The Future of General Practice

General practice education: things to come

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The introduction of vocational training has been one of the most important and successful changes in general practice. Indeed, many would claim that it is responsible for the prominent role of general practice in the NHS reforms. These reforms and the changing needs of undergraduate medical students will present many challenges to the profession over the next 20 years. Below I give a view of medical education in the year 2011.

Undergraduate education

Of the different components of medical education, undergraduate education has changed most. In 1991 most students were being taught to a pattern that was recognisably the same as the one that had been introduced more than a 100 years previously. General practice had gradually found its way on to the clinical (and in some cases the preclinical) curriculum of all the medical schools,[1] mostly after the recommendations of the Todd commission in 1968.[2] However, it had failed to make a major impact on course structures and was still an underused teaching resource. There was only limited understanding of what could be achieved: most teachers, both in hospital and in general practice, thought that the hospital was still the place to learn clinical knowledge and skills and that general practice the place to apply it in community settings. The idea of turning this model entirely on its head, placing general practice at the centre of undergraduate courses, had been discussed,[3] and the first tentative steps were being taken by 1991 (P Booton, annual scientific meeting of university teachers in general practice, Southampton, 1991), but the idea had not gained widespread acceptance.

Different elements have helped to change the traditional view and to give general practice much greater importance. Firstly, throughout the 1980s the pre-eminent position of teaching hospitals had become increasingly difficult to sustain. The combination of shorter hospital stays and greater specialisation within teaching hospitals made it impossible for students to acquire anything like the broad, patient centred education that remained the aim of every school.

Secondly, there was the clamour, unanimous at least among educationalists, to create curriculums that were less overburdened with the need to learn facts.[4] We wanted to concentrate more on the ability to evaluate factual information critically, together with a wide range of intellectual and personal skills that we recognised were essential to the practice of good medicine. The need for all medical students to be grounded in all specialties up to the standard of competent general practice had formed the original basis for the traditional curriculum. It was superseded by the introduction of compulsory vocational training in 1980, but this went largely unnoticed at the time. Thirdly, the fundamental principle on which medical education had been based—namely, the need to learn basic science first and apply it to clinical medicine afterwards—had been destroyed both by theoretical ideas of good educational models and by the experience of those brave medical schools that had already tried a problem based approach.[5]

The success of the changes has also depended on being able to provide adequately trained and resourced general practitioner teachers and on our ability to show their skills to sceptical hospital teachers.[6] The vital change was the advent of a system for adequate remuneration for general practice teaching, which was introduced with the 1990 contract. The sums concerned have not been huge, but they have enabled university departments to insist on a commitment from the teachers that often includes attendance at teachers' courses.

How dated such thoughts look now. I greeted a new intake of first year students only last week, shortly after their arrival in the medical school. General practice has always offered unrivalled opportunities of a wealth of clinical problems and a one to one relationship with an experienced clinician in a secure environment. The students were about to start their studies with the first general practice firm, and I was carefully explaining how they were to use such opportunities and the library facilities to learn general principles about clinical method and something of the basic sciences that underpin that aspect of medicine.

As in every other medical school in the country, our students now spend a substantial part of their first years with general practitioners, and occasionally go into hospital when the patients they are following have to be admitted. Later on they have longer spells attached to hospital consultants. What is much more important is the basic approach: they are expected to learn the fundamental principles and to develop a critical, questioning approach to medicine. We are much more honest than we used to be about not expecting them to learn vast amounts of basic science (much of which rapidly went out of date and most of which they always promptly forgot) or indeed to try to cover the whole of clinical medicine. As I told the students in their introduction, the message is clear: they must study a few things in as much depth as they can, integrating all the sciences, from molecular biology to epidemiology, and all the skills and be excited by it.

The honesty allows us to run a shorter course than we used to; just think how difficult it would have been 50 years ago to persuade people that a medical degree could be accomplished in four years of undergraduate study. This has been made possible by teachers from different disciplines in the medical school working

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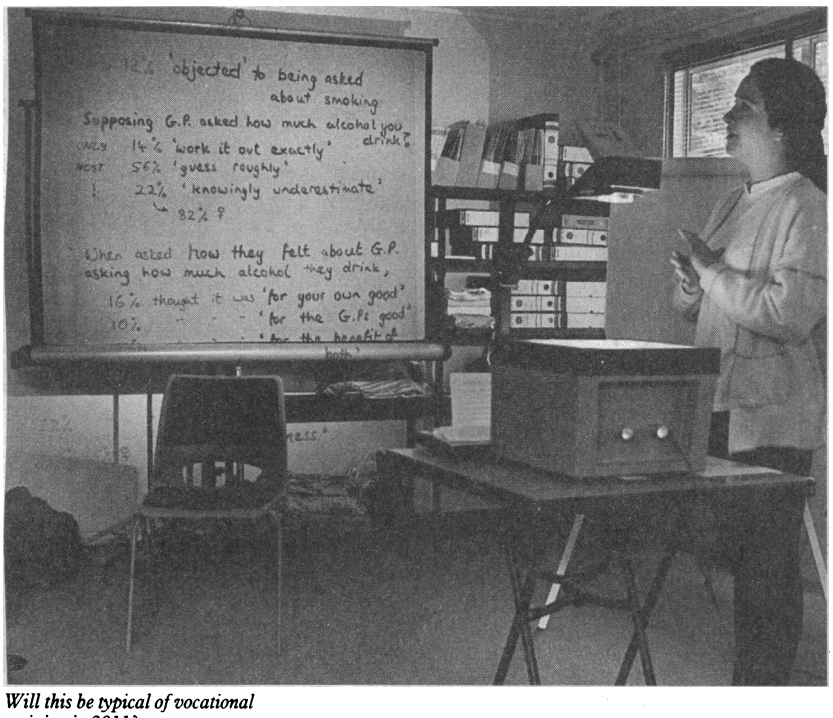

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Will this be typical of vocational training in 2011?

together to agree joint statements of educational objectives. Departments now are not allowed to determine their own agenda but undertake to teach parts of the jointly agreed objectives. During last week's talk I suddenly felt that the students were becoming restive. I often have to remind myself that I continue to see their course from the perspective of a student in the 1970s, and talk about it as a wonderfully adventurous course. For them it is now a standard model, and one that, as we had foreseen many years ago, leads on directly from the sort of experience they have all had at school.

Vocational training

In 1990 vocational training looked the best organised and most established component of education in general practice and probably of all medical education. Again it's odd to think now that there are many of us who can still remember doctors going straight from one year's house posts to a job as a principal in general practice. Vocational training had, long before 1990, established its basic curriculum, the criteria that practices had to fulfil to be approved for training, and the principle of protected time for education. By 1990 the European Community had endorsed the value of this structure by adopting it as a standard for all the member states. The examination for membership of the Royal College of General Practitioners had already become the benchmark for doctors completing their vocational training. As one of my friends predicted many years ago, general practice has indeed followed the example of internal medicine by making it almost impossible for a doctor without the MRCGP to be appointed as a principal, without actually passing any rules to make it compulsory.

For these reasons it is not surprising that, of the three components of medical education, vocational training is the one that has changed least since 1990. The changes that have occurred have been more of content than of form and have been occasioned by the changes of the undergraduate curriculum. I was struck by this very forcibly when I was going through the programme with our current trainee a few weeks ago. For instance, when I was a trainee in 1979 we spent a lot of time on communication skills and understanding the behavioural aspects of clinical medicine. This was not only because they are important aspects of general practice (as they still are) but because none of us had learned much about it as students. Now that behavioural science plays a larger part in undergraduate courses it still appears in vocational training programmes, but is less the matter of overriding concern than it used to be. Instead trainees spend more of their time learning the detailed information needed to practice as general practitioners—all the vast amounts of "real medicine" with which our undergraduate careers used to be plagued and which we have successfully removed from undergraduate degree programmes. Today's trainees have to work hard to acquire all the information required to sit the MRCGP, but this was always so and is as it should be for a professional exam. The benefit of this approach is that the clinical information is so much easier to make sense of and remember when they are using it every day as part of their working lives.

One interesting aspect of the overall shift in content between undergraduate education and vocational training is that it brings us more into line with other professions in Britain. Students entering medical school now get a much freer, more exciting undergraduate course, comparable with any other course on offer in our universities, followed by four years' very hard and intensive practice based training leading to the higher professional exam. I was challenged many years ago by a solicitor asking how we could justify giving the title doctor to someone whose expertise was little more than that of an articled clerk. It was never quite true as medical students continued to get some grounding in clinical skills. However, acknowledging it as partly true has enabled us to attain a much more suitable balance between undergraduate and immediate postgraduate courses and between the service and education components of junior hospital jobs.

Continuing medical education

If the changes in undergraduate studies and vocational training have made enormous differences to medical education, general practice itself has been transformed by changes in continuing education for those in practice. The need for continuing education over the whole working lifetime had been acknowledged for many years. One of the more farsighted changes of the 1990 contract was the introduction of the postgraduate education allowance, freeing continuing provision from the straitjacket of the old section 63 expenses. An immediate gain was that a much wider range of activities could count towards the allowance and that in practice education was specifically encouraged. The most important result of the change, however, was not appreciated for some time, partly because so much effort went into bureaucratic approval and evaluation of courses and partly because the Department of Health had tried to retain control over doctors' programmes with its fatuous insistence that they divide their time among the wholly arbitrary categories of practice management, prevention, and disease management. The real importance of the education allowance has become apparent only as course organisers and tutors have been able to devote more time to helping general practitioners assess their specific educational needs and to devising tailored courses to answer those needs. Each tutor works with a group of doctors according to a method that was pioneered in the Republic of Ireland.[7]

The tutors here who oversee continuing education now give the allowance when they receive a report on the last year's activities and a plan for the next year from each general practitioner. Sometimes the plans are made without our assistance, but many local general practitioners use university facilities to help

them: either a straightforward advice session with one of the tutors or an hour's self assessment with the computer or joining in a clinical assessment. Clinical assessments are still expensive on staff time and money, but they are good fun and everyone enjoys them. The rules for reaccreditation every seven years helps as the assessment is intended as a formative rather than a summative procedure, and everyone can use the profile that comes out of the assessment procedure to plan their future needs. The most valuable part of this is that all general practitioners are responsible for their own programmes and are encouraged to plan a coherent programme of study rather than attend a random collection of courses.

The real transformation of general practice has been in the move towards all general practitioners developing expertise in specialties.[8] In the early 1980s we were not exercised by this need. The whole climate was against it. Vocational training schemes offered excellent broad experience; experiments such as that in Southampton, where general practitioners worked as specialists in age specific care, had been abandoned[9]; and the Royal College of General Practitioners was still confidently asserting the primacy of the generalist. However, the increasing importance of medical audit, the requirements for certification procedures for certain skills to be carried out in general practice, and the increasing development of subspecialisation among hospital doctors all pointed towards some limited role for specialists in general practice.

As with the other changes described several factors contributed to the change, some of which were in place even before 1990. Firstly, we had to convince ourselves that having specialist skills was compatible with being a generalist in the consulting room. Now that we all do this it is odd to remember how difficult it was. It was no problem for the patients, who had always valued personal characteristics above paper qualifications.[10] Secondly, we had to accept the basic principle that vocational training and gaining the MRCGP examination was not an end but, just like the MRCP, the point of entry into further specialist training. Of course we have been able to learn from the mistakes of others, so we don't insist on general practitioners doing higher training immediately after the basic training. Rather we see it as a voucher scheme that they can use at various stages during their professional lives. Nevertheless, most doctors now leaving vocational training schemes do go straight on to some programme of higher training, partly to make themselves more attractive as prospective partners, but also, I suspect, to postpone the final decision about where to live. Thirdly, we had to be able to provide protected time for education. Here the provisions for extended study leave had already led the way, and by 1990 there were several MSc courses in operation which showed how the time could be used.

The final plank was the realisation that clinical assistant posts could be used less to provide additional hospital staff at low cost and more as valuable training posts for general practice. It is now made clear to clinical assistants and the consultants that the aim of their appointment is not to provide extra help for the consultant but to equip the general practitioner with additional skills and expertise for use in general practice. The distinction is a fine one: clinical assistants both before and now would expect to provide a service as well as learn from the experience. However, there is a shift in both their expectations and the experience they get, and this is emphasised by the need to have all such posts approved by regional advisers in general practice.

The profession has taken some while to accept specialisation but is now an enthusiastic supporter. My feeling is that it has enormously enriched the discipline. For instance, it has provided one means of developing a career structure without having to leave general practice, and this has, I am sure, improved morale enormously.[11] Some general practitioners take the opportunity to get properly trained as managers. They have improved the overall management of general practice, and some of them leave clinical medicine to work as full time managers. Again, we have now recognised that this is not a skill that all doctors need and we have abandoned the brief experiment of having a management module in the undergraduate curriculum. Many general practitioners have now had basic training in research and epidemiology. This has provided a much stronger basis for the academic structure of general practice.[12] The discipline has become more rigorous, so that we can now give better reasons for our actions than we could in 1991 and there is a more critical approach to innovation. It has also brought the vital job of assessing the needs of whole populations and planning intervention programmes back to those who are in personal and daily contact with those populations and who are best equipped to translate population needs to personal doctoring.

The future

Plus ça change. Some of the challenges that face us now were with us 20 years ago. Many of us still suffer the institutional divide between the academic departments of undergraduate medicine and the regional advisers dealing with postgraduate education. The reason for this is now lost in the mists of prehistory, but it makes no sense and hampers the development of a unified approach to general practice education.

Some of today's problems have arisen as a direct result of the developments of the past 20 years. Many teachers, including some general practitioners (but not myself), now worry whether undergraduate students have insufficient experience of hospital medicine when they qualify. My own concern is that we have tilted the balance in general practice too far in favour of specialist skills and not valued enough the traditional role of a generalist personal and family doctor. I don't know whether we can redress this, or whether we would have to go back to working from our own homes as single handed doctors to bring it back.

The real challenge is maintaining recruitment to the discipline. We all remember the great days of the 1980s when everyone wanted to be general practitioners and the training schemes were attracting the brightest and best graduates. Now students have more experience of general practice and the postgraduate training is more demanding and takes much longer. We can be proud of the way we have adapted our education system to serve the changing needs of learners and patients, and now we worry about finding the bodies to fill the spaces.

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