Introduction
The role of the Military General Practitioner (GP) is, at its core, very similar to a National Health Service (NHS) GP. That is, to deliver Primary Care to a given patient population. However, there are additional roles and wider responsibilities that the Military GP has in addition to this core role. Managing civil servants, being a Divisional Officer, management of the occupational health of specialist workers and deploying to conflict zone are all additional roles that do not apply to the vast majority of NHS GPs.

Overview of GP Training
Training in General Practice is directed by the Gold Guide (1), (which applies to all postgraduate specialty training in the UK) and the curriculum as laid down by the Royal College of General Practitioners (RCGP)(2). In order to qualify as a GP in the UK, all trainees, civilian or military, must meet the learning outcomes and competencies defined by the RCGP and adhere to the Gold Guide throughout training.

Compared to other specialties, GP Training in the UK is short (3). Upon commencing GP Specialty training, all trainees must complete a selection of hospital rotations in Specialty Training (ST) years 1 and 2, which may vary in length between 4 and 6 months. A rotation in a General Practice Surgery of between 4 and 8 months is usually incorporated. There may also be specific rotations, that are only available for military GP trainees, either for Rehabilitation at Headley Court or Psychiatry at a Department of Community Mental Health (DCMH). The final year of training in ST3 is always in Primary Care at a GP Practice. A typical example of a GP Training plot is shown below.

For military trainees, the option to undertake the ST3 GP Registrar year in a Military Practice may be available. The Army and the RAF have some Family Practices that are accredited for GP training. These practices look after serving personnel along with their immediate families and are thus considered suitable for GP training, as a trainee is likely to see a wider age and pathology range (and thus be able to adequately cover more of the curriculum) than would be experienced in a Military Practice that only looks after Service Personnel.

Aim
This article aims to compare the benefits and disadvantages that can occur when training in an NHS or a Military Practice and discuss options for future improvements to GP training.

The Military GP
Defining what makes a good, effective and competent Military GP is quite difficult. At the end of their GP training, a newly qualified Military GP is considered to be a competent GP for the NHS setting. The examinations for MRCGP are designed around competencies for the delivery of primary care to a civilian population within the NHS setting.

Defining the competencies required for the delivery of safe and effective primary care (and the associated administration) in the military setting is not straightforward. The role of the GP in the military is varied, as are the specialist groups that are looked after, and proceeding directly from completion of training back to the military setting as a Deputy Principal Medical Officer (DPMO) or Regimental Medical Officer (RMO) is a significant step-change.

This step-up from supervised to independent practice is recognized by the RCGP and they have developed a support package called First5 (4). This has the aim of supporting newly qualified GPs through their first 5 years of independent practice on to becoming established practitioners. There are preliminary discussions underway to develop a Military version of the First 5 initiative, but no firm plans have been announced.

It is arguable that the step-change on qualification for Military GPs is even greater than for those colleagues in the NHS, but the standard GP training based on the RCGP curriculum and delivered by the NHS is not designed to prepare Military GP trainees for this.

For example: the managing of civil servants that work in a Military Health Centre - writing their reports etc, the occupational health aspects of looking after specialist workers, being a divisional officer to junior personnel, managing diving accidents (e.g. in Gibraltar), are just a small example of a wide range of responsibilities that are

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usually inherited when a newly qualified Military GP takes up his/her first post. Another example: For a relatively senior OF3 (Lt Cdr/Maj/Sqn Ldr), it is considered important in the wider-Military to have undertaken a Staff Course, but this is not feasible whilst in GP training and can prove a significant handicap on return to the Military. Indeed most Non-Medical Branch Officers (Warfare, Logistics etc) will have routinely undertaken staff course as an OF2 (Lt/Capt/ Fit Lt) or at the latest as a junior OF3, as it is important not only for staff work, but also for promotion.

NHS Training
In ST3 a GP Registrar in an NHS practice will easily see a wide range of age groups, social backgrounds and pathologies - in particular, chronic disease, palliative care, drug & alcohol abuse and psychiatry. This is often at the expense of military contact, as practices may not be near to a military base and the daily routine precludes it. The training experiences available in the NHS in preparation for exams and ultimately becoming a competent GP, is likely to cover far more of the curriculum than may be achievable in a military practice.

But, working full time in an NHS Practice and consequently having minimal time for any regular contact with the military can result in an ‘admin burden’ for the trainee, with difficulty accessing the Military DII computer network or the Joint Personnel Administration (JPA) computer system, getting reports done and keeping up to date with defence issues, among many others. It also runs the risk of the trainee becoming demilitarised.

Military Training
Some Army and RAF Medical Centres are Family Practices, of which several are accredited for GP training and it is therefore possible to complete the ST3 GP Registrar year at one of these practices. The clear advantage with training in this setting is in the day-to-day contact with the wider-military, military patients and with the experienced Military GPs and Civilian Military Practitioners (CMPs). It will also likely make for a smoother transition from ST3 to the first appointment as a qualified Military GP.

However, there are disadvantages when it comes to training in this setting, mainly in the breadth of pathology that is encountered – it is likely to be narrower than in the NHS. The average patient age in a Military Family Practice is much lower than in the average NHS practice and consequently a large range of pathology associated with advancing years (mainly chronic disease) is far less likely to be experienced. Some Military Family Practices have a restriction on the number of dependents that may register and may also stipulate that they must be living in service accommodation (5). This may further restrict the practice population and contribute to providing a comparatively narrower spectrum of patients and pathology than would be seen in the NHS setting.

Also, when considering revalidation, it is important for Military GPs to complete an adequate number of Out Of Hours (OOH) shifts or in-hours sessions per year, in order to continue to be considered a competent GP from the RCGP’s point of view. By undertaking OOH work or doing sessions in a NHS practice, the Military GP is able to maintain contact with managing a wider age and pathology range and thus be considered to remain ‘current and competent’ for appraisal and revalidation purposes. It is the best of a difficult situation, to balance the need to remain current from the civilian revalidation point of view, whilst recognising that Military GPs have busy, time-consuming commitments in their main role. It therefore makes little sense for the GP trainee to be underexposed to the wider age and pathology base of the general population during their GP training, as this potential lack of valuable experience can only really be a drawback for the both individual and the Military, whether for exams, deployments or in future years.

The Military-run Highlands & Islands Course offers Military GP trainees the opportunity to undertake a weeklong residential training course, covering areas such as discussion of training issues, lectures and small group teaching, maintaining contact with the Military (e.g. meeting with the Single Service Advisors in GP) and exam preparation. Held at least three times a year at either Fort Blockhouse or Keogh Barracks, it is considered one of the cornerstones in Military GP training, delivering high quality training that is highly regarded and generally considered to be significantly better than some of the training available to NHS GP trainees.

The Halfway House
The RN does not have any Family Practices that are accredited for GP training. To try and offer the benefit of both worlds, there is the option available to train for half a week in a RN Health Centre and the other half of the week in an NHS Practice. This has a limited capacity of four trainees at any one time and is open to all services.

This model seems to potentially satisfy the problems outlined so far with training in purely a NHS or a Military Practice, however issues do remain. It is quite feasible for a trainee to be ‘disconnected’ from both Practices and not fully integrate into either team. For example, it is possible that they may miss meetings at each Practice and for training opportunities to be difficult to arrange. Each Practice has its own quirks and working styles and training between two is not ideal. There may also be difficulty in supervision and getting consultations observed etc., because neither practice is fully responsible for the trainee.

The Future...
There has recently been a proposal by the RCGP for an extension to GP training of 1 year, making it a 4 year programme (3). This has received initial approval by the Department of Health, but the more difficult task of securing agreement on funding remains. If the proposed extension goes ahead, it could potentially provide an invaluable opportunity for the Defence Deanery to define a Military component to the curriculum, which could be incorporated into the 4th year of training for Military GP
trainees and would provide recognition for some of the formal and informal learning which currently takes place during the first appointment post-training.

**Discussion**

There is no completely perfect training model for producing a military GP within the current 3-year training period. Each Single Service has its quirks, with different structures for the delivery of primary care and each has different requirements of their GPs. For example an Army GP does not have the need for an in-depth knowledge of the maritime environment and conditions at sea, whereas a RN GP certainly does. With the new Defence Primary Health Care structure, a more tri-service approach to postings may develop.

The majority of Military GP trainees complete their training in the NHS, so it is easy to become demilitarised and relatively out of touch as a result, despite opportunities for brief contact with the military, such as the Highlands & Islands Course. The extra competencies required to make effective Military GPs are not measured or clearly defined and it is arguable that there is a requirement for a period of ‘re-militarisation’ immediately post-qualification on receipt of the Certificate for Completion of Training (CCT). This period of time, at least 12 weeks in length for arguments sake, would provide a valuable period to re-engage with the Military in general, re-familiarise with medical administration procedures and go on courses (such as Staff Course, Practice Managers Course etc.). This could all take place prior to commencing the first DPMO/RMO post and would likely result in a smoother transition to independent practice within the military, enabling the newly qualified Military GP to be more effective from the outset. If the proposed Military First 5 initiative were to be implemented then it could be a very useful source of support to newly qualified Military GPs.

The possibility of an extension to GP training and potentially incorporating a military component to the curriculum is likely to be several years in the making, but if it could be achieved, it would be an effective solution to many of the issues outlined in this article. In the intervening years, the proposal for a defined period post-CCT for military re-engagement would be fairly straightforward to implement and could prove hugely beneficial to the individuals and their units.

Revalidation raises a difficult issue. Revalidating within one’s scope of clinical practice in the military is relatively straightforward. But taking into account the restrictions in breadth of clinical practice (little elderly care or paediatrics, etc.) that exist for the Military GP and if as an organisation, the Military does not encourage and facilitate its GPs to maintain their wider skills set (e.g. through OOH work or a session a week in a civilian Practise) then the ultimate outcome is GPs becoming de-skilled in these areas, which in the long term is detrimental not only to the individual GP for future career prospects, but just as importantly it is also damaging for the military as an organisation, primarily because when deployed the GP will have lost vital skills in clinical areas that whilst not always important when working at a base in the UK, may prove invaluable when operational with their unit.

**Summary**

There is clearly a significant step from being a well-supported GP Registrar to being a fully independent GP in the NHS and this is even more apparent for a newly qualified Military GP. There are many additional duties and responsibilities placed upon a Military GP that the current training curriculum and exams do not cover and which must be learnt post-CCT, whilst undertaking independent practice for the first time. Having a Military First 5 initiative for support during this time would no doubt be of some use, but having a dedicated period of training to re-militarise newly qualified Military GPs would provide an opportunity to improve and make more efficient the initial transition from training to independent practice. In the long term, incorporating as much as possible of this proposed period of post-CCT Military training into a 4th year of GP training would be the ideal. However, discussions between Surgeon General, the Defence Deanery and the RCGP would be required to define which training elements would be acceptable to be incorporated and there will no doubt be some aspects (e.g. weapons handling) that might be deemed unacceptable by the RCGP, and thus a period of post-CCT Military training may still be a key component of a longer term solution. The options for enhancing Military GP training warrant thorough exploration as they have the potential to provide significant benefit not only for future trainees but also for the military in general.

**References**

5. RAF Marham Medical Centre http://www.raf.mod.uk/rafmarham/aboutus/rcm.cfm Accessed 19 Nov 13

**Authors:**

Surgeon Lieutenant Commander T Herod RN, GP Registrar  
Dr Johnson G A (MRCGP, MFTMRCPS (Glasg), Partner  
Tavyside Health Centre, Tavistock, Devon, PL19 9FD