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Family Medicine

NARRATIVE ESSAY

Just in One Lifetime

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I have been fortunate in the United Kingdom (UK) to have been part of substantive changes to medical education that favor and utilize family medicine. I was driven to use education as a tool for change by my emerging appreciation of why primary care is essential to good health care and my experience within a system that effectively excluded family medicine from my training as a doctor.

It is worth reflecting on the fact that I could never have been a successful candidate for medical school if I had not been born with a brain protected by good National Health Service care in my mother's difficult pregnancy and had the benefits of vaccination, child health checks, and a good family doctor. Other factors helped too: a loving family with financial and psychological resources, a really good state education, and societal opportunities becoming more equitable for women.

In the 1970s, a typical medical course was 2 years of university science modules and 3 years of combined theory and patient contact, of which only 1 week was in general practice![a] All my teachers were biomedical scientists or hospital clinicians, and the message I got was *primary care does not matter*. There are still many countries that mirror this perspective, where the status of family medicine is low and where it is not even a recognized speciality—despite our hugely complex generalist medical knowledge and skill base.

So how did things change? Some personal stages. I chose to become a general practitioner (GP), finding others with shared values and vision who supported one another in advocacy efforts. I ensured that my practice was committed to training, teaching, and community engagement, believing that family medicine placements during training might change our learners' perceptions through positive and effective learning. My ongoing concern about the lack of adequate primary care input to the medical school curriculum meant that when the local medical school asked for GPs to help with a small but important innovative opportunity, I applied—even though it meant more work!

There were many structural barriers: Curriculum committees included only people with academic contracts; I had gaps in my educational expertise; and historic biases and assumptions about GPs (especially female ones) meant that it was difficult to get my voice heard. So I chose to extend my academic qualifications, which got me onto those curriculum committees!

Effective advocacy also always needs good networks and multiple actors. I worked with others who wanted to see similar changes, and we focussed on key outcomes across the health system and university sectors. These were (and remain) to achieve increased status for and resources into primary care, do more research based in communities and primary care, and develop enhanced training and teaching in primary care settings to encourage people to choose jobs in that sector. I also looked at who was able to have a voice at a national level and found bodies like the Royal College of General Practitioners and the American Academy of Family Physicians. These entities could make arguments at government and university systems levels, and they also know who holds power. I also learned that effective advocacy requires not only evidence, but also the ability to convey this effectively to others. Our voice is heard not only through publications, teaching, and the curriculum for our speciality, but also through stories from practice and through media and political lobbying, which can be used at any level.[b] And a final advocacy learning point: Change happens more swiftly when one set of messages align with another. The emergent emphasis on primary care's crucial importance to effective and efficient health systems pushed political

interest in training primary health care workers; this emphasis remains key to the World Organization of Family Doctors' (WONCA's) interface with the World Health Organization and to our global efforts to achieve worldwide family medicine. This emphasis also meant that universities became expected to emphasise primary care earlier in trainings.

By the end of my career in 2022, UK family medicine had had compulsory postgraduate training for more than 30 years, with general practice now being the basis for about 10% of the curriculum in UK medical schools. In my own medical school, students go to general practice every week for at least half the academic year, and many GPs also teach them on campus, which is linked with a relatively high output into the GP workforce. This structure is the core of the model that WONCA has championed globally: positive exposure to family doctors early on followed by consistent visibility and equivalent status to other specialities. And none of this happened due to my own efforts and commitment alone. As my story shows, change needs enough people with a vision, who work hard over time to create a climate of possibility, as well as use of needs, networks, evidence, communication, and power dynamics across different settings. For me personally, it was a combination of opportunity, choice, effort, persistence, and collaboration by many. I hope you can see the key elements in my story and use them to help your own journeys. Good luck!

FOOTNOTES

[a] General practice is the United Kingdom name for family medicine; general practitioners (GPs) are family doctors.

[b] There are many layers that matter in a health system. I use micro/meso/macro as a framework, that is, the personal and interpersonal, the local clinic/team/health economy, and the national/international/political level. Action for change often needs to occur at different levels.