

Exploring the Use of Generative AI in Postgraduate GP Training: A Qualitative Study of Resident Doctors' Experiences and Perceptions

Gabriele Tankard

Newcastle University

Jiawen Dong

j.dong11@ncl.ac.uk

Newcastle University

Hugh Alberti

Newcastle University

Sarah Redford

Newcastle University

Sneha Punchayil

North Tees and Hartlepool NHS Foundation Trust

Alasdair Anderson

Auckland Medical Group

Research Article

Keywords: Generative artificial intelligence (GenAI), General Practice (GP), GP resident doctors, Qualitative research, Postgraduate medical education, Clinical Practice

Posted Date: October 14th, 2026

DOI: <https://doi.org/10.21203/rs.3.rs-11103417/v1>

License:   This work is licensed under a Creative Commons Attribution 4.0 International License.

[Read Full License](#)

Additional Declarations: No competing interests reported.

Abstract

Background

The use of generative artificial intelligence (GenAI) is increasing across healthcare, with existing research demonstrating its potential value and applications in medical education and clinical practice. However, less is known about how general practice resident doctors (GPRs), who have a unique position as both learners and practicing clinicians, are using generative AI in their everyday work.

Methods

This qualitative study, conducted within a post-positivist paradigm, explored the use of generative AI by GPRs, and their perceptions of its benefits, risks and training needs. Five semi-structured focus groups were conducted with 19 GPRs from the Northern region.

Results

The data were analysed thematically, and four themes were identified: 'AI as a response to workload and time pressure', 'AI as a clinical cognitive aid and educational support', 'Safe use of AI requires professional judgement and accountability' and 'Preparing for an AI-enabled future'. Participants used AI to improve efficiency with repetitive, admin-heavy tasks, such as documentation, written communication and portfolio development. AI was also viewed as an aid that supported clinical reasoning and learning by producing personalised outputs and reducing the time required to prepare learning materials. Participants highlighted concerns regarding accuracy, confidentiality and loss of skills, and described mitigating these risks by verifying AI-generated outputs and avoiding over-reliance on AI.

Conclusions

Our findings support emerging evidence that GenAI can reduce administrative burden while also assisting clinical reasoning and learning. However, concerns regarding accuracy, confidentiality and over-reliance reinforce that GenAI should supplement, rather than replace, clinical expertise, with responsibility for patient care remaining with the doctor. Focussing specifically on general practice (GP) resident doctors, this study provides insight into how clinicians who are still developing their skills and professional judgement perceive and navigate the introduction of GenAI into clinical practice. Their experiences highlight inconsistencies in current AI training and the need for clearer guidance to help GP resident doctors balance the benefits of generative AI against emerging clinical and professional risks as its role in routine practice continues to expand.

Background

Artificial intelligence (AI) has rapidly emerged as a potentially transformative technology, attracting substantial attention to its application in healthcare.⁽¹⁾ Unlike traditional, task-orientated AI systems, generative AI can create original visual, audio and multimodal responses to complete a wide range of

tasks.⁽²⁾ As generative AI becomes increasingly accessible and incorporated into many aspects of healthcare, studies have shown the significant promise AI holds in healthcare, including a range of medical, economic and social benefits.⁽³⁾ Research has also demonstrated the value of generative AI as a tool in medical education, which can support learning by gathering and synthesising information, and increasing access to timely feedback and reflective practice.^(4, 5)

At the same time, both individual clinicians and professional bodies have recognised the opportunities and challenges associated with generative AI. The Royal College of General Practitioners (RCGP) have issued a statement and produced further guidance on AI in GP training, which recognised that a consensus view on the use of AI is still emerging.^(6, 7) The RCGP describes AI literacy and 'effective, critical use of AI technology' as 'a skill all [general practitioners] GPs need', while also highlighting the potential danger of using generic AI products to generate diagnosis, interpret clinical information, or to advise on clinical management.⁽⁶⁾

Although studies have identified and discussed the use of AI for drug discovery, clinical trials, patient care and medical equipment,⁽⁸⁾ less is known about how clinicians are using generative AI in their everyday work, and how they perceive its role within clinical practice. Similarly, limited research has been conducted with GP resident doctors, who have a unique position as both learners and practicing clinicians. As healthcare systems continue to evolve and adopt digital technologies,⁽⁹⁾ GP resident doctors may be the early adopters of generative AI within healthcare systems.

Understanding how GP resident doctors currently use and perceive generative AI is essential in order to inform future training strategies. This study therefore aims to explore how GP resident doctors are utilising generative AI in their postgraduate training and clinical practice and to understand their perceptions of its benefits, risks, and training needs.

Methods

A qualitative study from a post-positivist paradigm was undertaken to explore the use of generative AI in postgraduate GP training and to understand the opinions and views of GP resident doctors in the Northern region. The participants were GP resident doctors, at any stage of training, in one UK region. They were invited to join focus groups via email and posters. Participant recruitment was voluntary, and they were given the choice of online or face-to-face participation.

Five focus groups were conducted, three online and two face to face. In total 19 participants were involved, varying from two to six per focus group. Focus groups lasted approximately 60 mins. The focus groups were delivered through a facilitated semi- structured approach. The interview schedule was designed by the research team based on the available literature and personal views of the research team (Supplementary File 1 – Interview Schedule). Participants were given the opportunity to explore their initial thoughts and own experiences and then the discussion explored the benefits, risks and future implementation of AI in medical practice. Informed consent was gained, and participants were reminded

by the facilitators that any information would be anonymised. Interviews were undertaken by SR, AA and SP. The focus groups were recorded and transcribed verbatim using digital platform auto-transcription software. The transcripts were then checked by the team before analysis.

The data were analysed thematically. The transcripts were read and coded and then recategorised into broader codes by GT and JD. The codes were cross-referenced by other members of the team for completion. The broader codes were then grouped into overarching themes to identify patterns in GPRs' AI use, perceived benefits and risks, and future implementation of AI in medicine. The final themes were discussed and agreed upon by all members of the research team.

Results

20 codes were constructed and subsequently arranged into four: 'AI as a response to workload and time pressure', 'AI as a clinical cognitive aid and educational support', 'Safe use of AI requires professional judgement and accountability' and 'Preparing for an AI enabled future'.

Theme 1 – AI as a response to workload and time pressure

Participants described AI as a tool that was commonly used to support everyday administrative and documentation tasks, and participants valued using AI as a tool to improve efficiency with repetitive, admin-heavy tasks. Rather than replacing clinical decision-making, AI was viewed as an option that allowed clinicians to spend more time on patient care.

Participants described a wide range of ways in which they were using AI, primarily to assist with routine tasks that clinicians were already capable of completing independently, to reduce the time and effort required. Although some tasks were clinically relevant, participants highlighted that the role of AI was in improving efficiency, rather than making decisions for them. Clinical documentation was one of the most commonly described uses of AI. Participants discussed their use of AI to draft or transcribe consultation notes, referral letters and other clinical documentation, which helped improve efficiency.

Participants differed, not only in the specific documentation tasks for which AI was used, but also in the extent to which AI was incorporated into their work. At one end of the spectrum, AI was used selectively to refine, or suggest additions to, documentation produced by the clinician. At the other, participants described using ambient AI systems that transcribe consultations in real time, and generated consultation notes, where the clinician was primarily required to review the output.

"I have my own way of documentation. I just use it to enhance my notes per se." (Focus group 3)

"[AI] records the consultation when the patient is in the room with you and then transcribes for you...once you finish the consultation everything is documented" (Focus group 3)

Participants also described using AI to structure information and improve the quality of written communication. Rather than generating new content, AI was used to refine or produce documents based on information already obtained by the clinician. For example, when writing referral letters, the clinician was responsible for the content by inputting relevant clinical details, while AI streamlined the writing process by generating a clear, well-written letter. Beyond generating documentation, AI was also used more broadly to refine the language and grammar of a range of written communications, including emails, letters and other correspondence. A number of participants valued the use of AI to proofread and improve the clarity of their writing, in particular International Medical Graduates (IMGs), and GPRs who report that 'English is not [their] first language'.

"The e-mail that AI formulated was exactly what I was thinking of writing, but maybe I wasn't getting the terms right" (Focus group 5)

In addition to clinically relevant tasks, participants also used AI to assist with time-consuming professional and educational activities outside of clinical practice. This included using AI to support portfolio development and writing reflections, where AI was used to organise reflections and map them to relevant competency requirements. Participants found this reduced the time needed to maintain their portfolios and ensure evidence and reflections were aligned with training requirements.

Theme 2 – AI as a clinical cognitive aid and educational support

In contrast to the use of AI to reduce administrative burden, participants also described another distinct use of AI as a cognitive and educational tool that supported clinical reasoning, data interpretation and learning. Rather than producing outputs on behalf of clinicians, AI was viewed as an aid that helped participants think through problems and develop understanding by producing personalised outputs. Participants noted that these uses also improved efficiency by reducing the time required to search for information or prepare learning materials.

Participants commonly described using AI to support clinical reasoning in a range of stages of the patient journey, such as generating differential diagnoses and exploring unfamiliar presentations, management pathways or prescribing options. In particular, AI was often used to broaden participants' thinking and generate ideas that might otherwise have been overlooked. This helped summarise information before participants applied their own clinical judgement.

"it's able to consider things that you probably wouldn't do, because it's like a machine doing the work... generative AI is able to consider all the factors in whatever you're doing" (Focus group 3)

Alongside supporting clinical practice, participants used AI as an educational resource to develop knowledge, practice a range of skills and support the interpretation of clinical information. This ranged from explaining clinical investigations, such as electrocardiograms (ECGs), to analysing data from audits and quality improvement projects, enabling participants to better understand and learn from clinical

data, and develop their skills of data interpretation. The conversational style was viewed as a positive way to facilitate discussion with AI to help participants interpret or understand new information.

Participants noted AI was also useful in summarising learning resources, generating presentation structures for teaching and preparing for exams, where AI was often used to generate practice questions or clinical cases, and explain concepts. Several participants also highlighted the use of voice-based AI to simulate interviews or clinical scenarios, which allowed participants to practice communication skills and clinical reasoning through interactive conversations with AI.

"it was amazing... The voice was so natural, it felt like it was an actual person speaking" (Focus group 5)

Theme 3 – Safe use of AI requires professional judgment and accountability

Whilst many of the GP resident doctors agreed that AI was a useful clinical and administrative tool, there were also concerns regarding confidentiality, clinical safety and potential skill loss with its increased use. To mitigate these risks, clinicians were checking their AI inputs, verifying AI outputs and discerning credible and unreliable AI generated information. Participants were particularly concerned about the risk AI posed to confidentiality, consent and data protection. The GP resident doctors discussed that gaining informed consent from the patient was an important prerequisite before using AI in the consultation but commented that this was not always obtained.

"But sometimes it's used without consent being taken, and there may be questions here and there."
(Focus group 5)

Furthermore, participants raised more serious concerns about the storage of data in AI systems. They expressed deep concerns that if data were leaked and third parties had access to patient information, it would directly compromise patients' right to privacy and confidentiality. GP resident doctors were also troubled by their own human error, with a handful admitting how easy it is to enter patient identifiable data inadvertently and the potential ramifications of this.

"You really don't have that patient confidentiality... you don't know who has access to it... the confidentiality is lost." (Focus group 2)

Participants were endeavouring to mitigate these concerns through practical safeguarding measures at both an individual and organisational level. There was a consensus amongst all the participants that regardless of the AI system used, they all had the potential to hallucinate and produce clinically inaccurate outputs with some participants echoing this through real- life experiences.

"I've had an instance where I said that a patient had a recent bereavement... but it [AI] quoted it as the dog passed away, and I kind of missed that." (Focus group 5)

Concerns regarding clinical inaccuracies were raised and participants expressed reservations about the reliability of AI generated information. They emphasised the need to use their own clinical judgement and review AI generated information to counter these hallucinations.

"Essentially using artificial intelligence to formulate your diagnosis is an area I don't think I would rely on." (Focus group 5)

Participants worried that use of AI would foster an environment where they would become more deskilled, over reliant and lose their clinical competence. They therefore advocated for AI as clinical adjunct and not as a clinical replacement, with participants admitting to using it judiciously and finding the right balance.

"If you're purely using it on every single occasion... you sometimes turn off your executive decision-making abilities a bit less." (Focus group 5)

Across all focus groups there was an acknowledgement that AI is a useful clinical tool. Nevertheless, clinicians need to be aware of its drawbacks and be able to professionally and critically evaluate its outputs to ensure that its implementation is safe, ethical and clinically appropriate.

Theme 4 – Preparing for AI enabled future

Participants were unanimous that AI was going to have an ever-growing role in medicine but felt that current preparation to adapt to this inevitable shift was limited and inconsistent. They remarked on a lack of formal training with many developing AI related skills through self-directed learning and learning through experience. They highlighted the uncertainty surrounding safe and effective AI use, how to select suitable AI platforms and how to adapt to the use of AI by patients. To address this, participants advocated for standardised training and clear, profession-specific guidelines to ensure AI use moves beyond individual trial and error to a more safe, consistent clinical tool.

There was an overwhelming consensus that AI was going to have a prominent role in healthcare in the future. Participants did not view it as solely as a short-term solution to increasing workload and administrative burden, but rather a new technological development that will increasingly affect our everyday lives as doctors and become a part of what is considered standard clinical practise.

"It looks like it's something that is going to be used even more and more in the future." (Focus group 3)

Whilst focus group members were aware that AI was having an increasing role in their clinical lives, they felt the training provided, to navigate this, was variable, disproportionate and sometimes even non-existent. Consequently, participants highlighted their feelings about the necessity of formal AI training. Specifically, they advocated for AI teaching that was not generic but instead, provided practical guidance on how to use AI appropriately and how, more importantly, to recognise unsafe use of AI. The GP resident doctors argued such teaching should be delivered at all levels of healthcare training, ranging

from undergraduate to consultant level. In addition, they believed such training should be delivered by a medical specialist with sufficient expertise to appropriately explain the use and integration of AI in healthcare.

“Some basic minimal level of this is not safe to do... might be more helpful than here’s how to use the platform.” (Focus group 4)

“they should be delivered by specific people... specialists... but not just anyone” (Focus group 2)

Participants remarked on the growing number of AI platforms available and how only through personal experience had certain GP resident doctors determined which platform best suits particular tasks. Conversely, others acknowledged a lack of competence in this area and remained confused and uncertain on which AI system to use in specific clinical scenarios. Participants agreed that to improve AI literacy, they should be provided training on not only how to use AI but also guidance on AI platform selection.

“I don’t know enough to say, oh, this one’s better for this.” (Focus group 1)

Amongst the GP resident doctors, there was a shared perception that AI was beginning to influence and alter the consultation dynamic. This stemmed from anecdotal accounts of patients using AI to self-diagnose, request investigations or form expectations about conditions and the way to best manage it. Whilst some believed this can occasionally be positive, others noticed how it was rendering consultations more challenging especially when patients come in anxious with fixed opinions based on AI generated information. As a result, participants believed preparing for an AI enabled future was a multi factorial process that should focus on clinician training but also patient use of AI and the potential ramifications of this on the doctor-patient relationship.

“I’ve had patients come in... really worried because they’ve looked something up in the AI and it’s told them they’ve got a serious diagnosis.” (Focus group 3)

“Some of the things they will be saying to you will be more a demand rather than a discussion” (Focus group 2)

Discussion

Our novel study exploring GP resident doctors’ views of GenAI has shown that GP resident doctors view GenAI as a useful clinical adjunct, that assists clinicians with documentation, writing refinement and general administrative tasks. There was consensus that using it reduces daily workload by streamlining tasks that are repetitive and time-consuming. However, its perceived value extends beyond administrative efficiency, with it also serving as a purposeful cognitive and educational aid that clinicians were using to formulate differential diagnoses and tailored management plans.

Despite these perceived benefits, reservations regarding the clinical safety and accuracy of AI particularly in relation to hallucinations, data protection, confidentiality and overreliance were abundant. To ensure safety, GenAI required clinical verification, professional judgement and nous. Consequently, it was concluded AI should be used responsibly as a clinical supplement, at the discretion of the clinician, with ultimate responsibility of patient care remaining with the doctor. As a result, there was a clear belief amongst GP resident doctors that, to address these concerns, healthcare professionals would require standardised guidance and training.

Comparison with previous literature

Our study is consistent with emerging literature that shows that doctors are using GenAI increasingly to assist with administrative tasks and to lessen the workload burden. Previous research into the use of GenAI by GPs, show that a considerable proportion in the UK use it to help with clinical tasks including documentation, formulating differential diagnosis, treatment options and writing letters ⁽¹⁰⁾. This corroborates the emerging perspective that GenAI has a valuable role in general practise as a clinical adjunct. Our results align with existing General Medical Council (GMC) guidance, stating that doctors should remain vigilant with AI outputs, using professional judgment to critically evaluate and verify AI generated information, with the responsibility of the patient fundamentally remaining in the doctors' hands ⁽¹¹⁾. The wider existing literature echoes GP concerns regarding AI inaccuracies and hallucinations, and the need for training to properly integrate GenAI into healthcare and avoid the risks associated with it ⁽¹²⁾. A recent qualitative study of undergraduate students and GP teachers reported similar concerns, as well as perceived benefits, of AI use in undergraduate training ⁽¹³⁾.

Although the results of this research are consistent with existing literature on GenAI use by doctors and GPs, a key contribution of this study is understanding the specific views of GP resident doctors who are still developing and refining their clinical skills. This provides an insight into how GenAI is being used clinically and educationally in postgraduate training, and how the next generation of GPs observe its introduction into everyday practise. In doing so, this study highlights that whilst GenAI simplifies repetitive administrative tasks, its use by GP resident doctors may influence their clinical reasoning, confidence, professional judgement and preparedness for AI-enabled future healthcare systems.

Existing literature is clear that doctors and healthcare professionals require training to ensure GenAI is being properly integrated and used safely and appropriately in clinical practise. Our study adds a practical perspective to this literature by exploring how GP resident doctors, who are themselves in training, believe they should be best equipped for GenAI in medicine, based on their lived experiences and uncertainties. These findings provide insight into the perspectives of GP resident doctors currently navigating GenAI, in practice, and suggest that whilst training should provide general professional guidance, it should also address GP resident doctors' practical needs and the challenges they encounter day-to-day as clinicians.

Implications for practice and future research

These findings have significant implications for the integration of GenAI into healthcare. GP resident doctors were cognisant that AI was going to become increasingly used in everyday life and become a fundamental part of clinical practise. Unfortunately, current guidelines and preparation for this inevitable shift were perceived to be inadequate and requiring improvement. They expressed the need for formal, expert-led training that reduces the disparities in clinicians' AI literacy and provides clear guidance on AI use and platform selection, including their inherent risks.

Our findings suggest that training should prioritise appropriate AI use and address risks of AI, including confidentiality, hallucinations and data security. This should be supported with practical demonstrations that illustrate both safe use and the potential consequences of misuse. Furthermore, our study reinforces the need for guidance into effective AI output evaluation and avoiding AI overreliance.

A key implication of this study is the necessity for clearer guidance on AI platform selection. This is important as GP resident doctors displayed significant uncertainty in which platform to use for particular tasks with many currently employing a trial-and-error approach. Future training should therefore address these platform differences, highlighting the reliability, clinical uses and limitations of respective platforms.

Finally, our study advocates that AI training should prepare clinicians to enter a field where the consultation dynamic and doctor-relationship are continually evolving as patients use AI increasingly to shape expectations, understanding and decisions regarding their care. As a result, whilst training should primarily focus on GenAI use by the doctor, it should also explore the implications of patient use of AI.

Future research should focus on the perspectives of GP resident doctors in other regions and countries, to assess the transferability of findings. Following the introduction of AI training, formal evaluation studies would be essential to determine whether it was adequately addressing the concerns identified in this study and subsequent studies. Future research should also explore the long-term impact of GenAI on clinical reasoning and overreliance. It should establish whether regular use contributes to a decline in doctors' clinical acumen or supports clinical and educational development. Similarly, future research should explore the effect of patient AI use on consultation dynamics.

Strengths and limitations

To the best of our knowledge, this is one of the first qualitative studies that explores the perspectives of GP resident doctors on GenAI. In doing so, it provides unique insight into the views of clinicians who are undergoing postgraduate training and still developing their clinical skills and professional judgment. Additionally, GenAI is a rapidly emerging area of clinical practice, with growing implications on patients and doctors. By exploring GP resident doctors' real-life experiences and uncertainties, our study provides data on how this is affecting doctors on a day-to-day level, that will help inform future guidance and training needs.

We acknowledge that our study has some limitations. Firstly, the study included a small sample size from one geographical region, limiting its transferability to other areas and healthcare settings. Secondly, as GenAI is rapidly evolving, it should be noted that these findings, while pertinent, should be considered as an early understanding of GP resident doctors' perspectives and views of GenAI.

Conclusions

Our study explores the experiences and perceptions of GP resident doctors on the use of generative AI in postgraduate GP training. It found that GenAI was perceived to be a useful clinical adjunct that reduces administrative and workload pressures, whilst also supporting clinical and education development. Despite this, there were significant concerns surrounding GenAI hallucinations, clinical inaccuracies and the potential for confidentiality breaches. It was concluded that the fundamental responsibility for patient care should remain with the clinician, and that clinicians should critically examine AI generated content and use it responsibly as a clinical aid. To address these ongoing concerns and support the safe integration of GenAI in healthcare, GP resident doctors and other healthcare professionals will require standardised training that focuses on appropriate use, platform selection, risk mitigation and the changing consultation dynamic associated with increased patient use of AI. Ultimately, the potential for GenAI to assist with clinicians' day to day lives is substantial, but its use should be supported with formal guidance to ensure it does not compromise patient safety or clinical standards.

Abbreviations

Generative artificial intelligence (GenAI)

General practice resident doctors (GPRs)

Artificial intelligence (AI)

Royal College of General Practitioners (RCGP)

General practice (GP)

International Medical Graduates (IMGs)

Electrocardiograms (ECGs),

General practitioners (GPs),

General Medical Council (GMC)

Declarations

Ethical Approval and Consent to Participate

Our study aligned with the declaration of Helsinki statement of ethical principles for medical research.

Ethics permission was granted by the Newcastle University Faculty Ethics Committee (number 70637) and permission was granted by the local Postgraduate Deans management committee.

Written informed consent was obtained from all participants. Participants were provided with information about the study, including the voluntary nature of participation, confidentiality, and data handling.

Consent for Publication

Not applicable

Availability of Data and Materials

The datasets generated and analysed during the current study are not publicly available due to participant confidentiality and the potentially identifiable nature of qualitative focus group data. Supporting quotations and relevant findings are included within the article.

Competing interests

The authors declare that they have no competing interests.

Funding

This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

Authors' Contributions

The focus groups were conducted by SR, AA and SP. The focus groups were recorded and transcribed verbatim using digital platform auto-transcription software. The transcripts were then checked by the team before analysis.

GT and JD coded the data and produced themes, which were finalised by the whole team. GT and JD were the major contributors in writing the manuscript. HA also assisted in this process. All authors read and approved the final manuscript.

Acknowledgements

Not applicable

Clinical Trial Number: Not applicable

References

1. Jiang F, Jiang Y, Zhi H, Dong Y, Li H, Ma S et al. Artificial intelligence in healthcare: past, present and future. *Stroke Vasc Neurol* [Internet]. 2017 Dec 20 [cited 2026 Jul 10];2(4):230–43. Available from: <https://svn.bmj.com/content/2/4/230>
2. He R, Cao J, Tan T. Generative artificial intelligence: a historical perspective. *Natl Sci Rev* [Internet]. 2025 Apr 4 [cited 2026 Jul 10];12(5):2025. Available from: <https://dx.doi.org/10.1093/nsr/nwaf050>
3. Chustecki M. Benefits and Risks of AI in Health Care: Narrative Review. *Interact J Med Res*. 2024;13:e53616 <https://www.i-jmr.org/2024/1/e53616> [Internet]. 2024 Nov 18 [cited 2026 Jul 15];13(1):e53616. Available from: <https://www.i-jmr.org/2024/1/e53616>
4. Boscardin CK, Gin B, Golde PB, Hauer KE. ChatGPT and Generative Artificial Intelligence for Medical Education: Potential Impact and Opportunity. *Academic Medicine* [Internet]. 2024 Jan 1 [cited 2026 Jul 16];99(1):22–7. Available from: <https://dx.doi.org/10.1097/ACM.0000000000005439>
5. Cardona MA, Rodríguez RJ, Ishmael K. Artificial Intelligence and the Future of Teaching and Learning Insights and Recommendations Artificial Intelligence and the Future of Teaching and Learning. 2023 [cited 2026 Jul 16]; Available from: <https://tech.ed.gov>
6. RCGP statement on the use of artificial. intelligence (AI) in postgraduate training, examinations and registration [Internet]. [cited 2026 Jul 15]. Available from: <https://www.rcgp.org.uk/mrcgp-exams/artificial-intelligence-exams-training>
7. Generative Artificial Intelligence in GP Training and Workplace Based Assessment. Guidance for GP registrars and GP Educators [Internet]. [cited 2026 Jul 15]. Available from: <https://www.rcgp.org.uk/mrcgp-exams/wpba/generative-artificial-intelligence>
8. Shaheen MY. Applications of Artificial Intelligence (AI) in healthcare: A review. *ScienceOpen Preprints* [Internet]. 2021 Sep 25 [cited 2026 Jul 16]; Available from: <https://www.scienceopen.com/hosted-document?doi=10.14293/S2199-1006.1.SOR.PPVR8K.v1>
9. Fit for the future. 10 Year Health Plan for England - executive summary (accessible version) - GOV.UK [Internet]. [cited 2026 Jul 16]. Available from: <https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future/fit-for-the-future-10-year-health-plan-for-england-executive-summary>
10. Blease CR, Locher C, Gaab J, Hägglund M, Mandl KD. Generative artificial intelligence in primary care: an online survey of UK general practitioners. *BMJ Health Care Inform* [Internet]. 2024;31(1):e101102.]. [cited 2026 Jul 16]; Available from: <http://dx.doi.org/10.1136/bmjhci-2024-101102>
11. General Medical Council. Understanding doctors' experiences of using artificial intelligence (AI) in the UK: a qualitative research study for the GMC [Internet]. London: General Medical Council; 2024 Nov. [cited 2026 Jul 16]; Available from: https://www.gmc-uk.org/cdn/documents/understanding-doctors--experiences-of-using-artificial-intelligence--ai--in-the-uk_pdf-109934543.pdf
12. Kharko A, Locher C, Torous J, Rosch SA, Hägglund M, Gaab J et al. Generative artificial intelligence in medicine: a mixed-methods survey of UK general practitioners. *BMJ Digit Health* [Internet].

2025;1(1):e000051. [cited 2026 Jul 16]; Available from: <http://dx.doi.org/10.1136/bmjdhai-2025-000051>

13. Ramsay M, Alberti H. (2026). Student and teacher views of using GenAI in GP undergraduate medical education: 'to complement not replace.' *Education for Primary Care*, 1–4. [cited 2026 17 Aug]; Available from: <https://doi.org/10.1080/14739879.2026.2690642>

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- [SupplementaryFile1InterviewSchedule.docx](#)