Expanding primary care-based medical education: a renaissance of general practice?

Martin B Van Der Weyden

The time to make it happen is long overdue

There is a tide in the affairs of men,
Which, taken at the flood, leads on to fortune;
Omitted, all the voyage of their life
Is bound in shallows and in miseries.

William Shakespeare, *Julius Caesar*

Australian medical education is facing a crisis of unforeseen proportions. This crisis will not only affect the quality of the education of future medical students but may also impact on their opportunities for vocational training. In essence, there is a mismatch between future demands for quality medical education and the capacity of the health care system to support this in both the undergraduate and postgraduate years.

The immediate precipitant of this looming crisis is the recent undisciplined and poorly planned increase in medical school numbers. In response to projected medical workforce shortages (a predicament of the government's own making), the Australian Government, in rapid succession, announced the establishment of seven new medical schools. The increase in medical school places was further augmented by a relaxation of the restrictions on local and international full-fee-paying students. From 2005 to 2012, the number of annual domestic graduates will increase by 81% (from 1348 to 2442), and the number of international graduates will nearly double (from 260 to almost 500).[1] There will be at least 12 000 students in the system at any given time, and around 3000 will graduate each year.

While the increase in medical school places is obviously welcomed, where are the educational resources to accommodate these student numbers? And, more importantly, will quality teaching and learning be sacrificed?

The demand for an expansion of educational capacity comes at a time when teaching hospitals are losing their value and status as educational powerhouses.[2] The reasons for this are diverse and complex, but include: the diminishing numbers of hospital beds; shorter lengths of stay for patients; a move to day-only admissions for surgical patients;[3] and and the increasingly complex conditions of hospital patients, compared with those seen in primary care.[2] Added to this litany of problems are the difficulties experienced by students in seeking access to patients in the hospital setting.[4]

As a consequence of these developments, there has been a reemphasis on involving general practice in medical education.[5,6] This issue of the Journal features a number of articles exploring diverse issues related to this task. Thistlethwaite et al (*page 124*) argue the case for general practice becoming a leading provider of medical education in the 21st century;[7] Pearce et al (*page 129*) expose the challenges involved in teaching in general practice;[8] and Dick et al (*page 133*) emphasise the importance of vertical integration in general practice-based medical education.[9] Finally, Jackson and Marley (*page 84*) present accounts of two established academic general practices, which may prove useful models for general practices involved in teaching.[10] Other Australian models also exist, such as Lubims Inc, a not-for-profit Family Practice Network owned and operated through a trust by the University of Adelaide. However, whatever the model, we will need upwards of 500 new teaching general practices across Australia (Professor Justin Beilby, Executive Dean, Faculty of Health Sciences, University of Adelaide, personal communication).

One intriguing outcome of all these developments is that this trend may well support a renaissance of general practice, which, sadly, has often been the target of negativism by both general practitioners and specialists alike.[11,12] Furthermore, compared with general practitioners, doctors in teaching hospitals undoubtedly benefit from a profound professional advantage, which flows from the academic ambience and collegiality of their workplace; their ability to shape the learning and interests of young minds; and the institutional infrastructure that provides manifold opportunities for research.

However, it can be argued that all these advantages and attributes can easily be replicated in general practice, if it is given appropriate infrastructure and funding. Importantly, the realisation of increased teaching in general practice should not depend on yet another series of temporising governmental inquiries. The time has come for a national taskforce to make it all happen — and happen soon!

The Flexner Report of 1910, which provided the foundations of modern medical education, also arose from a crisis: community disquiet in the United States at the end of the 19th century over the quality of medical practice and practitioners. This crisis also had its origins in medical education — in the mediocre quality of many North American medical schools, with their inadequate curricula, atrocious facilities and their rapacious focus on profits.[13]

In response to this crisis, the American Medical Association (AMA) carried out an inspection of North American medical schools in 1906 and uncovered widespread deficiencies in teaching, and unacceptable profiteering. The report was not published, as it was deemed imprudent for a medical organisation such as the AMA to be critical of medical schools.[13] However, the AMA invited The Carnegie Foundation for the Advancement of Teaching to look into the matter, and the outcome was the Flexner Report. Its recommendations for reform were widely accepted as principles for governing medical schools,[13] and they are equally relevant for medical education in a community setting today.

Firstly, Flexner urged that teaching should be equipped with appropriate infrastructure and funding; secondly, that the teachers must be adequately trained; and thirdly, that research should be a central activity, integral to and informing all medical practice. In practice, this means modern and appropriate facilities, good teachers, a university affiliation, and a commitment to excellence in research and care; in short, general practice with TLC — Time

for teaching, Learnedness in the art and science of teaching, and a Commitment to teaching the next generation of young doctors the art and science of medicine.

The national taskforce for implementing an expansion of teaching in general practice should not inadvertently "throw the baby out with the bathwater". Obviously, there will continue to be a need for teaching hospitals, but these should be better configured, with closer ties to the general practice community, allowing students to follow patients on their journeys from the community to hospital.[14] In keeping with a recommendation of the recent Productivity Commission report on Australia's medical workforce, support for this taskforce should be provided by the Australian Government Department of Health and Ageing.[15]

Also in this issue of the Journal, Scott and Coote (*page 95*) present their analysis of performance outcome measures pertaining to the Divisions of General Practice.[16] The relevance of their findings is further developed by Sprogis (*page 68*).[17] Both these contributions raise questions as to whether the Australian Government (and indirectly the community) obtains value for its not inconsiderable financial support of the Divisions. Could not all or a considerable proportion of this money be more profitably diverted to provide educational infrastructure in Australian general practices, using the models described by Jackson and Marley,[10] or strategically located general practice teaching centres with a "hub and spoke" configuration linking with other local general practices and hospitals, as proposed by Douglas and his colleagues almost 15 years ago?[18] Back then, the suggestion apparently fell on deaf ears, but maybe with the looming crisis in medical education, its time has come. At the very least, the teaching-in-general-practice movement should be able to capitalise on the developed infrastructure and facilities of the Divisions and of the General Practice Education and Training program.

The fulfilment of general practice as a major provider of medical education remains an exciting and challenging task — and its realisation may well mean a continuing renaissance of Australian general practice.

Author details

Martin B Van Der Weyden, MD, FRACP, FRCPA, Editor
The Medical Journal of Australia, Sydney, NSW.
Correspondence: medjaust@ampco.com.au

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