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A qualitative study of the experiences of training in general practice: a community of practice?

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Doctors training to become general practitioners (GPs) enter new 'communities of practice'. For instance, they initially experience various types of isolation, need new skills and knowledge and find the organisation of general practice different to hospitals. 'Communities of practice' concepts help explain some of their experiences. The social nature of learning is shown by their need for relationships that support them and the diverse ways in which they receive feedback. But there are limitations to communities of practice concepts. The registrars need to feel an important part of the practice; we argue that 'peripheral participation' is an uncomfortable position for them. The importance of individual consultations with patients in registrars' learning experiences means that defining shared goals of the particular community of practice is also problematic. It may be useful to regard relationships with patients as part of the complex social relationship web within the community of practice rather than its object.

Introduction

Although the emphasis is changing, medical education is still predominantly based in hospitals (secondary care) rather than general practice (primary care) both at undergraduate and postgraduate levels. Indeed junior doctors themselves tend to prefer work traditionally associated with hospitals such as acute over chronic illness, rare over common diseases and determinate over indeterminate problems; general practice is viewed as a compromise between more desirable hospital work and a life outside medicine even for most doctors who decide to become general practitioners (GPs) (Petchey *et al.*, 1997). Becoming a GP involves significant learning and training experiences for the junior doctor. Not only do hospitals differ from general practice in the range of illnesses seen, but the organisation within hospitals differs markedly from the organisation within a general practice. There is surprisingly only limited work investigating the transition required from hospital to general practice

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work for junior doctors. Doctors training to be GPs experience stresses such as family and job conflict, forming relationships with patients, knowledge gaps and preparing for examinations (Diamond *et al.*, 1995; Chambers *et al.*, 1996). In contrast, known positive experiences include establishing rapport with patients, using listening skills, being thorough and starting investigations confirming diagnostic abilities (Diamond *et al.*, 1995).

The training of doctors in the UK is currently undergoing change and will require more junior doctors to undergo a period of training in general practice regardless of their career intentions. At the time of the study reported here, junior doctors were required to work as a 'Pre-Registration House Officer' (PRHO) for one year after qualification to become fully registered. Following the PRHO year (usually spent in hospitals) the junior doctor wishing to become a GP could enrol on a 'vocational training scheme' as a registrar, either immediately or at a later date. A minimum of three years' training after the PRHO year was required to become an independent GP. Typically this consisted of two years in hospital posts considered relevant to general practice and one year in general practice. If the registrar had undertaken hospital work after the PRHO year before enrolling on a GP vocational training scheme, the hospital (but not general practice) component of the training might be reduced provided the previous training was in specialities considered relevant for general practice.

There are a variety of approaches as to when the junior doctor undertakes the GP based work. A commonly used approach is six months at the start and six months at the end, but other approaches include three months at the start and nine months at the end, or a full year of GP attachment at the end of the training. Within the practice the registrars work under the supervision mainly of the GP trainer, but also on occasions of other GPs. The amount of supervision typically will vary according to the experience and seniority of the registrar. It is expected that the registrar will receive one tutorial a week with protected time lasting approximately one 'session' (about three hours) and will receive informal teaching for a further session, not necessarily in protected time. The trainer is required to undergo a training programme before being appointed, and the whole practice in which the trainer and registrar will work is assessed and accredited as having reached certain standards for a training practice. The trainer is expected to undergo training for teaching, and both trainer and training practice are required to be re-accredited at intervals for training purposes.

Apart from completing the work in the hospital and GP attachments, the registrar is required to pass 'summative assessment' by the end of the training in order to work as an independent GP. There are various components to summative assessment, which included at the time of the study a Multiple Choice Questionnaire (MCQ) examination, satisfactory completion of an audit, the submission of a certain number of video consultations with patients which are assessed and required to be of a certain standard and a structured report completed by the registrar's trainer.

During the attachment to the vocational training scheme, the registrars meet together as a group. The arrangements for this vary between different schemes and

might include one afternoon a week during the whole of the training period both in general practice work and hospital attachments or more extensive blocks of work with longer gaps in between.

A potentially fruitful way to investigate learning and training within general practice is by comparison with research describing 'communities of practice' and 'legitimate peripheral participation' in other work environments (Lave & Wenger, 1991). According to their research, learning occurs within communities of practice—peripherally at first, but becoming increasingly engaged and complex with time (Lave & Wenger, 1991, p. 34). Learning is predominately a social activity and through engagement in the community of practice, the identity of the co-participant worker (and learner) is formed (Lave & Wenger, 1991, p. 52). Because of the predominantly social nature of the learning experience, learning in one given situation differs between individuals and particular activities lead to particular learning experiences. Learning, in contrast to the more traditional, 'vertical', transmission implied in the teacher/pupil relationship and 'mentoring' concepts, occurs between individuals in a horizontal and, to a large extent, non-cognitive way. Assessing the learning occurring involves assessment of what is happening to the individual, relationships in the organisation, goals and activities of the organisation and how the organisation is situated in the larger context—including, for instance, how it interacts with other organisations or 'worlds'. Such organisations or 'worlds' have indistinct boundaries, so individuals will work across the boundaries. Conflict is described as an inevitable characteristic of 'communities of practice' (Lave & Wenger, 1991, p. 54). There is, for instance, a conflict of power between established and new members. Changes and challenges of new goals within the organisation, or in the wider context as it impinges on the organisation, lead to discontinuity of the previous aims and practices of the community and conflict—indeed continuous change is a feature of such communities of practice.

A general practice would appear to have many features of a 'community of practice'. It consists of doctors, nurses, secretaries and managers and other health professionals working together. The practice will have certain goals, although perhaps these are not as simple as might at first be apparent. They might be effective treatment of patients, though often a single patient will only see one member of the practice. Other goals might involve the general direction and longer development plans of the practice as a whole. The registrars would fit into the concept of peripheral participants, since they do not form part of the central personnel of the practice who would be the GP partners who 'own' and share the profits of business together with employed staff. They differ from the concept of legitimate peripheral participant in that they usually will only be part of the practice for a specified period of time and so do not have the opportunity to move from the periphery to the true centre of the community of practice. Yet they take part in the work of the practice and learn to some extent as a co-participant in the work of the organisation. Learning for them is likely to be at least partially a social activity as they interact with the doctors, nurses and other personnel in the practice in the joint work of dealing with patients; horizontal relationships are likely to apply and be part of their working

and learning experience. They will join a specific community of practice with its own history and goals either explicit, or hidden and poorly articulated.

There are two related aims to this paper. The first is to draw upon qualitative data to investigate the problems encountered by registrars during training and assess how trainers and practices support them. The second aim is to investigate how GP registrar learning exemplifies, expands and differs from the communities of practice concepts described by Lave and Wenger (1991).

Method

Semi-structured interviews were carried out with 32 registrars (six as a pilot) and one focus group drawn from two training schemes serving a variety of practices from urban to rural settings in the North of England. The interviews and analysis were conducted by one of the authors, a trainer from one of the schemes (CSC).

Recruitment

The intention had been to interview two registrars from one scheme as pilot interviews and then interview registrars in their first six months from a different scheme. However, of 49 letters sent, only four replied agreeing to participate. Interviews with the total of six registrars therefore formed the pilot study. To improve engagement in the study, the results of the pilot interviews were given as 10-minute presentations to four groups of registrars (each of the three-year groups in one scheme, and one first-year group in the second scheme). The purpose of the study was outlined and a list drawn up of registrars willing to be interviewed. Letters explaining the study were sent to registrars from the first scheme absent at the time of the presentations inviting participation. Registrars willing to participate were contacted, choices of venue offered, and a mutually convenient time arranged.

The interviews

Open-ended questions were used to explore the areas of interest followed by more closed questions for clarification. The areas of interest included reasons for becoming a registrar, what had gone well and problems faced. Ways in which the trainer and practice had helped and supported, or failed to do so, were explored. A 'critical incident' technique (Diamond *et al.*, 1995) was used to study specific positive and negative events in their work. Daloz's (1986) and Connor's (1997) description of 'mentoring' and mentoring roles formed the basis of the interview schedule exploring the registrars' understanding of relationships with trainers. The amount and quality of feedback and the role of the day or half-day release scheme were explored. The focus group, a different group of 11 new registrars, were given the results from the individual interviews and the ensuring open-ended discussion was tape-recorded.

The interviews were audio-taped, fully transcribed and anonymised.

The analysis

Coding of each interview identified both descriptive and interpretive 'units of meaning' (Miles & Huberman, 1994, p. 57). Once 15 interviews had been coded, a 'scatter diagram' (Riley, 1990) grouped related codes to determine 'pattern codes'—themes encompassing several descriptive and interpretive codes (Miles & Huberman, 1994, p. 69). After further coding of the remaining interviews, all transcripts were re-read and a preliminary writing-up made of the findings. All transcripts were read again deliberately looking for non-confirmatory data and the writing-up modified to account for discrepancies.

Results

The details of the 26 registrars interviewed from 36 approached (72%) are given in Table 1.

Problems faced: knowledge gaps and isolation

The registrars were asked to describe the move from hospital work into general practice.

Many registrars expressed feelings of a 'jump' and knowledge gaps despite evidence that trainers had made considerable efforts to ensure a gentle induction. There was variation in how stressful the start felt—some feeling little anxiety, others feeling overwhelmed. 'Gaps' included knowledge of clinical disciplines not encountered before, the different organisation in general practice and dealing with indeterminate problems, as for this registrar:

> I think there are so many things in general practice that there aren't necessarily answers to or that you would never come across in hospital practice, sort of, you know from weird and wonderful things like skin rashes to sick notes. (Sarah)[1]

Feelings of isolation were common and particularly vivid for registrars transferring from House Office posts and for registrars interviewed in their first six months of training.

They articulated concerns about isolation in several ways. Some (11/26) thought general practice work inherently isolating. One doctor consulting contrasts with

Table 1. The registrar interview sample by year group and gender

	Year One		Year Two	Year Three	
	Scheme 1	Scheme 2	Scheme 1	Scheme 1	Total
Female	6	3	5	6	20
Male	3	1	1	1	6
	9	4	6	7	26

hospital work where several doctors and other professionals are involved with a patient, typified by 'ward rounds'. This registrar expressed the idea:

> and it's quite ice-breaking, just kind of going into work and going into little rooms, not really seeing anybody from hour to hour really. (John)

Other registrars (8/26) found their particular practice isolating, either from problems in cohesion between partners, or through exclusion from sensitive areas (such as partners' sickness) as occurred for this registrar:

> When I've walked in the coffee room and some of the partners are in there and they are obviously talking either about the reception staff or something and they just shut up when I walk in … I feel if I'm part of their team it shouldn't really matter what they say in front of me, because I won't repeat it, but I think sometimes they see me as something else, I'm not one of their team. (Becky)

Some registrars felt excluded wholly or partially from practice meetings. They resented this because similarly it had the result of making them feel they were not part of the practice.

The registrars (20/26) commonly mentioned isolation from peers. Hospital peers had several functions, including gossiping, moaning and socialising. They also allowed comparison—the way other junior staff worked could be seen directly. The registrars often made reference to age differences between themselves and the GPs, who in the registrars' view had different status, interests and responsibilities:

> I felt very lonely I think, I think that was the main thing when you start, you don't have that camaraderie and everyone else is that much older than you, yes it was lonely, you didn't quite mix with the staff because they all called you doctor which was most peculiar to me in the first place, and I didn't quite mix with the other doctors because they were all older with families and you'd be going out clubbing and you'd feel that they were sort of disapproving a little bit, and other things you were doing, yes it was just more lonely. Especially before you got into the group of the Wednesday afternoons. (Mary)

In contrast, a few registrars, significantly older and more experienced, regarded the GPs more like peers. In some practices receptionists and secretaries were also significantly older, although in other practices registrars shared some interests with receptionists of similar ages.

For less experienced registrars there was a sense of isolation in making decisions and taking responsibility for the first time (9/26). The registrar might be the only doctor seeing that particular patient which contrasted with hospital work:

> I thought it was pretty scary having come from being a house officer where you've got an SHO to ask to being in a room, and you can't really leave the room, to ask you know what's best. (Julie)

Now separated from the different career orientations of other hospital junior staff, a few registrars also felt isolated on returning to hospital training posts for part of their training. Educational events within hospitals served to emphasise the difference.

Faced with these stresses and shifting perspectives caused by the transition to general practice work, the next two sections—difficulties with self-confidence and importance of feedback—can be readily understood.

Lack of confidence

Poor self-confidence was apparent in half of the interviews. Direct questions concerning confidence were not asked; evidence was apparent in response to different questions.

Registrars described needing to maintain feelings of competence with patients, as for this registrar:

> Those are the difficult ones I think and not sort of really putting across to the patient that you really don't know what's happening and trying to sort of sound as though you. (Louise)

Home visits were difficult for some registrars who felt advice during surgeries could be more easily obtained without feelings of competence in front of patients being compromised.

Registrars also needed to maintain impressions of competence with trainers. Asking questions risked revealing inadequacies. Some registrars described limiting the number asked. Problems were exacerbated if relationships were poor:

> I get on very well with the trainer and so I don't hesitate at all to ask him anything really and some of the senior partners I tend to ask infrequently because, not that they've said anything or shown any reflection or anything like that. (Angela)

Feedback

The pilot interviews showed the need for more feedback and so questions about feedback were incorporated into the main interviews. It was apparent, though, from various areas in the interviews that registrars received feedback in diverse ways, some of which they would not necessarily define as 'feedback'. For instance, registrars mentioned gifts and cards from patients, the satisfaction of patients deliberately returning to see them and positive relationships with staff members.

Registrars commonly said they needed more feedback (20/26), but the type of feedback required varied. Some wanted more formal, structured feedback or more direct observation of their work; others a more informal, global assessment of comparison with others, more like reassurance:

> Well I think I'm getting quite good feedback on actual, like specific things, sometimes I maybe just want, it's not even feedback it's more like reassurance that I'm not doing too badly. (Sue)

Some registrars interpreted the lack of feedback from their trainers as indicating they were working satisfactorily; others worried that their trainer had not provided feedback for fear of upsetting them:

> I sometimes wonder if I don't get enough feedback when things go wrong and if they go drastically wrong I don't hear about it. (Angela)

Helps and supports

The registrars were asked how their trainers provided 'challenge' and 'support'. Clinical encounters and not teaching from trainers provided 'challenge'; good relationships with trainers provided support.

Good relationships with trainers (revealed by registrars' appreciation of trainers who showed interest in them as people, showed understanding and empathy and who went out of their way to help) enabled the registrar to ask questions freely. Explicit encouragement to ask questions and good organisational arrangements (such as reduced appointments in the trainer's surgery) to allow questions to be asked freely were also valued. Poor relationships described by a few registrars with opposing characteristics stifled the ability to ask questions.

The importance of 'role models' failed to come across in the interviews. With the possible exception of different case mixes of patients caused by the balance of male and female GPs in a practice, the gender of the trainer made no difference to the female registrars—it was the personality of the trainer that seemed important.

The half-day or day release scheme helped prevent isolation, although the registrars varied in how much they valued the structured programme of teaching. It enabled them to meet peers and make comparisons about workload such as appointment times, although those registrars, realising they had an easier workload, did not necessarily respond positively since it risked lowering their confidence. Other comparisons made included progress with examinations.

It was not just the individual trainer and day release scheme that was important in providing support but the whole practice environment as well. Registrars valued partners and other practice members whom they could relate to well and ask questions of freely. Often practices had a mixture of supportive and less supportive members. This might be a problem depending upon the ease of access to supportive members. Registrars might choose particular partners for particular questions, as for this registrar:

> I would take him a problem like 'I've got a woman with say … menstrual bleeding, who's on this, what shall I do?' Right, I would take it to him if I had that kind of problem but I wouldn't take to him a problem which I'm really worried about this patient, personally really worried. (Lucy)

Feeling part of the practice helped prevent isolation. Although a few registrars believed it was not feasible to be part of a practice in a six-month post (or only to a limited extent) and appeared content with this, most registrars who were happy in their practices felt part of the organisation and felt they were contributing positively to the practice, including workload. Participation in social events (usually with receptionists) and coffee meetings was important. Although a few registrars found it difficult when asked their opinion, particularly about sensitive areas within the practice, being invited to practice meetings and being included in minutes was important as evidence of being listened to and having one's opinion valued.

There was considerable variation in how much they were enjoying the experience, how the challenges were viewed, the extent of isolation felt, and how well they related to trainers and other practice members. Although data from the focus group discussion mainly only confirmed findings from the individual interviews findings, one focus group member argued that the particular fit between individual registrar and individual trainer might sometimes account for difficulties—it was not necessarily any one's fault. Evidence for this also came through interviews with

three sets of two registrars who had the same trainer but who differed in their reported experiences.

This registrar, with a good relationship with her trainer who had supported her through personal problems, articulated well the gaps in knowledge faced, the rewards found from facing them and how general practice, at least for her, was not a compromise between the more desirable work in hospital and a life outside medicine:

> Oh it's a challenge every day, all the way through, but not in an atmosphere where I've felt worried at all. That's what I've found, it's one of the reasons why I've decided to change career because I'm finding it a challenge and a stimulation. As I say you just don't know what's going to come through the consultation door and even if you flick through the notes and you think oh that patient, that'll just be such and such, they'll just surprise you with something completely different. You know, I've had lots of issues, social issues that have been discussed with me, domestic violence, child sexual abuse, and things that I just never ever dreamed that people would just sit there and tell me all about these kind of things that go on in their lives and it just amazes me that they do and that's not a situation I've ever dealt with before so it's a challenge all the time. I'm having to find new skills in myself to be able to deal with these kind of things. (Amanda)

Discussion

This study showed that the registrars were confronted with significant knowledge gaps which they found disquieting and feelings of isolation from various sources. They often displayed a lack of confidence and were worried about appearing competent. Requests for more feedback were common, though the nature of feedback was complex and included the need for reassurance. Challenges resulting in learning opportunities were provided by patient contacts and 'support' was more apparent than 'challenge' from trainers. Meeting peers was felt valuable for several reasons, and the whole practice was important in the learning experience.

There are many parallels with the evidence concerning student and initial teacher training. Work on mentoring relationships in teacher training would suggest 'support' is more important and more apparent than 'challenge'. In teacher training there is also an apparent need to feel competent in front of pupils and colleagues (Cole, 1991). Novice teachers find it advantageous to meet peers for reasons of support, making comparisons, feeling others are in the same position and prevention of isolation (Gibson, 1995). Requests for more feedback are common also in teacher training (Moran *et al.*, 1999). The need to feel part of the working community—practice or school—applies to both groups (Hebert & Worthy, 2001).

For training practices and GP trainers, there are a number of practical suggestions. There may be value in allowing more than one registrar in a practice simultaneously. Feelings of isolation occur early on; the release scheme should start early. Methods of encouraging involvement in the practice are important and include social activities with non-medical members of the practice where possible, attendance at practice meetings—important for feelings of inclusion and not just for management training—and being informed about 'sensitive' areas within the

practice. It is necessary to remember to provide positive reassurance on an informal as well as formal basis to those registrars working well. It was apparent that where relationships with trainers had floundered, problems had occurred early on—vocational training schemes should concentrate progress meetings early to identify the few registrars having particular difficulties. It is also a reassuring reminder that important teaching comes not from the trainers, but from patients. The evidence that registrars view 'challenge' as coming directly from professional practice may be encouraging since 'practical' knowledge (knowledge that has not been, and can not be, fully articulated) learnt in a professional context is what is essential for competent practice (Eraut, 1994, p. 33). Practical knowledge comes from consultations with patients and can only indirectly be articulated through formal teaching with trainers.

The presentation of the pilot interviews to each group helped engage the registrars and resulted in a good response rate. The presentations also helped the development of the study because the registrars would reflect on the presentation during individual interviews to confirm or modify the initial analysis. Although a trainer conducted the interviews, the registrars' accounts did not appear inhibited by this and indeed often were more open about their thoughts than they had been with their own trainers, reflecting the different role of researcher and trainer and also perhaps indicating inevitable differences in status between registrar and trainer.

The registrars provided considerable evidence that general practices can be considered 'communities of practice' (Lave & Wenger, 1991). For instance, registrars' descriptions of new challenges such as coping with significant gaps in knowledge, coping with indeterminate problems and taking more responsibility for decisions would indicate that they are now working within a significantly different environment compared to their previous work experiences in hospitals. Further evidence is apparent in their experience of feeling to some extent separated from the different goals and aspirations of their hospital colleagues. They also were very aware of the differences in the organisation of general practice work compared to hospital work. They are in effect 'newcomers' in, for them, a new 'situated activity' (Lave & Wenger, 1991, p. 32).

Lave and Wenger's work (1991) is useful in providing insights about the social nature of the learning experience of registrars within general practice. But it also has limitations. We illustrate first some of the social aspects of learning within the practice. We then discuss the limitations which include evidence that peripheral participation is an uncomfortable position for the registrars, and make a distinction between objective and subjective experiences of peripheral participation. Other limitations include the ideas of shared meanings of work within the community. We discuss the importance of consultations with patients in the work and learning experiences of registrars and suggest that it may be useful to consider relationships with patients as part of the complex social relationship web within the community of practice rather than the object and goal of the community of practice.

The social nature of learning, with relationships with others comprising the learning experience, was apparent in a number of diverse and complex forms.

Support from relationships with trainers was important to the registrars as they engaged in their new 'community of practice' and according to them was more important, or at least more apparent to them, than challenging learning experiences from such relationships. In their interactions, the registrars felt that they had to be seen as competent in their role as a doctor in front of patients, and indeed with other doctors. This was despite their training position where they are not expected to be as yet fully competent GPs. The importance of relationships with GPs other than the trainer, and with other members of staff within the practice, was highlighted by the registrars. This is again in keeping with the importance of 'horizontal' relationships within the learning organisation, as well as 'vertical' hierarchical relationships.

Receiving feedback was a further demonstration of the social nature of their learning experience. Requests for more feedback were frequently mentioned. Feedback experiences occurred with staff and patients as well as formally from trainers. But feedback incorporated not just cognitive aspects of performance, but also reassurance, support and positive feelings of being competent as a doctor. These complex forms of feedback are apparent only within and through relationships.

A criticism of Lave and Wenger's work (1991) is that they fail to acknowledge the significance of the prior learner identity in determining the type of learning experienced (Fuller *et al.*, 2005, p. 63). This research would support the importance of prior learner identity. Although the GP registrars came with an apparently similar (medical) background, their experiences within different practices varied considerably. Although in part this was due to the practices being different, experiences of different registrars working at the same practice differed, and indeed this was noted by the registrars themselves in the focus group. It would seem likely that both the differences in practice organisations and registrars' different prior identities accounted for different types of learning experience.

The registrars indicated that feeling on the periphery may not be conducive to the best learning experiences and so the concept of *legitimate* 'peripheral participation' does not fit their experiences easily. There may be a need to distinguish between 'objective' and 'subjective' experiences of peripheral participation. In many objective ways registrars are peripheral—they are present only in the practice for a specified, short time, with the remit specifically of training, and indeed a few explicitly stated that it was impossible to be part of the practice in a full way because of these aspects, and were content to be peripheral. Yet there were several examples of how feeling 'peripheral' was not comfortable for most of the registrars. Isolation from peers was one such example. In hospital, peers were common; their working community therefore had many more people in the same position, and in that sense they were more central in their community. In their new general practice working community, registrars felt that peers were absent. Some registrars felt hurt because they were excluded from sensitive areas in the practice, or were excluded from practice meetings. In contrast the learning experience was very different for those who did subjectively feel they were in the centre of the practice by, for instance, contributing significantly to the workload, being involved in social events, being invited to practice meetings, as well as receiving positive feedback from patients, GPs and

other staff. There are parallels with research investigating collegiality and feelings of being marginalised in other communities of practice. For instance, there are dangers of feeling marginalised, both to the developing identity of trainee lecturers in further education colleges and to future development of the experienced lecturers themselves (Bathmaker & Avis, 2005). The importance of collegiality over individuality for newly qualified teachers has also been described (Williams *et al.*, 2001).

A further difficulty concerns the shared understanding of what the 'community of practice' is doing and shared understanding of meanings of work. Although Lave and Wenger argue that a community of practice demonstrates such shared meanings (Lave & Wenger, 1991, p. 98), it would seem likely that different members of the practice will have different understandings of their work. For the practice manager they might involve practice development or financial improvements. GPs have different goals, as will nurses, and there may be different goals between individuals from the same discipline. The goals of the registrars are likely to vary considerably from the other members of the practice, since they are based on learning to become a GP, passing exams, and usually leaving the particular practice to become a GP elsewhere. This difference was illustrated by attendance at practice meetings which were valuable for the registrars, not so much for involvement in practice developments but for feeling part of the practice.

What does seem important for registrar learning and a contrast from other work investigating 'communities of practice' is the importance of consultations with patients as the learning experience. For the registrars the focus of the learning experience is consultations. The challenges for learning come from them; other relationships within the practice are important largely for how they support this activity. There are parallels between the GP registrars' understandings of the role of trainers' teaching in the practice and the differences in understandings between students and educators in a 'community of inquiries' (Darling, 2001). Students emphasise the compassion and reassurance aspects implied by 'community', rather than the more rigorous, 'inquiry' aspects implied in the phrase.

Defining or characterising the registrar–patient relationship within the model of communities of practice is therefore important. One possible approach would be to define the 'goal' of the community of practice as ensuring high quality consultations between doctors and patients. The difficulty with that approach is that in any individual consultation, only one doctor may see that patient—indeed this difference with hospital work was explicitly discussed by many of the registrars. Characterising the goal or goals of the practice as providing effective care for patients fails to account then for the individual nature of the consultation.

There is an interesting parallel with work distinguishing historically the relative position of general practitioners to hospital doctors (Armstrong, 1979). Arguably in the case of hospital doctors, the community consisted of other doctors and their power and influence was dependent upon how they were viewed by doctors in that setting. This was because they were able to form powerful bodies independently of patients. In contrast, GPs' influence had been determined more by how patients

viewed them and, in keeping with the registrars' experiences, were more isolated from medical peers. Providing effective care might be a reasonable goal for a community of doctors and other professionals working together for the care of an individual patient. In general practice, rather than viewing effective care as the primary goal or object of the organisation, the patient may be best seen as a person with whom relationships are established within the community of practice, rather than just the object or goal of care. This would seem to account better for the registrars' experience and learning goals, where individual patients in their consultations provide the challenging learning experience, and their relationships with patients provide feedback, identity formation and affirmation of the doctor as a competent GP.

Notes

1. Pseudonyms used throughout.

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