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[00:00:00] **Cheryl:** Welcome to the podcast from Cambridge University Medical Education Group, or CUMEG for short. This is a podcast from the University of Cambridge Clinical School, focusing on medical education. We discuss a range of topics that medical educators are dealing with. I'm your host, Cheryl France, Head of CUMEG.

Today, we welcome Dr. Richard Darnton, Director of Studies and General Practice at the University of Cambridge. Welcome, Richard. It's wonderful to have you chatting with us today.

[00:00:29] **Richard:** It's great to be here, Cheryl.

[00:00:31] **Cheryl:** So, could you start by telling us some more information about yourself and your role as the Director of Studies and General Practice here at the University of Cambridge Clinical School?

[00:00:41] **Richard:** Yes, sure. So I became a GP, or otherwise known as a family physician in other countries, in 2004. And since then, I've been spending half of my week working in medical education. In those sessions, I've been teaching medical students over the years from universities of Leeds, then Sheffield, and then more recently Cambridge.

I've also been quite heavily involved in postgraduate GP training and that means taking doctors and turning them into fully qualified GPs. I'm also an examiner for the Royal College of GPs and I was an Associate Dean at the East of England GP school. So that's kind of my background.

[00:01:27] **Cheryl:** Quite busy then.

[00:01:29] **Richard:** I guess so, yes, and it has been, it has been wonderful. I love General Practice in the UK and I also have loved spending half of my week in medical education, really, throughout my whole career. But now I'm responsible for a large section of the medical course at Cambridge, and that's basically everything that is taught in primary care.

And strategically, that's a really important role because it provides vital teaching capacity for the medical school, and it also supports medical students choosing general practice as a future career.

[00:02:04] **Cheryl:** Okay. Oh, so that's quite interesting. So quite a lot then if you're the whole of the GP curriculum and how that training happens, that's quite a vast amount to be covering.

[00:02:15] **Richard:** Yes, absolutely.

[00:02:17] **Cheryl:** Excellent. So in the UK, general practitioners or GPs play a vital part of the healthcare system. Although this isn't the case in other countries. So I think it might be worth, if you don't mind, starting out by telling our listeners a little bit more about the role of GPs and why that's important.

[00:02:36] **Richard:** So yeah, sure. I mean, a general practitioner is called a family physician in other countries and we are essentially primary care doctors. In the UK, most primary care occurs within the NHS, which is our national free at the point of care health service. Now, the World Health Organization defines five core functions of primary care, and those are: first contact accessibility, continuity, comprehensiveness, coordination, and being people centered.

And that all sounds quite a hefty remit really and it's interesting because the World Health Organization Declaration of Astana in 2018 says we are convinced that strengthening primary health care is the most inclusive and effective and efficient approach to enhancing people's physical and mental health.

So yes, it's a big remit, but internationally it's recognized that primary care is really the jewel in the crown for a health service when it comes to making a difference to people's health.

[00:03:53] **Cheryl:** Yeah, that's really interesting. I appreciate those points because that There's five core points. It's quite a lot there.

 So a patient going to see a general practitioner, there's a lot that they need to, to kind of think about to encompass that holistic care model, but it's also really important. And I can see why the World Health Organization has said that's vital to have that core point of contact for healthcare for an individual.

[00:04:21] **Richard:** Yes, absolutely. And what's really interesting is that, not only is it vital, but it's actually incredibly efficient. You know, that statement says that they believe it is the most efficient approach to enhancing people's physical and mental health. And, you know, if you think about the UK, in the UK, 90% of health contacts in the NHS occur in primary care.

[00:04:48] **Cheryl:** 90%?

[00:04:49] **Richard:** 90% of contacts. Makes sense. With patients. Yeah. But guess what proportion of the NHS budget is spent on primary care?

[00:05:00] **Cheryl:** Tiny. It's not the biggest budget at all.

[00:05:04] **Richard:** Yeah, it's, it's less than 10% of the NHS budget. And actually for the 21/22, it was 8% of the NHS budget spent on primary care.

[00:05:12] **Cheryl:** Wow.

[00:05:13] **Richard:** And yet we undertake 90% of the NHS's patient contacts.

So that's incredibly efficient, isn't it?

[00:05:22] **Cheryl:** It is. It absolutely is. And it will keep people out of hospital. I think that's one of the key points is that it does keep people away from having to go to a hospital setting. But equally it gatekeeps to get those people into the right care.

[00:05:38] **Richard:** Yeah, and the right people in the right care is really important because if you think about the fact that 90% of healthcare contacts are occurring in primary care on 8% of the NHS budget.

Well, if some of that 90% of contacts shifts into secondary care when it shouldn't, just imagine what that does to the NHS budget.

[00:05:59] **Cheryl:** Absolutely.

[00:06:00] **Richard:** So effectively, if primary care falls over, then the whole of the National Health Service in the UK falls over. But at the same time, it's not just about efficiency, Cheryl, okay?

[00:06:10] **Cheryl:** I'm pleased to hear this.

[00:06:12] **Richard:** There's a huge body of evidence for how effective primary care is. I mean, just that one of those principles we said from the five functions of primary care, the World Health Organization said, One of them was continuity, and there's masses, masses of evidence for the medical benefits of continuity.

Similarly, patient centered care, there's loads of evidence that patient centeredness has real concrete benefits in terms of medical outcomes. And then you've got the fact, you know, comprehensiveness was one of the other five points they mentioned. So, you know, patients come with a problem that spans multiple body systems. It has biological and psychological and social elements that can involve multiple interacting medical conditions and medications. You know, they need a doctor who is an expert in integrative thinking and problem solving.

[00:07:07] **Cheryl:** Absolutely. And I think that's really important to highlight as well, particularly when you think about complex cases, the elderly, when you've, as you talked about various medical conditions and coming together all at once and having that hold of what medications are being given at the same time and how can we think about this from a patient-centered care.

 So that, that's really important to highlight, so thank you.

[00:07:32] **Richard:** Yeah, and what's really interesting about being a generalist, we call, often call ourselves expert generalists, where you have to integrate lots of different guidelines and conditions within a patient problem is we will often get times where, the guidelines for one condition that a patient has conflict with the guidelines for another condition that a patient has. And at the same time their medications might interact in an unhelpful way as well. And then you've got to think about their social context and how it all fits within that. So, and that is one of the things I love about general practice. It's this skill of integrating everything that you've learnt at medical school and applying it to a patient rather than a single condition.

[00:08:19] **Cheryl:** So I think that's really helpful to understand. So it is quite complex. It's not just a, Hey, how you doing? You've got a cough, take some cough medicine. It's very complex in terms of the role of a GP. And I think you've explained that really well. So thank you for that.

I think moving on from that, how do we think about educating our medical students? You know, we often hear about medical students in hospitals and going around to see all the complex cases in a hospital. How does it work in terms of students having placements in GP surgeries and, and you know, getting to understand these complex conditions and knowing how to treat patients. Can you tell us more about how the placements work?

[00:09:07] **Richard:** Absolutely, I'd love to, yes, as it is my core business really. So clinical placements are, as you know, the part of a medical course where students are doing work based learning, normally at a healthcare facility of some sort. And universities vary in terms of the proportion of these placements that are based in a primary care centre, rather than a hospital.

At the last count, for example, Cambridge was in the top fifth of UK medical schools in terms of how much of the placements take place in primary care.

[00:09:44] **Cheryl:** Wow, okay.

[00:09:45] **Richard:** Compared to being in secondary care.

[00:09:46] **Cheryl:** Yeah. No, that's quite high, isn't it?

[00:09:47] **Richard:** So, yeah. Okay. It is. And, and also a fifth is a really good number to remember because not only. Are we in the top fifth in terms of how much time students spend in primary care? But students basically undertake a fifth of their placements on the Cambridge course in primary care.

[00:10:05] **Cheryl:** Okay. Oh, that's quite good. And is that in one primary care facility, or how does that work?

[00:10:11] **Richard:** Yeah, well, it's a really good question.

I mean, basically, this is no small task. It means that the team and I oversee about 3,000 GP placements per year.

[00:10:23] **Cheryl:** Oh, that is a lot.

[00:10:19] **Richard:** Yeah, and we've basically got 183 highly motivated primary care centers with physicians who are excellent supervisors and teachers and they are distributed across the whole of the East of England.

Students go to these primary care centers for anything up to six weeks at a time and they become part of the team and that carries many benefits in terms of sort of learning from the rest of the team, but also being known by the rest of the team. They're not just somebody who comes and goes. They know the people around them and they become known and they also get to sit in the hot seat, basically. And that's where the power of a GP learning placement really takes place when you have a student sitting in the doctor's seat, effectively running their own clinics with patients. Obviously with support, but, you know, we're into high challenge and high support. And our students tell us that there's nothing quite like sitting in the hot seat, in a clinic room, running your own surgeries. Which is the UK word for clinics. So high challenge, high support, but we get really, really good feedback from the students.

They tell us that they love their GP placements. They say things like, this is where I got to see the most patients. This is where I got to feel really useful, like I was doing something useful. This is where I got to really learn how to put everything together. This is where I had to learn about constructing management plans, not just diagnosing, but also Where am I going to go with this now that I've made a diagnosis?

And of course, the whole way that our placements are designed in primary care is that, you know, it's small ratios. So you've got one GP supervising one or two students doing a surgery, doing a clinic. And so they get really close supervision and support. So like I say, high challenge, high challenge, but good support, and it really works.

And it's no accident that this works. Because the way we've designed the teaching at Cambridge is we've designed it... And quality assured it and funded it to achieve these sorts of outcomes. You know, it doesn't happen by accident. You've got to have the right policies, procedures, quality assurance and overall design in place if you want it to be an excellent learning experience.

And it truly is an excellent learning experience. And that's what our students are telling us.

[00:13:03] **Cheryl:** Yeah, and I think that's really important. I think it was good to highlight that there's a lot of things that happen behind the scenes to get them in the hot seat as it were but wonderful for them to, as you say, put everything together because we have had previous podcasts where we've talked about, you know, how does it work for practical procedures? How do you, you know, clinical reasoning, these sorts of things that we've had in previous podcasts. And I think it's really important to say, well, actually, when that student is in the hot seat, all of those things have to come together to think about it.

And I thought it was really interesting what you also said about once you've just diagnosed a patient, it doesn't typically end there. So there's a management plan. What does that mean? How do you put something like that together? Because the relationship with the GP is far more than just a, Hey, I'm here for five minutes, bye.

[00:13:58] **Richard:** Yeah, absolutely. And that management plan has to again, take into account all sorts of multiple factors that, that the student has to integrate as well, including their social circumstances, but also whether or not that this plan is acceptable to the patient. So yeah. And going back to what you said about putting everything together, that is one of the key skills that our medical students need to learn.

And what's interesting is that academia is arguably often quite reductive, whereas our students need to learn at this stage not to be reductive but actually building everything together and looking at things across the board.

[00:14:44] **Cheryl:** Yeah, absolutely. So can I just clarify what your groups are going to the primary care facilities? Because I think that's quite important too. You don't throw them out in year one and say, here you go for a week. Here at Cambridge have a six year course.

So perhaps you could kind of elaborate on what your groups would be in the GP surgeries.

[00:15:03] **Richard:** Yeah, that's a really good question. The structure of the Cambridge course is that most of the hands on contact with patients happens in the last three years of the six year course. However, in the first year, students do spend some time with patients, just kind of having the experience of talking to a patient.

But really where the rubber truly hits the road is in year four. Then very quickly. I mean, we get them sitting in the hot seats almost from day one and they very quickly go into taking histories from patients, having their own surgeries, then starting to be able to build in a bit of the management plan themselves.

And then eventually they have a six week placement in a general practice in their final year where they really are embedded and they can be really quite useful for the practices where they're based.

[00:15:54] **Cheryl:** I bet. And I thought that was great too, where you were saying about the six week placement and how important that is because the staff know them just as well.

And as you say, they can become really useful. So thank you. That's really helpful to gain a better understanding of how it works for our students as well and how others could consider using this sort of model and what works and why it works. So thank you for that. That's really helpful.

I'm going to kind of ask you a slightly different question now. You know, in the news we hear that GPs are under enormous pressure, so this is due to staff shortages and the increase of patient numbers. So do you think that this is something that will be alleviated by encouraging more students into general practice and can help that pressure that's currently there?

[00:16:44] **Richard:** Yeah, that's a really good question, Cheryl. General practice, as you say, is under extreme pressure in the UK and the number of full time equivalent GPs per head of population has been falling at the same time demand has been rising. So, GPs being the first point of open access in the health system are exposed to the full force of this demand.

We do need to stem the tide of GPs leaving the profession. Obviously, but yes, we do also, like you say, need to encourage more medical students to choose a career in general practice if we want to really address this issue. And large amounts of high quality general practice experience in the curriculum are thought to make students more likely to choose a GP career.

Now it's easy for me to say that. However, that is no small task. You need to have the GP practices there to take the students. And our research, published recently in BJGP Open, has shown a number of threats to practices continuing to take students in primary care. And that's because you need to give practices money, to free GPs up, give them time to, to teach.

But you need to have space in those practices. You need to have consulting rooms that those students can use for their clinics. And you need to have enough GPs in those practices who can teach. Now, we have been addressing some of those issues. I, for example, co-led the negotiations in England that put primary care placements on the same funding footing as secondary care placements, because in the past, primary care placements were not funded as well as secondary care placements.

So we've, you know, we've helped address the money issue. But at the same time, inflation's been roaring in the UK and so at the moment that inflation has eaten into our funds that we have available to pay practices to teach.

I also mentioned space was another threat that we identified in our research. And primary care premises in the UK, at the moment, have been deprived of building upgrades and extensions for many years, which means they are now incredibly short of physical space in which they can put our students and consulting rooms for those students to use. And then I said that you need to have enough GPs in those practices who can actually teach the students.

And there is an aging educator workforce, unfortunately, in primary care and also in other sectors of their health service. So we need to be really thinking about how can we make sure that we still have sufficient numbers of doctors who are trained to be educators on all our placements and especially in primary care.

So there's quite a lot of factors that need addressing. You know, I've just mentioned money, space and staff to supervise these students and teach them. All of those factors and more need addressing so that we can continue to do what we do, putting students into GP practices and giving them a great learning experience.

In addition, our research on medical student career choice has shown that career opportunities in academic general practice are also needed to attract our research oriented students into a GP career.

[00:20:14] **Cheryl:** That's interesting. Yeah, so there's lots of factors that play into this.

[00:20:19] **Richard:** Yeah, absolutely. And what's really interesting is that primary care holds the key to many things in terms of the future of the NHS.

For example, you could argue it also holds the key to expanding medical student places in the UK.

[00:20:36] **Cheryl:** Yes, which is a hot topic at the moment.

[00:20:37] **Richard:** Yeah, it really is. As you know, we are short of doctors in the UK and we need to train an awful lot more medical students to have the number of doctors that we need but what's interesting about that is that is clinical placements are the building blocks of any medical course.

[00:20:56] **Cheryl:** absolutely,

[00:20:57] **Richard:** If you don't have enough clinical placements it doesn't matter if you take more medical students, you've not got anywhere to put those students to learn the hands on important business of medicine. Now, the issue that we have in the UK when we're thinking about doubling medical student numbers is that hospitals are absolutely rammed with medical students.

There is not a lot of space left for extra clinical placements in hospitals in the UK, I would argue. But, primary care could actually hold the key. Because although the practices that currently take medical students in primary care, although they're full of students, Only a third of primary care practices take medical students.

[00:21:42] **Cheryl:** Okay, that was going to be one of my questions, so that's interesting. So only a third take medical students, so there is an opportunity to increase that. Providing that we put all those other points that you mentioned previously in place. The training, the money, the capacity.

[00:21:56] **Richard:** Yeah, exactly. So hospitals, really most hospitals take medical students, but yeah, two thirds of practices, you know, roughly speaking don't.

And if we put all the right things in place, maybe that could be the way that we could get those extra clinical placements that are going to enable us to train more doctors of the future.

[00:22:20] **Cheryl:** Okay. Oh, that's quite interesting. Thank you. That's really helpful to understand and could help fill those gaps of the retiring population, as it were in the GP surgeries.

[00:22:32] **Richard:** Yeah, absolutely. But it, as I said before, is no small task, but that's not a task that daunts us. I mean, I'm used to helping medical schools think about using primary care to support expansion. You know, during my time at Cambridge, we've increased our student numbers by 50% and I had to lead a large growth in primary care teaching capacity here.

This required me and my team to divide and implement a whole host of new systems, processes, and policies to support that growth. And having drafted the National Guidance on the Organization and Funding of Medical Student Teaching, you know, I often provide advice to medical schools on matters relating to organizing and financing their primary care teaching.

So I'm not daunted by that task, but it is a task that requires experience and an understanding of this specialist territory in primary care. And to be fair, across the globe, I think primary care is an underused context for medical student teaching. I mean, it's an excellent context for teaching; for the reasons that we discussed earlier. And I am convinced that with the right development work, and the right funding, and the right organisation, then teaching medical students in primary care centres can be a solution, not just for the UK, but for many countries who are looking to expand their medical student teaching capacity.

[00:23:56] **Cheryl:** Yeah, I would agree. I would agree. And I think it is an underused resource and I'm glad you mentioned the fact that this was increased here in Cambridge and we increased our numbers because it was a big task; and it's something that made a big difference here in Cambridge. So I think it's important to highlight that, that it can be done.

And there are ways in which you do it, which you've mentioned already, which I think is really helpful to understand it's not just, Oh, just go ask somebody. It'll be fine. There's a lot to it.

[00:24:24] **Richard:** Yeah, it can be done, but I must emphasize that you can't just think, great, let's just send a load of students to these primary care centers that have never had students before and hope for the best.

You've got to have the correct resourcing to free up those primary care doctors to do some teaching. And you've got to have all the policies, systems and quality assurance processes in place as well.

[00:24:46] **Cheryl:** Yeah, that is vital. So thank you for highlighting that again. And I think it's important to recognize too that.

The teaching is not just putting the student in the hot seat, there's this watching first, discussing the cases, then going on and showing, now that you've got that diagnosis, how do we do the management plan? So there is a lot to it, and I think that's really important to highlight that, so thank you for that. Really useful.

So during the pandemic, and since then, I know that you've conducted some research on remote consultation. Do you want to share some of the findings and your thoughts about remote consultations within the GP setting?

[00:25:24] **Richard:** Yes, absolutely. I mean, this happened quite organically due to the COVID-19 pandemic.

As you know, when the pandemic started, all medical students in the UK were pulled out of clinical placements, metaphorically speaking, and sent home. And so we were the first medical school in the UK, to our knowledge, to have medical students based at home consulting remotely with patients who were also based in their home and they were supervised by GPs who were based in a primary care centre at a separate location.

So three different people in three different locations all coming together online to do a video consultation. And we evaluated that using qualitative methods and we found that it was acceptable and feasible. And we also learned a lot about the practical issues surrounding making that happen. So that was really interesting.

There was a really useful research paper that came out of that when we wrote that up called *Medical Students Consulting from Home*. And that paper has been widely cited and has changed attitudes across the UK about whether or not it is acceptable for medical students to consult from home. In the past that was thought not to be acceptable, but this work that we did showed that it was acceptable and feasible and we've had people writing to us multiple times since then saying thank you so much for writing this up. I find this paper really useful for showing to people to say actually this can be done and it can be done safely and it can be done well with the right safeguards in place. And now we do this in our university too. And what was really interesting was that for us once students went back into placements; it was still a useful tool for us to have a student being able to consult from home because we would still have some students that needed to isolate occasionally.

[00:27:32] **Cheryl:** Yes.

[00:27:33] **Richard:** And, and in the past, if a student missed a clinical placement, they would have to make that up some other time.

Whereas we didn't need to have so many of these catch up placements for students who'd been ill or absent because actually many students were able to still have clinical placement experience while they were isolating from home because they were consulting with patients from the student's own home remotely.

[00:28:00] **Cheryl:** Yes, I bet that was a big benefit because it was a long time where a lot of people were just isolating because they may have been exposed. so, they're fine and to have the opportunity to still be present as it were in terms of online. That's quite useful.

[00:28:15] **Richard:** Yes, absolutely. That was the first part of the journey as it were with remote consulting and medical education for us; but then students went back onto clinical placements again towards, you know, later on in 2020.

And then the concern was, well, we've got students back in primary care centers, but you know, it's November 2020; there's still a lot of COVID around. GPs are still doing a huge proportion of their consultations remotely. Yes. So when we're sending these students out to primary care centres across the east of England in November 2020, and they're based in the primary care centres now, but their experience is very, very different from what would have happened before the pandemic.

There's a huge body of evidence that has evaluated what it's like learning medicine in primary care, but that all happened before the pandemic. So what's it like learning medicine in primary care now, that, you know, it's November, 2020 and a huge proportion of consultations are occurring remotely. So we had students, you know, in a consulting room on the telephone or doing video consultations for a lot of their time. They still got a bit of face to face, don't get me wrong. But there was a lot of remote that they were doing from a health centre. So then we thought, okay, we need to look at what that change means for the educational value of learning medicine primary care.

And we expected students to say, Yeah, being on this placement in this primary care centre is good and everything, but we really don't like doing remote consultations from the health care centre. We want to be doing more face to face. And of course they wanted to be doing more face to face consulting, but that wasn't an option really.

They were doing some, but couldn't do as much as we would have liked. And we were expecting them to say that they really didn't like doing remote consultations and thought that they were a bad idea educationally. And indeed, students from other universities have been writing into medical journals saying we are worried that we are going to miss out on our education because we're doing lots of remote consulting but no face to face consulting.

So students have been writing those sort of letters to medical journals but, so we thought maybe our students would be having the same sort of worries. What was really interesting was that actually when we spoke to them and we did a full sort of qualitative evaluation, talking to the students on this placement and the educators, and they said, actually no, remote consulting has got some specific benefits and we really appreciate those.

So that was the next step in our journey. And then the third stage in our journey was later on when the pandemic was starting to recede and we wanted to know, okay, a lot more face to face consulting is happening in primary care. There's still significant amounts of remote consulting happening in primary care.

How much remote consulting are our students doing now? And indeed. If medical students consulting from home was a useful tool during the pandemic, to what extent is that tool being used now that the pandemic is receding? And more than that, what are the challenges that our practices are facing? Is remote consulting one of the challenges that they feel is making it difficult to teach or are there other challenges? And similarly, how do our supervisors in practices feel about supervising medical students, consulting from home? And how might we understand some of the barriers and facilitators to that happening? So we surveyed all our teaching practices just over a year ago.

And we had a fantastic 96% response rate, got an amazing data set showing us how much remote consulting still occurred with our students and how variable that was from one practice to another and what our supervisors attitudes were towards medical students consulting from home. And also what some of the facilitators and barriers were to teaching medical students in primary care now that we're just coming out of the pandemic.

And that has generated some really useful papers and some really useful information. So I think that is now telling us about how we can really support practices to carry on taking medical students. And it's telling us about some of the factors that may affect the wider adoption of medical students consulting from home.

So it's been a really interesting journey. You know, there's lots in the medical literature about remote consulting, but there's not so much in the medical literature about student involvement in remote consulting. And it has just been great to explore that second element. And I think we've come up with some really useful learning points that people can benefit from.

[00:33:15] **Cheryl:** Yeah, that is really interesting; and you're right there. The literature won't have as much about students learning from remote consultations. And I think it's great that you've captured that at a time when everything else was kind of chaotic and crazy. And it sounds like your results were fantastic in terms of getting that information back. So it's something that we should definitely look at. And we will add that to the podcast information so that people can look at those papers.

[00:33:42] **Richard:** Yes, thank you. And I guess just to add that what I haven't really said much about in relation to remote consulting here is this this is the idea of video consulting.

Now obviously I told you that when we have students consulting from home, video consulting makes that really easy, because it's easy to have people in three different places all meeting in a video room, for want of a better word. But we believe that video consultations could be a real game changer in medical education.

Now, what's really interesting is video consultations haven't really caught on much in the UK, particularly in primary care. I mean, there is a really interesting paper in the *British Journal of General Practice* from a couple of years ago called, *Why do GPs Rarely do Video Consultations?* And they found that GPs perceive that video consultations add extra complexity, but it's not worth it in terms of the extra benefit that they think can be brought to bear.

Now that's obviously just the view of the people that were interviewed in that study. Basically, they felt there wasn't sufficient added clinical benefit to justify the added complexity. But we wrote a response, we wrote an editorial in the *British Journal of General Practice* saying, actually, you may not feel that video consultations confer extra benefits in terms of clinical care, but we believe they confer extra benefits in terms of clinical education.

[00:35:06] **Cheryl:** And, you know, what about the patient? For a lot of patients, it's much easier than having to go into a GP surgery that they may not have transport or other issues. So yes, there's all sorts of conditions that should be looked at.

[00:35:21] **Richard:** Yeah. And interestingly where video consulting is used in the UK is actually in sort of the Highlands of Scotland, which is a remote area of the UK and where particular, there's a really interesting paper, showing that out of hours care is in video consultations are really useful because if you're going to bring a patient down to your health care centre in the middle of the night because they phoned up with some problem; well having a video consultation might prevent that from having to occur and they may not have to travel that large distance So where there are large distances involved video consultations are occurring. But we think that they could also occur where we want to have specific educational benefits and there are huge benefits that could be leveraged from video consulting.

I mean, we mentioned medical students consulting from home, but you've also got the fact that it makes it really easy to record consultations which you then can then play back for educational purposes and you can drop into consultations on the other side of the world and you can do all sorts of things and access all sorts of populations and you can prevent students from travelling, having to travel and also if you've not got enough space in your surgery then consulting from home really helps with that.

So, could be a real game changer.

[00:36:35] **Cheryl:** Absolutely.

[00:36:36] **Richard:** And still to be fully leveraged. And you can look at the stats for clinical care and there are, NHS Digital has statistics for every month where you can see what proportion of consultations occurred via video, telephone, and face to face. And you'll see that video is just negligible.

So watch this space.

[00:36:57] **Cheryl:** Interesting. That's really interesting. Thank you for that. Fabulous. Thank you. It's been so interesting talking to you today. We've talked about quite a wide range of aspects in terms of general practice and, and educating our students and, and how that could work. Do you have any top tips or top things from today's podcast that you'd like listeners to take away?

[00:37:21] **Richard:** Yes, absolutely. I mean, I think the first thing that I would want our listeners to take away is that general practice, otherwise known as family medicine, is essential to the future of medical education, especially for those health systems looking to accommodate greater numbers of medical students.

I think the second thing I'd like our listeners to take away is that, firstly, that general practice, otherwise known as family medicine, is essential to the future of medical education, especially for those health systems looking to accommodate greater numbers of medical students. Secondly, that teaching medical students within a primary care context needs to be properly organized with suitable underpinning policies, procedures, and quality assurance. Needs to be properly resourced to free GPs up to teach, and you need to have sufficient space so that students can do their own clinics.

Thirdly, the remote consulting should be included in medical education. Apart from the fact that students will need to be able to do this when they're doctors, it has specific affordances for learning. As I say, you can find out a bit more about that from our papers. In particular, although video consultations are not widely used in general practice, we think they could be a game changer from a medical education point of view.

Not least because they enable medical students to consult from home. And that could help overcome lack of space in health centers.

[00:38:54] **Cheryl:** Excellent, thank you. That was a great summary of everything we've talked about today. Dr. Richard Darnton, I cannot thank you enough for today's podcast. It's been really wonderful to talk to you today.

[00:39:05] **Richard:** It's been great to be here. Thanks for having me, Cheryl.

[00:39:07] **Cheryl:** Thanks again. Really appreciate your time.

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