

# A primary care-led medical education system?

**T**he primary health care sector is an under-utilised resource for medical education.

The combined forces of ageing demographics, advances in community-based medical treatments for chronic diseases, a commitment to reducing health inequalities, and cost pressures increasingly conspire to push health care into primary care settings. Medical education must mirror this trend—if for no other reason than the practical imperative that medical education needs to occur where the bulk of treatment occurs. The numbers are compelling: four out of five children and adults visit their GP at least once in a 12-month period, and with a mean number of visits being 3.2 this accounts for millions of individual contacts.<sup>1</sup> About one quarter of children and adults use a public hospital service in a 12-month period (counting emergency department use, outpatient, day case and inpatient episodes).<sup>1</sup> Our medical graduates must be prepared to meet the treatment patterns reflected in these numbers.

The shift of medical education into community settings is happening in many countries, and is readily evident in New Zealand with the setting up of rural programmes at both our medical schools, the increasing use of general practice in undergraduate medical education, and government funding support for increased numbers of vocational training places for general practice.

But the barriers to increasing primary care-based medical education are numerous. Not least is the lack of a long-established tradition of widespread, routine, undergraduate medical education in primary care, resulting in weak or absent basic physical infrastructure for teaching, the absence of a well-established pattern of GP registrars teaching undergraduate medical students as occurs in hospitals, and poor career structure for primary care-based teachers. Added to this is the relatively

low level of government support for specialist GP vocational training compared with other specialist training programmes, notwithstanding the strong policy emphasis this decade on New Zealand's 'primary care-led health system'. Then there is the sticky problem of ownership; we need to find mechanisms for government to invest in basic infrastructure for primary care-based education in a way that secures and protects public investment and simultaneously meets the needs of trainers.

A head of steam is rapidly building to see these problems addressed, fuelled by recognition not only of the above issues, but also that the current training system is not especially orientated towards equipping graduates for a career in primary care. This point is well made in a recent report of the Workforce Taskforce:<sup>2</sup>

The traditional model of training doctors and nurses focuses on preparing them to work in hospital environments. This model does not meet the demands of an aging population, the rise in chronic disease and co-morbidities, and the emphasis on treatment in the community.

Primary health care requires a workforce with skills and competencies to implement primary and population health services in the community. Practitioners need to be flexible, contextually responsive, innovative and engaged in a process of life-long learning.

A new and exciting development is the recent establishment of a project by the Universities of Auckland and Otago and the RNZCGP. They have jointly funded the establishment of a National General Practice Clinical Placement Coordination position. The first-year objectives of this project are to:

- coordinate student and registrar placements in general practice settings;

## Peter Crampton

MBChB, PhD, FAFPHM,  
MRNZCGP, Dean and  
Head of Campus,  
University of Otago  
Wellington

## CORRESPONDENCE TO: Peter Crampton

School of Medicine  
and Health Science,  
University of Otago,  
Wellington, PO Box 7343,  
Wellington, New Zealand  
peter.crampton@  
otago.ac.nz

- establish a common database of teaching practices;
- develop and implement a joint communications plan to promote GP teaching;
- initiate liaison with DHBs to link with second-year house surgeon placements; and
- provide project management support for combined University and College policy development.

This project is a coordinated attempt to plan and build basic infrastructure for primary care-based medical education in the hope of meeting the medical needs of New Zealand's population in 20 and 30 years' time. It will require the support of the Ministry of Health and the Tertiary Education Commission to promote and fund some of the vital elements such as quality standards for teaching practices and student consulting rooms.

I am hopeful that the Journal will keep abreast of medical education issues and play an important role in disseminating research papers related to primary care-based teaching and learning. While this editorial has focused on medical education, needless to say similar attention must be paid to the future of primary care-based nursing education. In the meantime, the challenge for the sector is to translate the vision of a primary care-led health system into a primary care-led medical education system. There is much work to be done.

#### References

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2. Workforce Taskforce. Working Together for Better Primary Health Care, Overcoming barriers to workforce change and innovation, Report to the Minister of Health from the Workforce Taskforce. Wellington Workforce Taskforce; 2008.

## Using psychoactive medication to intervene in children's behaviour: An evidence-based practice?

### Barry S Parsonson

MA(Hons),  
PGDipClinPsych, PhD,  
FNZPsS,  
Registered Psychologist,  
Special Education Group,  
Ministry of Education,  
New Zealand

### Introduction

This paper arose out of concern that many child clients with behaviour issues also are clients of paediatric and child and adolescent health services which prescribe medication as a means of behaviour management. In addition, concerns arose over the increasing moves to 'pathologise' children's behaviour. For example, in an editorial preceding a series of research articles on 'preschool pathology', Angold and Egger<sup>1</sup> state 'We can now confidently assert that we have the wherewithal to assess the psychiatric status of children down to age two [years]'. While admitting perfection was not yet attained, they added that, as a consequence, there was no reason to exclude such young children from studies of specific psychiatric disorders. They describe studies of parental, teacher and self assessments of preschoolers which predict subsequent behavioural and emotional disorders at school age without questioning

the validity or reliability of such instruments. Even more troubling is their opinion that if these emergent disorders are not treated by age two to three years, it may be too late to produce effective change via primary prevention interventions. Sterba, Egger, and Angold<sup>2</sup> claim that the rates of DSM-IV disorders<sup>3</sup> in preschoolers are similar to those for children and adolescents and that DSM-IV diagnoses are relevant for children in the two- to five-year-old range, even though the DSM manual itself does not make such provision.

Angold and Egger do not comment on what they consider to be 'primary prevention' for preschoolers, nor do they consider the possibility that predictions made in toddlerhood that then are confirmed in childhood may well be a result of constant environmental factors (e.g. parenting, parental depression or poverty), rather than products of a child's 'psychopathology'.<sup>1</sup> One

### CORRESPONDENCE TO:

Barry Parsonson  
PO Box 829, Napier,  
New Zealand  
drp@appliedpsych.co.nz