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REFLECTION

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The role of the teaching practice in undergraduate education – A British perspective

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Abstract

This article describes and reflects on the role of the teaching practice in undergraduate education on the basis of the author's experience in the United Kingdom. Recognizing that China is addressing the huge task of developing a general practice workforce in an unprecedented short time, I hope that sharing these ideas will be helpful. General practitioners are well able to teach the basics of medicine. However, their real strengths come when they are focusing on key consulting skills needed for general practice, developing reflective lifelong learners, and cultivating good attitudes. The practice is also able to demonstrate preventive medicine, chronic disease management, and multidisciplinary care. By providing exposure to general practice at this early stage in a medical career, the teaching practice will hopefully inspire and attract the general practice workforce of the future.

Keywords: General practice; teaching; consulting skills; reflection

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Background

In November 2017 I delivered a talk to a general practice conference in Beijing on the role of the teaching practice in undergraduate education. This was based on my experience in the United Kingdom of nearly 30 years as a general practitioner (GP), 20 years of tutoring undergraduates in general practice, and more recently 10 years of providing support to other such tutors in their practices, as a deputy head of academy for Birmingham University.

China is addressing the huge and challenging task of providing GPs for its population of nearly 1.4 billion people. The short timescale in which China hopes to achieve this is unprecedented. The very first GPs started in 1989, by 2010 there were fewer than 89,000 GPs, and China is working toward developing 300,000 by 2020 [1]. Clearly there is a need to motivate students and trainees to come into this new career, and also to provide tutors and trainers to deliver the general practice education. With this in mind, I was privileged to share my experience of undergraduate teaching in the United Kingdom.

The undergraduate system at Birmingham University

Birmingham University has a program of community-based medicine (general practice) teaching that takes place within practices under the supervision of GP tutors. There is a detailed curriculum for years 1 and 2, which is closely aligned with the topics students are taught in the medical school. For years 3 and 4 the program relates to their hospital placements. The students attend the practices in groups of four, usually coming

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for 1 day every 2 weeks. Each day combines patient contact with set interactive tutorials where students may also develop their presentation skills. We have 64 practices recruited to deliver this teaching for a total of approximately 400 students a year. For the final year, students are sent individually to one of more than 120 practices selected for a 5-week attachment.

Year 1 starts with the opportunity for students to talk to patients for the first time in their capacity as health care practitioners. The students really like this role so early on in their training, and some say they come to Birmingham specifically for this reason. We give them a prompt list of questions and send them into the waiting room to approach patients. Although most students cope very well with this, it still needs care and supervision as one tutor explained. He heard a student diligently asking the questions but not listening to the answers. So when he asked “Who lives with you at home?” he went straight on to the next question, despite the answer being “Well since my husband died 3 months ago I live on my own.” However, this was a great opportunity to explore with students the importance of appropriately reacting when given more sensitive information, explaining that just an “I am so sorry to hear that” means the information has been acknowledged and respected.

In the second year we move on to clinical skills, with the students first practicing on themselves, and then on selected patients. From the third year we start the students doing their own consultations within surgeries, with ample time allowed for students to see the patients on their own before the tutor comes in to supervise. The students are very limited at the beginning of year 3, but by the time they have finished year 4, they are ready for the final year, when they are mostly doing surgeries. Each consultation in the final year must still be supervised. However, this may be minimal, for a competent student, with time focused more on discussion round the problems presented.

The role of the teaching practice

The question to be asked is “What do medical students actually gain from coming out into general practice?” Of course most medical consultations in the United Kingdom take place in general practice, and so we are well placed to teach the “nuts and bolts” of medicine. However, we teach and demonstrate so much more than basic medicine.

Perhaps the first point to be made is that although GPs are generalists, their expertise lies in key consultation skills specific to general practice. Often students are aspiring to become specialists, and they see the role of a “generalist” similar to the saying “jack of all trades; master of none!” However, I am very careful to inform them that GPs are “masters of consultations.” Yes, we deal with “anything and everything,” and how we do that is a very skilled process. Teaching about consultations is a huge part of what we do with students. To consult to a high level requires many considerations, including knowledge, communication skills, and good ethical attitudes. I often talk about the “consultation toolbox” and having the ability to select the right “tool” to use for the patient in front of us.

As we know our patients, we can show how the psychosocial aspect of any patient is crucially important to understanding what is going on. A story I tell all my students, to introduce this, is from when I was a brand new GP. I was fresh from the more “certain” world of hospital doctoring. A 12-year-old boy with headaches, accompanied by his father, consulted me. The headaches appeared worrying, and I referred him for investigations. I received a letter from the hospital confirming that there was no significant disease, and I remember looking forward to the consultation, where I could, with certainty, reassure the pair of them. This was not to be the “good” consultation I had anticipated, though. Instead the headaches appeared to have been forgotten, and the boy now described some worrying abdominal pains. My heart sank – was I now to refer him for these? I remember discussing this in the coffee room after surgery. There was a receptionist there who immediately turned round and said, “Well that boy’s not been the same since his brother died.”

I reflected on this long and hard. I should have known about the brother’s death. This would have had a significant impact on the way I should have handled the consultation. I felt bad that I had not known – and had I taken an interest in the patient as a person rather than just the medical history, I might have found out. To quote the words of William Osler, “A good doctor treats the disease; a great doctor treats the patient.” And so I tell my students not to make this same mistake and to be curious about their patients. I insist they always tell me a little about the actual person when they are presenting the “case.”

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I teach my students that it is essential to find out why the patient has come and what the patient is expecting. This may sound obvious, but is often missed. I insist all my students start their presentations from their surgeries with an introduction followed by "they have come today because…."

We also have the chance to promote "focused" histories, and teach about bespoke management plans, negotiated with the patient. For example, a patient with anxiety and depression may benefit from medication or counseling or some time off work. It is good if the students can observe a discussion with the patient that takes into account the patient's views, and culminates in a joint personalized treatment plan. It is better still if the tutor can observe the student negotiating this in the consultation!

General practice also provides a great opportunity to discuss the concept of "possible" versus "probable" when it comes to making a diagnosis. I find that students are very good at coming up with a list of possible diagnoses, for a given set of symptoms, which usually includes rarities. I need to gently remind them that "common things are commonest!" Tropical diseases are unlikely in the United Kingdom, and in the absence of travel, they would not be my first thought when assessing a patient with pyrexia. Chest pains in a fit and healthy 23-year-old woman are unlikely to be cardiac related, as opposed to chest pains in a 65-year-old man who smokes and has diabetes. General practice is an ideal environment to demonstrate how we "sift" symptoms and match them to a likely diagnosis, taking care to ask about significant (red flag) symptoms, and always to explain to the patient the need to seek medical advice again if the problems get worse or do not settle (safety netting).

Sometimes I find that new tutors are overwhelmed with the extent of teaching they are expected to deliver. I reassure them that, although they should try to complete the tasks as much as is possible, the students will be able to access the knowledge from other attachments, lectures, reading, etc. However, what is really important is the experience they gain from talking to patients and that they learn "how to learn" from this. If the student does not know something factual, to say "How can we find this out?" is far more powerful than just giving the answer. This must, of course, be supervised, and followed up by discussion. Additionally, I often ask my students, after they have seen a patient, "How do you feel about that consultation?" I might throw in "I am not sure that patient walked out entirely happy." "What could we have done differently?" In this way we are encouraging our students to become reflective lifelong learners to stand them in good stead for the future. To quote an old proverb: "Give a man a fish and you feed him for a day; teach a man to fish and you feed him for a lifetime."

Another important aspect of the attachment is the group discussions that we facilitate within the tutorials. For example, I might talk about a patient who demands a home visit, which I feel is not appropriate. There is no right or wrong way to handle this, and I ask the students for their suggestions. We discuss how we might best handle this situation. This is fundamental to helping students form good attitudes, and they are still at a stage where we can hopefully guide them down the right path that they will always respect patients, and also learn to balance the conflicting demands on a physician's time.

Tutors are often an inspiration to students to come into general practice. We want them to role-model the career for them. You may be aware that British general practice is going through a tough time with recruitment at present. We tell our tutors that if they are having a bad day, they should discuss this with a colleague. However, if they are having good day, they should tell the students! One of my recent high moments occurred when I visited a practice and found that the tutor had been one of my first students back in 1996! It felt life had come full circle!

It is hugely rewarding when students recognize that general practice will be the right path for them in the future. Interestingly, there is a higher conversion rate of students to GPs from universities that invest more undergraduate time in general practice. The average is 24% (we would like and need 50%!). It is also important to recognize that general practice is not for everyone, and students wanting more direct results from their efforts may make better surgeons, for example, and those who find uncertainty more difficult to live with may be happier in hospital medicine. The earlier students have these insights, the more time and stress can be saved later on.

There are other opportunities for students in general practice. They can directly observe preventive medicine in operation; for example, immunization clinics, routine childhood checks, and antismoking clinics. Most chronic disease management

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occurs in general practice, with the nurses providing the bulk of care. The primary care team operates from the practice, and it is a must for the students to observe multidisciplinary meetings where management plans can be formulated for complex patients so everyone is "singing from the same song sheet." The students experience information sharing between the various members of the team both in more formal meetings and on a day-to-day basis. In practice, the informal sharing often happens in the kitchen when people are making cups of coffee. I joke with the students that the powerhouse of all surgeries is the kitchen, and this is where most major decisions are made!

Good communication is essential in any health care system. The students are able to observe communication from general practice to the hospital and vice versa. When students are seeing patients who need to be admitted the same day, it is a useful exercise to ask them to write the letter the patient will take into the hospital. This really sharpens the mind as to what is the essential information for patients to take in with them. The students also see the discharge summaries in general practice, and can evaluate how useful these are in terms of not only the information contained but also the timeliness of receipt. I can point out that if the hospital wishes us, for example, to do a blood test, it is better to be highlighted on it own rather than be buried in the middle of a long paragraph.

With increasing numbers of students at the medical school, general practice is the one placement where a relationship can build up between the tutor and the student. If a student is absent for any reason, the student will be missed. The students often turn to the tutor for support if they are struggling, and fourth- and fifth-year tutors will frequently be asked for references.

Teaching undergraduates is not a one-way street! From my own experience and from discussion with other tutors, I can say that students so often give back far more than they take. Their enthusiasm can be a real tonic for a weary GP. I still remember another of my first students, Laura, who was so enthusiastic about her days at the practice and confessed that she did not sleep the night before! The students can also provide a challenge. They ask questions, of which the hardest is "why?" I once found myself completely changing a patient's management plan after being asked this question! They provide a fresh pair of eyes, which can be so illuminating.

Table 1. Key roles of the teaching practice

1. Develop consulting skills, including focused histories, psychosocial aspects, red flag symptoms, bespoke management plans, and safety netting
2. Explore and develop reflection on consultations, and therefore how to enhance learning from experience
3. Cultivate good attitudes, centered round the patient experience, and also balancing the conflicting demands on a physician
4. Inspire the workforce of the future

Conclusion

So, in summary, I feel the most important aspect of undergraduate teaching in general practice is to allow the students as much patient contact as possible, and then to spend time reflecting on the cases to maximize learning from the experience. The student can also absorb the holistic and multiprofessional care that general practice provides. This teaching takes considerable time, but is a hugely worthwhile investment, as it enables students to become reflective lifelong learners, and can provide inspiration for general practice as a future career (Table 1).

Recognizing that China has its own cultural context and challenges, I hope that these thoughts will be informative as China moves forward with the globally unprecedented scale of expanding its GP system.

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Reference

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