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64 – An Ideal Training for the Future Career Patterns of Family Medicine

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It has been fourteen years since the presentation of innovative training posts in the UK combining clinical experience in primary and secondary care education within the same working week (1). This chapter considers how far we have come since then in achieving the ideal education for family medicine. It uses the NHS in the UK as an example, but the principles apply worldwide.

What is the ideal educational environment? One in which the learner feels fully supported and encouraged to achieve their maximum potential. An apprenticeship, described by Dreyfus, in which they move through advanced beginner, to proficient and possibly expert in their future career choice; in this case, family medicine. A learning environment where they achieve Mintzberg's "shortcut to the acquisition of experience", on a daily basis in their future career choice. Learning from both formal education and informal education in the workplace environment, whilst caring for patients.

The vision outlined in the 2013 RCGP report "Enhanced GP training" is for a focus on community approaches and integration of care (2). To have primary care experience early on in training, to move to 24 months in primary care, with more child health and mental health experience, for all trainees.

The report describes a "spiral curriculum model where expertise in generalist medical care is built up incrementally over time" (2). Five educational themes are identified for the four year curriculum. These are relating to others, applying clinical knowledge, managing complex care, working in systems of care, and caring for the whole person. Opinion in the UK is moving towards more generalist training with capacity to adapt to future pluri-potential integrated care posts spanning across secondary, primary and community care (3, 4).

However the current reality of today is similar to the 1980s. Doctors training for UK family medicine still rotate through a range of separate specialties where the focus is predominantly on learning related to the secondary care specialty setting. There is considerable value and insights that continue to be derived from secondary care experience for doctors with careers in family medicine, but it does not appear that the full potential of GP training is being recognised.

In the GMC national training survey these secondary care posts were consistently rated lower by general practice trainees than their secondary care colleagues and also lower in comparison to training posts in the primary care setting (5). Part of this is the context of education, and the relevance of education to future career, but part of this may be due to the quality of education. Factors such as the ratio of learners to educational supervisors, the professional recognition of educators, the demands of service pressures, the lack of protected time and shift systems all play a part in the secondary care setting. Educators, as professionals, need the time to supervise, teach, review and improve their own practice.

Until now the focus for change has been on the proportion of time spent in primary

care. Moving towards 18 out of 36 months, with regular one day primary care focused education once a month during hospital based posts. Change is happening around the basic structure of GP training rather than to the core of GP training.

Attempts to integrate secondary and primary care education in 2002 did move on from this current model by combining primary and secondary care experience each week in the same post (1). Satisfaction was high (1). Trainees gained insight into both sectors and had the opportunity to follow patients from primary to secondary care and back. Their learning was more focused on future career needs, even though doctors still experienced two distinctly separate learning environments. Looking back it is evident there is still room for yet greater integration of education with contributions to be made not only from secondary care specialist knowledge, but social care, community care and voluntary care as well as primary care.

However, the support for these basic initiatives to flourish was not present. For most of the UK the basic model of siloed secondary care education for the primary care doctor continues. It is possible that healthcare itself needs to integrate more effectively before education for healthcare becomes more integrated.

One current example of future integrated models related to future career needs is the rural medicine course in Scotland, which has a placement in a developing country. The course makes use of video-conferencing for both service delivery and education. There are rural attachments and additional training in medical retrieval, intubation and roadside care.

Since 2000 there have also been a selection of ST4 and clinical fellow posts across the UK emerging as optional add-ons to help get trainees up to speed for real general practice, following their core training. This gives them skills in a range of settings including management, research, leadership and integrated healthcare.

In addition, external factors such as technology are bringing about developments. Websites, apps, YouTube, podcasts, wikis, discussion rooms, twitter, and Facebook are moving on line education into the workplace and the learners' pocket. The difficulty is picking out what is really needed and retrieving it quickly, when required, within the consultation.

Simulation has also evolved. Examples now exist of manikin simulation running from the road side, through the emergency department to the wards and into intensive care, involving a range of multi-professional teams in the real life workplace, providing learning that is immediately relevant. Actors and actual patients, including children, now take on the simulated patient role. Trainees take exams with simulated patients, but there are, as yet, no simulations of the real life pressures of full-on, busy primary care.

In conclusion, education for family medicine has evolved by having proportionally more time in the primary care setting. However, there is a long way to go before we attain a shared NHS vision and plan to create the ideal integrated care education for future family medicine in the 21st century.

Take home messages

- Education for family medicine continues to be predominantly in the secondary care setting
- Education in secondary care is consistently rated less favourably than in primary care by trainees
- Technology is opening a range of new educational approaches
- The full potential of integrated care education for family medicine has yet to be recognised

Original abstract

http://www.woncaeurope.org/content/1-ideal-training-future-career-patterns-family-medicine

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