Contribution of academic departments of general practice to undergraduate teaching, and their plans for curriculum development

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SUMMARY

Background. *In 1991, the General Medical Council suggested the development of a new undergraduate curriculum, on a 'core plus electives' basis. The combination of National Health Service reforms and the rising profile of academic departments of general practice had led to a consideration of general practice as an alternative teaching environment. These departments now face escalating expectations from their medical schools of their ability to provide additional community based teaching.*

Aim. *The aim of this study was to investigate the present contribution of academic departments of general practice to undergraduate teaching and their plans for curriculum development, including the introduction of community-based clinical skills teaching.*

Method. *A questionnaire was circulated in June 1993 to all academic departments of general practice in the United Kingdom and Eire.*

Results. *Twenty seven out of 28 questionnaires were returned. Twenty two departments provided pre-clinical teaching and all provided a clinical practice attachment. Eight medical schools were organizing community-based clinical skills teaching, and in two this formed the basis for a community-based medical attachment. Eight planned to reduce the factual content of their curricula and introduce problem-based learning while nine were contemplating a 'core plus electives' option. Fourteen medical schools had primary care input in teaching basic clinical skills and an additional seven planned to introduce this. Problems encountered by the general practitioner tutors in teaching clinical skills included insufficient time and resources and poor self-esteem; they identified a need for good central and peripheral organization.*

Conclusion. *Compared with a 1988 study, academic departments of general practice are increasingly involved in teaching both general practice and general medical skills at undergraduate level. Curriculum change is occurring rapidly, with an increasing trend towards community teaching; the implications for both academic departments and general practitioner tutors are discussed.*

Keywords: university departments of general practice; undergraduate education; undergraduate training; curriculum.

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Introduction

CONCERN has long been expressed about the state of undergraduate medical education.[1,2] The education committee of the General Medical Council has attempted to address this with the development of a core curriculum, with a selection of elective subjects for more detailed study, the introduction of problem-based learning[3] and more emphasis on community-based learning, to produce a doctor better equipped for postgraduate education.[4] Radical curricular review of this kind was initiated by McMaster University, Canada[5] with Newcastle, Australia[6] and Sherbrooke, Canada[7] following, but in United Kingdom medical schools, the impetus to change has been slow with relatively few examples of innovative teaching[8] and assessment[9] within a persistently didactically taught curriculum.

University departments of general practice face escalating expectations from their medical schools of their ability to provide increased community teaching. Teaching hospitals have traditionally been the dominant learning environment for medical students but the combination of National Health Service reforms, reduced inpatient numbers, shorter patient stays and superspecialization has resulted in a shift of balance between primary and secondary care.[10] This, along with the rising profile of academic general practice, has led to increasing consideration of general practice as a complementary teaching environment.[11] Its importance to undergraduate medical education was highlighted in a major report in 1984[12] and later recommendations included extending present general practice courses and introducing community-based clinical skills teaching.[13,14] The need for revision of undergraduate curricula was echoed by the King's Fund Centre[15] and recently a successful pilot scheme was introduced at King's College, London to teach general medicine principally within a general practice setting.[16]

The aim of this study was to investigate the curricular contribution of academic departments of general practice, their plans for curriculum development, including the introduction of community-based clinical skills teaching, and their concerns about the implementation of such changes.

Method

A questionnaire was circulated in June 1993 to the heads of all 28 undergraduate departments of general practice in the UK and Eire. The questionnaire, which had been compiled following a literature search of past studies, contained a mixture of closed and open questions and enquired about: the department's present teaching contribution to the undergraduate curriculum; plans for future curricular change, including time scale; and the teaching of basic clinical skills (history taking and clinical examination) by general practitioners. Respondents were asked whether their department currently provided any teaching of basic clinical skills and if so, details were requested about training and support for general practitioner tutors, and methods of payment. If no such teaching occurred, it was asked whether this would be introduced in the future. Comments were invited about identified and perceived barriers to both curricular change and the introduction of community-based clinical skills teaching.

Non-respondents were sent a reminder and further question-

naire after four weeks and followed up by telephone where required. The results of the questionnaire were then circulated to all respondents for their comments.

Results

Twenty seven out of 28 questionnaires were returned by the undergraduate departments of general practice (96%).

Contribution to undergraduate teaching

Pre-clinical teaching. Five departments provided no pre-clinical teaching (the first two years of medical student training). Thirteen organized patient contact early in the undergraduate curriculum, with practice visits and related project work. The major contribution of departmental teaching was in communication skills, provided by 10 departments. Nine provided a behavioural sciences or medical sociology course, three contributed to the pre-clinical lecture course and two organized a clinical skills course. Ten medical schools had a mixture of departmentally-based teaching and practice attachments.

Clinical teaching. In the first clinical year (the third year of medical student training), 14 departments provided communication skills teaching. In addition seven organized practice visits/attachments, one involved students in a family case study and one contributed to the lecture course. In Southampton there was combined practice and departmental teaching. Six medical schools had some form of community-based clinical skills teaching, and two others, University College, London and King's College, London organized a community-based medical attachment. Five schools had no general practice contribution to third year teaching.

In the fourth and fifth year, all medical schools included a general practice attachment. In four schools this was divided between the two clinical years and in five, students experienced both inner city and regional general practice. Nine departments were involved in collaborative teaching with other departments, for example public health and psychiatry. Optional elective periods in general practice were offered in seven schools; three provided additional communication skills teaching. At St Mary's Hospital, London eight students per year per rotation were taught general medicine in a general practice setting.

Plans for curriculum change

One medical school, St Bartholomew's, London, had no plans for further curriculum change. A new curriculum had been introduced in 1990, pre-empting the 1991 General Medical Council recommendations, which included community-based clinical skills teaching and the development of a clinical skills laboratory.

Changes to pre-clinical teaching included the development of a more integrated course, with greater clinical input and communication skills teaching; increased early clinical contact; increased general practice exposure; revised behavioural science courses; and the introduction of clinical skills teaching. At Nottingham University, there was to be enhanced general practice teaching with a major contribution to a 'professional and personal development' course and departmentally-based clinical skills teaching.

The predominant clinical changes were the development of a core plus options curriculum and community-based clinical skills teaching. Eight medical schools were already involved in discussions to reduce the factual content of curricula and introduce problem-based learning, and in nine a core plus electives approach was being planned. It was planned that introductory clinical skills teaching would have a community base in five schools, but would remain principally hospital-based in three. At University College, London, where a community-based medical attachment already existed, the number of medical students participating was planned to increase from 48 to 100 per year. The existing general practice attachment would be lengthened in three medical schools and a community module to include general practice, community paediatrics and obstetrics was planned in one. Eighteen medical schools stated their proposed changes would be implemented by 1994–95, and seven by the end of 1996. However, 14 acknowledged that their changes were still in the discussion/planning stage.

Clinical skills teaching

Additional clinical skills, for example measuring blood pressure, were often reviewed during the general practice attachment. However, 14 medical schools had primary care input in basic clinical skills teaching (history taking and examination) at some stage in the undergraduate curriculum. Of these, 11 planned to expand the teaching time. Clinical methods teaching within a primary care environment had been provided at Edinburgh University for 10 years but abandoned in 1990 because it was considered an inefficient use of time and resources, despite being more popular with the students than hospital teaching.

Teaching process. Twelve of the 14 departments providing clinical skills teaching offered training for the general practitioner tutors. Nine arranged pre-course training, 10 further in-course support, seven had developed a tutors' handbook and two ran departmental workshops. Tutors were paid by family health services authority undergraduate tutor payments alone (two) or in combination with university funds (three), service increment for teaching and research money (four), 'tasked' money from the Department of Health (one) and external grants from the King's Fund (two). University employed staff only were used as clinical teachers in one school and in another the clinical tutors received no payment.

Of the 14 departments, 10 admitted encountering problems, including insufficient time and resources and tutors' lack of self-esteem; they identified the need for good organization, both centrally in the department and peripherally in practice.

Future developments. Six of the 13 schools with no general practitioner involvement in clinical skills teaching had no plans to alter this. Reasons included lack of general practitioner interest, overworked and underfunded departments, previous unsuccessful experiences and resistance from within the medical school.

However, seven medical schools were planning to introduce such teaching into their curricula. All seven planned to provide pre- and in-course training for tutors. Payment would be via a combination of family health services authority undergraduate tutor payments and service increment for teaching and research money except in one department where a private payment from the medical school would be used. Perceived problems included lack of confidence, high expectations and initial resistance from the general practitioner tutors, difficulties in providing appropriate training and support, difficulty in recruiting and maintaining an adequate list of patients for examination by students, increased demand on practice organization, and difficulty ensuring protected time and space within practice.

Discussion

The General Medical Council education committee updates its recommendations on medical education approximately every 10 years and so far they have discovered limited application of their 1980 recommendations.[3] The last study to explore the contribution of academic general practice departments to undergraduate teaching in 1988 found that teaching was considered a priority for development in all departments, with one third requesting additional curriculum time and one quarter expressing a desire to be involved in teaching basic clinical skills.[13] The present study has revealed that the extent to which academic departments are

involved in both pre-clinical and clinical teaching, and the range of teaching provided, has increased considerably since then. In 1993, 22 departments were providing pre-clinical teaching compared with eight in 1988, with a trend towards early clinical exposure and formal communication skills teaching. Twenty two were involved in third year teaching (six of which included community-based clinical skills teaching) compared with nine in 1988, and all departments provided a fourth and/or fifth year general practice attachment compared with two-thirds of respondents previously. Since the questionnaire was circulated, further innovations have occurred in several schools, demonstrating that curricular development is a dynamic process, and that the pace of change is rapid.

However, as the General Medical Council has discovered, curriculum change seldom occurs following a single pronouncement and consequently in 1991 a series of proposals for discussion was published instead of the expected recommendations.[3] Although 26 medical schools in the present study described plans for curriculum change, 14 were still in the discussion/planning phase. At St Bartholomew's, London curriculum change had been initiated following a student survey, with strong support from the dean[17] but in other medical schools such as King's College, London changes in the NHS provided an opportunity to transfer further teaching in to the community. One department in this study commented that 'moving teaching into the community must be for positive reasons' and not as a means of consolidating policy-led hospital changes.

This study has revealed a powerful trend towards utilizing general practice both for teaching general practice itself and for teaching general medical/clinical skills, provided that tutors are adequately supported and appropriate financial and administrative resources are available. General practitioners' interest in teaching clinical skills remains high but so does resistance from hospital specialists and faculty committees; one head of department stated they had offered the possibility of undertaking clinical skills teaching but had had no takers so far. The introduction of such a scheme has recently been shown to be feasible for practitioners and valuable and enjoyable for students.[18] It provided small group teaching in protected time and, most importantly for effective learning, immediate individual feedback.[19] However, concerns do remain, with one long-established scheme being withdrawn, and the expansion of existing pilot schemes slowled, partly owing to the inability to recruit additional general practice tutors, that is, the absence of adequate long-term funding mechanisms (P Booton, personal communication).

The first steps to introducing curriculum change should be to identify existing barriers and develop strategies to minimize or overcome them.[20] In the UK, an important factor is the low status accorded to medical teaching in academic departments.[2] Undergraduate education often occupies a role secondary to research, both in terms of individual reward and promotion and of University Funding Council research selectivity ratings and resource allocation.[21,22] The Kings' Fund initiative suggested that change could be stimulated by the introduction of university contracts for teaching commitments, the diversion of service increment for teaching and research money for general practitioner tutor payment and a continuing strong lead from the General Medical Council. General practitioner teachers will require adequate financial remuneration to provide protected teaching time, support and feedback from their academic department, and acknowledgement from both practice and hospital colleagues of their roles as clinical tutors.

In conclusion, this study has shown an increase in the contribution of academic departments of general practice to undergraduate teaching. Pre-clinical changes include a move toward early clinical contact and combining departmental teaching with practice visits. All clinical students now experience a general practice attachment before qualifying. Academic departments of general practice are heavily involved in communication skills teaching and increasingly so in clinical skills teaching. A variety of curriculum changes are to be implemented in many schools in the near future. However, attempts to follow the latest General Medical Council guidelines by reducing factual overload and introducing a more problem-based approach to learning are proceeding more slowly. Such changes will necessitate major curriculum review and will need to be carefully negotiated and planned before implementation if they are to succeed. The formation of curriculum review committees with appropriate departmental representation and the appointment of curriculum development staff may allow curriculum change to become fact rather than fiction.

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