Future developments in medical education – can Family Medicine make a global impact?

Amanda Howe

The World Organisation of Family Doctors (WONCA) aims to improve the quality of life of the peoples of the world by fostering high standards of care in general practice/family medicine; promoting personal, comprehensive and continuing care; promoting equity of access, cost and quality of health services; and representing general practitioners/family physicians to other world organisations and forums concerned with health and medical care.[1] However, many countries still do not fully understand what a family doctor does.

One working definition is that a family doctor is trained to deal with people across all life stages and all types of health problem at point of first contact in a community: and offers a service, that is "*comprehensive, accessible, focuses on a specific community, allows continuity over time, and is centred on the care of people, not specific parts of their body or diseases*".[2]

The features of fully functioning family health care are therefore:

- First-contact care – patients attend here, and are then directed as needed to other sectors.
- Comprehensiveness-preventive, curative, chronic and palliative care available from same provider.
- Continuity of care - a degree of choice, but with some kind of registration system that commits the patient and doctor / family and primary health care team to a relationship over time.
- Coordination of care between different team members and providers.
- Person-centeredness – a perspective that works with the individual's ideas, needs and background.
- Family-orientation – seeing the context of the person's immediate social context and impacts.
- Community-orientation – working with the needs, strengths, and challenges of the locality.

HK Pract 2017;39:

Amanda Howe, OBE, Med, MD, FRCGP
President
World Organisation of Family Doctors (WONCA)

Although in many global health systems family medicine is at an early stage of development[3], the numbers of family doctors are growing fast. This is driven by the needs of populations and governments to minimise cost and maximise health gain, plus the "changing" nature of health and illness – with an increasing proportion of the population who have multiple co-morbidities and chronic conditions. There are many new technological, diagnostic and treatment opportunities that are suitable for use by appropriately trained staff in primary health care and ambulatory settings. Help with psychological aspects of health and illness (including chronic sequelae), and intervention in lifestyle and occupational risk factors are also amenable to intervention in Primary Health Care settings.[4] So more can be done earlier with strong family medicine embedded in the community.

There is evidence for this move towards the Primary Health Care sector: Starfield[5] found that strong primary health care was associated with better health outcomes at all levels; that health was better in areas with more primary care doctors; that people with access to primary care were healthier than those without: and that universal access to primary care was associated with reduced inequalities in health outcomes. Her team also found that higher quantity and quality of primary care was associated with less and more appropriate use of hospitals, and that embedding of primary care in a health care system was associated with lower system costs.[5]

Medical education has to shift to train doctors for this more person-centered and preventive approach. A traditional medical training had little contact with patients in the early years, and rarely sent students outside the hospital or university setting. The scientific content did not draw on population or social sciences,

prioritising laboratory and dissection sessions instead of consultation skills or clinical simulations. By contrast, a modern medical course will integrate theory and practice, ensure use of applied learning methods such as problem based learning, send students to community and ambulatory settings on a regular basis to "learn from people about people"[6], and also ensure that learners have to develop professional as well as clinical competencies.[7]

This is partly driven by the changing face of public expectations: in many countries, unconditional trust in the medical profession is over, and the public expect a more equal relationship. They are better informed, their time is precious, and they expect personalised (though professional) care – with higher standards and less risk.[8] Doctors similarly expect less hierarchy, set higher standards, are more driven by evidence and regulatory requirements, and they are more risk averse. Change continues, driven by both societal and scientific factors – among many others, the Internet, the new genomics, and assistive technologies are continually shaping the nature of medical practice and the possibilities for medical education.

So where does family medicine fit into this changing picture? The United Kingdom is just one example where, as care has shifted to the community, education has followed.[9] In parallel, the discipline of family medicine / general practice has become a full postgraduate speciality, and is now established in every medical school, with an increasing presence in the basic curriculum. Practising family doctors can employ modern self-directed learning methods, and become owners of our own professional development - learning through experience, with our colleagues, team, patients and community. We need to undertake continuing professional development (CPD) to keep up-to-date, and we also play a role in team supervision, and clinical leadership - often taking responsibility for the learning activities for our own clinic and staff. Thus many family doctors are also active educators.

When a family doctor becomes a teacher or clinical supervisor, they will have a formal role in learning by staff, students, and speciality residents in the practice and community. They may also undertake leadership for the CPD of colleagues on a broader level – developing courses, training placements, supporting e-learning, and doing appraisals. As a university teacher, family doctors who teach on campus bring the primary care generalist perspective to lectures, group work, consultation skills, or pastoral support. If they undertake postgraduate academic study, such as a Masters or PhD, they will start to emphasise critical thinking and evidence even more in their other work settings, and may produce new evidence through research. All these roles broaden the scope of family practice, by reaching a greater audience. And if family doctors get involved in national and even international settings, advocating for excellent family medicine, they will be helping others to learn about the work of family doctors and their importance.

The importance of bringing learners into community settings is a crucial one for the visibility and impact of our discipline, and so the engagement with family doctors in hosting students and postgraduates in their clinics is key. Future doctors need to learn about different diseases across the management spectrum from presentation to chronic disease management; to understand the different roles of Primary Health Care in health / social care system; and to understand the importance of the population heath perspective and socio-demographics. Studies looking at the role of community based medical education have shown that it enhances understanding of how the broader social determinants of health – environment, infrastructure, income, education, employment and political context – impact on well-being and life opportunities. It is the natural environment to learn about primary health care and what it does within health systems, and a good learning experience can encourage students to consider the choice of family medicine as their future career.[10] This is especially important in rural settings, for which many students will have had little exposure or training[11], and securing the future rural workforce was the main motivation behind the Australian creation of a parallel track for future rural practitioners.[12] But now that most patients are kept in hospital for a minimum period, and many more are treated in ambulatory settings, the community is also the best place to learn medicine! Patients with long term conditions, and who have had serious illnesses, can meet with students and give a full picture of their condition and its management, with access to records if permitted. So a balance of placements in community and hospital together give a rounded education, and also give learners greater respect for primary health care professionals. In addition, learners often feel empowered and motivated by the experience of being in this setting, where they

themselves are visible as an individual and can be, for a time at least, part of a team.[13]

Family doctors bring their clinical skills to teaching, where being student centred and good communicators goes a long way to making a good teacher. If family doctors are to take on roles as educators, they do of course need to learn how to design and deliver good learning experiences. Preparation and understanding by tutors, other staff, and the community improves educational outcomes, and the GP also plays a crucial role in gaining patient consent and access for learners to this precious resource – also being a role model for patient centeredness in the process. They also need to be allowed time to teach - working with learners needs longer appointments, or for the tutor to release from service in order to teach and supervise.

Finally, the role of family medicine educators can increase the status of the discipline at a national and international level. Setting standards, having an effective presence in university and professional training bodies, conducting robust postgraduate assessments, demonstrating the evidence for outcomes of educational impact, and developing a high quality workforce are all professional commitments that count in medicine. Through such roles, we create and manage change - workforce planning and capacity building, new initiatives in service, and by supporting staff, educators and learners in different phases both individually and organisationally. This can also have global impact through many routes – training people from other countries, acting as expert resources to other countries as they develop a modern curriculum or a new role for family medicine, and through study visits, exchanges and other networks. The role of global network organisations such as WONCA (the World Organisation of Family Doctors, www.globalfamilydoctor.com) is an important means by which expertise is shared and models of best practice made visible.

Some global impacts of good education can have a down side – a few of the challenges include the brain drain of qualified staff from under-resourced countries[14], the continued inequities of workforce between areas of rural and urban poverty and their more affluent counterparts, and the dictates of private and commercial sectors when there is poor governance and regulation. Private medical schools are on the increase, and there are many who emphasise the economies of online and distance learning. Among these, we need to ensure that medicine remains a socially accountable profession where the needs of all for healthcare can be met equitably. Much of the professional motivation that persuades us to work hard in hard places for the most difficult patients comes from our early exposure to tutors and staff who themselves were passionate about excellent person centred care that was consistent over time and did not discriminate according to the specific background of the patient. Family doctors are a crucial part of the system – and a crucial part of good medical education, whose impact can be global as well as local.

Acknowledgements

This article is based on a plenary lecture given by Professor Amanda Howe at the 40th anniversary conference of the Hong Kong College of Family Physicians. The author of this article is grateful for the opportunity to attend, for the support for her visit, and for Family Medicine! ■

References

1. Kidd M. eds. The Contribution of Family Medicine to Improving Health Systems: A guidebook from the World Organization of Family Doctors, Second Edition, 2013. UK; CRC Taylor Francis ISBN: 9781846195549.
2. European Definition of General Practice. Available from: http://www.rcgp.org.uk/policy/rcgp-policy-areas/european-definition-of-general-practice-and-family-medicine.aspx
3. Arya N, Gibson C, Ponka D, *et al*. Family medicine around the world: overview by region: The Besrour Papers: a series on the state of family medicine in the world. *Canadian Family Physician*. 2017;63(6):436-441.
4. The World Health Report 2008: primary health care now more than ever. World Health Organization. ISBN 978 92 4 156373 4.
5. Starfield B, Shi L, Macinko J. Contribution of Primary Care to Health Systems and Health. *The Milbank Quarterly*. 2005;83(3):457-502. doi:10.1111/j.1468-0009.2005.00409.x
6. Howe A, Campion P, Searle J, *et al*. New perspectives – approaches to medical education at four new UK medical schools. *BMJ*, 2004;328 (7435):327-332.
7. Howe A, Barrett A, Leinster S. How medical students demonstrate their professionalism when reflecting on experience. *Medical Education* 2009;43: 942-951.
8. Mónica Petracci, Patricia K. N. Schwarz, Victoria I. Ma. Sánchez Antelo, *et al*. Doctor–patient relationships amid changes in contemporary society: a view from the health communication field. *Health Sociology Review* 2017; 26(3):266-279.
9. The standards set for curricula in UK by the GMC. Available from: http://www.gmc-uk.org/education/27394.asp
10. Howe A, Ives G. Does community-based experience alter career preference? New evidence from a prospective longitudinal cohort study of undergraduate medical students. *Medical Education* 2001; 35:391-397.
11. Strasser R, Couper I, Wynn-Jones J, *et al*. Education for rural practice in rural practice. *Education for Primary Care* 2016; 27(1): 10-14.
12. Wilkinson D, Laven G, Pratt N, *et al*. Impact of undergraduate and postgraduate rural training, and medical school entry criteria on rural practice

among Australian general practitioners: national study of 2414 doctors. *Med Educ* 2003 Sep;37(9):809-814.
13. Howe, A. Patient-centred medicine through student-centred teaching – a student perspective on the key impacts of community-based learning in undergraduate medical education. *Medical Education* 2001;35:666-672.
14. The Huraprim report. Available from: http://cordis.europa.eu/result/rcn/173965_en.html