Are GP trainees ready to manage palliative care patients independently by completion of training?

Grace Rowley MBChB, MRCGP, Dip. Pal Med, DRCOG

Newcastle, United Kingdom

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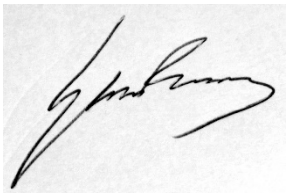
SIGNED: 

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iii. ABSTRACT

Background

Palliative care in the community is predominantly carried out by General Practitioners (GPs). As palliative care is part of most GPs workloads then trainees need to be prepared to manage this group of patients by completion of training (CCT). The aim of the study was to find out about GP trainees' exposure to palliative care during training and to explore whether GP trainees felt that they were ready to manage palliative care patients independently by CCT.

Methods

Semi-structured interviews were carried out by telephone with ten final year GP trainees. The trainees were voluntarily recruited through the North East GP Vocational Training Scheme. The data was analysed using thematic analysis.

Results

The findings emphasise the importance of palliative care experience during training and the value of hospice placements. The findings demonstrated that many of the skills attained through working with palliative patients were transferrable and enhanced the overall practice of the trainees. Opportunities to develop complex communication skills were particularly valued by the trainees. The interviews highlighted that there were sometimes challenges in accessing palliative care experience in community placements. The interviews were conducted during the Covid-19 pandemic and this had resulted in trainees having opportunities to gain additional experience in advance care planning.

Conclusions

The study acknowledged that learning does not stop at CCT however the trainees generally felt that during training they received good preparation for independent practice in palliative care. The study supported the importance of good palliative care teaching and experience during training for managing both palliative care patients and providing transferrable holistic skills helpful in all aspects of clinical practice. Further work could be done to explore the variability of trainees' exposure to palliative care patients in the community and how trainers and practices could be supported in providing this experience.

iv. LIST OF ABBREVIATIONS

A&E – Accident and Emergency

CCT – Certificate of Completion of Training

COTE – Care Of the Elderly

CPD – Continuing Professional Development

CSCI – Continuous Subcutaneous Infusion

DNACPR – Do Not Attempt Cardiopulmonary Resuscitation

ENT – Ear, Nose and Throat

GMC – General Medical Council

GP – General Practitioner / General Practice

MDT – Multi-Disciplinary Team

OOH – Out Of Hours

RCGP – Royal College of General Practitioners

ST3 – Speciality Trainee (year) 3

TIPS – Training In Palliative Care Sessions

VTS – Vocational Training Scheme

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1. BACKGROUND

In the UK palliative care became an independent medical specialty recognised by the Royal College of Physicians in 1987 (Doyle D, 2005). Despite it being an independent specialty community palliative care is predominantly carried out by general practitioners (GPs) (NHS England, 2019). With GPs carrying out such a large proportion of community palliative care it is important that they have the opportunity to develop these skills during training.

GP Training in the UK generally lasts for 3 years full time equivalent. GPs are, by definition, generalists and this means that during the 3 years of training there are many specialties to be considered. This particular study is focusing on the palliative care training that occurs during their training. It is an important aspect of their education both for management of palliative care patients and overall care. Medical generalism, which general practice embodies, requires a broad holistic approach (Royal College of General Practitioners, 2013) which is an integral feature of palliative care.

2. LITERATURE REVIEW

I carried out the literature review so that I could understand the topic areas better and to help to inform my research questions. It was an opportunity to explore existing literature and put the topic area into context. The process of carrying out the literature review allowed me to develop my understanding of the topic area and provided a framework for my research.

Literature searches were conducted in MedLine, Google Scholar, British Journal of General Practice, InnovAIT, Palliative Medicine, Medical Education and BMJ: Supportive and Palliative Care. The keywords General Practice, Palliative Care/Medicine, End of life care, Education, Vocational training, Preparedness for practice, were used. The searches were limited to the past 20 years. Twenty-nine articles were found to be relevant.

Background

In the UK nearly 24% deaths occur in people's homes and 22% in care homes with these numbers gradually increasing (Public Health England, 2018). The patients that die in other settings often spend a large proportion of time during their illness cared for at home (Barclay *et al.*, 2003). Palliative care specialist teams do carry out some of the care however they do not have the capacity to provide all palliative care. There is also the issue that if care can be provided by the existing specialist, in this case the GP, this can protect existing therapeutic relationships (Quill and Abernethy, 2013). A questionnaire of GPs conducted in 2016 showed that over 50% of those surveyed were involved in end of life care at least weekly (Mitchell *et al.*, 2016). Palliative care is going to be part of any GPs workload and so trainees need to be confident in managing this group of patients by completion of training.

Exploring the GP's Role in Palliative Care

When considering the job that GP registrars are preparing to do it is important to explore the role that GPs have in managing palliative care patients. GPs have the benefit of a longitudinal view of the patient and their family which may have developed over many years (Mitchell, 2002). This can be of great value when caring for this group of patients. Continuity of care allows treatment of episodes of illness in the context of the patient, family and social circumstances (Mitchell, 2002). The length of time spent working as a GP has been suggested to be the best predictor of comfort in managing palliative care patients (Mitchell, 2002) with

GPs more likely to feel confident with increased experience (Giezendanner *et al.*, 2017). Experience is something that develops over time and continues to grow well beyond completion of training, this needs to be considered when conducting the study as it supports both the need for good training but also the skills for lifelong development.

A study done by The Kings Fund into end of life care highlighted the importance of the multidisciplinary team (MDT) and communication in delivering effective community palliative care (Addicott, 2010). The focus of the GP in palliative care is changing and it can often be seen as more of a coordinating role (Mitchell, 2002). When GP roles were discussed anticipatory prescribing, death certification, continuity of care and bereavement care (Addicott, 2010) were all highlighted as important aspects of care. These are all areas that are important in delivering good palliative care and trainees need to be comfortable with before completion of training. Bereaved carers were interviewed to find out what they perceived the GP role to be and the overriding feature was the ability to provide basic support that enabled them to care for the patient at home (Grande *et al.*, 2004). They valued a patient centred approach and listed empathy, sensitivity, listening, giving time, and effective communication as important aspects of care provided by the GP (Grande *et al.*, 2004).

The RCGP recognises the increasing challenging role for GPs in managing palliative care patients as patterns of illness change alongside medical advances (Royal College of General Practitioners, 2016). They also are aware of the overall increasing pressures on primary care (Royal College of General Practitioners, 2016). Within general practice palliative care barriers which have been identified include time pressures, maintaining an up to date knowledge base and the unclear role definition for GPs (Mitchell, Reymond and McGrath, 2004). When a study was conducted asking GPs about barriers they perceive to delivering palliative care the respondents talked about demands on time, energy and emotions (Groot *et al.*, 2005). However, in the same study, palliative care was considered to be one of the best parts of the job (Groot *et al.*, 2005).

When GPs and registrars have been asked to highlight areas of concern in palliative care skills there have been similarities with syringe driver use and bereavement care frequently being highlighted (Barclay *et al.*, 2003; Low *et al.*, 2006). In a more recent study GPs perceived

themselves to lack confidence in managing spiritual, cultural and legal issues (Giezendanner *et al.*, 2017). The roles of GPs overall are changing which is impacting on their role in delivering palliative care. There are concerns that changes in Out of Hours (OOH) care has affected continuity (Charlton, 2007; Addicott, 2010). Palliative care crisis often occurs OOH (Charlton, 2007) and there are concerns that poor communication between services affects continuity of care (Mitchell *et al.*, 2016).

The literature highlights that there are challenges to the provision of quality palliative care related to experience, confidence and resources. However there are also some really important aspects of the role identified particularly focused on the continuity and co-ordination of care.

GP Palliative Care Education

GP educational needs in palliative care can cover a broad range of subjects as demonstrated by the concerns GPs have raised. Those educational needs identified by a study in 2017 (Selman *et al.*, 2017) included identifying palliative care patients, the responsibilities of the GP, difficult conversations, symptom management and OOH care. If these are areas that qualified GPs are finding challenging they are likely to challenge a registrar. Making sure the GPs are prepared themselves is important as they are the main source of teaching for the registrars.

A systematic review of GP delivery of palliative care suggested that traditional forms of education may not be as effective as case based education (Mitchell, 2002). A programme of palliative care training that involved practice based interventions was successfully piloted allowing GPs to improve and apply knowledge (Boakes *et al.*, 2000) which supports the need for more practical education. It has been suggested that the skills required to provide good end of life care are ones that are used in all aspects of work (Forrest, S. Barclay, 2007) which further supports the need for good quality education for both palliative care and the transferable skills it provides. The skills of good palliative care have been thought to closely align with those of a good GP (Mitchell, Reymond and McGrath, 2004).

Education is an important part of training particularly when there are multiple specialities to cover in a relatively short period of time. An interesting part of the study would be exploring the education that the trainees receive, both formal and clinical, and how effective they find the different aspects of learning.

GP Training in Palliative Care

GP trainees have palliative care as part of their curriculum and it a requirement to have evidence for this at completion of training. However, it has been suggested that GP registrar exposure to palliative care patients during training is inconsistent and inadequate (Selman *et al.*, 2017) and a disparity has been perceived in the amount and content of teaching (Lloyd-Williams and Carter, 2003). When trainees have been asked about palliative care the challenge of gaining enough experience, particularly practical, has been raised (Low *et al.*, 2006). GPs have suggested that training fails in preparing registrars to recognise the complexities of real-life patients (Selman *et al.*, 2017), something for which practical experience is essential.

There are concerns that GP trainees are lacking experience in follow-up and anticipatory care, in part, due to reductions in home visiting (Charlton, 2007). A study of GP attitudes to palliative care and confidence in managing palliative care patients associated benefits to an increased amount of home visiting (Giezendanner *et al.*, 2017). This suggests that the role of home visiting is important for registrars and should be maintained as part of training, if not increased.

Suggestions made to enhance registrar palliative care training includes involvement in practice meetings, joint visits with specialist nurses, hospice visits and following patients up in the last weeks of life (Watson, 2014). It has also been suggested by registrars themselves that taking on the care of a terminally ill patient themselves is beneficial (Charlton *et al.*, 2001). Effective communication has been associated with improved outcomes for example pain management and treatment adherence (Slort *et al.*, 2011). When GP communication in palliative care has been explored then suggestions for improvement include encouragement of patients, talking in everyday language and initiating conversations about end of life issues

(Slort *et al.*, 2011). GP registrars need the opportunity to practice these skills both in the controlled environment of role play and in real-life.

There are a lot of suggestions from the literature identifying aspects of training that could be beneficial to trainees including home visiting, communication training, taking on individual caseloads and hospice visits. In the North East VTS some of the trainees will complete hospice placements during their training and so it will be interesting to see the effects that these have on their confidence in managing palliative care patients.

Palliative Care and the GP Curriculum

In 2016 the RCGP position statement on End-of-Life Care ensured that it was part of the curriculum and ongoing CPD (Royal College of General Practitioners, 2016) which supports the argument that it is an important part of training. The most recent Royal College of General Practitioners (RCGP) curriculum: Being a GP (RCGP, 2019b) was implemented in August 2019. It includes palliative care under one of the five stages of life, referring to it as 'people at the end of life' (RCGP, 2019b). The curriculum provides a basis for what is expected of trainees and the expectations of them by completion of training. They are required to provide evidence for each area of the curriculum. It is also helpful in guiding teaching (Getty, 2018). The training structure can mean that there is pressure to produce evidence to demonstrate curriculum competency achievement (Lewin, 2012). This can be provided in several forms including assessments, reflections and teaching. When designing a GP training scheme and curriculum one of the challenges is deciding when the individual is ready to move into unsupervised practice (Hibble, 2009). The assessments and reflections can provide supporting evidence.

The RCGP curriculum outlines five areas of capability which can be applied to all aspects of work as a GP (RCGP, 2019a). These include 'caring for the whole person and wider community' which focuses on a holistic approach, something that is very much encouraged in palliative care. They explore the different types of learning that can be used and encourage using a combination of them all. These include work-based learning, self-directed learning, learning with peers and with other health and care professionals, in formal situations and lifelong

learning (RCGP, 2019a). These are important to consider when thinking about how GP trainees are prepared for practice and what methods are effective.

The section in the curriculum looking at end of life care includes different aspects of training to develop palliative care skills. This includes dealing with uncertainty, holistic care, management of signs and symptoms like cachexia, emergencies, reflective practice and advance care planning. These are all important areas of palliative care and can be quite challenging to teach or find clinical experience. An interesting aspect of this study will be looking at whether the curriculum is helpful in guiding learning and preparing trainees or whether it is perceived as simply part of the portfolio that requires completion.

Preparation for Practice

GP training is preparing trainees for independent practice. One of the challenges in training is knowing how much preparation for independent practice is the responsibility of the trainee and how much of it lies with the curriculum and training scheme (Lewin, 2012). Undoubtedly the support of a curriculum to guide training and an experienced and supportive trainer are essential however there is also the role of the trainee themselves. When a doctor reaches completion of training they take on the responsibility for meeting their own educational needs (Barclay *et al.*, 2003) which can be a big step from the support of a training scheme. Being prepared for independent learning as part of training is important for their future career.

The General Medical Council (GMC) commissioned a report looking at preparation for practice in UK medical students. They considered four domains including knowledge, skills, attitudes and personal readiness (Monrouxe *et al.*, 2014), the latter two being hard to quantify. Becoming a fully qualified GP is a transition. As doctors make transitions then often their responsibilities increase (Kilminster *et al.*, 2011). This does make it challenging as unavoidably there is a difference in the role of a trainee and that of a GP. There are findings that suggest that good social support and a supportive group of colleagues at the point of transition is effective (Westerman *et al.*, 2013). Mentoring schemes have been discussed as a useful method of supporting these transitions (Westerman *et al.*, 2013).

The GP Training Scheme

Developing palliative care skills in a three year training scheme, with posts often lasting a maximum of six months, is challenging. There has been discussion by RCGP about extending GP training (Lewin, 2012). There are concerns that trainees exposure to the community context is limited (Rughani, Riley and Rendel, 2012) and this would be helped by the extension of training. It may also allow a more equal access to different training environments (Rughani, Riley and Rendel, 2012) as presently posts vary with some trainees having a full six months in a hospice and others having very little practical palliative care experience.

Researching Palliative Care in General Practice

There have been several studies over the years looking at palliative care in general practice. They have explored relatively similar themes. A postal survey in 2003 looked at communication, pain control, other symptoms CSCI and bereavement (Barclay *et al.*, 2003). Lloyd-Williams and Carter also used a postal questionnaire but took a slightly different approach by looking at the role of those delivering palliative care training to registrars including their backgrounds, teaching methods and whether access to hospice placements is available (Lloyd-Williams and Carter, 2003). Lazenby et al (2012) devised a 'validity at the end of life professional caregiver survey' aimed at being used with multidisciplinary professionals which includes multiple questions in the broad domains of clinical knowledge and skills, communication, spiritual and cultural issues, ethical and legal principles, organisational skills, attitudes, values and feelings. These studies are helpful in considering the broad spectrum of palliative care and how research has been conducted.

A Dutch study, that employed the use of interviews, approached it by looking at perceptions of the task load of a GP working in palliative care alongside perceived barriers (Groot *et al.*, 2005). This produced some interesting responses from the GPs with the use of interviews allowing a deeper insight into GPs perceptions. The use of scenarios was adopted by Charlton et al. where registrars were given scenarios at two different intervals over their registrar year and then asked to rate their perceived confidence (Charlton *et al.*, 2001). This allowed the researchers to compare confidence ratings and whether the time spent working in the GP setting affected the outcomes.

These methods are helpful starting points when thinking about conducting research in this area. They highlight different methods and the benefits and challenges that they bring.

Conclusions

The literature review provided an opportunity to explore the research that has already been carried out and the subsequent issues that have been raised. These ranged from the role that GPs have in palliative care, how to approach preparing trainees for this role and the structuring of training. It confirmed to me the importance of the GP in palliative care and therefore the value of providing GP trainees with understanding and confidence.

The process of carrying out the literature review allowed me to develop the way in which I think about the research questions. My initial thoughts about research questions had looked at both the trainees and the trainers. The literature review would support both these areas of enquiry. However, it also demonstrated the challenges of conducting research in this area. It has made me consider focusing on the trainees in this particular project as I feel that there is the potential for a considerable amount of data to be generated by this group. It also allowed me to explore mechanisms of research. I had been exploring questionnaires however interviews may be a method to allow a deeper understanding of the topic.

Moving forward from the literature review there are several areas that I feel are important to maintain an awareness of when developing and conducting the research. The research supported the importance of palliative care in general practice which is reassuring considering the focus of the project. The literature that explored the role of the GP in palliative care was helpful. Enquiring about trainee perceptions of the GP role could provide insight into what they perceive they are being trained to do. When considering palliative care education the research highlighted some helpful observations like the benefits of clinical experience. There seems to be space in this area for further investigation particularly from the trainees' perspective. My initial thoughts on research questions didn't consider the curriculum and having done the literature review it has focused my attention on the importance of the curriculum in a training setting. It will certainly guide my research question development. The word 'inconsistency' is something that jumped out from the literature review, something I would like to explore further. If there is inconsistency then it would be significant to look into

the potential causes. A review of the key concepts and variables from the literature review influencing a framework for research development are demonstrated in Appendix 1.

As I proceed from here I feel I am better equipped to develop my research with the approach of exploring the overall question of 'whether GP trainees are prepared for practice in palliative care by completion of training' from the perspective of the trainees. The literature has provided me with focus and looking at other projects has given me a better understanding of what can realistically be achieved with this scale of project. This is translated into the review of my research questions making them more concise rather than trying to investigate every possible angle of the topic area.

3. AIMS

The aim of the study is to evaluate how prepared GP trainees in my area are to independently manage palliative care patients by completion of training. This includes coverage of the end

of life care section of the RCGP curriculum (RCGP, 2019a) . It is important because they should, by the end of training, have met the curriculum outcomes. A role of the curriculum is to ensure that they are competent in the different domains. Meeting curriculum outcomes is an important step for completion of training. The teaching and learning methods that are used to deliver the curriculum are important and the study will describe the methods that are used and how they attempt to meet the RCGP curriculum guidelines (RCGP, 2019a). The study is also aiming to explore GP trainees' perceptions of palliative care education in training and whether it is effective in preparing them to practice independently. Preparedness for practice is explored in a paper looking at the GP training environment and how this affects preparedness (Wiener-Ogilvie, Bennison and Smith, 2014). They explore what preparedness means and the central elements of confidence and adaptability emerge. One of the aims is to explore preparedness, what it means to the trainees and how this links in to curriculum coverage.

4. RESEARCH QUESTIONS

Having reviewed the literature the following research questions were developed. The questions aim to explore the GP trainee experiences of training, how training and the curriculum are linked and ways in which training can be enhanced. I also plan to explore how

the study may influence my educational practice working as a palliative care specialist registrar.

- Do the GP trainees in this study feel ready to manage palliative care patients independently by completion of training?

- Are palliative care curriculum requirements being met during training and in what ways?

- How might GP training in palliative care be improved?

- How might undertaking this project influence my educational practice?

5. METHODS

Research approach

The study was designed to explore whether GP training prepares GP trainees to manage palliative care patients independently by completion of training. In other studies this has been done by using the methods of confidence rating and knowledge tests (Low *et al.*, 2006). The concern I had about self-assessment is that it can be unreliable with physicians having limited ability to self-assess (Davis *et al.*, 2006). Knowledge tests will only access a small area of the curriculum as the curriculum has a great deal of focus on attitudes and approaches. I considered questionnaires or surveys however when reviewing the literature it appears the use of interviews have the potential for providing a deeper insight (Groot *et al.*, 2005) therefore semi-structured interviews were chosen for this reason.

Exploring the use of a semi-structured interview it became clear that pre-determined questions were formed to provide some structure however the interview would be carried out in a conversational manner (Longhurst, 2015) giving the interviewees the freedom to discuss topics. The interviews would explore how the trainees perceive their training, curriculum coverage and preparation for practice. I planned to use open-ended questions which would be based on the topic areas. These could then be followed up with cues or prompts (Hancock *et al.*, 2007). I hoped that the interviews would be a helpful way to provide insight into the experiences of the GP trainees, allowing them to 'tell their story' (Crouch and McKenzie, 2006).

At the point where the interviews were being planned the Covid-19 pandemic had hit and this meant I had to re-structure in the research method. The initial plan had been to carry out face to face interviews however this was no longer possible. I made the decision to carry out telephone interviews. I was aware that semi-structured telephone interviews were not so commonly used with the challenge of trying to prevent an agenda-driven format (Cachia and Millward, 2011).

It is important to acknowledge at this stage that this study is going to be a small-scale qualitative study. This has implications for the results as the nature of this study will provide concepts rather than conclusions (Crouch and McKenzie, 2006). This will be explored further in the discussion.

Data collection

I formulated the interview schedule (Appendix 5) following the literature review. It focused on areas that had been highlighted in the review and it also took into account the RCGP curriculum (RCGP, 2019a) and the areas that the trainees were expected to cover by CCT. The research questions had been formulated from these sources of information so it was focused on trying to explore the research questions. I contacted the Regional Vocational Training Scheme in the North East of England to inform them that the study was taking place. They kindly assisted me in recruiting trainees for interview. This was done by email as there was no face-to-face teaching being carried out due to the Covid-19 pandemic. I had initially planned to attend their group teaching sessions to introduce the study and recruit face to face. Instead all the ST3 (final year) trainees in the region were contacted and invited to participate in the study. It was a voluntary process and apart from the requirement of being an ST3 there was no other selection criteria. The sample was an accidental sample (Vogt, 2005) as it was made up of the GP trainees that voluntarily responded to the emails.

I piloted the interview schedule with a recently qualified GP. This provided the opportunity to trial carrying out interviews on the telephone and also the use of the voice recorder. Some of the questions were quite clumsy when asked during the pilot and so it gave me the opportunity to refine the interview schedule. This included rearranging the order of the questions so that it was in a more logical order and allowed a more effective flow of the conversation. The pilot gave the opportunity to gauge how long the interviews might last. It also highlighted the support aspects of training. This led to the addition of a further area of exploration in the schedule.

Ethical considerations

Ethical approval was applied for and granted from the IRB (Institutional Review Board) at Keele University (Appendix 6). This process is to avoid harm to the participants, respecting both their autonomy and confidentiality. When the interviews were changed from face-to-face to telephone then I re-contacted the ethics board to ensure that they were in agreement with the change of plans. Participants were provided with information about the study (Appendix 2). They were also required to complete a consent form (Appendix 3) electronically prior to the interview. Alongside the consent form they had to complete a form stating whether they were happy for quotations to be used from their interview (Appendix 4). At the time of the interview participants were asked verbally whether they were happy to proceed

and if they had any questions. I recorded the interviews having gained verbal consent. At the end of the study the recordings, transcriptions and any identifying data will be destroyed.

Interviews

Ten trainees were recruited to carry out the interviews. Nine of these trainees were in their final year of training. One of the interviewees was the second week into their first salaried job as a GP having just completed training. I chose this number partly for practical reasons as there were ten respondents to the request for interviewees. I therefore interviewed every one of the respondents. I felt that by the tenth interview similar themes were arising (Hancock *et al.*, 2007) and there was a good amount of rich data to analyse. I collected demographic data which included gender, age, whether they had a palliative care placement during training and whether they had previously done training in another speciality and the number of years they had worked as a doctor. The collection of demographic data provided background information while also allowing an introduction to the interview and an opportunity to build some rapport.

Immediately after each interview was complete I carried out a short period of reflection, writing down anything that had stood out from the interview or any immediate feelings. The telephone interviews were all recorded with verbal permission from the interviewees at commencement of the call. The interviews lasted between 20-40 minutes depending on where the conversation went and the depth of the discussion. In some cases areas of the interview schedule were covered in different ways as the conversations were allowed to flow. I transcribed all of the interviews word for word. This was a time-consuming stage however it provided the opportunity to immerse myself in the data before commencing any analysis.

Data analysis

Having explored different methods of qualitative analysis (Hancock *et al.*, 2007) I chose thematic analysis to explore the data from the interviews. This was because it seemed relatively straight-forward and accessible (Braun and Clarke, 2006). It also appeared to be a way to attempt to understand the experiences, thoughts and behaviours of the trainees

(Braun and Clarke, 2006; Kiger and Varpio, 2020). It was an important starting point to return to the research questions and consider what was being asked. The six-step-process of analysis described by Braun and Clarke (Braun and Clarke, 2006) was a helpful structure in analysing the data.

Step 1: Familiarisation with the data was something that happened during the process of transcription and then having access to the transcripts made it a straightforward process to re-read the data. After the initial transcripts had been done I checked them against the audio which allowed a further step in the familiarisation process.

Step 2: Generation of the initial codes (Braun and Clarke, 2006) was done in a systematic manner. I read the paper transcripts and highlighted codes in the process. I then inserted the codes into an Excel spreadsheet (Bree and Gallagher, 2016). This allowed review of the codes and in the process themes began to emerge.

Step 3: Using Excel for the codes was a helpful way to then look for themes (Bree and Gallagher, 2016). As themes began to emerge I used different colours to sort the codes into the potential themes.

Step 4: There were initially nine themes which I then combined into seven themes in the process of review and refinement (Braun and Clarke, 2006). The different thematic areas were then grouped on separate spreadsheets. This meant that I could review each theme to codes which could be grouped within the theme. This process combined with review of the raw interview data helped to clarify whether the themes worked and how they all fitted together in the overall narrative (Braun and Clarke, 2006).

Step 5: Once the themes were identified my next step was to define them, to be able to name them clearly and succinctly and provide a description of each theme's story (Braun and Clarke, 2006). The seven themes were defined as:

- Formal Palliative Care teaching
- Clinical experience related to Palliative Care
- Learning relevant to Palliative Care
- The Role of the GP in Palliative Care
- Issues around rotations
- Issues around GP Training Practices
- Trainee Support

Step 6: Bringing everything together into a report required a return to the original transcripts and review of quotations. I had previously highlighted quotations during the different stages in the process of the thematic analysis. The quotes were used to support the themes that had developed.

Validation

I followed the thematic analysis approach described by Braun and Clarke (Braun and Clarke, 2006) when analysing the data. During the process of review and refinement I asked a practicing local GP and trainer if they would review the codes and the subsequent themes that had emerged and provide feedback. This was helpful in focusing the themes and an opportunity to discuss the areas of overlap.

Reflection

When analysing the data I was aware of my bias and I did try to avoid my opinions influencing the results. My experience is that of a qualified GP who, having worked in practice for 4 years CCT, re-entered training and is now working as a senior palliative medicine registrar. I am obviously looking at the data from this perspective however by providing validation and having an awareness of bias I hope this is reflected in the analysis. Some of the ideas and discussion that came from the data surprised me and highlighted different experiences. Thinking about the use of the telephone instead of face to face interviews, it meant that there

was not the ability to pick up on non-verbal cues and using silence to allow the interviewee to gather thoughts was more challenging.

6. RESULTS

In this section I am going to outline the results of the interviews. There was a large amount information collected from the ten interviews and so this is an attempt to summarise the main findings from that data. A thematic analysis was used to explore the data therefore the results have been organised under the headings of the themes that arose from the analysis.

Demographics

Demographic information was collected at the start of the interviews. It was helpful as part of the interview to gather this information in part to allow an introduction and it also has helped to contextualise the data.

The gender of the interviewees was disproportionately female at 90%. The GP workforce has an increasing number of females with around 54% (GMC, 2017) particularly in the younger workforce. However, 90% female is not aligned with the general GP population.

The age of the interviewees and the time since they graduated had quite a wide spread ranging from 28 to 36 years. This could suggest a broad range of experience. A third of those that were interviewed had previously trained in other specialties.

The recruitment of interviewees was voluntary and I think this is reflected in the numbers that have had a palliative care placement. The trainees that had done a palliative care placement were all enthusiastic about this opportunity and this may be the reason that they volunteered to speak about their experiences.

The trainees that were doing extended training programmes were doing these to allow additional study in the areas of medical ethics, medical education and leadership and management. The reasons for extended training for all those involved were a combination of personal interest and for career progression.

I plan to return to return to the demographics in the discussion as this is a small-scale research project and therefore the characteristics of the sample may have influenced the results.

Age	25-29	2 (20%)

	30-34	5 (50%)
	35-39	3 (30%)
Gender	Male	1 (10%)
	Female	9 (90%)
Stage of Training	ST3	9 (90%)
	Recent CCT	1 (10%)
Number of years since medical school graduation	0-5	1 (10%)
	6-10	7 (70%)
	11-15	2 (20%)
Palliative Care placement during training	Yes	4 (40%)
	No	6 (60%)
Previous training in a different speciality	Yes	3 (30%) COTE, A&E and Surgery
	No	7 (70%)
Extended training programme	Yes	3 (30%)
	No	7 (70%)

Formal Palliative Care Teaching

Palliative care teaching is part of the GP training scheme. The first part of the interview schedule was about formal teaching. The responses were generally quite factual about the amount and format of the formal teaching that is delivered by the training scheme. In addition to this there was some discussion about other sources of palliative care teaching during training.

The general response when trainees were asked about formal teaching was that they had two sessions during training, one of these being at the hospice.

'I do feel that palliative care is so crucial for GPs to be able to do; almost it deserves as much time as it can have with teaching. I guess giving it two half day sessions is a lot in the scheme of everything that they've got to teach in three years.' (Interview 2)

There was recognition that there are many specialties that need to be covered during training and so there is a limit to how much time can be allocated to palliative care.

The hospice visit was unanimously described as a positive and very useful experience.

'To see what a hospice is like. How do you describe a hospice to a patient? It was really helpful.' (Interview 1)

Teaching at the hospice was carried out by palliative care specialists. This was commented on as being a useful aspect of the visit. This was partly put down to the benefit of their experience.

'I think it's helpful that it's the palliative care team doing the teaching. The palliative care consultants seem to be able to see it from a GP point of view and having it at that higher level - it's helpful.' (Interview 2)

It was also the recognition that everyone can find palliative care challenging.

'I remember talking about difficult conversations. It's nice to know that even specialists in palliative care find it hard.' (Interview 1)

One of the challenges in teaching palliative care which was discussed was that teaching does not always translate into practice.

'I found the teaching helpful at the time, going through symptom management and emergencies. That was good but I think in practice sometimes the palliative care emergencies or which symptoms are the problem isn't as obvious.' (Interview 8)

Some trainees felt that there were good opportunities to discuss and reflect on the practical application of teaching.

'GP teaching is incredibly well supported. They promote discussions and reflections about difficult cases amongst each other.' (Interview 2)

The hospice teaching was considered to be interactive and this was seen to be a positive.

'They were super helpful. I say lecture, but it was more dynamic than that. We could ask questions, we could talk about certain scenarios that we come across and if we wanted to get her opinion we could ask.' (Interview 7)

However, there was some discussion about whether there needed to be more emphasis on the practical aspects rather than factual knowledge.

'a topic like red eye, they would talk about the causes of red eye and treatment and fine that is helpful to an extent but no 'one ever talks about real life examples or other problems that you might encounter, what you might mistake the red-eye for. I feel we need real life cases because I can look things up'. (Interview 1)

Aspects of teaching that were felt to be helpful included signposting of services, knowing who to speak to for advice, lectures on symptoms, hands-on helpful techniques and teaching on bereavement.

The conversations in palliative care were an aspect of teaching that some trainees felt weren't prioritised and as a result this impacted on confidence.

'I think there's a lack of teaching to give you enough confidence to deal with palliative problems in terms of understanding the problem and understanding palliative care. I think there is too much emphasis on the drugs and not enough emphasis on conversations.' (Interview 10)

Some trainees have had the opportunity to attend teaching through their hospital or GP posts. These have included Care of the Elderly posts, hospital palliative care teams and GP teaching. One of the positives of different sources of teaching is that they can have a variety of professionals attending.

'It was insightful to have the practice nurses and GPs all in the same room asking different questions to the palliative care consultant. It was interesting to hear the range of questions that maybe if it was all GP trainees we wouldn't have asked.' (Interview 6)

A variety of types and styles of teaching have been discussed in the interviews which included formal, presentation-based formats.

'I think formal teaching does have a role but I don't think that it should end there and I guess probably most of the learning that I take is from the clinical experiences that we have and hopefully building on cases and people that you see.' (Interview 6)

The interviews provided much reflection around how variety was important combining both formal teaching and clinical based experience.

'More lectures, I'd be happy to have more. The practical learning has to come as well. You learn from situations and can improve your knowledge base.' (Interview 7)

TIPS (Training in Palliative Care Sessions) teaching is organised for GP trainees who have a hospice placement. It goes over topics like pain management but also areas like palliative care endocrinology and cachexia -anorexia. Those trainees who had attended the sessions all found them really beneficial.

'The TIPS teaching is brilliant. If more people could access TIPS I think that would be amazing'. (Interview 2)

There were issues that arose around attendance at teaching. Palliative care teaching had been missed due to night shifts or holidays. Sessions had also been missed if trainees had been out of programme and then returned out of synchronisation.

The discussion about formal teaching was helpful in opening up the interview and developing a flow to the conversation.

Clinical experience related to Palliative Care

Moving on from formal teaching the theme of clinical experience developed. This created a much broader collection of responses as the trainees had been through different training posts and sites. Interestingly, having not been part of the interview schedule, out of hours (OOH) care was brought up by several trainees with regards to palliative care.

Clinical experience is a large part of the GP training programme. This occurs both in hospital and in general practice. Trainees acknowledged the benefit in seeing the difference between

hospital and community and importantly the opportunities to experience the interface between the two. There are many skills to be acquired during training to prepare trainees for independent practice and all the interviewees, in their own way, recognised that clinical experience was an integral part of training.

'With palliative patients come the ethical decisions the discussions with family and relatives, making personalised care plans, thinking about preferred place of death. If I just had the teaching solely without the clinical practice it wouldn't necessarily make sense, but once you start being exposed to it things fall into place.' (Interview 9)

There were specific experiences that were felt to be helpful. Observing others practice, joint visits, hospice ward rounds and shadowing in the OOH settings were all areas that were highlighted. Having their own palliative caseloads was recognised as being difficult to achieve but when it was possible it was seen to be a helpful learning tool.

'It is really helpful having been able to follow palliative patients through their journey and have that opportunity to discuss their plans.' (Interview 9)

When trainees complete training they are awarded their Certificate of Completion of Training (CCT) from the General medical Council (GMC) which allows them to practice independently. Trainees recognised that they would continue to gain clinical experience past this point and there were aspects of work that simply couldn't be experienced during training like continuity.

'I think for palliative care then some of it does have to be gained experience-wise when you come out of training because then you'll be someone's doctor, you're not just a trainee. You've got more stability. You're probably going to be somewhere for years rather than six months.' (Interview 3)

They also recognised that GP training was not there for learning lots of facts, knowledge of where to access information was crucial to independent practice.

'I don't think I'll be perfect at it but I think that I have sufficient skills and knowledge behind me to know where to look for the information. You can't know everything as a GP, but actually knowing where you can access the right information is very key and critical.' (Interview 6)

Confidence is a word that came up frequently during the interviews. Some trainees felt that challenging experiences built resilience and confidence in managing palliative care patients. Many felt that visits were a good way to gain this confidence although equally recognised that being out in the community could be very scary. Some trainees had recognised this discomfort and proactively sought out experience.

'I felt going into ST3 I did not have enough experience at all and it was quite an anxiety driven time. So I discussed this with my trainer and they decided that I would take on palliative patients so I had my own caseload and it was only through that I became quite comfortable with it.' (Interview 1)

Out of hours (OOH) was raised in a number of the interviews. There were quite conflicting views on the experience. It allows trainees to see different GPs working. There are often palliative care patients to see on OOH shifts.

'Out of hours is really good for palliative care experience because almost every out-of-hours shift I end up going to see at least somebody who has symptoms or somebody who is dying so that's one of the best places to get some exposure'. (Interview 8)

However, there were several concerns raised about OOH. Trainees were concerned that they might have to administer injectable medications to patients without support. There were concerns that they were not taught how to manage patients in an OOH situation and very quickly were expected to be practicing independently in this setting.

'In out-of-hours you're completely on your own in the middle of nowhere with a patient you don't know and the practice you don't know and the supervisors don't know and that seems to be a really vulnerable situation especially around palliative care.' (Interview 10)

Learning relevant to Palliative Care

This theme gathered together the aspects of learning that arose during training. There was overlap with other themes particularly clinical experience which is a rich source of learning. The curriculum was covered as a document to guide learning. Alongside this there was consideration of the skills that are needed to practice effective palliative care such as communication and advanced care planning. This theme focused on how trainees met these learning needs.

The curriculum was discussed in the interviews. Trainees reflected on aspects of the curriculum's role in their training. Some found that it did guide training to an extent but could also feel a little bit like you were finding cases to fit the curriculum.

'I found the curriculum a little bit of a tick box, but I can see how it is useful because obviously we do need to know these things for GP but as with any portfolio you do get used to a bit of a tick box exercise.' (Interview 5)

Other trainees found that they covered many parts of the curriculum through the process of training.

'I think it's quite a vast document. I don't know if it necessarily is about me knowing the finer details. It's the kind of thing that a lot of these things just happen surreptitiously and you do cover all these areas, you just don't realize that you're covering them'. (Interview 6)

When considering the evidence used for end of life care there was some concern that it could be interpreted in many ways and the suggestion that there needs to be a more prescriptive requirement for evidence.

'You make these subheadings like you need to show competence in palliative care but what do you mean? That's very vague. You could get away with just saying I looked after a patient who had dementia, but what did you do? It's not specific enough.' (Interview 1)

‘I think it would be nice if it was maybe compulsory in your portfolio that you need to have discussed maybe a handful of palliative care patients that you've been involved in.’ (Interview 1)

There are many skills that managing palliative care patients can develop. These can include recognition of deterioration, complex prescribing and dealing with uncertainty. The trainees recognised that some of these skills are very difficult to teach and experience is essential.

‘It's not necessarily about symptom control but the switch from treating actively to when do you reach the point of being palliative and I think recognizing that is something that I don't think personally am very good at I don't think it's something you really can teach but it's something that I probably struggle with.’ (Interview 8)

Learning from experience was mentioned a lot in the interviews. Palliative care patients were often seen as complex and challenging and learning on the job seemed an important way of developing the skills to manage this patient group.

‘I think I learn from experience and ultimately that's where a lot of my experience, knowledge and learning comes from just doing the job. So I don't want to make it seem like we don't have enough lecture based teaching and we're left to flounder because a lot of the learning is a matter of just doing it and then speaking to colleagues.’ (Interview 7)

The hospice placements were highlighted as helpful sources of learning from experience. One trainee talked about the hospice ward rounds and the skills that they gained from this placement.

‘the psychology of trying to manage a family, relatives and patient who are going through someone dying, using analogies like the pull and tug of feelings where you want them to keep living, but you don't want them to be in pain. It would be really helpful for us to learn these little nuggets because it helps us be able to explain things to patients.’ (Interview 8)

It was really interesting to hear the observations from several trainees about how they were developing the skill of not always rushing in and feeling like they had to do something immediately. This was particularly in relation to difficult conversations.

'These sorts of things should maybe be one of my key learning points that in general practice decisions don't always have to be made there and then. You need to build up that rapport and relationship with the patient on a few occasions to slowly introduce these conversations into your consultations.' (Interview 6)

There were also the situations where they recognised that intervening is not always appropriate and the need to try and make things better was not always necessary.

'I feel I'm more able to recognize and realize that you don't always have to try and intervene to make things better - this is part of a person's natural life. I guess what I struggle with is it coming down to my call as such and sometimes I think 'who am I to judge?' in terms of am I the best person to be making that call and maybe it's because I don't accept the experience behind me.' (Interview 6)

Working in different practices allowed trainees to learn different skills such as the importance of bereavement follow-up with relatives.

'I think of the parts of good practice that I've been exposed to where clinical experience teaches you things that learning in a classroom doesn't. In my last practice we would phone the next of kin of anyone who had died and ask them how they are getting on and I think that is good practice.' (Interview 6)

Having a structure to consultations was considered a skill that helped when reviewing palliative care patients.

'When you have a structure it becomes less challenging. Knowing things to ask like who else is involved in the situation? Is there a DNACPR in place?' (Interview 9)

It was interesting that several trainees made the suggestion that all GP trainees should read the book 'With the End in Mind' by Dr Kathryn Mannix (2018). It was felt to *'help in terms of language and conversation.' (Interview 10)*

Advance care planning is an important aspect of both palliative care and general practice. The interviews were conducted during the Covid-19 pandemic which meant that advanced care planning was particularly topical and this had built confidence among trainees because of the additional experience.

'I think one of the things out of the Covid-19 pandemic is the driver to do the frailty assessment on patients and using that not as the only tool but as a supportive tool in making certain decisions or starting to have conversations with patients and also trying to get patients to lead those conversations as well.' (Interview 6)

When discussing advance care planning and developing these skills much of it was through practical experience. This included reading plans that have already been composed by other doctors.

'I've picked up a lot from reading other people's Advance Care Plans - particularly during training you have to do a certain amount of out of hours shifts and a lot of patients you go and see on visits have health care plans because they're in nursing homes, and I found reading them quite useful.' (Interview 5)

Learning in palliative care as a theme incorporated many aspects of palliative care which are important in delivering effective patient-centred care. It was really encouraging to hear about the experiences of trainees and the awareness they have around the importance of developing these palliative care skills.

The Role of the GP in Palliative Care

When the interview schedule was developed it felt appropriate to enquire about what the trainees felt was the role of the GP in palliative care. This in itself developed into a theme. It seems important to know what the trainees perceptions are about the role of the GP as this in turn influences their approach to palliative care work and training. Exploring this area also allowed insight into their experiences in working with palliative care patients in GP.

The role of the GP as a co-ordinator was a recurrent theme along with how they work with the multi-disciplinary teams in the community and how they will often be the first point of contact.

'I think the GP should be in the community having the conversations and taking the lead.' (Interview 10)

GPs were said to have *'a unique role, not anything you would find anywhere else in medicine' (Interview 7)* largely on the basis that they look after both the patient and their family, providing support for all. They can have the continuity of care that allows them to build up relationships helping facilitate difficult conversations and recognising deterioration. There was a lot of emphasis on their role in bereavement care and family support.

'I think afterwards we're really important for the family that are left behind because sometimes it's hard and they just need to process that and talking to someone like their GP who knows the family.' (Interview 7)

There was recognition that time restraints can make the GP role challenging particularly when they are trying to do advanced care planning.

Issues around Rotations

During GP training, which generally lasts 3 years full-time, trainees will rotate around different posts both in the hospital and the community. There was a great deal of discussion in the interview concerning rotations. Some of this was about palliative care posts as not all trainees will spend time working with a palliative care team. Forty percent of the trainees interviewed had completed a palliative care post. It did allow an understanding of the perceived benefits of a palliative care placement alongside the challenges it may bring.

Trainees commented on the duration of training acknowledging that there is a lot to fit in to the 3 years when, as a GP, so many specialties could be helpful. It was suggested that posts

could be shortened to allow exposure to a greater number of specialties however it was also raised that six-month GP posts can limit the ability to follow-up palliative care patients.

'You do feel disadvantaged compared to your colleagues who have had a posting in palliative care. I think it's one of the postings that everyone has requested. I requested for it because I was interested in palliative care. I guess it's hard because I have been privileged to do an ENT posting which other people wouldn't have been able to do.' (Interview 9)

Palliative care posts are available as part of training for some trainees. Some trainees stated that they felt disadvantaged having not been able to have a palliative care post. Those who did have a post worked in hospice settings and the feedback was very positive. They were felt to be emotionally tough posts but important in building confidence in managing palliative care patients and unusual drug doses.

'I think having palliative care post for GP trainees is so important and so glad I did that job and even though it was incredibly tough probably the most difficult six months of my actual training it's provided so much support so much knowledge and help for me going forward as a GP'. (Interview 2)

Suggestions were that every trainee should do some palliative care but don't necessarily need 6 months to gain adequate experience. The hospice posts were very popular but it was also considered that there needed to be a greater focus on what can be done in the community for this cohort of patients.

'Six months was too long for me in palliative care but maybe if it was a bit more varied, say three months community and three months in hospice. I left the hospice thinking I feel confident in palliative care and went to a GP job and I'd forgotten all about the community prescription'. (Interview 10)

When considering the hospital rotations there was some concern that the posts need to have more focus on learning skills that are relevant to the community. Some of the roles were considered too specialised and others very relevant like paediatrics in a non-tertiary centre.

'What would be really useful to me is doing more of the palliative care stuff because that's relevant to me in the community. Seeing what's transferable, what's available when we discharge people home from hospital.' (Interview 4)

Care of the Elderly jobs were highlighted several times as being helpful in gaining palliative care experience and one of the interviewees considered the secondary care posts to be where they gained the most palliative care experience.

The palliative care placements do appear to be helpful although there is the acknowledgement that providing this experience for all trainees is logistically difficult. This has brought up the question that has ongoing discussion in the wider GP community about whether 3 years is long enough to be able to accommodate such a wide variety of specialties. This study is only looking at one of many.

Issues around GP Training Practices

GP trainees spend part of their training in GP practice. During these posts they will have a clinical supervisor who is one of the GPs in the practice. The variety among trainers became apparent during the interviews. It was observed that they can have very different approaches to aspects of training. Some had fixed agendas and some were flexible around teaching. There was also variability in how they encouraged trainees to seek out experience.

There were several suggestions by the trainees about the qualities that make a good trainer. A supportive trainer was seen to build confidence. Joint visits were identified as a helpful activity along with discussion of difficult cases. There was discussion about how trainees can be supported in seeing palliative care patients, how trainers can identify them or allocate them to the trainee. This encouragement to follow-up palliative care patients was considered extremely helpful. The ability to feel comfortable to ask trainers questions about anything was also considered a useful quality.

'Knowing and having confidence in my clinical supervisor that I can go and talk to them about difficult cases. Sometimes I feel I'm going with stupid questions, but at least I know I'm going in to someone who won't berate me or ignore me when I ask a stupid question. It can be turned into a teaching opportunity.' (Interview 6)

One of the biggest challenges that trainees raised was accessing palliative care patients. They often encountered difficulty in gaining experience because patients were already known to GPs in the practice who prioritised continuity of care.

'I found it very difficult as a trainee to access palliative care clinical experience because I think a lot of these patients are quite well-known to the more senior GPs and I think unless you really want to get involved in this they kind of overlook you because they know what's going on.' (Interview 4)

Training practices are part of the collective community experience, a good training practice has been said to be an essential learning tool. Most trainees will be placed in different practices during their training. This was commented on for a number of reasons. Different practices work in different ways and it can help to inform a trainee about the qualities they might look for in a practice when they complete training. It can also be helpful in figuring out what sort of GP they want to be. Different practices provide different exposure to palliative care patients; factors can affect this like the area demographics.

'My next practice was a different demographic. It was quite high socioeconomic, quite a young population and I really didn't come across much of any palliative care in that practice.' (Interview 7)

The interviews highlighted the importance of a good trainer and training practice. In particular this was related to the access to clinical experience which seems to be quite practice dependent. This could be related to many different factors such as the aforementioned area demographics or it could be trainer confidence in palliative care. Trainer confidence in palliative care could be a whole area of further research.

Trainee Support

Palliative care can be challenging emotionally. During the interviews support for trainees was discussed. The conversations that led to the emergence of this theme were varied, they included the recognition of a need for self-care, the practical support provided by the training scheme and the reflective methods that can be helpful in processing a challenging palliative care case.

One of the features of GP training in the North East is the Wednesday morning 'Check-in' where trainees are given the opportunity to talk within groups. The interviews provided a large amount of positive feedback, it was considered to be a chance to offload and talk about emotionally draining cases or any worries they might have. Having this opportunity was seen as recognising that GP is stressful and provided a way to manage these aspects of work.

'We have the weekly teaching where we have teaching hugs, where we chat about our feelings and I think it's really well set up for dealing with any hard patients you've got or anything you're struggling with.' (Interview 5)

Some of the trainees have found that the support from the group sessions has expanded into their day-to-day practice as demonstrated by this trainee who was new to the area when she commenced GP training.

'Everyone I've met is through my GP programme and now I have a core group of friends and I know that we're constantly supporting each other. Every day we're messaging, supporting each other.' (Interview 2)

For one of the trainees they considered check-in to be '*a total waste of time'* stating *'I've got friends I can debrief with. I want to go to teaching to learn something.' (Interview 1)* However they considered debriefing to have an important role.

The peer support has been noted to be particularly helpful in the community posts. One of the challenges when trainees go out into community is that they have often come from hospital jobs where there may be several junior doctors at a similar level.

'When you work out in GP, you're suddenly with people who are potentially at a very different stage and may have been in the job for many years. You may not have another trainee or F2. You may be by yourself. I really miss the peer support.' (Interview 3)

Palliative care patients can be complex, both medically and emotionally.

'I think because of the speciality it is you often spend a lot more time thinking about these patients and reflecting on them and also discussing them with your supervisor because they can bring up a lot of feelings a lot of worry and you want to make sure you're doing the right thing.' (Interview 8)

Trainees talked about the importance of self-care linking this to aspects of fitness to practice in the curriculum.'

'Maybe it's a change over the years that there's been recognition that if you don't look after yourself you're probably not going to be able to look after your patients.' (Interview 7)

Talking about the use of reflective practice in GP training the hospice posts seemed to provide an opportunity to reflect on cases whereas it wasn't something that was routinely experienced in GP posts.

'It's discussed in the hospice, but it's not really talked about in general practice. Even in the palliative care meetings that we're doing general practice it's not really even touched upon then.' (Interview 10)

It was suggested that more case reviews or teaching with focus on the emotional aspects of work could be helpful.

'I wonder if you had more experience with it and debriefing or specific case review stuff in the GP training program like teaching sessions where maybe that would bring more of the emotional side out and how other people manage it and how more senior GPS manage it.' (Interview 4)

The trainees were very open about their experiences and carrying out the interviews by telephone did not appear to hinder this fluency. When they were talking about the challenges of managing palliative care patients and the emotional burdens that can accompany these experiences they all recognised the need to find a way of dealing with these feelings constructively. The methods of self-care were different for each trainee which demonstrated an insight that different people require different forms of support.

7. DISCUSSION

The interviews provided rich complex data about the palliative care experiences of GP trainees. The discussion has given me the opportunity to reflect on this information and think about the original research questions which were the basis for the study. Following on from my initial literature review, I had set out to look at whether GP training supported trainees to feel prepared to manage palliative care patients independently by the completion of training. I also planned to explore ways in which this process can be supported.

In the process of drawing together the results and being mindful of the research questions I reflected on each of the four research questions in the discussion. While doing this I also considered my findings in relation to the literature discussed earlier in the study. By doing this I attempted to place the findings within the framework of existing work in this area. I also discussed the nature of this being a small-scale qualitative study and discussed the use of the demographic information collected during the interviews.

Do the GP trainees in this study feel ready to manage palliative care patients independently by completion of training?

The trainees demonstrated a mature and considered response when discussing the role of the GP in palliative care. They had good insight into the responsibilities the GP had and also how this fits into the bigger picture of community care.

The GMC commissioned a report that looked at medical students and their preparation for practice at graduation. It explored four domains; knowledge, skills, attitude and personal readiness (Monrouxe *et al.*, 2014). This provides an interesting structure to apply to the GP trainees. They identified that knowledge is important when teaching was discussed. However, during the interviews there seemed to be a good appreciation that GP training was just the start and that this is part of the process of lifelong learning. This is acknowledged by the GP curriculum (RCGP, 2019).

When asked if they feel ready for independent practice in palliative care the general response was that they were ready to take the next step acknowledging they still had learning to do and experience to gain but had been provided with many tools to make this transition. In the

literature Mitchell (2002) highlighted that GPs generally have a longitudinal viewpoint and skills develop over years which the trainees acknowledged. Experience was felt to be an ongoing lifelong development, recognised by the trainees. The trainees demonstrated a real awareness that at completion of training they will take on the responsibility of their own educational needs (Barclay *et al.*, 2003).

Their identification of important skills required for palliative care was insightful as they needed to have had the experience to realise that these skills are necessary for effective clinical management of palliative care patients. Core elements that have been identified for good generalist palliative care practice include the alignment of treatment with patients goals and basic symptom management (Quill and Abernethy, 2013). Both of these elements were demonstrated by the trainees in the interviews. An example would be the trainees showing a good understanding of the complexities and challenges of advance care planning. Alongside this was a recognition that knowing where to access services was going to be an integral part of post-CCT practice.

Their attitudes and personal readiness came across in the interviews. The awareness of the importance of looking after themselves was apparent. Having received support during training there was a strong sense and realisation that this is an ongoing process. Research findings have shown that a supportive group of colleagues at the point of transition, such as CCT, is effective (Westerman *et al.*, 2013) which is what the training scheme appears to be providing.

In existing studies, areas that concerned fully qualified GPs, or where they lacked confidence, included use of syringe drivers, bereavement care, spiritual support, cultural and legal issues (Barclay *et al.*, 2003; Low *et al.*, 2006; Giezendanner *et al.*, 2017). Interestingly these were not the main areas of concern that were raised with the trainees. They talked much more about lacking confidence in conversations with patients and advance care planning. This might be a reflection of the teaching they have received as bereavement care was certainly mentioned among other topics. It might be that these are areas that they might be sheltered from during training and it is the independent practice and longevity in a workplace that leads to a greater awareness of these issues.

Are palliative care curriculum requirements being met during training and in what ways?

Teaching was discussed in the interviews and one of the overarching themes that arose was the importance of diversity. Alongside the diversity in teaching styles was the variety of topics covered in the teaching organised by the training scheme. The areas that have been covered in teaching, which have included pain, nausea and vomiting, bereavement and overview of services, do align with the curriculum (RCGP, 2019a). Review of the TIPS teaching timetable, which is offered to the GP trainees working in palliative care posts, shows that it covers more of the GP curriculum than the teaching which is offered to all the trainees. It appears to offer a comprehensive, curriculum-based teaching programme providing a strong foundation for clinical experience to build upon.

There are the challenges that some parts of the curriculum may only ever be taught theoretically as recognised in the curriculum document. There are cases, such as the care of a child with a life-limiting condition, that GPs may only see a few times in their working lives (RCGP, 2019a). Learning how to access the required support if faced with this situation is an important feature of education and through the interviews this appears to be recognised in teaching. There is always going to be the challenge of translating the theory into practice.

Clinical experience was recognised in the interviews as an essential partner to the classroom based learning. In a speciality like palliative care aspects of the curriculum necessitate practical application. Advance care planning, holistic practice and compassionate care (RCGP, 2019a) are all examples of the importance of hands-on experience. Trainees have reported in past studies that gaining experience can be challenging (Low *et al.*, 2006). Through the interviews it does appear that the training scheme is providing a good amount of hands-on experience.

The GP curriculum suggests that trainees follow a patient at the end of life (RCGP, 2019a). Taking on a terminally ill patient has been thought to be a beneficial part of palliative care training for GPs (Charlton *et al.*, 2001). This was indeed recognised by the trainees as being a helpful exercise. However, there were barriers that were encountered by some of the trainees in accessing palliative care patients in practice. This included the reluctance of some GPs to have trainees transiently involved with palliative care patients. It can be perceived as affecting continuity of care. This does support the concerns raised by Rughani, Riley and Rendel (2012) that exposure to a community context might be limited. They suggested this could be addressed by a longer period of GP training. The study brings to attention the importance of

continuity of care (Mitchell, 2002) which is something that the trainees highlighted as sometimes presenting a barrier to their training due to the frequent movement between posts.

As part of the curriculum there is a case reflection that then provides questions to prompt discussion (RCGP, 2019a). There is a focus on the process of reflective practice and its importance. The interviews discussed reflective practice and how there was space in training to explore cases. Some of this was trainer dependent and different placements did affect trainees' experiences. There was a positive response from the trainees about reflective practice and its merits as a training tool. This is helpful when considering the curriculum as there is a requirement to participate in reflective practice (RCGP, 2019a).

How might GP training in palliative care be improved?

Lengthening the duration of GP training has been a point of discussion for some time (Lewin, 2012). The trainees who were interviewed initially discussed how palliative care posts were extremely helpful. This led to comments about post allocation and how it is difficult to cover so many specialties in three years. Those trainees who hadn't been allocated a palliative care post all spoke about how it was something they would have valued as part of training. This brings it back to the idea of a longer training scheme to allow more specialties to be covered or alternatively shorter specialty posts to allow exposure to wider variety.

The literature does raise concerns about inconsistency in training of exposure to palliative care patients (Selman *et al.*, 2017). Inconsistency does feature in my interviews. It appears to be predominately due to variation in rotations and training practices. There was discussion during the interviews about access to palliative care patients which seemed to have variation between trainees. This is not a new problem. Trainees asked in previous studies have raised the issue of gaining adequate practical experience (Low *et al.*, 2006). As already discussed, some practices seemed reluctant to allow the trainees to have a palliative care caseload citing concerns about continuity of care for patients.

Home visiting was raised in the literature review as being an important part of training and a source of confidence in overall practice (Giezendanner *et al.*, 2017). The interviews supported

this concept as home visits were considered a helpful learning tool including joint visiting with trainers. The trainees were keen to do more home visiting where possible.

Out of hours (OOH) had both positive and negative feedback. OOH is an area that has been identified as important when considering GP educational needs (Selman *et al.*, 2017). In previous studies it has been found that communication in OOH is an issue and this in turn affects continuity of care (Mitchell *et al.*, 2016). The trainees found it to be a rich source of palliative care experience however there was a strong sense that they needed more preparation for OOH shifts, better support for the OOH GP supervisors and better support for the trainees during the shifts particularly on home visits. Continuity was an issue as some of the concerns about the lack of support stemmed from being in new situations with unfamiliar supervisors.

Reflective practice and a deep approach to learning are related (Mann, Gordon and MacLeod, 2009) which supports the use of reflective practice. The trainees generally agreed that reflective practice was a positive part of GP training. It was suggested that it could be helpful to specify that a certain number of palliative care cases need to be discussed and also to encourage training practices to adopt a more reflective approach to work using the process in wider practice. There was an acknowledgement among the trainees that they did not experience much reflective practice outside their training and there was little evidence that this is a practice that is nurtured post-CCT apart from within the hospice setting. Trainees felt that a culture of reflective practice within GP could nurture the benefits it can bring to training.

How might undertaking this project influence my educational practice?

GP educational practice as a whole is seen to have a learner centred approach (Ahluwalia, Hughes and Ashworth, 2019). The interviews with this group of trainees demonstrated many aspects of a learner centred approach in the training they received with positive feedback. This supports a learner centred approach and this does influence how I approach teaching. Keeping in mind the importance of establishing at the beginning of teaching the needs of the

trainees in a session would be a helpful addition to any teaching. Many of the trainees reflected on how helpful interactive teaching was as opposed to a more didactic approach. This emphasised the importance of keeping teaching interactive.

When reviewing aspects of the teaching that had been discussed, for example the TIPS teaching, the content was in line with the curriculum (RCGP, 2019). This emphasised the benefits of consulting curriculums when planning teaching. A comment was made that certain topics were taught on a number of occasions such as pain. There were some benefits that were identified such as helping to cement the information. However, it also suggested that it is important to enquire about what has already been taught to a cohort of students before planning teaching.

Teaching can often be on set topics like nausea and vomiting or pain. The trainees in the interviews recognised the importance of what might be considered 'softer skills'. An example would be learning that as a GP you don't always have to rush in and do something, sometimes supporting the patient and family is the action that is needed. Having an awareness of this when teaching is important as these skills may not necessarily be found in a textbook but are equally important for patient care. One of the interesting findings from the literature has been that end of life care skills are seen to be readily transferrable and can be used in all aspects of work (Forrest, S. Barclay, 2007). The trainees recognised that there were skills, like communication, that could be used throughout their practice. I think this is an important point when teaching that palliative care skills are transferrable and making sure students are conscious of this in the learning process.

One of the points raised in the interviews was that teaching doesn't always translate into practice. They followed this up with acknowledging that the teaching may still be worthwhile however it may help when teaching to acknowledge the gap between theory and practice.

The hospice visit received positive feedback and was felt to be important in providing the trainees with insight into the services available. This is a learning point about the importance of first-hand experience. When you work somewhere it's easy to overlook how helpful it might be for trainees to have something to visualise when talking to patients about what services are available.

Studies have provided evidence that being a GP training practice improves overall patient experience (Weston *et al.*, 2017). Having conducted the interviews it demonstrated to me all the positive work that is done by a training practice to provide the correct training environment. This sometimes needs some development however it has given me an awareness of the benefits of working in a training environment and the multiple benefits that this can bring.

Demographics

When looking at the results I initially considered looking at the ways in which the demographics might have influenced the different interviewees, for example, a trainee with hospice experience may respond in a different way to one who had non-hospice posts. I feel that bringing the demographics into the results could have enriched the findings. My concern with exploring the demographics in too much depth in a small-scale study was that I believe it would have easily made the interviewees identifiable. This would have been unethical and would have breached confidentiality.

Small-scale Research

It is important to acknowledge that this is a small-scale qualitative project. This can have its strengths. Stand-alone qualitative research can often be small-scale with the depth of the study compensating for the lack of numbers (Barbour, 2000). Small-sample research allows careful history taking and cross-case comparisons which could be challenging with larger samples (Crouch and McKenzie, 2006). The study discusses contextualised concepts that have arisen through the interviews. It has allowed me to explore in detail this particular situation. The findings tell us a lot about this specific situation with this group of trainees. The findings generally do demonstrate good practice and this is helpful information that can be used in service development.

There are limitations to this nature of study. This is small scale qualitative research, the nature of which is to indicate rather than to conclude (Crouch and McKenzie, 2006). The results are not generalizable, they don't tell us what is happening in other areas. However, there is a

degree of transferability of qualitative findings to aid understanding in similar situations (Barbour, 2000).

8. RECOMMENDATIONS

There is a lot in this study to be celebrated about the palliative care training that these GP trainees are receiving. There are always ways in which practice can be developed and enhanced to provide the best possible educational experience. When considering recommendations I have divided them into those for the GP training scheme, suggestions for further research and the ways in which I would aim to adapt my own practice.

For the GP training scheme

Having variety among trainers has many positives including the opportunity to experience different ways of working. The challenge, as described in some of the interviews, is making sure that there is some uniformity to training. Concerns were raised by some trainees about access to seeing palliative care patients or having a palliative care caseload. Joint visits were another useful learning tool that was used by some but not others. It might be helpful to explore trainer's thoughts about palliative care training and if necessary create some guidance about what trainees find helpful for learning.

Out of hours (OOH), as discussed, provides a rich source of learning. There were concerns raised that trainees can feel unsupported in the OOH environment which they acknowledged was in part the contrast between OOH and everyday practice. They suggested that there was more training prior to commencing on OOH shifts and that there was clarity with the OOH GP supervisors as to what their role was in supervision.

The interviews were conducted during the Covid-19 pandemic. There have been necessary changes in practice as a result and some of these changes are likely to continue for some time. There has been a reduction in face to face teaching across specialties. It is difficult at present to quantify the impact that this will have however I feel it is important to remain mindful of these changes. The interviews demonstrated a real strength of the GP training scheme is the trainee group support which will undoubtedly now look different. The challenge is trying to capture the important elements of the support and find ways in which to deliver it in different formats.

The GP curriculum interestingly picks up on the role that the arts can have in training and how these resources may be helpful to assist in group discussions (RCGP, 2019). The book 'With the End in Mind' (Mannix, 2018), written by a local palliative care physician, was

recommended by several of the trainees as a helpful resource which could be brought into group teaching.

For further research

The area of further research that I feel would be interesting and potentially beneficial would be to explore the thoughts and feelings of the trainers around palliative care teaching and supervision. There appears to be variety in the approach to training and support and it would be helpful to understand why this might be the case. Reasons could include wider practice policies, trainer confidence in the topic area or other reasons that might not yet be understood.

For my practice

I have learnt a lot about education through conducting the project. If I was to make recommendations for myself these would be around my future work in palliative care education. My recommendations would include the use of curriculums to guide teaching alongside ensuring an awareness of what has already been taught on the subject. Considering the 'softer skills' in palliative care and identifying ways in which these can be taught. Also recognition that teaching does not always translate directly into practice and therefore trying to support teaching with clinical opportunities to aid learning.

9. CONCLUSIONS

In conclusion the project has shown that it is difficult to provide a uniform training scheme however the diversity can add to the richness of GP training. Trainees will have different needs, as demonstrated by the demographics, and even at the commencement of training there is a variety of past experience. It is important to tray and capture existing experience and work with it to provide individualised learning. Palliative care is an important part of GP training that requires both formal teaching and clinical experience. Confidence is an important part of this learning process as cases can be challenging. Finding ways to develop skills and confidence is integral to good preparation for palliative care practice post CCT. Alongside this is the importance of preparing trainees for life-long learning.

Learning and developing skills in palliative care is important for the care and management of palliative care patients. The interviews have also shown that many of the skills learnt in palliative care are transferrable skills that are important for effective holistic care of all patients. This includes the complex communication skills developed through palliative care experience.

10. REFLECTIONS

This has been my first individual research project and the thought of it was incredibly daunting. It was very helpful to have the support and guidance of my supervisor at every step providing the reassurance that I wasn't going in an unhelpful direction. Reaching the end of the project has made me reflect on the journey that I have done and all the learning that has occurred through the process of conducting the project. When reflecting on the project I have looked at the challenges, the learning, the surprises and what I am going to take away from the experience.

Challenges

The Covid-19 pandemic posed one of the biggest challenges to the project. The pace of the work slowed down as every step seemed to take longer and there was the addition of general disruption in the workplace with constant changes in guidance. It led to the interviews being conducted via the phone which was a change to the initial plan. The uncertainty that arrived with the pandemic did affect everything including my dissertation.

Learning

One of the biggest challenges has been trying to move away from thinking about the project as a whole and slowly working through every stage. With the gentle encouragement of my supervisor this has made the project possible. I found the idea of a piece of research overwhelming but I have learnt that taking it step by step can make it a realistic venture. Capturing the whole process in writing-up has at times felt hard. There are so many steps that have taken place from the initial project design to data analysis and I have learnt a lot throughout every stage.

There are many new techniques that I have learnt through conducting the project. These include the formulation of research questions, conducting a literature review, carrying out semi-structured interviews, and the process of thematic analysis. I feel that at every stage I have been learning new methods which has been hard at times but I also feel that the project has been a rich source of personal learning.

Surprises

I think the biggest surprise for me during the project has been that I've enjoyed it. It has been a great deal of work and has created quite a bit of anxiety at times feeling like it was never going to end however I feel the experience has been very positive. In the processes of transcription and analysis of the data I realised that there was some really interesting data and I found this an exciting part of the project.

Moving forward

I still feel like a novice when it comes to research but I am no longer afraid of it. I now find myself becoming involved in projects that I would have previously avoided because of a lack of understanding. I've realised that it is the process of doing the research that is the greatest source of learning.

Alongside learning from the process I feel that there is a lot that I have learnt from the actual research. I found the interviews really interesting and at times unpredictable. I plan to share the information with the GP Vocational Training Scheme and there has been interest from the palliative care teams that are involved in the teaching of GP trainees. I hope that the findings may provide some helpful insights that can influence future teaching and training.

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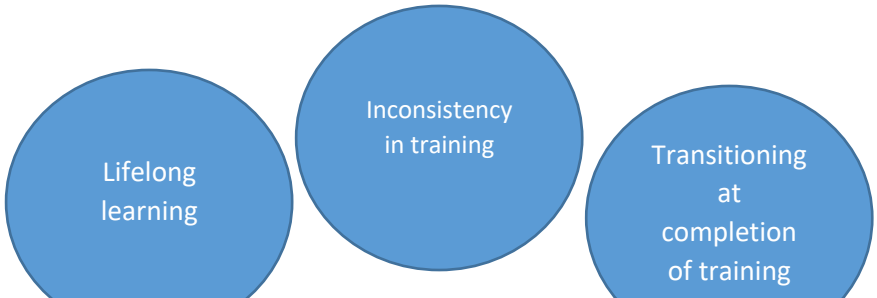
12. APPENDIX

i. Key Concepts



ii. Study Information

INFORMATION SHEET

Study Title: Are GP registrars ready to manage palliative care patients independently by completion of training?

Invitation

You are being invited to consider taking part in the research study looking at GP registrar's experiences of palliative care teaching and training during their time as a GP trainee. This project is being undertaken by Dr Grace Rowley (supervisor Dr Jane Bell). Before you decide whether or not you wish to take part, it is important for you to understand why this research is being done and what it will involve. Please take time to read this information carefully. Ask us if there is anything that is unclear or if you would like more information.

Aims of the Research

The aim of the study is to evaluate how ready GP trainees are to independently manage palliative care patients by completion of training. The study will aim to explore the teaching and training methods that are used and how they attempt to meet the RCGP curriculum guidelines. The study is also aiming to explore GP trainees' perceptions of palliative care education in training and whether it is effective in preparing them to practise independently.

Why have I been invited?

The study is being carried out using semi-structured interviews. The participants are all final year GP trainees who have been voluntarily recruited for the study. 10-12 interviews are being carried out.

Do I have to take part?

You are free to decide whether you wish to take part or not. If you do decide to take part you will be asked to complete a written consent form. You are free to withdraw from this study at any time and without giving reasons. If you withdraw from the study then you will be asked whether you are happy for the data that has been collected already to be used. If you don't want it to be used then all data will be deleted.

What will happen if I take part?

You will take part in a semi-structured interview where you will be asked a series of open questions about your experiences of palliative care training as a GP registrar. The interview is likely to last 20-30 minutes.

What are the benefits (if any) of taking part?

The benefit of taking part is that you get the opportunity to confidentially share your experiences and opinions on the topic which, depending on the findings of the study, may contribute to future development of teaching and training in palliative care.

How will information about me be used?

The interviews will be recorded on a Dictaphone. All the information will be confidential. No identifiable information will be used in the study. The data will be transcribed from the Dictaphone and then through all the interviews qualitative analysis will be performed looking for themes that

might arise. If there are specific quotes that could be helpful in illustrating a point they may be taken directly. The data is only for the purpose of this study.

Who will have access to information about me?

All participants' confidentiality will be safeguarded, only the interviewer (Dr Grace Rowley) will have access to identifiable information. The transcripts may be looked at by the project supervisor however all participant identifiable data will have been removed. Data will be stored securely on a password protected computer. Data will be securely disposed of once the dissertation has been completed.

Who is funding and organising the research?

The research is part of a Masters Programme in medical Education through FAIMER and Keele University. The Masters programme is funded by The Health Education North East.

What if there is a problem?

If you have a concern about any aspect of this study, you may wish to speak to the researcher(s) who will do their best to answer your questions. You should contact Dr Grace Rowley on grace.rowley1@nhs.net. Alternatively, if you do not wish to contact the researcher(s) you may contact Dr Jane Bell, Jane.Bell@winchester.ac.uk.

If you remain unhappy about the research and/or wish to raise a complaint about any aspect of the way that you have been approached or treated during the course of the study please write to Nicola Leighton who is the University's contact for complaints regarding research: n.leighton@keele.ac.uk, Tel: 01782 733306

iii. Consent Form

CONSENT FORM

Title of Project: Are GP registrars ready to manage palliative care patients independently by completion of training?

Name and contact details of Principal Investigator:

Dr Grace Rowley, grace.rowley1@nhs.net, Tel. 07825661693

Please initial box if you agree with the statement

1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions
2. I understand that my participation is voluntary and that I am free to withdraw at any time. In the event of withdrawal, and where it is possible, relevant data will also be withdrawn. ☐
3. I agree to take part in this study. ☐
4. I agree to be contacted about possible participation in future research project. ☐

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature

iv. Quotation Consent

CONSENT FORM (for use of quotes)

Title of Project: Are GP registrars ready to manage palliative care patients independently by completion of training?

Name and contact details of Principal Investigator:

Dr Grace Rowley, grace.rowley1@nhs.net, Tel. 07825661693

Please initial box if you agree with the statement

1. I agree for my quotes to be used ☐

2. I do not agree for my quotes to be used ☐

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature

v. Interview Structure

NB The questions in bold were the main areas of exploration. The questions subsequent questions acted as prompts.

Date:

Participant number:

Consent form completed	

Introduction:

Part of Master's project

Call is recorded but as soon as it is transcribed it will be deleted

Stored on password protected computer

All information will be anonymous

Demographics:

Age	
Gender	
Stage of GP training	
Number of years working as a doctor	
Palliative care placement during training?	
Previous specialty training?	

Can you tell me about teaching you have had in palliative care?

Has this been helpful?

Has there been enough?

Could this be improved?

Can you tell me about your clinical experiences working with palliative care patients?

What clinical experience have you found helpful e.g. joint visits?

What challenges have you experienced e.g. accessing experience?

What positive experiences have you had?

Have your experiences been different in different practices?

What are your thoughts about the GP curriculum?

What evidence have you used to meet curriculum requirements for palliative care?

Do you find the curriculum helpful?

Do you use the curriculum?

The GP curriculum covers different areas of palliative care.

How do you feel about managing these aspects of care?

Advance care planning conversations and documentation

Patients with multiple comorbidities

Palliative care emergencies

Managing palliative care symptoms

Recognising when a patient is deteriorating

What do you see as the GPs role in managing palliative care patients?

Thinking forward - do you feel prepared for managing palliative care patients independently?

Anything that would help?

What do you think challenges are?

How do you feel about managing uncertainty?

Palliative care patients can be emotionally draining to care for - how do you manage this aspect of work?

Where do you get your support?

Is there enough support?

vi. Ethical Approval

Keele University

Name Grace Rowley

School of Medicine

Date March 2020

Dear Grace Rowley,

Re: Application 20-08

Title: Are GP registrars ready to manage palliative care patients independently by completion of training?

Thank you for submitting your ethics application to the School Student Project Ethics Committee (S-SPEC). The project has been reviewed by panel members and has been granted S-SPEC approval.

Please note that you must inform us of any changes or deviations to the approved project.

Good luck with the research.

Best wishes,

Dr Clive Gibson
Chair,
S-SPEC

Keele University, Staffordshire ST5 5BG, UK
www.keele.ac.uk +44 (0)1782 732000