# Education for general practice:

## Where are we going in the next fifteen years?

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ABSTRACT

Vocational training has made general practice visible to other medical specialties and statutory bodies, and it has consolidated the theory and practice of generalist medical practice. But it is time for reappraisal; vocational training now needs to be integrated into a continuous pathway of medical education, and better grounded in the modern primary health care context. A three-phase structure for general practice education is proposed, where a first-phase generic medical degree leads into a second concentrated experiential clinical learning phase, and then a third, ongoing phase of lifelong reflective learning and critical thinking. It is envisaged that a complete vocational training programme spans the latter portion of the second phase, includes initial summative assessment, and extends into the third phase, to fully meet vocational registration requirements.

**Key words**

Medical education; primary health care; general practice vocational training

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### Introduction

It is over 30 years since vocational training for general practitioners in New Zealand became a reality. Much has been gained; it is hard to believe now that 50 years ago physicians and surgeons vigorously opposed the formation of the Royal College of General Practitioners in Britain as unnecessary and divisive, and that only 35 years ago the New Zealand College faced similar prejudices in this country.[1] Then general practitioners were considered renegade and disruptive, precisely because of innovative ways of considering medical practice and patient care, challenging the status quo and challenging the 'old professionalism' of medical practice.[2] It was a hard won battle to persuade the government of the day of the need to fund a single year of vocational training (originally the year long General Practice Vocational Training Programme); that battle required the instigators to clearly articulate their vision for the future of general practice.

We owe much to recognised international figures, Horder and McWhinney, Huygen and Neighbour, but here in New Zealand, people such as Eric Elder and Peter Anyon, Ashton Fitchett and Peter Snow, also made their mark; they were passionate about general practice as a discipline and the promotion of vocational training for general practice. They described general practice (generalist medicine) as a discipline in its own right, with its own body of knowledge and its own specialist skill sets. Its models of clinical medicine were relationship-based, taking account of the person of the practitioner as well as the person of the patient, in the context of family and community.[3,4,5,6,7]

But general practice education is now at another crossroads. Thirty years is a long time in New Zealand, where *'history is extraordinarily*

*compressed and close at hand'*.[8] Events as diverse as the Springbok tour in 1981, the Cartwright report in 1988, the introduction of independent midwifery in 1991, as well as multiple health system reforms, and accelerating advances in information technology in the last fifteen years, have all profoundly affected health care delivery. This is especially so in the provision of health care in the community, underpinned as it is by contemporary cultural and societal context.

Yet in many ways the structure of the current vocational training programme is little different to that introduced in 1974; it is time for reappraisal and change. The need for reappraisal becomes obvious when the current intensive vocational training year is placed in a broader context, within two important separate but intersecting strands that run through the intensive vocational training year. The first is the strand of medical education, and the second the strand of primary health care.

**Vocational registration places generalist practitioners alongside other specialist colleagues; collectively it is a recognition of the 'specialism of generalism'**

### Medical education

Medical education for general practitioners, of course, does not start with vocational training. The intensive vocational training year is underpinned by the undergraduate medical education that is common to all medical professionals.

The foundation is the body of knowledge, and critical enquiry that underpins and constantly informs clinical method in medicine, including good generalist practice. Currently in New Zealand, the undergraduate medical curriculum is taught over six years; as well as the traditional biomedical content base, all the undergraduate programmes now incorporate a wide variety of teaching and learning. There is more small group teaching, more understanding of patients as people, self directed learning, case-based learning, more problem solving, more e-learning and use of information technology, more professional development, and ethics, than ever before. Nevertheless, the biomedicine content of undergraduate education forms the basis on which clinical method and clinical skills are introduced and built, initially in undergraduate years, but also in the immediate postgraduate, or house surgeon, years.

Only after this foundation comes the intensive vocational training year, and since that programme was first developed, there has been recognition that further educational consolidation and experience is necessary to produce a thoroughly competent specialist; the generalist practitioner. The drive for the need for advanced vocational education (AVE) has come not only from general practitioners, here and in other countries, but also from statutory bodies such as the Medical Council. Advanced vocational education aims to achieve and consolidate independent ongoing learning as an essential component of clinical practice. Whether it does this or not depends on a number of factors; in reality, emergent general practitioners often find from this point onwards in their careers that high workloads and business responsibilities in effect preclude significant ongoing professional development, especially if the skills necessary for wholly independent learning have not been fully developed.

But, at present, AVE is the pathway to vocational registration, where the special status of generalism is recognised. Vocational registration places generalist practitioners alongside other specialist colleagues; collectively it is a recognition of the 'specialism of generalism'. Vocational registration gives general practitioners the right to be employed on the same salary scales as other medical specialists and practise fully independently; it also bestows equivalent clinical, legal and professional responsibilities.

### Primary health care

A quite different strand that is intertwined with the intensive vocational training year is the strand of primary health care, the health care that is provided and undertaken within the community.

Primary medical care is part of primary health care. The notion of primary medical care is not new; it is the work that doctors in the community do in caring for people who present with problems, usually within the context of a consultation.[9] Yet one does not have to be that experienced in consulting to realise that what patients (and doctors) bring to consultations is only a tiny part of a much wider context. The person of the patient, their family and the community they live in and the population they are part of, all affect health and illness; the good general practitioner will recognise this and want to maximise health and prevent illness wherever possible. Taking full account of this context requires a change in mind set and philosophy from one of primary medical care to one of primary health care.

Primary health care is a strategy to integrate all aspects of health care, underpinned by principles of social justice and equality, self-responsibility, international solidarity, and acceptance of a broad concept of health.[10] The notion of primary health care was first articulated at the Alma Ata conference of the World Health Organization in 1978,[11] and was originally understood to be most applicable in developing countries. Health systems with strong primary health care emphasis in OECD countries have also been shown to provide better care, and better health

outcomes, at lower cost, than secondary care dominated systems.[12,13] In the shift from primary medical care toward primary health care, there is a change in focus from illness and cure to health and prevention of illness; from episodic care of specific problems to health promotion and continuous, more comprehensive care.

Of all the disciplines within medicine, general practice is well placed to see that prevention of illness is better than cure, that early detection of disease more often ensures better outcomes than later detection, and that good continuity of care supports people through life's difficulties better than sporadic attention to episodic crises. And indeed, the principles of family medicine and general practice articulated 40 years ago[3] are those same principles that gave rise to the advent of vocational training for general practice, and espoused not just a duty to undertake the care of patients with acute episodic illness but also to undertake health promotion and disease prevention, the care of families, communities and populations and as well as individuals.[5]

These people all recognised the importance of opening the consulting room door, of working with others who provide health care in the community. However, while the vision was sound, and it seemed doable at the time, there was little appreciation of the enormity or complexity of the job. It is little wonder that general practice has struggled to add systematic population health care to the immediate demands of primary medical care. As a profession we cannot, and indeed should not, do it alone. It is too big and complex a job, and frankly, we do not have all the necessary skills to do it.

Instead, we need to be effective members of primary health care teams that can collectively not only provide best practice patient and population care, but also respond appropriately to an ever-changing community environment.[14] General practitioners are part of a large primary care health workforce. In New Zealand, some 35 000 health professionals and support staff work in the community; nurses are by far the largest group, followed by doctors, pharmacists, physiotherapists and midwives.[15]

**If we are to fully realise the vision for primary medical care as part of primary health care, we need to learn and work closely and collaboratively with our skilled nursing, pharmacy and physiotherapist colleagues, more so than we have done in the past**

Internationally, the philosophy of primary health care already incorporates the key principles of general practice into a more wide-ranging model of health care provision in the community. This philosophy encompasses and strengthens the vision for general practice. Effective teamwork and collaborative working between different health professional groups helps protect against stress and burn out. It creates the opportunity for better time management, protected time for open communication, and ongoing professional development. If we are to fully realise the vision for primary medical care as part of primary health care, we need to learn and work closely and collaboratively with our skilled nursing, pharmacy and physiotherapist colleagues, more so than we have done in the past.

However, at the moment, training for general practice is almost wholly concentrating on training for primary medical care. It is uni-professional, with little opportunity for interprofessional education, where a group of students (or workers) from different health-related occupations with different educational backgrounds, learn together, with interaction as an important goal, to collaborate in providing promotive, preventive, curative, rehabilitative and other health related services.[16]

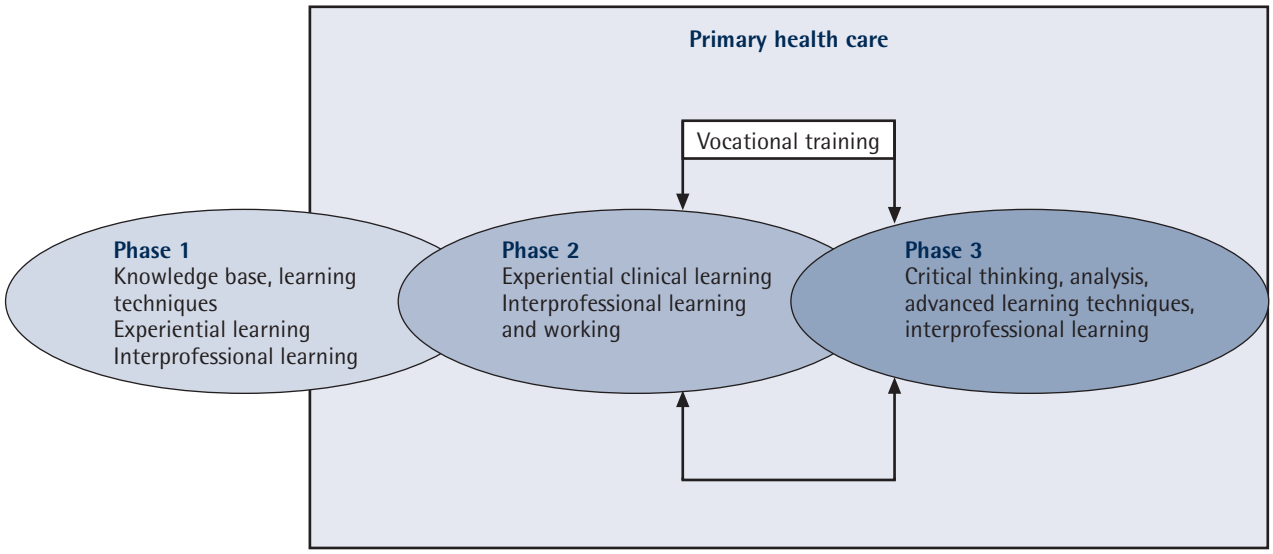
### The intense vocational training year – an entity all of its own?

The vocational training programme continues to differentiate between generalist, inclusive models of care, and reductionist, exclusive models of care. It develops advanced consultation skills within the context of the doctor-patient relationship, it follows principles of patient-centred medicine to illustrate the complexities of the human condition on an individual basis, and it draws on a valuable body of biomedical knowledge, combined with equally valuable diagnostic and procedural skill sets.[17]

However, the vocational training programme has also got rather stuck with the notion of patient-centred medicine. The theory of patient-centred medicine was developed in Canada;[18] in part it was an important response to paternalism in medicine and the overwhelming doctor-centredness of the 1970s. It gave much new understanding at the time, but it is not a model that necessarily meets New Zealand needs in 2006; it takes no account, for instance, of Maori and Pacific Island ways of communicating. The doctor-patient relationship, and the associated communication skills, has become so enshrined in the intense vocational training programme that it now risks overshadowing equally important professional relationships and population health concerns. The job of differentiating generalist practice from specialist practice within medicine is now largely done; now the task is to articulate the unique contribution that generalist doctors need to make to primary care teams.

Younger doctors increasingly report that general practice is 'threatened'. Not by physicians or psychiatrists but by midwives, other nurses, physiotherapists and pharmacists. These doctors appear to have little understanding of the role of generalist doctors within a primary care team,

*Figure 1*




let alone an understanding of the role, rights and responsibilities of midwives or nurses, nurse practitioners or pharmacists. They have not learned that generalist doctors are especially able to bring biomedical knowledge and skills to the primary care team, using a structured clinical method to undertake advanced diagnosis and problem solving.[19,3] They are also unaware that they do not understand the wider context of care and concern within a wellness model that nurses bring, nor the specific skill set of the midwife in caring for pregnant women.[20]

The development of professional identity, as well as the understanding of others' roles are fundamental to effective teamwork.[21] As a discipline, and as individual general practitioners, we need to acknowledge new problems. As general practice has moved from cottage industry to larger health services, business roles have become increasingly burdensome and problematic and, as a profession, we struggle with long hours and too much work; work/life balance is often poor. The irony is that we don't have to do it all, or feel responsible for it all, if we work effectively in teams.

**The intense vocational training year is located within, but has become isolated from, the strand of medical education; it is located within, but is also isolated from, the strand of primary health care. It should be part of both**

The intense vocational training year is located within, but has become isolated from, the strand of medical education; it is located within, but is also isolated from, the strand of primary health care. It should be part of both; many current problems can be solved by better integration with medical education pathways and better integration with primary health care professionals.

### A wider structure for general practice education

Instead of continuing to view the vocational training, and particularly the intense vocational training year, as an 'entity all of its own', it needs looking at as part of the whole educational pathway. In essence, there are three key, overlapping phases. There is a first phase of learning that introduces a large and established body of knowledge, develops clinical method, clinical decision making and problem solving skills. There is a second phase of learning that is largely experiential, consolidating and building on clinical method in the context of patient care. And there is a third, ongoing phase of learning that continues to consolidate consultation processes, but also now increasingly combines advanced knowledge and skills with clinical experience to enhance critical thinking and analysis that advances the discipline. These three phases are not discrete, but should merge one into the other, and each incorporate interprofessional learning components, as shown in Figure 1.

### The first phase

A generic medical degree, as the first phase of learning, provides an essential base in science, biomedicine, and clinical medicine, which underpins the development of a range of specialty areas within medicine, including generalist practice. But there is room for improvement; the current undergraduate medical degree would benefit from much better integration across disciplines. No longer is it enough to be integrated within medicine; medicine must stand

alongside the sciences and the humanities and measure up, be challenged, be better understood and be more intellectually rigorous for doing this. Two possible models are shown in Table 1.

*Table 1. The first phase; integration with other disciplines, and incorporating interprofessional learning*

| Phase One | Either | Or |
|---|---|---|
| | Pre-requisite choices for undergraduate degree in health science and/or humanities, studying with other health professionals | A five year undergraduate degree |
| | Then a four year graduate degree | Including limited option elective papers, e.g. biomedical sciences, psychology, anthropology, nursing, public policy, studying with other health professionals |
| | Individual career advice | Individual career advice |
| | Graduate with medical degree | Graduate with medical degree |

### The second phase

The second main phase of learning is one of increasing clinical experience and practice. I envisage a four year (minimum) clinical experience phase that is based in clinical practice, one that amalgamates the current trainee intern year (current undergraduate 6th year) and three junior medical officer years. Predominantly utilising experiential learning, the first two years would be generic for all doctors, carry increasing clinical responsibility introduced in a graduated way, and include clinical service rotations much as occurs now, with a compulsory 20% component of dedicated study time within working hours. Students would apply to enter vocational training for general practice at a mid-point (or later) during this phase, becoming 'junior general practice registrars' for a further two years, rotating through accredited general practice and hospital attachments, while still retaining a continuous core educational component (20%) in their course, as shown in Table 2. This phase would draw to a close as initial summative assessment is achieved; assessment that is necessary to ensure that clinical standards of safety and effectiveness are met prior to a new level of independent practice.

*Table 2. The second and third phases; complete vocational programme highlighted*

| Phase Two | Building clinical experience | Attainment |
|---|---|---|
| | Pre-registration year 1 | |
| | Pre-registration year 2 | |
| | (more years possible) | General registration achieved; able to apply to enter vocational training as junior registrar |
| | Vocational training - junior registrar Year 1 | |
| | Vocational training - junior registrar Year 2 | |
| | (more years possible) | Initial summative assessment; able to become senior registrar |
| **Phase Three** | Vocational training - senior registrar Year 1 | |
| | Vocational training - senior registrar Year 2 | |
| | (more years possible) | Later summative assessment; able to apply for full vocational registration |
| | Specialist general practitioner - lifelong professional development | Full vocational registration continues |

### The third phase

Success in initial summative assessment should open the gateway to wider educational opportunity for senior general practice registrars whilst also working in increasingly independent clinical practice. An integrated and structured educational plan, with certain prerequisites, including interprofessional learning with other primary health care professionals, should be key to this phase, but wide educational choice should be available. The skills for independent on-going vocational education and professional development need to be consolidated by these emergent general practitioners (senior general practice registrars) early in this phase, as shown in Table 2; it is the integration of ever-increasing clinical experience with advanced knowledge, reflection and critical thinking that distinguishes education from training. Vocational registration can be achieved when senior general practice registrars can ably demonstrate not just sound, successful clinical training and experience, but also the ability to critically review their knowledge and practice.

### Educational provision on a phase-by-phase basis

At the Phase One level, the priorities are an integrated curriculum, fertile cross-disciplinary learning and teaching, and considerable academic and intellectual challenge, where both clinical practice and research informs and influences teaching. Universities are well placed to provide this kind of learning. They are part of a wider academic community within which they can gain, and give, benefit, and they have considerable potential to inform excellent teaching with best clinical practice, that is in turn informed by sound research.

In contrast, at the Phase Two level, the key requirement is the integration of knowledge and skills already gained into sensible, safe, effective and sensitive patient care. Clinical skills and teamwork skills need further development as students learn to take on increasing clinical responsibility.

National co-ordination of clinical placements is the key to achieving good clinical experiential learning for all, in a fragmented service provision market. Practice capacity both in hospitals and in general practice needs to be actively managed and supported. National standards need to be set and maintained across education and service providers, including security of employment for registrars; security of supply for service providers, including general practices, and a requirement for registrars to have a proportion of the working week free from direct clinical commitment and devoted to structured educational requirements.

For this phase of learning there is considerable teaching and learning capacity in general practice, but it must be well managed, well resourced and well supported, not only to meet training needs but also to meet workforce and service needs. National professional colleges are well placed to provide national co-ordination and standard setting for both hospital and general practice placements; this College also has a proven track record in the provision of learning based in practice, and it is well placed to provide or oversee graduated programmes of increasing clinical responsibility that drive learning.

Beyond this second phase of experiential learning, Phase Three is life-long. While it has an initial task of preparing emergent general practitioners (senior general practice registrars) for full vocational registration, its wider purpose should be to develop wisdom and ongoing enquiry, drawing together experience, advanced knowledge and critical reflection. It is where the discipline grows and flourishes.

**No matter where professional development takes place, it needs dedicated time if it is to be done well; protected study time should be part of the working week**

### On-going professional development

Phase Three is as yet largely underdeveloped. Maintenance of professional standards is a maintenance minimum, not professional development. One-off continuing medical education (CME) sessions and conference sessions that constantly repeat introductions to topic areas have some use, but these are limited compared to programmes of learning that are flexible, individualised and build research and development in the sector.[22]

Professional development that is inspiring and exciting should include wide choices for programmes of study, where individual learning need is met and where experiential learning is integrated with further academic development. Teaching and learning should be underpinned and integrated with research, and interprofessional learning should be the norm across disciplines and sectors.

Universities are currently underutilised in this phase, but now that postgraduate programmes have been developed specifically for those working in primary health care,[23,24,25,26] they are not only well placed to provide structured flexible learning that develops good enquiry and research skills, but also to build a cohort of expert general practitioners who are able to develop career pathways in specialist areas (such as teaching). Vocational registration should include a postgraduate qualification requirement. This would ensure that practitioners have the enquiry and research tools necessary for advanced and independent learning, as well as the development of at least one advanced special interest area. Other organisations, particularly health service providers, are beginning to develop integrated programmes of learning, and although less likely to equip practitioners with enquiry and research tools, they may well develop valuable areas of special interest. No matter where professional development takes place, it needs dedicated time if it is to be done well; protected study time should be part of the working week.

In fifteen years time it will be 2021. By that time, I hope that my vision for the future of general practice education includes:

- A medical degree that is intellectually rigorous and better integrated across health and other disciplines;
- A concentrated clinical learning period that is nationally coordinated, spans the early postgraduate years, including early vocational training (the 'junior registrar' years) and closes with flexibly-timed summative assessment;
- A comprehensive vocational training programme for general practice that is four years long, with security of employment, with:
  - The first two years as 'junior general practitioner registrars' in clinical service rotations, predominantly accredited general

practice (20% educational component, 80% service component);
- The latter two years as 'senior general practitioner registrars', either in further clinical service rotations, or in independent, but supervised practice, still supported with a 20% educational component;
- Vocational registration that has considerable tangible benefits, including the right to be known as a fully independent 'general practitioner'; a specialist in generalism.

And,
- Where ongoing professional development is fostered to excellence with dedicated study time within the working week;
- Where all vocationally registered general practitioners have completed at least one postgraduate qualification that has structured their learning.

And perhaps,
- Where practice nurses also have a structured vocational training programme that not only reflects core nursing values but also shares substantial common components with the vocational training programme for general practitioners;
- And that this model sustains an ongoing contribution to general practice that extends into 'retirement'.

A tall order? Yes, but quite possible if we step back from examining training components, and instead view general practice education as a whole, embedded not just within medical education, but also within primary health care and across education and service providers. Different types of education providers, and different types of service providers are all important in an education pathway that aims to produce practitioners who are not only well-trained in safe and effective clinical practice, but are also passionate, inspired and confident about their work in health care teams. Only then will we have a sustainable workforce that feels understood and valued, that is proud to be an integral part of an interprofessional team, and that will remain committed to the highest standards of patient care in the primary sector of the country's health system.

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## Competing interests

None declared.

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