Whither general practice education in the next 5–15 years?*

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***Lucy O'Hagan** has been a part-time, shared-care GP in Wanaka for 11 years. She says that she mainly gives out tissues and condoms and puts plasters on. Sometimes at night. She learns most by teaching anyone who is interested but mainly TIs, PGY2s, registrars and her kids. She loves biking, ideas and the MGP.*

I would like to take you on a journey into the future. What will general practice be like in 15 years? How can we best educate doctors for this changing world? What will become clear is this. We need to educate GPs to be adaptable, reflective and confident in themselves as GPs and as individuals. But most of all we need to instil our trainees with an attitude of optimism.

It is on this theme of optimism that I would like to tell you a true story. Dr Pollyanna meets Dr Doom. Be warned, some of the content is disturbing.

Once upon a time about two weeks ago there was a country doctor who did a bit of teaching. One day she put on her town clothes and drove about 500km to the city for some CME.

There she met a young doctor, a fellow of about 33, married with two young kids and a mortgage.

Being a friendly sort of country person, she asked him where he worked...

'Oh I go to Australia and do locums.'

'That's quite a hard life with a young family,' she said.

'No,' he said, *'it's great. I work nine days and get three weeks off.'*

Slightly curious, she asked, *'Have you done GP training?'*

'Yes,' he said *'but general practice is doomed.'*

A little surprised she said, *'What?'*

He repeated, *'General practice is doomed.'*

Thinking that perhaps he knew something she didn't know, that maybe she'd been too long in the country, she asked him to explain.

'Well,' he said,

'
- *you'd be mad to buy a practice; it doesn't make economic sense*
- *GPs just do diabetic checks and form filling all day*
- *the midwives and A&M clinics have taken over the good bits*
- *look at this red letter – there will by fee regulation before Christmas*
- *the Ministry of Health hates doctors*
- *the College just puts you through a whole lot of hoops that are a complete waste of time*
- *the nurses are going to take over general practice anyway*
- *and don't do a locum for a woman doctor – all their patients are on prozac.'*

At this point the country doctor's eternal optimism was slightly shaken but she managed to splutter, *'Goodness me, if you carry on talking like that we will be doomed; it'll be a self-fulfilling prophesy.'*

'I'm just cynical,' he said.

'But you're too young to be cynical; at your age you should be brimming with enthusiasm. I'll have to call you Dr Doom.'

'Well my friends all agree with me.'

Feeling the need for a change of tack she asked, *'So where do you see yourself in 10 years?'*

After a long pause that filled her with some hope, he said, *'I dunno.'*

'General practice education has failed you,' she said. *'Haven't you ever had an enthusiastic GP teacher who really inspired you?'*

* Modified from a paper presented at the RNZCGP Education Convention in Wellington, 23–24th June 2006.

'Well I was a seminar attendee but I worked in a teaching practice. The teachers are all cynical too. And they teach because they can't hack general practice; same old thing – if you can't do it teach it.'

Recovering from that body blow, she said, *'have you thought of working in the country? We're all having quite a good time out there.'*

But as they parted she reflected on his negativity and she knew that everything he said she had heard from other GPs. You see we all have a bit of Dr Doom tucked away. Dr Doom comes out when we are under pressure and slightly paranoid. Dr Doom stifles our enthusiasm and saps our energy.

As teachers we need to challenge Dr Doom. Teachers have a powerful influence on the younger generation and we have a responsibility to lead the way with a positive and optimistic attitude to general practice.

We can do this because there is another way to see the world. We need to go deep inside ourselves and find the Dr Pollyanna within and then we can play the Glad Game.

So let's look at the future – there will be change in general practice.

But that's fine. We should be glad, change is good, change is what challenges us, keeps us thinking, gives us vitality. Change provides us with opportunities to see options we might never have thought of.

So what changes can we expect over the next 15 years? It's a very important question because we need to be planning GP education for the next decade and beyond. I'm glad again, because we can get bogged down in the present. And in the country we know that when your gumboots are stuck in a bog the solution is often found not in the mud but in the mountain tops.

So looking up, let's move on…

1. In 15 years we will need more GPs. We have a growing population, an ageing population and a population that loves prevention. We need to be grandiose in our planning of GP education. We will not accept another cohort of uninspired seminar attendees.
2. If recent trends continue, GP funding will change many times over the next 15 years. But that's OK because we now have good GP advocacy at a national level. At a practice level we are developing business management structures that allow us to absorb change seamlessly. Our practice managers are masters of bureaucracy.
3. In 15 years we will all be speaking into our computers. We will communicate with patients by e-mailing, texting, skyping, virtually consulting and other new technologies that will challenge our concept of the consultation. At times we will be out of our comfort zone. But that's OK because we will have some enthusiastic young trainees around to show us which button to press. In this learning exchange the teacher might offer the wisdom of knowing when to push the button.

   Technology will help us define what we are not; we are not technical robots, diagnostic computers, or cardboard cut-outs of McDoctor. We offer much more than that because as doctors we are fully human. Fortunately we have not yet realised what the fully human doctor looks like, we are still more comfortable hiding behind the cardboard cut-out of some other, 'real doctor'. We still talk of putting on our 'doctor's hat' as if 'the doctor' is somehow separate from us.

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4. In 15 years we will have even greater access to information. We will have to become more expert at finding and decoding information for patients. We will need to be much better at explaining risk and evidence. We need to be seen as purveyors of quality information. Information that is independent from the interests of drug companies and other agents of bias. In the future patients may trust us not because we know everything, but because we know how to find the answers.
5. Another 15 years of medical technological advances; how can I possibly keep up? I mean I know what a CABG is, but when my patient has a PCSSTI or a DACS I really need my registrar to translate. We must not forget the educational needs of the GP-in-practice. MOPS is a good structure, but the current style of CME where a specialist gives a mini-lecture seems inadequate for the learning needs of practising GPs. We need to know a lot more about how GPs in practice actually learn.
6. In the future we can expect increasing sub-specialisation within general practice. We need training opportunities that allow GPs to develop procedural skills such as endoscopy and minor surgery. We also need to develop our role as generalists to include outpatient clinics and other services previously the realm of specialists. The College and the Medical Council may have to provide vocational pathways that are flexible. Doctors want to be able to move from family planning to endoscopy to sports medicine to rural practice without jumping through too many hoops.
7. The next 15 years will see the emergence of real teamwork in primary care. Capitation within general practice provides great scope for the development of practice nursing. However nurses

need far better educational opportunities to reach their full potential. GPs also interact with many teams outside their practice, but in the past communications have been difficult because teams are fluid structures with changing memberships and our best efforts resulted in playing telephone tag with the wrong person. Already email, texting and skype-conferencing are bringing teams together. Of course, a communicating team offers a whole lot of other challenges for GPs

What is my role here? Is this team doing the best for the patient? How many team emails can I handle in a day?

8. In the next 15 years there will be more part-time GPs and shared care will become the norm. We will have to drop our obsession with continuity of care with one GP as the gold standard. This is heresy to some but, done well, shared care within a practice can offer great opportunities for the patient and the doctor. Shared care allows the patient choice. He or she can choose to have one doctor or they can look at their practice and choose the doctor that fits the ailment. Shared care gives the patient the benefit of more than one opinion and reduces mutual dependency. Shared care offers doctors freedom from full-time work and results in greater communication, continual peer review and support between colleagues. GPs sharing care are not working in isolation.

9. If current trends continue there will probably be more GP-based teaching. We have a great opportunity to alter the human face of medicine. But we need more teachers. I am certain that there is a large pool of GPs dying to be teachers, so what are the barriers?

Firstly, many more GPs work part-time and yet at every level we offer only full-time students. This mismatch can easily be accommodated by flexible shared-teaching.

Secondly there are internal barriers to taking up teaching. For there is a voice inside every GP that says, *'I can't teach because I really don't know what I'm doing.'* The voice of Dr Doubt is quite common in general practice. It's going to take a pretty special marketing campaign to bring these people on.

Thirdly, we need a coordinated national career pathway for GP teachers. Here is a great opportunity for the College and the universities to work together. In six years of teaching trainee interns from all four clinical schools I was never once invited to a teachers' meeting or given any support or guidance. Yet we wonder why we have to beg GPs to take students. Give us teachers' diplomas, teachers' peer groups, teachers' conventions, teachers' sabbaticals...teachers' morning teas? Teachers anything and then teaching will be seen as a dynamic and sought after career choice.

What a dynamic and exciting time for general practice. What a great time to be a teacher. And the key to the future lies with us, with our adaptability and vision

10. In 15 years we will continue to practise a form of patient-centred medicine. We have become expert at the question *'who is this patient?'* What we need to ask now is *'who is this doctor?'* Patient-centred medicine has been a great movement in our lifetime but, because historically it was a reaction to paternalism and doctor-centredness, I believe that it actually neglects the self of the doctor. Indeed the original Canadian textbook of *Patient-Centred Medicine* devotes just two pages to doctor self-awareness.

Practising patient-centred medicine without self-awareness is dangerous for the patient and the doctor.

We have a great opportunity over the next decade to look at the self of the doctor, and define more clearly our place in the doctor-patient relationship, the health service and the communities in which we live.

Well, are we all feeling good about the future? What a dynamic and exciting time for general practice. What a great time to be a teacher. And the key to the future lies with us, with our adaptability and vision.

Adaptability and vision are only possible through reflective practice.

Reflective practitioners are in constant conversation with themselves.

Reflective practitioners ask themselves:

- what is my role here?
- what is happening for the other person?
- where is the line between friendship and medicine?
- what's in this for me, what's driving me here, am I on dangerous ground?

Reflective practitioners ask themselves:

- why am I whingeing to my registrar about my job?
- is there a better way to do this?
- what part of this is in my control?
- what part of this threat is actually an opportunity?

Reflective practitioners ask themselves:

- Do I need to pee, eat, take a holiday, see my kids?
- Do I need more information or support?

Reflective practitioners can hear their own Dr Doom, Dr Pollyanna and Dr Doubt and mix all these voices into realistic solutions.

Reflective practitioners ask themselves:

- Who is under my doctor's hat?

Reflective practitioners have a sense of their own skill set and the confidence to appreciate the skills of others.

Reflective practitioners have strong professional values and bottom lines in patient care but they also know that today's professional values and bottom lines may hinder them in facing tomorrow's challenges.

A reflective practitioner strives in pursuit of that old-fashioned attribute – wisdom.

So how on earth are we going to educate a new generation of reflective practitioners?

The short answer is to carry on with what we are doing. General practitioners are some of the best medical teachers because we are the only specialty that has embraced patient-centred medicine. We can translate the same skills into our teaching. If we can ask *'who is this patient?'* we can ask *'who is this learner?'*

As teachers we have to be reflective practitioners ourselves. We all do this but we have to actively model this by being transparent about what is often an internal process. We can show our trainees how we think, how we meet challenges, how we adapt, how we act with conscious awareness.

A reflective practitioner strives in pursuit of that old-fashioned attribute – wisdom

One-on-one teaching is the perfect setting for reflective practice. In this supportive, safe relationship, the teacher has a unique opportunity to challenge the trainee and lead them to new understandings. Unfortunately this learning outcome may not be valued by funders because it is hard to measure.

Reflective practice can also be learned in small well-facilitated groups. The current use of small peer group learning is potentially a great way to experience the value of peer support.

While some of us may attend supervision or Balint groups, the reality for most GPs is that the best support is right next to them; the colleagues with whom they work. We need to harness this incredible support system by modelling a more co-operative and more open relationship with our colleagues.

We have a lot to be glad about. The future is bright. General practice is still in its infancy, there has only been a College of GPs in New Zealand for 30 years. Nothing is set in stone; we have a great opportunity to take general practice to new heights.

Bring it on Pollyanna, bring it on.

Competing interests

None declared.

Fostering interest in Family Medicine

'Fostering interest in FM among medical students is vital for maintaining a healthy number of family physicians in this country [Canada], and undergraduate medical education plays a crucial role. As educators, we must take advantage of opportunities available throughout the undergraduate medical curriculum to nurture future family physicians. These opportunities amount to every encounter that we have with medical students, but clinical clerkship remains most important. Clerkship is a time when medical students' decisions about their future careers can be shaped and directed by the quality of their clinical experiences. It also offers medical students exposure and interaction with FM and its practitioners. Every medical student deserves a memorable experience in FM so that he or she can make an informed choice about whether to include it in career plans.

To stimulate student interest in FM successfully, we must provide an environment where medical students can have enjoyable and rewarding experiences. There are many ways to accomplish these goals, but the unique longitudinal patient-physician relationship is the most important tool available. This relationship characterizes our interactions with patients and is one aspect of our specialty that we enjoy immensely. Further, it defines the way we care for our patients. By holistically knowing our patients, we define and manage presenting medical problems, their context, and their effects on patients' lives. Most importantly, we are granted the privilege of being involved and connected to the lives of our patients.'

Wong E. http://www.cfpc.ca/cfp/2003/May/vol49-may-resources-2.asp