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Title page

General practice is “different”: qualitative study of adaptation experiences of East Staffordshire general practice specialty trainees

D.P. Perera (https://orcid.org/0000-0002-5600-206X, @dinushapperera)[1,2], K. Mohanna[1] (https://orcid.org/0000-0003-0558-2196, @kay_mohanna)

1.University of Worcester, UK

2.University of Kelaniya, Sri Lanka

General practice is "different": qualitative study of adaptation experiences of East Staffordshire general practice specialty trainees

Abstract

Background: Undergraduate medical education and foundation training are still largely hospital based. General practice trainees, also spend nearly half of their specialty training in hospitals. *Aims*: To explore adaptation experiences of general practice specialty trainees throughout training. *Method:* Semi-structured participant observer interviews with 18 purposively selected trainees on the East Staffordshire vocational training scheme, observation, stakeholder discussions and concurrent inductive thematic analysis. *Results:* Undergraduate and early general practice experience during specialty training, general practice trainer role modelling and mastering core general practice skills, facilitated transition. An inclusive and supportive general practice environment, facilitating engagement with a community of practice involving peers, general practice trainers and vocational training programme fostered belongingness. A reduced sense of belongingness during hospital rotations impacted on training and work. Building bridging social connections, personal agency initiatives to bring general practice relevance into hospital training, sign posting to general practice relevant duties and mastery of secondary care relevant competencies helped gain belongingness in hospital. While some international graduates required assistance in specific areas; overall, general practice trainees had optimistic views of their future. Conclusion: The main contribution of this study was to relate the adaptation experiences of trainees to learning and practice based on Wenger's communities of practice to enable a better understanding of how they can be influenced to enhance training.

Keywords: General Practice Training, Transition, Belongingness, Community of Practice

Background

A large proportion of undergraduate [1], as well as postgraduate foundation training still occurs in secondary care despite an increasing emphasis on primary care based training. Plans are underway to increase general practice specialty trainee time spent in general practice under the new GP contract [2]. There is a significant paradigm shift in adapting hospital dominated training to general practice (GP); which is an academic and scientific discipline, with its own educational content, research, evidence base and clinical activity [3–5]. The different stages of transition from medical student to independent medical practitioner have been extensively investigated [6–11] and a few studies explore general practice specialty trainee (GPST) experiences of transition into general practice training [12–18].

Having invested in the discipline of general practice; GPSTs spend nearly half of their training in hospital-based settings where GPST learning needs are sometimes viewed as of secondary importance to core medical training [19–22]. Little is known about how trainees adapt and move forward with their training in this context.

Wenger defines communities of practice as groups of people who share a concern or passion for something they do and learn how to do it better as they interact regularly.[23]. In our study GPSTs, GP trainers, senior GP colleagues and peers formed a community of practitioners sharing the domain of GP. Wengers social theory of learning - communities of practice helps understand how learning is linked to meaning making, negotiating identity as a participant in the community of practice (CoP), gaining competence in the practices relevant to the CoP and developing belongingness within the community [24].

This paper focuses on GPST experiences of adaptation to general practice and is part of a wider study looking at different aspects of GP specialty training [25]. We posed the research question 'what are the expressed adaptation experiences of general practice specialty trainees throughout training?'. Our findings provide insight into how trainee experiences of adaptation relate to learning and practice, and are relevant in the context of current challenges to GP workforce recruitment, retention and a shift towards new ways of working and collaborating across community and hospitals.

80 **Methods**

81 The East Staffordshire VTS currently comprises of six, four-month posts over the first two years
82 with first GP post in the first year. There was some movement in and out of the VTS during the
83 study period from July to December 2019 but at the start of data collection there were
84 approximately 58 trainees attached to the VTS. There were 28 female trainees and 40 of the 58
85 trainees were international medical graduates.

86 The principal investigator was a Sri Lankan GP trainee and an undergraduate family medicine
87 teacher in Sri Lanka. Through participation in VTS educational activities and informal
88 interactions with trainees the PI gradually moved to a space between insider and outsider [26].
89 This made the recruitment process and flow of information easier generating rich contextual
90 descriptions. Information shared by the participants in a trusting context, was handled in a
91 respectful and ethical manner [26,27]. The supervisor of the study was a UK GP trainer and did
92 not participate in interviews however, her analysis of the anonymised data added an insider
93 perspective to interpretation of the data. Researchers were careful to maintain a reflexive stance
94 throughout the study in an effort to minimise the potential impact that their own general practice
95 background and experience could have on shaping the analysis of data. Knowledge was co
96 constructed through the double lenses of researchers and participants [27]. Purposive sampling
97 was used to capture a diverse range of experiences with respect to characteristics such as gender,
98 stage of training and country of primary medical qualification. GPSTs were informed about the
99 nature of the study during group events and recruited through word of mouth and email.
100 Individual participants gave written informed consent.

101 A topic guide was developed to explore GP training experiences based on literature review,
102 discussion among researchers and pilot interviews with two non-participating general
103 practitioners. Face to face interviews were conducted, audio recorded and transcribed verbatim
104 by the principal investigator till the point of data saturation.

105 Data from interviews and field notes were open coded concurrent to data collection using
106 constant comparison and inductive thematic analysis with the principal investigator and
107 supervisor working independently but in constant discussion [28]. The field notes on
108 observations helped to provide contextual information and there was convergence between data
109 from interviews and field notes. Data were triangulated through observation, and informal
110 discussions with trainees, trainers and TPDs [29]. During the second stage of analysis initial
111 codes were interpreted with reference to the scientific literature and the two investigators
112 identified patterns related to concepts of Lave and Wenger's work on communities of practice
113 within the data [24,30] . These and other evolving themes were explored in-depth during further
114 data collection. We were able to map all codes from interviews to the sensitising concepts of
115 meaning, identity, belonging, practice and legitimate peripheral participation in CoP which
116 helped to interpret, organise and provide a wider understanding of the findings [31]. The coding
117 process and development of themes is presented in table 1.

118 Findings were presented to participants for member checking and some participants requested
119 clarifications on some terms. None of the participants disagreed with the interpretations.

120

121

122 Table 1. The coding process and development of key themes

Open coding	Subthemes	Themes
Undergraduate and early exposure to GP during specialty training	**Meaning (experience)**	**Managing the transition into general practice**
GP trainer role modelling Work life balance as a GPST Placement at one hospital for almost all hospital rotations Comparative ease of entry into specialty training programme Duration of only three years Expectancy of satisfactory work life balance and intellectually stimulating career as a general practitioner	**Identity (becoming)** • Imagination	
Acquisition of GP relevant knowldege and skills - Managing diverse patient presentations, management of common ailments and chronic disease, holistic approach, consultation and communication	• Alignment	

skills, continuity of care, doctor patient relationship, use of doctors personality, personalised care		
Professional conversations with peers, senior colleagues and trainers Balint sessions	• Engagement	
Supervised experience in GP settings	**Practice (Doing)**	
Inclusive CoP Interaction with multiple members of the community Adequate support towards training and wellbeing needs – GP trainer, VTS, senior colleagues Peer support Need for more support for IMG GPSTs	**Community (Belonging)** **GP setting**	**Belongingness**
Sense of isolation, devaluation Need to master secondary care relevant competencies	**Hospital setting – Legitimate peripheral participation**	

Need for signposting to GP relevant learning and practice opportunities
Bridging social connections
Personal agency initiatives
Impact on learning and practice

123

124 **Results**

125 18 GPSTs participated in interviews lasting between 20 and 51 minutes. The demographics of
126 participants are shown in Table 2.

127 Two main themes were developed: managing the transition into general practice, and
128 belongingness. Figure 1. illustrates important information on the interrelation between codes,
129 subthemes and themes.

130 Table 2. Participant demographics

Demographic		**n**
Age	20-29	4
	30-39	13
	40-49	1
Gender	Male (M)	7
	Female (F)	11
Stage of training	First year GP specialty trainee (ST1)	6

	Second year GP specialty trainee (ST2)	8
	Third year GP specialty trainee (ST3)	4
Undergraduate training	UK primary medical qualification (UKG)	8
	Non-UK primary medical qualification (IMG)	10

131

132 **Managing the transition into general practice**

133 **Meaning**

134 GPSTs reported that the transition into general practice training was a challenge. Undergraduate
135 and early exposure to GP during specialty training helped in navigating the transition through
136 meaning making and understanding ones "fit" with the chosen career.

137 It helped to see the difference and get experience ….. what GP's like. (undergraduate
138 exposure) GP16 (interview code), M, ST3, UKG

139 Applying things to the way that you're actually going to be working the rest of your
140 professional life, it's really helpful to do that quite soon in your training …in terms of
141 knowing whether that was what I wanted to do. GP10, F, ST3, UKG

142 **Identity**

143 **Imagination**

144 Developing identity within the world of general practice was an important aspect of transition.
145 General practitioner role modelling was influential in creating an image of future identity within
146 the profession.

147 She's also specialist in women's health which has influenced me to wanting to do that as
148 a GP in the future. GP3, F, ST2, UKG

149 Work life balance as a GPST was generally thought to be good especially because GPSTs remain
150 attached to one hospital during almost all of their training. Disruptions to work life balance
151 during hospital rotations were accepted as a temporary and essential aspect of training. Due to
152 the increasing numbers of places for GP training, trainees perceived that it was easier to get into
153 GP and the duration of only three years was considered an incentive.

154 We are really fortunate compared to other specialties. We have a really supportive
155 training; we've got a short training and also it's just nice. GP15, F, ST2, UKG

156 Trainees envisioned a satisfactory work life balance as a general practitioner in the future.

157 I can have a family it's not going to be a massive strain you can have a life .... a lot less
158 stressful than every other medical and surgical specialty in the UK. GP4, F, ST3, UKG

159 A few GPSTs mentioned "increasing litigation" (GP17, ST1, M, IMG) and a "politically driven
160 NHS" (GP16, ST3, M, UKG) as negative aspects but the majority were satisfied with their
161 choice of career, found the work intellectually stimulating and looked forward to the future as a
162 general practitioner.

163 Every part of the body that's what GP is doing. I mean little bit of everything. I think this
164 is the right job for me and I think I'm a better doctor at the moment. GP14, ST2, F, IMG

165 It's a tough job it's a risky job um and that's basically why you go through the training.
166 One thing I like about GP I think they try to protect themselves, do things to make things
167 work well for them, for example, the surgery, nobody works more than four days a week.

168 Definitely your pay is going to be less but then you have time to relax you have time to
169 um get yourself refreshed and you're not that stressed I'm looking forward to it. Let's see
170 what the future holds. GP13, ST2, M, IMG

171 **Alignment**

172 Initially GPSTs were unfamiliar with fundamental concepts of day to day GP and they prioritised
173 understanding and acquiring the unique knowledge and skills they perceived as necessary to
174 practice successfully as a general practitioner.

175 Trainees had to adjust to the diversity of patient presentations.

176 Patient coming in to discuss about diabetes and how it's affecting his health or somebody
177 coming in with an acute abdomen. GP13, M, ST2, IMG

178 They developed knowledge and skills to manage "common ailments" through training and
179 experience in GP settings as many trainees felt there was an initial gap in knowledge on
180 management of common primary care presentations.

181 What to do with common ailments. You don't get taught in medical school. With the
182 support of the clinical supervisor I was able to get used to it. GP15, F, ST2, UKG

183 Learning how to manage chronic disease was better acquired within the GP setting as opposed to
184 ward work that were more oriented towards management of acute problems.

185 Ward work does not help with managing chronic conditions you see again and again.
186 GP5, F, ST3, IMG

187 The holistic approach to patient management had to be developed.

188 In the hospital usually the nurses and the allied health professionals they will be looking
189 after the psychosocial side. As a GP it's like taking on the role of all these people alone.
190 GP8, F, ST2, IMG

191 GP has traditionally been a discipline with a strong emphasis on communication, continuity of
192 care and the doctor patient relationship and personality as a strong therapeutic tool. GPSTs
193 recognised the importance of these concepts.

194 We're looking at consultation styles......You 've got less experience of that. You've been
195 a clerking machine for many years. It's just, different. GP4, F, ST3, UKG

196 Patients come in again and again and know that this is my doctor. In hospital there are
197 lots of doctors and patient cannot pinpoint that this is my doctor. GP14, F, ST2, IMG

198 Enjoy having my own setting and having the personality. Working in hospital you lose a
199 bit of your personality. GP15, F, ST2, F, UKG

200 They became more aware about personalised care based on contextual judgements.

201 What you would do in this particular case might not be the same thing you do in a similar
202 case. GP13, M, ST2, IMG

203 **Engagement**

204 In addition to professional conversations with GP trainer, GP colleagues and peers; VTS Balint
205 group sessions could be seen to help trainees orientate themselves to what is was to be a general
206 practitioner and gain confidence in their role through reflection, feedback and support in a safe
207 environment.

208 **Practice**

209 Trainees valued the opportunity for supervised practice and feedback that helped refine the

210 competencies relevant to the profession.

211 Because I did my GP first, I still had the mentality of hospital, so he (trainer) was trying

212 to tell me ok this is the community this is what we do in the community you know

213 although the symptoms may seem worrisome or vague but you have to think as a

214 community doctor. (GP6, F, ST1, IMG)

215 **Belongingness**

216 **General practice setting**

217 While transition into the discipline was an initial challenge; all GPSTs declared they felt a sense

218 of belonging within the GP setting.

219 No other place where you are so inclusive than the GP rotation. GP7, M, ST1, IMG

220 When the whole practice and not only the trainer was supportive it improved the overall training

221 experience.

222 Even the people who are not my trainers they are really helpful and they give good

223 feedback. So I think it's a good place for me. GP9, F, ST2, UKG

224 Most trainees felt adequately supported regarding their training and wellbeing needs.

225 Diagnosed with a medical condition… I was able to get the pastoral support that I needed

226 from GP side of things; GP surgery, deanery and the TPDs. GP8, F, ST2, IMG

227 GP trainers they 'own us' and they just want us to prepare for the exams as well and for

228 becoming a better GP. GP14, F, ST2, IMG

229 Some IMG trainees felt that more support was necessary in specific areas such as orientation to
230 working within the NHS, information technology, allocation of hospital rotations during the
231 initial acclimatisation phase and more support to face the added challenge of adapting to a new
232 country.

233 When I came here, my first job, they put me on nights after I think four, five days … I
234 never worked in NHS; I was so scared… I was preoccupied with a lot of things. I was a
235 bit depressed initially how to cope and everything. GP14, ST2, F, IMG

236 Most trainees, particularly IMG GPSTs, appreciated the “GP centred” (GP2, F, ST1, IMG) VTS
237 teaching. Observation at VTS showed how VTS participation supported the development of
238 well-rounded professionals. in addition to GP relevant clinical teaching, sessions covered areas
239 such as selfcare, communication skills and use of English during consultations for IMGs. Trainee
240 led sessions helped develop leadership and teaching skills. A “buddy” system was in place for
241 mentoring of juniors by senior trainees and observation of “cluster sessions” revealed how
242 trainees supported colleagues who were taking exams even when not taking the exam
243 themselves. Observation at junior doctor forum meetings and informal conversations at VTS
244 sessions revealed how trainees benefitted from discussion of common problems regarding
245 training and possible solutions among themselves.

246 You need the resilience you need the networking. You share your experiences with each
247 other. We need more of that. GP4, F, ST3, UKG

248 There’s a strong peer support. GP7, M, ST1, IMG

249 **Hospital setting – Legitimate peripheral participation**

250 In contrast, many GPSTs felt a sense of isolation and devaluation in the hospital environment.

251 No discrimination about the workload but there was discrimination regarding treating us.
252 GP14, F, ST2, IMG

253 We were just filling the gaps, the rota gaps. GP4, F, ST3, UKG

254 In the situation of training and working in a context that was relatively alienating one GPST
255 illustrated the underlying "them" and "us" mentality that prevailed.

256 Just in the ward managing their patient, their workload. GP14, F, ST2, IMG

257 Some trainees mentioned that having worked in the same hospital before and knowing others
258 helped improve inclusion while others felt they had to match their skills to the secondary care
259 relevant competencies of their hospital colleagues to gain acceptance.

260 Here since F1, pretty much know everyone, which helps massively. The mess is quite
261 sociable as well. You just kind of have to get in there talk to people. GP11, F, ST2, UKG

262 In their mind they feel GP is for the less … but depending on what you are doing or how
263 well you are doing (talking about secondary care relevant skills) oh ok, GPs are not bad
264 after all. GP6, F, ST1, IMG

265 GPSTs described that during hospital rotations where they felt well integrated into the team, they
266 were able to learn more and contribute more.

267 Because of the support I had and because I felt I had trust, I felt I could do more, and I
268 learned more as well. GP5, F, ST3, IMG

269 Trainees suggested that allocation to duties that were more aligned with GP skills and
270 competencies whenever possible for example in managing outpatients would translate into
271 GPSTs being seen as valuable members of the hospital team.

272 Instead of being seen as rota pluggers or clerking doctors if we can take on more
273 responsibility in the outpatients clinics for example that would be so good … by having
274 that awareness of how the practice is different and how all these skills can be used
275 differently. GP8, F, ST2, IMG

276 Some described how practising personal agency in communicating learning requirements to
277 clinical supervisors and colleagues often led to a better training experience through introducing
278 general practice relevance to hospital training.

279 I try to bring my own questions like; if I saw this patient in GP what I will do and
280 sometimes they just realise oh, actually at the GP setting it's not possible to CT someone
281 straight away. GP8, ST2, F, IMG

282 If you say; I totally understand that when I'm on call I need to go on the wards but when
283 I've got a lighter day can I go to clinic which would be relevant for GP most of the
284 doctors I've worked with understand that we need something out of the training. GP 10,
285 ST3, F, UKG

286 **Discussion**

287 This study provides insight into GPST transition into GP training, belongingness in GP and
288 hospital settings and how this related to learning and practice.

289 The influence of GP trainers, senior GP colleagues, VTS and peers on transition, in our study
290 underlines the need for adequate support during transition periods [8-10, 32–35]

291 Increasing contact with primary care learning environments during undergraduate training is
292 associated with the proportion of medical graduates who later enter general practice training

293 [36]. In our study undergraduate exposure to GP facilitated the transition into GP training and it
294 is likely that both these phenomenona were mediated, at least in part, by the opportunity to
295 develop meaning and belonging in the primary care world [37]. During the phase of alignment of
296 skills to GP it was surprising that many trainees were unfamiliar with managing common day to
297 day GP presentations. With government targets of 50% of medical graduates being placed in the
298 community it seems logical that by the time doctors have completed foundation training they
299 should be competent in fundamental aspects of day to day GP [38]. Our findings therefore
300 highlight the importance of more undergraduate and foundation training based in primary care
301 settings [39–41].

302 Identity formation played a central role in successful transition in our study as in other studies
303 looking at the various transitions in a doctors career [9,11,33]. Wenger's theory of communities
304 of practice; proposes the development of knowledge is closely linked to the development of an
305 identity within a community for which this knowledge is a meaningful way of being [24,42].
306 Trainees constructed an image of their identity within the GP CoP through general practitioner
307 role modelling, envisioning of the future, engagement with colleagues through professional
308 conversations and reflective activities such as Balint groups and aligning their skills to the
309 competencies considered important and relevant within the CoP [43].

310 Studies of postgraduate training in UK have highlighted challenges to work life balance faced by
311 doctors in training [44,45]. In our study GPSTs were content with their work life balance, career
312 choice, felt that their work was intellectually stimulating and were optimistic about the future.
313 This is compatible with the findings of a previous survey of junior doctors' career choices [46].
314 Completing almost all hospital placements in the same hospital was a main determinant of good

315 work life balance for the participants in our study however, in other training schemes trainees
316 may rotate through different hospitals depending on local arrangements.

317 The impact of belonging to a CoP on the engagement, performance and wellbeing of learners has
318 been established in higher education but there is little research on this in primary care medical
319 education settings [37,47–50]. GPSTs in our study described a strong sense of belonging within
320 the GP CoP and where there was input and mentoring from other general practitioners in the
321 practice the quality of training was strengthened. While the concept of CoP is open to many lines
322 of criticism [42], it appears that a strong, nurturing and inclusive CoP had a positive impact on
323 training and practice for this cohort of GPSTs [51].

324 IMG GPSTs were especially appreciative of VTS activities perhaps due to a holistic approach
325 that offered them support in adaptation. Although recruitment of GPSTs has seen a recent upturn
326 [52], this does not guarantee retention and continued support is necessary for GPSTs, especially
327 IMGs, in specific areas to prevent future losses to the workforce.

328 GPSTs are temporary members of the hospital clinical environment during their clinical
329 rotations. The participant experiences in this study illustrate how they were neither fully inside
330 nor fully outside the hospital CoP [18], and what strategies were used in negotiating the process
331 of moving from the periphery to the centre as described in Lave and Wenger's 'legitimate
332 peripheral participation' [30]. Many GPSTs felt isolated and devalued in the hospital setting [13,
333 20–22]. Lack of a sense of belonging affected training and practice, which could impact on
334 patient care. If plans to increase primary secondary care collaboration are to succeed [53],
335 workplace cultures that allow for positive interactions between primary and secondary care must
336 be supported. Some trainees recognised the importance of forming bridging social connections to
337 increase inclusion. Facilitating connectivity across borders of CoP could help create mutually

338 respectful fluid communities of practice with the care of "our" patients at the core [54–56].
339 Some GPSTs practised personal agency initiatives that sought to introduce a GP relevant
340 narrative into hospital based teaching [57]. Having the opportunity to contribute and be valued
341 for their unique skills was important for GPSTs but maintaining GP identity while integrating
342 well into the hospital environment was a challenge. Some trainees described gaining
343 belongingness within the hospital setting through matching the secondary care competencies of
344 hospital specialty colleagues which is of concern as benchmarking secondary care competency
345 criteria could lead to conflict with unique GPST identity [3,58].

346 **Strengths and limitations**

347 This study was conducted with participants from a single VTS therefore findings could be region
348 specific. However, the selected participants represent a diverse range of training stages, gender
349 and UKGs versus IMGs.

350 **Conclusions**

351 In conclusion, our study presents some interesting findings on the transition experiences of
352 participating GP trainees, their sense of belonging in GP and hospital settings, the impact on
353 traing and practice, collaboration between general practice and hospital communities of practice
354 and how the actions of GP educators and peers supported this. The various activities that have
355 been explored will be familiar to experienced GP educators. These findings are transferable to
356 the Sri Lankan GP training setting according to the PI's experience of training in Sri Lanka.
357 Mapping the activities explored in our study to Wengers social learning theory – communities of
358 practice enables a wider understanding of how they might be influenced to enhance training.

359

360 **Recommendations for practice**

361 - Provide adequate support towards transition into GP
362 - Foster inclusive CoP in GP and hospital settings
363 - Promote workplace learning and practice opportunities that facilitate interaction between
364 GPSTs and other specialty trainees
365 - Prioritise signposting of GPSTs to GP relevant skills
366 - Provide more undergraduate and foundation training based in primary care settings

367 **Ethics**

368 Ethics approval was granted by the University of Worcester (CHLES18190033-R). None of the
369 participants received any incentives for participation. Trainees under the direct supervision of the
370 study supervisor were not interviewed.

371 **Abbreviations**

372 Community of practice: CoP; general practice: GP; GPST: general practice specialty trainee;
373 male: M; female: F; first year GPST: ST1, second year GPST: ST2; third year GPST: ST3; UK
374 based primary medical qualification: UKG; Non-UK primary medical qualification: IMG

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383 **Declaration of interests**

384 No potential conflict of interest was reported by the authors

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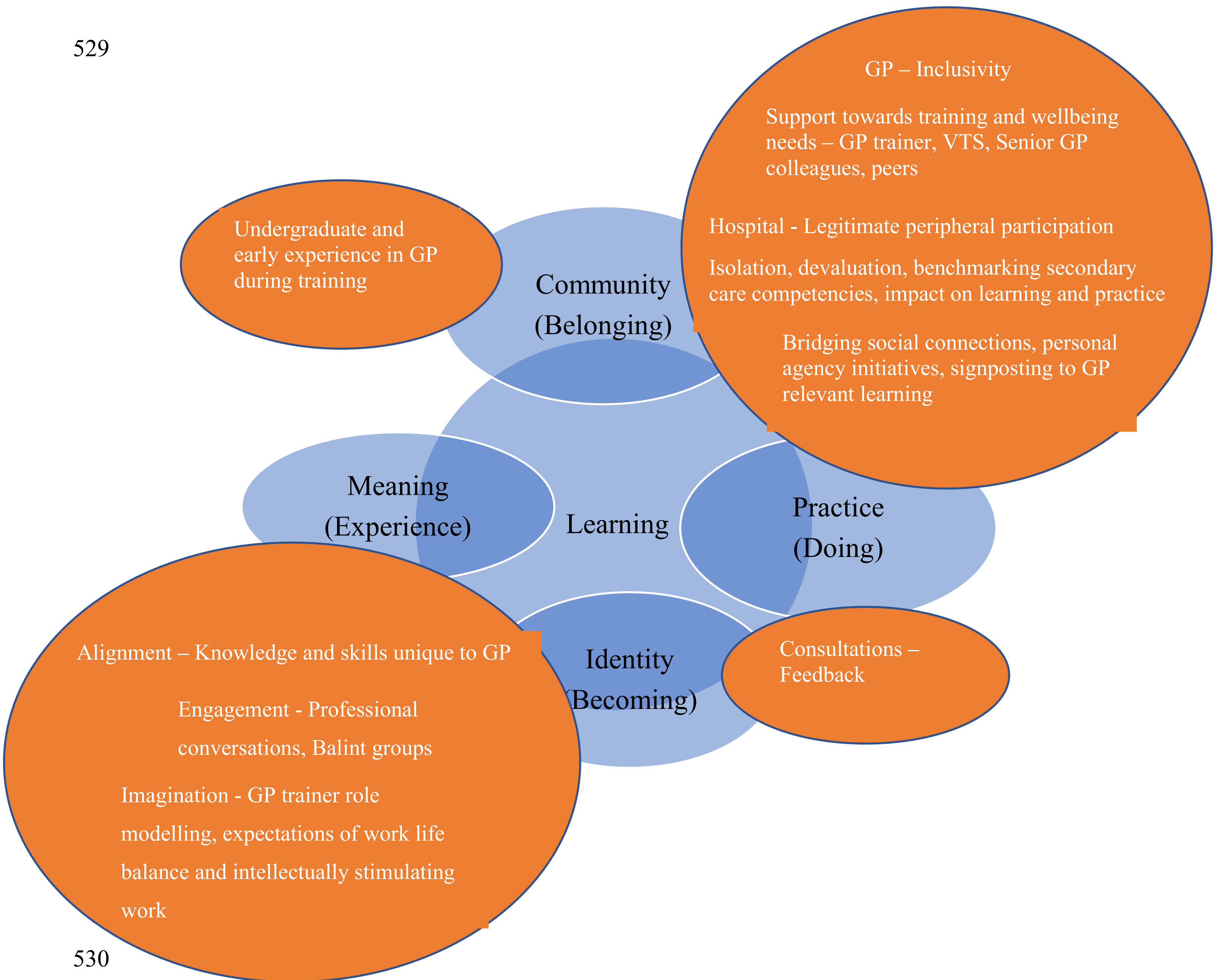

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531 **Figure 1. Mapping of study findings onto Wenger's communities of practice to illustrate**

532 **the interrelation between concepts**

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