Middle Articles

MEDICAL EDUCATION

Teaching of Family and Community Medicine

J. H. WALKER,* M.D., D.P.H.; H. G. BARNES,† M.B., B.S.

Brit. med. J., 1966, 2, 1129-1130

Although almost 50% of medical graduates in this country ultimately work in general practice, family medicine remains an insignificant part of most undergraduate experience. At the same time traditional public health teaching has become increasingly handicapped by a lack of clinical contact immediately appealing to the student. The new pattern of medical education established in Newcastle in 1962 provided an opportunity for experiment in an attempt to correct both of these shortcomings.

Under the new regulations the student's first clinical experience comes in his third year—the mornings of which are spent in rotation through four-week or eight-week periods of paediatrics, psychiatry, outpatient teaching, casualty and radiology, and family and community medicine.

The first family and community medicine course began in 1964. Twelve local general practitioners were appointed "tutor in family medicine." Eight members of the local authority health and social services department became tutors in community medicine, and a full-time lecturer in public health responsible for tutorial teaching in community medicine acted as general co-ordinator. Six hospital specialists each associated with two of the family doctors completed the teaching group.

Family Medicine

With only 16 mornings of teaching-time available, the main problem was what to teach. We wanted to break away completely from the old idea of taking the student round a general practice. Family medicine, like any other branch of medicine, consists of a body of knowledge. This is extensive and not always clearly defined, and the question was, What should be presented to the student at this early stage of his clinical experience? By analysing the contents together, the general aims of the group became clearer: to introduce the student to family medicine and to show him the essential functions of the family doctor. By demonstrating some of the diseases and encouraging the student to share in some of the situations peculiar to family practice he would be given an understanding of the special contribution made by family and community medicine to medicine as a whole. The diseases and situations selected were grouped under five broad headings:

Measures concerned with the maintenance of family health and well-being.

Common illnesses dealt with entirely by the family doctor.
Chronic and disabling disease.

Illnesses needing referral to hospital and which illustrate the relationship between family doctor and consultant.

The acute medical or surgical emergency.

Within this general framework, the student is asked to look more closely at a particular family. Each group studies a different type of family, which over the full period has included young parents with the first pregnancy; a family with young children; a family with schoolchildren; a three-generation family living together; a family with one member chronically sick; a family with mental illness; a family with a member in hospital; an old person living alone.

Time-table

Each month the 12 students are available on 16 mornings from 9 a.m. to 12.30 p.m. They take part in family medicine and community medicine on alternate days. Six of the 12 tutors in family medicine teach during any one month and each has two students working with him every Tuesday and Friday morning.

They begin by sharing a morning surgery, which though reduced in size to allow for discussion contains both new and selected patients. Coffee with the doctor and his partners after surgery is followed by home visiting. On some mornings, and by arrangement, the student will call on his special family. The student is introduced by his tutor to such a family early in the month and is encouraged to spend as much time as possible with them in an attempt to appreciate the personal, social, and clinical factors involved. The student's clinical training at this stage is too limited for him to deal in detail with illness, but we have been impressed with how quickly the student recognizes the interaction of physical, emotional, and social factors in different situations. In addition to the family study, each student keeps a diary of each day's attendance in which interesting illnesses or problems are briefly recorded.

Many of the students, with the encouragement of their tutors, have attended evening surgeries, domiciliary confinements, and domiciliary consultations, in their own time. During the last week the two students meet their tutor and his associated consultant at the surgery to review their experience. The written account of the family and the diaries are considered. On the last Saturday of each course there are two seminar discussions, each attended by six students, their tutors and consultants, and certain members of the planning committee. The family of the month is presented by each student and discussed in detail. After coffee, students present clinical or social situations which have aroused their special interest. We have always managed to have consultants

* Lecturer in Public Health, University of Newcastle upon Tyne.

† Clinical Tutor in Family Medicine, University of Newcastle upon Tyne.

experienced in adult medicine, social medicine, and psychiatry at all sessions; with obstetricians, paediatricians, and surgeons when appropriate. The chair is taken by family doctors and consultants in turn, and the discussions are so lively that the nominal one-and-a-half-hour period is often exceeded.

Community Medicine

The eight mornings in family medicine alternate with eight in which the community services particularly relevant to family practice are studied. Monday and Thursday mornings are spent in this way and begin with a 50-minute tutorial in which one particular aspect of community health is discussed. The subjects covered are:

The epidemiology of common social disorders.

The domiciliary team, the training, work, and relationship of district nurses, midwives, health visitors, and social workers.

Community child care, with particular reference to the identification and care of handicapped children.

Community care of the mentally ill.

Environmental control—illustrated by food inspection, housing, and smoke abatement.

Rehabilitation and the role of an industrial rehabilitation unit.

The care of the elderly in the community.

Health education, with special reference to the work of the health visitor.

After the tutorial, visits are paid by the students to a variety of community services which illustrate some aspect of the subject of the day. The epidemiology of common disorders is illustrated by the findings of a joint research project between the city health and welfare departments and the city planning department, in which social pathology is being related to housing and other factors. The work of one member of the domiciliary team is illustrated when each student accompanies a district nurse on morning rounds. Some of the problems of handicapped children are demonstrated at a school for the physically handicapped, where the students are encouraged to establish personal contact with the pupils. Mental health in the community is dealt with by the city psychiatrist, who includes a case presentation in his discussion of community care. The students then spend the remainder of the morning with a mental welfare officer at a training centre for severely subnormal children or at a residential hostel for the mentally ill. Rehabilitation is demonstrated at the local Ministry of Labour Industrial Rehabilitation Unit. The problems of an ageing community are discussed by the city's geriatric medical officer and welfare officer and at a residential home for the elderly. On the last morning after the various aspects of health education have been drawn together, the role of the health visitor and the many problems with which she deals are seen as each student spends the morning visiting some of the families for which she is responsible.

The family and community aspects of the course are finally brought together in the Saturday morning seminar, when the social and clinical problems presented are used to illustrate the unity of community and domiciliary medicine.

We consider it especially important that these students have already taken or will soon take their introductory periods in paediatrics, psychiatry, and outpatient consultation.

Student Assessment

Forty-four students completed an anonymous questionnaire during the first year. They were asked to classify each part of the course as A excellent, B good, C average, D poor, E very poor. The results are:

	A	B	C	D	E	Total
Family medicine ..	26	15	3	—	—	44
Community medicine..	10	24	10	—	—	44

The students were also asked to comment on the course. They expressed particular satisfaction at the close relationship with their tutors and their sense of real involvement in patient-care. The sense of relief that the kind of doctoring which had initially attracted them to medicine still existed was often put into words. They also found the study of patients in their home surroundings, and particularly their special family, very informative. The expressed desire to become personally involved in patient-care was again illustrated in their comments on community medicine. Of the 44 students who completed the questionnaire, 25 commented favourably on their visits on a one-to-one basis with district nurses, health visitors, or social workers, and many particularly enjoyed the visits to the school for handicapped children.

Deficiencies and Limitations

Although there is satisfaction with the early development of the course, much remains to be done. Integration between family and community medicine is still incomplete. Similarly, demonstration of the relationship of family medicine to hospital practice could be extended. The five categories of experience suggested to each family doctor have not always been sufficiently covered and there has not been adequate opportunity for demonstrating certain aspects of prevention and health education.

Despite these reservations, it is felt that a satisfactory start has been made. If the 50% of students who completed the questionnaire are representative of the whole, this course is as highly regarded as any part of the new curriculum. After two years the teachers are increasingly sure of its value, and at evening staff seminars each term progress has been made towards a more precise definition of the functions of the family doctor, the content of family and community medicine, and the parts most appropriate for students at this stage of their education. We have no doubt that the combined teaching of family and community medicine is an effective way to present these important aspects of medicine to the undergraduate.

Summary

The Family and Community Medicine Course in the revised Newcastle undergraduate curriculum is described. A close association between teaching in family practice and community medicine is shown to be an effective way of introducing the student to the social and family aspects of illness at an early stage in his clinical career.