Educating the good GP

The 33rd William Arnold Conolly Oration

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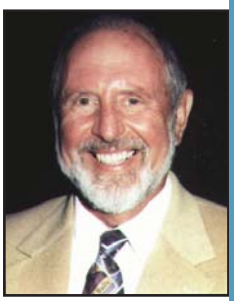

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'Special training is required for doctors in general practice and this was, and is, the main aim and objective of this college and we resent any suggestion that standards in general practice should be any different from the standards in other branches of medicine'. Dr Monty Kent-Hughes[1]

The above quotation reflects the aims and driving force behind the founders of this college of whom the doyen was 'Bill' Conolly. He was aware that the good general practitioner was 'an educated person committed to the scientific method, empathic of the needs of his (or her) patients and their families, moved by a genuine concern for the inequities of man's social condition, a capacity to define precisely the nature of his (or her) patient's problems, and an ability to help most patients directly, or when unable to do so, to know where to find the most competent consultant.[2]

The public view is similar. They want GPs who are accessible, good listeners, interested in them as well as in their disease, up-to-date in science and technology but not uncritically reliant on it or on drugs, and who are concerned with the special needs of special groups.[3–6]

Formal medical education occupies 10–12 years and our students come from the top 5% of academic achievers. It should therefore be easy to achieve our ideals. Why then is there so much ambivalence about general practice from GPs ourselves, patients, consumer organisations, specialist colleagues and government?

There are societal, structural and fiscal impediments to good general practice that require deeper attention than that of the pre-election fix. Medical educators too have a leading role in regularly examining the realities and myths behind our claim that our training programs are among the best in the world.[7]

Career choice

Educating the good GP begins with attracting medical students and recent graduates to general practice and this is harder today than it used to be.[8] Most students enter medical school already seduced by the glamour of technology and the drama of the emergency room. In one University of Western Australia study, only 12% of students entered medical school with the aim of being a GP. At graduation this rose to only 13.5% and 4 years after graduation only 30% were in a general practice training program.[9]

One solution is for members, fellows and registrars of this college to have a greater contact and higher profile with medical students than is currently the case.[10]

Undergraduate medical education

The aim of undergraduate medical education is to provide students with a firm scientific foundation and to introduce them to the ethos and language of medicine and the different fields of health care. The GP contribution is in teaching about the tasks of general practice,[11] the 30 most frequent reasons for seeing a GP,[12] 'the exceptional potential of the consultation'[13] and about John Murtagh's 'Safe Diagnostic Strategy'[14] which will protect them and their patients against missed diagnosis. Medical students should also be introduced to some of the stories of the innovators and researchers of general practice such as water-born cholera in the United Kingdom[15] and amoebic meningitis in Australia.[16]

Boredom

This is also the time when we can turn students off being a GP. Being a passive observer in a general practice surgery can get very tedious. Students need to see patients and test out their diagnostic abilities against those of their mentor. They are also an underused resource, who relish being put to work reviewing patients with chronic diseases and being asked to suggest ways of improving their care.

Vocational training

The first 6 months of general practice training

– the so-called 'basic term' is a steep learning curve. This was encapsulated by a Canadian friend of mine, the late Dr Martin Bass in describing his first venture into general practice, 'When I left the hospital I knew an awful lot. The problem was that the patients didn't have anything I knew about'.

The aim of general practice vocational training is to take the hospital experienced doctor from varying stages of basic competence to becoming insightfully confident and objectively competent enough to practise independently.

In Australia, our method has been based mainly on an apprenticeship and faith in the principles of adult learning.[17] But registrars want the accent of their general practice terms to be on learning rather than being used as workforce. They also want a salary, their own consulting room, work in a quality practice, an adequate number and variety of patients, more involvement in managing chronic health problems, new experiences coupled with a reflection about those experiences and GP supervisors who are available, approachable, provide some live supervision and who are concerned that their registrars are getting the best educational value from their training program.[18,19] They 'want to work and have a life as well'.[20] This is desirable but always needs to be balanced against an awareness that our medical and social status and credit depends on being seen to have high professional ideals of which a service obligation is a major one.

Adult learning and evaluation

The principle behind adult learning is that adults learn when they need to solve a problem. Its major defect occurs when the registrar doesn't recognise there is a problem and the patient is being short changed. In hospitals, a registrar's work is critically observed by nursing staff, interns and a consultant. In this situation it is highly likely that the registrar's unknowns will become known.

In general practice, the supervisor is available, but the registrar works almost solely alone and unobserved. Here it is highly likely that the registrar's unknowns will remain unknown. Registrar's deserve – and most welcome – rigorous and systematic feedback. Feedback should also include the views of reception and nursing staff and patients and their carers, especially on a registrar's professionalism, defined by the recently departed BBC broadcaster Alistair Cook, as: 'doing your best when you don't particularly feel like it'.[21] Anything less is a 'dumbing' down of education.

In the first 3 months of any world class program, GP supervisors should be resourced to do a chart audit of every consultation, investigation and referral, as well as direct supervision of every minor procedure. This is for the learning benefit of the registrar and the quality of care for the patient.

The apprenticeship

The Australian Concise Oxford Dictionary defines an apprentice as: 'a novice who is learning a trade by being employed in it for an agreed period on low wages'. Hippocrates – 2500 years ago – taught his students, around a patient, under the shade of a plane tree. Since then we have always relied on some form of the apprenticeship model because it is one of the best forms of learning a craft. Our apprentice masters are the GP supervisors and they are the most important teachers in vocational training. Many are fine role models whose 'teaching penetrates to unnumbered patients who profit from encounters with his or her students'.[22] Good teachers care about their students and learn from them; listen more than they talk, convey enthusiasm for their discipline, encourage curiosity and reflection, welcome feedback and think about how to improve their teaching and students' learning.[23]

Education and training

Apprenticeships are particularly good for learning a skill or a trade. They are less effective in engendering curiosity and challenging the learner to aim to be better than the apprentice master or to challenge the status quo and accepted methods of doing the job. Good teachers must therefore be aware that education is not the same as training. Training is about learning a skill. In medicine it is about doing procedures and using machines properly and skilfully. It is an important and necessary part of general practice training that requires proper evaluation. Education is of a higher intellectual activity than training and is about developing a broad understanding about one's task in clinical, scientific, sociological and political terms. In the words of a Chinese proverb it is 'lighting a fire not filling a bucket'. Teaching is one of the most important but under rewarded of occupations. If anyone in medical education deserves a greater share of the GPET dollar it is the GP supervisor. Also, the teacher workshops should cater for the increasing educational sophistication of GP supervisors. After all we don't ask experienced teachers to attend 'Education 101' for 20 years in a row.

The organisation of vocational education

The way in which vocational medical education and training is organised in different countries is mainly an accident of history. In the United Kingdom, Henry VIII and his personal doctor ensured that vocational training is under the patronage of the royal colleges. In Australia, an outgoing minister of health placed general practice under his appointed committee, and in North America vocational training is the province and responsibility of universities.[24]

It is my firm impression that the North American model has embraced diversity and lead to a cohesion and breadth of educational endeavour while the UK/Australian model continues to foster self interest with its never ending battle for control of vocational training.

In the 1980s, the Saint and Doherty reports recommended the structural amalgamation of university departments and the Family Medicine Program (FMP) as the means of obtaining a necessary critical mass of general practice educators and scholars, a continuity of education as occurs for other medical disciplines and for greater medical student contact with FMP registrars and medical educators as an aid to increased recruitment to that program.[25,26] But the FMP resisted such

change. One can only postulate on how many general practice educational decades further forward we may have been had our territorial imperatives been moderated by Saint and Doherty's educational commonsense.

The current 22 times devoluted approach to vocational training is an experiment in 'small is beautiful'. It may improve the quality of education and rural retention by giving ownership to local groups. It may also be an example of reform without change and expensive overgovernance. Competitiveness can also override cooperation with several boards of governance insisting board members sign blanket confidentiality clauses. This gags them, puts some in a compromised situation with their main employer and is hardly likely to encourage the inclusion of all major educational stakeholders in program development. Also, the lack of a collegiate underpinning impedes the development of a much needed sense of general practice community and belonging, which is one of the reasons for being of this college. In many ways we have moved from teaching under a plane tree to teaching under a river gum, a much more dangerous tree with a propensity to unexpectedly drop its branches.

I predict that the training program will probably revert to this college and to ACRRM. But whatever does eventuate, I make a plea to government, the college and ACRRM to continue along the path of university rural clinical schools' experience, and vertically integrate undergraduate education with vocational training as a means to a seamless continuity of learning and the utilisation of all of the scarce teaching and educational research expertise that is available.[27]

Conclusion

Thirty years ago we could lay claim to having a world best practice general practice training program. In my view, that is no longer the case. I have examined some of the conceptual and structural impediments to the regaining of this ideal and suggested ways of progressing it. But our biggest challenge still lies in the level at which we pitch our expectations of future GPs. We should take our cue from Goethe, 'If you treat an individual as he is, he will remain as he is; but if you treat him as if he were what he ought to be and could be, he will become what he ought to be and could be'.[28] Our task as mentors of the next generation of GPs is to challenge them to be better than those of us who taught them.

References

1. 1970 Presidential Address of Dr Monty Kent-Hughes. Melbourne: The Royal Australian College of General Practitioners 1958–1978:23.
2. Bogdonoff MD. On the merit of university responsibility for graduate education. Arch Intern Med 1973;132:455.
3. Ewan C. Objectives for medical education: expectations of society. Med Educ 1985;19:101–112.
4. EFPO co-ordinating centre. Educating future physicians for Ontario. Executive summary of the component interim report. Hamilton, Ontario: McMaster University, 1992.
5. TNS (market information company). Proportionally randomised poll of 1001 Australians on 3–4 July 2004.
6. Infante FA, Proudfoot JG, Davies GP, Bubner TK, Holton CH, Beilby JJ, Harris MF. How people with chronic illnesses view their care in general practice: a qualitative study. Med J Aust 2004;181:70–73.
7. Kidd MR. Is general practice vocational training at risk? Med J Aust 2003;179:16–17.
8. Coote W. GP career not grabbing students. Australian Doctor, 26 May 2004.
9. Ward AM, Kamien M, Lopez DG. Medical career choice and practice location: early factors predicting course completion, career choice and practice location. Med Educ 2004;38:239–248.
10. Howie J. Professional virtues. BMJ 1969;3:73–75.
11. Kamien M. The tasks of general practice. A new kind of GP? Aust Fam Physician 2002;31:857–859.
12. Britt H, Sayer GP, Miller G, Charles J, Scahill S, Horn F, Bhasale A, McGeechan K. Bettering the evaluation and care of health: general practice in Australia 1998–1999. University of Sydney and The Australian Institute of Health and Welfare, 1999.
13. Stott N, Davis R. The exceptional potential in each primary care consultation. Coll JR Gen Pract 1979;29:201–205.
14. Murtagh J. A safe diagnostic strategy. General practice. 3rd edn. Sydney: McGraw-Hill 2003:157–163.
15. John Snow. Cholera and the Broad st. pump. In: Leavesley J, Biro G, eds. Flies in the ointment. Sydney: Harper Collins, 2001;18–26.
16. Cooter R. The history of the discovery of primary amoebic meningoencephalitis. Aust Fam Physician 2002;31:399–400.
17. Fabb W, Harbison R, Stone P. Basic and advanced training course handbook for tutors and participants. 3rd edn. Jolimont: Family Medicine Program, 1973.
18. Stewart J, Hyde P. Learning from the learners: what do trainees want from general practice vocational education? Asia Pacific Family Medicine 2002;1:28–32.
19. Saba GW. Live Supervision: lessons learned from behind the mirror. Academic Medicine 1999;74:856–857.
20. Joyner P, Napoli S, Booth K. I want to work and have a life as well. How one rural general practice retains its work force. Med J Aust 2004;181:96–97.
21. Quotes of Alistair Cooke. Available at: www.en.thinkexist.com/quotes/Alistair_Cooke/. Accessed 20/9/04.
22. Miller GE, ed. Teaching and learning in medical school. Cambridge: Harvard University Press, 1962;295.
23. Markert RJ. What makes a good teacher? Lessons from teaching medical students. Acad Med 2001;76:809–810.
24. Porter R. The greatest benefit to mankind. A medical history of humanity from antiquity to the present. London: Fontana Press 1999;530–533, 645.
25. Saint E. Community practice in Australian medical schools. Tertiary Education Commission Evaluative Studies Program. Canberra: AGPS, 1981;17–18.
26. Doherty RL. Report on the Committee of Inquiry into Medical Education and Work force into the 21st Century. Canberra: AGPS, 1988;205–206, 607–623.
27. Birks J, Farrell E, Newson A. Flexible teaching and learning in general practice. Aust Fam Physician 2004;33:687–689.
28. Quotes of Johann Wolfgang von Goethe, 1749–1832. Available at: www.en.thinkexist.com/. Accessed 20/9/04.

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