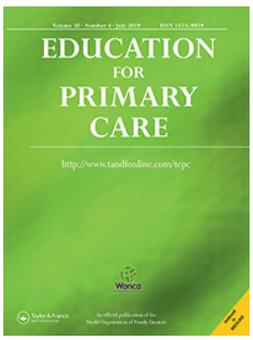

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LEADING ARTICLE

A pedagogy of the particular – towards training capable GPs

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ABSTRACT

The General Medical Council (GMC) has called upon the Royal Postgraduate Medical Colleges to redesign their curricula using principles of capability. This offers an opportunity to better align the General Practice training curriculum with the role of the general practitioner, and we argue that approaches have already been developed that may be adapted to support the teaching and assessment of capability. We set out our understanding of how capability differs from competency, in particular how the former emphasises the ongoing creation of everyday knowledge within clinical practice. We offer an expanded version of capability comprising a prospective disposition towards noticing and responding to novelty. We offer some suggestions around how capability can be developed: through heightened sensitivity to context, development of divergent thinking and assessment of zones of professional practice. We emphasise the role of the supervisor in helping to support these dispositions through an appreciative, and collaborative, approach that acknowledges the full range of reasonable decisions applicable to each particular context.

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Competency-based training; capability; assessment; entrustable professional activities

Introduction

The General Medical Council (GMC) has called upon the Royal Postgraduate Medical Colleges, including the Royal College of General Practitioners (RCGP), to redesign their curricula using the principles of capability [1]. The move towards capability-influenced curricula has received acknowledgement amongst educational practitioners. Our day-to-day experience suggests a need for clarification about how capability is taught and assessed, and what this means for curriculum planners, trainees and trainers.

In this article, we propose that curricula based on capability are well suited to guiding the training of postgraduate doctors in general practice (GP). Furthermore, if the implications of capability are appreciated beyond 'competency-plus' this creates an opportunity realign the training curriculum with the complex realities of everyday practice, where uncertainty represents the rule rather than the exception. Central to this argument is our view that the hallmark of capable practice is the complementary use of guideline and algorithm on the one hand, with the creation of new knowledge in response to novel or particular circumstances on the other [2].

Our classroom experience suggests that, with a little priming, both novice and experienced educators can teach and assess capability in their workplaces. We review aspects of competency-based medical education (CBME) as it is currently implemented and offer some preliminary perspectives for GP trainers to adapt their educational activities towards a training that prioritises the development of an expanded version of capability, which we term a 'Pedagogy of the Particular'. These include heightened sensitivity to context; the development of divergent thinking; assessment based on appreciation [3] which acknowledges a range of reasonable answers; and a shift from structuring curricula around competencies towards interrogating zones of practice or 'entrustable professional activities' (EPAs) [4].

Alignment between curriculum and role

Competency-based medical education, whilst not a new idea, has dominated professional training particularly since its introduction in the UK with Modernising Medical Careers (MMC) in 2005 [5]. Its significant contribution has been to require evidence, derived from workplace contexts, to underpin judgement about professional progression, so providing regulators and the public with assurance that clinicians are equipped to undertake their professional duties to a defined level. Overall

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competence is assumed when trainees can demonstrate achievement of described competencies deemed to be relevant to clinical practice.

Whilst competencies are sampled from everyday clinical practice, they are not the same as the role from which they are derived. No matter how many competencies may be sampled, they cannot ever fully represent the scope of practice of the modern General Practitioner (GP) [5–7] whose role is longitudinal (as part of a team); unpredictable and unstable; performed at speed in stressful settings; under variable conditions of mental and physical well-being.

Educators and trainees respond to this mismatch between the competencies and the role in a variety of ways: by treating the attainment of competencies as an end in itself, assuming that capability will follow; by 'strategic compliance' [8] whereby the boxes get ticked but assessment is seen as distinct from the process of becoming a GP, risking duplication of purposes and tasks as well as cynicism; or by 'creative subversion' [9] whereby the tools we are given for one purpose (e.g. competency) are adapted to support another (e.g. capability).

We argue that capability offers an opportunity to continue to support progression decisions based on evidence from workplace settings whilst better aligning curriculum with the professional role.

This may be realised through building a curriculum around entrustable professional activities (EPAs) or 'the units of professional practice that make-up what professionals do in their daily work' [4]. These may be thought of as a manageable number of zones of practice that comprise the everyday job of a GP and might include: seeing undifferentiated patients in a surgery; being duty-doctor; doing repeat prescriptions; dealing with results; working out of hours; participating in an MDT; dealing with clinical correspondence; and running a long-term conditions clinic.

Capability as knowledge creation

CBME and its tools of teaching and assessment are relentlessly retrospective and assume that knowledge, once acquired, can be faithfully reproduced henceforth. Clinicians are encouraged to value and learn from the similarity or continuity between different cases over time; and to defer to formal clinical guidance and precedent.

Whilst capability can be thought of as an ability to fulfil a professional role, it has also been defined as: '*the extent to which individuals can adapt to change, generate new knowledge, and continue to improve their performance*' [10]. Hence, capability is a future-orientated concept that requires clinicians 'will do' rather than just 'know', 'know how', 'show' or 'do' [11]. Capability requires that trainees can perform their intended role, able to function in an unknown yet imminent future; develop the judicious ability to see differences or 'discontinuity' [12]; and value possibilities (yet to be created) as well as precedent [13]. A pedagogy to support capability therefore demands an ability to see novelty as well as familiarity and create new knowledge in response to that novelty.

Tuning into and responding to novelty

The ability to see and respond to novel professional situations as they unfold has been described most notably in Schön's reflection-in-action [14], though there is little in the medical literature on how this ability can be nurtured. Reflection-on-action [14], has an important role in showing learning, and justifying decisions retrospectively, but says little about how decisions form in practice [15].

Conscious reasoning and deliberative learning are only partially fit for purpose, and are not well suited to guide decision-making in complex and rapidly unfolding situations due to limitations in working memory and response times of the conscious mind [16]. As such, clinicians need a tacit disposition towards recognising novelty, to see patterns and deviations from these patterns; and to develop their intuitive skills, by learning to trust their judgement as they form [15].

Such enduring dispositions are strengthened by habitual use [17] and by having opportunities to rehearse [16] and to articulate associated feelings and discomforts [18]. These opportunities in turn rely on them being prioritised and valued relative to other abilities [16]. In order to embed them in the identity formation of young GPs and to encourage trainers to model and teach these traits requires that they are encouraged as part of the formal as well as informal curriculum. It is not enough that managing uncertainty appears as a sub-section of the 'managing medical complexity' competency, nor will it suffice to replace the language of 'competence' with that of 'capability'. Instead, the GP curriculum should explicitly incorporate the disposition towards noticing novelty, identifying knowledge and practice needs arising from novelty, and creating new knowledge individually and collaboratively, both prospectively and retrospectively.

The work of the trainer and trainee includes becoming expert in understanding context. Whether in sharing live performance via consultation analysis, telling stories or discussing cases, a role of the GP educator is to shine a light on context [13], highlighting the particular features of cases, including the instability of these features, and exploring how this may turn the seemingly familiar into something novel. Ahluwalia and Launer [19,20] have previously suggested that trainers take the role of

observer-participants and conversational partners rather than experts providing facts and solutions. They offer several approaches for exploring context including using their own uncertainties and ways of thinking; modelling tolerance to uncertainty and using their 'rules of thumb'; whilst acknowledging that all knowledge is contingent, situational, and contestable.

The creation of new knowledge within the setting of the doctor–patient interaction is a creative and imaginative act that depends upon the ability to think divergently [21], thus broadening the range of 'constructing resources' at the clinician's disposal [13]. Rather than accepting the idea of a single best answer, or worse still requiring conformity with the supervisor's preferred plan, as a proxy for the 'right answer', we advocate that supervisors encourage trainees to habitually generate multiple options and evaluate their applicably to the situation under consideration; having many ideas and selecting the best idea for the situation [22]. In this way, supervision becomes a joint evaluation of a range of reasonable options, and a heightened appreciation of the reasonable-unreasonable boundary [13] rather than an analysis of deficit.

The novelty paradox

Given that uncertainty, complexity and novelty are ubiquitous in general practice, it seems surprising to us that it features so infrequently in the trainee portfolios that we see. Trainees often describe applying NICE guidance, but rarely describe how to adapt or dispense with formal guidance, in response to a particular nuance or patient context, nor how they utilise or collaborate with colleagues and community resources to generate new ideas. This omission may be partly due to the challenge of showcasing a prospective concept (capability development) within a competency framework designed to look backwards. Another reason is that the process of selecting individual patient cases for a portfolio of competencies, steers trainees away from showcasing this facet of their work; far safer to show compliance with a guideline than deviation from it.

Whilst EPAs were originally intended to support CBME in assessing 'competence in context' [5], they can be applied to systematically evaluate what happens within zones of practice, thus revealing novelty more robustly than does the approach of sampling practice to unearth competencies. It is worth noting that entrustability (the ability to trust a colleague) is inherently orientated to future behaviours and requires that trainees show reliability (the ability to perform in multiple challenging contexts) and humility (the ability to identify support and knowledge when at the limits of current ability) [4].

To enrich these assessments, ten Cate and Hoff [23] have proposed 'entrustment based discussions' which explore professional actions and contextual thinking. To see how this might work, imagine assessing a trainee for capability in fulfilling the duty-doctor role: To assess competency the trainee would select individual cases for discussion and the trainer would assess management. In assessing capability, however, there would be an incentive to select complex cases and these would be subjected to an enquiry into all reasonable options considered and the rationale for choosing the preferred option. The discussion will move from particular patients to an entire duty-doctor session. Pressures such as time or hostile/anxious patients, could be considered and the trainee would reflect on how these affected the options considered reasonable. The supervisor would draw attention to differences in management of similar cases and explore the reasons for these; and would play with context to ask how the trainee might respond if things were different. This reveals a complex landscape of multiple decision points throughout the session, incorporating novelty and improvisation. Safety netting could be considered including the impact on the trainee overnight, supplemented by purposeful follow up of patient outcomes (admission, re-attendance, etc.). This tests the emotional aspects of managing uncertainty, and the impact of following or overruling guidance. A capable trainee would consistently identify and evaluate a range of reasonable options in the face of divergent scenarios and settings; identify key contextual variables; and recognise the conditional nature of each decision.

A curriculum based on a set of EPAs, like all workplace assessment, relies upon the supervisor making subjective, but expert judgement [24] of capability based on entrustment. In expanding the capability curriculum to incorporate our proposed dispositions we envisage a different, less transactional, type of subjectivity; comprising an appreciative engagement with the trainee's novel dilemma and response, arousing the curiosity and dissonance of the supervisor who starts then to ask questions of the trainee, the case, the context and themselves personally. The trainee's dispositions could therefore be said to be forming at the point the supervisor becomes aware of their observer-participant role [19] and that through their collaboration they are both learning.

Conclusions

General practice needs a capable and self-confident workforce, able to critically implement evidence-based interventions, but also to exercise contextual judgement and

creativity in practice. We propose a curriculum based on an expanded definition of capability, incorporating the recognition and creative response to novelty, organised around EPAs and a mutually enhancing collaborative assessment, guided by the trainer's expert subjectivity.

Disclosure statement

No potential conflict of interest was reported by the authors.

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