Southampton: the first years

V—Primary medical care in Southampton

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British Medical Journal, 1976, 2, 161-162

Let me begin by stating what we are *not* trying to achieve in undergraduate teaching in primary medical care. I quote from the recommendations on basic medical education of the General Medical Council¹:

"In medical education, there should be a single objective for all doctors up to the time of full registration, whatever their subsequent career. The object of this basic medical education should be to provide a basis for future vocational training; it is not to train doctors to be biochemists, surgeons, general practitioners, or any other kind of specialist."

Expressed another way, neither I nor my staff teach undergraduates about general practice as part of the system of health care, nor do we try to influence students by suggesting they might consider general practice as a career. Our object is to teach students about the practice of clinical medicine outside hospital, and general practices are convenient, readily accessible vehicles for carrying this out. In a way we are more interested in teaching primary medical care to young men and women who seem destined to become, for example, psychiatrists and pathologists, than to those who have already put general practice as their first career choice. We like to think that future psychiatrists, pathologists, and other specialists may have more insight and understanding into the problems associated with the practice of medicine outside hospital and may relate this experience to their work in hospital.

Objectives

We are trying to achieve four main aims in primary medical care teaching.

Introduction—We aim to introduce the student to the problems of primary diagnosis and to provide a balanced view of the incidence and prevalence of disease. Patients referred to hospital have been selected from many people with a wide variety of medical complaints, ranging from a minor infection of the respiratory tract to cancer. In clinical medicine in the community leukaemia is uncommon, urinary tract infection is common; myxoedema is rare, low back pain is common. Hernias are commonplace, but a general practitioner will probably see only one patient with carcinoma of the cervix in three years. The doctor in primary medical care should elicit information and examine with care when necessary, but primary diagnosis has to be based in many cases on his knowledge of incidence and prevalence—on probability.

Experience—The student needs experience of illnesses that may not be seen in hospital. Otitis media may not be a major illness in hospital terms, but it is certainly major so far as a young child is concerned. Low back pain in a young man in a hard manual job may have many implications.

Continuing care—We aim to introduce the undergraduate to continuing care, resettlement, and rehabilitation. Prevention in the narrow

sense is well established in clinical medicine, but a wider view of prevention has to be taken in primary medical care. Further deterioration in established disease—for example, hypertension—must be prevented, and the doctor must at least try to maintain or improve the quality of life.

Complementary roles—The course in primary medical care underlines the complementary roles of the hospital and the community services. It goes without saying that the general practitioner and community services cannot function effectively without a hospital back-up service. The converse is equally true. If it is to provide a planned, productive, and efficient service to the community, the hospital service depends on an organised system of care from the general practitioner services.

How are these aims achieved?

In primary medical care we try to achieve these objectives by introducing students to patients in their own homes within six weeks of their coming to University, when we try to emphasise the impact of illness—socially, psychologically, and economically—on the patient and his family. Students accompany a general practitioner to see four selected patients during the first year. At this stage the students know nothing of anatomy, physiology, or pathology. The emphasis in teaching is on the patient as a person. Hospital medicine is often cross-sectional and episodic. In our first year teaching the emphasis is on the "before and after" of disease and its impact on the patient and the family—income, house, design, the extent of dependence, the contribution of the community services, and the profound psychological effects of prolonged illness.

Patients that a student may visit are: (a) a family with a mentally subnormal child; (b) an isolated elderly person with multiple conditions clinging determinedly to an independent existence; (c) a man of 35 with paraplegia as a result of a road accident; (d) a lorry driver of 50 who has recently survived a myocardial infarction; (e) a patient with schizophrenia coping with life in the community.

Our next contact with students is in the third year of the curriculum (first clinical year). In 1969, two years before we had our first intake of undergraduate students, it was suggested that students should spend a two-month rotating block in primary medical care. At the time, I opposed this, and I still hold the same view. By this method, I felt that students might get the impression that primary medical care was in some way divorced from the mainstream of clinical medicine, whereas the same methods and skills apply whether in hospital or general practice. Even though there are differences in approach, content, and attitudes, the fundamental principles of clinical medicine are the same in any setting. This view was accepted and in our third-year clinical course primary medical care is closely integrated with the hospital disciplines. For example, when a student is studying psychiatry over five weeks, he spends one morning a week in primary medical care looking at the problems of psychiatric care in the community. The same principles and organisational methods apply in medicine, surgery, obstetrics and gynaecology, child health, and geriatric medicine. Thus in the 3rd year the student spends about 15% of his time in clinical instruction in primary medical care.

Resources

The philosophy and policy of Southampton Medical School has, from inception, been to extend its activities in service, research, and teaching throughout the Wessex Region. In the fifth year students are

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attached for two weeks to general practices around Basingstoke, Portsmouth, and Winchester and subsequently will be attached to practices in Bournemouth, Poole, Salisbury, and other centres.

Our resources consist of: (a) a university practice about half a mile from the medical school consisting of 7500 patients and another practice of 4000 patients which we will "inherit" in two years. These two practices form the bases for our teaching; (b) eight members of academic staff, all salaried and full-time; and (c) the general practitioners who teach in all three courses.

A teaching programme of this extent could not be sustained without the support of general practitioners. About 40% of general practitioners in Southampton take part in undergraduate teaching, and an increasing proportion are taking part in fifth-year teaching in Wessex. General practitioners must be involved in teaching for two reasons. Firstly, and more importantly, they are teachers; but, secondly, they act as agents of the medical school in that they provide through their registered lists of patients access to a large population for teaching purposes. I hope the medical school gives general practitioners something in return. I believe we add a new dimension to the continuing education of general practitioners. To be in contact with young people who question, who persist in asking you "why," and who sometimes suggest that your assessment and management of a patient might be improved seems to be a relatively painless, effective, and cheap form of postgraduate education. Being a teacher in daily contact with undergraduate students improves standards of patient care.

Evaluation

The overall aims in primary medical care teaching are to add

to the knowledge and skills the student has acquired in hospital and to influence his attitudes towards patients whether inside or outside hospital. Evaluation is probably one of the most neglected fields in medical education, indeed in all facets of education. Evidence on whether we are being successful in achieving these aims cannot be given. So far as we can tell in Southampton, most students enjoy themselves in primary medical care, particularly in early medical contact, and this is in itself a highly desirable educational goal. But in the next five years outside observers must evaluate the course scientifically, not just by crude questionnaires but by questionnaire and structured interview and other more sophisticated techniques, and we must attempt "before and after" studies in which we measure the student's skills and attitudes when he first comes to primary medical care and particularly his attitudes after five years as an undergraduate.

We have set up in Southampton what appears to be a successful primary medical care teaching model. But income must equal expenditure, and primary medical care teaching is expensive and administratively difficult on the scale we have aspired to. In the next five years we must try to find out whether we are getting our money's worth.

Reference

- ¹ General Medical Council, *Recommendations as to Basic Medical Education*. London, GMC, 1967.

VI—The fourth year: study in depth

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British Medical Journal, 1976, **2**, 162-163

Medical science teaching is often a "study in width," in which a very wide range of subject material is covered in a shallow manner. This approach has several disadvantages. Students may have little opportunity to develop their own skills in handling problems and developing answers to them, or gain little experience of the discipline of working in a team. The sheer volume of facts to be learnt means that they are often presented as oversimplified half truths, and the uncertainties surrounding much accepted knowledge remain concealed. There is over-emphasis on the solved problems of the past rather than on the unsolved ones of the present.

An alternative approach was advocated by Epstein,¹ who has introduced students into methods of scientific work by discussing a current research topic with them from the outset. No attempt was made to cover all the "facts" of science, but every effort was concentrated on allowing students to grapple with real scientific problems. This is the basis of training offered in most MD and PhD projects and many BSc courses.

In Southampton almost the whole of an academic year has been allocated to this type of learning in which each student chooses a field of interest to himself and studies some aspect of it in detail. It is placed late in the curriculum, after the student has had one year of experience in clinical medicine, so that the

options can be in either clinical or in basic science fields, or preferably in a combination of both. All medical students have to take this year and exemption is considered only for graduates who have achieved good examination marks and clinical assessments and whose previous degree was in a subject forming a substantial part of the medical curriculum—for example, biochemistry or physiology—and included work on a project.

The goals

The goals were established during the early planning of the curriculum and have not been significantly modified. It was agreed that the student should follow a flexible programme of advanced study and project work, suitable for his or her needs, under the guidance of a supervisor. This was intended: (a) to enable the student to learn that the extent of medical knowledge is infinitely wider than the extent of his medical undergraduate education; (b) to develop in the student a basis for critical self-education so that he is in a position to continue to educate himself after registration; (c) to provide the student with an opportunity to study the way in which scientific data are collected and handled, and in particular to illustrate their sources of variability; (d) to provide personal experience of the experimental method. These goals anticipated by some years the statement in the Merrison Report² that the medical graduate "... will recognise the limitations of his own knowledge and abilities and will be prepared for a career in medicine that is based upon continuing education."

It was also recognised that there was a need during this year for continuing clinical contact with patients and the practice of basic clinical techniques. An attempt has been made to meet this need by allotting one day each week to clinical study in the following special subjects: orthopaedics, ophthalmology, ear, nose, and throat, dermatology, sexually transmitted infections, and rehabilitation. For many students the field in which they are working also involves them in clinical work.

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