

# Education for general practice in the 1980's

by Dr M W Heffernan

## Introduction

This paper deals with two aspects of the future development of general practice — global trends and vocational training.

In the first section I will present a quick review of those factors which I see affecting the development of general practice at a global level and in the second section I will review the Australian experience in vocational training.

This review is mostly based upon experience gained within the Royal Australian College of General Practitioners' (RACGP), Family Medicine Programme (FMP), and the Department of Family Medicine of McGill University, Canada.

As this vocational training for general practice occurs at a post-graduate level there will be little comment on under-graduate factors affecting general practitioner development and I do not intend to deal with any issue relating to continuing medical education.

## Global trends

I believe that this is one of the most exciting times in history to be associated with general practice. I believe this because: general practice is now an 'acceptable' medical career; it is now clear that there are many intellectual challenges that are specific to the discipline e.g. patient education, the development of a five minute model for the psycho-therapy consultation, the study of the epidemiology of disease; the community is seeking once again the competent general practitioner as a key figure in the health care of the family.

Thus the 1980's should comprise an exciting decade for those with the intellectual and attitudinal capacities to engage in the practice of general practice.

I would like to consider three areas within this section of the paper — the growth of the discipline of general practice and its institutions — manpower considerations — and the need for change. What of our growth and institutions?

## The growth of the discipline of General Practice and its institutions

Most Western countries now have Colleges of General Practice/Family Medicine as do a smaller percentage of the less well developed countries. However if South-East Asia is any indication of the future<sup>1</sup>, then most developing countries will have Colleges within the next ten years.

It would appear on review that the development of such Colleges is essential to the development of the discipline as a whole, but it is of interest to note how these Colleges have grown in political influence in the last five years.

The fact that we are sought out as advisers to many governmental and other bodies can only augur well for the future of our craft.

Where Colleges exist there is often an associated examination. The importance of such an examination is two-fold. Firstly it allows other learned Colleges to concede that we are a 'speciality'.

Secondly, in those countries where vocational registration is being considered it is generally suggested that the successful completion of such an examination by a candidate would allow him to become 'vocationally registered'.

Recently in Australia we have seen most medical academics, and an increasing number of politicians, accept the fact that it is **absolutely necessary** for every graduate wishing to enter general practice to undergo vocational training.

Much more recently health bureaucrats/planners and politicians have become convinced that general practitioners are cost-effective deliverers of health care.

Unfortunately this belief is not related in any way to the quality of care. It is based on the simple premise that the doctor who charges least for any doctor-patient contact is clearly the most 'cost-effective.' Because of this they can believe that primary care physicians are cost-effective, but not necessarily have any commitment to supporting the vocational training of general practitioners.

Most Western countries and many developing countries have well developed vocational training programmes which enjoy substantial or total governmental funding.

By comparison with the establishment of post-graduate examinations, the establishment of such vocational training programmes seems to have been achieved with much greater ease.

Vocational registration — the certification of one's competency to undertake *unsupervised* general practice — which implies the existence of a register — is being strongly supported in Canada, the USA and Australia. It is already an established fact in Britain.

The aetiology of this circumstance seems to be multi-factorial, being stimulated at least by the apparent sufficiency of general practitioners in many countries, an influx into many developed countries of less well trained medical graduate immigrants and an overall concern for the quality of care delivered by primary care physicians.

This trend is often viewed with suspicion by bureaucrats, who see it as an attempt to create a 'closed-

shop', and thus it enjoys variable support amongst the political and health planning communities.

Delineation of privileges — the limitation by regulation of what one can do in hospitals (such regulation often being supervised by one's peers) — has been a fact of life in Britain and North America for a considerable period of time.

However, this practice seems to be spreading and is closely interwoven with the trend to vocational registration and various kinds of audit such as the techniques of Quality Assurance and Peer Review.

In summary, it would appear that we are becoming both institutionalised and 'certified'.

### Manpower considerations

Developed countries such as Canada, U.S.A. and Australia are reporting an impending surplus of doctors. Most specialties reflect this surplus, but there is not always an associated surplus of general practitioners.

Our review of manpower within Australia has led us to become cognisant of three important factors within the area of manpower planning.

Firstly, to say that there are too many doctors is not to say that there are too many general practitioners. At this point in time there is no accepted way for deriving from a statement about the overall doctor/population ratio, what percentage of these doctors will be in general practice.

Thus one has to conduct an independent enquiry into the number of general practitioners within any country, in order to engage in any sensible debate about the relative numbers of practitioners in general practice.

Secondly, one can apparently have 'too many' general practitioners for two reasons. There may in fact be too many general practitioners in terms of *absolute numbers*.

However, where the *rate of increase* in the number of general practitioners is too rapid for the medical community and community at large to absorb the numbers, one also gets an *apparent* sufficiency.<sup>2</sup>

It is important to distinguish between these two circumstances because the changes that need to be made to correct them, are, as one

would expect, quite different, and have differing long term implications for medical manpower once initiated.

However, whilst there is this apparent excess in some countries, there is, and will continue to be, a global shortage of family physicians for the foreseeable future.

It is not uncommon in underdeveloped countries for there to be GP/population ratios of  $\frac{1}{3 \cdot 15,000}$

and whilst great efforts are being made by these countries to correct this situation, changes in this ratio will by force of circumstance, be slow.

As already noted ratios of practitioners to population are often used as a means of guiding manpower planning.

That used in the area of general practice is a ratio of 1/1500. Because of its central place in such planning, the manpower working party of the RACGP decided to review the validity of this index.

Our conclusion is that when promulgated, this ratio was probably based on the GP/population ratios existing during the 1960's in several developed countries. That is, this was about the ratio of general practitioners to population, and as primary care services were felt at that time to be inadequate it was concluded that this ratio was 'about right', and could thus be used in future planning exercises.<sup>3</sup>

This ratio has been reviewed by the RACGP's manpower working party which has come to the conclusion that: the ratio of 1:1500 is an inadequate ratio; a range should be used for manpower planning rather than a fixed ratio; a range of 1/900 — 1/1300 is appropriate for Australian conditions.<sup>4</sup>

If circumstances do not alter substantially in the next ten years, then Australia will have about one practitioner for every 900 people by about the year 2000.

A final and significant change within medical manpower, at least in Western countries, is the increasing proportion of under-graduate positions being taken by females.

In Australia the overall percentage is probably around 30% at the present time, but in some universities the percentage is almost 50%, and

there is every reason to expect that in the near future approximately half of all medical under-graduates, and therefore graduates, will be women.

At this point in time nobody has any idea as to what effect this radical change in percentages will mean for manpower.

It is quite likely, that if these women marry and have families, that whilst on paper there will be too many 'graduates', in fact the numbers of graduates in the work place will not reflect this circumstance. That is, the effect of this change will not really be felt in the manpower market-place until the late 1990's, though the graduations will occur in the early 1980's.

### The need for change

Surveys show that there are large unmet needs existing within the community in the area of primary care.<sup>5,6</sup>

This is also supported by reviews of non-medical health care appearing in the Australian press, where the numbers of consultations given by paramedical people in Australia, such as natural healers and chiropractors, is variously estimated at between 500,000 and 1 million consultations per annum.

From talking with patients about this, I believe that people seek such help from non-medical practitioners because the medical community is not prepared to meet the patient's needs, as the patient sees that need. It is not that they are 'anti-doctor'.

In fact I believe that they would prefer to attend the medical profession could they get the kind of service which they believe is appropriate — or at least be able to discuss same.

I would conclude therefore that should we revise our approaches to many aspects of health care, that these patients would return to general practitioners for most of these visits:

The implications for general practice are that it must review its role within primary care, perhaps alter its attitudes, and probably in the process undergo substantial change.

This ultimate conclusion is borne out by McWhinney's historical analysis of the develop of our craft,<sup>7</sup> at the end of which he concludes:

*These historical events are not irrele-*

vant to the position of the medical profession today. Two lessons we would do well to ponder:

1. If the profession is failing to meet a public need, society will find some way of meeting, the need, if necessary by turning to a group outside the profession.
2. Professions evolve in response to social pressures, sometimes in ways that conflict with the expressed intentions of their members.

What are some of the changes that we might anticipate?

I believe that the general practitioner will have to get used to being, once again, the central figure in a family's health-planning over a continuum of time.

This in turn implies accessibility, and the acceptance of responsibility for managing a large number of factors relative to the patient's health at any one time. That is, we will have to practice once again holistic medicine.

I am reminded of one of my own current patients, where I am required to manage simultaneously the dynamics of the family, the police, the neighbours, a consulting psychiatrist, and the school programme of one child who requires a substantial remediation programme.

Life-style will also be a concern of this future physician. I see that our young graduates are concerned with their tri-partite roles of doctor, spouse and parent. Unlike members of our generation they are not prepared to take from the role of spouse and parent in order to be a doctor, and this circumstance seems to be in conflict with the projected return to the 'old-style' family physician. However I believe that the two circumstances can be resolved, and it will be interesting to see how the resolution occurs.

I believe that the future family physician will be more concerned about the normal functioning of the human mind and will be better able to engage in therapies related to the resolution of psychological problems.

This in turn places a greater emphasis on counselling and psychotherapeutic techniques in training programmes.

It also means that we will be much better able to engage in patient

education and preventative health endeavours because the skills required in the psycho-therapeutic process are generalisable to the teaching role implied in these latter two areas.

If we are to enter into such areas, then the nature of health funding will have to change in most countries, in order that the general practitioner can engage in these time consuming activities, without incurring a financial disadvantage.

Superficially it would seem that this judgement is correct whether or not one is delivering primary care within a socialist or private enterprise health care system.

We will also have to change the technology which we use in our practices. The most obvious change will be the adaptation of the micro-computer to uses within our domain.

I believe within the next five years most primary care physicians in developed countries will have desktop units, which they will use to display a variety of information ranging from the patient's history to information about various drugs.

Two unusual future developments are as follows. The first, if it occurs will be welcomed by the profession.

This is that I believe that we will be less concerned with learning about new drug advances. I think it is fair to say that the rate of introduction of new therapeutic substances has slowed dramatically, and that in the future whilst there will be occasional new and unexpected compounds to learn about, the reality will be that in most instances new substances introduced will be very like others which we already know of, or will be old drugs delivered to the body in some new form of drug delivery system.

The second unexpected item is the likelihood that we will have to mount particular courses about 'unseen' diseases, which whilst a significant threat to health or life when they occur, have largely been eradicated over the last 40 years.

One can name such diseases as Scarlet Fever, Osteomyelitis, Acute-Glomerule-Nephritis, Lobar Pneumonia and Rheumatic Heart Disease. It is important that any practising primary care physician be able to recognise diseases such as these and I believe we will have to devise particular ways of introducing them to him, given that they are largely non-existent within most Western

countries at this time.

Let us turn now to vocational training and our experience within this area in Australia.

### What is the family medicine programme of the RACGP?

In brief, the characteristics of FMP are as follows. It was initiated by, and is run by, the Royal Australian College of General Practitioners as its vocational training programme.

The programme is federally funded with an annual budget of around A5.5 million dollars.

All graduates wishing to undertake vocational training are accepted, and currently there are approximately 1600 young doctors in training.

The programme uses about 800 accredited practices as the major location for training. About 1000 general practitioners conduct its teaching programme in the field, and these are co-ordinated by a group of around 100 regional co-ordinators.

Innumerable hospitals are used to provide a wide range of elective experiences for the general practitioner trainees.

Hundreds of College members give of their time in various committees within the College, where these committees have important liaising and supporting roles to play between the College and FMP.

FMP has the equivalent of 22 full time medical staff, and employs about 100 other staff in such positions as secretaries, printers and accountants etc.

Importantly FMP has developed all elements of what I call the 'general practice training trinity' which comprises: a model of family practice; teaching undertaken by 'unadulterated' general practitioners. This teaching takes place in **their environment** and further reinforces the model of family practice noted above; a well thought out educational philosophy that is translated into training realities.

It is possible to engage in a vocational training programme without having each element of this trinity worked out in any degree. That is, one can initiate and run such a vocational training programme largely on the basis of prior experience, thus replicating the teaching model that we have all experienced as under-

graduates.

In particular it has been my experience that many programmes are initiated without adequate thought to the third element of the triad noted above i.e. the educational philosophy.

The educational philosophy of FMP is briefly as follows.

Firstly we believe that the individual must share with the teacher, an equal measure of responsibility for the goals of their training, the means by which they will gain the appropriate learning, and the evaluation of such learnings.

This results in the development of individual programmes, based on individual needs.

Such programmes are developed by a mentor working in association with each trainee, and within this relationship the trainee and the 'teacher' establish appropriate long and short term goals and the means for achieving and evaluating same.

This philosophy and its practice is strongly influenced by writers such as Rogers,<sup>10</sup> and Bruner,<sup>11</sup> and is consistent with the concept of adult learning outlined by Knowles<sup>12</sup> and Hefernan.<sup>13</sup>

Whilst we have developed documents outlining a potential syllabus for such a vocational training programme,<sup>9</sup> we believe that the syllabus for general practice presents in the general practice consulting room, in the form of patient problems, and that the basic requirement in order to be trained is that one should spend considerable periods of one's vocational training time in the general practice consulting room, in a variety of general practices.

Whilst we support the use of evaluation, we are not convinced that the use of formal examinations is a useful means of measuring competence at this level, and we are convinced that the use of examinations for such alleged purposes distorts the manner in which any examinee goes about his education.

Thus for these reasons we have initiated a programme without any formal examination requirements.

However we are committed to the development of appropriate assessment techniques, and a great deal of our time is spent in the development of such measurement strategies.

It is also true, and in this regard we are fortunate, that our parent College

does have available a post-graduate examination for those of our trainees who elect to obtain a post graduate qualification.

It is interesting to note that increasing numbers of FMP trainees are choosing to present for this examination.

Why adopt such an educational philosophy? In response to this question we would present at least the following arguments.

Firstly, we believe that a trainee engaging in such an educational process develops the necessary educational skills to undertake the task of life long continuing education — where often-times they will be the only ones interested in their continued intellectual growth.

Further we believe that such a process promotes learning which is associated with greater retention times of the material learnt; an increased ability to use the knowledge learnt in unexpected situations (generalisation); and learnings which are totally unanticipated and unpredictable from a teacher point of view. Such outcomes are predictable from education theory,<sup>14,15</sup> and we believe that we see evidence supportive of such predictions.

One might ask: 'Doesn't this approach lead to omissions in the trainees learning?' This question seems to be based on a belief that any curriculum can be all inclusive. Having attempted to devise such a curriculum, I believe I can say with safety that one can never devise such an all inclusive curriculum.

Given that in FMP both the trainee and his mentor are devising a programme based on the trainee's future needs and perceived inadequacies, it is likely that — he will not waste time on matters he already knows about — he will correct deficiencies that might otherwise be left uncorrected — he will learn those skills critically important to the nature of his future practice.

Would any centralized planner attempting to devise a syllabus or curriculum for 1,600 trainees, make such a claim?

### The Australian experience

The RACGP was established in 1958, and very soon began to think about the issue of vocational training for general practice. This ultimately led to the establishment in 1973,

with the assistance of funds from the Australian government, of the Family Medicine Programme.

At this time there were no undergraduate chairs associated with the discipline of general practice, but these followed quickly beginning with the appointment of the first chair in 1974.

FMP's vocational training role and its relationship to the discipline of general practice is direct and clear. However such is not the case with the under-graduate departments.

All such departments are university based and funded and are therefore, independent of the RACGP, though all of the professors maintain a liaison with the RACGP.

The policies and endeavours of such departments are understandably greatly influenced by their university peers, whose stated interests are much more related to research than teaching.

It is not surprising therefore that such units might find themselves highly conflicted in their relationship to general practice, and in any attempts to provide teaching directly related to the practice of our discipline.

A further consequence is that the teachers within such units inevitably become labelled as being 'academic', and this tends to ostracise them to a degree from the general practice community at large.

Further the reason for the inauguration of such departments was not always related to the desire to present teaching about general practice in the under-graduate curriculum.

For example, some departments in Australia have been established within departments of community medicine and epidemiology, and thus their role is by no means clear, when viewed from the perspective of post-graduate general practice.

It is true however, that such departments generally undertake teaching of sections of the under-graduate course which are perceived by the university in question to be directly related to primary care.

Thus such a department might find itself responsible for the teaching of such matters as preventive medicine, communication skills and epidemiology.

It is thus inevitable that such departments do not model general practice though they try.

This state highlights an issue which has been operating since universities abandoned the objective of training general practitioners by the end of the under-graduate course, thereby creating the need for post-graduate vocational training.

Whilst this was gradually recognised, an important associated issue is as yet unaddressed so far as I am aware, in any developed country.

The issue is: Which elements of general practice are most effectively taught in the under-graduate setting and which in the post-graduate?

The writings of such educational theorists as Ausubel et al.,<sup>14</sup> suggests that much that needs to be learnt about the practice of general practice, cannot be taught until the trainee is experiencing the responsibility of clinical care in that setting.

If we accept this view then we should be attempting to define which elements should be taught in the under-graduate setting, and how such teaching can be integrated with teaching in the post-graduate setting, so that the under-graduate and trainee who elects to go into general practice experiences an organised teaching programme.

Addressing this issue is of primary educational importance, but it also has significant implications for vocational trainees in general practice. After all who wants to be 30, and have undergone 10 years of tertiary education, before being able to enter the vocation of general practice, unless such a circumstance is absolutely necessary?

We have had both good and bad experiences in the development of the Family Medicine Programme and I would like to list some of these positive and negative features briefly.

### Positive aspects of the development

Because of the value of these factors in our own development, I would strongly recommend that these items be considered by any group either running or considering the establishment of, a vocational training programme for general practice.

I will list these points serially in order to allow the reader to focus upon them individually.

There have been many advantages

to being conceived and fostered by a learned College. I would suggest that all vocational training programmes should be developed in this manner.

FMP is a national programme, with provincial offices. Our programme of training is further decentralized because major emphasis is placed in training in general practitioner surgeries. However despite this educational decentralization, there are substantial gains to be made by having a national overview.

The core of our vocational training programme is the expansion provided for our trainees by established general practitioners within their general practices.

This experience takes the form of attachments of 10-13 weeks each, and we encourage our trainees to have at least three of these attachments within their vocational training period, preferably with different practitioners.

The advantages of having real general practitioners acting as the teachers within a vocational training programme cannot be overstressed. It is these general practitioner teachers who are the strength of the Family Medicine Programme, not the academic staff such as the author.

Whilst our trainees spend substantial periods of their training time within hospital settings, and whilst to the casual observer this may appear to be hospital based training, the important philosophical difference is that we see trainees moving from general practices into hospitals and not in the reverse direction.

That is, compared to the classical vocational training model within medicine, where one is hospital trained and moves out into the community (i.e. inside to out), our philosophy and practice is definitely 'outside-in'.

FMP is federally funded, and whilst it enjoys support at a provincial level, it is not dependent on such peripheral support for its annual budget. This allows the Programme to pursue national goals, with minimal perturbation caused by local politics.

As previously noted we have a well developed 'general practice training trinity,' and this has been crucial in our development.

Medical practitioners run the programme. Whilst it would be possible for administrators to hold the senior

positions in a programme such as FMP, our experience suggests that it is desirable for medical practitioners to hold the senior positions in such a vocational training programme.

Our senior staff are divided into two groups — administrators and educators. All are medical graduates, the former group being concerned with the organisation and running of the programme in any province, whilst the latter group are concerned with developing the educational programme provided within that structure. This has proved a useful division.

Our educational philosophy outlined earlier led us to the conclusion that a consensus model of decision making was the most desirable for us to initiate, and this decision has been validated with the progress of time.

Important outcomes of it have been the establishment of a National Trainee Association, and the appointment of trainees on a six monthly rotation to our provincial offices as trainee liaison officer/assistant director.

Whilst we have not insisted that all medical staff recruited to the programme have an interest in education, (with the exception of those employed in educational roles), all of the doctors who have joined to the present time have had such an interest, and I would believe that such a characteristic should be sought in the medical employees of such a vocational training programme.

Because of the emphasis on training in the general practitioner surgery, little distinction has arisen between those teachers teaching within our vocational training programme, and all the other general practitioners in the field who are not related to our programme.

It is true that staff such as the author, may be seen as 'academic and ivory tower' by many general practitioners, but this cannot be raised as a criticism of the teaching within the programme, thereby insinuating that the teaching is irrelevant, because in fact the teaching is undertaken almost exclusively by practising general practitioners.

The division noted above is well recognised and known by the pseudonym of 'town and gown.' Where it occurs it is often divisive.

From the earliest days of the pro-

gramme we have placed a great deal of emphasis on developing the teaching skills of our teachers.<sup>16</sup> Whilst progress has been slow in this area we can now see substantial benefits occurring from this continued activity.

FMP takes all graduates wishing to train for general practice. This is not the case in the unit based system of training in North America, and it is thus possible in such circumstances for some trainees wishing to undertake post-graduate vocational training to miss out on such training.

We believe that such a circumstance threatens the quality of primary care delivered within the community, and any vocational training plan should not allow this circumstance to arise.

From the earliest days we have emphasised physician health as a topic and we believe that our trainees are taking a balanced approach to their needs to have a career in medicine, to be a spouse, and to be a parent. This issue has been addressed earlier.

From the beginning we have had

adequate supporting staff appointed within the programme. This is often overlooked in my experience. For example, every full time medical member of staff probably requires a full time secretary. Such issues as this need to be given detailed consideration in the development of such vocational training programmes, and are probably best addressed by visiting other established programmes whilst one is in the planning stages.

We have fought a protracted battle to retain adequate funds in order to ensure that our staff, dispersed around the country, meet regularly on a national basis. Even where the country concerned is not as vast as Australia, I believe that the objective of regular planning meetings with such staff is essential, and that adequate funding must be provided for this activity.

From the inception of the programme we have had a small public relations department, though we have not exploited it sufficiently. However we have learnt that to do the job isn't enough, and we are

now giving a substantial amount of attention of our external relationships.<sup>17, 18</sup>

From the outset we have built up a national, multi-media resource centre, which functions along the lines of a library, and stores a wide range of films, television recordings, slide-tape programmes, books, journals and the like. These are loaned from this centre to all our participants throughout Australia, using privately run courier services to distribute the material. This has proved to be very effective, and has conserved the capital expended to build up such a resource centre.

The remainder of  
Dr Heffernan's article  
will be published in  
the January issue of  
SA Family Practice/  
SA Huisaartspraktijk.

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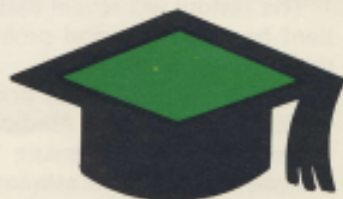
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