Editor's Choice

Solving the problems of practice-based education

Doctors are accustomed to taking on clinically related tasks — including management, organisational redesign, quality improvement and teaching — despite a lack of formal training, funding or protected time.

There is a great tradition in medicine of clinical teaching while providing patient care. Although doctors are encouraged to base practice on evidence, their teaching methods are often simply based on the methods by which they themselves were taught.

There is considerable pressure on general practitioners to provide more medical student education (*MJA* 2007; 187: 124-128) and to take on more general practice trainees (*MJA* 2009; 191: 102-104). Renewed pressure to place interns and postgraduate year (PGY) 1 and 2 trainees in general practices adds to this load.

Currently, academic departments of general practice are small and under-equipped to build teaching capacity in general practice. The high workload of general practice makes it hard to "squeeze teaching in". The GP, who often works alone, lacks the advantage of the hierarchical structure of the teaching hospital, where medical students, interns, PGY1 and 2 trainees, junior and senior registrars and consultants are all available, and appropriately delegated teaching and supervision generally occur.

GP supervisors also lack the ability to assess trainees' progress in the graded manner that is possible in some other specialties. In procedural specialties, trainees' progress toward independent practice is partly assessed by their performance of a specified number of procedures. In contrast, GPs deal with a seemingly infinite variety of patient presentations and, without direct supervision, it is very hard for GP supervisors to be sure that trainees will be able to cope on their own with the next patient who comes through the door.

The Journal recently published on future GP-training models, including the proposal to vertically integrate vocational training with undergraduate education (*MJA* 2011; 194: S97-S100). In this issue, some fundamental concerns are raised. Sturman discusses the tension GPs feel about allowing medical students to play major roles in the care of patients whom the GPs will bill (*page 231*). There is a broader ethical issue too — the possibility that the patient's needs may be marginalised in the teaching context. Wearne lists some problems with the current model of GP training (*page 224*). Of special note is the risk to patient safety when GP supervisors are interrupted in their own work with patients. Interruptions disrupt cognition (memory of the primary task begins to decay when a new task is taken on) and thus may contribute to medical errors (*Qual Saf Health Care* 2010; 19: 304-312).

Our present system is unable to cope with the rapid increase in demand for practice-based medical education. Wearne suggests a new and expensive supervisory model for general practice training but, as she observes, this cost merely "reflects … the true cost of quality supervision in general practice". Both training and time are needed and will require funding. Creative approaches to solving this problem are clearly called for.

Ultimately, it is most important that the placement experience is a positive one for patients, GPs and students. For students, it may otherwise mean they will not choose a career in general practice.

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