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Foreword

WONCA Europe and its teaching organization EURACT have produced several important documents on the definition and description of the General Practice/Family Medicine (GP/FM) specialty. EURACT specifically dealt with the different aspects of education in GP/FM – from undergraduate to specialist education – and also incorporated continuous medical education/continuous professional development. EURACT has documented the European landscape of specialist training for GP/FM: there are some common features but also great diversity.

EURACT's subcommittee, the "Specialist Training Committee" has taken the initiative to make a compilation of the many educational documents (from 2006 to 2014) and to add some recommendations for Specialist GP/FM training in Europe.

It is our hope that this document can be used as an inspiration and guidance for all countries to bring their GP/FM specialist education and training to the highest standards, warranting registration of GP/FM as a medical specialty. The patients in GP/FM across Europe deserve excellently trained specialists in GP/FM.

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A. European Training Requirements for TRAINEES

1. What do trainees have to learn/achieve (competence-driven)?

The WONCA Europe consensus document on the **European definition of GP/FM** (2002, with revisions in 2005 and 2011) states that “GP/FM is an academic and scientific discipline, with its own educational content, research, evidence base and clinical activity, and a clinical specialty orientated to primary care”¹.

To determine the ‘core’ competences’ of the general practitioner or family doctor, twelve central characteristics of the discipline, and thus abilities that every specialist family doctor should master, are defined (see Table 1).

Table 1: twelve central characteristics of the discipline¹

The characteristics of the discipline of GP/FM are that it:	
a	is normally the point of first medical contact within the health care system, providing open and unlimited access to its users, dealing with all health problems regardless of the age, sex, or any other characteristic of the person concerned.
b	makes efficient use of health care resources through co-ordinating care, working with other professionals in the primary care setting, and by managing the interface with other specialities taking an advocacy role for the patient when needed.
c	develops a person-centred approach, orientated to the individual, his/her family, and their community.
d	promotes patient empowerment.
e	has a unique consultation process, which establishes a relationship over time, through effective communication between doctor and patient.
f	is responsible for the provision of longitudinal continuity of care as determined by the needs of the patient.
g	has a specific decision making process determined by the prevalence and incidence of illness in the community.
h	manages simultaneously both acute and chronic health problems of individual patients.
i	manages illness which presents in an undifferentiated way at an early stage in its development, which may require urgent intervention.
j	promotes health and well-being both by appropriate and effective intervention.
k	has a specific responsibility for the health of the community.
l	deals with health problems in their physical, psychological, social, cultural and existential dimensions.

The twelve characteristics can be clustered into six core competences (with reference to the characteristics):

1. Primary care management (a,b)
2. Person-centred care (c,d,e,f)
3. Specific problem solving skills (g,h)
4. Comprehensive approach (i,j)
5. Community orientation (k)
6. Holistic modelling (l)

Each core competence can be described by certain abilities. See next table (Table 2).

Table 2: The 6 core competences and their included abilities^{1,2}

Core competences of the GP	Included abilities
Primary care management includes the ability	<ul style="list-style-type: none"> - to manage primary contact with patients, dealing with unselected problems; - to cover the full range of health conditions; - to co-ordinate care with other professionals in primary care and with other specialists; - to master effective and appropriate care provision and health service utilisation; - to make available to the patient the appropriate services within the

* ‘Core’ means essential to the discipline, irrespective of the health care system in which they are applied

	health care system; - to act as advocate for the patient.
Person-centred care includes the ability	- to adopt a person-centred approach in dealing with patients and problems in the context of the patient's circumstances; - to develop and apply the general practice consultation to bring about an effective doctor-patient relationship, with respect for the patient's autonomy; - to communicate, set priorities and act in partnership; - to provide longitudinal continuity of care as determined by the needs of the patient, referring - to continuing and co-ordinated care management.
Specific problem solving skills includes the ability	- to relate specific decision making processes to the prevalence and incidence of illness in the community; - to selectively gather and interpret information from history-taking, physical examination, and investigations and apply it to an appropriate management plan in collaboration with the patient; - to adopt appropriate working principles; e.g. incremental investigation, using time as a tool and to tolerate uncertainty; - to intervene urgently when necessary; - to manage conditions which may present early and in an undifferentiated way; - to make effective and efficient use of diagnostic and therapeutic interventions.
Comprehensive approach includes the ability	- to manage simultaneously multiple complaints and pathologies, both acute and chronic health problems in the individual; - to promote health and wellbeing by applying health promotion and disease prevention strategies appropriately; - to manage and co-ordinate health promotion, prevention, cure, care and palliation and rehabilitation.
Community orientation includes the ability	to reconcile the health needs of individual patients and the health needs of the community in which they live in balance with available resources.
Holistic modelling includes the ability to	to use a bio-psycho-social model taking into account cultural and existential dimensions.

As GP/FM is a person-centred scientific discipline, three features are added as they are essential in the application of the core competences¹ (more details in Table 3):

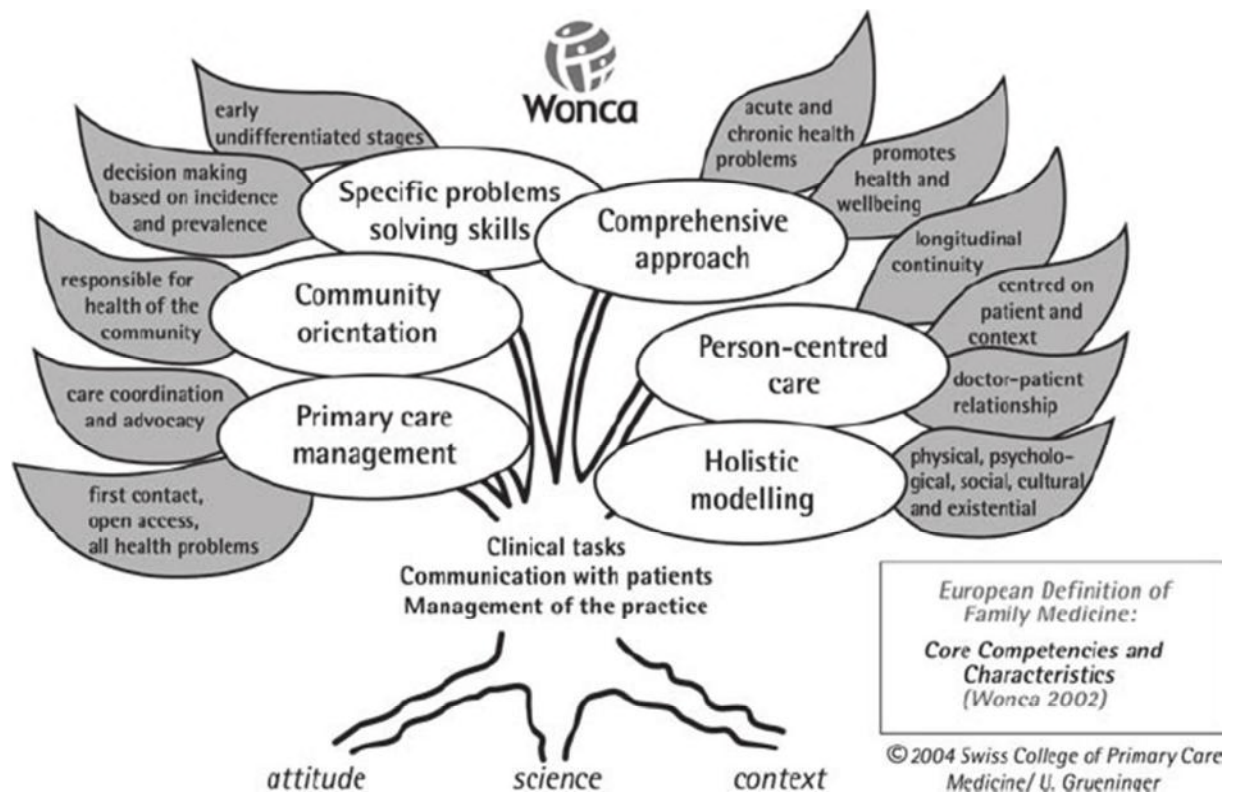
- I. Contextual: understanding the context of doctors themselves and the environment in which they work, including their working conditions, community, culture, financial and regulatory frameworks.
- II. Attitudinal: based on the doctor's professional capabilities, values and ethics
- III. Scientific: adopting a critical and research based approach to practice and maintaining this through lifelong learning and quality improvement.

Table 3: detailed description of the three features wherein GP/FM is embedded

Contextual	- Use the context of the person, the family, the community and their culture in diagnosis, decision making and management planning; - Show personal interest in the patient and his environment and be aware of the possible consequences of disease for family members and the wider environment (including working environment) of the patient.
Attitudinal	- Based on the awareness of one's own capabilities and values; - Identifying ethical aspects of clinical practice (prevention/diagnostics/therapy/factors influencing lifestyles); - Justifying and clarifying personal ethics; - Being aware of the mutual interaction of work and private life and striving for a good balance between them.
Scientific	- Being familiar with the general principles, methods, concepts of scientific research, and the fundamentals of statistics (incidence, prevalence, predicted value etc.); - Having a thorough knowledge of the scientific backgrounds of pathology,

	<p>symptoms and diagnosis, therapy and prognosis, epidemiology, decision theory, theories of the forming of hypotheses and problem-solving, preventive health care;</p> <ul style="list-style-type: none"> - Being able to access, read and assess medical literature critically; - Adopting a critical and research based approach to practice and maintaining this through continuing learning and quality improvement.
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All these – the characteristics, the core competences, and the additional features – are interrelated as is demonstrated through the WONCA Tree produced by the Swiss College (2004)³.



2. How trainees have to achieve this?

In 2005 the EURACT Educational Agenda was published². It provided a comprehensive framework **to teach and learn** the core competences and was designed to different aims, all related to GP/FM education; (1) for those involved in delivering GP/FM education and in developing programs of teaching to provide a framework to teach the core competences, (2) for those who learn the discipline, to offer an educational framework for setting the learning aims, and monitoring their achievement, (3) for those involved in curriculum building, to determine priorities in teaching and learning GP/FM.

The EURACT Educational Agenda defines for each core competence and the related abilities the learning objectives². These objectives cover the knowledge, skills and attitude required at the end of a GP/FM training program (*for details see the Educational Agenda*). Also educational methods are described (see Table 3), next to consequences on setting (*see point 5*) and on

assessment (see point 3). The latter is extensively illustrated in a later EURACT document, i.e. The EURACT Performance Agenda of GP/FM (2014)⁴.

Although specialty training programs can differ, it is strongly advised to take into account some general principles:⁵:

- The training should be **outcome based**: the focus on goals should prevail the focus on time-frames;
- The training should be **learner centred**. It should be based on the individual learning goals, according to a learning needs assessment that is discussed with the trainer. Out of this comes an individual learning plan, which is updated regularly;
- Trainees should be trained during every day work at the practice or clinic (**workplace learning**);
- Trainees should practice in interaction with trainers especially trained in Specialty Training (see also II);
- Protected study time for trainees should be provided;
- Self-directed learning and reflective practice should be promoted as well as small group reflection on critical incidents and/or concrete doctor-patient interactions;
- **Learning environments** should be safe and should be considered as developmental spaces for trainees: this means contextually oriented as well as socio-emotional oriented⁶;
- Feedback should be continuously provided in a constructive way;
- The 'doctor as a person' should be explicitly emphasized. This means developing personal strengths and trying to balance personal values and health.

Table 4: The 6 core competences and examples of relevant educational methods²

Core competences of GP	Ways to learn or teach the core competences
Primary care management	<ul style="list-style-type: none"> - Direct observation by the learner of the trainer performing in general practice; - Performance of general practice tasks by the learner during a general practice attachment; - Simulation of general practice tasks with feedback on performance; - Portfolio learning to encourage learners to document the performance of a wide range of learning activities in practice such as case presentations, audits, and guided reading.
Person-centred care	<ul style="list-style-type: none"> - Teaching that starts from the patient's presenting problems, giving a central place to narratives and patient stories in different educational events; - Using instruments like genograms, family plots and eco-mapping that includes aspects related to work and leisure; - Training in a patient-responsive communication model as a prerequisite for the patient-centred method of clinical practice; - Thematic sessions on explicit topics like mutual decision making, respecting autonomy, giving feedback, non-threatening questioning, etc.; - Lectures on defined concepts and models in relation to the topic to offer a framework for understanding and meta-cognitive interpretation of what is happening in the doctor-patient encounter; - Tutored practice and reflective learning models during practice training.
Specific problem solving skills	<ul style="list-style-type: none"> - Self-study on incidence and prevalence (reading, lectures); - Creation of (or reading an existing) practice profile; - Performance of consultations in general practice with reflection and supervision of decision making; - At the knowledge level, reading texts of physical diagnosis and case study methods; - At the skills level, simulation of history taking and physical examination (e.g. in a skills lab); - Observation of trainee performance in real daily practice and feedback to the trainee; - At the attitude level, discussion with the trainee on the value of partnership with the patient.

Comprehensive approach	<ul style="list-style-type: none"> - Mandatory early exposure to clinical experiences within the primary care setting; - Short lectures in order to explain the concepts of multi-morbidity and the functioning of the health care system; - Role-playing in teaching communication skills; - Assignments (e.g. presentations to patients in a community health care setting); - Case descriptions and small groups discussions in order to assess the complexity of the patient; - Individual consultation review; - Clinical audit; - Continuing work and reflection in primary care setting.
Community orientation	<ul style="list-style-type: none"> - Structured reflection on work-based experience (case discussion, patient records review); - Conventional classroom methods (lectures, seminars, small group sessions, problem solving); - Visiting health and social care institutions; - Field work; - Projects; - Audit of practice; - Facilitated personal study.
Holistic modelling	<ul style="list-style-type: none"> - Case studies, single case descriptions and presentations; - Videotaped interviews, video analysis of clinical encounters, simulated patients; - Group discussion, one to one discussion. - Field visits, observation in practice, supervision in tutor practices, - Work with art, literature and movies.

3. How to assess the achieved competences?

In 2015, the Specialty Training Committee (EURACT) wrote a statement on assessment in Specialty Training for GP/FM⁷. As the document proposes a comprehensive model for assessment in GP specialty training, we quote the entire document to introduce this assessment topic.

Historically, assessment has been rigidly defined as either summative or formative but this division has been discredited. It is now recognized that assessment needs to be embedded within training, be integral to the curriculum and be a driving force, which encourages the development of the trainee. Assessment should be collaborative and facilitate a partnership approach between the trainee and the trainer. The statement outlines the basic principles and tools that can be used and can be adapted for local purposes.

The assessment process will promote reflection. Reflective activity is a cognitive process, which enables learners to turn learning into performance. Learners that reflect well perform better than learners who do not reflect. Reflective activity can increase professionalism in the learners and better engagement with their professional life.

The goal is to ensure the development of a confident doctor who is competent, takes responsibility for care of the patient and functions as a safe, independent, professional family doctor. A strong appreciation of the need for reflective practice and life-long learning will be fostered by this approach.

The most important features of the GP trainees' assessment are:

- Assessment should be high quality, programmatic[†] and embedded in the curriculum of specialty training. It should be transparent and planned in advance as part of the specialty training program. Curriculum planning will require the inclusion of a clear assessment plan at the outset. The assessments will need to be effective, robust, sensitive, professional and scientifically grounded.
- Assessment will require a commitment to providing adequate protected time and training of assessors; this training will need to include bench marking of assessors.
- Assessment should lead to the production of meaningful feedback as opposed to producing a score as the only assessment outcome. Meaningful feedback is characterized by a two-way conversation between trainer and trainee, a dynamic process where the trainee learns about his or her performance from the trainer and reflects on means of adapting his/her performance in future if required. This process can be instantaneous or over a relatively short time frame.
- A process for the documentation of the assessments and reflections on learning will be required.
- Assessment at this level correlates with activity at the top of Miller's pyramid - the "Does" level, and provides an environment for professional, ethical, spiritual and personal growth.
- This form of assessment helps to identify issues with the trainee's performance at an early stage and to determine whether these will improve with appropriate intervention. It also provides evidence for decisions to be made about whether the trainee should proceed with training.
- The assessments will contribute to a periodic aggregate assessment performed by an external resource, close to the educational process but not part of the ongoing trainee-trainer relationship. The aggregate evidence will be reviewed by the external resource. The importance of the external resource is that it affords an element of protection to the vital trainee-trainer relationship. These are high stakes judgements, which need to be defensible.
- Assessment will inevitably be mainly based in the work place and involve review of different aspects of practice, e.g. hospital, domiciliary visits, practice.
- Feedback will be obtained from patients, peers and other professionals. Much of the informal mentoring that trainers undertake is integral to this framework. Multiple methods can be used but they all must stimulate reflection and facilitate feedback and learning.

In general, assessment of a practitioner's performance is best assessed in physicians' everyday practice settings, on-site, at his/her workplace (workplace-based assessment), and preferably done by direct observation⁴. It can happen during or at the end of the educational process.

To obtain sufficient reliability and validity, it is essential to use a variety of methods; i.e. a mix of tools, in different settings and by different raters. An educational management system that ensures protected time for education, planned follow-up and direct observation is also of significant importance

With these general principles in mind, it is possible to define per core competence some specific assessment tools or methods that can be used (tool-box). To obtain a qualitative correct/robust assessment of the trainees, training developers should make choices adjusted to their objectives, settings and organization of the Specialty training Program.

[†] Programmatic means that the assessment is embedded in the whole learning program. By planning in advance the mix of assessment tools that should be used at different times and at different settings by various assessors, trainees can use this feedback to develop and to grow towards being a professional, a GP.

In the next Table (table 5), tools per competence are listed (see: EURACT Educational Agenda)². Additionally, assessment methods per competence are described in detail in the EURACT Performance Agenda⁴.

Table 5: The 6 core competences and examples of related assessment methods^{2,4}

Core competences of the GP	Examples of related assessment methods
Primary care management	<ul style="list-style-type: none"> - Knowledge- MCQs and essays; - Management skills - OSCE and exams with simulated patients; - Performance in the daily work - repeated checklists and global ratings; Acquisition of attitudes - observation, (e.g. direct observation, sit-in, video recorded); - Discussion or interview in summative and formative assessment. - Case based discussion (CBD) - Consultation observation tools (COT) - Multi-source feedback (MSF) - Naturally occurring evidence (NOE) - Patient satisfaction questionnaire (PSQ) - Review of patient records (RPR) - Performance audit (PA) - Simulated patient or standardized patient (SP)
Person-centred care	<ul style="list-style-type: none"> - Observation (direct consultation observation or through simulated consultations). - Patient-based feedback ratings. - Chronological case progression. - Video patient-case recording and reflection. - Patient-case discussions and oral simulated patient-case reflections. - Group discussions, problem presentations or practice staff meetings. - Reflective educational portfolio.
Specific problem solving skills	<ul style="list-style-type: none"> - OSCE - Direct observation of practice using checklists and global ratings. - Oral examination by using hypothetical and developing case situations. The knowledge of prevalence and incidence can be assessed by MCQ, MEQ and orals. - Patient interviews or questionnaires can be used to assess patient satisfaction with the trainee's attempts to involve them in their care.
Comprehensive approach	<ul style="list-style-type: none"> - Cross-sectional (observation of a few patients) and longitudinal (several encounters in medical records): - Observation by peers: sitting in, video and audio recordings, one-way mirror; - Audit of medical records; - Feedback from patients/relatives.
Community orientation	<ul style="list-style-type: none"> - Records review to review achievement against target; - Records review to assess procedures to address needs of the non-attenders; - Case report, case description; - Observation of doctor and team in action. - Who could assess? - Self-assessment, internal audit; - External audit – review of process through peer appraisal. - Documentation tools: <ul style="list-style-type: none"> - Check lists; - Observation lists; - Consultation maps.
Holistic modelling	<p>Direct methods</p> <ul style="list-style-type: none"> - Sitting in with GP - Videotaped consultation analysis; - Simulated consultation; - Interviews with: Patients, members of the family, doctors; caregivers (formal and informal), other medical staff in the practice. - Interviews with peers or specialized professionals. <p>Indirect methods:</p> <ul style="list-style-type: none"> - Medical records consultation for search of information concerning the three fields/levels

4. How long should training last?

Training in GP/FM takes time. In addition to be mastered in all the clinical and generic knowledge and skills, GPs/FDs need to be confident in dealing with the uncertainties and complexities of the GP/FM workplace^{8,9}. Trainees have to learn how to deal with patients with undifferentiated symptoms and signs that consult GPs/FMs as front line doctors. Moreover, the changing nature of the GP workforce asks for increased skills in practice management and life-long learning⁸.

A survey among EURACT Council members shows the need of upgrading GP/FM to at least the same level as other medical disciplines/specialties given the complexity and relevance of GP/FM¹⁰. Average training time in GP/FM in Europe varies between two and six years^{8,11†}. Recent publications plea for a revision of the minimal length^{8,12}. Fundamental is the quality of basic medical training and GP specialty training in acquiring the above-mentioned competences.

In 1986 the European Community made specific training for GP/FM mandatory in all member states¹³. In 1993 a Directive (Directive 93/16/EEC) also defined the minimal acceptable length of specific training¹⁴, which was adapted in a new Directive in 2005 (Directive 2005/36/CE)¹⁵ (see Article 28 & Annex 5.1.4). Both Directives state that the following minimum requirements should be met: 1) a full-time course lasting at least three years⁵, and 2) on the one hand, at least six months in an approved hospital or clinic and, on the other hand, at least six months in an approved general medical practice or in an approved centre where doctors provide primary care^{14,15}. Training must be more practical than theoretical and must be centred in a GP practice (at least 50% of the training)^{8,14,15}. The latter is essential to obtain adequate training outcomes (*see point 5*).

5. Where should training be organized?

As stated above (*point 4*) the essential part (at least 50% of the training) of the training should take place in GP setting, since it is the only place where the core competences of GP/FM can be learnt. In the GP setting trainees encounter patients who are representative of their future populations¹⁶. In most of the (Western) European countries this is the case^{8,11,17}.

This is in line with the educational principle of workplace based learning, i.e. within patient care (on-the job learning). However, important and specific outcomes can also be acquired in hospital setting.

Trainers should work in **GP/FM practices** approved for speciality training. The major principles of approved training practices include:

- there should be evidence of a full cycle of audit of educational activity
- trainers should be specialists in Family Medicine and have satisfactorily completed a certified teachers course (on teaching and assessment) and in addition to this they should demonstrate that they are involved in educational activities
- practice should ensure protected teaching time with designated trainer
- provide advice and tutoring from designated tutor at all time during the consulting hours
- provide access to reference texts/journals
- ensure facilities for trainer-observed consultations
- training should make use of the national GP/FM curriculum
- the practice should provide a multi-professional training environment

† These data were checked and completed by a survey among EURACT Council Members (April 2018).

⁵ Article 28 of the Directive states that 'The specific training in general medical practice leading to the award of evidence of formal qualifications issued before 1 January 2006 shall be of a duration of at least two years on a full-time basis. In the case of evidence of formal qualifications issued after that date, the training shall be of a duration of at least three years on a full-time basis.' For evidence of formal qualifications of general practitioners see Annex 5.1.4.

- the practice should have a good structure for interaction with other contributors of healthcare.
- trainers must provide training and training environment that ensures fairness for all trainees independent of ethnicity, gender, disabilities, special educational needs.
- trainers must have a Personal Learning plan based on learning needs and the plan should be reviewed annually
- trainers should learn effective use of and reflection on the personal learning plan
- GP training should be developed, organised, administered and evaluated by GPs coming from an active GP background and by academic GPs

Hospital posts have traditionally played an important role in training of future GPs – mostly due to the service to hospitals these young doctors delivered – and training was based on the apprenticeship system of learning by doing. Hospital-based training is still of value for GP/FM trainees. However, in selecting adequate hospital posts, one should pay regard to some essential key principles. EURACT has provided guidance in this matter in a statement on Hospital Posts¹⁶.

Key principles (*educational context*):

- training in hospital posts is important and explicit aims of learning there should be formulated by GP Colleges or other representatives of GPs. As such learning in hospitals is also competence driven and goal oriented towards GP/FM.
- all specialist teachers should be adequately trained and accredited as teachers
- all trainees should have an educational supervisor during the educational period – preferably a GP
- all trainees should receive regular formative feedback of their educational needs leading to an educational plan
- at the end of each post continued learning needs should be appraised
- all posts should have release time to general practice
- the content of the training and the clinical work should be relevant for the future work as a GP – especially emphasis on the ambulatory work
- selection and evaluation of hospital posts should be based on the achievements of educational aims – and periodic inspection.

Training in hospital posts should add to the trainees' knowledge of (brief summary of the *clinical content*):

- life-threatening diseases and their complications and consequences and provide practical experience in a broad range of management decisions
- offer concentrated exposure to and experience of serious morbidity which is very important to clinical management within general practice but infrequently experienced
- giving insights into the interface between primary and secondary care

Apart from where the trainee works/learns also off-the-job learning (outside the practice) should occur. During protected study-time trainees must organise themselves to derive extra curriculum-based training. This is time for group learning, reflection, peer learning, seminars and workshops, visiting conferences, and learning specific skills. Such training should involve supervision and assessment of the trainee by a teacher. The trainee should use their personal learning plan to plan these activities.

6. How should selection of trainees occur?

Selection procedures play a crucial role in obtaining access to GP/FM specialty training. These procedures should be credible, fair, and publicly defensible.

Countries in Europe face different situations when it comes to selection for admission to GP/FM specialty training. Between countries, there is a great variety in selection procedures¹⁸. Procedures are likely to be shaped by local circumstances such as the number of vacancies, the number of candidates or the height and origin of financial resources. Is the aim to identify and eliminate the candidates who will underperform in training (selecting out) or to identify the best performing candidates in order to get the best future GPs/FMs? Should the process that enables those who have performed best during the selection process to be selected rank the candidates? Or is almost every candidate welcome because the number of doctors applying for GP specialty training low?

The central aim of a selection procedure should be to select the most suitable candidates. This is not as straightforward as it seems. It all depends on the predictive validity of the applied selection tools. Best selection practice involves a job analysis that identifies the required competences, the design of reliable assessment methods to measure them, and an ongoing review of predictive validity against future performance. In a recent BEME review on selection procedures for postgraduate specialty training (not only GP training) Roberts et al. found that Multiple Mini Interviews, Situational Judgement Tests and Clinical Problem Solving tests have favourable psychometric evidence. However, they come with a cost. Cost-effectiveness has not been evaluated properly. For traditional interviews, references, and personal statements there was no firm evidence of utility¹⁹.

In every country decisions should be made on what procedure best fits the local situation, regarding the number of vacancies, candidates and costs. When trainees fail it is wise to look back to the selection procedure and evaluate whether there were signs during the selection procedure that could have been picked up.

B. European Training Requirements for TRAINERS

In 2002 (and updated in 2012), the EURACT ST Committee described criteria on selection of trainers and teaching practices for specific training in GP/FM²⁰.

As regards GP/FM trainers it is stated that they should:

- work in a GP/FM practice approved for Specialty Training
- have satisfactorily completed an approved/accredited teacher's course
- demonstrate that they are involved in educational activities relevant to GP/FM teaching within and external to the practice, e.g. being engaged in CPD teaching and learning activities
- participate in CPD concerning training and teaching methods (teach-the-teachers)
- be certified as having completed specialist training in family medicine
- be familiar with the regulatory framework surrounding specialist training in GP/FM
- be familiar with the technical and administrative aspects of the assessment of GP/FM trainees
- make use of their national GP/FM curriculum
- understand the structure and purpose of their role in the training program of their designated trainees

Also for the GP/FM practices where trainees are educated, guidelines are given. A distinction between infrastructure, governance, and educational facilities is made.

- Infrastructure: GP/FM Specialty Training teaching practices should:
 - comply with national health and safety legislation
 - provide trainees and educators with safe working environments where personal safety is not compromised
 - ensure medical records are maintained to an adequate standard, compliant with national regulatory standards
 - ensure a well-equipped dedicated room for trainees' consultations
 - demonstrate provision of a comprehensive, cost effective and continuing service to patients (supported by relevant protocols and procedures)
 - demonstrate evidence of effective use of the primary health care team
 - maintain a significant incident review process / patient-complaints procedure
 - maintain and develop a Practice Orientation Guide for each incoming trainee
- Governance: GP/FM Specialty Training teaching practices should:
 - systematically inform patients that it is a training practice
 - demonstrate role-modelling for clinical governance
 - provide evidence of an active
 - program of audit
 - hold regular practice meetings, in which the trainee is expected to participate and contribute to
 - respond to patient satisfaction surveys
- Educational facilities: GP/FM Specialty Training teaching practices should:
 - maintain an educational environment adequate to accommodate each trainee
 - ensure relevant specialty-specific educational expertise where this is necessary (access to a relevant specialist – e.g. an ophthalmologist – for tutorial or clinical experience)
 - provide access to adequate IT facilities in the practice
 - ensure protected teaching time with a designated trainer
 - provide advice and tutoring from a designated trainer at all times during the consulting hours
 - ensure facilities for trainer-observed consultations
 - provide access to reference texts / journals

Next to the guidelines, other conditions are specified to ensure appropriate implementation of ST in GP/FM; trainers and GP practices should provide educational opportunities, adequate feedback based on observations and assessment, a training schedule, and appropriate supervision. Furthermore fairness for all trainees, independent of ethnicity, gender, and special educational and other needs should be fostered.

As it cannot be assumed that every competent GP is also a competent teacher, trainers would benefit from extra and systematic training in teaching skills, theory or knowledge²¹. They should learn to deal with different learning styles and learning needs of trainees. Furthermore (new) concepts of teaching, coaching, and assessing should be part of train-the-trainer sessions. In this sessions or courses the different levels and expertise of teachers should also be taken into account. Therefore some programs – like the Leonardo da Vinci project (collaboration of EURACT with seven partner organisations) – organises courses at three levels of teacher expertise (novice, competent, and expert)²¹.

Being a trained teacher alongside extensive clinical work is a challenging issue that asks for ensuring sufficient time and resources to train the trainers. This should be especially resolved on macro-level; this is by faculty members and policy makers.

C. European Training Requirements for TRAINING INSTITUTIONS

With reference to the European legislation, the 2005 Directive¹⁵ speaks about a “competent authority”. This is any authority or body empowered by a Member State specifically to issue or receive training diplomas and other documents or information and to receive the applications, and take the decisions.

Although there are examples of good speciality training outside the realm of the universities, training institutions are preferably embedded in, or connected to universities or other academic institutions. This is important for the academic level and scientific quality of the training programs and the teachers. This also means investment in research and research projects specifically for GP/FM¹⁰. Furthermore, to provide continuity in education, GP specialty training institutions should have close relations with the GP program provided during the medical education curriculum. Good GP teaching for undergraduates and early clinical GP exposure is also important to attract future GPs^{10,22}.

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