



Educational CPD: how UK GP trainers develop themselves as teachers

Dr Mark Waters & David Wall

To cite this article: Dr Mark Waters & David Wall (2007) Educational CPD: how UK GP trainers develop themselves as teachers, Medical Teacher, 29:6, e160-e169, DOI: [10.1080/01421590701482431](https://doi.org/10.1080/01421590701482431)

To link to this article: <https://doi.org/10.1080/01421590701482431>



Published online: 03 Jul 2009.



Submit your article to this journal [↗](#)



Article views: 979



View related articles [↗](#)



Citing articles: 3 View citing articles [↗](#)

WEB PAPER

Educational CPD: how UK GP trainers develop themselves as teachers

MARK WATERS & DAVID WALL

Birmingham Research Park, West Midlands Deanery, Birmingham, UK

Abstract

Background: There is little in the literature giving the perspective of UK General Practice (GP) trainers on their development as teachers.

Aims: What motivates GP trainers develop themselves as teachers? What obstacles to their professional development do GP trainers perceive?

Method: A questionnaire to all GP trainers in the West Midlands Deanery in 2004.

Results: 360/444 (81%) questionnaires were returned. 56.6% of GP trainers had another educational role in addition to training GP Registrars in the practice. 15.8% of trainers possessed an educational qualification. 13 had completed a Certificate in Medical Education and 28 were engaged in study towards that qualification. Trainers wanted more time to spend on their development as teachers than they presently have, and would then be interested in a wider variety of learning methods. However, 56.6% of trainers would still not choose to undertake a university-accredited course. Female GP trainers perceived more difficulty in obtaining protected time for their development as teachers (Educational CPD) ($p=0.021$), were significantly less sure of their partners' support for this development ($p=0.033$), and were more likely to agree with trainers undertaking a Certificate in Medical Education ($p=0.003$). Having an additional educational role did not affect trainers' ability to take protected time, but significantly increased the amount of time aspired to ($p=0.005$). Nothing made more difference to trainers' perception of their ability to undertake Educational CPD than did the perceived attitude of their partners.

Conclusions: Educational CPD was very important to GP trainers, but getting protected time was difficult. Consideration of the needs and opinions of partners was a very strong barrier to trainers taking sufficient protected time. Given more available time, GP trainers would be more likely to consider gaining academic qualifications in education. However, this was not be something that all trainers wanted.

Introduction

Much has been written by statutory bodies, universities, postgraduate deaneries and The Royal College of General Practitioners concerning the essential competences of GP trainers, how these should be developed, and the most effective ways for them to be assessed (Joint Committee on Postgraduate Training for General Practice 2001; Freeman et al. 2002; Boendermaker et al. 2003). There is much less in the literature giving the GP trainer perspective (Spencer-Jones 1997; McKinstry et al. 2001). The new term 'Educational CPD' will be used here to describe trainers' professional development in their educational role.

GP Trainers merit separate consideration from their hospital teaching colleagues (Langlois and Thach 2003; Starr et al. 2003), whose faculty development needs have previously been described (Wall and McAleer 2000). There are long-established attitudinal differences, as illustrated by Pereira-Gray (1984), who summarized the core values and beliefs held by GPs in relation to their teaching role:

General Practitioners believe that teaching skills are separate from, although closely related to,

Practice points

- GP trainers thought that educational CPD was very important to their development as medical educators.
- GP partners understood the need for trainers to undertake educational CPD.
- Getting protected time for educational CPD was difficult, and was perceived more so by female trainers and by urban general practitioners.
- Female trainers valued the credibility of university educational qualifications more than male trainers.

clinical medicine; that they require additional time to learn; and that time spent in teaching deserves additional remuneration.

There are several factors which make GP Trainer Educational CPD relevant now, including: the NHS appraisal process; the movement to professionalise medical teachers (Eitel et al. 2000; Herrmann et al. 2003; Rashid and Siriwardena 2005) and the creation of GPs with Special Interest (GPwSI) (Thornett et al. 2003).

Correspondence: Dr Mark Waters, Cantilupe Surgery, 51 St Owen Street, Hereford HR1 2JB. Tel: (01432) 268031; fax: (01432) 352584; email: mark.waters@nhs.net

It has been said that faculty development programmes within an organization are a window on the values and beliefs of that organization (Bligh 2005). Examining GP trainers' attitudes and perceptions of their own opportunities for development may therefore be a measure of the relationship between trainers and the Deanery that exists as part of faculty development. Meighan (Meighan and Siraj-Blatchford 2004) wrote of learners picking up 'an approach to living and an attitude to learning' from the teaching institution and in this way the values and norms of the Deanery can be seen as a kind of hidden curriculum in the faculty development of GP trainers. In general faculty development has been seen until recently as a neglected area (Meurer and Morzinski, 1997; Wilkerson and Irby, 1998; Quirk et al. 2002, 2005; Langlois and Thach, 2003; Bligh, 2005).

The specific questions of interest for this study were:

- what motivates GP trainers to spend time on their professional development as teachers?
- what obstacles to their professional development do GP trainers perceive?
- when engaging in educational CPD, what activities do GP trainers find most effective?

Methods

Subjects and settings

There were approximately 440 GP trainers in the West Midlands Deanery (the exact number varies from year to year), and this was chosen as a suitable population to study. The West Midlands Deanery has a population of 5.6 million people, about 10% of the United Kingdom as a whole. This Deanery includes a very wide variety of geographical settings, from very rural areas (Herefordshire, parts of Staffordshire and Shropshire), through small University cities (Worcester and Warwick), to industrial conurbations (Birmingham and the Black Country), which contain inner city areas with notable deprivation. This population can reasonably be said to represent the variety of geographical contexts in which GP training occurs in the UK as a whole.

The West Midlands Deanery office provided a spreadsheet of the current GP trainer database on 12th March 2004. At this time the database contained 444 names and addresses. These were used to produce address sheets for the questionnaires.

The questionnaire

The questionnaire was developed by the authors and initially presented by MW in the context of a workshop for GP trainers in Herefordshire. The feedback on relevance and usability of the questionnaire resulted in several useful modifications. All efforts were made to maximize the return of completed questionnaires (Edwards et al. 2002). These strategies included sending the questionnaire accompanied by a personalized letter from the authors, printed on West Midlands Deanery notepaper, and the questionnaire itself was printed on pink paper. Freepost return envelopes were included. A schedule

was planned for sending out the questionnaires, with second and third postal reminders to non-responders.

The questionnaire was designed so as to include a range of question-types. Most questions were multiple choice or dichotomous (yes/no). One question was made up of eight sub-questions, each with a 6-point Likert scale. Word descriptions ranging from 'Strongly disagree' (for 1) through to 'Strongly agree' (for 6) were provided. This was an ordinal scale, as each point on it was defined, and they can be seen to have a hierarchy, but the interval between each point could not be held to be uniformly consistent (the difference between 'slightly agree' and 'agree' cannot be assumed to be the same as the difference between 'agree' and 'strongly agree'). A six-point scale was chosen so as to force a commitment in response; there was no option to say 'I don't know'. All questions addressed a single issue. In the Likert questions, some positively framed and some negatively framed statements were used, in an attempt to ensure careful application of the rating scale.

The final questionnaire was formally piloted on 15 GP trainers by post, resulting in a 100% return.

Statistical analysis

Data from the questionnaires was entered into SPSS for Windows 13.0. Because of the non-parametric nature of the Likert data, one-way analysis of variance (such as ANOVA) was not an appropriate test, and so Mann-Whitney and Kruskal Wallis statistical tests have been used (Jamieson 2004, 2005). These tests assign a rank to each of the data (for example, based on the range 1 = strongly disagree, up to 6 = strongly agree), and then use the calculated mean of these ranks. Because no assumptions were made about the distribution of the data in the wider population, the test has less predictive power than both the t test and the ANOVA, both tests being more appropriate to parametric data (Pell 2005).

Results

Descriptive statistics

A total of 360 out of 444 questionnaires were returned (81% response rate). Not all respondents answered every question. Most trainers (251; 69.3%) were male. Trainers had been qualified as doctors for a mean of 22 (10–36) years. The GP Trainers in the West Midlands had a wide range of experience, and just under half had been in the role for more than 8 years. Almost every one of the trainers (355/357) worked in a group practice. There was a wide range of practice setting represented within the training community of the West Midlands Deanery, as shown in Table 1. (Note that almost 20% of respondents did not answer this question, which suggests the format may have been confusing to some).

A total of 211 (56.6%) GP trainers had another educational role in addition to training GP Registrars in the practice. The range of other roles is shown in Table 2 (some trainers had more than one additional role).

Only a small proportion of trainers (57/360; 15.8%) in the West Midlands possessed an educational qualification at the

time of the questionnaire study. When asked if currently studying for an educational qualification, a total of 61/360 (16.9%) said they were; a slightly higher proportion than those already having completed a qualification. The number of those already having completed a Certificate in Medical Education (13) was less than half of those now engaged in study towards that qualification (28). The number of current Masters students (18; 5%) was three times the number who had already completed their studies (6; 1.7%).

One of the factors expected to affect GP trainers' attitude to Educational CPD was the provision of some protected time for this activity. Responders to the questionnaire were evenly divided; 173 (48.1%) said they did have protected time, and 177 (49.2%) said they did not. However, when asked how much time was protected for Educational CPD, more than 80% of responders considered they did get at least one day a year. When asked what activities were undertaken during this protected time, the Trainers' Workshop was easily the most frequently cited, with 82.2% of trainers declaring this activity. Personal reading, learning through meeting other trainers and Deanery-organized courses made up the majority of other activities.

Trainers were asked how much time they would like to spend on educational CPD, if it were properly supported and funded, and generally there was a desire for a greater amount of time (see Table 3). 276/366 (75.4%) indicated they would like between one and four hours per week. This would translate into a range of 5.75–23 days a year based on a 46-week year, and an 8-hour working day. This contrasts with the 1–6 days a year declared by the majority of trainers at the moment.

Table 1. Location of training practice.

Urban	89 (24.7%)
Suburban	81 (22.5%)
Rural	40 (11.1%)
Mixed	80 (22.2%)
Non-responders to this question	70 (19.4%)
Total	360 (100%)

Table 2. Other Educational Roles of trainers.

Educational Role	Frequency
GP tutor	16
Course organizer for vocational training scheme	27
GP tutor for primary care organization	15
Deanery Associate director	4
Deanery programme director	12
Undergraduate tutor	89
GP appraiser	74
Lecturer or senior lecturer	24
Other	44

When asked what activities might be undertaken in the desired protected time, there was a much wider variation than the activities cited as currently undertaken, and a willingness to undertake more challenging learning methods. Table 4 shows the activities currently taken, and those that trainers indicated they would undertake, given sufficient protected time.

The Trainers' Workshop, currently easily the most frequently undertaken activity, would not remain so. Personal reading was cited as trainers' most preferred activity, with 69.1% choosing this. Many more trainers indicated their willingness to undertake distance learning activities, university-accredited courses, and to use videos of their own teaching to help them develop. However, even with as much protected time as they wish, 56.6% of trainers would still not choose to undertake a university-accredited course in medical education.

Comparative analyses

Although for all trainers, there was an even split between those able to take protected time for educational CPD and those not, female GP trainers did seem to perceive more difficulty in obtaining protected time for Educational CPD (Pearson's Chi-Square test $p=0.021$) (see Table 5).

Having an additional educational role did not affect trainers' ability to take protected time for Educational CPD, but significantly increased the amount of time aspired to. Pearson's Chi-square test (with 4 degrees of freedom) gave a p value of 0.005 (see Table 6).

The location of the trainer's practice did not make a difference to their declared ability to take protected time for Educational CPD.

Likert questions

In Table 7, all Likert responses are listed with the modal average responses. Because of the non-parametric nature of the data, means and standard deviations were not calculated. Modes of 1, 2 or 3 imply disagreement, and those of 4, 5 or 6 imply agreement with the statement.

Table 3. Amount of time desired for Educational CPD.

Amount of time desired for educational CPD (%)	
Less than an hour a month	5 (1.4)
An hour every month	51 (14.2)
An hour a week	166 (46.1)
2–4 hours/week	110 (30.6)
5–10 hours/week	13 (3.6)
Total responders to this question	345 (95.8)
Non-responders	15 (4.2)
Total	360 (100)

Table 4. comparison of educational activities that were currently undertaken with those that would be considered if adequate time were available.

Educational activity	Actually undertaken (%)	Would be undertaken, given sufficient protected time (%)
Trainers workshop	296 (82.2)	223 (61.6)
Personal Reading	170 (47.2)	250 (69.1)
Using videos of own teaching	60 (16.7)	155 (42.8)
Meeting with other GP trainers	147 (40.8)	197 (54.4)
University-accredited courses	63 (17.5)	157 (43.4)
Courses organized by the Deanery	158 (43.9)	182 (50.3)
Distance learning	27 (7.5)	124 (34.3)
Anything else	26 (7.2)	11 (3)
Total	360 (100)	360 (100)

Table 5. Ability to take time for educational CPD by gender of trainer.

	CPD time	No CPD time	Total
Male	132 (48.4%)	116 (46.8%)	248
Female	40 (39.6%)	61 (60.4%)	101
Total	172	177	349

Table 6. Time desired for educational CPD for those with and without other educational roles.

			Other educational role	
			Yes	No
Time desired for educational CPD	Less than 1hr/month	Count	3	2
		Expected count	3.0	2.0
	1 hr/month	Count	19	32
		Expected count	30.2	20.8
	1 hr/week	Count	102	64
		Expected count	98.4	67.6
	2–4 hrs/week	Count	70	41
		Expected count	65.8	45.2
	5–10 hrs/week	Count	11	2
		Expected count	7.7	5.3

From the frequency table, some very broad conclusions may be drawn about the opinions and beliefs of GP trainers in the West Midlands.

- Trainers did have difficulty in getting time for educational CPD.
- Educational CPD was important to GP trainers.
- There was no strong feeling that all GP trainers should do a Cert Med Ed.
- The MRCGP was important to being a GP trainer.
- Trainers believed that good trainers were not born that way, but developed into the role.

- In general, GP partners did understand the need for trainers to undertake CPD.
- There was ambivalence about whether a Certificate in Medical Education was a more relevant qualification than the MRCGP for GP Trainers.
- Protected time for Educational CPD should be in addition to leave.

Because of the already noted significant difference between male and female GP Trainers with regard to their perceived ability to take protected time for educational CPD, Table 8 shows the mean ranks of the responses to the Likert questions

Table 7. Likert responses.

	SD	D	SI D	SI A	A	SA	Total	Mode
I have no difficulty in getting time for educational CPD in my practice	32	110	84	57	40	24	347	2
Educational CPD is important to GP trainers	4	5	6	27	150	153	346	6
All GP trainers should do a Cert Med Ed	74	94	74	70	26	13	351	2
The MRCGP is not important to being a GP Trainer	99	107	45	36	41	25	353	2
Good trainers are born, not made	44	115	75	86	26	7	353	2
My partners do not understand my need for CPD	71	122	65	51	30	11	350	2
A Cert Med Ed is a more relevant qualification than the MRCGP for GP Trainers	29	74	78	82	43	15	321	4
Protected time for Educational CPD should be in addition to study leave	7	17	20	62	141	105	352	5

SD = Strongly disagree (1); D = Disagree (2); SI D = Slightly disagree (3); SI A = Slightly agree (4); A = Agree (5); SA = Strongly agree (6).

Table 8. Likert responses according to gender of trainer.

	Gender	Mean rank	p value
I have no difficulty in getting time for educational CPD in my practice	Male	178.62	0.168
	Female	162.74	
Educational CPD is important to GP trainers	Male	173.08	0.896
	Female	174.49	
All GP trainers should do a Cert Med Ed	Male	166.03	0.003
	Female	200.34	
The MRCGP is not important to being a GP Trainer	Male	174.02	0.383
	Female	184.13	
Good trainers are born, not made	Male	170.75	0.066
	Female	191.97	
My partners do not understand my need for CPD	Male	168.27	0.033
	Female	192.83	
A Cert Med Ed is a more relevant qualification than the MRCGP for GP Trainers	Male	156.88	0.189
	Female	171.73	
Protected time for Educational CPD should be in addition to study leave	Male	173.77	0.414
	Female	183.01	

broken down according to gender. The differences between male and female responses have been tested for significance using Mann–Whitney U, and the *p* value is quoted in the final column of the table.

Two of these gender differences reached statistical significance. Firstly, with a *p* value of 0.003, the statement ‘All GP trainers should do a Cert Med Ed’ was significantly more likely to be agreed with by a female GP trainer than a male GP trainer. This was particularly interesting considering that in general GP trainers tended to disagree with this statement.

Secondly, the statement ‘My partners do not understand my need for CPD’ was also more likely to be agreed with by female GP trainers, with a *p* value of 0.033. This has to be seen in the context of the overall view of trainers that their partners did understand their need for CPD. However, it seems that female trainers were significantly less sure about this than their male counterparts.

In Tables 9–12 the results for these two Likert questions were shown for female and male trainers separately.

The possibility of a relationship between the perceived ability to take protected time for educational CPD and other attitudes and beliefs of trainers was explored. Table 13 shows the mean rank responses to the Likert statements in the group of trainers who answered ‘yes’ to the question ‘Do you currently have protected time for your CPD as a trainer?’ compared to the group that answered ‘no’.

These data demonstrated some internal consistency in the questionnaire, with a highly significant association between answering ‘yes’ to the question ‘Do you currently have protected time for your CPD as a trainer?’ and agreeing with the statement ‘I have no difficulty in getting time for educational CPD in my practice’. The other significant correlation shown here was between a trainer’s ability to take educational CPD time and the trainer’s perception of his/her partners’ attitudes. Those trainers who answered ‘no’ to the question ‘Do you currently have protected time for your CPD as a trainer?’ were more likely to agree with the statement ‘My partners do not understand my need for CPD’, with a highly significant *p* value of 0.008. None of the other parameters have a significant association, suggesting that

Table 9. All GP Trainers should do a Cert Med Ed (female trainers only).

	Frequency	Modal average
Strongly disagree	12	Slightly agree
Disagree	26	
Slightly disagree	23	
Slightly agree	28	
Agree	8	
Strongly agree	5	

Table 11. My partners do not understand my need for CPD (female trainers only).

	Frequency	Modal average
Strongly disagree	17	Disagree
Disagree	33	
Slightly disagree	17	
Slightly agree	19	
Agree	11	
Strongly agree	6	

Table 10. All GP Trainers should do a Cert Med Ed (male trainers only).

	Frequency	Modal average
Strongly disagree	62	Disagree
Disagree	68	
Slightly disagree	51	
Slightly agree	42	
Agree	18	
Strongly agree	8	

Table 12. My partners do not understand my need for CPD (male trainers only).

	Frequency	Modal average
Strongly disagree	54	Disagree
Disagree	89	
Slightly disagree	48	
Slightly agree	32	
Agree	19	
Strongly agree	5	

what a trainer believed about the importance of educational CPD, or the MRCGP, or the value of a Certificate in Medical Education made less of a practical difference to their ability to take protected time for developing themselves as teachers than did the attitude of their partners.

Trainers who had another educational role were significantly more likely to believe that all trainers should do a Certificate in Medical Education (p =less than 0.001) (see Table 14). Although trainers as a whole group believed that Educational CPD was important, those with other educational roles believed this significantly more emphatically than those without (p =0.004).

Trainers working in rural practices were more likely to agree with the statement 'I have no difficulty in getting time for educational CPD in my practice' (see Table 15). Those in 'mixed' settings were next most likely, followed by 'suburban', and those in 'urban' practices were least likely to agree (p =0.007). The same pattern of responses were reflected in the association between practice setting and the statement 'My partners do not understand my need for CPD', with trainers working in urban settings most likely to agree, and those in rural settings more likely to disagree (p =0.026).

An association was also seen between practice setting and the statement 'A Cert Med Ed is a more relevant qualification than the MRCGP for GP Trainers'. Trainers working in urban settings were least likely to agree with this statement, and those in mixed settings more likely to agree (p =0.015).

Table 16 shows the association between years spent as a trainer and the responses to the Likert questions. For the statement 'Educational CPD is important to GP trainers' trainers

in their first year of practice were much less likely to express agreement. Those who have been training for between 1 and 4 years were most likely to agree (p =0.01).

Trainers in their first year of training were more likely to agree with the statement 'My partners do not understand my need for CPD' (p =0.005).

Summary of factors affecting GP trainer attitudes

Female GP trainers were more likely to agree that all trainers should do a Certificate in Medical Education, and more likely than their male counterparts to feel that their partners did not understand their need for CPD. Trainers with other educational roles were more likely to believe that trainers should do a Certificate in Medical Education, and be more emphatic in their belief in the importance of educational CPD. In general, trainers' perception of the attitudes of their partners appeared to be the most powerful influence on their ability to take protected time for educational CPD. Trainers working in urban areas were more likely to believe that their partners did not understand their need for CPD. Those in urban areas were also least likely to believe that a Certificate in Medical Education was more relevant than the MRCGP. Trainers working in rural areas appeared to find less difficulty in getting time for educational CPD, and those in urban areas most difficulty. Trainers in their first year of training were least likely to see the importance of educational CPD, and most likely to feel that their partners did not understand their need for CPD.

Table 13. Likert responses according to ability to take protected time for CPD.

	CPD time?	Mean rank	p value
I have no difficulty in getting time for educational CPD in my practice	Yes	205.51	<0.001
	No	137.48	
Educational CPD is important to GP trainers	Yes	179.32	0.076
	No	162.08	
All GP trainers should do a Cert Med Ed	Yes	171.54	0.857
	No	173.42	
The MRCGP is not important to being a GP Trainer	Yes	170.79	0.612
	No	176.09	
Good trainers are born, not made	Yes	167.38	0.251
	No	179.35	
My partners do not understand my need for CPD	Yes	158.02	0.008
	No	185.42	
A Cert Med Ed is a more relevant qualification than the MRCGP for GP trainers	Yes	155.58	0.705
	No	159.37	
Protected time for educational CPD should be in addition to study leave	Yes	176.31	0.526
	No	169.82	

Table 14. Likert responses according to other educational role.

	Other educational role	Mean rank	p value
I have no difficulty in getting time for educational CPD in my practice	Yes	174.89	0.841
	No	172.75	
Educational CPD is important to GP trainers	Yes	185.49	0.004
	No	156.49	
All GP trainers should do a Cert Med Ed	Yes	192.82	0.000
	No	151.53	
The MRCGP is not important to being a GP Trainer	Yes	172.12	0.268
	No	184.00	
Good trainers are born, not made	Yes	177.60	0.892
	No	176.14	
My partners do not understand my need for CPD	Yes	178.46	0.497
	No	171.21	
A Cert Med Ed is a more relevant qualification than the MRCGP for GP trainers	Yes	162.36	0.737
	No	158.87	
Protected time for educational CPD should be in addition to study leave	Yes	178.36	0.664
	No	173.81	

Discussion

What motivates GP trainers to spend time on their professional development as teachers?

Starr's (2003) study into community preceptors in Massachusetts identified a number of factors which motivated those doctors to teach, including the intrinsic satisfaction of being involved in education, the enjoyment of having knowledge and skill about teaching, the sense of belonging to a group of teachers, and the feeling of a sense of responsibility to teach medicine. There was also a clear identification that in some way all doctors were teachers, regardless of a formal teaching appointment. In Spencer-Jones' (1997) study of UK GP trainers, similar motivations were identified. In addition, trainers

were motivated by their own experiences as learners and GP training was seen as having a high status within the profession.

The attitude of the trainer's GP partners has emerged from this study as a pivotal force. To a large extent, this did seem to be a potentially negative influence. Some trainers were motivated by the opportunity to undertake a university qualification in medical education. However, there was a great deal of ambivalence. Trainers were more likely to see its value if they had another role as well as GP training, and if they were female. Trainers who were least likely to see value in carrying out a university-accredited course in medical education tended to be male, working in urban practices, and did not have an additional educational role. One of the reasons for trainers with other educational roles being more motivated to gain qualifications could be their awareness of the need to compete

in the 'educational marketplace'. This issue does not apply at the moment to training registrars in the practice. It may also be that trainers who have taken on additional educational roles were a subset of doctors with greater than average enthusiasm for teaching and learning. Another positive motivating force for undertaking university-accredited qualifications was the increased esteem in which trainers believed they would be held by their partners as a result. This could potentially explain the greater attraction of a university qualification to female trainers, who as a group tended to feel less confident of support in their educational role from their partners.

What obstacles to their professional development do GP trainers perceive?

The two biggest obstacles to professional development were the attitude of the GP trainer's partners, and the challenge of finding protected time. The trainer's beliefs regarding the

importance of educational CPD, or the MRCGP, or the value of a Certificate in Medical Education made less of a practical difference to the protected time taken for developing themselves as teachers. This effect of partners' attitudes was felt most acutely by trainers in the first year of the role, and by female trainers.

Trainers working in the most urban areas found greatest difficulty in taking protected time for their educational CPD, which reinforced the conclusion that the pressure of clinical workload was a significant obstacle to be overcome.

A conflict was perceived by trainers with regard to finding time to support development in their training role, and finding sufficient time to support their other clinical and non-clinical CPD. The training role was seen as a peripheral activity, and so worthy of less time for CPD than their 'core' work. Trainers in this study suggested that around four days a year was a suitable amount of time for their educational CPD.

Table 15. Likert responses according to practice location.

	Location	Mean rank	p value
I have no difficulty in getting time for educational CPD in my practice	Urban	127.28	0.007
	Suburban	134.46	
	Rural	175.48	
	Mixed	153.21	
Educational CPD is important to GP trainers	Urban	140.09	0.980
	Suburban	144.21	
	Rural	138.95	
	Mixed	141.68	
All GP trainers should do a Cert Med Ed	Urban	155.21	0.196
	Suburban	140.56	
	Rural	122.54	
	Mixed	145.81	
The MRCGP is not important to being a GP trainer	Urban	139.49	0.469
	Suburban	136.92	
	Rural	155.23	
	Mixed	152.59	
Good trainers are born, not made	Urban	148.09	0.850
	Suburban	139.20	
	Rural	140.25	
	Mixed	148.09	
My partners do not understand my need for CPD	Urban	159.86	0.026
	Suburban	146.13	
	Rural	115.58	
	Mixed	136.37	
A Cert Med Ed is a more relevant qualification than the MRCGP for GP Trainers	Urban	120.52	0.015
	Suburban	122.15	
	Rural	127.91	
	Mixed	155.06	
Protected time for educational CPD should be in addition to study leave	Urban	143.74	0.726
	Suburban	141.91	
	Rural	134.45	
	Mixed	151.35	

When engaging in educational CPD, what activities do GP trainers find most effective?

One of the interesting insights from the questionnaires was the indication that trainers were prepared to consider a much broader and more innovative range of teaching and learning activities, given sufficient protected time. Most educational CPD at the moment involves personal reading, learning through meeting other trainers, and Deanery-organised courses. The trainers' workshop is the most important resource.

Trainers would like to have more protected time for their development, and if this were available then this picture would change. The trainers' workshop, currently easily the most frequently undertaken activity, would be overtaken by more personal reading. Many more trainers indicated their

willingness to undertake distance learning activities and to use videos of their own teaching to help them develop. Although many more trainers would consider a university-accredited course if more protected time were available, more than half still would not. Time was not the only obstacle to undertaking a Certificate in Medical Education.

Summary of conclusions, and suggestions for future research

- Educational CPD was very important to GP trainers, but getting protected time for this activity was difficult. Trainers believed that good trainers were not 'born that way', but developed into the role.

Table 16. Likert responses according to years spent as a trainer.

	Years	Mean rank	p value
I have no difficulty in getting time for educational CPD in my practice	<1 year	166.95	0.548
	1–4 years	158.54	
	5–7 years	180.55	
	>8 years	171.36	
Educational CPD is important to GP trainers	<1 year	142.13	0.010
	1–4 years	192.57	
	5–7 years	168.82	
	>8 years	160.29	
All GP trainers should do a Cert Med Ed	<1 year	174.32	0.656
	1–4 years	167.05	
	5–7 years	184.49	
	>8 years	167.21	
The MRCGP is not important to being a GP trainer	<1 year	181.07	0.395
	1–4 years	159.20	
	5–7 years	167.97	
	>8 years	179.37	
Good trainers are born, not made	<1 year	159.38	0.665
	1–4 years	170.85	
	5–7 years	165.93	
	>8 years	178.38	
My partners do not understand my need for CPD	<1 year	207.46	0.005
	1–4 years	162.83	
	5–7 years	193.26	
	>8 years	156.49	
A Cert Med Ed is a more relevant qualification than the MRCGP for GP trainers	<1 year	138.79	0.630
	1–4 years	157.22	
	5–7 years	163.55	
	>8 years	156.51	
Protected time for educational CPD should be in addition to study leave	<1 year	158.58	0.532
	1–4 years	182.55	
	5–7 years	166.93	
	>8 years	169.78	

- There was ambivalence amongst GP trainers regarding university-accredited qualifications in medical education. Although the MRCGP was important to being a GP trainer, trainers as a group were undecided as to whether an educational qualification is more relevant.
- In general, trainers perceived that their GP partners did understand their need to undertake CPD. However, consideration of the needs and opinions of partners was a very strong barrier to trainers taking sufficient protected time for the educational CPD they need.
- Female GP trainers were generally less confident about the support of their partners, and may have valued the credibility gained from a university-accredited educational qualification more than did male GP trainers.
- Given more available time, GP trainers would be more likely to consider gaining academic qualifications in education. However, this will never be something that all trainers will want, and this should remain optional.

These findings were consistent with, and build on previous research findings. Further research is needed to explore the attitudes of groups of GP trainers who have not specifically been focused on in this study. Examples of these groups were

- those who have gained academic qualifications in education;
- those who have recently given up training, (why do trainers stop training?);
- those considering becoming a trainer in the future.

The views of senior GPs in the Deanery would be very helpful to give another perspective on these issues, although to an extent these have been the authors of some of the opinion pieces in the medical education literature, so in that sense their views may be already known.

More female GP trainers were part time than their male counterparts. It was not clear from this study whether the views attributed to female trainers could be explained entirely by part time working, rather than a gender difference. Further research could explore this.

The views of GP Registrars (the trainees) on the effectiveness of teaching from their trainers, and on the appropriate level of protected time, and educational CPD would give a 'user' perspective which this study has not addressed.

Different qualitative approaches could offer more insights into the issues identified here. Ethnographic studies of training practices could explore the dynamics between trainers and their partners, and in-depth interviews with individual trainers may be a better method for untangling the complex and conflicting forces affecting educational CPD and development in the teaching role.

Limitations of this study

No attempt has been made to establish whether non-responders differed significantly from responders to the questionnaire component of this study. This is a limitation to the validity of the conclusions, but this bias has been minimized by the excellent response rate of 81%.

Notes on contributors

MARK WATERS is a GP in Hereford. He has been involved in GP training, and providing teaching and learning opportunities for medical educationists for 13 years.

DAVID WALL is Deputy Regional Postgraduate Dean in the West Midlands Deanery and Professor of Medical Education at Staffordshire University.

References

- Bligh J. 2005. Faculty development. *Med Educ* 39:120–121.
- Boendermaker PM, Conradi MH, Schuling J, Meyboom-de-Jong B, Zwierstra RP, Metz JCM. 2003. Core characteristics of the competent general practice trainer, a Delphi study. *Adv Health Scie Educ* 8:111–116.
- Edwards P, Roberts I, Clarke M, DiGuseppi C, Pratap S, Wentz R, Kwan I. 2002. Increasing response rates to postal questionnaires: Systematic review. *Br Med J* 324:1183–1192.
- Eitel F, Kanz KG, Tesche A. 2000. Training and certification of teachers and trainers: The professionalization of medical education. *Med Teach* 22:517–526.
- Freeman R, Smith F, Hornung R. 2002. Courses for new GP trainers: A literature review and survey for the UKCRA. *Educ Primary Care* 13:1–12.
- Herrmann M, Lichte T, Gulich M, Wächter H, Donner Banzhoff N. 2003. Academic professionalization in and of General Practice Experiences, Evaluation, Outlook. *Zeitschrift für Allgemeinmedizin* 79:609–612.
- Jamieson S. 2004. Likert scales: How to (ab)use them. *Med Educ* 38:1217–1218.
- Jamieson S. 2005. Author's reply. *Med Educ* 39:971–971.
- Joint Committee on Postgraduate Training for General Practice. (2001). Recommendations on the Selection of General Practice Trainers. Available at: <http://www.jcptgp.org.uk/policy/selection.pdf> (access June 13th 2005).
- Langlois JP, Thach SB. 2003. Bringing faculty development to community-based preceptors. *Acade Med* 78:150–155.
- McKinstry B, Dodd M, Blaney D. 2001. What teaching skills do trainers think they need to improve? The results of a self-assessment questionnaire in southeast Scotland. *Educ Primary Care* 12:412–420.
- Meighan R, Siraj-Blatchford L. 2004. *A Sociology of educating* (London, Continuum International Publishing Group Ltd).
- Meurer LN, Morzinski JA. 1997. Published literature on faculty development programs. *Fam Med* 29:248–250.
- Pell G. 2005. Use and misuse of Likert scales. *Med Educ* 39:970–970.
- Pereira DJ. 1984. Minimum standards for training. Selecting general practitioner trainers. *Br Med J* 288:195–198.
- Quirk ME, Stone S, Chuman A, Devaney ONS, Mazor K, Starr S, Lasser D. 2002. Using differences between perceptions of importance and competence to identify teaching needs of primary care preceptors. *Teach Learn Med* 14:157–63.
- Quirk ME, Haley HL, Hatem D, Starr S, Philbin M. 2005. Primary care renewal: Regional faculty development and organizational change. *Fam Med* 37:211–8.
- Rashid A, Siriwardena AN. 2005. The professionalisation of education and educators in postgraduate medicine. *Educ Primary Care* 16:235–246.
- Spencer-Jones R. 1997. Why do trainers train? *Educ Gener Practice* 8:31–39.
- Starr S, Ferguson WJ, Haley HL, Quirk M. 2003. Community preceptors' views of their identities as teachers. *Acade Med* 78:820–825.
- Thornett A, Chambers R, Baker M. 2003. Pick'n' mix career options for GPs. *BMJ Career Focus* 326:s213–215.
- Wall D, McAleer S. 2000. Teaching the consultant teachers: identifying the core content. *Med Educ* 34:131–138.
- Wilkerson L, Irby DM. 1998. Strategies for improving teaching practices: A comprehensive approach to faculty development. *Acade Med* 73:387–396.