

Curriculum for Specialty  
Training for General Practice

The Core Statement:

# Being a General Practitioner



Royal College of  
General Practitioners

# Being a General Practitioner

One in a series of curriculum statements produced by the Royal College of General Practitioners:

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## Foreword

The Postgraduate Medical Education and Training Board (PMETB) was established in 2005 to supervise postgraduate medical education and training across the UK. Its responsibility for validating all postgraduate training in the UK stimulated reviews of training in all medical specialties so as to ensure that training contributes to achieving the highest standards and quality of learning. The Royal College of General Practitioners (RCGP) was given unconditional approval of its curriculum by the PMETB in September 2006 – one of the first to achieve such recognition.

Under the direction of Professor Steve Field, Chair of the RCGP Education Network, the RCGP set up a working group to define the curriculum for specialty training for general practice. The group undertook a number of key tasks – reviewing the literature; conducting a national survey of those involved in training; reviewing existing curriculum models; consulting on models and methods; and developing curriculum statements.

The curriculum document marks a watershed in postgraduate training for general practice. It is the first national training curriculum for general practice and gives us a unique opportunity to reshape training for our discipline. Set within a framework for a structured educational programme, it is designed to address the wide-ranging knowledge, competences, clinical and professional attitudes considered appropriate for a doctor intending to undertake practice in the contemporary UK National Health Service. The framework draws on the WONCA Europe 2005 *European Definition of General Practice/Family Medicine* and the learning outcomes developed by EURACT in its Educational Agenda. It is mapped to *Good Medical Practice*, the General Medical Council's guidance on the duties of a doctor.

The curriculum is a challenging and complex document that will change and develop as medicine changes and develops. In view of this, it was never the intention that the whole document be published in a traditional printed format. Instead, it is available on the RCGP website ([www.rcgp.org.uk](http://www.rcgp.org.uk)). However, to mark the launch of the curriculum, it was decided that the core statement – *Being a General Practitioner* – should be published in printed format with the rest of the curriculum statements in accompanying CD-ROM format.

*Being a General Practitioner* is the core statement in the Royal College of General Practitioners' Training Curriculum. It describes the generic professional competences necessary for UK general practice and sets the context for all other statements. It is, quite simply, essential reading for anyone with an interest in general practice.

Dr Bill Reith | Chair

RCGP POSTGRADUATE TRAINING COMMITTEE

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## Acknowledgements

This curriculum statement is based on the *WONCA Europe 2005 European Definition of General Practice/Family Medicine*, authored by Professor Justin Allen, LNR Deanery Leicester, United Kingdom; Professor Bernard Gay, University of Bordeaux, France; Professor Harry Crebolder, Maastricht University, The Netherlands; Professor Jan Heyrman, Catholic University of Leuven, Belgium; Professor Igor Svab, University of Ljubljana, Slovenia; and Dr Paul Ram, Maastricht University, The Netherlands. It has also drawn on *The Educational Agenda of General Practice/Family Medicine* work on the competences currently being undertaken by EURACT Council, coordinated by Professor Jan Heyrman.

This statement was presented for discussion at many academic conferences and meetings across the UK, Europe and the world, notably at the RCGP's Council, Executive Committee and Education Network meetings, at many vocational training scheme and RCGP Faculty Board meetings, the Education Committee of the General Practitioners Committee of the British Medical Association, the RCGP spring meetings in 2003 and 2004, the Association of Course Organisers Conference 2004, 11th International Ottawa Conference on Medical Education in Barcelona 2004, the 33rd Annual Scientific Meeting for the Society for Academic Primary Care in Glasgow 2004, the WONCA World Scientific Meeting in Florida, USA 2004, the Association for Medical Education in Europe annual meetings in 2003 and 2004, and at many other specially convened meetings to discuss the new GP Training Curriculum across the UK; the RCGP would like to express its thanks to individuals and organisations involved in those meetings.

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## Introduction

**This is the core curriculum statement produced by the Royal College of General Practitioners (RCGP) that defines the learning outcomes for the discipline of general practice and describes the skills required to practise medicine as a general practitioner in the National Health Service (NHS) of the United Kingdom.**

### Rationale for this curriculum statement

This statement covers the core competences required to become a general practitioner (GP), and outlines the elements of the discipline. Specific clinical areas of application are dealt with elsewhere; this 'core' statement underpins them all.

Several documents in this area are already available. The publication *Good Medical Practice* (1998), produced by the General Medical Council (GMC), provides a framework against which doctors can judge their own performance and by which they can also be judged.<sup>1</sup> *Good Medical Practice for General Practitioners* (2002) was developed from this text by the RCGP and the General Practitioners Committee of the BMA, and designed specifically for GPs.<sup>2</sup> Each of the curriculum statements produced by the RCGP has been mapped to statements in this document to ensure that coverage of the professional expectations of the discipline is complete. An illustration of this cross-referencing is provided in Appendix 1.

The curriculum statement is based on the framework statement for the discipline of general practice developed by WONCA Europe, and formally launched during its meeting in London in 2002 and revised in 2005.<sup>3</sup> The WONCA framework was subsequently endorsed by the RCGP and the Joint Committee on Postgraduate Training for General Practice (JCPTGP) here in the UK. In developing its new curriculum a number of models were considered by the RCGP, including those put forward from the Oxford Region,<sup>4</sup> and the model developed by the Royal Australian College of General Practitioners.<sup>5</sup> The decision to use the WONCA Europe framework was taken because of its international applicability and acceptance by the national colleges and associations of family medicine in 30 countries in Europe. The United Kingdom is, like other European Union and EEA countries, subject to EU Directive 93/16,<sup>6</sup> which promotes free movement of doctors through mutual recognition of training. Directive 93/16 only defines the length and placement of training, however, and so it is clear that family doctors should receive training that enables them to practise across Europe.

The WONCA Europe Definition contains a description of *11 fundamental characteristics* of general practice, a role description of the specialist in family medicine and the competence framework derived from these (they appear in Appendix 2). The 11 characteristics of the discipline relate to 11 abilities that every specialist family doctor should master. They are not specific to any particular type of healthcare system, or to any pathological conditions.

Further work carried out by EURACT, the education network organisation of WONCA Europe, has further analysed the six categories of core competences and this has greatly assisted design of this curriculum.<sup>7</sup>

## UK health priorities

General practice is a key element of all healthcare systems in Europe and is recognised by health service providers as being of ever-increasing importance.<sup>8</sup> International evidence indicates that health systems based on effective primary care, with highly trained generalist physicians (family doctors) practising in the community, deliver care that is both more cost-effective and more clinically effective than in systems that place less emphasis on primary care.<sup>9</sup>

In the United Kingdom, general practice has been a fundamental element of healthcare provision since the inception of the National Health Service in 1948. Since 1948 patients have had the right to choose their GP and primary healthcare provider. This right to choose to register with a practice is a fundamental building block of the NHS. GPs in the UK carried out 261 million consultations in 2001, or 741,000 each day. On average, patients consult their GPs five times a year.

The importance of general practice has been further emphasised by some of the changes to the structure of the NHS, such as the development of the 'Primary Care-Led NHS', the development of GP fundholding, and more recently the emergence of primary care trusts (PCTs) and other primary care organisations (PCOs) as major commissioners of health care for local populations across the UK.

Society has altered over the last 30 years, and there has been an increasing role for the patient as a determining factor in health care and its provision. The opinion of the clinician is no longer regarded as sacrosanct and a new dialogue is emerging between healthcare consumers and providers. The expectations of patients, the interest of politicians and the media, the impact of new information systems such as the internet and the increasing cost and complexity of healthcare delivery all have resulted in a climate of continual change. The future GP has not only to be aware of this but also thrive in such an environment. Family doctors must continue to practise medicine as clinical generalists, applying the 11 fundamental characteristics, but they also need to be involved in the continuing development of their healthcare system. As individual professionals they must adapt and grow in order to meet these new challenges.

## The RCGP domains of competence and essential features

Using the six independent domains of core competences, and the three background features of the discipline described in the WONCA 2005 definition and the learning outcomes developed by EURACT, the RCGP further developed the domains of competence and background (now called essential features) in 2004. These provide the framework for the development of the curriculum for general practice both for the core competences of the family doctor, and also for specific content areas in general practice. These are summarised below:

### *The six domains of core competences*

1. Primary care management
2. Person-centred care
3. Specific problem-solving skills
4. A comprehensive approach
5. Community orientation
6. A holistic approach.

### *The essential features*

As a person-centred scientific discipline, the three essential features should be considered as fundamental. These are:

1. **Contextual** ○ using the context of the person, the family, the community and their culture
2. **Attitudinal** ○ based on the doctor's professional capabilities, values and ethics
3. **Scientific** ○ adopting a critical and research-based approach to practice, and maintaining this through continuing learning and quality improvement.

## Learning Outcomes

In order to demonstrate competence as a GP, the learner will need to acquire knowledge, skills and professional attitudes in a number of areas. The scope of these core competences is described below.

From the end of basic medical education to the completion of specialist training it is envisaged that learners will develop progressively in all these competence areas from a state of being a novice to that, in some cases, of becoming an expert.<sup>10</sup>

Successful completion of training will be judged to have occurred once a learner has been considered competent by the Postgraduate Medical Education and Training Board (PMETB), which sets the standards for all postgraduate medical training in the UK. Competence is technically defined as acquiring knowledge in order to develop expertise, knowledge that is increasingly 'coherent, principled, useful and goal-orientated'.<sup>11</sup>

In cases where duplication might occur (the referral process could be placed in paragraphs 1.3, 1.4 and 1.5, for example) the competence concerned has been described in only one place.

### THE RCGP DOMAINS OF COMPETENCE

#### Domain 1 – Primary care management

The work of the GP is primarily focused on populations with a low prevalence of serious disease, so it is crucial that the physician develops concepts of health, function and quality of life as well as models of disease. This finds expression, first, in the preventative and health promotion activities of physicians and in risk management. It is also expressed in decisions made in palliative and terminal care. Family doctors are also increasingly challenged by the need to be conscious of healthcare costs. An understanding of cost-efficiency is therefore a key learning issue for physicians in training.

In caring for patients, GPs work with an extended team of other professionals in primary care, both within their own practice and in the local community, and also with specialists in secondary care, using the diagnostic and treatment resources available in hospitals. Thus primary care education must promote learning that integrates different disciplines within the complex team of the NHS. 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.

#### *This competence is concerned with the ability*

##### **1.1 To manage primary contact with patients, dealing with unselected problems.**

This requires:

- Knowledge of the epidemiology of problems presenting in primary care
- Mastering an approach that allows easy access for patients with unselected problems
- An organisational approach to the management of chronic conditions

- Knowledge of conditions encountered in primary care and their treatment.

#### **1.2 To cover the full range of health conditions.**

This requires:

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

#### **1.3 To coordinate care with other professionals in primary care and with other specialists.**

This requires:

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

#### **1.4 To master effective and appropriate care provision and health service utilisation.**

This requires:

- Knowledge of the structure of the healthcare system and the function of primary care within the wider NHS
- Understanding the processes of referral into secondary care and other care pathways
- Skills in managing the interface between primary and secondary care including communication with other professionals.

#### **1.5 To make available to the patient the appropriate services within the healthcare system.**

This requires:

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

#### **1.6 To act as advocate for the patient.**

This requires:

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

## Domain 2 – Person-centred care

In his nine principles of family medicine, McWhinney quoted three as basic (core) elements: committing to the person rather than to a particular body of knowledge; seeking to understand the context of the illness; and attaching importance to the subjective aspects of medicine.<sup>12</sup> 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.<sup>13</sup> Sharing the management of problems with the patient and disagreement over how to use limited resources in a fair manner may raise ethical issues that 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. Continuity is a large, multidimensional issue that includes many different aspects, but it can be split up into three main types: personal continuity (seeing the same doctor); episodic continuity (ensuring that information is always available when taking over or referring); and the continuity provided by the discipline (which guarantees organised 24-hour care).<sup>14</sup> McWhinney stresses that the key word is responsibility, not personal availability at all times.<sup>12</sup>

### *This competence is concerned with the ability*

#### **2.1 To adopt a person-centred approach in dealing with patients and their problems, in the context of patient’s circumstances.**

This requires:

- The basic scientific knowledge and an understanding of the individual, together with his or her aims and expectations in life
- 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
- Mastering patient illness and disease concepts
- The skills and attitudes to apply these in practice.

#### **2.2 To use the general practice consultation to bring about an effective doctor–patient relationship, with respect for the patient’s autonomy.**

This requires:

- 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
- Communicating findings in a comprehensible way, helping patients to reflect on their own concepts and finding common ground for further decision-making
- Making decisions that respect the patient’s autonomy
- 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).

### 2.3 To communicate, to set priorities and to act in partnership.

This requires:

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

### 2.4 To provide long-term continuity of care as determined by the needs of the patient, referring to continuing and coordinated care management.

This requires:

- 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)
- The ability to help the patient understand and achieve an appropriate work–life balance\*
- Utilising disease registers and data-recording templates effectively for opportunistic and planned monitoring of long-term conditions to ensure continuity of care between different healthcare 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, many trainees find it hard to adjust to the differences in problem-solving between general practice and hospital work. These differences were described by Marinker in the following terms: GPs in solving problems have to tolerate uncertainty, explore probability and marginalise danger, whereas hospital specialists have to reduce uncertainty, explore possibility and marginalise error.<sup>15</sup> Although this model polarises these two situations, it provides some useful pointers, and each learner will need to work out how differences occur in specific clinical contexts.

There are certain models of general practice problem-solving that should be considered. The concept of the hypothetic–deductive model was described by Marinker in the RCGP text that underpinned early general practice training in the UK.<sup>16</sup> 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.<sup>17</sup> And there are a number of other consultation frameworks that may assist learners in understanding this topic (Pendleton *et al.*,<sup>18</sup> Stott and Davis,<sup>19</sup> Neighbour,<sup>20</sup> Cambridge–Calgary<sup>21</sup>).

Use of time as part of the diagnostic process, incremental investigation and coping with uncertainty are part of the skills of learning general practice. There is a growing body of literature on these topics to support teachers who want to encourage learners to reflect on these unique aspects of problem-solving.<sup>22</sup>

\*for those in employment

*This competence is concerned with the ability***3.1 To relate specific decision-making processes to the prevalence and incidence of illness in the community.**

This requires:

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

**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.**

This requires:

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

**3.3 To adopt appropriate working principles (e.g. incremental investigation, using time as a tool) and to tolerate uncertainty.**

This requires:

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

**3.4 To intervene urgently when necessary.**

This requires:

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

**3.5 To manage conditions that may present early and in an undifferentiated way.**

This requires:

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

### 3.6 To make effective and efficient use of diagnostic and therapeutic interventions.

This requires:

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

## Domain 4 – A comprehensive approach

GPs 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 wellbeing. Reducing risk factors by promoting self-care and empowering patients is an important task of the GP. The family doctor should aim to minimise the impact of a patient's symptoms on his or her wellbeing by taking into account the patient's personality, family, daily life, economic circumstances and physical and social surroundings.

Coordination of care also means that the GP is skilled not only in managing disease and prevention, but also in caring for the patient, providing rehabilitation and providing palliative care in the end phases of a patient's life. The physician must be able to coordinate patient care provided by other healthcare professionals and care provided by other agencies.

*This competence is concerned with the ability*

#### 4.1 To manage simultaneously multiple complaints and pathologies, both acute and chronic health problems.

This requires:

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

#### 4.2 To promote health and wellbeing by applying health promotion and disease prevention strategies appropriately.

This requires:

- The ability to understand the concept of health
- The ability to promote health on an individual basis as part of the consultation
- The ability to promote health through a health promotion or disease prevention programme within the primary care setting

- Understanding the role of the GP in health promotion activities in the community
- Understanding and recognising the importance of ethical tensions between the needs of the individual and the community, and acting appropriately.

#### **4.3 To manage and coordinate health promotion, prevention, cure, care, rehabilitation and palliation.**

This requires:

- An understanding of the complex nature of health problems in general practice
- An understanding of the variety of possible approaches
- The ability to use different approaches for an individual patient and to modify these according to an individual's needs
- The ability to coordinate teamwork in primary care.

### **Domain 5 – Community orientation**

GPs 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 and therefore they must understand the potentials and limitations of the community in which they work and its character in terms of socio-economic and health features. The GP 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 being rationed, and doctors are being involved in the rationing decisions; they have an ethical and moral duty to influence health policy in the community.

*This competence is concerned with the ability*

#### **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.**

This requires:

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

- community in which they live
- An understanding of GPs' role in the commissioning of health care.

## Domain 6 – A 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. The definition of *holism* widely accepted for medical care, and which will be used in this document, is taken from the work of Kemper: it involves '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'.<sup>23</sup> Or, as Pietroni puts it, 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'.<sup>24</sup>

Holism and patient-centredness are core values of general practice. Holism, described by Howie *et al.*<sup>25</sup> 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.<sup>26,27</sup> There is good evidence that this is promoted by longer consultations<sup>28,29,30</sup> and by greater continuity of care.<sup>31,32,33</sup> Howie and colleagues in Scotland built on that evidence to develop their 'consultation quality index' (CQI) for use in general practice, which 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.<sup>34,35</sup>

Holistic care can only be interpreted in relation to an individual's perception of holism, so if we accept that holism will always be individualistic, then even therapies or interventions offered to the patient will have different meanings to different people. This is the reason why it relates so closely to general practice and family medicine. The holistic view acknowledges objective scientific explanations of physiology, but also admits that people have inner experiences that are subjective, mystical (and, for some, religious), which may affect their health and health beliefs.<sup>36</sup>

The recognition that illnesses have both mental and physical components, and that there is a dynamic relationship between them, has led to criticisms of the purely biomedical model and to the development of the bio-psycho-social model of modern medicine.<sup>37</sup> This model was spelt out most clearly by Engel, who argued that for psychiatry to generate a fully scientific and inclusive account of mental disorder it was necessary to understand the illness (not the disease) as a process, giving equal importance to biological, psychological and social determinants for pathogenesis, diagnosis and therapy – in other words the holistic approach.<sup>38,39</sup>

It is also important to stress that a basic understanding of our own limitations as doctors is crucial. Bearing in mind the fundamental autonomy of the patient, there is a limited opportunity for the GP to intervene, and there is always a limit to the degree of influence that can be handled by one person in a therapeutic environment.

### *This competence is concerned with the ability*

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

This requires:

- Knowledge of the holistic concept and its implications for the patient's care
- The ability to understand a patient as a bio-psycho-social 'whole'
- The skills to transform holistic understanding into practical measures
- Knowledge of the cultural background and beliefs of the patient, in so far as they are relevant to health care
- Tolerance and understanding of 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: *context*, *attitude* and *science*.<sup>29,30,31,32,33</sup> They are concerned with features of doctors and determine their ability to apply the core competences in real life in the work setting. In general practice these may have a greater impact because of the close relationship between the family doctor and the people with whom they work but they relate to all doctors and are not specific to general practice.

### 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.

1. Having an understanding of the impact of the local community (including socio-economic and workplace factors, geography and culture) on 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 he or she provides.

### Essential Feature 2 – Attitudinal aspects

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

1. Being aware of their 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.
5. Being aware of the interaction of work and doctor's own 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.

1. Being familiar with the general principles, methods and concepts of scientific research and the fundamentals of statistics (incidence, prevalence, predicted value, etc.).
2. 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 health care.
3. Assessing medical literature, reading and assessing it critically and putting the lessons from the literature into practice.
4. Developing and maintaining continuing learning and quality improvement.

## Further Reading

### Examples of relevant texts and references

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# Appendix 1

## Mapping of curriculum to *Good Medical Practice*

Good Medical Practice	Corresponding paragraphs in this core curriculum statement
<p><b>Good Clinical Care</b></p> <p>1 Clinical care</p>	<p><b>Domain 1: Primary care management</b></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 coordinate 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> <hr/> <p><b>Domain 2: Person-centred care</b></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, with respect for the patient's autonomy.</p> <p>2.3 To communicate, to set priorities and to act in partnership.</p> <hr/> <p><b>Domain 3: Specific problem-solving skills</b></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 that may present early and in an undifferentiated way.</p> <hr/> <p><b>Domain 4: A comprehensive approach</b></p> <p>4.1 To manage simultaneously multiple complaints and pathologies, both acute and chronic health problems.</p> <p>4.2 To promote health and wellbeing by applying health promotion and disease prevention strategies appropriately.</p>

Good Medical Practice	Corresponding paragraphs in this core curriculum statement
	<p><b>Domain 5: Community orientation</b></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> <hr/> <p><b>Domain 6: A holistic approach</b></p> <p>6.1 To use bio-psycho-social models, taking into account cultural and existential dimensions.</p>
<p><b>Good Clinical Care</b></p> <p>2 Keeping records, writing reports and keeping your colleagues informed</p>	<p><b>Domain 1: Primary care management</b></p> <p>1.3 To coordinate care with other professionals in primary care and with other specialists.</p> <hr/> <p><b>Domain 2: Person-centred care</b></p> <p>2.3 To communicate, to set priorities and to act in partnership.</p>
<p><b>Good Clinical Care</b></p> <p>3 Access, availability and providing care out of hours</p>	<p><b>Domain 2: Person-centred care</b></p> <p>2.4 To provide long-term continuity of care as determined by the needs of the patient, referring to continuing and coordinated care management.</p>
<p><b>Good Clinical Care</b></p> <p>4 Treatment in emergencies</p>	<p><b>Domain 3: Specific problem-solving skills</b></p> <p>3.4 To intervene urgently when necessary.</p>
<p><b>Good Clinical Care</b></p> <p>5 Making effective use of resources</p>	<p><b>Domain 3: Specific problem-solving skills</b></p> <p>3.3 To adopt appropriate working principles (e.g. incremental investigation, using time as a tool) and to tolerate uncertainty.</p> <p>3.6 To make effective and efficient use of diagnostic and therapeutic interventions.</p> <hr/> <p><b>Domain 4: A comprehensive approach</b></p> <p>4.3 To manage and coordinate health promotion, prevention, cure, care, rehabilitation and palliation.</p> <hr/> <p><b>Domain 5: Community orientation</b></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><b>Maintaining Good Medical Practice</b></p> <p>6 Keeping up to date and maintaining your performance</p>	<p><b>Essential feature 3: Scientific aspects</b></p> <p>4 Being able to develop and maintain continuing learning and quality improvement.</p>

Good Medical Practice	Corresponding paragraphs in this core curriculum statement
<b>Relationships with Patients</b> 7 Providing information about your services	<b>Domain 2: Person-centred care</b> 2.3 To communicate, to set priorities and to act in partnership.
<b>Relationships with Patients</b> 8 Maintaining trust	<b>Domain 2: Person-centred care</b> 2.1 To adopt a person-centred approach in dealing with patients and their problems, in the context of patient's circumstances. 2.2 To use the general practice consultation to bring about an effective doctor–patient relationship, with respect for the patient's autonomy. 2.3 To communicate, to set priorities and to act in partnership. <hr/> <b>Essential feature 2: Attitudinal aspects</b> 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.
<b>Relationships with Patients</b> 9 Avoiding discrimination and prejudice against patients	<b>Domain 6: A holistic approach</b> 6.1 To use bio-psycho-social models, taking into account cultural and existential dimensions.
<b>Relationships with Patients</b> 10 If things go wrong	<b>Essential feature 1: Contextual aspects</b> 1 Having an understanding of the impact of the local community (including socio-economic and workplace factors, geography and culture) on 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 he or she provides.
	<hr/> <b>Essential feature 2: Attitudinal aspects</b> 1 Being aware of their 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.

Good Medical Practice	Corresponding paragraphs in this core curriculum statement
<b>Working with Colleagues</b> 11 Working with colleagues and working in teams	<b>Domain 1: Primary care management</b> 1.3 To coordinate care with other professionals in primary care and with other specialists. 1.5 To make available to the patient the appropriate services within the healthcare system. <hr/> <b>Domain 4: A comprehensive approach</b> 4.3 To manage and coordinate health promotion, prevention, cure, care, rehabilitation and palliation.
<b>Working with Colleagues</b> 12 Referring patients	<b>Domain 1: Primary care management</b> 1.3 To coordinate care with other professionals in primary care and with other specialists. 1.5 To make available to the patient the appropriate services within the healthcare system.
<b>Working with Colleagues</b> 13 Accepting posts	<b>Essential feature 2: Attitudinal aspects</b> 1 Being aware of their own capabilities and values. 4 Justifying and clarifying personal ethics.
<b>Teaching and Training, Appraising and Assessing</b> 14 Teaching and training, appraising and assessing	Not explicitly covered in this statement but covered in other RCGP curriculum statements
<b>Probity</b> 15 Research 16 Financial and commercial dealings 17 Providing references	<b>Essential feature 2: Attitudinal aspects</b> 1 Being aware of their own capabilities and values. 2 Identifying ethical aspects of clinical practice (prevention, diagnostics, therapy, factors that influence lifestyles). 3 Justifying and clarifying personal ethics.
<b>Health and the Performance of Other Doctors</b> 18 Protecting patients when your own health or the health, conduct or performance of other doctors puts patients at risk	<b>Essential feature 2: Attitudinal aspects</b> 1 Being aware of their 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

### Characterising the discipline of general practice/family medicine

General practice/family medicine is an academic and scientific discipline, with its own educational content, research, evidence base and clinical activity, and a clinical specialty orientated to primary care.

These 11 characteristics of the discipline relate to 11 abilities that every family doctor should master and should be the basis for developing the curriculum for training in general practice.<sup>3</sup>

#### *General practice*

1. Is normally the point of first medical contact within the healthcare system,\* providing open and unlimited access to its users, dealing with all health problems regardless of the age, sex or any other characteristic of the person concerned
2. Makes efficient use of healthcare resources through coordinating care, working with other professionals in the primary care setting and by managing the interface with other specialties. It also means taking on an advocacy role for the patient when needed
3. Develops a person-centred approach, orientated to individuals, their family and their community
4. Has a unique consultation process, which establishes a relationship over time, through effective communication between doctor and patient
5. Is responsible for the provision of longitudinal continuity of care as determined by the needs of the patient
6. Has a specific decision-making process determined by the prevalence and incidence of illness in the community
7. Manages simultaneously both the acute and chronic health problems of individual patients
8. Manages illness that presents in an undifferentiated way at an early stage in its development, some of which may require urgent intervention
9. Promotes health and wellbeing both by appropriate and effective intervention
10. Has a specific responsibility for the health of the community
11. Deals with health problems in their physical, psychological, social, cultural and existential dimensions.

#### The specialty of general practice/family medicine

GPs/family doctors are specialist physicians trained in the principles of the discipline. They are personal doctors, primarily responsible for the provision of comprehensive and continuing care to every individual seeking medical care irrespective of age, sex and illness.

\*under the self-care strategy, general practice may not be the first point of contact with the healthcare system

They care for individuals in the context of their family, their community and their culture, always respecting the autonomy of their patients. They recognise they will also have a professional responsibility to their community. In negotiating management plans with their patients they integrate physical, psychological, social, cultural and existential factors, utilising the knowledge and trust engendered by repeated contacts.

GPs/family physicians exercise their professional role by promoting health, preventing disease and providing cure, care or palliation. This is done either directly or through the services of others according to health needs and the resources available within the community they serve, assisting patients where necessary in accessing these services. They must take the responsibility for developing and maintaining their skills, personal balance and values as a basis for effective and safe patient care.

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