Career preferences of medical students: some unanswered questions

A great deal of energy and many financial resources are used to provide undergraduate medical students with an experience of working in primary care. The study reported by Morrison and Murray[1] examined the career choices of students after such an attachment. If our perspective is restricted to having a general practice or family medicine attachment during clerkship in the hope that students will be attracted towards making a career choice in primary care, then the results of this study must be disappointing. In this age of declining resources at every level, and given the great difficulty in changing career choice at postgraduate level, some would argue that the undergraduate experience should be sufficiently broad to enable each student to make a truly informed career choice. If one looks at the results of the Glasgow experience from such a perspective, i.e. one that is more 'student centred', then the results are much more encouraging.

There is evidence to suggest that there are factors associated with choosing primary care as a career.[2,3] Among these factors are the desire to provide comprehensive care, to keep options open, and to undertake ambulatory care. A family practice attachment during clerkship has been shown to confirm or strengthen a decision already made to enter family practice. Such an attachment, however, does not seem to positively influence others towards choosing primary care. For those who enter medical school undecided, there are other influences that occur during the attachment experience that can dominate career choices. Nevertheless, it is concluded that positive educational experiences in the primary care setting need to be enhanced.[2] It should be noted that family practice was the leading career choice in the United States (US) in 1995, and that evidence of interest in this area can be determined at the time of application to medical school. Perhaps admission policies need to be altered to determine this particular interest if the goal of a medical school is to entice more recruits into primary care.[3]

As we have seen, there are reasons to believe that there are positive factors influencing a career choice in family medicine. The negative influences directing people toward general practice noted by Morrison and Murray in the United Kingdom are similar to those noted by Jennet *et al* in the US in 1990.[4] This suggests that similar problems and issues exist on both sides of the Atlantic.

Why bother with a general practice attachment?

If one were completely pessimistic, one would have to look at the above debate and ask, 'Why bother?'. The general practice attachment merely serves to confirm a choice that some students have already made, and at the same time fails to persuade others to choose general practice as a career. Career preference defies statistical analysis.[5,6] Being the devil's advocate, it might even be argued that there is a need simply to ask the right questions at the time of medical school application, in order to find out which students have a preference for general practice as a career. Having overseen many changes to the medical school selection process during a six-year period, I can attest to the difficulty of that task.

Let us return to the question 'Why bother?', but let the question be stated differently. What is the purpose of the undergraduate attachment in general practice? Why do we have departments of general practice in medical schools? What should be the contribution of general practice to undergraduate medical education?

As I review the undergraduate scene, it seems that the general purposes of the undergraduate curriculum are far from settled and still debatable. Many would argue that the goal of undergraduate medical education is to provide a very general preparation for subsequent postgraduate training. This education includes factual knowledge, skills training, and the formation of appropriate attitudes. For those who hold this point of view, recruitment to a particular field of practice is not one of the main goals of the curriculum. This perspective is in contrast to the apparent influences that affected the curriculum changes made in Glasgow.

If it is accepted that the purpose of the undergraduate curriculum is a general one, then each clinical department has a responsibility to contribute to the general curriculum. Each clinical department also has a responsibility to contribute its own special knowledge and skills to the student experience, and to reinforce other skills learned elsewhere. Departments of general practice are not excluded from this. I firmly believe that is our primary role.

The fact that the general practice attachment was so highly rated is not surprising. It is the rule rather than the exception. The students, whatever their career goal, recognize the quality of the educational experience: the one-to-one supervision, the generally effective feedback on performance, being made to feel a member of a practice, and so on. Whatever the rotation, when students feel useful they will rate the experience highly.

Influencing curriculum change

Morrison and Murray note that young doctors prefer flexibility in choosing posts and locations.[1] This is entirely compatible with Professor John Bain's perspective in his editorial in the June Journal.[7] There is a real need to change undergraduate and postgraduate curricula in order to meet the rapidly changing patterns of practice. Academic general practice or family medicine cannot influence such curriculum changes unless we are deeply involved in the planning and implementation process at the faculty level.[8] That is why we have to have academic departments in each medical school.[9]

Conclusion

Ultimately, the curriculum must come to be less dominated by the three tertiary care specialities: medicine, surgery, and obstetrics and gynaecology. The greater part of medical care today is based in the community and is delivered in family doctors' offices or in outpatient clinics and day surgery units. In order to train young doctors to practise skilfully, their undergraduate and early postgraduate experience must allow them to participate actively in such settings. The curriculum should be determined by the needs of the patients, who will ultimately be the patients of these doctors. Control of the curriculum needs to be removed from the traditionally dominant power houses in our medical schools. It has been said to me that things are done the way they are because 'we've always done it that way'. This is a doctor-centred perspective. We need to change that. What is needed is a curriculum designed to meet the real needs of our patients and to appropriately prepare the young doctors who are to deliver that care. In that sense, the editorial by Professor Bain is quite correct. The influence of university departments of general prac-

tice on curriculum planning needs to be expanded, and the contribution made by community-based general practice teachers needs to be continuously enhanced and supported.

Academic departments of general practice need to redefine why they are in medical schools, and to take encouragement from the fact that their efforts are highly appreciated by the medical students, regardless of their ultimate career choice. At the same time, we need to guard against the wrong conclusions being drawn from research such as that carried out by Dr Morrison and Professor Murray, whose work is important. The challenge now is to describe more fully what made the general practice attachment so positive, and to use this information to change the other parts of the clerkship that are negatively rated.

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Learning for a multicultural society

MEDICAL education has failed to keep pace with the needs of the multicultural population of the United Kingdom.[1] The General Medical Council has clearly endorsed the need for including multicultural health care within the objectives and values of undergraduate education.[2] Last year, a British Medical Association (BMA) report clarified the position at both undergraduate and postgraduate levels.[3] Of the 74% of institutions that replied to their survey, only 42% addressed this issue in any way at all. The report clearly demonstrates the need for training in multicultural health and health care. In addition, it offers guidelines for the development of such programmes.

What is the rationale for education in multicultural health care? First, doctors are not adequately prepared to assess or manage patients from these diverse backgrounds.[1] Both doctors and patients can experience difficulties when dealing with someone from a different ethnic group.[4,5,6] Cultural factors are relevant not only to patterns of disease, but also to communication. The lack of a shared culture means differences in beliefs and expectations, as well as the more obvious language issues.[5,6] Future doctors are expected 'to be more aware and respond sensitively to the culturally determined expectations of their patients'.[7] It is important to remember that learning about the cultural dimensions of health care is not just about 'other' cultures. It is aimed at understanding the cultural constructions of disease, and of the health beliefs and health-seeking behaviours of *all* cultures, including the majority white culture.

Secondly, minority ethnic groups can sometimes receive poor quality health care.[8] To achieve equity within the health service, the needs of all groups have to be addressed.[9] This can only be achieved by rejecting 'colour-blind' approaches and considering cultural differences and needs as an essential factor. Health inequalities are related to economic and social consequences of migration, including limited access to healthcare provision.[10] This is exacerbated by discrimination, professional practice, health workers' attitudes and expectations,[11] and communication difficulties.[5,6]

What issues need to be covered? The health needs of minority ethnic groups can be considered by exploring such factors as health beliefs and practices, expectations of the health service, communication, traditional and alternative forms of health care, family systems, diet, and patterns of illness.[5,6] Two levels of educational needs have been identified.[5] First, there is the conceptual level — for example, the definition of ethnicity and culture, and the different approaches to health, illness and death in different cultural groups. Secondly, there is the practical level — for example, the patterns of disease in different cultural groups, the factors underlying these, and the presentation and appropriate management of disease. More details are given in the BMA report.[3]

Where do we start? Deficiencies exist at both undergraduate[1,3] and postgraduate[12,13] levels. The aim of any educational programme must be 'to provide students with a level of knowledge, sensitivity and awareness from which they can go on to develop and learn for themselves'.[3] This learning needs to continue throughout the professional careers of all doctors and should be included within all accredited training programmes. This will help the profession to respond more effectively to the health care needs of the total population.

Probably the first priority is to include multicultural education in the undergraduate curriculum. Cultural issues have implications for all areas of medicine. Current teaching tends to be opportunistic, taking the form of stand-alone lectures, electives and clinical teaching by enthusiasts. What is needed is a strategic approach, reflecting the multicultural nature of British society throughout the curriculum. This will avoid the implication that minority ethnic groups are marginal or abnormal.

Can it be done? In other professions, such as teaching, health visiting and social work, multicultural aspects are already addressed. For example, in order to gain basic qualifications, social workers and probation officers are required to demonstrate an awareness of cultural issues relevant to their work.[14]

How would this work in medical practice? At undergraduate