curriculum statements and help us to understand what the core curriculum means by 'holism'.

For the MRCGP, the domains and essential features of the core curriculum statement have been translated into 12 competency areas which we call the **competence framework**. The relationship between this framework and the curriculum is as follows:

The Curriculum:	Related MRCGP competency areas:
Primary care management	Clinical management Working with colleagues and in teams Primary care administration and IM&T
Person-centred care	Communication & consulting skills
Specific problem-solving skills	Data gathering and interpretation Making a diagnosis/making decisions
A comprehensive approach	Managing medical complexity
Community orientation	Community orientation
A holistic approach	Practising holistically
Contextual features	Community orientation
Attitudinal features	Maintaining an ethical approach to practice Fitness to practise
Scientific features	Maintaining performance, learning and teaching

Why translate the curriculum?

The core curriculum was written in order to explain the essence of being a GP. It contains many ideas, but was not designed to specify the behaviours that doctors must have in order to pass the licensing exam. This is why a translation was needed. The competence framework doesn't represent the entirety of the curriculum and to understand each of the 12 assessment areas properly, you need to read about the area of the curriculum to which it is related, as shown in the table.

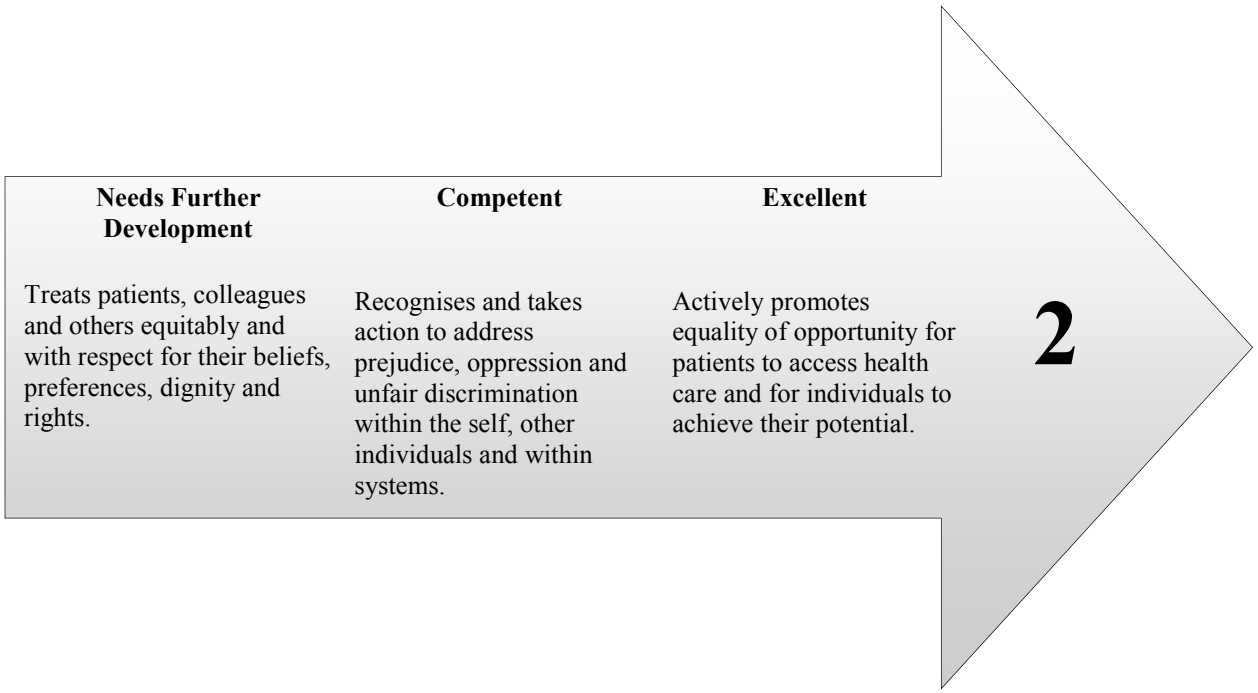
By having behaviours that are specified, trainees know what they are expected to do for the MRCGP and assessors to know what to look for.

What is the structure of the competence framework?

Each of the 12 areas in the framework is further broken down into a number of themes which are separate from each other. For example,' Managing medical complexity' contains themes on:

- Managing several problems together.
- Assessing and managing clinical risk
- Health promotion

Each theme is itself developed from a lower level in the 'needs further development' column to an 'excellent' level on the right-hand side. If you look at the chapters in this book, each theme is represented by an arrow that illustrates this progression. For example:



This has been done so that trainees can see the trajectory of learning and can see how to improve their performance over time. Don't be fooled by the terminology, though. The lower-level of 'needs further development' is taxing and it is expected that most trainees will not be able to perform above this level until late on in training. It also carries with it the obligation on the trainer to offer feedback on how performance can be improved to reach the 'competent' level and beyond.

So what is good enough for licensing?

The standard required for licensing is described by the middle column labelled 'competent', which is short for 'competent for independent practice'. To achieve this licensing standard, trainees need to demonstrate the behaviours in the first column **and** the second column. The final column (excellent) is there to provide goals for those who are still in training but are already achieving the 'competent' standard in that area of performance. It also describes the trajectory of learning beyond GP training and is therefore valuable as it informs the professional development of all GPs.

Where are the 12 assessment areas tested in the MRCGP?

All 12 assessment areas are tested continually through workplace-based assessment. Most of them are also tested in the other two examination components. For example, clinical decision-making and interpersonal skills and attitudes are tested in CSA and the knowledge base of general practice and how it is applied, is tested through the AKT.

But what does it all *mean*?

Seeing the wood from the trees

Around now, you may well be feeling overwhelmed with frameworks, domains, competencies and so on, but hang on because we will now try to see the wood from the trees!

First, a word of advice: the rest of this chapter contains a lot of information and ideas which help us to understand the complexity of GP performance, and the ways in which it might be analysed for assessment and training purposes. It is not an easy read but becomes more understandable and useful as the reader becomes familiar with the book. It is therefore well worth revisiting this part of the book periodically.

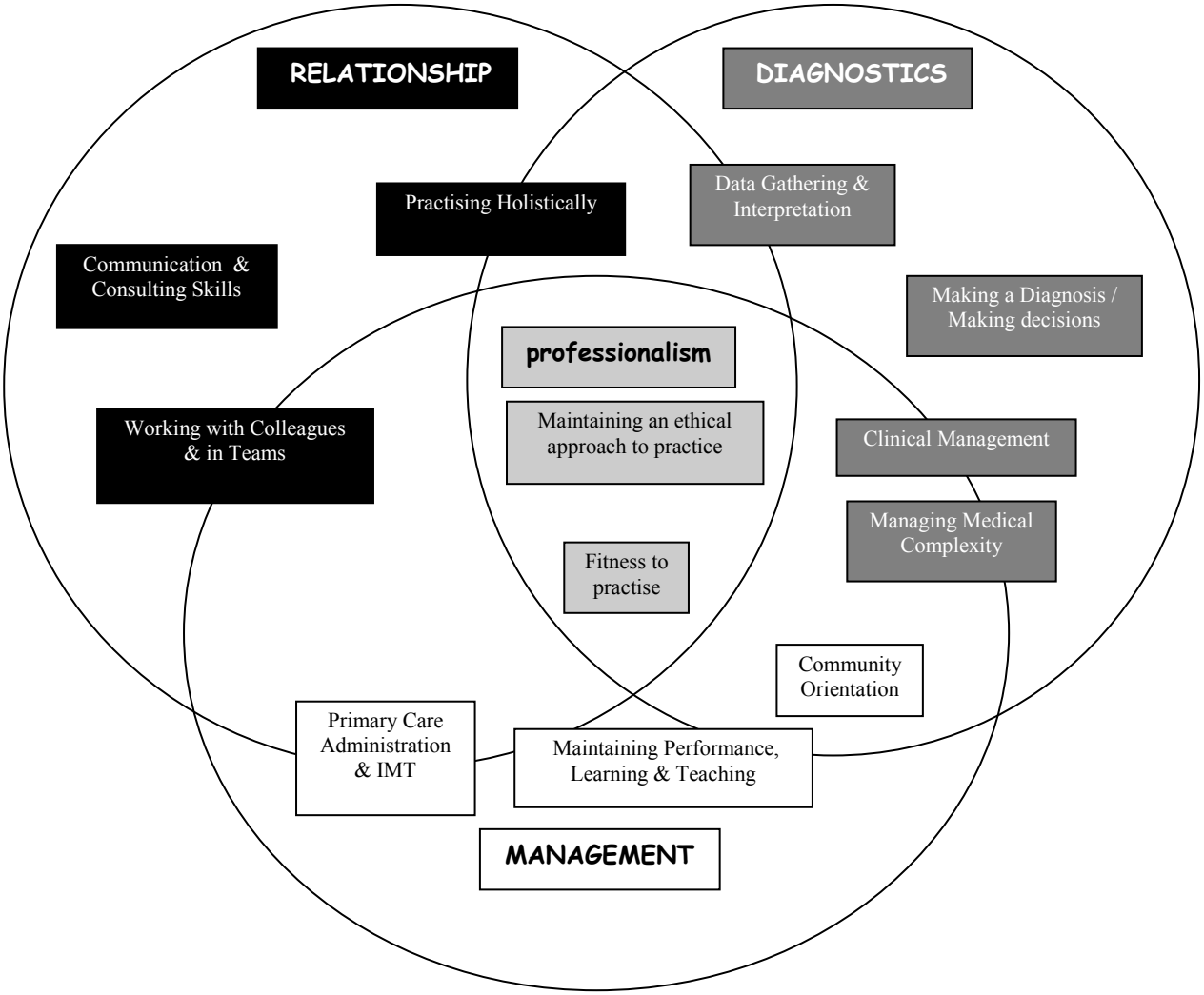
As we've seen, the MRCGP is designed to test the curriculum and it does so by using the competence framework. The language of the framework is extensive but in it, there are a large number of job-related competencies and a number of deeper features which in this book I have called our 'DNA'. The term should not be taken too literally as these features are ***not immutable*** but can be developed through training and education.

The job-related competencies and the deeper features can be clustered into a 'wood' which most GPs find easy to recognise. The reason that we have all the trees (the detail of the competency framework) rather than just the wood is that the trees give us the anchor points we need in order to help us learn and in order to gauge our performance.

So how do we see the wood? The method used in this book is to bring the 12 areas of the competency framework into 4 clusters. In recent years, Tim Norfolk has developed a clustering model of medical competence called RDMp which is applied to the competence framework as shown below in Figure 1.

- **Relationship**: the doctor's ability to understand and develop human relationships principally with patients, families, colleagues and teams.
- **Diagnostics**: the doctor's ability to problem-solve particularly within a clinical context.
- **Management**: the doctor's ability to manage issues ,events, relationships and him/herself over time.
- **Professionalism**: the attitude that the doctor has about the responsibilities of the job, expressed through the level of respect and commitment demonstrated for people, professional guidelines and duties.

Figure 1: RDMp



Seeing the deeper features

Amongst the text of the word pictures of the competency framework, lie hints of deeper features. We recognise that they are present, although they are not stated explicitly. These deeper features are important because:

- They bring items of performance together in a way that we can make sense of. This is similar to the RDMp clustering idea that we have just discussed. Both methods are ways of having an overview of performance that allows important links to emerge. This then allows further training/assessments to be appropriately and efficiently targeted.
- Deeper features have prognostic importance. If they are present, then doctors are more likely to train successfully. Just as importantly, trainees can adapt to changes in their jobs over the years. If the deeper features are *not* present, it may be very difficult to do this and doctors may become poorly-performing.
- Each of the deeper features manifests itself in a large number of different contexts. Therefore, each one that is mastered can help trainees to perform well in a large number of job-related areas.

Screening for performance

We've discussed how to see the wood from the trees, but how do we bring these ideas together in a practical way? On the following pages, there are four screening forms one for each of the four RDMp clusters. In each form there is a top section from the competence framework, a middle section of deeper features and a bottom section to summarise the interpretation. **These forms can be downloaded** from www.medpublishing.co.uk

Shaded areas *may not be fully evident until the final year of training* **Some areas can be linked to more than one root. Where this is often the case we have used the following to suggest this **R (link to Relationship) or **p (link to professionalism etc.**			Please grade the trainee in comparison with doctors at the **same** stage of training				Unable to grade	Concerns?
			Below expectations	Border line	Meets expectations	Above expectations		
Relationship	**Communication and consultation skills**	Explores patient's agenda and ideas, concerns & expectations						
		Recognises the impact of the problem on the patient's life						
		Works in partnership to negotiate a plan						
		Explores what the patient has understood from the consultation						
		****M** Flexibly and efficiently achieves consultation tasks						
	Practising holistically	Understands the patient's socio-economic/cultural background						
		Recognises the impact of the problem on family/carers						
	Working with colleagues and in teams	Works co-operatively with team members, using their skills appropriately						
		Communicates proactively with team members						

Deeper features are shown below. Ring any that apply

POSITIVE	NEGATIVE
• Shows interest • Encourages contribution	• Shows little interest in the patient's thoughts and feelings
• Uses open questions, adjusts questioning • Expresses ideas clearly.	• Uses too many closed questions • Unable to adapt language,. • Unclear when communicating
• Good non-verbal behaviour e.g. eye contact	• Lacks warmth in voice/manner
• Demonstrates team working & leadership skills	• Inappropriately works in isolation
• Gives constructive feedback & support	• Critical, confrontational, gives little support

Summary & interpretation:

Action:

Shaded areas may not be fully evident until the final year of training			Please grade the trainee in comparison with doctors at the **same** stage of training				Unable to grade	Concerns ?
			Below expectations	Border line	Meets expectations	Above expectations		
Diagnostics	**Data gathering and interpretation**	Takes a history, examines and investigates systematically & appropriately**M						
		Elicits important clinical signs & interprets information appropriately						
		Makes appropriate use of existing information about the patient's problem.						
	Making a diagnosis/ making decisions	Addresses problems that present early and in an undifferentiated way by integrating information in order to aid pattern recognition						
		Uses time as a diagnostic tool.						
		Decides what is probable and uses this to aid decision-making						
		Makes or excludes important diagnoses						
		Revises hypotheses in the light of additional information.						
		Thinks flexibly around problems, generating feasible solutions						
	Clinical management	Formulates appropriate management plans in line with best practice						
		Varies management options in response to changing circumstances.						
		Refers appropriately and co-ordinates care with other professionals						
		Provides continuity of care for the patient rather than just the problem						
	Managing medical complexity	Simultaneously manages acute and chronic problems						
		Tolerates uncertainty where appropriate						
		Addresses risk and safety-nets appropriately						
		Encourages health promotion						

Deeper features are shown below. Ring any that apply

POSITIVE	NEGATIVE
• Identifies key issues • Prioritises appropriately • Elicits necessary detail / routinely looks for red flags • Rarely loses sight of wider needs of situation • Aware of appropriate options	• Fails to explore important cues/overlooks important issues • Fails to recognise the seriousness of the situation • Shifts focus largely to immediate worries/needs • Suggests too narrow a range of options
• Shows sound/systematic judgment **M	• Random/disorganised **M
• Tries to think around an issue • Flexible and open to new ideas/possibilities	• Makes immediate assumptions • Rigid

Summary & interpretation:

Action:

Shaded areas *may not be fully evident until the final year of training*			Please grade the trainee in comparison with doctors at the **same** stage of training				Unable to grade	Concerns?
			Below expectations	Border line	Meets expectations	Above expectations		
Management	**Primary care administration and IMT**	Uses the primary care organisational and IMT systems routinely and appropriately						
		Uses the computer during the consultation whilst maintaining rapport with the patient.						
		Keeps good medical records						
	Community orientation	****D** Identifies important characteristics of the local community that might impact upon patient care						
		Encourages patients to appropriately use the community resources.						
		Uses resources cost-effectively						
	Maintaining performance, learning and teaching	Critically appraises guidelines and research evidence to inform decision-making.						
		Keeps up-to-date and shows commitment to addressing learning needs						
		Participates and learns from audit and significant event reviews						
		Completes learning cycles and routinely learns from reflection						
		Contributes to the education of students and colleagues						

Deeper features are shown below. Ring any that apply

POSITIVE	NEGATIVE
• Thinks ahead, plans effectively	• Fails to think ahead, plan and think about knock-on effects
• Co-ordinates activities	• Disorganised **p
• Remains calm under pressured conditions	• Unable to cope with challenging situations
• Delegates appropriately / seeks help when necessary	• Inappropriately tries to deal with situation alone
• Delivers on time	• Misses reasonable deadlines
• Regularly updates skills	• Doesn't have a system for keeping up to date

Summary & interpretation:

Action:

Shaded areas *may not be fully evident until the final year of training*			Please grade the trainee in comparison with doctors at the **same** stage of training				Unable to grade	Concerns?
			Below expectations	Border line	Meets expectations	Above expectations		
Professionalism	**Maintaining an ethical approach to practice**	Shows awareness of own values, attitudes and ethics and how these might influence professional behaviour.						
		Identifies and discusses ethical conflicts						
		Shows respect for others						
	Fitness to practise	Understands and maintains awareness of the GMC duties of a doctor						
		Responds to complaints appropriately						
		Takes appropriate responsibility for decisions and actions						
		Ensures work-life balance protects professional obligations & personal health						

Deeper features are shown below. Ring any that apply

POSITIVE	**NEGATIVE**
• Demonstrates adequate respect for others • Is non-judgemental & fair	• Lacks sufficient respect for others • Shows prejudice
• Positive/enthusiastic when dealing with problems	• Treats issues as problems rather than challenges
• Able to admit mistakes/learn from them	• Avoids taking responsibility for poor decisions/ideas
• Committed to equality of care for all	• Shows favouritism
• Backs own judgment appropriately	• Colludes with the patient's preferences when it is not in the patient's best interest to do so
• Respects importance of meeting all requirements of the organisation	• Puts insufficient effort into fulfilling certain obligations (e.g., meeting deadlines, producing documentation etc)

Summary & interpretation:

Action:

Using the performance screening forms

In the **top section**, working from left to right and using the *Relationship* form as an example, we see:

1. The cluster area (relationship)
2. The relevant performance areas from the competence framework (communication & consulting skills, practising holistically, working with colleagues and in teams)
3. The key word pictures for each of the performance areas

There is a rating scale that can be used by assessors or by trainees for self-assessment. The wording of the scale suggests that comparisons are made with doctors at the same stage of training. For doctors at the *end* of training, the standard will be the 'competent for licensing' standard described in the word pictures that you will find in the large arrows of this book. For doctors at an earlier stage of training, the expected standard will be either at the level described by 'needs further development' or between and this and the 'competent' level.

Some competencies are more advanced and therefore unlikely to be developed until late on in training and these are shaded *grey* on the form.

In the **middle section**, the deeper features are listed with positive ones on the left and negative ones on the right. Positive behaviours need to be seen repeatedly and in a variety of contexts if we are to be sure that they are truly embedded and not just a fluke. The negative behaviours should not be thought of as being 'one strike and your out' offences but if any of them are seen, they should not be ignored. If a negative behaviour occurs once, it should be noted. If it is seen again, it should be regarded as a red flag and should prompt us to be concerned and to explore this area of performance in more detail.

In the **bottom section**, the summary and interpretation can be written after which any action points can be noted. The *interpretation* may include any learning needs that have been identified. The *action* might include any further training or assessment that might be required.

How are these ideas brought together in this book?

Being joined up

General practice can't ever be defined but by describing certain behaviours in detail, important elements can be visualised and understood.. The jigsaw picture on the right appears regularly through the book to remind learners and assessors that the detail is there to help the connections and thereby the bigger picture to be seen. This section goes on to explain these connections.

The competence framework is the backbone

As we discussed earlier, to become a GP we have to learn to use our cognitive and emotional intelligence much better than we have done before. This requires us to develop our understanding and insight. In this book, the competence framework is the backbone that is used to develop this understanding. The competencies are the building blocks of performance and lots of methods are used in the book to help readers understand not just the competencies, but the *connections* between them that help novices to become GPs.

The competence framework is presented in clusters

Each of the 12 performance areas of the framework has its own chapter. The chapters are arranged in four sections based on RDMp and at the start of each of these sections, there is a short chapter that explains why and how the performance areas in that cluster belong together.

In each performance area, there are many word pictures that describe the competencies. *It is very important that you don't look upon the competencies as being separate and unrelated items of behaviour*. If you did, you might be tempted to think that becoming a GP was simply a matter of ticking off the list of competencies.

The competencies are interconnected

The competencies are integrated at a number of levels and fit together in ways which I will illustrate using an example from the 'Communication and consultation skills' area of the framework (chapter 3 page 27).

Firstly, the competencies are arranged in **themes** in the grey arrows, with each theme being numbered. Within each theme, the competencies are placed in a sequence from left to right that illustrates the same type of behaviour but at different levels of development. For example:

'Achieves the tasks of the consultation but uses a rigid approach' is a basic level skill.

The next step up is ' flexibly and efficiently achieves consultation tasks, responding to the consultation preferences of the patient'

As you can see the second is in the same ballpark but is developed from the first and is more advanced.

Secondly, the themes are collected in 12 separate performance **areas**. Each of these has more than one theme within it, but all the themes relate to the same area of performance. In the communication and consulting skills area, there are separate themes relating to understanding the patient's thoughts, negotiating a management plan and making explanations. So, attending to the competencies helps you to master the theme which in turn helps you to master the area of performance.

Thirdly, the **areas are clustered** under the headings of RDMp.

This clustering helps us to understand how the performance areas themselves are not separate from each other but are integrated within clusters and how mastery of one member of a cluster can help us to master the whole group. Likewise, if we have problems mastering one member, we may have problems with the other members of the cluster.

To use the example of communication and consultation skills, we can see from figure 1 that this domain sits with 'practising holistically' and 'working with colleagues and in teams'. These belong to the R or 'Relationship' cluster of RDMp. Thus if we have problems with communication skills in the consultation, there is a possibility that we may also have problems with working with colleagues and team members.

Alternatively, if our problem is only with patients, we might ask what it is that stops us from being able to communicate with patients as well as we do with say a colleague (or indeed vice versa!). This is because at root we are drawing on the same range of verbal and non-verbal skills when communicating with patients, colleagues or any other member of the team.

This may sound pretty obvious but let's take other examples. 'Practising holistically' requires us to explore the impact of the patient's problem on their life. Seeing its position within Relationship helps us appreciate the fact that holism is going to be difficult to practise if we don't have the skills to develop a relationship with a patient, take an active interest in them and use communication skills to explore the impact of the problem. In the other direction, digging deeper into the patient's problem, which is what holism requires, actually helps to develop our communication skills because by behaving holistically we learn to find ways of helping patients to talk about various facets of their problem and to disclose sensitive information.

Do you notice from figure 1 that Holism overlaps with the Diagnostics field? This is because the exploration/ assessment we make of the link between the patient's problem and their life clearly requires diagnostic skill in the same way as, say, exploring the patient's past history alongside their current presentation.

Interesting, isn't it? Can you think of examples of your own?

Performance can be quickly and repeatedly screened

Using the screening forms shown earlier in this chapter, performance can be repeatedly gauged throughout training both by assessors and by learners themselves. One approach is as follows:

1. The first step is to conduct a brief screen of performance using the screening forms. The screening forms represent the four RDMp clusters and it is worth screening all four areas rather than one at a time as the clusters are interrelated and affect each other as shown in figure 1.

2. The second step is to look for links between related areas. The material that has been brought together in each form can help you with this. To take an example from the screening form for Diagnostics, if a doctor routinely over-investigated, we might mark them down on the following competency:

   'Takes a history, examines and investigates systematically & appropriately'

   We might also expect such a doctor to have difficulty with the competency:

   'Tolerates uncertainty where appropriate'

   If there was a mismatch in performance between the two, this might prompt further discussion. For example, if the doctor was over-investigating and yet was thought to be tolerating uncertainty, we might ask whether we need to look more closely at the latter.

3. The third step is to look at the deeper features. How do these correlate with what has been shown from the competency rating? To take an example from the screening form for Professionalism, a doctor might be thought to have difficulties with the following competencies:

   'Is organised, efficient and takes appropriate responsibility'
   'Deals appropriately with stress'

   The deeper features that underlie this area of performance might suggest why this might be. For example:

   - Able to admit mistakes/learn from them
   - Backs own judgment appropriately
   - Recognises own limitations and can compromise
   - Able to seek help when necessary

   We can see from this how the screening forms can be used to investigate and diagnose a problem at a competency level and also at a deeper level of performance.

4. Because RDMp areas do not stand alone but overlap with each other, the next step might be to look at problems shown up in one cluster and check for problems in associated areas. For example, Relationship & Diagnostics overlap with each other, particularly in the area of data gathering & interpretation.

   If the doctor had problems with data-gathering we could look at the **Diagnostics** screening form where we might see that the doctor had problems with the following deeper features:

   Didn't do this: Elicits necessary detail
   Did this: Fails to explore important cues/overlooks important issues

   This might prompt us to look at the screening form for **Relationship**. By completing this form, concerns might arise over the deeper features because the doctor:

   Didn't do this: Non-judgemental, shows interest and understanding, encourages contribution
   Did this: Makes assumptions, authoritarian, lacks warmth in voice/manner

   This exercise would help us to see that the data-gathering problem was not really tied in with a lack of diagnostic expertise, but was more likely to be due to a *lack of interest* in encouraging sufficient information from the patient.

5. The deeper features are shown on the screening forms, but they are an abbreviated version of what was referred to earlier in this chapter as being our 'DNA'. The full version is shown in the first chapter of each RDMp section of the book. In these short chapters, the deeper features that are particularly relevant to that section are listed and explained. Deeper features often appear in more than one section but have more impact in some areas of performance than in others. This weighting is also illustrated in the chapters.

6. The final stage is to bring these pieces together in the summary box at the bottom of the screening form and make a plan of action. We can see from the above that it is vital to take care with the diagnosis of the

problem before launching on a solution. For example, the doctor who was having problems with data-gathering would find it much harder to improve if relationship skills were not identified as being the primary problem.

The screening forms also help us to plan how best to evaluate the improvement in performance that the trainee will be working towards when the action plan is implemented.

Awareness-raising techniques

In each chapter, there are numerous boxes that are designed to expand upon the text, make connections and thereby improve insight. These boxes are of various types that ask questions, give tips and make comments about learning and about assessment. A number of competencies are thought to be particularly important and these are annotated with a 'key' symbol as mastering these can help to unlock the meaning of the domain of which they are a part.

What are the stages of learning?

So far, we've looked at ways in which we can think about the curriculum and, by using the competencies, learn to develop behaviour in order to become GPs. However, where do we start? This final model, which is based upon the patient-centred clinical method, shows how we can make use of what we already know, making it the foundation of further development. Trainees do not come into GP training as complete novices. They usually already know how to consult with patients in secondary care and this is a vital anchor point for the rest of GP specialist training. We can illustrate this idea in the following diagrams (Figures 2 & 3). The headings come from the core statement of the curriculum.

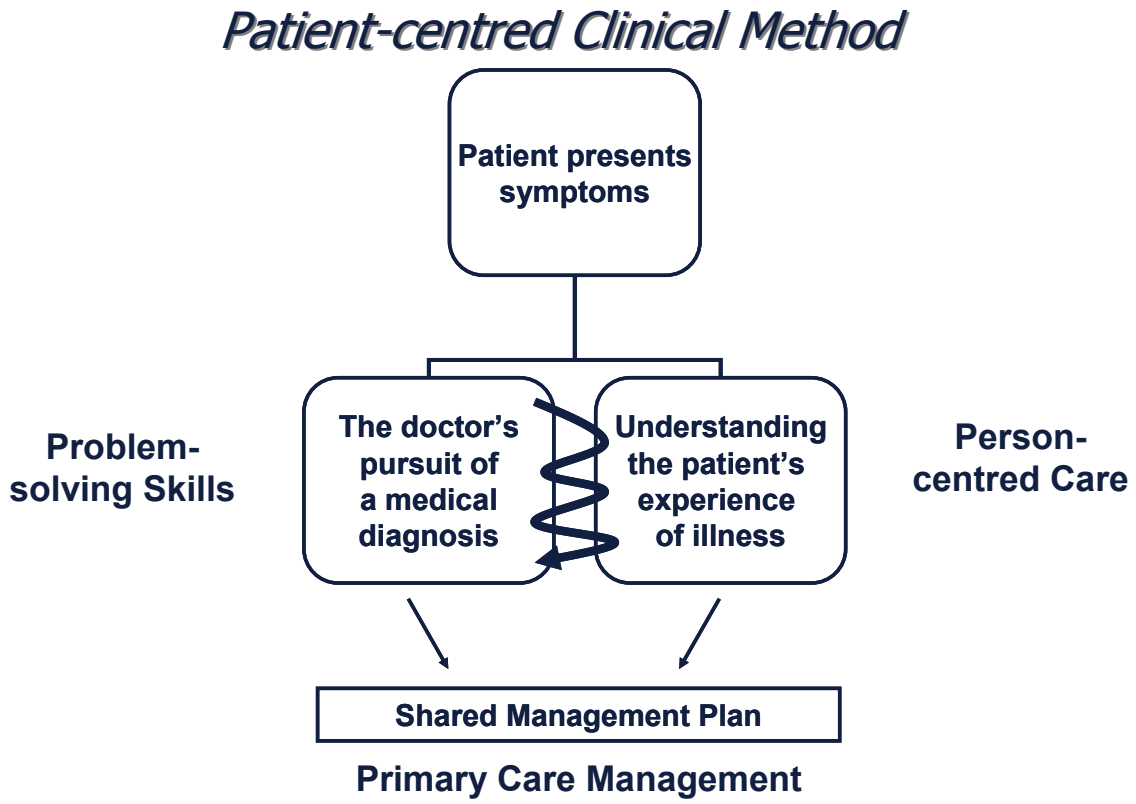


Figure 2

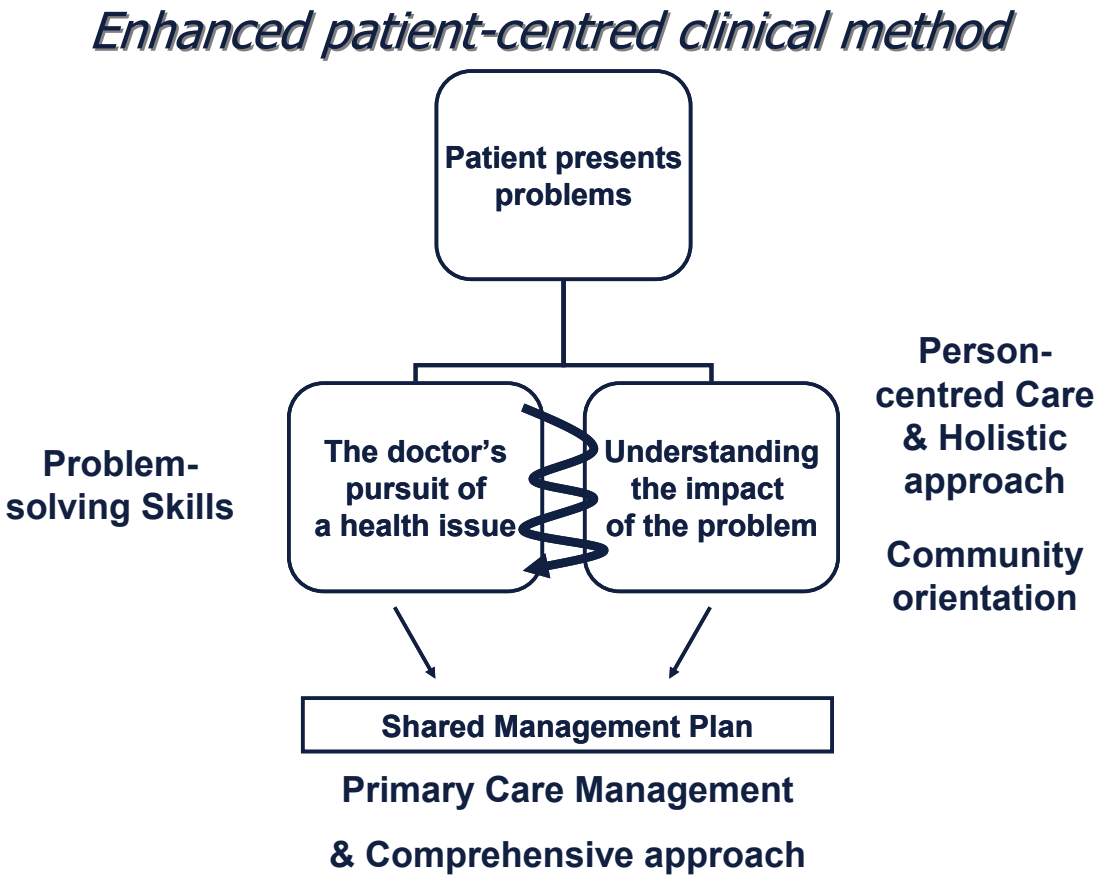
Figure 2 shows how the consultation begins with the patient presenting symptoms to the doctor. There then follows an attempt to understand the patient's experience of illness by exploring the patient's agenda, health beliefs & preferences. Whilst doing so, the doctor gathers information, clarifies the problem and begins to consider what management options might be appropriate. As shown by the serpentine arrow, this process

involves continual dialogue between doctor and patient. As a result, doctor and patient are in a position to develop a mutually acceptable management plan that is based on a sound understanding of the nature of the problem.

Usually when doctors come into GP training, they are familiar with this model although they need time to understand the different range of illnesses that are dealt with in the community and how common symptoms can be differentiated from the early stages of more serious illnesses.

Now look at Figure 3. This shows how, with experience in primary care, each of the three boxes in figure 2, which describes skills that all doctors need irrespective of specialty, become 'enhanced' by taking on a specific primary care dimension.

Figure 3



Firstly, patients do not present 'symptoms' alone, but *problems* that may or may not be the signs of disease although they may still have an impact on health. Because of this, the doctor no longer exclusively pursues a medical diagnosis, but attempts to clarify the problem and determine whether there is a health issue with which s/he can help. This problem-based approach rather than disease-based approach is a critically important feature of generalism.

Dialogue is still a central feature, but through this the doctor now searches to understand not only the patient's experience of illness but also the way in which the problem affects the patient's life and the lives of those with whom the patient is associated. What we are describing here is the 'holistic approach' to patient care.

Additionally, the doctor has an understanding of the community and is able to see how the problem might, for example, have implications for other patients in the practice and how it might be addressed by using community resources.

Through dialogue, doctor and patient can develop plans for straightforward common diseases and also for more difficult tasks such as dealing with simultaneous problems, co-morbidity and problems in evolution. The skills required to manage these challenging areas are described by the doctor's 'comprehensive approach'.

We can therefore see from this section that there is a predictable trajectory to learning that begins by practising the patient-centred clinical method with which foundation doctors are familiar and using this as a starting point, enhancing it by learning to add the primary care skills described above. Because adults learn incrementally by connecting new experiences and insights to anchor points from the past, we can see why it would be inappropriate and counter-productive to expect some of the enhanced skills described above to be present early on in GP training. This understanding can help us to tailor educational programs better and to have more realistic expectations of what can be achieved in performance terms at different stages of training.

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