The Review

'In my day ...':

towards the utilisation of living history?

INTRODUCTION

This essay starts from the premise that the phrase 'in my day ...' so beloved of our teachers may have more significance now that we are undergraduate teachers ourselves. We feel that earlier eras of medicine have something to contribute to younger generations and that recent evolutions are invaluable resources to consider the changing role of primary care in general and academic general practice in particular.

We set out to show some of the changes over the last 20 years or so through the eyes of individuals with varying GP academic experience. However, it is not intended to be mere idle musings, because we mean to show that a blend of the good from the past, combined with the good from our contemporary position will improve ongoing academic primary care medicine and teaching.

PRIMARY CARE MEDICINE

The job of a GP used to be more clearly defined; various definitions of general practice were recognised and were the basis of the vocation;¹ in Britain being a GP comprised becoming a partner in a practice providing 24-hour care to a defined population and largely being paid by capitation; out-of-hours work was often done in collaboration with other surgeries or cooperatives.

The linking of GP pay to externally set indicators of performance at a population level began with the unpopular 1990 GP contract.² This changed once more with the present contract and its combination of permitting GPs to opt out of 24-hour care while offering money for quality care as defined by interim, largely population-based outcomes (QOF),³ although this aspect of the contract has debatable utility.^{4,5} There is even speculation in the media that a new contract may be discussed by the current government soon.⁶

Twenty years ago, trust was a large aspect of primary care, although some saw this as excessive paternalism.⁷ There were fewer 'ancillary roles' to general practice; salaried doctors, nurse practitioners, healthcare assistants, and walk-in centres have all evolved in the last 20 years. Evaluations show good support for these roles, and evidence of benefit to patients as a consequence.^{8,9} Furthermore, portfolio careers, flexible and

part-time working are all second nature to the younger authors of this paper.

Essentially primary care continues to change. Not all would see this as an improvement,¹⁰ and some would argue that such 'old-fashioned' values as continuity of care,¹¹ holistic care and patient autonomy¹² are at risk here. Further, it has been noted that future GPs may see the job as an occupation rather than a professional vocation.¹³ These aspects could form a focus of discussion for others intending to join our ranks, and possibly for others during their undergraduate medical course.

UNDERGRADUATE TEACHING

The basic purpose of teaching has remained unchanged; that is, to equip individuals with the basics of history taking, examination skills, use of investigations, and the fundamentals of clinical management. Many years ago, it was regarded as the norm to be taught by humiliation as a means of learning, although the younger authors of this essay commented that this still takes place more recently. As teachers, we argue that kinder, more student-centred teaching is the norm for all contemporary GP teachers.

Medical schools themselves are getting bigger; Lionel Jacobson went to Southampton University from 1981 to 1986 in a year group of approximately 120 students, but the intake at Cardiff for 2011/2012 is expected to be upwards of 300 students. Further, the trend is for more assessment of such aspects as communication skills, attitudinal aspects of medicine, and ethical aspects of medicine, reflecting changes brought about by various evolutions of GMC recommendations for *Tomorrow's Doctors*.¹⁴

However, it is our contention that the biggest change is as a result of tuition fees. The means of financing universities has resulted in students taking up loans to pay fees for being on all university courses. This has resulted in an entire generation of students who are seen as 'consumers of education',¹⁵ rather than a generation of learners, and who wish each and every teaching experience to be 'value for money'.

UNIVERSITY DEPARTMENTS

University departments are bigger to allow for greater teaching, although it is noticeable that they have also grown to reflect the more

multidisciplinary nature of primary care research. Each member of the department is assessed on the quantity of their work in research and teaching terms; this is not to say that quality is an irrelevance but universities as a whole are now judged by outputs which may be considered as 'productivity' by any other name.

University departments of general practice were often performing studies on the modelling and evaluation of consultations which are the very 'stuff' of primary care and had pertinence for all students, both undergraduate and postgraduate. Nowadays, it is equally likely to be about the epidemiology of disease and disease management, and is by nature more robust and broader in scope, but it may have the downside of encouraging both conformity, and a 'one size fits all' mentality of patient care, which has its associated problems.¹⁶⁻¹⁸

Once again, this is merely a comment on the changes apparent in the ethos of one department and how they have affected the authors. We recognise that students and their teaching also forms the lifeblood of departments of general practice, but that the nature of the changes in perspective from the science of patient care and its evolution to management and preventive management strategies is an important change worthy of note and further discussion.

WHAT HAS BEEN GAINED, LOST, AND RE-FOUND

Our own answers to this issue take note of the positive changes of having GPs who are less tired and less burnt out from the perception of constant toil that comprised a GP's lot in an era even before GP cooperatives. Further, since all of us are GPs and university teachers it means we come fresher to our university roles nowadays.

Clearly, the scientific gains from the body of published primary care research have created a sense of being able to perform as both better clinicians and better teachers. University departments should continue to view this as one of their purposes, and it is central to all universities to improve the knowledge base, and hopefully to impart this knowledge in a better manner to future generations.

However, it is equally valid that we comprise a group who recognise that a

sense of vocation and 'care'¹⁶ can be lost if we disregard this aspect of our professional lives, and there is evidence that younger doctors view the job of being a GP as just a job, rather than as a vocation.¹³ We share a sense of concern that this might be a significant loss, and that this change needs to be discussed further.

Medicine needs to maintain its professional and vocational values and this should be continually re-emphasised to students.¹⁴ The importance of such values was so pertinently discussed recently by John Howie from an even longer perspective,¹⁸ and we feel that the role of values in our proposed 'living history' educational component is not to be underestimated.

CONCLUSION

This has been an exploration of the changing medical culture during four (unfinished) professional lifetimes. As such it is not intended to be definitive, authoritative, or indeed a 'grumpy old man' type essay, and there are no definitive overall conclusions. Furthermore, the worry about the future of general practice is not new; in researching this paper, an article from 1956 was discovered that indicated concern over future status, funding, and the importance of general practice.¹⁹

This is perhaps echoed in the article by Howie and colleagues from a more recent issue of the *British Medical Journal*.¹⁰ They

indicated four areas of potential concern for the future vision and provision of general practice: the population health agenda, perverse incentives, access, and their concerns for learning opportunities within general practice. We share these concerns and previous papers have commented on the potential loss which may occur as a result of these issues.^{16, 20, 21}

One of the links to our colleagues (past, present and future) is a shared view of providing appropriate, caring general practice. An article by John Howie ably described a historical perspective, and he recognised too that an appreciation of history is relevant when considering the future evolution of the discipline.¹⁸ We want our present-day 'consumers of education' to be good teachers of future generations, and this must include some of the values from the past, and some reflection on the changes that will occur during their future professional lives.

This essay should not become a paean to an illusory golden era allowing too much looking backward to an era of pioneers in the primary care research discipline. It is all too easy to look backward and over-venerate 'important names' as a parody of the Shinto tradition of ancestor-reverence. Further, too much retrospection runs the risk of stagnation, and we feel that, to misquote Bob Dylan, the times should always be a changin'. We consider that the best of both worlds requires an ability to blend 'living

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history' with our contemporary world, and to use this historical perspective as a resource and a springboard for reflection on present and future primary care.

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