MEDICAL EDUCATION

ROLE OF FAMILY MEDICINE IN UNDERGRADUATE MEDICAL EDUCATION

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ABSTRACT

Family physicians in medical education can enhance clinical learning of the following;

- knowledge and awareness of the principles and application of health promotion and disease prevention,
- awareness of psycho-social, cultural, familial, and socioeconomic aspects of medical problems as they relate to patient management,
- role of the family physician within the health care delivery system and understanding of general practice in real life experience.

All these objectives are relevant with the global aim of optimal primary care. As medical care is changed by proper medical education, it will be necessary to utilize family medicine and family physicians in undergraduate medical education as role models for students. In a medical education system that only promotes post graduate medical education on specialties but not general medicine, it is obvious that the student will not be motivated about primary care or the health needs of the community.

In order to inject that kind of perspective to the medical students, changing or at least integrating, community- based education or primary care- based rotations with family physicians as mentors, is not only an international but also a national requirement because primary care is what most of the graduates will be dealing with.

Key Words: Family medicine, Undergraduate Medical examination, National needs,

INTRODUCTION

Global target for Medical Education

The primary purpose of this report is to examine the role of family physicians/general practitioners in undergraduate medical education. As medical practice is performed relevant to the needs of the people and communities, and medical education has to change to train physicians responsive to that kind of care;, before discussing education, it is necessary to learn about the needs of the community. Optimal health care, medical practice and medical education are team members that should work in harmony towards a single aim.

The Alma-Ata Declaration promises an appropriate health care workforce, including

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physicians "suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community" (1). Although, undergraduate medical education and medical practice are closely linked, during the past 50 years in the world and 15 years in Turkey, medical education has steadily moved away from training physicians who can meet the community health needs. This deviation from the community health needs may be caused by learning medical practice in narrowly specialized hospital- based rotations, meeting with selected patients' problems which are not so common in the community, observing the costly types of primary care practice and absence of psychosocial approach in tertiary settings, following complex problems which are less representative of the common health problems and a lack of primary care physicians as members of the "team". But this out-put is not only a problem of the undergraduate medical education system but also national health care delivery system. Contrary to the situation in Turkey, countries that mainly aimed to improve the population's health status, are investing public funds in medical education and research related to national coverage and primary and preventive care (2).

After this declaration and strategic plan, WHO advocated the need for relevance and efficiency in medical education and for education of health professionals in general (2,3). The Turkish Medical Association (TMA) has declared the similar aim in "The Undergraduate Medical Education Report" in 1997. This report was prepared by a working group of academics from different medical schools and different departments, officers from the Ministry of Health and members of the Turkish Medical Chamber. After drawing a portrait of the existing Turkish medical education system, a summary of primary health problems in Turkey was revised and a list of recommendations was made (4) (Table I).

The emerging social needs for the coverage of the essential individual and public health needs were a call for medical education reform. Also medical practice by itself, determined changes in medical education. Some of the Turkish Universities have followed the changes in medical education around the world.

DISCUSSION

What might be provided by family physicians in undergraduate medical education?

Everywhere in the world in-patient care as a proportion of all medical care is decreasing and patient care has migrated from the wards to the out-patient department (4,5). As an out-come of this, teaching must change. ***Firstly*** because it is difficult to answer the following questions effectively at the end of the "hospital- based only" clinical undergraduate medical education model. How many, and what diseases can the students be taught on wards? How many of them are the most common illnesses of the community? Under these difficult circumstances how many of the students can complete history taking, physical examination at one sitting? How many of the patients

Table I: Recommendations of Turkish Medical Association Undergraduate Medical Education Report

Recommendations of Turkish Medical Association Undergraduate Medical Education Report
• Medical schools should define their missions, strategic plan, admissions policy, faculty composition, curriculum and training sites.
• A sufficient number of medical students must be considered and that number of physicians should be trained to acquire the competencies needed to provide qualitative medical care.
• Students should be exposed to medical practice, community based learning and biopsychosocial approach earlier.
• Clinical skills education should begin in the preclinical phase in clinical skills laboratories before meeting real patients.
• The curriculum must be designed by taking care of the previously mentioned steps and studens' opinion must be regarded during curriculum development activities.
• Medical schools should place more emphasis on education, primary care and population-based research.
• To assess the needs, to plan and evaluate the educational activities, and to improve the system, Medical Education Departments should be established.

'clerked' is the student able to revisit (to observe the natural history of the illness and the effect of treatment) before they are discharged or follow after discharge for the management? In how many cases taught on wards can the students find out about the social or environmental factors of the patient? or who the people are at home to help the patient? And what his needs are? ***Secondly*** there is growing attention to the human rights and the need to respect for peoples' dignity and autonomy. Different skills are necessary for the physician to be able to deal with very sick and dependent in-patients or patients and families in ambulatory care. The medical student must observe and practice both situations and acquire skills in communication issues in ambulatory cases essentially to prevent disastrous results in relationship issues with patients, care givers and health team members.. ***Thirdly***, in fact diseases which used to require hospital admission should be safely excluded in ambulatory care. So the core of the hospitalized problems are not the ones that a primary care physician investigates and manages but the ones that he should exclude. Today, other than the classical reference system, tele-medicine and access to the Internet will accelerate this continuous need of the physicians and help them to find answers.

In conclusion it is clear that changing or at least integrating, community- based education or primary care- based rotations in undergraduate medical education as a method is an operational requirement (5).

On the other hand as students learn the basic sciences at ever deeper levels down to molecular biology they find it harder to understand the "whole" elegant rhythm in the human organism. During the clinical years the patient should be considered as a whole rather than an individual system and its organs. The student must learn to perceive the patient's loss of social function and its restoration should be the ultimate goal of medical care rather than identifying the pathology. But if the students' time is carved up between specialist departments this goal will be failed.

The family physician can have a role in the achievement of such a goal as he works in primary care settings, community- based giving individual care, depending on cost effectiveness and quality. Family medicine especially interferes with the physicians who work as a first-contact professional in health problems. This first contact usually occurs in primary care. But whatever the context, family medicine deals with the patient whose problem has not yet been identified. These practitioners use their essential knowledge and clinical skills in terms of the illness and its management rather than simply the disease and its treatment. This view is relatively easy for a family doctor to demonstrate, and this will be a contribution to the end formation of the medical student. Both the location and the treatment method are important. Family physicians as teachers in undergraduate medical education would mean for students learng their future role "in real life". By this way the recommendations of the TMA may be realized.

What is more, the recognition of family physicians by other disciplines as team members may provoke the medical students' acceptance of optimal health care depending on primary care. Of course to fulfill this responsibility, family physicians must be highly competent both in patient care, integrating personal and community care and must continuously develop themselves. Like all other disciplines and may be more so, they should refer to educationists for help to set needs-derived educational objectives of the faculty, how to select content, and the methods necessary for small group education.

Once, these facts are recognized and accepted the tactics for utilizing family medicine in the undergraduate education must be revised. Some of the tactics that are offered by experienced institutions are listed below (Table II) (5).

Table II: Ways to utilize family medicine in undergraduate medical education

"Tactics" for utilizing family medicine in undergraduate education
Combined teaching.
Clerkship in a family medicine teacher's practice.
Community follow-up.
Combining session.

Combined teaching. Combined ward rounds or visits to family physician's practice by inviting a specialist colleague to come and teach in cases presented by the family physician may be established as a supplementary activity.

Community follow-up. To learn about the social life, supports or environmental issues After discharge, medical students visit their patients at home. During the planning of these follow-ups, coordination and evaluation of the students and development of the program family medicine teacher may serve as a team member to emphasize especially, comprehensive care and continuous care.

Clerkship in a family medicine teacher's practice. This is a more usual model. This is a straightforward attachment to a family medicine teacher in his or her own practice (6). This allows demonstration of holistic medicine as it should be practiced and shows insights into decision making such as the choice of investigations, whether to refer the patient or which procedural skills they need. Being truly responsible for patients under supervision of a family physician will enhance procedural training and build confidence (7). But "family medicine teacher " is the key word that makes this activity real. Because it defines the physician who is trained in education skills. Outpatient teaching, patient education, one-to-one education, context-based education and assessment methods relative to each kind of education type are the primary subjects that a family physician must be aware of.

Combining session. These sessions are planned to demonstrate the intimate connection between hospital and ambulatory care. They may be around the real or simulated cases with interdisciplinary approach.

Reasons to utilize Family Medicine in undergraduate medical education

The responsibility of Medical Schools is to define their educational activities related to the priority needs of the individuals and communities at a national and regional level (8). All governmental and non governmental organizations point at strengthening primary care as a priority. To have family medicine in undergraduate medical education curriculum of a Medical School means:

- To recognize and support the primary care settings and family physicians as training opportunities in order to make the primary care as an integrated part of the undergraduate curriculum.
- To enhance the integration of preclinical patient-oriented introductory courses (ICP in Marmara Medical School) with other specialties.
- To let all students experience continuous health care within a community context and the problems that he will be confronted in medical practice, in a family practice based care (9).
- To demonstrate, the effect of team work and health management as "physician as a team member" to the students (10).
- To let the students observe the skills required for general medicine and self-directed learning through a training, guided by a family physician (9).
- To provide role models for the career choice of the students, closely linked to the needs of the population and to establish a balanced generalist/specialist number (11).
- To encourage the other specialties to combine with family medicine to provide basic education in a generalist dimension.

What are the barriers to teach Family Medicine in undergraduate medical education?

Family Medicine is a new discipline so,

- as the other emerging ones it is under the pressure of older ones because of "the innate conservatism of Medicine".
- it is sometimes perceived to have been added for "political" reasons in Turkey, that useless and false belief makes it "a new current" more than a discipline.
- it has to compete for finite resources and a share of limited curricular time of the Faculty which are usually closely related with the established departments.
- its knowledge base overlaps and is derived from that of all the other clinical departments so it has to convince the partners that it has a

different approach to the same subject and this approach is not "under" their vision but before, and is not "over" but after chronologically.

- it is difficult to teach well in the hurly burly of outpatients but family physicians have to teach through their practice. An ordinary ambulatory care office which is appropriate for education may be a solution for this unavoidable issue.
- its achieved research is yet relatively small in academic world and tends to be socio-medical rather than biomedical.
- and its members are active practitioners and inexperienced teachers rather than deep theoreticians so need to be "parented" by other disciplines and need training in well established family medicine departments.

CONCLUSION

The challenge of medical education from seventies is to maintain a focus on preparing physicians who have the skills and motivation to make a difference in health care delivery. A medical education resulting in graduates familiar with the people's needs, and the community-based care is aimed to establish. Studies demonstrate that students' prior experiences in the related area may make a contribution to their development (12). Only giving an opportunity to general medicine in education may facilitate this establishment.

The recommendations of TMA, that were previously offered changes in medical education were highly relevant to the Turkish Government's targets about attracting more medical graduates to general practice and reaching the objectives parallel to the national health care.

On the otherhand, postgraduate training in practicing knowledge and skills and educational skills for primary care physicians must be motivated by underlining that competency in family medicine requires postgraduate education.

Medical schools, health authorities and non-governmental organizations should emphasize the importance of primary care and population research, and new posts for family medicine should be provided for the increased number of research fellows and lecturers so to promote general practice/family medicine. Of course the investment of the financial, human and technical resources would improve primary health and encourage family doctors to take their role in this new discipline.

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