

Undergraduate general practice attachments



Implications and challenges

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Community settings, including general practices, have become increasingly important for the delivery of medical undergraduate education in the past 20 years.¹ The reasons for this are well documented and include: changing patterns of health care delivery with reduced numbers of hospital inpatients,^{2,3} recognition that patients in teaching hospitals are not representative of the general population,⁴ and an emphasis on community management of chronic disease.⁵ Experiences in general practice include early patient contact, learning basic clinical skills (history taking and physical examination) and enhancing knowledge of medical conditions, especially chronic disease in nonhospital settings.

The increasing involvement of general practitioners in medical education in the United Kingdom has led to discussion on appropriate levels of remuneration, as well as research projects focussing on the meaning of, outcomes from, and resources required for primary care based learning.^{6,7} Australian general practice also faces challenges due to increasing student numbers and our experiences at James Cook University have prompted this discussion paper.

The program

The 6 year undergraduate medical course at James Cook University (Queensland) began in 2000. The course is community orientated

with a rural and remote focus.⁸ Students spend time in general practice in the first, second, fourth and fifth years. Attachments in fifth year involve students spending one session a week in general practice throughout the year, a total of 40 sessions. The attachments provide a longitudinal and integrating experience across the year, with students spending the rest of the week on hospital based rotations including child, adult, mental, and reproductive health.

The problems we are encountering in setting up new general practice attachments for undergraduate students reflect national and international issues relating to the increase in community based medical education. The founding of a new medical school has tremendous implications for the community it serves. While there is a vision and hope that graduating doctors will remain in that community to practise, this is not certain; however, there is some evidence that training in rural areas increases local retention of graduates.⁹ What is clear is the need for goodwill and enthusiasm among GPs in the community who are asked to participate in the training of medical students.

There will be an increase in student numbers over the next few years and we need to think carefully about the risk of providing suboptimal learning experiences in our attempts to find placements for every student.

Our students have told us in a preliminary evaluation that they want to see patients on their own, in line with previous research in this area.¹⁰ However, at some practices this is not happening: students have a passive role, just sitting in on consultations. They rapidly become unmotivated and question the purpose of the attachments. This may negatively influence their attitude to general practice as a future career. It is also desirable that students are observed consulting and given feedback, as feedback helps students learn desirable behaviours and facilitates learning.¹¹

Discussion

It could be argued that students should see and understand the nature of patient care across the full range of general practice offered in the region. Our practices are a mix of bulk billing and fee charging establishments, usually offering appointments of 10–15 minutes per consultation. Should students also be exposed to practices with a high throughput of patients, with 5 minute consultations as standard? And what about students having experience of out of hours general practice and the way in which medicine is practised under these circumstances? If we feel the main objectives are for students to learn medicine in its broadest sense in the community, then time and teaching quality is paramount. If, however, we also want stu-

dents to know about the different ways that patients are cared for outside hospital, the range of experiences that patients have, and to understand general practice and its diverse nature in Australia, perhaps we are trying to shelter our students too much from reality.

Most of our GPs enjoy teaching and plan to carry on with the activity. Teaching clinical skills has been shown to have a positive effect on the morale of GPs and to improve their own skills.¹² However, there are issues relating to training that we need to address as most of these tutors have no formal training in teaching and have indicated that they have no time to undertake such training in the present climate of doctor shortage. There will need to be a financial incentive for any training to be taken up successfully but this is not the sole answer as patients still need to be seen. At the least we should expect GPs to attend tutor training for 1 day per year and to be paid adequately for their time.

General practitioners tell us that most patients are happy to be interviewed by students as evidenced by the low rate of patients declining to have a student involved. This is in line with previous research that shows patients are a willing resource for training medical students in Australia¹³ and the United Kingdom.¹⁴ However, we know female patients are less keen to have male students involved in their care, a fact consistent with earlier findings.¹⁵ We have to acknowledge that many female GPs prefer to have female students, leading to concerns that male students may have less experience in certain areas. This has already been noted in relation to different educational opportunities between male and female students on gynaecology rotations.¹⁶ The increasing presence of students in practices has differing effects on patients. A British questionnaire study found that patients report learning more from consultations in which a student is present and they also feel they have more time to talk. However, 10% stated they had left the consultation without saying what they wanted to say and about a third found it more difficult to talk about personal matters.¹⁷ Such figures have implications for GPs who

become involved in undergraduate education. They need to consider the impact of students on the quality of their consultations.

Local GPs have commented on the financial pressures of having a student. Few GPs leave gaps in appointments to fit in teaching as this reduces income. Many practices have spent years and energy building up their patient base and do not want to risk losing the goodwill of patients – with a subsequent loss of business – by imposing on that goodwill with too much student exposure.

The payment for hosting students in a practice is less than the actual cost to the practice, even with the recent increase in the Practice Incentive Payment (PIP) to \$100. To sustain GPs' involvement and to encourage GPs to become involved in teacher training activities, a further increase in the PIP payment should be considered. The importance of increasing financial incentives to GP tutors is well recognised.¹⁸ The ideal teaching attachment would include time set aside between patients for discussion of the case and the learning points arising from it, as well as an opportunity for the student to interview patients alone in a separate room and on a regular basis. Students should be observed interacting with patients and given structured feedback.

Conclusion

We believe that general practice is an integral part of the undergraduate medical curriculum; it deserves proper funding and nurturing for it to fulfil its potential as an outstanding learning experience. The rise in student numbers and the current lack of GPs in certain areas may pose problems for recruiting enough practices in the future. General practice attachments and teacher training should receive adequate funding and should not be primarily reliant on the goodwill of practitioners.

Conflict of interest: none declared.

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