Education in Family Medicine – Gains and Dangers

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This editorial discusses the emerging evidence base for using family medicine as a core setting for medical training, and evaluates the challenges and impacts of this role on family medicine practice. Substantive, well designed educational opportunities can be effectively delivered in family medicine, and this has positive impacts on learning of clinical medicine, student attitudes towards patients, their understanding of population health, their choice of careers, and their respect for family medicine as a discipline. However, a poor standard of clinical practice and a lack of capacity in community based health care facilities could militate against such results being sustained and replicated in all countries. Medical schools in all parts of the world should be considering whether their family medical system can sustain a useful input to their curricula, and seeking to support colleagues in family medicine to develop their disciplinary base, because of the valuable contribution they can make to education as well as patient care and research.

Key words: education, medical; family practice; teaching

Historical Perspectives

Forty years ago, the UK had one professor of family medicine, virtually no clinical training took place outside hospitals, and anyone gaining a medical qualification could practice for a lifetime as a general practitioner (GP) (family medical practitioner) without further postgraduate training. Most practices were still single handed businesses, with GPs' homes housing the majority of clinics, and with few additional services or personnel to call on. The mentality was very much one of clinical isolation and marginalization, although the basis for a national health service had already been in place for nearly twenty years, and the public health system was strong. Now, in the early part of the 21st century, we have 34 medical schools all with at least one professor of family medicine (63 in total at last count); all GPs must have at least 4 years of postgraduate training with an endpoint assessment, career preferences for general practice are around 1 in 3 trainees; and there are an average of up to 10 staff members in each clinic providing a wide range of preventive and chronic disease management services as well as acute primary care. In addition, an average of 4 months of any medical course in the UK is based in general practice rather than university or hospital premises. This represents a major policy shift, and many other countries express surprise at the very substantial input which family medicine is making to the academic and training effort. The conditions under which these changes occurred included lobbying by family medical practitioners themselves, a policy drive to reform education from the UK accreditation body (the General Medical Council), a need for support from hospital clinicians whose ability to provide for learners in busy clinical settings was proving increasingly problematic, a climate of patient empowerment, and a change in service provision from secondary to primary care settings for which the students needed to “follow the patients.”

Challenging Status Quo

The ability of family medicine to be seen as an adequate site for education of either students or postgraduates was led by a number of well respected clinicians working through national bodies such as the Royal College of GPs (1). They campaigned to secure a compulsory postgraduate disciplinary qualification (2), and thus both provided a national profile for family medicine, an improved standard of practice, and an entry criterion akin to those of other specialties.
Criteria of “scholarship” (3) such as research, application of theory to practice, and a track record in teaching were developed over time, and innovative methods of education adopted within established medical schools which became early change agents for their broader curricula (4). Alliances with other community based disciplines such as public health and other staff providers (5) increased the variety of options outside hospital, enabling more student placements to occur in community settings. These innovations, however, may not have become widespread had it not been for professional leadership and governmental policy making a formal “challenge” to other parts of the profession.

**Tomorrow’s Doctors – Real Force for Change**

In 1993, the General Medical Council (GMC) issued “Tomorrow’s Doctors” (6), which advocated the need for students to do more learning outside hospital. The reasons given included a critical need for learners to gain a patient perspective on healthcare, to see clinical conditions in all stages of their development, to gain a more balanced view of the epidemiology of illness, to understand the role of all health and social care workers, and to become less disease oriented – to understand care as well as cure (7). This was supported by government because of the emerging evidence that low cost interventions in community settings and having an effective primary care gatekeeper role in a health system was highly cost effective. A system of national medical school inspection and accreditation by the GMC allowed this policy to be widely disseminated, and put medical schools under considerable pressure to reform their curricula. Thus, family medicine, who had already established a small university presence and a strong postgraduate training track record, found themselves suddenly “welcome at the table.”

**Family Medicine – Essential to Educational Capacity**

While some historical enmities and arguments about resource allocation persisted, there was increasing recognition that the need to train more doctors in a more systematic and thorough way was putting considerable stress on the hospital clinicians to provide adequate supervision. In addition, as outpatient procedures improved, patients were spending decreasing amounts of time as inpatients, and both the quality and quantity of patient contact was becoming increasingly skewed to rare diseases and the severely ill – not a sound basis for understanding the natural history of common conditions. Thus hospital specialists were forced to acknowledge that the placement of students needed to change to accommodate both larger numbers and their core learning needs. Family practitioners proved a valuable resource in this regard, and the amount of overall patient contact time was increased through larger numbers of community placements. A wide range of different types of placement were developed, based on good educational principles, and from this came much of the educational research which has shown the value of family medicine as an educational resource.

**Learning in Family Medicine – Types of Learning Opportunity**

A large variety of learning placements now exist across UK (Box 1), and only one is aimed at direct postgraduate training (helping future GPs to learn the discipline of family medical practice). Some placements are in communities rather than clinics, and may be supervised by nursing as well as medical staff. Three principles have dictated these developments – the principle of setting, where learners specifically need to learn about community and primary care rather than secondary care; of following the service and patients to where they are being cared for in a community rather than hospital site (9); and of ethos, where a particular type of professional values are deemed to be necessary. For example, students will go to a hospital to learn about cardiac surgery, to a family medicine clinic to learn about primary care, and to a community clinic to learn about child health – it is not possible to learn about one of these settings while based in another. Similarly, they will need to go wherever diabetics are being looked after to see their problems – this could be in a hospital ambulatory clinic in one country, or in a general practice clinic in another – students then are not being sent to family medicine for its own sake, but because that discipline is providing a particular service for a certain population of patients. Finally, because family medicine is perceived as “holistic” or patient centered, students are given such placements to balance a more disease oriented or biomedical approach. Many choices can be made through different combinations if these three drivers are recognized as key to design of learning opportunities. The evidence of their impact is the issue which will influence their continuation.

**Box 1**

Examples of teaching by family medicine practitioners in UK:
- Behavioral sciences – through attachments to patients and families
- Communication skills
- Clinical skills
- Population health assessments
- Community based specialties (child development and health, sexual health, maternity care, women’s health, mental health, care of the elderly, and palliative medicine)
- Chronic disease management
- Disability and rehabilitation
- Practice of family medicine
- Systems and organization of care (including teamwork, clinical audit…)

**Learning in Family Medicine – Evidence of Impacts**

A large number of descriptive and evaluative studies have examined this issue, of which only a handful are cited here. Patients have proved very keen on such learning (10), even though fears were expressed...
that such placements could interfere with the intimacy of the doctor patient relationship (11). High quality educational contact with family medicine has altered career aspirations in favor of the discipline (12), and GPs have proved as good as hospital-based colleagues in teaching basic medicine and clinical skills (13). The ethos of a more patient-centered approach does appear to impact on student perceptions of the practice of medicine (14), and students appear to retain patient-oriented values more effectively than in previous curricula (15). Recent new courses have used primary care intensively for the delivery of structured group learning of clinical medicine (16). A broader understanding of primary health care and public health can be facilitated (17), and hosting students for patient contact in settings where the majority of patients are relatively well can provide a gradual introduction to clinical practice which is motivating and allows early application of theory to practice (18). In addition, practitioners themselves can benefit from involvement in education (19), and this increases both quality of clinical care and capacity for further educational leadership and development (20). But some of these findings may be culturally specific examples, and the context can easily change.

Learning in Family Medicine – Essentials

It may not be possible to offer placements to all students at all levels of training, and each region or practitioner must decide for themselves which opportunities they can most effectively support. Nevertheless, to campaign for some education to occur in family practice clinics in both undergraduate and postgraduate settings appears essential if GPs are to have any profile and impact with tomorrow’s doctors. The humanizing impacts of family medicine are profound, and these are often best understood by relationally junior students who have not yet entirely accepted the predominant clinical culture, and who may be more “open minded” when placed in a different social or medical environment. Role models and respect are key to the overall profile and impact of family medicine (26), especially in the parts of the course which do not take place in general practice, and university employment of GPs as faculty, seminar and tutorial leaders may help in this regard (27). National representative bodies and journals and a compulsory specialist qualification for family medicine practice are crucial for quality of training and political profile, and the international linking with others can also be both encouraging and effective. Networking with others involved in medical education and providing the evidence base for success can also be powerful.

Learning in Family Medicine – Dangers

Even when the historical conditions were facilitating the acceleration of learning in family medicine to occur in the UK, there were ongoing concerns about the potential quality of teaching in some practices, the resources available, and the availability of time to teach and offer patient care (21,22). Not all family medicine practices have these concerns, and large numbers of practices (more than 40%) now host training of some kind (23) on a regular basis. However, the voluntary “opt-in” nature of such involvement is a constant cause of instability, with partnership disagreements and lack of clinical replacement being major causes of discontinuation. Change is often problematic in an inherently conservative profession (24), and when associated with a particular discipline this can easily undermine both educational innovation and the ability of family medicine to effect change (25). In addition, UK is a small country which is relatively well endowed with family medicine practitioners. In a country with a less established system, a larger geographical area, and a less integrated health service, what additional problems may occur, and what priorities should be chosen if any education at all is to occur in these settings?

Learning in Family Medicine – Conclusion

Motivations for family medicine practitioners to become involved in educating others include their own desire to learn more; helping others to learn as they themselves were once taught and supported; a responsibility to sustain and promote their own discipline; and attracting others to a job they love. The case has been made by many examples throughout the international literature, and family practitioners can have confidence that they are usually successful teachers with excellent evaluation by students. They need to campaign for the conditions to exist that will enable them to give their best to learners at any stage they can possibly offer, as the impact they can have on young doctors is generally positive and important for effective patient-centered practice. Even in the most underdeveloped primary care settings, students can benefit from meeting many patients whose health care is 99% in the community, and may be able to offer something back. GPs are experienced doctors with a person-centered clinical method, which transfers well to a teaching and mentoring role. Their central role in education is due for worldwide recognition.

References
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