Integrating undergraduate and postgraduate education in general practice: experience in Tayside

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Several forces have resulted in the creation in Tayside of the first formally integrated unit of undergraduate and postgraduate education in general practice in the United Kingdom. Forces that helped this integration included the desire for change, national developments in education, financial support through funds set aside to cover the additional cost of teaching, and a management structure which concentrates on shared leadership. Forces that hindered the integration included uneasiness about ideas for reforming traditional structures, institutional inertia, the complexity of financial arrangements, and tensions over priorities. The experience of managing institutional changes in Tayside has been invaluable and will lead to a more cohesive approach to undergraduate teaching, postgraduate training, and the provision of services relevant to the development of general practice.

Background

General practice, despite its short academic pedigree, has increasingly featured in British medical schools over the past 25 years.¹⁻⁶ Vocational training for general practice has a similarly short history: training was regulated by statute only in 1980, and this led to the formal creation of support networks of regional and associate advisers. Responsibility for undergraduate and postgraduate education has remained within two separate organisations, and some people believe that this separation has impeded development of the discipline of general practice.^{7,8} With recommendations for changes in medical education,⁹⁻¹² opportunities existed to test the feasibility of creating an integrated unit which would embrace both undergraduate education and postgraduate training in general practice.

Tayside

The original university department of general practice in Dundee was based in a practice with two core staff, who, in addition to academic duties, had responsibility for 2500 patients. The postgraduate department of general practice operated in parallel with the university department and was responsible for the vocational training scheme and continuing medical education. It had funding for only seven sessions a week, these being shared between a regional adviser and three associated advisers.

Visions of change

In 1990 four strategic decisions were taken.

- The university department would no longer be based in practice but would have links with selected general practices in Tayside. This would result in the university giving up any direct involvement with a

department practice, with the patients in the practice being absorbed into an established NHS practice.

- The clinical academic staff would be affiliated to NHS practices and no longer have responsibility for their own practice.
- The regional adviser and associate advisers would be accommodated in the university department.
- An integrated unit would be formed in which university lecturers, postgraduate advisers, and research and audit staff shared both resources and accommodation.

The integrated unit was to have three broad aims:

- To promote the education of undergraduates, postgraduates, and established principals in practice in Tayside;
- To contribute to service development in Tayside by providing a resource centre for general practitioners and their staff;
- To develop an approach to research and audit in general practice that incorporated all members of the primary care team.

To achieve these aims we have focused on five themes: (a) patient care (range and presentation of disease in general practice), (b) communication (between people and in groups), (c) the organisation (how it manages information and negotiates change and promotes team learning), (d) how to influence and improve professional values, and (e) personal and professional growth (adult learning and regeneration).

Forces helping to bring about change

DESIRE FOR CHANGE; NATIONAL DEVELOPMENTS

Leaders in general practice education recognised that two separate units with similar broad aims in teaching and training was not a model to take general practice in Tayside into the 21st century. The institutions to which the two arms of academic general practice related—the medical school and the postgraduate department—were supportive in principle, although they had some difficulty in grasping the full implications of this major change in the reorganisation of academic general practice.

In addition, the General Medical Council has stimulated changes within Dundee Medical School that will entail much more community based teaching throughout the five years of the undergraduate curriculum (fig 1). Developments in vocational training in the region have responded to national strategies for formative and summative assessment, information management support for practices, and initiatives on audit and research.

MANAGEMENT OF CHANGE

Soon after the inception of the unit priorities were identified, which were tackled by three programme

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FIG 1—General practice in new undergraduate curriculum formulated by General Medical Council

development groups: (a) teaching and assessment; (b) research and audit; and (c) practice development and continuing medical education. Each group has one person responsible for ensuring that all actions necessary for the group's success are undertaken. With the professor of general practice, the regional adviser, and two non-medical staff these programme coordinators form the Finance and General Purposes Group, which is responsible for staffing policy, financial management, and allocation of responsibilities. A steering group that includes representatives from the university, the health board, the medical school, and Tayside Centre for General Practice meets at intervals, mainly to be kept informed of progress and help in negotiating change. Academic accountability for undergraduate teaching is still to the dean of medicine and for postgraduate training to the postgraduate dean (fig 2).

RESOURCES: HUMAN AND FINANCIAL

In Scotland funds to cover the additional cost of teaching had previously been limited to supporting teaching hospitals and affiliated units. The application of such funding for general practice provided much needed money for development. One senior lecturer in general practice and three full time non-medical staff with backgrounds in information management, social science, and administration have been appointed within the past two years. In addition, 24 weekly sessions (undergraduate and postgraduate) have been distributed among 10 general practitioners who are appointed as honorary lecturers or associate advisers, or both, for between two and five sessions weekly.

FIG 2—Management of Tayside Centre for General Practice and its relationship with other bodies

This has included the appointment of three general practitioners who hold shared appointments in undergraduate and postgraduate teaching. General practitioners with sessional commitments in undergraduate and postgraduate teaching are all paid on the consultant scale (pro rata). Some of the funds to cover the additional cost of teaching have been pooled with money provided from postgraduate sources to provide training courses for all members of the primary care team.

The introduction of clinical audit led to the formation of an audit resource group supported by Tayside Health Board that was to be housed in the centre. This group now has four support staff and four facilitators in general practice under the umbrella of the centre's practice development programme (fig 3). This group works in close harmony with researchers in the unit when projects overlap in design and analysis.

FIG 3—Integrated activities of Tayside Centre for General Practice

Forces hindering change

INSTITUTIONAL VALUES

The values and styles of management in large institutions operate within a bureaucracy in which privileges of rank can result in asymmetrical power relationships. Our management style has at times been seen as non-conformist and has been frowned on. This disapproval is probably due to a lack of understanding of what we are trying to achieve. We have not intended to upset people in bringing about changes in direction; our motives have been driven solely by a desire for open rather than closed systems of decision making.

TRAINERS, TUTORS, AND CHANGES IN CURRICULUM

In the past, undergraduate tutors and postgraduate trainers were largely in separate groups. Although these groups occasionally overlapped they tended to have their own identities. Bringing these groups together to think about common aims in teaching and training has taken time but is now central to the region's educational activities.

Challenging a resource driven rather than an educa-

tionally driven undergraduate curriculum has not been easy. Our contribution to the undergraduate programme will increase substantially and will ensure that students receive a better balance of clinical experience in primary and secondary care. Absorbing people into a critical appraisal of strategies for education has highlighted the need to spend time on identifying the needs of students and young doctors and on clarifying the boundaries of responsibilities.

TENSIONS OVER PRIORITIES

In the undergraduate and postgraduate education programmes the pressure has been considerable to establish a timetable rather than think through a curriculum for change which would ensure that teachers and trainers are conversant with the educational aims and required methods of teaching.

One of the main hurdles has been ensuring that groups of people allocate time specifically to meet and plan a programme of development. The new contract does not allow partners in practice to have many gaps in their day to day activities, and despite reimbursement for sessional work, partners of part time staff can be reluctant to give credit to colleagues who are absent from the practice for teaching and training purposes.

Some issues about the amount of core funding from the medical school remain unresolved. Resources are still allocated primarily on the basis of research activity and there are few signs that teaching will be given priority over research.

Key successes

Within the past two years many of our original aims have been achieved and we have been successful in four key areas.

- We have created an integrated approach to developments in teaching and training. Monthly workshops for tutors, trainers, and primary health care professionals are now a regular feature of the centre's activities. We also have a pool of teachers and trainers with common aims.
- We now have an input into the five years of the undergraduate curriculum rather than isolated slots within the course. The option of an attachment for three months to a general practice or community hospital in the fourth year has widened the teaching base and has been welcomed by students. This would not have been possible without a cohesive group of teachers in general practice.
- The formation of an information management and audit resource centre has attracted external funding to provide education and training in practice development, communication systems, and computer assisted records in primary care. This is proving to be an asset for teaching and for training practices.
- Research and development initiatives affect a wide range of staff. Specific successes have been the creation of methods of formative assessment for both students and trainees.

Discussion

When introducing a change of this scale it was important to have a plan which was shared with all the key players; to set achievable targets in terms of staffing and responsibilities; and to review progress regularly and encourage and praise those who had to implement specific changes. Issues relating to leadership, resolving conflict, problem solving, and negotiating roles were also essential to the organisation's growth and development. These were all

important lessons to be learnt in the practical application of the management of change.^{13 14}

Some of our successes in creating support for teaching practices and development initiatives in audit and research could have been achieved without formal integration of activities. New money for teaching and audit developments has been available throughout the United Kingdom, and most university departments of general practice continue to function without any formal links with postgraduate colleagues.

In recent years there has been a growing awareness of the need to consider the integration of the undergraduate and postgraduate arms of academic general practice.^{7 8} We think that the main advantage of our experience has been the lack of duplication of effort in creating alliances with practices that are essential to our teaching programmes. Sharing accommodation, equipment, and support staff has certainly been more cost effective than competing for resources. In addition, practices can relate to one educational centre that caters for their needs in staff development and clinical audit. Developing methods of formative assessment for students and trainees would not have been so readily achieved without an integrated unit. Finally, any academic endeavour needs to have people with a suitable range of skills to develop education and research. Without this, professional development is much more difficult to achieve.

Others considering similar ventures will have to consider their assumptions about power and control, avoid territorial possessiveness, let go of institutional norms that place too much emphasis on hierarchies, and be prepared to offer leadership to people with ideas rather than authority. The hindering forces we encountered are not insurmountable and provide valuable lessons about managing change.

General practice may be starting to recover from the disappointments of the early 1990s; our aim has been to promote and guide change at a pace which will show the advantages of an integrated approach. The external world is changing, and combining resources has provided us with opportunities to retain a firm foothold in academic medicine and move towards a strengthening of general practice education in this region and beyond.

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