What is the future of General Practice/Family Medicine - and how do we prepare and educate doctors for it?

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President-Elect WONCA
The faces of the future
The changing nature of health and illness

• ‘healthy’ ageing and co-morbidities / NCDs
• addictions and other lifestyle risk factors
• new interventions and technologies
• greater awareness of psychological well being and ill health (including chronic sequelae)
• Impacts of poverty and urbanisation ..
• increasing population and service disruption due to natural and man made causes
<table>
<thead>
<tr>
<th>The GP / FD model</th>
<th>The population served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single personal provider</td>
<td>Whoever registers</td>
</tr>
<tr>
<td>Multidisciplinary group</td>
<td>Whoever calls</td>
</tr>
<tr>
<td>Super – practice</td>
<td>A specific community</td>
</tr>
<tr>
<td>Provider networks</td>
<td>A specific population</td>
</tr>
<tr>
<td>DGH</td>
<td>Scope of practice</td>
</tr>
<tr>
<td>Managed care organisation</td>
<td>System model</td>
</tr>
<tr>
<td>Public and / or private sector</td>
<td></td>
</tr>
<tr>
<td>Specialist or not</td>
<td></td>
</tr>
<tr>
<td>1976</td>
<td>2016</td>
</tr>
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<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Preclinical – clinical split</td>
<td>FM academic medical school presence</td>
</tr>
<tr>
<td>Lectures / labs/ dissection</td>
<td>Integrated theory and practice</td>
</tr>
<tr>
<td>Ward based apprenticeship</td>
<td>Applied learning methods</td>
</tr>
<tr>
<td>Disease based learning</td>
<td>‘Learning from people about people’</td>
</tr>
<tr>
<td>1 week GP</td>
<td>Community placements throughout</td>
</tr>
<tr>
<td>Few FM academic units</td>
<td>GP teaching ~ 25% clinical time (u/g)</td>
</tr>
<tr>
<td>No postgraduate training</td>
<td>Postgraduate FM speciality training</td>
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<td></td>
<td>Training input to other disciplines</td>
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The (unchanging) essence of FM education

At the level of the learner – be excellent learner centred teachers

• Show them the real people – role model patient centredness
• Ensure good learning experiences – including continuity over time

In the system – promote the patients’ and learners’ need for FM

• As a setting to learn about public health and sociodemographics
• To learn about different diseases – from presentation to CDM
• To learn (and choose) family medicine

In the institution / region

• Ensure that learners are coming to FM
• MAKE THE ESSENCE OF THE DISCIPLINE VISIBLE – clear definitions, good evidence, strong advocacy
Moving up Miller’s pyramid


Knows about

Knows how / understands

Shows how

Does

Expert synthesis of knowledge

Can teach, can adapt

Can use in clinical context

Factual knowledge
Maslow’s hierarchy – no compassion without being loved?
The strategic future – UHC and PHC

UHC - aims to provide all people with access to needed health care services (including prevention, promotion, treatment, and rehabilitation) of the requisite quality to be effective, and without exposing the person to financial hardship (WHO 2010).

* Push at government level towards PHC

Accessible
Affordable
Acceptable
Effective
Implications for family medicine

1. The PHC model needs to serve a defined population so that systematic needs based interventions can be fully enacted

2. *community education & outreach, prevention, screening, vertical programme integration, effective consultations, NCDs, + extended roles for specific communities…*

3. OOP and fee for service should be low % or nil – for trust*

4. Even with UHC, health inequities will remain

5. For these to be diminished, strong PHC is essential

6. *Without a family doctor, PHC teams are less cost – effective (Starfield 2005)*
Change and sustainability- reflections on the context for FM medical educators

- Health service shift and need
- Workforce priorities
- Increasing FM visibility through evidence & global comparators
- Demands from regulators and government
- Positive evaluation from learners and patients
- Great opportunities – local, national, international
- Undergraduate and postgraduate input needed, also CPD
- Capacity building crucial – more input = more influence!
The challenges

• Being effective politically – co-ordination, both for strategy and delivery
• Making the right choices (‘the curse of the generalist’)
• Getting resources diverted to FM education
• Accepting / making change (capacity building, new initiatives, delivering on promises)
• Supporting FM educators in different phases
• Risk appraisal versus positive momentum
• ...

Implications for Wonca

• “The cause is just” – political shift towards FM / GP
• Need for FM associations to advocate and advise
• Value of exchanging ideas, expertise, and solutions
• Working together – with other health professional groups
• Support and professional development for FM leadership
• Need for policy making and government networks
• A 5 – 10 year strategy looking at risks and needs - >>
• Data analysis important
• Energy into the next generation
• Aspiration and persistence, vision and pragmatism ..
Implications for Euract

- A clearer identity – professional network, special interest group
- Effective alignment – with universities, colleges, other medical educators, WONCA
- The best added value?
- Resilience (5 Cs and an M!)
- Input into other WONCA regions
- ...

Implications for Euract

• Influence thinking
• Motivate and support
• Add capacity
• Increase impacts

WHAT IS THE BEST STRUCTURE TO DO THIS?
• Big shared definitions / consensus statements
• With others – WONCA, WONCA WPE, UEMO, MOs
Nationally – key political levers re. workforce and health systems needs
• Work more with any other groups with common mission
• Focus on training the trainers
Conclusion
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