Discourse analysis of general practice in medical education: a comparative study of undergraduate medical education policy in the UK and Brazil.

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‘I, Vitor Hugo Lima Barreto, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.'

CAREER SUMMARY

I qualified as a doctor in 2005 at the Federal University of Pernambuco (UFPE - founded in 1915), Brazil. I completed my training in family and community medicine at the same university in 2008. I was part of the first group of trainees in this field of medicine at UFPE. I hold a Master´s Degree in Medical & Health Education Sciences at the CEDESS-UNIFESP, one of two medical education research centres in Brazil (2010-2012). I am the first assistant professor with family medicine training in the Department of Social Medicine of the UFPE. I have worked as a family and community doctor at the city of Recife since 2008. I trained as a psychotherapist and psychoanalyst member of the Psychoanalytic Circle of Pernambuco, from 2010-2013 and continued this process in the Institute of Psychoanalysis – British Psychoanalytic Society. My research experience is in medical education, especially qualitative methods, and psychoanalytic case studies. I have published articles in the Brazilian Journal of Medical Education (RBEM) and also in an international periodical. My Master's dissertation on clinical tutor's perspectives of clinical teaching has been published as a book in 2017 by the UFPE.

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Many institutions have been involved in this endeavour. The Brazilian National Committee for the Development of Scientific Research (CNPq) offered full funding of the research and the PhD programme. Prof. Heloísa Mendonça, my CNPq tutor, supported my stay in the United Kingdom for the duration of the programme. The Federal University of Pernambuco granted me four years' paid leave from my position of assistant professor and further leave for the completion of the programme. This leave was approved by the department of social medicine under the leadership of Prof. Albanita Gomes and Prof. Petrônio Martelli. The Health Department of the city of Recife, under the leadership of Dr Jailson Correa, granted me leave from my

position of family doctor at the health unit of Sítio Wanderley. During the five years of this research, I have felt strongly for the small parcel of the extremely poor population of Recife to whom I was not able to offer my health care services. I promised myself I would go back to clinical practice to offer them what I have learned and developed professionally, especially in the current context of Brazil's political, social and economic turmoil. A time in which historically constructed human rights, like universal education and health care, are constantly under threat.

Completing this thesis while living in a different city, country, culture and academic environment has been a challenge. The initial solitude that helped me dedicate all my energy to this project gradually became one of my difficulties. I am grateful for the support of family and friends who have maintained my motivation through their encouragement and company. This includes my wife, Lara, my first son, Bernardo (born in 2016) and the little one who is about to come. Lara helped by reading drafts and providing a reader's stance in my own mind. My mother, Eleonora Lima, supported me in the hardest of times and kept things organized and going back home. My father, Emanuel Barreto, inspired me through his dedication to the health care in the countryside of Brazil. My mother and father in law, Angela and Perícles, offered a safe haven for my little Bernardo during the time when I needed to be 100% dedicated to the thesis. Titi Eliane who always kept me believing it was possible. My special friends Era, Michel, Ana, Rayanne, Diloa, and little Flora became my family in London and kept me alive and comforted during weekends. Prof Rosine Perelberg, my psychoanalyst throughout this journey, helped me find the emotional balance to undertake this and other challenges.

ABSTRACT

Introduction: Despite increasing research on medical education, the field of medical education policy, including general practice teaching, has been overlooked. Discourse analysis has recently been introduced to investigate education policy in medical education. This research analyses general practice development in undergraduate medical education policy in both the UK and Brazil. In the UK, general practice is consolidated as an academic field of medical knowledge, whilst in Brazil, it is being established. The historical context of the specialty in each country and the participation of general practitioners in medical schools are considered. Two main dimensions of medical education are emphasized: the alignment with health care systems and the outlook for medical care workforce. The aim of this research was to depict the discursive continuities and discontinuities characterizing general practice knowledge in undergraduate medical education policy in two distinctive contexts.

Method: Foucauldian discourse analysis was used to investigate the representation of general practice as a field of medical knowledge in undergraduate medical education policy in a comparative study design. This research method offers a critical perspective of power relations in policy documents by exploring what is made thinkable and legitimate. It supports the analysis of the assumptions of truth that delineate the frontiers of general practice.

Results: General practice knowledge holds a discursively fragile position in both countries, a consequence of the differences in discursive polarities. The polarities consisted of (a) academic and non-academic knowledge and (b) specialist and non-specialist knowledge in the UK; and (a) public and private health care and (b) generalist and specialist knowledge in Brazil. The similarities included a close relationship between medical education and

national health systems. In the UK, the biomedical discourse directs the portrayal of general practice, whereas in Brazil, the counter-discursive element opposed to this biomedical discourse predominates.

Conclusion: The predominant discourses in medical education policy places general practice knowledge in a fragile position compared to other medical fields. A policy focused on the reflexive cycle between academy and practice and between general and specific knowledge could help strengthen general practice knowledge in undergraduate medical education. This could produce stronger, more stable and authoritative thinking in this area of medical science.

IMPACT STATEMENT

According to the discourse analysis conducted in this research, general practice holds a fragile position in medical education policy, which has traditionally assigned greater value to academic and specialized knowledge. However, its close association with public health systems and universal care has, at critical moments in recent history, served to strengthen its presence in policy documents.

This thesis provides a detailed and critical account of a particular approach to discourse analysis, rooted in the ideas of French social theorist Michel Foucault, as it applies to general practice knowledge. The value of the approach to the current research lies in its critical analytical perspective and its consideration of the historical, contextual and power dimensions of discourse. Foucauldian discourse analysis could be used to explore other questions in medical education research, for example relating to academic curricula, research literature, student textual assignments and communication and teacher and student feedback.

An important potential impact of this research is in the area of public policy design. Policymakers are likely to gain a more critical perspective of policy discourse by understanding the possible presence of contradictions and paradoxes in policy text. Also, the ahistorical nature and lack of formal conceptualization of terms in policy documents could be improved through better social contextualization and bibliographic references to concepts and ideas. An awareness of discourses that are repeated throughout time but not

truly incorporated into medical education (known in the literature as “discursive carousels” and “appropriation by diffusion”) could help develop specific measures to promote more efficient policy implementation.

With regards to policy on general practice as a medical discipline, the institutions representing general practice knowledge should be able to reflect upon their differing levels of participation in policy production over time and the characteristics of this contribution. Armed with this insight, they should aim to strengthen the position held by general practice in medical education policy.

The thesis will also help academic departments and medical school staff associated with general practice teaching reflect on how the portrayal of the discipline in policy documents has impacted upon the development of the medical undergraduate curriculum. Clinical tutors in primary care might also consider how their teaching experience relates to the findings of this research. If the position held by general practice in policy reflects an equally fragile discursive status (in the medical curriculum and in clinical teaching), the development of a discourse that regards general practice as a valued medical field of knowledge could have positive implications in these areas too.

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LIST OF ACRONYMS

ABEM	Associação Brasileira de Educação Médica (Brazilian Medical Education Association)
AMB	Associação Médica do Brasil (Brazilian Medical Association)
BIREME	Brazilian Regional Library of Medicine
BMA	British Medical Association
CFM	Conselho Federal de Medicina (Brazilian Federal Medical Council)
CINAEM	Comissão Interinstitucional Nacional de Avaliação do Ensino Médico (National Inter-institutional Committee for the Assessment of Medical Teaching)
DCN	Diretrizes Curriculares Nacionais (National Guidelines for the Medical Curriculum)
EURACT	European Academy of Teachers in General Practice
GMC	General Medical Council
NHS	National Health Service
PAHO	Pan-American Health Organization
PMM	*Programa Mais Médicos* policy
PSF	Programa de Saúde da Família (Family Health Program)
RBME	Recommendations of Basic Medical Education
RCGP	Royal College of General Practitioners
SBMFC	Socieade Brasileira de Medicina de Família e Comunidade (Brazilian Society of Family and Community Medicine)
STFM	Society of Teachers of Family Medicine
SUS	Sistema Único de Saúde (Brazilian National Health System)
UFPE	Universidade Federal de Pernambuco (Federal University of Pernambuco)
TD	Tomorrow's Doctors
TR	Todd Report
UK	United Kingdom
USA	United States of America
WHO	World Health Organization
WONCA	World Organization of Family Doctors

1 INTRODUCTION

This study is a documentary research project using a comparative design to analyse policy documents from two countries: one where general practice is consolidated in medical education (UK) and another where it is in the process of consolidation (Brazil). It considers the development of general practice in undergraduate medical education policy, taking particular account of the different histories of the specialty in both countries and the varying degrees of participation of general practitioners within medical schools. Two main dimensions of medical education are emphasized: the alignment with health care delivery systems; and the impact on the medical care workforce. This research has important implications for medical education policy, teaching practice and curriculum design as it makes visible the power relations between general practice and other fields of medicine within medical education context through the use of a Foucauldian (based on the writing of Michel Foucault) discourse analysis. It adds another dimension of understanding to the complex issues surrounding the crisis of general practice recruitment in both countries, which has been the focus of medical education research on general practice teaching.

In this study, I am considering general practice knowledge as everything that depicts general practice as a distinct field of the medical sciences, including its theoretical and practical understanding. This includes facts, information and skills acquired through experience or education. In the UK, general practice is a consolidated medical field in undergraduate schools (i.e. with established academic departments in all medical schools, large numbers of teachers in medical schools, all schools offering placements in the

field, considerable research in the area). In Brazil, the role of family and community medicine is still being established, as depicted later in this chapter. Despite the different terminology used in these countries, both fields of medical knowledge are in the area of health/medical sciences concerned with primary medical care.

The World Organization of Family Doctors (Wonca) (2011) and the World Health Organization (WHO) (2004) regard “general practice” and “family medicine” as synonymous. Wonca defines general practice / family medicine as “an academic and scientific discipline, with its own educational content, research, evidence base and clinical activity, and a clinical specialty orientated to primary care”. Wonca summarizes the core characteristics of what it considers general practice knowledge in a “tree” diagram (Figure 1). This definition has been endorsed by national general practice organizations throughout the world, including the Royal College of General Practitioners (UK) and the Brazilian Society of Family and Community Medicine. I have used the term “general practice” broadly in this thesis to refer to this medical field of knowledge, however, when referring to Brazilian documents, I have adopted the term “family and community medicine”, which is more commonly used in that particular context. Despite this standardization of terminology, my thesis is interested in contextual (UK and Brazil) and conceptual differences relevant to this research, as identified by the research questions and the method chosen for this study: discourse analysis.

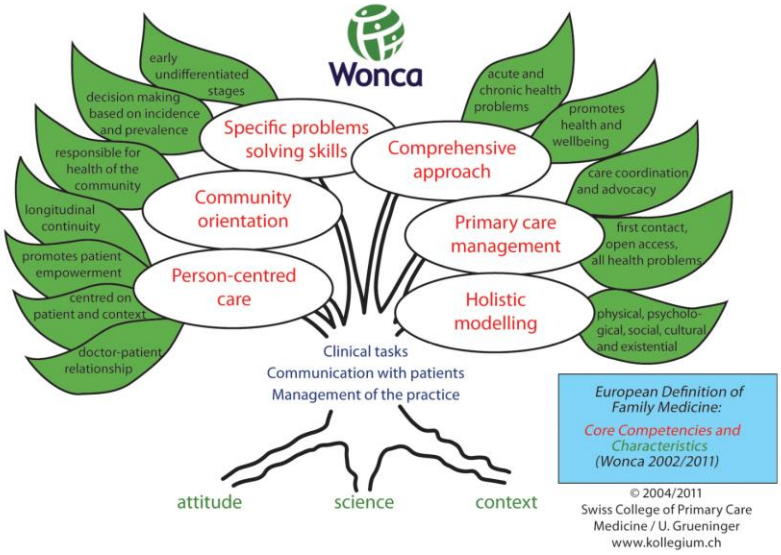


Figure 1. Wonca tree and the main characteristics of general practice.

In this introductory chapter, I aim to present the research rationale and to position it in relation to the current state of medical education research in general practice teaching. I therefore present the research gap addressed and this study's research questions, aims and objectives. I also present the scoping view of medical education research in general practice teaching and how this study can contribute to this area of scientific development.

1.1 The research gap

Despite growing efforts to develop medical education research, a particular aspect of the discipline has been overlooked: namely medical education policy, including that of general practice teaching. Analysis of education policy using discourse analysis has recently been used in medical education research. As described in this chapter, the 'current' crisis of general practice recruitment to primary care has triggered important research into the factors involved. Medical education researchers have studied

students' career pathway choices, learning outcomes in general practice and more. However, the contribution of policy has yet to be evaluated. Walsh (2014) has identified a lack of documentary research in this field, such as studies on policy papers, journal articles, textbooks and curricula. Few studies, as described throughout this thesis but especially in the methodology chapters (3 and 4), have analysed policy documents. Policies in medical education are particularly important as they establish the principles that guide medical schools on what, how and when to teach medical students. In the next chapter, I describe the conceptual approach to policy taken in this study.

Walsh (2014) has distinguished three broad approaches to analysing documents: (1) a positivist and quantitative approach that relies on a rational perspective; (2) an interpretative approach in which meanings are socially constructed in a specific social context; and (3) a critical approach in which ideology and politics form part of the analysis and a description of the production of power relations is constructed. In this research, I am particularly interested in the analysis of policy documents through an interpretivist and critical approach, taking into consideration social contexts and ideology in the construction of policy (further discussed in chapters 2 and 3). The particular countries selected present both differences and similarities with regards to social contexts and ideology; these are outlined in the method chapter, where the choice of approach is further explained, and described in more detail in the results and discussion chapters. The next section describes the research question and study rationale.

1.2 Research problem and study rationale

This study is a documentary research project using a comparative design to analyse policy documents from two countries: one where general practice is consolidated in medical education (UK) and another where it is in the process of consolidation (Brazil).

The following sub-sections briefly present the research questions, aims and objectives of this thesis. Their relationship to the research methodology is described in more detail in chapters 3 and 4.

1.2.1 Research question

How has general practice knowledge been characterized within undergraduate medical education policy and guidelines in the UK and Brazil?

This research question aims to explore how language is used to describe general practice in medical education policy. The characterization of general practice varies according to time and place (by country in this instance), with important implications for the value placed on general practice in medical education and the role played by general practitioners in educational establishments (e.g. do general practitioners have a teaching role in academic hospitals, medical schools and primary care services?). This research compares the features of general practice in two very different countries in order to inform the wider academic community for future developments. Through this research, more generalizable theories could be developed about general practice in medical education which might be relevant to other contexts. As a researcher, I do not position particular approaches to general practice teaching as “good” or “bad”, but simply recognize their difference. These contrasts and distinctions (e.g. settings,

documents) were used throughout the analysis to develop a critical engagement between and across the documents. Throughout the research I have reflected on my personal pre-conceptions and expectations which are described in a particular section in each results chapter.

1.2.2 Study aim and objectives

1.2.2.1 Aim

The overall aim of this research is to make visible the development of discourse within policy characterizing undergraduate general practice education in two contrasting settings where such education is consolidated (UK) and one where it is in the process of consolidation (Brazil).

1.2.2.2 Objectives

The principal goals of this thesis are to:

1. Examine the historical development and current context of general practice in undergraduate medical education in the UK and Brazil by conducting a literature review, presented in chapters 5 and 9.

2. Identify through this literature review important policy and guideline documents on undergraduate medical education, past and present.

3. Analyse from the identified documents the characterization of general practice and the discursive strategies used to establish and maintain general practice teaching in undergraduate medical education, using Foucauldian discourse analysis.

4. Map the characterization and discursive strategies on general practice medical education in the UK and Brazil, highlighting their particularities and relating this to the wider medical education context.

The selection of documents is further explained in a specific section in chapter 4. Chapters 5 and 9 present an account of the processes by which general practice was included in medical education in UK and Brazil. Both countries have primary care-led public health systems, in which general practice is an established medical specialty. However, the introduction of general practice into undergraduate medical education has followed a different path in each country. This difference provides a unique context in which to examine the discursive ways general practice is characterized in both consolidated and consolidating contexts. This comparative nature of the study highlights the features produced by the analysis of each set of documents.

The historical description (chapters 5 and 9) highlights certain conflicts in the construction of general practice in both countries. These provide the research object to be addressed through the method proposed by this study: Foucauldian discourse analysis. This type of analysis emphasizes the relationship between knowledge and power in a historical context. As such, it is an interpretative and critical approach to documentary research. My research explores this link between knowledge and power by investigating the characterization of general practice as an area of medical knowledge, its insertion over time into medical education policy, and the production of power produced in policy discourse.

Foucauldian discourse analysis will be used to investigate the depiction of general practice as a field of medical knowledge in undergraduate medical education policy. This research method offers a critical perspective of power relations in policy documents by exploring what is possible and

legitimate in the documents. Through this lens, it is possible to analyse the rules of tolerability that delimit the frontiers between what is considered general practice and what is not at a particular time. Another dimension of this analysis is the continuity or discontinuity of these rules of acceptability in time. The analysis of policy documents in a historical frame evidences the discontinuities in the description of general practice. Moreover, the study shows how this characterization structures the subject positions produced in undergraduate medical education (i.e. general practitioner tutors, students, patients).

This thesis draws upon and speaks to the research fields of medical education and general practice. In the following sections of this chapter, I explore the link between these two empirical fields of medical knowledge and determine the research gap that allows me to investigate them through the analytical lens of a Foucauldian discourse analysis of medical education policy (Dowling & Brown, 2009). In the following section (1.3) of this chapter, I briefly introduce the historical context of these fields (medical education and general practice). In section 1.4, I present a concise perspective of general practice teaching in undergraduate medical education in both countries, as it is today. I then present a summary of medical education research in undergraduate general practice teaching (section 1.5). This section informs the discussion of the results (chapter 12) with important scientific knowledge on this area of scientific development and evidences the gap addressed by this study. In section 1.6, I reflect upon my subject position as researcher and author of this thesis. Finally, in section 1.7, I describe the structure of this thesis.

1.3 Medical education, primary care and general practice

Over the past 100 years, medical education has developed significantly as a field of knowledge within the medical academic and professional environment. It has gathered together human and technological resources from the worlds of medicine, education and social sciences (teachers, learners and practitioners) to formalize and develop the instruction of undergraduate and graduate doctors (van der Vleuten, 2014). Global, national and local medical educational institutions have been established across the world and are gaining in size, knowledge, research and political strength (Lindgren & Gordon, 2011). Medical schools have in turn created university departments to focus teaching on staff development and educational research. At the same time, the number of publications and journals devoted to medical education has grown faster than in many other fields of medical research (Doja, Horsley, & Sampson, 2014). Such developments provide fertile ground for the elaboration of many specific areas of medical education, including evaluation of medical schools; research in medical education; new ways of funding universities; highlighting social accountability; use of new knowledge in education and practice; alliance with changes in health care systems; and consideration of the future shape of workforces (Skochelak, 2010). The last two areas are particularly important to this thesis which evidences through this discourse analysis how change towards primary care-led health systems have influenced – and been influenced by – the role of general practice in medical education.

Primary care has been the focus of political, economic, scientific and educational efforts throughout the world. Many global institutions,

including the World Health Organization, have documented the increasing importance of primary care. Fifty years ago, the Alma-Ata Declaration set a worldwide goal of *Health for All* through investment in primary care (1978). The Declaration defines primary care as: "…more than just the level of care or gate keeping; it is a key process in the health system. It is first-contact, accessible, continued, comprehensive and coordinated care. First-contact care is accessible at the time of need; ongoing care focuses on the long-term health of a person rather than the short duration of the disease; comprehensive care is a range of services appropriate to the common problems in the respective population and coordination is the role by which primary care acts to coordinate other specialists that the patient may need".

Many countries have embraced this goal, with overwhelming evidence of service improvements. Starfield and Macinko have shown that countries with robust primary care-based health systems achieve superior aftereffects with smaller budgets (Starfield, Shi, & Macinko, 2005). The 2008 WHO Report, *Now More than Ever*, re-iterated the relevance of primary care, espousing the same values of social justice, equity and solidarity described in Alma-Ata (2008). The success of primary care-led systems is attributed by Rawaf et al. to five core characteristics: accessibility, person focus, continued care, universality and care coordination (Rawaf, Maeseneer, & Starfield, 2008).

In response to the reorientation of health systems towards primary care, the role of general practice in medical education has also undergone a significant transformation in the past 60 years. General practice is now viewed by some as a medical specialty of excellence, coordinating access to other

medical specialties in hospital care (Starfield, Shi & Macinko 2005). In countries where demand for primary care services has increased, medical schools have shifted their medical curricula towards national medical education policies or guidelines which encourage general practice placements throughout the training period (Seifer, 1998). Universities have also changed their approach to teaching and research to incorporate general practice and primary care.

In the UK, general practice became part of the public health system in 1948, 70 years ago, with the creation of the National Health Service (NHS). Since then, the country's primary care has progressively expanded and evolved (Lewis, 1998; Livingstone & Widgery, 1990).General practice teaching is now an important and consolidated part of UK undergraduate medical education: primary care and/or general practice departments are the norm, many general practitioners work in university faculties and general practice and primary care placements are a feature of all undergraduate training (Pearson & McKinley, 2010). This consolidation, however, is not static. Roger Jones (2017) has described the current recruitment "crisis" of general practice in the UK and its links to medical education. He relates this crisis to a negative perception among undergraduate students and recent medical graduates, with its roots in the education process. Harding et al (2015) have warned of the threats to this consolidated state of general practice in medical schools: the amount of teaching in general practice per student decreased; number of departments falling.

In Brazil, the national health system, Sistema Único de Saúde (SUS), was created in the late 1980s. Its structure and organization shifted

towards primary care a decade later. The Family Health Programme (Programa de Saúde da Família, PSF) was developed in 1997 to support primary care, and evolved in the following decade to increase access to health, as described by Conill (2008). Family and community medicine (corresponding to general practice) was consolidated as a medical specialty in Brazil in the 1980s. However its introduction into undergraduate medical education is still at an early stage: only three out of more than two hundred medical schools have a department of general practice and/or primary care, general practitioners are a minority among medical teachers and primary care placements are not standard within the six-year undergraduate training programme.

Both the UK and Brazil have reported medical workforce crises in the past, including difficulty recruiting medical doctors to primary care and general practice training. According to the UK´s Department of Health, nearly half of newly graduated doctors would need to enter general practice postgraduate training in order to meet service needs (2008); however only 23% choose general practice as their first career (Lambert & Goldacre, 2011) and posts remain unfilled. In terms of education, The United Kingdom Conference of Educational Advisers Workforce Survey Report from March 2010 noted that, while the number of trainees specializing in general practice was increasing, there had been no proportional rise in trained postgraduate primary medical care educators (2010).

In Brazil, a rapid expansion of access to primary care has greatly increased demand for family physicians. In 2011, a survey outlined the educational profile of the doctors working in the PSF. According to its author,

Dr Juan Gervas, only 5% of health teams included physicians with a background in family medicine. Other studies have documented an increase in the number of residency posts for general practice in Brazil (Campos & Izecksohn, 2010); however these often go unfilled (Brazil, 2011). In the UK, as in Brazil, competition for recruitment to round one in general practice is among the lowest of all the various specialties (Howes, 2012).

This increased demand for general practitioners has influenced the teaching of undergraduate medical students. The Edinburgh Declaration (1988), drafted by the World Federation for Medical Education, called for a number of actions within medical schools, two of which were highly pertinent to the teaching of general practice in undergraduate studies: *widen educational settings* and *national health need as the context of curricula*. By embracing these goals, documents and policies in both countries have created a favourable environment for change. In the UK, the publication of *Tomorrow's Doctor* (a series of guidelines for medical schools) by the General Medical Council emphasized the importance of general practice in medical curricula (Pearson & McKinley, 2010), while in Brazil, the *National Guidelines for Medical Schools* (Brazil, 2001) outlined the key role of primary care throughout the six years of medical education, including the need for a mandatory placement. These proposals led to an increased contribution of general practice to undergraduate studies in both the UK and Brazilian medical education systems (Society for Academic Primary Care, 2002; Associação Brasileira de Educação Médica, 2010).

1.4 General practice in undergraduate medical education

In this section, I describe the role attributed to general practice teaching in undergraduate education, particularly in the UK and Brazil. General practitioners have important duties within national health systems, including meeting population health demands and teaching undergraduate and graduate students. In the UK, as much as 70% of undergraduate clinical teaching is undertaken by NHS clinical staff, including general practice (Spencer, 2003). In Brazil too, the work of federal, state and municipality health units is included in the training curriculum (Associação Brasileira de Educação Médica, 2010). In the following sub-section, I further detail the relationship between universities and general practice.

1.4.1 Universities shift towards general practice

In the UK, when primary care was first introduced into the national health system, general practice was typically taught during hospital rounds undertaken by students as part of their undergraduate medical education (The Lancet, 1989). Since then, general practice around the world has been defined as a set of knowledge, skills and attributes that cannot be taught in hospitals alone, requiring instead a dedicated academic and practical learning setting which is specific to the settings in question.

Papers from the late 1960´s, such as the Todd report, influenced general practice teaching in the UK. The Todd report, one of the documents analysed in this research, was developed by a Royal Commission of Medical Education (1968). A report (1969) from the Royal College of General Practitioners (RCGP) described how general practice was being taught in all medical schools in the UK (Fraser & Preston-Whyte, 1988). These reports

revealed a wide range of training experiences within the UK's 28 medical schools and noted the limited influence of general practice in medical education. At that time, only 25% of UK general practices were supporting practical teaching (Fraser & Preston-Whyte, 1988). The development of general practice as an academic career and the increasing availability of students´ and general practice tutors´ time for clinical placements required greater financial support (The Lancet, 1989). The book *Academic General Practice in the UK Medical Schools, 1948-2000* gives a detailed account of the development of general practice departments within educational establishments (Howie & Whitfield, 2011), highlighting the amount of clinical skills teaching being carried out in general practice departments. In 1994, a survey conducted by Robinson et al. showed that of the 27 academic departments of general practice (in 28 medical schools in the UK) 14 were involved in basic clinical skills training. This was regarded as significant but insufficient progress, given that most departments were involved in communication skills teaching, but not clinical skills teaching (Robinson, Spencer, & Jones, 1994).

From 1980 onwards, the General Medical Council (GMC) became a major actor in promoting change through its regularly published recommendations on undergraduate medical education (1980; 1993; 2009). These guidelines stimulated the expansion of general practice teaching in medical schools throughout the UK which, despite an increasing workload among primary care teams, was broadly welcomed by patients, students and general practice tutors, according to various research (Major & Booton, 2008).

In Brazil, the first medical postgraduate training in general practice began in 1976, at a time when health services and medical schools were still mainly focused on hospital care (Abath, 1985). The establishment of the national health system (SUS) in 1988 and the Family Health Programme (PSF) in 1994 were major landmarks in the development of general practice in Brazil (Falk J. W., 2005). The rapid expansion of primary care thereafter motivated a major curricular change in undergraduate medical education across the country. The Brazilian Medical Education Association (Associação Brasileira de Educação Médica, ABEM), following a national evaluation of medical schools and several workshops involving governmental, professional and academic participants, published the National Guidelines for Undergraduate Medical Education, which identified community settings as important learning scenarios for student development (Brazil, 2001). From that moment onwards, medical schools began to implement major reforms to their curricula.

Since general practice was not considered an academic discipline at the time (Falk J. W., 2005), community-based teaching was assigned to different departments within Brazilian universities, such as internal medicine, public health and paediatrics. Currently, only three universities have dedicated academic departments of family medicine/community health in Brazil: Federal University of Rio de Janeiro; Federal University of Paraná; and Federal University of Minas Gerais. Other Brazilian universities that do not have a specific primary care department have recruited and incorporated family medicine academics into the departments cited above.

Similar progress in general practice teaching has occurred elsewhere. The American Association of Departments of Family Medicine´s *Quick Hitter Survey* of 93 departments revealed that 95% of universities in the USA offered family medicine clerkships to undergraduate students (2010). A 2013 survey by the European Academy of Teachers in General Practice (EURACT) of 259 (out of 400) European medical schools showed that only 35 (13.5%) did not have a general practice curriculum, and of the remainder only 15 (6.7%) offered no practical component to their general practice training. The schools in question were mostly located in Eastern and Southern European regions (Brekke, et al., 2013). However, data published in the same year by a different survey showed that in all but two of the Central and Eastern European countries studied – Czech Republic and Russia – all universities offered an undergraduate general practice programme (Krztoń-Królewiecka, et al., 2013).

In the following sub-section, I discuss the content of general practice teaching in undergraduate curricula. A broad understanding of what is currently taught in general practice provided me with a comprehensive background of the teaching scope of this medical field. This helped in the analysis of historical policy documents by providing a set of parameters for identifying which elements of medical education could be attributed to general practice in different times.

1.4.2 General practice teaching: learning outcomes

The Wonca Europe definition of general practice has greatly influenced the approach to knowledge and skills development in academic medical education (Wonca Europe, 2011). An acknowledged strength of

Wonca´s paper is its detailed definition of general practice (Gregory, 2009; Saultz, 2012). However, general practice teaching is far from static (Canadian Medical Association, 2011): given the breadth of knowledge and skills understood to characterize general practice, medical schools have been able to adapt curricular programmes to local particularities, such as epidemiological profiles, curriculum deficits and community preferences (Society of Teachers of Family Medicine, 2009). Although such variations make it harder to define the precise content of general practice training, several efforts have been made worldwide to define regional or national core curricula to help schools define their priorities. These different sets of learning objectives and outcomes have significantly influenced the way general practice is taught, learned and understood globally.

In the UK, the GMC publication *Tomorrow´s Doctors* (2009) (undergraduate medical education policy) has reaffirmed the necessary shift from unequally distributed hospital-based education to more evenly distributed teaching in community care, especially primary medical care (Pearson & McKinley, 2010). Some researchers argue that very pragmatic reasons are motivating this shift, such as an expansion of student numbers, hospital care reforms and shorter hospital stays (El-Bagir & Ahmed, 2002). Pearson and McKinley (2010) point to more important medical education reasons for promoting community care teaching, especially primary medical care. These include: (1) the need to understand the social and psychological aspects of ill-health; (2) the fact that 90% of medical encounters happen in a primary care setting and that 50% of medical graduates will work as general practitioners; (3) a growing acknowledgement of the complex health system pathways

being coordinated by general practices. As to what can be taught in primary medical care, the authors affirm:

> *"Primary medical care is an ideal setting to teach early patient contact, learning of clinical method (including consultation skills), diagnosis and management of early presentations of illness, and of chronic medical conditions including complex multiple pathologies and associated poly pharmacy. It is also an ideal setting to teach much acute medicine and a wide range of 'specialties' including dermatology, ENT, ophthalmology, musculoskeletal medicine, women and child health, and mental health.* (Pearson & McKinley, 2010)*"*

A pilot study compared primary care clinical caseload data with the curriculum objectives of a medical school in the UK (Jepson & Hays, 2011). Its results showed that 40% of the intended learning objectives could be taught in general practice, while 14% could not be easily in either primary care or hospital settings. It should be noted that this research focused solely on learning objectives that could be translated into diagnostic classifications, leaving out non-disease centred knowledge, skills or attitudes.

Guidelines for Brazilian undergraduate medical courses have also promoted community care teaching but without establishing learning outcomes for this specific teaching setting (Brazil, 2001). The first attempt to define outcomes for medical teaching in primary care was published in 2007 by Gastão Campos. Campos attributed to primary care the responsibility of increasing accessibility, providing comprehensive care and promoting public health. His main focus was on creating the best conditions for students to learn in a primary care setting. This required political agreements between academia and health services, appropriate financing for professionals, consideration of the physical structure of the health units and the availability of

established and trained academic teachers to support the whole experience (Campos G. , 2007).

The Brazilian Society of Family and Community Medicine (SBMFC) and the ABEM organized workshops with general practice tutors and academic teachers from across Brazil to discuss the characteristics of medical education in primary care. The result was a series of published articles and a chapter in a medical education textbook dealing specifically with primary care teaching. These texts addressed issues such as: (1) why teaching in primary care was necessary; (2) what should be taught; and (3) when and how teaching should take place (Demarzo, et al., 2011). Regarding what should be taught, the learning outcomes were divided into individual, family and community approaches. The individual approach was patient-centred, dealing with unspecified problems and promoting the patient´s autonomy. The family approach considered the family´s particular structure and dynamics through the use of genograms and "ecomaps" in order to identify intra-familial influences on ill health. The community approach was associated with population/public health knowledge and technologies needed by particular health territories (Demarzo, et al., 2011).

Elsewhere in the world, the Society of Teachers of Family Medicine (STFM) (2009) in the USA commissioned a taskforce to develop the *Family Medicine Clerkship Core Content Curriculum* (C4). This document was a national effort to define the remit of medical schools in teaching undergraduate students. The C4 is structured into four sections: curriculum competencies and content, clerkship director roles and resources, educational methods, and assessment strategies (STFM, 2011; 2012). Canada´s attempts

to define nationally-accepted outcomes resulted in the production of the *Shared Canadian Curriculum for Family Medicine* by the Society of Teachers of the Canadian College of Family Physicians (Steyer, 2010). The structure and content of both sets of guidelines closely follow worldwide definitions of general practice, but with local variations to reflect particular contexts and developments. These two countries are examples in the literature (i.e. English language) of efforts to characterize general practice teaching.

As medical schools expanded their clinical and territorial range, medical education research also extended its focus to include general practice teaching. The result is a growing sub-field of research with a broad range of experiences, methods and results, which are detailed in the following section.

1.5 Medical education research into general practice teaching

Since general practice is a broad theoretical and practical discipline in medical education, I have organized this section into two sub-sections: (1) themes studied; and (2) methods used.

1.5.1 Themes

The earliest attempts to study general practice in medical education were largely concerned with understanding career pathways. Researchers were interested in understanding the factors which influenced students' specialty choice, particularly with regards to general practice as reported in historical accounts of research papers (Shadbolt & Bunker, 2009; Alberti, Randles, Harding, & McKinley, 2017). This was a direct response to changes in health care provision and remains a major concern today.

Throughout the world, a vast number of publications have reported students' experiences in their first clinical placements in primary care settings. These placements range from urban to rural sites where enthusiastic teachers, students and tutors describe their own particular way of approaching learning in the community (Bartlett, Rees, & McKinley, 2018). Just as varied are the themes being addressed by medical tutors, including specific clinical and non-clinical skills and disease-centred subjects, ethical aspects of health care and public and population health (Thistlethwaite, et al., 2013). Furthermore, a wide range of teaching methods and assessment techniques are being implemented and evaluated in a primary care setting, with the focus on developing student and tutor skills (Wolpaw, Papp, & Bordage, 2009; Ottolini, Ozuah, Mirza, & Greenberg, 2010; Parrot, Dobbie, Chumley, & Tysinger, 2006). The development of teaching and learning in general practice has prompted medical schools to invest in improvement programmes for both academic staff and general practice tutors. From a research perspective, the roles and effectiveness of general practitioner tutors have been explored and described from various perspectives (students, patients, tutors and university staff members) (Sorinola & Thistlethwaite, 2013).

Research also associates general practice placements with the accomplishment of specific learning outcomes and the capacity to influence career choice (Thistlethwaite, et al., 2013). Park, et al. (2015) conducted a systematic review of research exploring undergraduate medical education in the UK general practice setting. The in-depth review of quantitative and qualitative studies found that students learned clinical skills equally or better in general practice placements than in hospitals. The in-depth qualitative review

demonstrated the role of general practitioner tutors as brokers of the relationship between students and patients, and characterized general practice settings as social-cultural and developmental learning spaces for students (Park, et al., 2015).

The impact of teaching on general practice health teams appears to vary. To some professionals, teaching medical undergraduates has a affirmative effect on confidence, fulfilment and motivation (Grant & Robling, 2006). On the other hand, the increasing number of students at times creates overload, leading clinical teachers to complain about lack of proper infrastructure and inadequate time and resources, including poor support from medical schools, as reported by Spencer (2003) and Barreto (2012). Other researches have focused on research that included patient satisfaction in teaching services with positive results towards the latter (Rees, Gay, & McKinley, 2016). More recently, longitudinal placements in general practice are being described and assessed (McKinley, et al., 2018).

Another area of research, which is not the focus of this study, has been postgraduate training (selection of entrants, trainee wellbeing and clinical decision-making) (Webster, et al., 2015).

1.5.2 Methods used to investigate general practice teaching

In order to understand the participation of general practice in medical education, researchers use a variety of scientific perspectives and methods. Studies involving surveys, focus groups, interviews and questionnaires have described how general practice can support a wide range of learning objectives and outcomes (Society of Teachers of Family Medicine, 2009). According to a literature review by Webster et al. (2015) of papers

published in the English language, the majority of research on general practice teaching has used quantitative methods. However, the authors could not specify the method applied in more than 60% of studies. The authors of these unclassified studies characterized their methods as evaluations of teaching experience. The studies whose methods were classified by Webster et al. employed surveys and documentary research (i.e. of medical records, exams). Webster, et al. (2015) suggested that rigour and identity in general practice research could be improved through a more theoretically informed approach to methodology.

1.6 My location in the empirical setting

I conducted this study as an insider, having been involved in medical education as a medical student, family medicine trainee, clinical tutor and academic teacher in Brazil. However, I also occupy an outsider's position with regards to the UK, since before conducting this research I did not have an experience of the UK health or medical education system. Nevertheless, throughout the research I have developed a closer (insider) perspective of UK health and medical education, while also distancing myself from the Brazilian experience.

I undertook my clinical clerkship at a time when the medical school I attended was just beginning to offer placements in primary and secondary care units, following a national medical education reform movement in the late 1990´s and early 2000. During a one-month placement in primary care, students, including myself, observed family physicians as they carried out their various activities.

I was also actively involved in changes taking place at my medical school, UFPE (Federal University of Pernambuco – Brazil). As a family physician trainee, I was given teaching responsibilities by my supervisor. From that moment, I began an empirical journey to discover ways of teaching undergraduate students in a primary care context. This included a weekly meeting, called the Teaching Initiation, in which all postgraduate participants in teaching were required to correlate their teaching experiences with the theoretical background of education sciences. My Master´s degree research project on undergraduate clinical placements included a series of 21 interviews with clinical teachers in diverse clinical settings. One of the themes to emerge from these discussions was the varying depiction of clinical teachers in medical education policy documents. While most of the clinical tutors paid little attention to official medical education policy, they still had an understanding of 'good clinical teaching' and how it related to the changes in medical education. Tutors from different generations had various understandings of their roles as educators, with the earlier generation being more attuned to current policy (Barreto, 2012).

I was also involved in the production of guidelines for teaching in primary care developed by the Brazilian Medical Society of Family Doctors (SBMFC) and the Brazilian Association of Medical Education (ABEM) (Associação Brasileira de Educação Médica, 2010). Through this work, I gained experience of the process of policy creation and how removed this can be from the actual practice of medical schools. This distancing between policy and practice can create an understanding of policy as an idealized text which has little to do with the problems faced by interlocutors at the micro-level.

Where communication takes place between policy writers and the actors affected by regulations it can have a major impact in terms of implementation. This is exemplified by the first Brazilian National Guideline (2001), which influenced a wave of reforms in medical schools that were directly involved in its production.

As a professor at the Federal University of Pernambuco, my first appointed task was to organize clinical placements for students in their second, fifth and sixth years. From my meetings with students and family physicians working as tutors, I began to understand how the organization of students´ activities and tasks differed from one primary care service to the other. Despite joint meetings with both students and clinical tutors to develop internal policies, each unit had a different teaching process, reflecting the particular experiences of the family physicians involved. Two aspects of this intrigued me: first, how did these different clinical teaching plans relate to national and local medical education policies? Second, how did national policies produce through discursive practices the positions held by students, trainees, tutors, academics and patients?

Throughout this thesis, I take a reflexive approach, recognizing my role in the research process and its influence on my assumptions of truth and the production of knowledge (Hodges 2007). This stance is reflected in the thesis structure, which contains numerous sections devoted to critical reflexivity.

When considering positions of power, I have been especially influenced by the work of the Brazilian educator Paulo Freire, clearly exemplified in his book *Pedagogy of the Oppressed* (Freire, Pedagogy of the

Oppressed, 1970): "*Even revolution, which transforms a concrete situation of oppression by establishing the process of liberation, must confront this phenomenon: many of the oppressed who directly or indirectly participate in revolution intend – conditioned by the myths of the old order – to make it their private revolution. The shadow of their former oppressor is still cast over them*". Developing my own critical perspective of this context and how it might affect the research was a particular challenge. It required me to constantly distance myself from my previous assumptions and to compare the findings of my analysis with what I had expected and not expected.

1.7 Structure of the thesis

This thesis begins with the current introduction (chapter 1), in which I outline the state of medical education research in general practice and present the gap in our current knowledge that my research aims to fill. I also define my research questions and briefly introduce the study design.

In chapter 2, I present a scoping review of research into medical education discourse in policy documents. I also review the use of discourse analysis in medical education and describe some important concepts associated with this method and how they are used in this thesis. Chapter 3 presents a theoretical and empirical understanding of the chosen research method: Foucauldian discourse analysis. In view of the different positions taken by other authors in applying this method, in chapter 4 I describe my particular approach to Foucauldian discourse analysis.

Chapters 5 (UK) and 9 (Brazil) describe the history of medical education in each country with a focus on the participation of general practice,

as set out in relevant publications, in order to help the reader contextualize the data selection and the research findings.

The results of the discourse analysis are presented in the following chapters, which are divided into three analytical periods for the UK (chapters 6, 7 and 8) and two for Brazil (chapters 10 and 11). A synthesis, comparison and critical discussion of the analytical findings for both countries are presented in chapter 12, while the final chapter (13) provides a reflexive account of the research process, my position as a researcher and the implications of this study for medical education research and general practice teaching.

2 MEDICAL EDUCATION RESEARCH AND DISCOURSE ANALYSIS OF POLICY

2.1 Introduction

In this chapter, I describe the current state of discourse analysis in medical education research. I present a scoping review of medical education studies that have used discourse analysis: their object of research, description of method and data set. Following this, I present a review of important concepts relating to discourse analysis in a broader theoretical context, beyond medical education research, and how they apply to this research.

2.2 Discourse analysis in medical education research

In this section, I describe the increasing use of discourse analysis as a research method in medical education. In 2016, I conducted a scoping review of the medical education literature of the past 50 years to gain a broader understanding of the use of the method and to identify studies that had followed a Foucauldian approach. I searched the most important databases for medical education research (Medline, Pubmed, British Education Index, Education Resources Information Centre, Australian Education Index and the Brazilian database, BIREME), using keywords (MESH terms) associated with medical education (with a focus on undergraduate education) and discourse analysis (table 1).

Table 1. Keywords used in literature review.

Medical Education		Discourse analysis
Medical education Undergraduate medical education Medical schools Curriculum Education	Learning Medical Schools Teaching Undergraduate Student	Discourse analysis Analysis Discourse

Of the total number of articles found (285), 83 mentioned discourse analysis in the context of medical education in their abstract (see appendix for the full list of articles – 83 – Appendix 15.1). I did not consider articles if they were not explicitly related to medical education (i.e. their focus was on other health professions), if they used other qualitative methods (i.e. content analysis, narrative analysis, thematic analysis, and others), or if they were not published during the timeframe of the review (1966-2016).

In reading the full text of the 83 articles, I looked for three specific elements of the studies: the object or theme of the research, the discourse analysis in use, and the data analysed. Seven studies used a Foucauldian approach to discourse analysis in medical education policy to investigate different research questions (Whitehead, Selleger, Kreeke, & Hodges, 2014; Klingenberg, 2013; Whitehead, Hodges, & Austin, 2013; Whitehead, 2011; Razack, Hodges, Steinert, & Maguire, 2014; Ho, Shaw, Liu, Norris, & Chiu, 2015; Cruz, 2004). The flow diagram below summarises the scoping review (Figure 2). The following sections describe the theme, method and data set of the 83 studies found to be using discourse analysis. The scoping review clarified the used of discourse analysis in medical education research in terms of what themes are studied; what subtypes of discourse analysis are used; what kind of data sets are analysed. It provided a descriptive summary of the basic characteristics of each identified relevant study. This helped me to

clarify the range of ways in which FDA has been used in medical education research and how I wanted to operationalise the method.

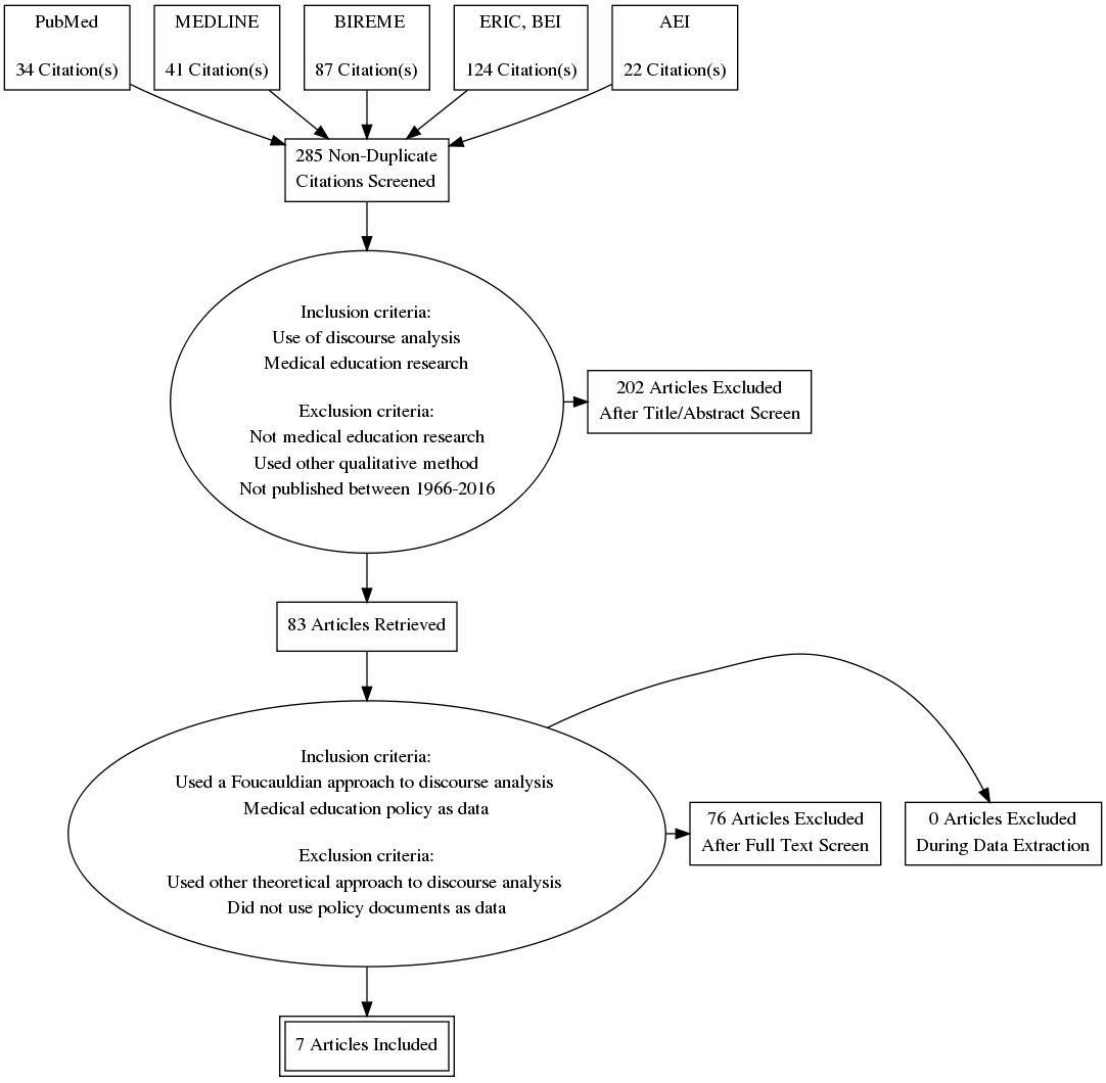


Figure 2. Flow diagram of scoping review.

2.2.1 Object of research

I divided the themes or objects of the 83 studies using discourse analysis in medical education research into five main categories, in descending order of frequency: (1) teaching interaction between student and teachers (i.e. problem-based learning, clerkships, classroom, and others); (2) medical education as a field of knowledge; (3) development of specific

competence (i.e. professionalism, leadership, different skills, compassion, and others); (4) specific discourses (i.e. gender, equality, disease and others); and (5) description of students' thought process. A Foucauldian approach was used in only two of these categories: to investigate medical education as a field of knowledge and specific discourses relating to gender, equality and disease. The research themes in these studies related to power relationships and knowledge.

2.2.2 Methods

The methods of the 83 studies identified fell into three distinct groups: discourse analysis, critical discourse analysis and Foucauldian discourse analysis. Within the discourse analysis category, a variety of approaches were followed, many of which were not described in full due to the nature of the publication (most were articles published in academic journals). Studies using critical discourse analysis adopted theoretical perspectives from a number of different authors (e.g. Fairclough). Discourse analysis was described as "critical" when it explored how discourse affected society or a specific context in terms of power and status (Dornan, 2014).

The studies claiming to have used a Foucauldian discourse analysis took a more explicit theoretical stance, using specific concepts linked to Foucault's work (although in many of these articles the approach went by different names, including Foucauldian discourse analysis, Foucauldian critical discourse analysis, Foucauldian approach to critical discourse analysis, Foucauldian analysis, and others). However, as with the papers on discourse analysis, they did not describe their method in any detail. The findings of these studies helped me identify the leading authors using

Foucauldian discourse analysis in medical education research. Further, investigation of their work gave me an understanding of the various ways in which the method is used in this research area, as described in chapter 3.

2.2.3 Data

The studies identified in this review used two types of data: texts (i.e. medical education journals, other scientific journals, textbooks, curriculum texts, student communications, policies and online learning platforms) and video or audio recordings (i.e. interviews, focus groups, teaching interactions). While only a few (7) analysed policy documents, all did so using Foucauldian discourse analysis. For example, a study by Whitehead et al. (2014) of medical education policies in Canada and the Netherlands examined from a Foucauldian perspective how certain educational roles appeared and disappeared in both countries. This provides further evidence of the method's suitability for research relating to power, knowledge and history, as described in the following chapter.

The scoping review of medical education research and the use of discourse analysis presented above also provided further evidence of the scientific gap addressed by this research. There is an increasing use of discourse analysis in medical education research and of a Foucauldian approach to analysing policy. Nevertheless, none of the studies identified above have used a comparative study design (e.g. comparing policy from different nations) focused specifically on general practice as a research object in medical education.

2.2.4 Understanding of discourse in medical education research

Dan Karreman and Carlotta Levay (2017) have recently conducted a literature analysis, published in the journal *Medical Education*, investigating the construct of “discourse” and “discourse analysis” in medical education literature. Their analysis is based on a framework that characterizes discourse in two dimensions: discourse in relation to meaning (horizontal axis) and discourse in relation to its own formation (vertical axis). Along the horizontal axis, discourse is viewed either as determining meaning (left) or not determining meaning (right). On the vertical axis, discourse can shape and be shaped by local and situational context (high) or be historically situated, determining universal truths (low), as depicted in Figure 3.

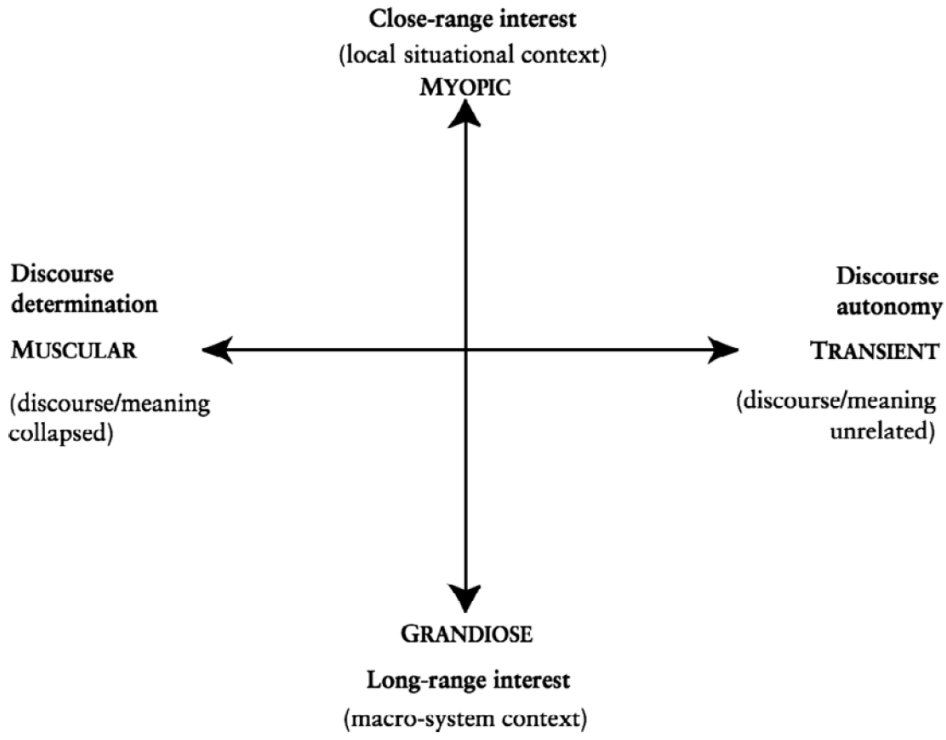


Figure 3. Framework for categorizing research publications and their use of the term “discourse” (Karreman & Levay, 2017).

The authors describe two understandings of discourse that predominate in research: “small d discourse” and “big D Discourse”. Small d discourse (upper right quadrant of the framework), in which meaning is transient and situational, assumes that linguistic communication between individuals produces and conceptualizes the social world. Big D Discourse (lower left quadrant), in which meaning is permanent and universal, is an expression of power and knowledge that shapes the object described through assumptions of truth that inform what is real, normal and natural. This conception of “Discourse” is majorly influenced by Foucault.

Most of the publications reviewed in the Karreman and Levay analysis could be placed on the left side of the matrix, demonstrating a closer association between discourse and meaning. There was also a bias towards the lower side of the matrix, with no publication placed in the upper right quadrant (Karreman & Levay, 2017). The authors identify two main problems with the studies analysed: (1) a tendency to take what people say or write as an unquestionable indication of their values, emotions or attitudes; and (2) a lack of attention to variance within the groups studied. Nevertheless, they valued the level of attention given to discursive phenomena and how different ways of reasoning on specific themes were identified and discussed. They also acknowledged the capacity of the studies to describe contradictions and tensions in the empirical material. Overall, Karreman and Levay warn researchers of the risks of jumping to conclusions: discourse analysis makes better supported arguments, they suggest, when it is possible to defend claims on three different levels – practice, text and meaning (Karreman & Levay, 2017).

My scoping review of discourse analysis in medical education research highlighted the increasing use of Foucauldian discourse analysis in this field of scientific investigation. In reading the seven studies identified as using Foucauldian discourse analysis in the scoping review, two research teams stand out in this respect. At the Wilson Centre of the University of Toronto, researchers such as Cynthia Whitehead and Brian Hodges have developed a strong investigative tradition using discourse analysis and Foucauldian discourse analysis to study medical education literature, policy and concepts (Whitehead, Hodges, & Austin, 2013). In the UK, Sophie Park, Michael Klingenberg and Caroline Pelletier at the Institute of Education, University College London, have used Foucauldian discourse analysis to study medical education research publications and policies (Klingenberg, 2013; Park, Pelletier, & Klingenberg, 2014; Park, 2016). Due to the nature of the publications (journal articles) of the seven studies identified, the description of the research method was limited to a few paragraphs that did not portray a full explanation of how the method was operationalised. I have, therefore, in chapter 3, looked for further bibliographic material from these research centres and from social sciences researcher for further understanding of the operationalization process. While every context is different, and will require particular judgements and decision-making throughout the analytical process, this did provide some useful examples about the range of ways in which other authors have approached the 'doing' of this method.

Commenting on the lack of a theoretical framework in medical education research, and the need to correlate bioscientific, learning and social

theories, Hodges et al. (2014) propose that a Foucauldian approach can help researchers reflect critically on established truths which influence what is thinkable and doable by medical students and teachers. Jennifer Johnston (2014) argues that a critical perspective of these assumptions of truths can help participants free themselves from fixed ways of being and acting, making space for opposition and transformation in medical education.

Park et al. (2012) affirm that medical education research has privileged certain methods of analysing text, especially content and framework analysis, which often rely on standardized assumptions of truth. They argue that these methods can be considered overly deterministic, “giving answers rather than raising questions” (Park, Griffin, & Gill, 2012). The authors present other methods of analysing text in medical education, including performative narrative analysis, influenced by Foucault’s theory. Park et al (2014) further explore the possible contribution to medical education research of Foucault’s early discussions on technology of power (how discourse is imposed to a subject) and his later work on technologies of self (how a subject can impose a discourse on himself), through the concepts of subjection and subjectivation (discussed later in the method chapter). The authors reflect on how medical education theory, practice and research “support or challenge ways of being (recognizable, intelligible and good)”. Through this discussion they open up the possibility of subjecting medical education research to meta-analysis.

This research uses Foucauldian discourse analysis to chart the development of general practice in medical education policy and, in so doing, test its potential and reveal its limitations. The aim is to understand the development of general practice in medical education through an analysis of

its historical development as a discursive strategy in medical education policies. By “discursive strategy” I mean the way in which a discourse is deployed to produce meaning and power for a specific object, in this case general practice (Wetherell, Taylor, & Yates, 2001).

My research question was: *how has general practice knowledge been characterized within undergraduate medical education policy and guidelines in the UK and Brazil?* I wanted to look at how general practice knowledge is discursively constructed within text and what power relation is produced between different medical areas.

I have used Foucauldian discourse analysis because its emphasis on knowledge, power and history provided the appropriate methodological structure for this investigation. In regards to knowledge, I am looking at general practice as a unit of medical knowledge and specifically what characterizes it. As a unit of medical knowledge, a Foucauldian approach to discourse analysis is focused on producing the ideas that conceptualize general practice knowledge. In regards to power, this method is able to create a clearer and deeper understanding of the dominant structures in a field of knowledge. A Foucauldian approach should, therefore, allow me to analyse the power structure in undergraduate medical education policy and what kind of positions are constructed for general practice knowledge in medical schools. The historical dimension of the method focuses on understanding the changes that happen to the unit of knowledge and to the power structure. This dimension, in this research, constructs the different characterization of general practice knowledge in time and the different power positions created for this unit of medical knowledge.

Furthermore, the method should allow for the construction of a critical perspective of general practice knowledge that could be or not in consonance with what is understood as general practice in different medical and non-medical environments (i.e. general practice institutions; medical professional institutions; or social common sense). The discursive characterization of general practice in medical education policy through a Foucauldian way of analysis should also permit the identification of the assumptions of truth that legitimate a particular way of understanding this knowledge. These assumptions of truth are the dominant discursive elements that could belittle and/or exclude what is unthinkable or not legitimated as a discursive possibility. Through the identification of what is not legitimate or unthinkable about general practice knowledge, it could be possible to think of the different and to construct future possibilities for its characterization. In comparison to other approaches to discourse analysis identified in this scope review, Foucauldian discourse analysis was the only one that gathered these dimensions in a multi-layered analysis. This is further described in chapter 3.

In the following section, I present some of the most important concepts associated with discourse analysis in the wider social sciences and how they are used in the current study. In chapter 3, I further acknowledge the work of the two research centres most closely associated with the development of Foucauldian discourse analysis in medical education research, mentioned above, as well as presenting examples of this method in use.

2.3 Discourse, discourse analysis and policy

2.3.1 Discourse and Foucault

Before presenting a theoretical account of Foucault's discourse analysis, it is important to define the term "discourse". The conceptualization of discourse, like other ideas in the social sciences, is complex and contested. I aim to present different theoretical interpretations of the term and highlight the approach that best supports the work described in this thesis. The theoretical systems that conceptualize discourse are associated with particular assumptions about the natural and social world (ontology) and how one achieves knowledge of it (epistemology). David Howarth (2000) has described five theoretical systems characterizing discourse: positivist, realist, Marxist, structuralist-constructivist and post-structuralist.

According to Howarth, the positivist understanding argues that discourse is a collectively shared "frame" or "cognitive schemata" of the world and identity that validates and inspires communal action. The goal of analysis is to measure how successfully a social group achieves these communal ends through the use of discourse. A realist perspective understands discourse as a particular object with an impact on the real world; the aim of a discourse analysis is therefore to discover how language, as a structured system, impacts the social world. Marxists emphasize the role of discourse in generating and maintaining a particular social-economic structure. Discourse from this perspective forms part of a socio-political system that supports an unequal allocation of power and capital. A critical discourse analysis, therefore, has to uncover how discourse misleads, and offer emancipatory alternatives (Howarth, 2000).

The structuralist-constructivist approach to discourse analysis, represented by the work of Norman Fairclough, differs from the positivist, realist and Marxist views in its emphasis on human meaning and understanding in explaining the social world. Fairclough assumes both social structure and human agency play a part in conceptualizing discourse and its relationship to society. A discourse analysis, from this perspective, scrutinizes this dialectical relationship and discovers how language and meaning are used by dominant actors to mislead and subjugate the dominated (Howarth, 2000).

Finally, the post-structuralist approach adopts the hermeneutical focus on social meaning considered by the structuralist-constructivist perspective and expands this to the social structure itself. The latter is seen as uncertain, unfinished and contingent. Discourse involves all practices and meanings determining a community of social actors. A discourse analysis, through this approach, investigates the historical and political production and functioning of discourse. This perspective is heavily influenced by the work of Foucault.

For Foucault himself, discourse is a written or spoken communication that actively contributes to the construction of knowledge and the social world (Foucault, 1970). It comprises a body of knowledge which systematically creates and reproduces particular social institutions. Discourses help maintain systems of social meaning which normalize and regulate people in disguised and seemingly natural ways. The policy documents analysed in this research are one such example. Medical education undergraduate policy constructs an ideal scenario to be achieved

by medical schools, teachers, university hospitals, students and clinical tutors. It also highlights the particular problems in medical education to be tackled. In this way, policy documents sustain a network of social meaning that regulates and controls subjects involved in medical education in an accepted way. In section 2.3.5, below, I describe the conceptualization of policy considered by this research. Chapters 5 and 9 show how the policy documents analysed in this research became accepted as regulatory in terms of their nature and perceived impact.

Foucault´s (1970) theory defines external and internal systems of exclusion that give stability to social institutions through discourse, defending them from external and internal critics. External systems include social procedures of prohibition (i.e. taboos, rituals, opposition between madness and reason) and the opposition between true and false. Internal systems include discipline-structured institutions (e.g. medical specialty departments), the restriction of rights to claim, use and restate knowledge, and fidelity to the author (Hook, 2001). Medical education can be seen as employing both systems of exclusion. An example of an external system is the assumption that professional institutions, in this case medical institutions, should be responsible for developing professional education policies (therefore, an engineering institution would not be involved in medical education). An example of the internal system of exclusion would be assigning the role of policy creation to a specific institution or committee, such as the education committee of the GMC. Documents produced by other institutions would be less valued and perhaps even ignored by a general medical audience. The characteristics of the post-structuralist perspective of discourse and discourse

analysis fit well with the study described in this thesis. My aim is to examine the construction of general practice knowledge in medical education policy throughout recent history. The assumption that discourse is contingent – i.e. politically and historically constructed – helped build a critical perspective of medical education and general practice.

2.3.2 Types of discourse analysis & Foucauldian discourse analysis

As described above, discourse analysis comprises several different methods, the best known being conversation analysis (positivist), critical discourse analysis (structuralist) and Foucauldian discourse analysis (post-structuralist). Wetherell et al (2001)have described four broad approaches to discourse analysis. The first focuses primarily on language itself, from a linguistic theoretical perspective. Researchers using this approach are most likely to explore the vocabulary and structure of language, describing regularities within an imperfect and unstable linguistic system. The second approach is focused on the use of language in human interaction, where meaning is both created and constrained by the interactive context. The third approach is concerned with the terms used in a particular topic or activity and how this use of language serves to create objects of reference. The fourth approach aims to identify the use of language as an instrument of power which enables and constrains not only ideas but also actions. Foucauldian discourse analysis comes into this latter category, but adds a historical perspective. History, from this viewpoint, is not merely seen as a continuum of events but is essentially characterized by discontinuities, which are expressed in the use of language (Foucault M. , 1972).

Taking into consideration the aim of this research, which is to understand the description of general practice knowledge in medical education policy over a period of time and in two different contexts, a Foucauldian approach to discourse analysis seemed appropriate, given its focus on power and knowledge relationships in different cultures and epochs (Wetherell, Taylor, & Yates, 2001).

2.3.2.1 Terminology

In my reading of studies which purport to use a Foucauldian approach to discourse analysis, I came across a number of different terms to describe the method employed. These included “Foucaultian discourse analysis”, “Foucauldian critical discourse analysis”, “discourse analysis informed by Foucault”, and “Foucauldian genealogical discourse analysis”. In some cases, the same author used more than one term. These inconsistencies could be seen to indicate different approaches or emphases in conducting a discourse analysis informed by Foucault’s theory. However, in most cases it was not possible to correlate the authors’ description of their method (chapter 3) with a specific nomenclature.

Foucault was clear about his wish not to found a school of thought or method under his own name. In his works on sexuality, madness and medicine, for example, he made no attempt to define a specific research technique. His position shifted, however, with his book *The Archaeology of Knowledge* (1972), in which he finally outlined the basic elements of his analytical method. Since then, many authors have produced guidance and protocols on conducting an analysis from this theoretical perspective. These mostly emphasize Foucault´s understanding of discourse, power and

knowledge and his method (archaeology, genealogy and self-technology) of examining this triad (Foucault M. , 1972). My understanding and use of this method is further described in chapters 3 and 4.

I chose the term “Foucauldian discourse analysis” for the current study as it is the one used most often in medical education research literature. I do not take as the main objective of my doctoral research a complete methodological discussion, which could be the focus of a whole PhD in itself. Throughout my PhD, I have worked on understanding the method of performing a discourse analysis informed by Foucault and relevant authors who take a similar theoretical position. A common acknowledgement of these authors is the absence of a straightforward step-by-step guide to Foucauldian discourse analysis. This has allowed different perspectives to emerge.

2.3.3 Foucault’s theory

Niels Andersen sees Foucault as a constructivist in relation to the social sciences (2003). Constructivism, to Andersen, is a critique of the traditional method of analysing the present and the future using established categories from the past. He understands Foucault´s work as questioning the construction of categories themselves, as well as concepts, history and its transformations. This is exactly what the current research sets out to investigate: the discursive construction of general practice (one of the categories in medical knowledge) in undergraduate medical education in history.

According to Willig, Foucault is a post-structuralist, adhering to the notion that language constitutes social and psychological life (Willig, 2001). The availability of discourse in a given culture enables and constrains what is

said, to whom, and when. She defines discourse as a set of statements that construct an object and a subject (psychological) position, describing a way to view the world and to be in the world. From this perspective, a discourse is an exercise of power which legitimize social structures and realities that are destined to become common sense. Discourses, though, are not static: they change over time, allowing counter-discourses to emerge. Changes in discourse over time have an important effect on social life and subjectivities. As Willig explains, Foucault considered not only the individuals involved in the production of discourses but also their relation to institutions. Institutions support discourses, which in turn legitimize the institutions, helping them to shape subjectivity, i.e. how people think, feel and act (Willig, 2001).

According to Andersen, Foucault developed a school of thought under his name, despite proclaiming against this notion (Andersen, 2003). In so doing he prepared the theoretical ground for an analytical strategy. As well as being a discourse analyst, Foucault can also be viewed as a formation analyst who investigates the creation and emergence of objects. His concepts are developed according to certain characteristics, such as a distinction between ideas, versatility (polyvalence), negative delimitations and the general absence of positive definitions. His work, to Andersen, is consciously unsystematic (Andersen, 2003).

With regards to structuralism and post-structuralism, both of which are concerned with latent logic to some degree, Andersen classifies Foucault as a transformation structuralist. For him, discourse is not itself a structure: each statement has to be considered individually as it comes into being (whereas a structure is supposed to be questioned through diachronic

analysis). It is the writer´s construction of the historical relationship between discourse and institutions that transforms structures (Andersen, 2003).

2.3.3.1 The concept of history for Foucault

Foucault is responsible for a new way of thinking about history and its relationship to current political struggles. He does not concern himself with the idea of progress from the past, or how historical facts inevitably inform the present. Instead, he is a historian of discontinuity. According to Mark Poster (1982), Foucault is influenced by Nietzsche's *The Use and Abuse of History*, in which the latter criticizes the theories of knowledge and the epistemology of history. In this work, Nietzsche associates the quest for knowledge with the will for power. The supposed impartiality of science is used to disguise the power struggle that lies beneath (Poster, 1982).

Foucault attributed to history, as a field of knowledge, the same struggle for power that Nietzsche conceptualized. He questions what the historian does to the past when producing continuity in a historical account. For Foucault, the historian creates an account of the past through conceptualizations of the present, proclaiming the attainment of truth without putting in question his own position. The historian becomes a source of power that produces the truth. The view that considers a historical account as a continuous truth is called by Foucault *total history,* in reference to a Hegelian totalization of the past and present (Foucault, 1972). In opposition to the concept of total (continuous) history, Foucault emphasizes the *discontinuities* in history as evidence of power struggles at different historical moments. This is exemplified by his account of the history of medicine and sexuality, discussed in the methods chapters. In this thesis, I present two historical

accounts of medical education – in the UK and Brazil – detailing the involvement of general practice in both countries. The first background account (chapters 5 and 9) is consonant with what Foucault described as total (continuous) history. The second is the result of a discourse analysis of policy documents in both countries (chapters 6-8 and 10-11). This is consonant with Foucault's understanding of discontinuous history.

2.3.4 Foucauldian discourse analysis

Foucauldian discourse analysis offers a distinct approach to policy research by considering wider settings and thoroughly scrutinizing discourses instead of imposing a particular theoretical agenda upon particular texts.

Foucauldian discourse analysis exposes the link between textual sources and the power held by social institutions, drawing attention to concerns about domination and subordination. Discourse refers to a system of expert language, granting membership and authority to those who possess it and establishing distinct styles of communication. Moreover, Foucauldian discourse analysis identifies how people construct objects and subjects, incorporating historical contexts but without necessarily accepting prior understandings (Willig, 2004).

As a discourse analyst, Foucault is concerned with questioning discursive assumptions and utterances relating to rules of acceptability (Andersen, 2003). He criticizes the way in which the humanities and social sciences establish regimes of knowledge and truth in order to regulate individuals and societies. The production of discourses involves including and excluding procedures, which are related to power relationships in society. The main intention of discourses, in Andersen's reading of Foucault, is to control,

as can be seen in Foucault's discourses on criminality, madness and sickness.

Andersen argues that Foucauldian discourse analysis can be defined using Foucault's own method: through negative delimitations. Discourse analysis is not a textual analysis, because a text exists due to a network of conditions in relation to other texts and discourses, which constitute a discursive field. It is not a literary analysis, because an *oeuvre* cannot be assumed to have a homogeneity or unique perspective. It is not structural, because it does not express an unspoken structure or truth, just as it is not a commentary attempting to expose underlying meaning. Foucauldian discourse analysis is, rather, the analysis of the statement in its emergence or positivity, what Foucault called a pure description of discursive facts (Andersen, 2003).

Andersen described the Foucauldian concept of the "archaeology of knowledge" as an understanding of discursive formation through the regularity of dispersed elements. Its historical dimension is referred to as the "genealogy" of knowledge, which is analysed in terms of continuity and discontinuity. Foucault was inspired by Nietzsche's work on the genealogy of morals, which described three types of historical study: (1) the monumental method, which harmonizes heterogeneity; (2) the antiquarian method, which protects and glorifies the past; and (3) the critical method, which breaks up and interrogates the past in order to build a new future (the present, past, and future methods) (Andersen, 2003). In the latter, history is regarded as a constructed perspective of reality.

The Archaeology of Knowledge (1972) was Foucault´s only explicitly methodological work, describing, in an "après coup" reflection, the methods of thinking and research he used in previous studies, for example of madness and medicine. In the following chapter, I describe his reflections on discourse analysis and how authors in the field of medical education and elsewhere have embraced the Foucauldian approach.

The following section describes the understanding of policy as a concept and its importance to this research.

2.3.5 Policy as text and discourse

According to the Cambridge English Dictionary, policy is a "set of ideas or a plan of what to do in particular situations that have been agreed to officially by a group of people, a business organization, a government, or a political party". In this study, I have used Stephen Ball's understanding of policy as text and as discourse (Ball, 1993). As text, Ball considers policy an intervention into practise determined by a complex relationship between different groups through "struggles, compromises, authoritative public interpretations and reinterpretations". The understanding of policy text is equally complex and involves the reader's interpretation of meaning in regards to their past, experience, abilities, supplies and background. In this sense, policy is constantly being re-interpreted/modified and it is impossible to predict how it will affect practice. Ball cites Foucault's perspective of policy: "Policies typically posit a restructuring, redistribution and disruption of power relations, so that different people can and cannot do different things" (Foucault M. , 1977).

Ball emphasizes that a purely textual understanding of policy will focus on what policy conceives as possible, but overlooks what it does not. He regards policies, like discourses, as capable of producing a “truth”. Ball, again, uses Foucault’s understanding of discourse: “Discourses are not about objects; they do not identify objects, they constitute them and in the practice of doing so conceal their own invention” (Foucault 1977). In this understanding, only certain voices are accepted as meaningful and therefore authorized to produce policy (Ball, 1993). This dual conception of policy as text and discourse influenced my choice of method and document selection in this study. In the following section, I make a distinction between policy analysis and policy as data for documentary research.

2.3.5.1 Policy analysis and policy as data for documentary research

In this section, I distinguish the use of policy as data, which is the approach taken by the current research, from policy analysis, which is an important but separate field of knowledge, involving different methods and focus. Policy analysis is defined by Greva-May and Pal (1999) as: ‘a technique used in public administration to enable civil servants, activists, and others to examine and evaluate the available options to implement the goals of laws and elected officials. Policy analysis involves the appraisal and examination of the making and implementation of a programme or sequence of actions. It also aims at "determining which of various policies will achieve a given set of goals in light of the relations between the policies and the goals." (Geva-May & Pal, 1999).

Policy analysis has long been the object of research, especially in the social sciences. An understanding of its conceptualization, research

methods and struggles has certainly contributed to the critical perspective I adopted towards the data analysed in my research: the concepts of policy, policy analysis and policy cycle (a tool used for analysing the development of a policy item), for example, informed all phases of my research, including the historical review, data collection, analysis, interpretation and conclusions. Analysing policy documents without this critical perspective could be compared to following a hermeneutic approach without Heidegger's insight: it would be like reading a text without considering the author's life, social condition, historical context and other aspects that could have played a major role in the document's creation. It is beyond the scope of this thesis to detail the relevant insights offered by the policy sciences, for example into the politics of power and the role of internal and external conditioners. I have, however, drawn on the work of several authors to enrich my own perspective of this field, including Lowi and Ginsburg, Dye, Jenkins, Anderson, Dunn, Ferrera, Lasswell, Fischer, Fairclough and Ball.

Despite these important influences, I do not consider my research to be a policy analysis of undergraduate medical education. While I recognize that the findings might be of interest to policymakers, I am not investigating the policy process involved in the creation of the documents used as data for the analysis. Instead I consider my research to be a discourse analysis of policy documents on undergraduate medical education, mapping how discursive practices produce general practice knowledge with a focus on assumptions of power, history and knowledge from a Foucauldian perspective. As an empirical example of this kind of research, I would cite the work of Carabine (2001) on the discourse on unmarried motherhood in public

policies (1830 and 1990) and of Whitehead et al. on medical education in North America (2010): both are further described in chapter 3.

Reflecting on the concepts described in this section gave me the theoretical background to consider each step of the research process. The historical review of the object of research was influenced by the evident complexity of the political agenda behind the production of policies. Documents analysed for this research were considered the most influential of their time; this was confirmed by their frequent appearance in the literature on medical education in both countries and by my conversations with key interlocutors (researchers and university teachers) involved in medical education. The selection of documents is described in detail in chapter 4.

2.4 Conclusions

In this chapter, I have described the current state of medical education research and its use of discourse analysis. This scoping review has helped me further delimit the research gap addressed by my study. No other study in medical education research literature has addressed the characterization of general practice as a field of medical education knowledge in undergraduate policy through a comparative design. I have also identified several authors and institutions currently developing discourse analysis in medical education research. This is further explored in the methodology chapters (3 and 4). I have then broadened the understanding of discourse and discourse analysis and presented the perspective used in this research to address the specific research question. Finally, I situated policy text as data to be analysed in this study and differentiated from policy implementation analysis.

3 THEORETICAL AND EMPIRICAL UNDERSTANDING OF FOUCAULDIAN DISCOURSE ANALYSIS

In this chapter, the chosen research method is described in detail. There are two reasons for providing such an in-depth account: (1) Foucauldian discourse analysis is not widely used by the medical education research community; (2) the method allows researchers some flexibility in its interpretation and implementation. It is important, therefore, to clarify the approach taken and acknowledge the influence of other researchers who have employed the method, both inside and outside the field of medical education.

The first section of this chapter discusses Foucault's own account of his method, contained in his book *The Archaeology of Knowledge.* I describe what Foucault called the elements of discourse (i.e. object, statement, subject, concept, strategy) and the focus of his discourse analysis: the discursive formation.

The second section sets out a practical approach to Foucauldian discourse analysis, drawing on the work of two authors who have made extensive use of the method, Willig and Andersen. In the substantial and diverse literature on this method, I have chosen these two authors for two main reasons: (1) they have developed detailed guidelines for the operationalization of the method; (2) they have different academic backgrounds (psychology and politics, respectively) that evidence the possibilities of different emphasis in this approach.

The following three sections describe how some selected authors operationalized Foucauldian discourse analysis in medical education policy

and in the social sciences. The medical education researchers described were identified in the scoping review detailed in chapter 2. Nevertheless, while information was provided about methodological choices, there was little detail provided about the contextual ways in which the method was applied during the analysis process. For this reason, I have included one author from the social sciences, Jean Carabine, who has employed the method to study policy documents through a well described operationalization. Her analysis included a detailed sentence-by-sentence examination of the text which delimited the construction of the analytical categories in consonance with Foucault's concepts (discursive objects, subject positions, strategies). Her operationalization represented to me a rigorous way capturing the data in the policy text before thinking about the broader discursive categories and working across two different countries and languages. This detailed approach facilitated the comparison between the two different contexts through their differences, similarities and connections.

In the fifth section, I compare how each of these authors has used the discursive elements described by Foucault. This sets the scene for chapter 4, which explains how this literature informed my approach of this research.

3.1 Foucault's approach to discourse analysis

This section presents an understanding of Foucauldian discourse analysis – its intentions, concepts, methods, questions and concerns – based on Foucault's own work. I focus particularly on his 1972 book *The Archaeology of Knowledge*, in which he describes the analytical approach of his previous studies.

This section outlines the elements of discourse that are fundamental to applying a Foucauldian discourse analysis, including the *discursive object, statements, the enunciative function, concepts, strategies,* and *discursive formation*. The analysis of these discursive elements constitutes the *archaeological* dimension of the analysis. The *genealogical* dimension describes the vicissitudes of a discourse over time in relation to different institutional power networks. According to Foucault, discourse analysis is the (re)union of statements in their chronological dispersion, a process described in the following sections. For Foucault, the final goal of analysis is to define the *discursive formation*.

The section below describes each of the discursive elements listed above.

3.1.1 Defining object and statement

According to Foucault, objects are characterized by discourse: they are matters to be "*named, described, analysed, rectified, re-defined, challenged, and erased*". Foucault begins with a definition of a *statement* as "the atom of discourse", which can be contained within a proposition, sentence or speech. These "acts of formulation" are created by an author in a determined time and space and take the form of *signs*:

> "*…there is a statement whenever a number of signs are juxtaposed – or even perhaps – when there is a single sign. The threshold of the statement is the threshold of the existence of signs.*" p. 84 (Foucault, 1972).

A discourse can be characterized by an established group of statements. All statements (i.e. written or spoken) referring to the same object across time constitute a group or a unity. With regards to the current research,

general practice knowledge is the *object* that the *statements* identified in policy documents characterize, relate to and define.

Foucault affirms that statements serve the function of revealing unities and structures in time and space. He called this the *enunciative function*:

> "*It is this function that we must now describe as such, that is, in its actual practice, its conditions, the rules that govern it, and the field in which it operates.*" p. 87 (Foucault, 1972).

The *rules* described here relate to assumptions of truth which, even if not clearly expressed in a discourse, are taken for granted by the author. These *rules/assumptions of truth* allow for discourse formation and are a major component of a Foucauldian discourse analysis, as described in the following sections.

Statements construct, identify and classify discursive *objects* (Andersen 2003). They also create the *subject position* of individuals, in that whoever speaks, writes or signals a statement must take the position determined by that statement. By building the rules that allow other elements to be created and reproduced, the statement expresses or refers to a *conceptual network*, either implicitly or explicitly. In this way statements are able to re-actualize concepts relating to the past, the present and the future. Statements are also integrated into a discursive *strategy*, determined by time, place and materiality. This strategy defines its own context of origin (i.e. among a range of other possibilities), always in close relation to time and space. "The world comes into being through the statement as event!" (Andersen, 2003).

3.1.2 The enunciative function

The enunciative function is not solely concerned with the relationship between the signifier and the signified or the connection between a sentence and its meaning. A statement's enunciative value pertains to its assumption of truth. The latter relates to the laws of possibility or rules of existence for what is "named, designated, or described" (Foucault, 1972). In short, the enunciative function *states* the conditions in which *subjects* and *objects* are characterized. It attributes a *value of truth* to the statement and establishes what is *conceivable or possible* in a particular discourse. Foucault writes:

> "*The referential of the statement forms the place, the condition, the field of emergence, the authority* ***to differentiate between individuals or objects****, states of things and relations that are brought into play by the statement itself;* ***it defines the possibilities of appearance*** *and delimitation of that which gives meaning to the sentence,* ***a value as truth to the proposition****. It is this group that characterizes the* ***enunciative level of the formulations****, in contrast to its grammatical and logical levels…*" p.91 (Foucault, 1972).

Analysis of the difference between statements on the same or diverse objects reveals each statement's enunciative dimension, while the variance of statements within a single discourse reveals its enunciative function, as described by Foucault:

> *"…the description of the enunciative level can be performed by the analysis of* ***the relations between the statement and the spaces of differentiation****, in which the statement itself reveals the differences*." p.92 (Foucault, 1972).

The statement, through its enunciative function, also has a peculiar relationship with the *subject* of a discourse (which is differentiated from the object). A statement characterizes the possible positions available to these *subjects*, relating individuals and social groups to the possibilities of practical

action in reality. A statement's *subject* can in fact alter within the same piece of writing in accordance with rules determining the emergence of *objects* and *statements*. Concerning the positions available for *subjects* to occupy, Foucault stated:

> *"… According to a **certain grid of explicit or implicit interrogations**, he is the questioning subject; according to a certain **programme of information**, he is the listening subject; according to **a table of characteristic features**, he is the seeing subject, and, according to a **descriptive type**, the observing subject…*" p. 52 (Foucault, 1972).

Foucault highlighted in this way variations in the *subject positions* available to actors, given a specific discourse. The enunciative function, he wrote, determines *"… what position can and must be occupied by any individual if he is to be the subject of it*" (p. 96).

With regards to the authorship of a text, which he described as a differentiated *subject position*, Foucault posed the following questions: "*Who, among the totality of speaking individuals, is accorded the right to use this sort of language? Who is qualified to do so?*" p.50 (Foucault, 1972). He illustrated this using the subject position of the medical doctor, which comprised a system of knowledge, institutions and legal conditions that entitled an individual to act, speak and write about the body, disease, life and death. Foucault also highlighted the importance of describing the institutions from which an author derived his privileges. In the case of a doctor, he described these as the hospital, private practice, the laboratory and the "library" or "documentary body" (Foucault, 1972).

An enunciative function cannot operate without another function, made up of alternative formulations, to which it relates in a positive, negative or neutral way. According to Foucault, all elements of a discourse are

characterized by their relationship to other discourses from various fields of knowledge:

> "*It is not enough to say a sentence, it is not even enough to say it in a particular relation to a field of objects or in a particular relation to a subject, for a statement to exist: it must be related to a whole adjacent field.*" p.97. (Foucault, 1972)

In this way, enunciative functions from other discourses are re-stated, adapted or recreated, building a network that is not limited to one knowledge field, and with which a specific discourse might be in agreement and/or opposition. Foucault described the relation between discourses from different fields of knowledge in the following quote:

> "*The associated field is also made up of all the formulations to which the statement refers implicitly or not, either by repeating them, modifying them, or adapting them, or opposing them or by commenting on them…*" p.98. (Foucault, 1972)

This network, Foucault concluded, exposed the social dispute expressed in discourse and its elements:

> "*Thus the statement circulates, is used, disappears, allows or prevents the realization of a desire, serves or resists various interests, participates in challenge and struggle, and becomes a theme of appropriation or rivalry.*" p.110 (Foucault, 1972).

In summary, there are four domains in which the enunciative function operates: the formation of *objects,* of *concepts,* of *strategic choices* and of *subjective positions* (Figure 4 summarizes this). These domains provide the main focus of Foucauldian discourse analysis and should be regarded as the delimitation of discourse in time and space (Foucault, 1972). Understanding the four domains reveals a particular *discursive formation*, which is the final goal of a Foucauldian discourse analysis. Each domain is described in the sections that follow.

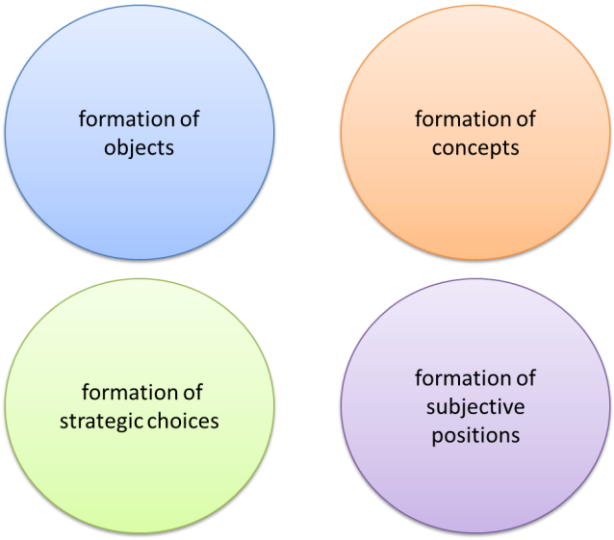


Figure 4. The four domains of Foucauldian discourse analysis. (Foucault, 1972)

3.2 Focus of the analysis according to Foucault

3.2.1 The formation of objects

In a discourse, objects are "*named, described, analysed, rectified, re-defined, challenged, and erased*." (Foucault, 1972) p 41. Foucault asks if it is possible to determine the rules (assumptions of truth) that make possible the object´s appearance and change. In order to accomplish this task, Foucault suggests three steps (1972):

The first step in understanding the object's formation, according to Foucault, is to map its emergence demonstrating its distinctiveness in terms of rationalization, conceptual understanding and theory (Table 2). Foucault wrote:

> *"… to define a group of statements in terms of its individuality would be to define the **dispersion** of these objects, to grasp all **the interstices that separate them**, to **measure the distances that reign between them** – in other words, to formulate their **law of division**."* (Foucault, 1972)

The analytical process of characterizing the object (i.e. by isolating a cluster of statements) describes how a discursive object is formed. An object is formed not only through the description of its own characteristics, but also by identifying its differences with other discursive objects. This "negative description" of discursive objects implies a certain *law of division* or assumption of truth. However, the differences between objects are not universal: they vary according to society, period of time and form of discourse. Foucault explains, for instance, how madness went from being a concern of religion to one of medicine:

> *"In the nineteenth century psychopathology, they (caregivers) were probably constituted by the family, the immediate social group, the work situation, the religious community, which are all normative, which are all susceptible to deviation, which all have a margin of tolerance and a threshold beyond which exclusion is demanded, which all have a mode of designation and a mode of rejecting madness, which all transfer to medicine if not the responsibility for treatment and cure, at least the burden of explanation."* p. 41 (Foucault, 1972).

The second step is to describe the authorities or institutions and fields of knowledge which are entitled to name and establish the object. In the previous quote, this entitlement shifted from the family to the community to religion and finally to medicine, each of which promoted a different discourse on madness. The characterization of madness was thus transformed along with the subject positions available to individuals and social groups involved with it. It is important to understand how different institutional realms such as religion, science, laws, literature and arts theorize similar objects. Foucault cited the example of literary and art criticism:

> *"…which in the nineteenth century treated the work less and less as an object of taste that had to be judged, and more and more as a language that had to be interpreted and in which the author's tricks of expression had to be recognized.*" p. 42 (Foucault, 1972).

The final step (3) in defining the formation of the object is to specify the relationship and differences between *statements* describing the same *object*, using what Foucault referred to as a "*grid of specification"* (Table 2).

Table 2. Identifying the formation of objects ("grid of specification")

Steps in analysing the formation of a discursive object.	Conceptual differences between different objects (Step 1)	Authorities of delimitation (Step 2)	Differences and relationships in description of the same object (Step 3)
Object A			Object A1
			Object A2
			…
Object B			Object B1
			Object B2
			…
…			

It is not enough, however, simply to define these three dimensions of the *object*: Foucault considered it even more important to determine the missing links between heterogeneous objects in a discourse. The first stage in this process was to analyse the diverse historical contexts (i.e. the social, cultural, political and economic characteristics of a specific society at a specific time) in which objects emerged. The second was to understand that the object's conceptualization did not, by itself, define its properties: understanding the object's external relationship with other objects was also necessary to complete this step. These external associations included established (real) affiliations between institutions and the discursive (reflexive) links between them (Foucault, 1972). In his 1963 work, *The Birth of the Clinic*, for example, Foucault charted the progressive association of medical education apprenticeship models in the 19th century and the academic milieu

of universities to the medical daily practice and basic sciences developed in laboratory settings.

If the researcher is successful in defining these missing links, he/she may establish the laws organizing a series of diverse statements. According to Foucault these laws/rules of formation are stable during a specific period, whereas objects, subject positions and concepts have a more fluid characterization within the boundaries established by the rules that define what truth is. Foucault suggests a number of questions to help the researcher understand these links, such as: who is the authorized and qualified speaker; who accredits statements as true; what status does the speaker hold; and is this status approved by law or tradition? (Foucault, 1972). In order to answer these questions the researcher must investigate the institutions that authorize objects, statements and discourses. He should also look for a correlation between the subject of speech (author) and a group of objects, exploring how the author questions the object, what instruments he uses to observe the object, and what positions he takes in relation to the object.

3.2.2 The formation of concepts

Foucault believed that a discourse could also be identified through the description and analysis of "well-established" concepts involved in defining the unity of statements. He writes that: *"…one might discover a discursive unity if one sought it not in the coherence of concepts, but in their simultaneous or successive emergence, in the distance that separates them and even in their incompatibility."* (Foucault, 1972) *p. 35.* In the current study, this process of discovery involved identifying the concepts used in the

characterization of general practice knowledge and how they related to each other.

When considering a concept's importance in describing the objects of discourse, Foucault emphasized the significance of rules that allowed the emergence of concepts. He argued that these rules were not organized according to known logic: to understand the formation of concepts, one had to "*describe the organization of the field of statements*" (Figure 2). This *field of statements* in turn configured enunciative fields, in which statements and concepts from different fields of knowledge (i.e. medicine, philosophy, law, religion) were agreed with, criticized or excluded. In Foucault's words:

> *"…the enunciative field involves what might be called a* ***field of memory*** *where statements that are no longer* ***accepted or discussed****, and which consequently no longer define either a body of truth or a domain of validity, but in relation to which relations of* ***filiation, genesis, transformation, continuity, and historical discontinuity can be established.***" p. 58 (Foucault, 1972).

The *field of memory* associated with the enunciative field provides evidence of the relations between a discourse (from a specific field of knowledge) and other fields of knowledge. These are traceable through the use of statements and concepts in agreement or disagreement, included or excluded. Therefore, the relations between the fields of knowledge in a discourse provide additional information to analyse the formation of concepts. Moreover, concepts used in a particular discourse can be consistent with or differentiated from the same concepts in another discourse.

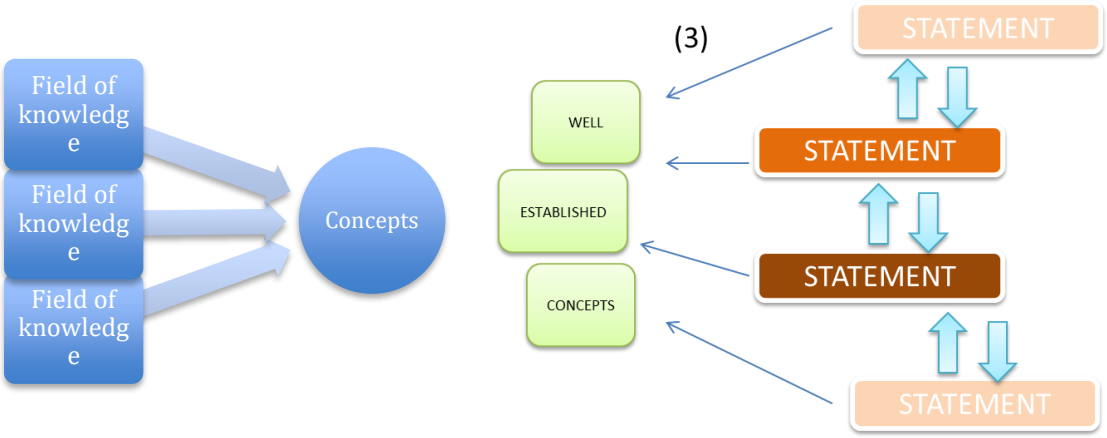


Figure 5. Emergence of concepts from various fields of knowledge

The connection between the elements presented in Figure 5 is just as important for the analytical process. As Foucault remarked: "*It is this group of relations that constitutes a system of conceptual formation*". Comparing the rules of formation of concepts in different contexts or fields of knowledge should help to reveal these connections.

3.2.3 The formation of strategies

Different discourses (e.g. on the economy or medicine) organize concepts and rearrange groups of objects that, through a set of rules or assumptions of truth Foucault called *strategies*, develop into a theory. These *discursive strategies* are the stance taken in the current social context through the inclusion and exclusion of other discourses. As an example, Foucault highlights how the analytical focus in *The Birth of the Clinic* was not on medical theory but on the position held in society by the field of knowledge and the doctor. One of the strategies identified in this study endorsed a new subject position for doctors in the late 18th century, entitling them to observe, question, search, touch, treat and write about the body, disease, life and

death. This medical discourse was understood as unquestionable and remained so for a long time. In *The Birth of the Clinic,* Foucault explains that:

> *"the essential point of the research was the way in which, at the end of the eighteenth and the beginning of the nineteenth century, the enunciative forms of medical discourse had been modified; the analysis was concerned therefore less with the formation of conceptual systems, or the formation of theoretical choices, and more* ***with the status, the institutional siting, the situation, and the modes of insertion used by the discoursing subject****."* p.65 (Foucault, 1972).

According to Foucault, in order to clarify these strategies one should follow three directions (Figure 5). The first consists of identifying a discourse's *points of diversion*. These can be understood as *points of incompatibility* which do not fit neatly into a particular series of statements but can nevertheless be seen as *equivalents,* as they are formed based on the same rules or *strategies*. Such *points of diversion* do not constitute an error of analysis but rather an internal contradiction revealed through careful reading. Foucault aimed to relate these *"equivalent incompatibilities*" as sub-groups within a discursive system.

The second direction consists of a study of the *economy of the discursive constellation*. This considers the strategic choices of inclusion and exclusion made by guiding authorities:

> "*A discursive formation does not occupy therefore all the possible volume that is opened up to it of right by the systems of formation of its objects, its enunciations, and its concepts; it is essentially incomplete, owing to the system of formation of its strategic choices.*" p. 67.

The third direction involves the identification of the authorities involved. These are characterized by the influence of the discourse in actions taken in daily life and by who is entitled to a discourse and how. Authorities

are also distinguished by the discourse's influence in society and how it awakens desire. In Foucault´s words:

> *"… the analysis of this authority must show that neither the relation of discourse to desire, nor the processes of its appropriation, nor its role among non-discursive practices is extrinsic to its unity, its characterisation, and the laws of its formation."* p 68.

These three aspects should be understood as part of the discursive strategy constructed at a specific point in time.

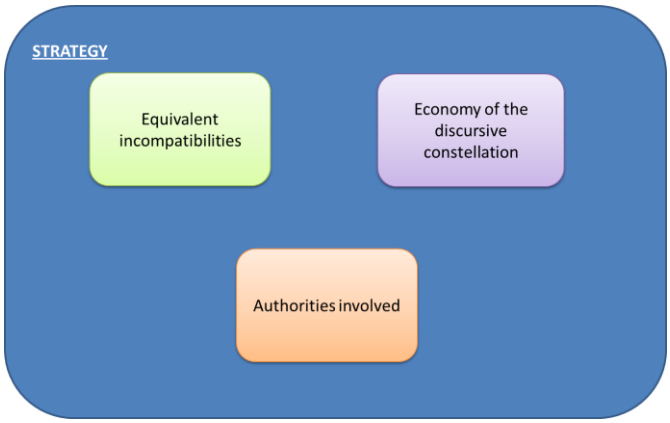


Figure 6. Three directions to clarifying strategic choices in a discourse

Foucault suggests that the unity of a discourse is established by the set of *rules* that allow the object's occurrence during a given timeframe. When describing the transformation of statements in his previous study on the vicissitudes of medical discourse, Foucault regrouped medical knowledge into a new set of statements, which were influenced by prevailing rules from different periods of medical history. The following quote describes, for instance, how cell pathology gained importance in medical practice, displacing an information system based purely on clinical examination of the patient. The doctor's role was thus modified and new tools of investigation adopted. Foucault wrote in *The Archaeology of Knowledge*:

> *"I also had recognized that this description has constantly been displaced: either because, from Bichat to cell*

> *pathology, the scales and guide-lines have been **displaced**; or because from visual inspection, auscultation and palpation to the use of the microscope and biological tests, **the information system has been modified**; or, again, because, from simple anatomo-clinical correlation to the delicate analysis of physio-pathological processes, the lexicon of signs and their decipherment have been **entirely reconstituted**; or, finally, because the doctor has gradually ceased to be himself the locus of the registering and interpretation of information, and because, beside him, outside him, there have appeared masses of documentation, instruments of correlation, and techniques of analysis, which, of course, he makes use of, but which **modify his position** as an observing subject in relation to the patient. All these alterations, which may now lead to the threshold of a new medicine, gradually appeared in medical discourse throughout the nineteenth century." p. 33-34* (Foucault, 1972).

In terms of the aims of the current research, a Foucauldian discourse analysis supports the identification of rules that allow the emergence of a characterization of general practice knowledge in undergraduate medical education in the UK and Brazil, over time and in different social contexts. To Foucault, this collection of rules or assumptions of truth make up what he described as the *archive.* Therefore, the *archive* of a discourse is the group of strategic choices that establish a system of what is or is not possible. It is important here to distinguish the *archive*, as described by Foucault, from the collection of documents that constitute the data set under analysis. The latter constitutes the totality of documents to be analysed in a research study, which is gradually defined during the research process through progressive additions and subtractions. Foucault's *archive* represents one of the products of the analytical process: it is the set of rules that determines which *objects, subject positions* and *concepts* are available in a discourse.

3.2.4 The formation of subjective position

In understanding an individual´s manifestation as a subject, Foucault, in his later theoretical development, talked of the *"Technologies of the Self"* (1988), a means of analysing the relationship between individuals and their subject position according to a particular discourse. *Technology* in this context refers to the way in which discourses "*pertain to the self-relation of the subject to its self-care*". The discourse can offer a position, in a process called *subjection,* and the subject has more or less freedom of choice to accept and incorporate this position to a greater or lesser extent: a process called *subjectivation.* *Subjection* implies a taken for granted position; *subjectivation* implies the autonomy of subjects to take certain positions (Porter, 2006). This research considers the subject positions produced by the analysis of the policy documents (subjection). The analysis of the subjectivation process would need to include other methods of investigating the impact of policy in practice (i.e. observation, interview, ethnography). It would consider four aspects of the formation of the subject position: (1) how the individual transforms him/herself from subjection to subjectivation; (2) the forms of knowledge the individual can establish about himself (as self) with regards to feelings, desire, will and culture; (3) self-activating activities like diaries, confession, time manager, competence interviews; (4) the need to go beyond mere activity. The process of subjectivation could be the aim of future investigations.

3.2.5 The final product of analysis: describing a *discursive formation*

The development of a theory regarding a *discursive formation* – the end product of Foucauldian discourse analysis – involves the regrouping of statements into new unities based on their interconnection through recurrent themes. Foucault writes:

> *"…whenever, between objects, types of statement, concepts, or thematic choices, one can define a regularity (an order, correlations, positions and functioning, transformations), we will say, for the sake of convenience, that we are dealing with a discursive formation."* p. 38.

To recap, there are the four steps leading up to this process (Figure 7): (1) the formation of *objects*; (2) the description and analysis of statements associated with the same *object* (i.e. the extent to which they agree or disagree); (3) the analysis of the formation of *concepts*; and (4) the analysis of the formation of *strategic choices*, which finally defines new groupings of *statements*.

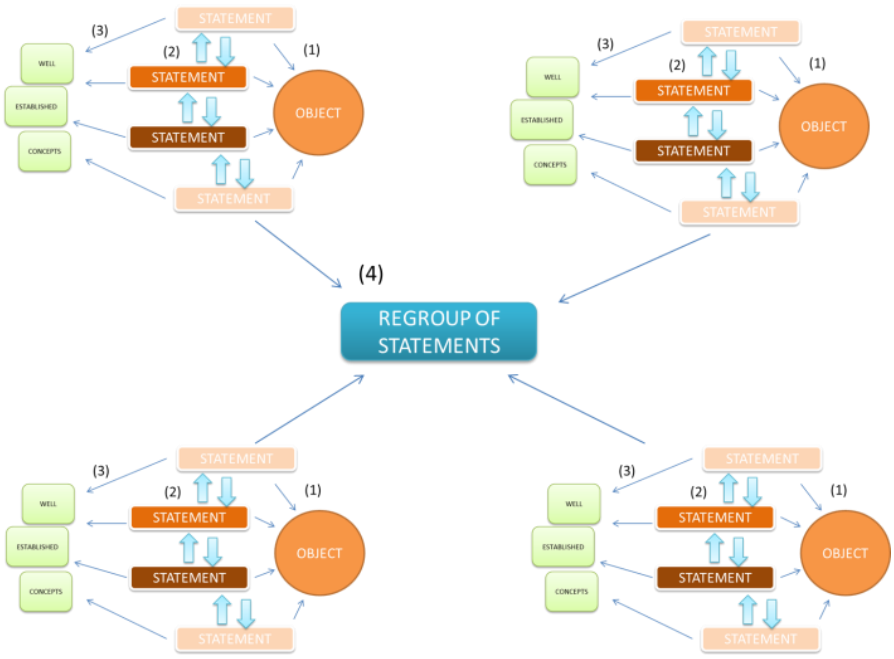


Figure 7. Identifying a discursive formation

Whilst the discursive formation itself consists of a regrouping of statements, the rules of formation are the conditions that make this division possible. In my study, one of the considerations when analysing data is whether general practice can be characterized as a discursive formation in undergraduate medical education policy.

In conclusion, the discursive formation comprises a dispersion of elements, which can be (re)grouped once the rules or system (4) that make this possible are elucidated. These rules apply to the formation of *objects, statements, concepts* and *strategies* relating to that *discursive formation*. Foucault underlines the point that the system or *rules* of formation include the relationship between institutions, techniques and social groups involved in a discursive practice. In my research, this meant identifying the network of social entities involved in producing the discourse of general practice in undergraduate medical education.

3.2.6 Conclusions

My analysis of Foucault's approach to discourse gave me the insight not only to conduct the current research but also to assess other authors' use of Foucauldian discourse analysis (see below). In the following section, I highlight Willig's and Andersen's theoretical understanding of Foucauldian discourse analysis. In my own approach, I have combined my understanding of Andersen's use of Foucault's concepts and phases with Willig's adaptation of Foucauldian discourse analysis to a field of knowledge (psychology) and object of research (conversations). The subsequent section describes the work of authors in medical education and their empirical use of discourse analysis influenced by Foucault's rationale.

3.3 Operational understanding of Foucauldian discourse analysis

Foucauldian discourse analysis has been studied and used in many different ways. For this research, I have drawn particularly on the approaches of Carla Willig (2001) and Niels Andersen (2003). These authors have developed operational guides to conduct a Foucauldian discourse analysis. Their different theoretical backgrounds offer insight on the different approaches to the method. Despite acknowledging the researcher-dependent nature of the method, both identified a series of steps which constitute a theoretical guide to Foucauldian discourse analysis. I found this helpful both to understanding Foucault's approach and to defining my own research method. In this section, I describe these two authors' approach to Foucauldian discourse analysis to highlight their different interpretations of the method.

To begin with, I describe Willig's method and how it relates to my own research *object*. Willig's method consists of six steps (2001):

Table 3. Willig's steps to Foucauldian discourse analysis (Willig, 2001)

Willig's steps	Correlation to my research's discursive elements
Step 1: "Discursive Constructions - identification of the discursive object constructed through lexical references and shared meanings."	The discursive object is general practice, which is "constructed" or characterized in policy texts.
Step 2: "Discourses - identification of various discursive constructions of the discursive object within a wider discourse."	General practice is presented differently in space (UK and Brazil) and time (historically).
Step 3: "Action Orientation - analysis of how and why the object discourse is constructed in a particular way, and how it gains functions, and relates to other constructions.	Analysis of why general practice is characterized in a particular way and its relationship to students, patients, health systems and other medical specialties.
Step 4: "Positionings - identify the subject's positions or location for persons, within a structure of rights and	Identify the position of general practitioners and the repertoire offered to them in medical education.

duties, who use that repertoire offered by the various constructions."	
Step 5: "Practice – discourse analysis maps the possibilities for action contained within the discursive constructions identified in the text."	Analyse the practical role of the general practitioner in medical education and health systems.
Step 6: "Subjectivity - traces the outcomes of adopting various subject positions by drawing links between discursive constructions and personal experiences."	Trace the relationship between the discursive characterization of general practice and the practical teaching experience of general practitioners. [This step is not considered in this research.]

It is interesting to note Willig's emphasis on the role of discourse in the formation of objects in dialogues or conversations and the formation of subject positions, which draw on the "echoes" of conceivable actions in practice (2001). Her step-by-step guide puts less focus on the institutional role of discursive production. Willig has adapted Foucault's approach to her field of knowledge – psychology – by prioritizing the role of analysis in understanding the impact on subjectivity (2001). This is made clear in step 6, where Willig suggests that the researcher go beyond the analysis of language to consider the *subject's* experience.

Andersen's approach to Foucauldian discourse analysis considers the discursive elements described by Foucault, and uses Foucault's own terminology to explain the method (Andersen, 2003).

According to Andersen, to comprehend the formation of a *statement*, it is important to conceive how each of its constituents is formed. The formation of objects takes into consideration their regularities in dispersion, the rules of acceptability, and the relation between objects. The formation of subjects considers the regularities in the dispersion of subject positions and tries to understand the reason for that position choice, as well as the rules of acceptability for the shaping of spaces from which one can

speak and observe. These regularities also specify the rules for entering the discourse. The formation of concepts refers to how concepts are organized and connected in statements, the choices of concepts and the rules of conceptualization. The formation of strategies analyses the choice of truth assumptions; it focuses on how a discursive formation relates to another discursive formation in conflict and/or mutual formation. The objective is to find “the unity of the mutual exclusion of the discursive formations” (Andersen, 2003) .

The final step of Foucauldian discourse analysis, according to Andersen, is dispositive analysis. This is a complementary analytical strategy which focuses on the interconnection between all elements of discourses – institutions, practices, subject positions and tactics – within a determined period. The dispositive is a heterogeneous ensemble connected by specific nature through a strategic imperative, i.e. a choice (Andersen, 2003). This strategic logic becomes apparent when a discourse is compared to another field of knowledge, to see how it is generalized. Two questions should be considered: (1) how are discourses generalizable into a schematic that forms a strategic logic? And (2) how are forms linked as functional elements in an apparatus that brings about a strategic logic?

Andersen summarizes the main phases of Foucauldian discourse analysis as:

Archaeology – regulation and dispersion

Genealogy – continuity and discontinuity

Self-technology – subjection and subjectivation

Dispositive analysis – definition of strategic logic (2003).

In this way, Andersen's perspective adheres more closely to Foucault's concepts, including statements, archaeology, genealogy and others. Andersen also acknowledges Foucault's concern regarding the historical dimension of discourse and its discontinuities. These are the main aspects of Andersen's approach which I adopt in my research. By contrast, Willig offers a condensed perspective of Foucauldian discourse analysis, adapted to her theoretical background and research setting. She makes less use of Foucault's terms and disregards some of the analytical phases emphasized by Andersen (e.g. genealogy and dispositive analysis). The study of these two authors provides a background for the following sections, where I describe how different researchers have used Foucauldian discourse analysis in their investigations. Before doing so, I review a number of studies that have used the method to analyse policy documents and others that have used the method in the context of medical education, as described in the following section.

3.4 Foucauldian discourse analysis in practice (empirical approach)

This section aims to provide a deeper empirical understanding of the method chosen for this study. To achieve this, I searched for empirical studies that conducted a Foucauldian discourse analysis, as described in the previous chapter, but this time, I also included studies beyond medical education. Through this search, I encountered a vast range of knowledge from different fields, including medical education, social sciences, psychology and educational sciences. I eventually focused my attention on texts relating to medical education (e.g. Whitehead, 2011) and analysis of policy documents

(e.g.Carabine, 2001), found in the scope review described in chapter 2 and in literature from the social sciences, both for their methodological aspiration (Foucauldian discourse analysis), research object (medical education) and type of data used (policy documents). I describe in the following sections those that were most relevant to my study, either because they used policy documents as data and/or their method description was particularly detailed.

My aim here is to describe the authors' journey through Foucauldian discourse analysis as a way to inform my own approach. From other authors' empirical use of Foucault´s ideas, I learned about their difficulties, emphases, additions and reflexions, making my own journey clearer and more grounded.

In the following sections, I first describe how each of the cited studies approached the data collection, analysis and interpretation process. Next, I present a comparison of the steps used by the authors in order to understand their systematic approach to discourse analysis.

I have drawn upon the works of Cynthia Whitehead and her group in the University of Toronto, who have analysed medical education policy in North America, and of Jean Carabine, who has studied social welfare policy relating to single mothers. I have chosen these two authors for their detailed description of their use of the Foucauldian method and the nature of their data set, which included policy documents.

3.4.1 Studies using Foucauldian discourse analysis

3.4.1.1 Cynthia Whitehead et al: medical education discourse in North America

Cynthia Whitehead, Associate Professor at the Department of Family and Community Medicine, University of Toronto, and her research team have published a series of papers describing a Foucauldian discourse analysis of medical education reforms in Canada, based on journal articles and reports published between 1910 and 2010 (Whitehead, Hodges, & Austin, 2013; Whitehead, 2013). The texts analysed included Flexner´s reports from the early 1900s, articles from the *Journal Academic Medicine* published between 1926 and 2010 and other important medical education reports. A review of the reference sections of these sources identified further relevant documents.

The authors looked for prominent recurring themes in these texts, which were grouped by subject and analysed for keywords, statements and metaphors to understand how these discursive elements were used and the context in which they appeared. Through this process, a discursive strategy was identified regarding the need for change and suggestions for innovation. The latter were justified primarily by the discourse of "avoidance of over-specialization" and "the importance of generalism" (Whitehead, Hodges, & Austin, 2013). The following passage illustrates the researchers' approach:

> "*In his 1910 Report, Flexner emphasized that all physicians, regardless of specialty, required the same inquiring approach to medical practice. He explicitly criticized those who set up a dual standard for generalists as opposed to specialists, and suggested that all could and should take a scientific approach to practise:*
>
> '*In the effort to teach the modicum of chemistry or*

physiology or pathology that "the family doctor needs to know," they neglected to teach anything of permanent scientific value at all…. The sciences were badly taught … because the teachers lacked abundant scientific knowledge and spirit.' (Flexner 1910, p. 59)." (Whitehead, Hodges, & Austin, 2013)

Later in this research, Whitehead et al. analysed a paper by Casberg to identify the subject position held by general practitioners in medical education (peripheral and low prestige). The extract below shows how this finding emerged from the data:

"*Movement towards greater specialization continued to be critiqued (in the documents). For example, in 1950 a medical educator commented:*

'A definite trend in medicine during the past fifty years has been that of specialization. This is the natural outgrowth of the tremendous expansion in medical science. No one man can possibly master the whole field of medicine…. However, as in the case with many good things, I fear the pendulum of specialization has swung too far.' Casberg 1950, p. 505).

Casberg argued that, in spite of growing medical knowledge, general practitioners manage the vast majority of medical problems. Unfortunately, he noted, students were disproportionately interested in entering into specialty training. This trend meant that:

'The general practitioner, who is still the backbone of medicine, has been forced dangerously near the periphery. The public, as well as the governing medical and hospital organizations, have contributed to the low ebb in the prestige of the general practitioner (Casberg 1950, p. 506).' " (Whitehead, Hodges, & Austin, 2013)

It should be noted that, although this research emphasized the contradictions within the documents analysed, there was little discussion of authorship – institutions, authors and their context were rarely taken into account.

In another publication based on the same data set, Whitehead (2013) investigated the discourse surrounding the concept of science and the *scientist-doctor* referred to by Flexner (1910). This was part of a broader exploration of the discursive characterization of the *good doctor* within the documents analysed. Again inspired by the work of Foucault, Whitehead identified statements, keywords and metaphors relating to the historical development of discourse on scientific medicine, highlighting recurrent arguments and variations in the meaning of particular concepts.

The following passage describes how the concept of science became a major object entrenched in the medical curriculum:

> "*Robert Loeb welcomed the incoming class of students to Colombia Medical School in 1950 by remarking that:*
>
> *'The emphasis now laid on scientific research with its critical exploitation of new ideas and the integration between the basic sciences and clinical medicine has produced within the lifetime of all of us momentous and tangible advances in the treatment of disease.'* " (Whitehead, 2013)

Whitehead used this data in her production of the discursive element entitled "science", which plays an important role in the results findings of my study, as described in the results chapters (6-11). The paper describes how students were exposed to vast amounts of scientific knowledge, despite a recognition that they would not be able to fully absorb, criticize, use or add to this. The concept of science adopted by medical schools was also understood as being deficient for the training of doctors. These findings were presented as recurrent themes, with examples from the texts analysed (Whitehead, 2013).

To summarize, the approach of Whitehead et al to Foucauldian discourse analysis shed light on the development of discourse across a historical collection of documents (in this case dating from the early 1900s to 2010) but did not touch upon the *formation of objects* or *strategic choices* in that discourse. The use of keywords in the analysis proved a useful tool in identifying statements and metaphors characterizing the discursive objects in question. However, portraying objects through the use of keywords alone would seem to undervalue the approach suggested by Foucault himself, which was to define the object *through its relationship to other objects* (1972).

From the perspective of this research, the studies outlined above (from Whitehead and Whitehead et al) were influential due to their use of the same methodological approach and type of data (medical education policies, although not exclusively) and their recognition of the importance of Foucault´s perspective on discourse, power and knowledge. The researchers do not, however, fully explain their analytical procedure, possibly due to word count limitations. The other studies found in the literature review likewise did not elucidate their method in detail. For this reason, I have chosen to review a unique study conducted by Jean Carabine on the discourse of unmarried motherhood in social care policy in the UK (2001). This clarifies significant aspects of Foucauldian discourse analysis, as described in the following section.

3.4.1.2 Jean Carabine: discourse of Unmarried Motherhood

This study, published as a chapter in Wetherell, Taylor and Yates's 2001 book, *Discourse as Data – A Guide to Analysis* (Carabine, 2001), uses social care policies from the 1830s and 1990s to investigate the discourse

surrounding unmarried motherhood in the UK. Following the traces left by Foucault in his investigation of the history of sexuality, Carabine focused on the sub-discourse of feminine sexuality. In accomplishing her aims, she, like other authors (Andersen and Willig), acknowledged the impossibility of following a definitive path or method in performing a Foucauldian discourse analysis. Following the example of her predecessors, however, she describes a series of stages in conducting the analysis.

The method she outlines coincides to a degree with Whitehead et al.'s approach, but includes more detail of the analytical process. A focus on absences and silences, resistances and counter-discourses, for example, provides a direct contact with Foucault´s perspective of *equivalent incompatibilities* and the relationship between objects and *statements,* which guides the researcher towards other dimensions of the analysis (Carabine, 2001).

Carabine´s description of her findings begins with a broad picture of the historical context of the discourses she chose to study (in the 1830s and 1990s). She then identifies three discursive strategies delimited by her analysis: women as immoral subjects, the absence of male responsibility, and the distinction between deserving and undeserving mothers. For the first strategy, she presents the reader with questions to be considered concerning the policy extracts under analysis, such as how the object of research (unmarried motherhood) was valued, who was responsible for the situation, what kind of language was used to describe the object, and the tone of the authors' comments. She ends this section with a brief discussion on the

analytical process. This is an example of one of the "exercises" she sets the reader:

> *"Discursive strategy 1- Constituting the immoral subject:*
> *Negative representations of unmarried mothers*
> *The aim of this section is to demonstrate the role of discourse in constituting unmarried mothers as immoral subjects. Let's begin first with looking at how the Commissioners 'speak' of unmarried mothers.*
> *Activity 3*
> *Read through Extracts 4 and 5 below, which provide some examples of how the Commissioners refer to unmarried mothers. Consider how unmarried mothers are 'spoken' of or are constituted in the extracts.*
> *It might help consider:*
> *– Whether unmarried mothers are presented in a positive, neutral or negative way*
> *– Who is identified as being responsible for unmarried motherhood/ prenuptial pregnancy*
> *– How premarital sex and prenuptial pregnancy is presented*
> *– The language used to refer to unmarried mothers*
> *–The tone of the Commissioners' comments*
> *EXTRACT 4*
> *…the female in the very many cases becomes the corruptor (British Parliamentary Papers, Poor Law, vol.8, Main Report. 1971.94)*
> *EXTRACT 5*
> *…continued illicit intercourse has, in almost all cases, originated with the females*
> *(Mr Richardson, British Parliamentary Papers, Poor Law, vol 8, Main Report, 1971-96)"* (Carabine, 2001)

Throughout this text, Carabine invites the reader to identify the characteristics of the object (unmarried motherhood) under investigation in the different passages of the policies analysed, so as to confirm her own conclusions. After discussing the three discursive strategies depicted, she describes the effects of such strategies, which in accordance with Foucault´s history of sexuality, builds an idea of acceptable sexuality, family and middle-class values.

In summary, Carabine's approach to Foucauldian discourse analysis is similar to the theoretical method described by Andersen (section

3.4). Both authors demonstrate a close relationship to Foucault's terminology, analytical strategy and genealogy. In the following section I attempt to correlate the discursive elements described by Foucault with the empirical method used by the researchers cited above.

3.5 Further description of the empirical use of the Foucauldian method

In this section, I try to link the core elements of discourse analysis (object, statement, concepts) described by Foucault in *The Archaeology of Knowledge* to the research of the authors featured in this chapter. For each of the elements explained, I point to the work of authors in whose research it featured. I have also referred to *The Birth of the Clinic* to understand Foucault's own empirical use of analysis, before he described his approach more formally in *The Archaeology of Knowledge.* This exercise provided me with the critical perspective needed to develop the approach used in the current study. The following sections discuss the use of the terms *archive*, *object, statement* and the *enunciative function*.

3.5.1 Building the *archive* and defining the data set

Foucault described the *archive* of his investigations as a group of truthful assumptions or rules of formation of a specific discourse. This concept of *archive* could be misinterpreted as referring to the researchers' data set or collection of documents under analysis. Here I describe how this concept has been used (or not used) by Foucault and the authors under study in this chapter. In *The Birth of the Clinic*, Foucault analyses the discourse built by medical treatises in a period of approximately 50 years spanning the latter

part of the 18th century and the beginning of the 19th century. Here, the *archive* is portrayed as the *medical gaze* through which human senses, especially sight, capture the essence of the pathological process, separating the patient´s body and identity (body-mind dualism). In this way, Foucault made a clear theoretical distinction between the concept of the *archive* as a product of analysis and that of the "archive" (collection of documents) constituting the data set to be analysed.

Authors who have subsequently used Foucault´s approach to discourse analysis in medical education have not often used the concept of *archive* defined by Foucault. Some use the term instead to designate the collection of analysed texts, as described above. In current scientific methodological terms, this collection of documents is referred as the data set. With regards to selection of documents, different authors have different approaches. Some (Carabine and Whitehead) begin with a "familiarization" phase and then assemble the archive of documents to be analysed; others (i.e. Klingenberg) define inclusion criteria for document selection (although the process by which these criteria are established is not generally explained, suggesting that a familiarization phase was carried out before the selection decisions were taken).

In *The Birth of the Clinic,* Foucault did not specify a process for selecting documents: the texts analysed were presented by title and author, often relating to a professional or academic institution or government entity. One can deduce that these documents, drawn from a broad range of medical texts, were selected as cases of a continuity and/or discontinuity in the *archive* supporting a discourse. In this regard, the documents included in the

data set should be ones that present the medical discursive arena with different rules regulating communication. It is through this collection of different sets of rules that Foucault constitutes his *archive*. Foucault did, though, familiarize himself with the broader context of medical knowledge before he defined the documents of his collection of documents. In the introductory chapter of *The Birth of the Clinic*, entitled *A Political Consciousness,* he described the political context of his analysis and cited some of the documents he considered important. These included:

> "[1] Th.Sydenham, 'Observationes medicae', Opera medica (Geneva, 1736,
> I, p. 32).
> [2] Ibid., p. 27.
> [3] Le Brun, Traité historique sur les maladies épidémiques (Paris, 1776,
> p. 1).
> [4] Lepecq de la Clo^ture, Collection d'observations sur les maladies et constitutions épidémiques (Rouen, 1778, p. xiv).
> [5] Razoux, Tableau nosologique et météorologique (Basel, 1787, p. 22).
> [6] Menuret, Essai sur l'histoire médico-topographique de Paris (Paris,1788, p. 139)." (Foucault M. , 2003)p. 38.

3.5.2 Discursive elements

3.5.2.1 The object of discourse, statements and enunciative function

The concepts of *object, statements and enunciative function* were described at the beginning of this chapter. The question in this section is: how have Foucault and the authors mentioned above used these discursive elements in their research?

In *The Birth of the Clinic*, Foucault´s *object* is medical practice and how it is characterized. He presents the concept of the *medical gaze* to describe a specific *object* that delimits a field of knowledge and power. In

medical education, as in other fields making use of Foucauldian discourse analysis, the object of research coincides with the *object* being described by discourse. These objects/*objects* range from "'good doctor", "patient centeredness" to "emotion" (Whitehead C. , 2011; Klingenberg, 2013). Many authors use the concept of the "keyword" to help identify the object of research in different documents under analysis. It is clear, though, that the keywords used may not coincide with the *object* of analysis, which may take different linguistic forms in the same or different texts, or be absent altogether (in which case the *object* might be defined in terms of what it is *not*). By using the idea of keyword as a tool to identify the object of a study, researchers can accelerate the process of finding the specific object of research in a text, through simple word-finding tools; however, they can also overlook the characterization of the object through its absence or its relationship to other objects.

In Whitehead et al.'s approach to the characterization of the discursive strategy of introducing science into the medical education discourse between 1910 and 2010, the authors used the keywords "science/scientific" to highlight a conflict between "specialist/specialty" and "generalist/family" doctors. These keywords were therefore the main tools in identifying the *object* of discourse in their study. In Carabine's paper, the unmarried motherhood discourse is identified through the use of keywords such as "female/woman" and "bastard/bastardy". However, the absence/presence of the male/father in the discourse also contributes to the characterization of the object of the research (Carabine, 2001). Her analysis, in other words, is not restricted to the presence of keywords which identify the

object; it also explores absences in the chosen texts and the *object's* relationship to other *objects* of the discourse.

Keywords can also lead a researcher to miss other descriptors of the *object* under investigation. If the *object* is portrayed negatively (through its absence) or its central characteristics are transferred to another *object*, a text search may not only deceive the researcher but deny them a broader comprehension of the discourse being conveyed and the *object's* position in it.

3.5.2.2 The statement and enunciative function

The authors studied in this chapter employ a variety of terminologies or expressions to refer to a Foucauldian *statement,* including "metaphors", "arguments" (Whitehead), "texts" (Carabine), "speech acts" (Klingenberg), and "lexical references" (Willig and Chin). What these have in common is that all carry an *enunciative function* (meaning, action, assumption of truth). As can be seen in previous sections, researchers used textual excerpts as the materialization of the *statement.* From these excerpts, each author captured the discursive strategy and subject positions to different extents. An important part of their analysis was to examine differences/similarities in *statements* that defined the same or different objects. It is unclear from their usage, however, if the objects of study were also characterized through a comparison with *statements* and *enunciative functions* describing other objects.

3.5.2.3 The analytical process

In *The Birth of the Clinic*, the analytical tasks described by Foucault are undertaken without a formal definition of their character and purpose. It is possible, though, to interpret Foucault´s description of the

medical gaze as the *object* of discourse. The text also makes clear the possible *subject positions* produced by the analysis to medical practitioners with regards to disease, patients, body, death, and how these are delineated and altered through historical vicissitudes in discourse. The *medical gaze* is defined as the main *discursive strategy* by which clinical/scientific institutions assume control over the dead and sick body. This shift of the medical gaze from the patient to the "*depths of the body*" is exemplified by the following extract, in which Foucault cites a passage from a 19th century medical dictionary to describe the change in discourse:

> "*Was not the change in medical knowledge at the end of the eighteenth century based essentially on the fact that the* ***doctor came close to the patient, held his hand, and applied his ear to the patient's body****, that by thus changing the balance, he began to perceive what was immediately behind the visible surface, and that he was thereby led* ***gradually 'to pass on to the other side'****, and to map the disease in the* ***secret depths of the body?***
>
> *'Pathological anatomy is a science whose aim is the knowledge of* ***the visible alterations produced on the organs of the human body by the state of disease****. The* ***opening up of corpses*** *is the means of acquiring this knowledge; but in order for it to become of direct use…it must be joined to* ***observation of the symptoms or alterations of functions that coincide with each kind of alteration in the organs*** *[31]. R.Laënnec, Dictionnaire des Sciences médicales, article 'Anatomie pathologique', II 1840'"* p. 135-136.

The discourse analysis undertaken by medical education researchers using Foucault´s approach places different emphases on the tasks delineated by Foucault. In general, greater stress is given to the formation of *objects* and the discursive *strategy.* With regards to the *object,* the focus tends to be on conceptual delimitation and the differentiation of *statements* describing the same *object*. The former procedure is given different nomenclatures by the various authors, such as identifying regularity

(Whitehead et al.), or repetitive (Klingenberg), recurrent (Carabine) and consistent (Willig) characteristics of *statements* describing the *object*. The analysis of *statements* is variously understood as a description of *statements'* relations (Whitehead et al.), position (Carabine), inter-relationship (Willig) and hierarchy interactions (Klingenberg). Special attention should be given to Carabine´s emphasis on the perception of *counter-discourses* that challenge the dominant discourse as an internal expression of resistance. Such counter-discourses may also be acknowledged through the identification of absences, as in the following extract:

> *"Contesting the Bastardy Clauses*
> *If we read outside of the Bastardy Clauses we find that there was widespread hostility and opposition to the 1834 New Poor Law which was 'rejected by working people as a thoroughly heartless attack on the comfort, dignity and customary rights of the poor' (Dinwiddy, 1986-72). According to Heriques (1967) the Bastardy Clauses were the most unpopular part of the 1834 Act. Protests focusing specifically on the provisions contained in the clauses criticized them for dealing with women unfairly, operating a dual standard of morality and for allowing men to seduce women with impunity (see Henriques, 1967; 112, 1979, 52-8; Rendal, 1985: 197; Taylor, 1983: 201-4). Indeed, the Bastardy Clauses were hotly debated in the House of Lords and they were only just approved by 93 to 82 votes (see Hansard (Lords) 8 August 1834 1096-7)."* (Carabine, 2001)

With regards to formation of strategy, attention is paid to recurring discursive elements and their internal contradictions. Authors also refer to "the rationale that legitimizes statements" (Whitehead) or to rhetorical *strategies*/conditions for possibility. Less importance is given to the institutional networks surrounding discourse and the social context of the different historical periods analysed.

Often these authors present the final discursive *strategies* as re-groupings of *statements* into different categories or themes. In Whitehead's

work, for instance, it was interesting to note the incompatibility between the scientific doctor proposed by Flexner (1910) and the “science-stuffed” doctor in later documents. In Klingenberg’s research, discourse produced by the Department of Health (UK) on patient-centredness becomes an “all-encompassing concept” – including not only patients’ health care but also “good management” – and a discursive strategy for recommended change. Incompatibilities presented by Carabine were clear in the examples provided: the relationship between unmarried motherhood and moral corruption, illegality, disgrace, guilt and blame is identified.

3.5.2.4 The concepts of Discourse, Archaeology and Genealogy

Discourse, archaeology and genealogy are Foucault´s broader definitions regarding the work of discourse analysis. According to Andersen, the *archaeology* of knowledge involves understanding *discursive formation* through the regularity in dispersed elements of discourse as an expression of power relations. The *genealogy* of knowledge is the historical dimension of the *archaeology*. The framework for the analysis of *genealogy* is continuity and discontinuity. In *The Birth of the Clinic* both *archaeology* and *genealogy* are clearly in play, despite Foucault not yet distinguishing the two.

All authors undertaking Foucauldian discourse analysis have used these terms, although with different emphasis on each depending on the research focus. Andersen, Whitehead and Carabine emphasize both *archaeology* and *genealogy*; Willig emphasizes *archaeology*, with a special focus on the *formation of subject positions*.

3.6 Conclusions

This chapter has focused on providing a theoretical and empirical understanding of how discourse analysis was operationalized by Foucault and some selected authors. The study of Foucault's work deeply influenced my own approach to the methodology. It also gave me a critical perspective with which to view the discourse analysis of authors such as Willig and Andersen, and to compare the use of Foucauldian elements of discourse in a range of other studies. The following table (4) summarizes the stages and tasks of analysis proposed by the three authors that developed a type of guideline cited in this chapter (Carabine, Willig, Andersen) and how these relate to Foucault's description of his method in *The Archaeology of Knowledge*. All have contributed to the approach I adopted in my research, as described in detail in chapter 4.

Table 4 Summary of the comparison of guidelines to Foucauldian discourse analysis

Foucault			Andersen	Willig	Carabine
Discursive formation	Archaeology: Formation of objects and concepts	Describe the object ("*grid of specification"* (planes of emergence, authorities of delimitation and forms of specification) through the analysis of the statements and their enunciative function (*intervention* on the statements, which can appear as: (1) *techniques of rewriting*, *methods of transcribing* (formalized or artificial language), (2) *modes of translating (*quantitative and qualitative), (3) *approximation of statements* (refine exactitude), (4) *delimitations* (extension or restrictions to statements), (5) *transfers (*statements from one field to the other), (6) *systematizing* propositions that already exist. Analyse the construction or recycling of concepts.	Archaeology – regulation and dispersion	"Step 1: Discursive Constructions - identification of the discursive object which is constructed through lexical references and shared meanings. Step 2: Discourses - identification of various discursive constructions of the discursive object within a wider discourse. Step 3: Action Orientation - analysis of how and why the object discourse is constructed in a particular way, and how it acquires functions and relates to other constructions." (Willig, 2001)	Identify themes, categories and objects of the discourse
	Genealogy – historical dimension of discourse	Continuity and discontinuity of discursive practices.	Genealogy – continuity and discontinuity in history.		Context 1 – outline the background to the issue. Context 2 – contextualize the material in the power/knowledge networks of the period
	Formation of subjective positions	Subject positions produced by the analysis and available to actors involved in practice.	Self-technology – subjection and subjectivation	"Step 4: Positionings - identify the subject's positions or location for persons within a structure of rights and duties who use that repertoire offered by the various constructions. Step 5: Practice – discourse analysis maps the possibilities for action contained within the discursive constructions identified in the text." (Willig, 2001)	Identify the effects of discourse
	Formation of strategic choices	Equivalent incompatibilities. Economy of the discursive constellation. Authorities involved.	Dispositive analysis - apparatus and strategic logic		Look for evidence of an inter-relationship between discourses. Identify the discursive strategies and techniques that are employed.
Dimension not considered by Foucault in discourse analysis				"Step 6: Subjectivity - traces the outcomes of adopting various subject positions by drawing links between discursive constructions and personal experiences." (Willig, 2001)	Reflexivity: be aware of the limitations of the research, your data and sources.

4 FOUCAULDIAN DISCOURSE ANALYSIS OPERATIONALIZED IN THIS RESEARCH

The purpose of this chapter is to clarify the approach to Foucauldian discourse analysis used in this research. The previous chapter on methodology (3) I described Foucauldian discourse analysis used by other authors, both inside and outside the field of medical education. This chapter provides a more detailed account of my approach to the method and its application.

In chapter 3, I explained Willig (2001) and Andersen's (2003) theoretical approach to discourse analysis and Whitehead and Carabine's empirical use of Foucauldian discourse analysis (Whitehead et al 2010) (Carabine, 2001). I also highlighted how their approaches influenced my own methodological pathway. In this chapter, I describe how I used this method in the current research, placing special emphasis on the ideas set out in Michel Foucault's book, *The Archaeology of Knowledge* (1972). As explained in chapter 1, where I summarized the research design, I used policy documents on medical education as data for a Foucauldian discourse analysis.

In the following sections of this chapter, I describe the composition of the research data and explain each phase of the analysis, using extracts from my dataset to demonstrate the approach taken and illustrate some of the opportunities and challenges it presented.

4.1 My approach to Foucauldian discourse analysis

This section presents a summary of my methodological approach. Following the example of some of the authors described previously (chapter

3), I developed a framework to guide me through the analytical process. In my analysis, I was concerned with the four tasks described by Foucault (description of the formation of objects, concepts, strategies and subject position). These tasks (explored in chapter 3) directed me through the *archaeology* and *genealogy* of general practice in medical education. The historical discontinuities in the characterization of general practice exposed by the *archaeological* analysis revealed its *genealogical* dimension, including its relationship to institutional power. Despite my focus on document analysis, knowledge of the social, political and economic context of the historical periods analysed provided relevant information on the institutions involved and how their choices produce particular power relations. This personal historical contextualization did not attempt to give meaning to the text, but allowed for a clearer understanding of the findings that emerged from the analysis of the policy documents.

From the analysis itself, I was able to define the discursive object described by the documents, identify the discursive subject positions and concepts that characterize the object, recognize the relationship between these elements, and describe the discursive strategy used in different moments in history.

The approach I developed set a series of tasks to be accomplished during analysis. Some of these were carried out simultaneously, each receiving more or less attention at a particular time. The framework adopted is summarized in the table below. The tasks themselves are described and illustrated in the following sections.

Table 5. Approach to Foucauldian discourse analysis

Initial approach to research object		1. *Define the object of research* 2. *Study the historical background of the object. Talk informally to different important interlocutors of the object.* 3. *Build an approximate definition of the collection of texts to be analysed*
Archaeology	Formation of objects	4. *Read and re-read the documents chosen using NVivo to code the four discursive elements of Foucauldian discourse analysis:* a. *Identify and analyse the object of discourse and the statements defining it, looking for regularities and variances, and comparing it to other objects*
	Formation of concepts	b. *Identify and analyse the important concepts used and their formation; understand how they relate to other fields of knowledge*
	Formation of strategy	c. *Identify and analyse the strategic choices with the help of mind map software, and how these choices shape the object:* i. *Identifying incompatibilities (resistances/counter-discourses)* ii. *Identifying what is included and excluded (absences and silences)* iii. *Identifying the institutions and persons involved and correlate with the historical context* d. *Synthesis of the characterization of the discursive object and statements, which are rearranged in different groupings*
	Formation of subject position	e. *Identify and analyse the subject produced by the characterization of the object*
G*enealogy*		5. *Identify the historical discontinuities revealed by the archaeological analysis of the object and the network of institutions involved*
Writing up		6. *Writing up context: Outline the historical background of the object of research (Chapter 5 and 9)* 7. *Analytical writing up: during this stage there are four actions taking place simultaneously* a. *Review of the mind maps and data in the software used* b. *Contextualization of the findings to the power/knowledge network of the period through literature research of secondary sources* c. *Final definition of the important concepts, strategic choices and subject positions to be emphasized* d. *Constant review of the research questions and method choice*
Ethics and limitations		8. *Awareness of method's ethical dilemmas and limitations*

4.1.1 Define the object of research

The definition of the object of study was provided in chapter 1. This has been the source of important personal reflections, taking account of my own academic and theoretical background, to which I refer throughout the thesis (reflexivity sections).

I started studying the historical background as part of a familiarization phase. I read broad historical texts summarizing the development of medical education in the UK and Brazil from the origins of university-linked medical schools to the present day. This historical account is described in chapters 5 and 9. I have opted to present these accounts before the results chapter of each country in order to provide background information for the reader and a justification of the choice of policies analysed. However, the review continued throughout the research process and has informed all the steps of the project: method, analysis and discussion.

I, then, identified the key institutions involved in medical education in both nations and contacted current experts who could provide an account of the development of general practice in undergraduate medical education and suggest documents/policies to be analysed. From these first two steps, I obtained a series of policy documents on undergraduate medical education in both countries before, during and after the establishment of their national health services. These outlined transformations in the organization of medical education and the different roles played by general practice in this process. In particular, they pointed to a significant period of discursive discontinuity as general practice began to appear in medical education documents and general practitioners took up roles in medical schools and university

departments. This included a shift in the rules of acceptable language on medical education as a whole and general practice specifically, as described in the results chapters.

In the next section I describe how policy documents for the period of the study were defined.

4.1.2 Choice of policy documents to be analysed

This section describes the selection of policy documents that constituted the data set for this research. The documents analysed in this thesis constitute important policies in undergraduate medical education in the history of both countries. Medical education publications and stakeholders reference these texts as influential in their particular time. These documents followed the development of primary care-led health systems: in the UK, after the development of the National Health System (1940s), and in Brazil, after the development of the Unified Health System (SUS - 1980s). As described in the historical background chapters (5 and 9), these historical points of reference are crucial as they mark the development of discursive discontinuities in how general practice is characterized in medical education in both countries. In the UK, documents such as the Goodenough Report of 1944 and the General Medical Council's recommendations on undergraduate medical education, entitled *Tomorrow´s Doctors*, constituted the analytical material. In Brazil, the National Guidelines for Medical Education, published in 2001 and 2014, were included (see Table 6 for a complete list of the documents and the evolution of documents included or excluded). The literature review helped to identify and describe the documents selected for the study. I have assumed that these documents in comparison to other less

important documents (e.g. non-nation wide policies) produce what could be understood as the dominant discourse. This dominant discourse overshadows other less influential discourses and documents.

Due to the large volume of documents available from the two countries under study (UK and Brazil), I defined certain criteria to delineate the scope of the research data (policy documents) described below. The documents analysed in this thesis consisted of policy documents or guidelines from governmental and non-governmental sources which dealt primarily with undergraduate medical education and were national in scope (both in the UK Brazil). Policies that did not address undergraduate medical education as their main theme (e.g. the Collins Report on UK postgraduate training) or which were aimed at an international audience (e.g. the 1988 Edinburgh Declaration from the World Federation for Medical Education) were not included. These criteria were defined during the familiarization phase of the historical review for both countries through the identification of continuities and discontinuities in the characterization of general practice (further explored in the results chapters). A final criteria was the closing date of the time frame under analysis, which I established as July 2016 (beginning of the fourth year of the PhD programme, dedicated to the writing up process). This time frame excluded any documents published more recently in both countries (e.g. Health Education England, 2016 - UK). The documents listed in Table 6 constituted the primary data for analysis. Policy documents referred to by these sources, when linked to the discursive elements associated with the characterization of general practice, were used as secondary data for analysis (e.g. the NHS White Paper of 1944).

Many of the national policy documents referred to above were publicly available on the Internet. Others were supplied by the GMC following an email request or found via an online database search at the National Archives and the Somerset Archives in the UK and electronically scanned. In Brazil, I visited the ABEM library and contacted two Brazilian medical education research centres to identify and access documents not available online. Each one of the documents analysed is further described in the historical background chapters and results chapters.

Table 6. List of documents identified and considered for inclusion from each country

Brazil	United Kingdom
(1994) National Primary Health Care Policy (not a national medical education policy) (1997) CINAEM 3rd Phase (2001) National Curriculum Guidelines for Medical Undergraduate Courses (2001) PROMED (Program to incentive changes in medical schools) (2005) Guidelines for Medical Education in Primary Health Care (2005, 2007) PRÓ-SAÚDE (Program to incentive changes in health undergraduate courses) *(2010) Competency Based Undergraduate Medical Education* (not configured as a national document) *(2011) Guidelines for Primary Health Care teaching in undergraduate medical education* (not configured as a national document) (2011) Undergraduate Clinical Clerkship Guidelines (2013) More Doctors (Mais Médicos) National Policy (2014) National Curriculum Guidelines for Medical Undergraduate Courses	(1944) Goodenough Report (1953) Basic Medical Education Recommendations (1968) The Todd Report (1976) Basic Medical Education Recommendations (1980) Basic Medical Education Recommendations (1993) Tomorrow's Doctors (2003) Tomorrow's Doctors (2009) Tomorrow's Doctors

(Documents excluded during the research appear in *italics*, documents included during the research appear underlined – as a result of fuller understanding of the documents contents.)

After a thorough reading of the policies selected, certain documents took on extra importance, as they appeared to produce a discontinuity of discourse (Goodenough Report, Todd report and the first edition of *Tomorrow's Doctors* in the UK; CINAEM 1st phase and the 2014 guidelines in Brazil). This first step in the analysis produced different discursive strategies regarding medical education and general practice. In

particular it identified a discontinuity in the characterization of general practice – and the roles produced for general practitioners in undergraduate medical education – arising from the gradual incorporation of general practice into the study and practice of medical school undergraduates. This shift is described in more detail in the results chapters (chapters 8, 9 and 10 for the UK and 11 and 12 for Brazil).

4.1.3 Description of my approach to the four tasks of Foucauldian discourse analysis

In this section I describe how I approached the four analytical tasks of a Foucauldian discourse analysis. After a broad reading of the historical background, the analytical process continued through a deeper and more systematic reading of the policy documents, guided by the Foucauldian notion of *archive* (described in the chapter 3). Sets of documents were gradually grouped according to different (discontinued) series of rules regulating the discourse of general practice in medical education over a specific period. These groups represented an *archive* of the rules regulating general practice in medical education for that period. Each of these steps is described below.

4.1.3.1 Formation of the object: identification and characterization of the *object of discourse*

The characterization of the *object of* discourse involved identifying and analysing its particular features through the *statements* that defined it, looking for regularities and variances which differentiated it from other *objects*. It is clear in the analysis of the policy documents that this description of the *object* relating to general practice in medical education changed over time. Through my familiarization with the texts, certain keywords were found to be

intimately related to general practice: these included *general practice*, *family practice* and *family medicine*. Other keywords were closely associated with general practice, such as *community medicine*, *primary medical care*, *primary health care* and *primary care*. These all played an important role in naming, describing, analysing, rectifying, re-defining, challenging or erasing this *object.* During the analysis process, I read the texts in full, noted the key presence or absence of the *object* under study, and identified broader ideas in the general discourse conveyed by the documents and their mission statements.

The following text from the Goodenough Report of 1944 exemplifies the characterization of the discursive *object* under investigation (general practice) as a medical field associated with the recognition of the effects of pathology on different dimensions of the patient's life: personal, social and economic. Undergraduate medical education was, in this document, focused on medical conditions frequently faced in general practice. The assumption was that the graduating doctor should be prepared to act in general practice. Another important aspect of this text is the assumption that teachers involved in teaching surgery (most frequently surgeons) should also have an understanding of conditions treated by general practitioners.

> "*The training of an undergraduate **in surgery** should be directed to the recognition, early treatment**, personal, social and economic** effects of those surgical **conditions commonly encountered in general practice**…*" (Goodenough, 1944, p. p. 29)

In the excerpt above, the *object*'s presence was directly identified through the keywords described. Its absence was recognized through the identification of other *discursive objects* characterized in the policy documents. These other *discursive objects* (i.e. medical schools, medical

specialties) characterized the *object* of this research (general practice) through direct comparisons described in the text or through a negative characterization, that is, by attributing characteristics to other *objects* that did not characterize general practice. The text below is an example of a negative characterization of the *object*. It reinforces the association between general practice knowledge and undergraduate education by implying that general practice is not a medical specialty requiring further (i.e. postgraduate) training. There is also an assumption that such specialists have superior educational status to that of general practitioners.

> "*All parts of teaching or of clinical practice that* ***relate only*** *to the fields of work of the* ***clinical or laboratory specialist*** *should be reserved for* ***post-graduate education****…*" (Goodenough, 1944, p. p. 125)

The selected documents therefore define general practice in relation to other *discursive* objects, especially medical specialties / consultants, medical schools, patients, medical students and health systems. Word-finding tools allowed me to check that I had identified all occurrences of these keywords in the text.

I used the concept of *statement* to identify different textual elements describing the characterization of general practice in medical education. Using the NVivo software, these elements were identified and grouped together in "nodes". A node is a tool in NVivo that allows the researcher to group textual excerpts in order to identify a specific object of study. The node containing statements that characterized general practice had over 500 textual references for both Brazil and the UK. (Figure 8 – NVivo screen of UK policy nodes).

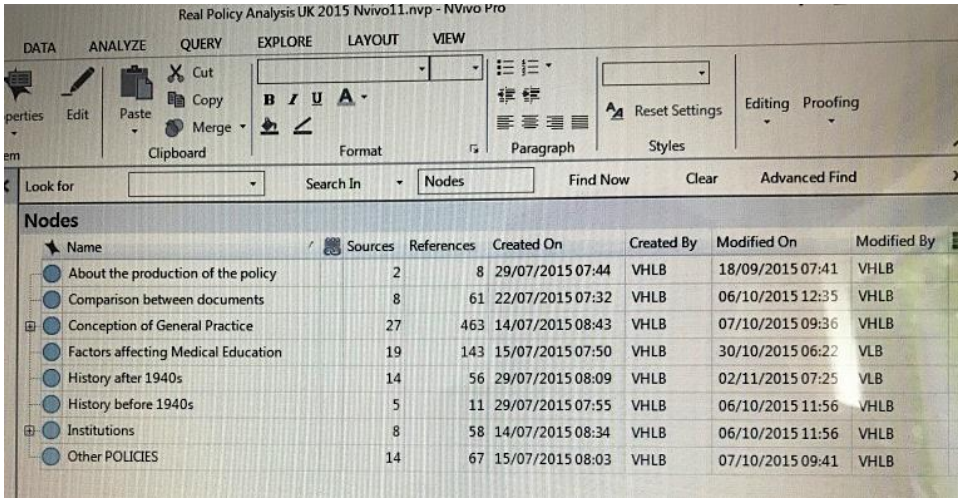


Figure 8. NVivo screen highlighting nodes of textual references from UK medical education policy that characterize general practice.

With the aid of NVivo nodes, I was able to focus on the most important passages for analysis without losing sight of broader discourses, which were grouped in separate nodes. The software also facilitated access to the original documents, meaning that selected passages could be studied in context rather than in isolation. The statements which played a vital role in delimiting my object of study are described in the results chapter (chapters 8-12)

4.1.3.2 Formation of *concepts:* identify and analyse the important concepts used to characterize the *object*

Key *concepts* were identified as links between fields of knowledge and their definitions, allowing their use by participating institutions in medical education discourse to be analysed and compared (formation of *concepts*). In the current study, the key institutions were the national governments of the UK and Brazil, their respective departments of health (NHS, SUS), the committees responsible for evaluating and addressing the future of medical education (i.e. Goodenough, CINAEM), the medical professional councils (i.e.

GMC, CFM), other professional associations (i.e. BMA, AMB), and organizations representing medical schools, teachers and medical students (i.e. ABEM). Secondary documents produced by these institutions, such as the 1944 NHS White Paper, were referenced where they shed light on the use of specific concepts in different contexts.

Here is an example of how I approached the analysis of a concept category. The following quote is an example of the identification of key *concepts* that characterize general practice. In the Goodenough Report (1944) the concepts of *health promotion* and *disease prevention* were used to link the foundation of the NHS to the role medical education would play in delivering the medical workforce the new service needed. Students, it was presumed, would be willing to assume these responsibilities, which were directly attributable to general practice, and therefore to work in this part of the NHS.

> "*The importance of the **promotion of mental and physical health** and of the **prevention of disease** is being increasingly recognized by the medical profession and the general public. There is growing support for the view that a **general medical practitioner should become the health adviser** of his patients and families and should participate to a greater extent in the conduct of the health services of the country. The evidence received from student bodies discloses encouraging signs that **many present-day students desire to fit themselves for these tasks.***" (Goodenough, 1944) p. 165.

In the text above, there is an assumption that medical education is supportive of the foundation of the NHS through the training of doctors who are prepared, as general practitioners, to *prevent diseases* and *promote health*. However, the connection between the use of these concepts in different fields of knowledge was difficult to discern, as the example above illustrates. There were no references to other documents that conceptualized

*health promotio*n and *disease prevention* and very few to areas of knowledge beyond the medical field. This could be seen as an attempt to insulate medical discourse from the influence of other knowledge areas or to stake a particular claim to the creation and use of these concepts. The few connections that do exist with other fields of knowledge are examined in the discussion chapter (13).

4.1.3.3 Formation of *strategies*: identify and analyse the *strategic choices* and how these choices shape the *object*

The consolidation of different choices in the production of a discourse reveals the *strategy* implemented by the authorities responsible for the documents reviewed (formation of *strategy*). The identification of these strategies involved three areas of focus: *equivalent-incompatibilities, economy of discursive constellation* and the *authorities* involved (previously discussed in chapter 3). Some practitioners of Foucauldian discourse analysis do not formally describe this phase of analysis (although they may follow it intuitively). I certainly profited from making discursive strategies explicit in the form of a mind map structure (see Figure 9).

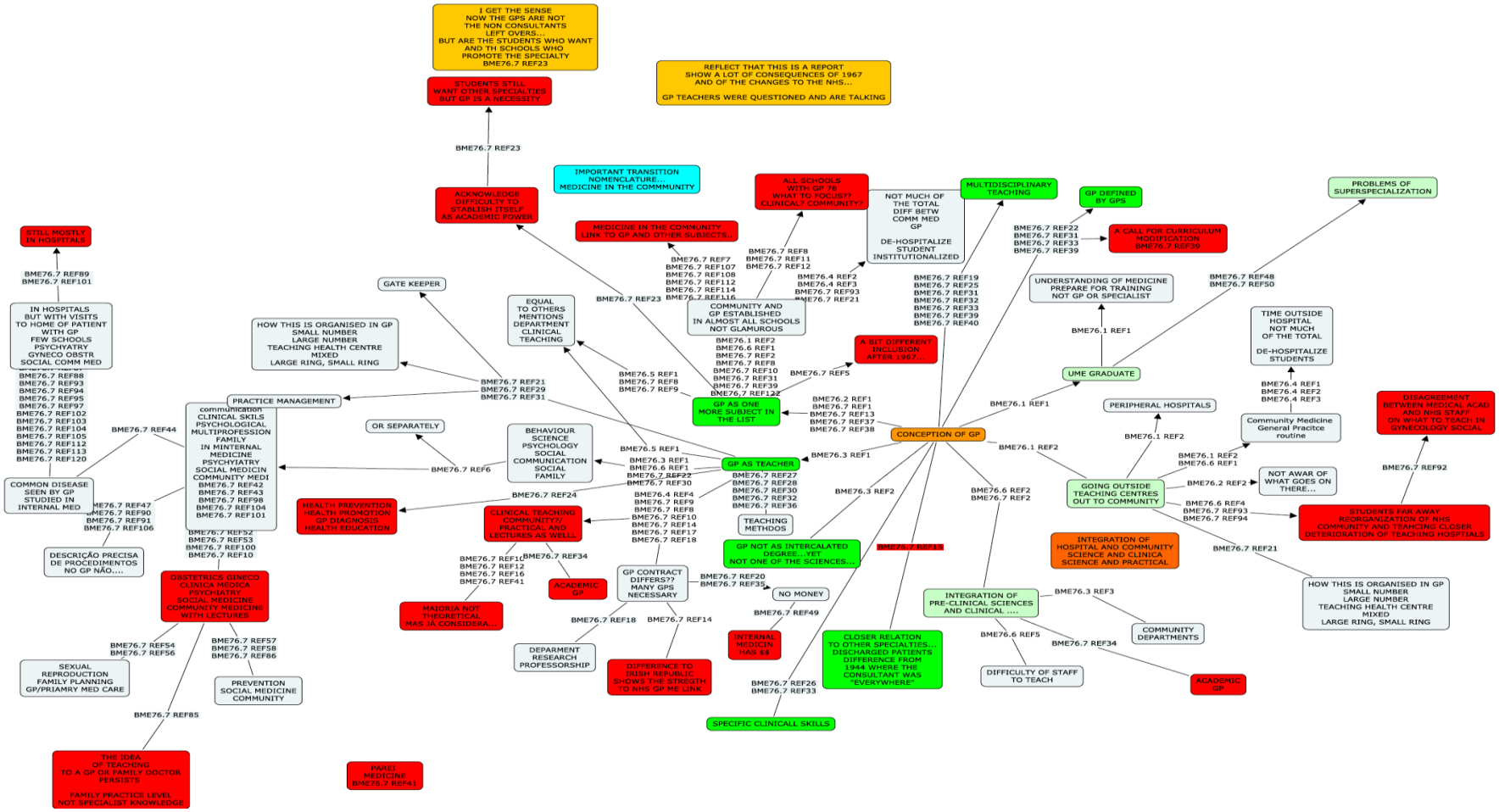


Figure 9. Example of a mind map of the analysis of discursive strategies and equivalent incompatibilities. The balloons in green represent characteristics attributed to general practice. The lines connecting the balloons are labelled with the number of the references so that they can be identified easily in the NVivo nodes and in the original documents. The balloons in light blue are equivalent statements and the ones in red are incompatible statements.

Following the identification of *statements* (section 8.2.3.1 – formation of objects), I used the structure of mind maps, like the one above, to analyse the formation of *strategies* and how these regulate the formation of the object. As the *statements* were plotted on the map, their *equivalences* and *incompatibilities* could be perceived more clearly than through the linear presentation of the text. *Statements* regarding equivalences of each *object* were given a specific colour on the map (light blue). The regrouping of *equivalent statements* that characterized the *object* of analysis exposed the underlying assumptions of truth that enabled the *object*'s features. These assumptions of truth legitimized the occurrence of the compatible *statements* and the homogeneous characterization of the *object*. The *incompatibilities* of each object were gradually identified and given a different colour (red) on the mind map (Figure 2). These were the main indications of a heterogeneous account of the same *object* (formation of *object*). Mind maps such as the one above proved exceptionally useful in recognizing strategies of inclusion and exclusion of the discourse and *object* of the current study (general practice). This was particularly evident when other *objects* (i.e. "specialties", "hospital", "primary care", "medical schools", "teachers") were defined and the "general practice" *object* was absent and/or excluded.

An example of *discursive strategy* identified in the analysis was the assumed dependency of the NHS on medical education.

> "*Properly planned and carefully conducted* ***medical education*** *is the essential foundation of* ***a comprehensive health service****…We think it is advisable to stress the* ***dependence of a successful health service on medical education****, partly because current discussions show signs of a tendency to concentrate prematurely on the detailed structure of such a service to the neglect of its* ***essential foundation****…*" (Goodenough, 1944, p. p. 14)

In return for government funding, medical schools and teaching hospitals were expected to provide a medical workforce (general practitioners) for NHS primary care. But despite this new relationship between medical education and the public health system, university hospitals would be responsible solely for teaching and research and would not provide services to the population as a whole. This division between teaching and non-teaching services created a hierarchy of services in the discursive practice of medical education policy, with the task of educating medical students presented as having higher value than that of caring for the overall population. General practice surgeries were excluded from student teaching. The quote below illustrates the independence of teaching services and the primacy of their educational role:

> "*The number and variety of patients in the wards and out-patient departments of the teaching hospitals* ***should be adequate to provide the students with such clinical experience*** *in the various branches of Medicine…The admission of patients to it must be* ***selective and controlled*** *in the interests of* ***teaching****.*" (Goodenough, 1944, p. p. 14)

This represented an incompatibility in discourse which helped to identify, through the analysis, the *discursive strategy* of hospital-based teaching as superior to other settings.

Identifying the authorities involved in the production of policies was greatly helped by the public nature of the documents. Names of authors and details of their professional background were readily accessible via the internet, mostly through governmental, medical or academic websites. Institutions had also posted documents offering a historical account of their foundation and development: these provided additional context for the

discussion of the results of the analysis (chapter 13). It was much more difficult to find critical (non-institutional) accounts of these organizations; indeed, during this research, none at all were found concerning the role played by these institutions in academic medicine or health practice, highlighting their seemingly unassailable status within the medical arena.

4.1.3.4 Formation of *subject position:* identify and analyse the *subject positions* available to the *object*

The characterization of the *object* produces different *subject positions* presented by authorities involved in the production of policy documents (formation of *subject positions*). Throughout the analysis, changes in the *subject positions* relating to general practice/general practitioners and other objects indicated a discontinuity in discursive strategy (i.e. the general practitioner as both learner and teacher). The policies reviewed, assigned particular subject positions to the actors involved in undergraduate medical education. The following example characterizes doctors involved in general practice as "*practical in nature*". This characterization is later used to justify the exclusion of general practitioners from teaching and research roles and from academic departments within hospitals (chapter 6).

> "*Such (refresher) courses should be specially designed for general practitioners, should be* ***practical in nature****, and full use should be made* ***of out-patient departments****.*" (Goodenough, 1944, p. 34)

This discourse / discursive practice produces a subject position of "eternal learner" for the general practitioner: the recipient of continuous "refresher" training from specialist teachers engaged in theoretical and scientific work in a university hospital setting (chapter 6).

The following section describes the writing-up process, which can be seen as the final phase of discourse analysis.

4.1.4 Writing up and analysis

4.1.4.1 Writing-up the background context (Chapter 5 and 9)

The review of the historical background of the involvement of general practice in undergraduate medical education began with the identification of policy documents in the UK and Brazil. The literature on medical education history in both countries was vast; however very few publications dealt specifically with the involvement of general practice. In the UK, the publication *Academic General Practice in the UK Medical Schools, 1948-2000* charted the development of general practice academic posts and departments in universities (Howie & Whitfield, 2011). In Brazil, a doctoral thesis by João Werner Falk offered a historical perspective of the development of the family medicine specialty, but did not address its participation in medical education (Falk J. W., 2005). Due to their linear, factual nature, these accounts did not conform to Foucault's understanding of history, as described in chapter 2. They did, however, provide useful background on the development of general practice over a relevant period which could be correlated with the socio-political and economic contexts of that time.

The historical backgrounds presented in chapters 5 and 9, which set the scene for the thesis's results, were constructed mostly from indirect accounts of the participation of general practice teaching in publications dealing with the history of medical education as a whole. This was the case in both countries. These publications presented in chapter 5 and 9 not only

helped to identify national policy documents (primary data), they also acted as secondary data sources which reinforced, contradicted and contextualized the analytical findings of this research. The results chapter of this thesis presents the findings of the analysis of policy documents (primary data) only. The correlation of these findings with the historical background, together with a comparison of the analyses for both countries, is provided in chapter 13.

4.1.4.2 Analytical writing up

During this stage of the study, five actions were taking place simultaneously. (1) I produced and reviewed the mind maps and documents with the aid of the two software packages used in the study (NVivo and CmapTools). The review process was important in enabling me to (2) record and synthesize the products of the analysis, which characterized the discursive *objects* and regrouped the *statements* defining these objects. The synthesis process was a moment in the analysis when I could progressively (3) contextualize the findings to the power network identified in the literature review of the history of general practice participation in medical education. As the content of a particular results chapter emerged, I had to (4) select the most relevant discursive elements to be described, having in mind the structure of the thesis as a whole. Throughout the writing up process, I would (5) remind myself of the research questions and method to ensure the analysis fulfilled the purpose of the study. Supervisory feedback of the drafts of each chapter was fundamental to maintaining the focus of the analysis and the writing up process.

4.1.4.3 Comparative framework

I conducted the processes described above separately for the documents from both countries. The results chapters for each nation, therefore, present discursive elements which are particularly notable in the policies of that country. Despite the occasional presence of similar discursive elements, the emphasis in each country and policy is different. Nevertheless, it is important to acknowledge the researcher's intrinsic comparative framework, influenced by my personal and professional history and stance, which is reflected upon in the reflexive sections. I did not start the analysis with a predetermined objective comparative framework. Like the categories/discursive elements presented in the results chapters, the comparative framework emerged during the elaboration of the discussion and writing up of each chapter. My approach was to look for similarities and differences while keeping in mind the contextual background of each country.

The comparative framework that emerged from the correlation of findings considered: 1) the discursive process by which general practice becomes part of formal university medical education; 2) the discursive emphasis of medical specialism and its appropriation of general practice; and 3) the continuous expansion of medical education in time and space and its influence on general practice knowledge. Another important part of this comparative framework considered the (re)actualization of certain discursive elements that justified change to medical education (discursive carousels).

4.1.5 Analysis team

Although I led the analysis, I was supported by a team of PhD supervisors – comprising two academic general practitioners (Greta Rait and

Sophie Park) and one academic educator (Caroline Pelletier) – who provided feedback throughout the analytical process and the writing up of the thesis.

4.2 Ethics and Reflexivity

In this section I consider the ethical dimension of the research and my reflexive stance towards this.

Dowling and Brown (2010) affirm that all research should consider ethical aspects of the investigation relating to morality, law and academy. They refer to the Ethical Guidelines of the British Education Research Association (BERA), which state that all research in education should respect the Person, Knowledge, Democratic Values, Quality of Education and Academic Freedom.

In fulfilling these requirements, this research has respectfully acknowledged authors and their contributions wherever they are cited. Medical knowledge and its different sub-specialties were approached critically in order to maintain the quality of the research and method undertaken. As a researcher, I tried to take an impartial stance towards the material, independent of the institutions that hosted and funded my PhD programme.

Given the public nature of the material they investigated, the authors cited in this thesis as having conducted a Foucauldian discourse analysis did not require or seek institutional ethics approval (Klingenberg, 2013; Carabine, 2001; Whitehead, 2013; Whitehead, Hodges, & Austin, 2013). Documents analysed by the current research were also in the public domain, allowing their authors to be named and recognized. An important ethical question, however, was the potential impact of the research findings on the communities it addressed (Stahl, 2004). In this study, these were

medical education research communities, medical schools and other governmental and non-governmental institutions involved in medical education (both in the UK and Brazil).

It is proposed that the results of this research could benefit these institutions by offering a critical perspective of their publications, for example identifying areas of potential social value and detriment. Policies on undergraduate medical education in both the UK and Brazil are renewed on average every ten years. Independent research on this subject, rooted in historical context, could be useful in informing the production of new policies and their revision cycle (Hammersley, 2013).

Although Foucault appeared to pay little attention to the ethical aspects of his research, certain authors using Foucauldian discourse analysis point to their ethical stance in conducting research (Graham, 2005). This generally involves a reflexive awareness of the researcher's partiality and preconceptions. Willig, for example, includes in her analysis a space for a bi-dimensional reflexivity about herself as a researcher (her influence in the process) and the development of her method. A similar approach was followed by Deborah Chin in her Foucauldian analysis of professionals' discourse of parents with learning disabilities (Chin, 2006). Chin's reflexive approach inspired me to consider the impact of my own preconceptions as a general practitioner coming from a particular part of the world, as described below.

4.2.1 Reflexivity

During the document analysis process, my professional background as general practitioner and university teacher continuously

influenced my understanding of the data. My experience of general practice in Brazil, for example, resonated with the medical training establishment's opinion of general practitioners in the UK one hundred years ago (characterized as "devalued" medical doctors) and with more welcoming attitudes towards the role of general practitioners in academic teaching and research currently. Above all else, this reflexive stance gave me a clearer understanding of the *vicissitudes* of discourse on general practice in medical education. This is further explored in the reflexive sections of each results chapter.

Throughout the research process, I experienced several "waves" of understanding, alternating from analysis to synthesis. These were separated by periods of time when I was focused on writing chapters and dealing with other aspects of the PhD (i.e. submitting abstracts to conferences, producing annual reports). Notebooks, tablets and mobile phones were often good companions in registering thoughts and insights about the analysis. The supervisory meetings with experienced academic researchers were particularly helpful in synthesizing and justifying the research findings as they emerged. Feedback from supervisors was essential to consolidating outcomes and developing a critical stance towards the research as a whole. Throughout the thesis, I have included reflexive sections in which I share considerations of my experience as a researcher and of the development of the analysis.

4.3 Limitations of Foucauldian discourse analysis

Discourse analysis in general has limitations. One is that it does not provide or even aim to offer absolute answers to research questions. Like

much qualitative research it positions the products of analysis as conditional on the specific factors surrounding the research process (i.e. researcher, historical period, institutions involved). The results presented in this research represent one analysis of the characterization of general practice in medical education policy – produced by a single researcher in a specific time and context.

Carabine (2001) warned of specific limitations associated with the research process, data and sources. These were encapsulated in a series of questions that I kept in mind throughout the research:

> *"What are the drawbacks of using historical sources: are they easy to access? Is all the information available? What records exist? Which perspectives do they represent? How reliable are our sources?*
>
> *How reliable can our interpretations be of material that is over 150 years old?*
>
> *Do the words and language used then have the same meanings as today?*
>
> *Is it appropriate to assume that the concepts and practices have the same meanings today?"* (Carabine, 2001)

Fadyl et al were concerned with the availability of texts in a historical analysis (Fadyl, Nicholls, & McPherson, 2012). Research, they argue, is dependent on documents that have been *preserved*. In the current context, for example, policies analysed were those considered most relevant at a specific time. Documents that were not preserved or acknowledged by the historical literature could be seen as a subjugated discourse. Foucauldian discourse analysis takes account of such contradictions in discursive formation (*equivalent incompatibilities*) (Foucault, 1972). In the mind maps created for the current research, I used the colour red to identify internal

contradictions in the text that pointed to incompatibilities in the dominant discourse.

Regarding the limitations highlighted by Carabine, the fact that the period under analysis is relatively recent (the last 70 years in the UK and 30 years in Brazil) meant there were no particular difficulties in terms of the availability of records or the terminology encountered. The archival institutions in the UK, together with the medical organizations in both countries, were able to provide all the documents identified in the search phase, which were comprehensible to a bilingual reader.

Carabine argues that another limiting aspect of research concerns the question of selectivity. A potential drawback of Foucauldian discourse analysis, she suggests, is the tendency of researchers to select only that text which supports their position. She proposes that, to avoid this, the researcher should actively seek out documents and passages that challenge his/her claims (Carabine, 2001). Whitehead (2011) raised the same concern in her series of studies on medical education discourse in North America. She acknowledged that her position as an “insider” within the research context, along with her background and personal perspective, would influence her data collection and analysis. Her reflexive approach helped her to recognize and communicate these assumptions and preconceptions to the reader, while at the same time recognizing the limits to a researcher’s self-awareness. My own approach similarly helped me to develop a critical and reflexive stance, which is documented throughout the thesis. As the findings of the current research began to emerge, I would question myself about my prior expectations, as suggested by my supervisors. This proved very helpful in

understanding the influence of a researcher's assumptions on the outcomes of an analysis.

4.4 Discourse analysis in different languages

With regards to conducting an analysis in different languages, it is important to consider the researcher's linguistic proficiency (can they speak, read and write in a particular language? Have they lived in the country where the language is spoken? Do they have a higher education qualification in that language?). The current research involved analysis of documents in Portuguese (my native language) and English (in which I have IELTS-accredited proficiency). Translation was not needed for the discourse analysis itself but was used occasionally to identify the correct technical or descriptive term for findings presented in the result chapters, particularly those conveying the uniqueness of the Brazilian medical education context. I describe these linguistic choices in detail in the two chapters (11 and 12) presenting the results of the analysis of the Brazilian data set.

4.5 Conclusions

This chapter has outlined the approach to Foucauldian discourse analysis used in this research. This approach was influenced by the work of Foucault and contemporary authors using Foucauldian methods. The chapter has focused on describing each one of the tasks of the discourse analysis: formation of *object, concepts, subject positions* and *strategic* choices. I have also described the writing-up process, which is inseparable from the analytical task. The ethical issues discussed underline the importance of adopting a

reflexive stance. This critical and challenging aspect of the method is further developed and demonstrated in the chapters that follow.

5 HISTORY OF GENERAL PRACTICE IN MEDICAL EDUCATION IN THE UK

5.1 Introduction

This chapter presents a narrative of the history of general practice in medical education in the UK. This account informed my decisions about the selection of texts and provided context for the analysis. It also offered a background for the discussion of the results. In this chapter, I describe the view presented in articles and books that were included in this focused review. Through these various sources, I was able to understand how these policies and their impact on medical education were positioned by the authors concerned. These authors bring a linear and global perspective to the history of medical education, giving a sense of continuous progress while not considering possible discontinuities. For this reason, this chapter contrasts with the results chapters of this thesis, which adopt a historical perspective compatible with Foucault's discontinuous historical emphasis.

This literature review produced an important insight into the history of general practice in medical education, in which the 1940s was clearly a landmark for important changes. I have therefore used this timeframe to inform my analysis and divided this chapter into two main sections: before the 1940s and after the 1940s. This division establishes the historical frame for this study. As presented below, the 1940s marked an important shift in the history of medical education and health care provision in the UK, following the establishment of the National Health Service.

5.2 History of general practice in medical education in the UK

Given that the history of medical education in the UK dates back to the middle ages, the focus of this particular narrative (general practice in medical education) has both a enabling and limiting factor. It can potentially contribute to a better understanding of the history of general practice in medical education, as few texts have tackled this specific topic. Nevertheless, as a limitation, the reader is offered a specific historical perspective of a broad area of knowledge.

5.2.1 Medical education before the 1940s

The aim of this section is to chart the origins of general practice and its relationship to medical education. Edwin Clarke (1966) divides the history of British medical education into five periods, each characterized by major changes in its organization. He defines these stages as: (1) Antiquity; (2) Fragmentation (from the medieval period to 1421), (3) Chaos and conflict (from 1421 to 1815); (4) Legislation (from 1815 to1944); and (5) Post-Goodenough (from 1944 to the present day). To accomplish my goal, I have focused on the description of general practice and its presence in medical education, paying special attention to the origins of this medical field. The two words that constitute the term general practice/general practitioner served as a guide in understanding this background context, as described in the following sections.

5.2.2 The "Antiquity" and "Medieval" periods (before 1421)

During this early period, the "*British practitioner*", as Drabkin (1944) called the all-purpose medical professional, was an unregulated service

provider, often trained, like many other professionals of the time, through a family-based apprenticeship, with no formal schooling. Clarke (1966) defines two types of practitioner, the orthodox and the lay, with the former offering services to the wealthy and the latter to poor communities. In both cases, practice was grounded in folk medicine mixed with magic, religion and superstition.

The *"British practitioner"* played an important role in the development of the next generation of the medical professional: the apothecary and barber-surgeon. Through offering allopathic cures, these direct ancestors of the modern general practitioner were distinguished from more prosaic "healers" but did not enjoy the social standing of university graduated "physics" (general medicine professionals). In this fragmentation, which occurred from the medieval period to 1421, one can understand the origins of the differential status of medical specialties today.

Whereas apothecaries and surgeons were trained through 7-year apprenticeships, physicians were exclusively educated at Oxford and Cambridge universities during an 8-year degree which was mainly theoretical, with very little practical teaching. All of these emergent professions were vastly outnumbered at the time by lay practitioners (healers) (Bullough, 1959). According to Clarke (1966), the next phase of medical education history (from 1421 to 1815) would be distinguished by a conflict between these professions for accreditation and influence over health care provision.

The first two periods ("antiquity" and "medieval") characterized by Clarke (1966) did not produce important policies regarding medical education.

What little regulation that existed was limited to students training in universities and to the professionals belonging to local craft guilds.

5.2.3 The “Chaos” period (1421-1815)

The first attempt to regulate medical professionals in the UK took the form of a petition by unnamed physicians in 1421. This first important public policy demanded that all practising physics and surgeons have a university diploma or medical degree. This reform was impractical due to three main factors: the multiplicity of institutions providing medical training, competition between the different categories and the number of lay practitioners still in practice (Colson & Ralley, 2015).

While never implemented, the petition prompted the establishment of a diverse range of professional institutions across the country, structured by the type of medical profession (e.g. physician, apothecary or surgeon) and region and providing regional/local training for professional accreditation in competition with private schools. During this period, universities such as Aberdeen and King´s College (1494) also started to offer medical teaching similar to that provided by Oxford and Cambridge.

These multiple training trajectories led many student doctors to qualify as apothecaries, surgeons or a combination of both, becoming the general practitioners of the 17th century. University-trained physicians continued to make up a small proportion of medical professionals in this era, with unqualified healing practitioners still providing the majority of treatments, especially in rural areas (Clarke, 1966).

The rise of general practitioners followed the organization of the apothecaries and surgeons’ institutions and education in the first half of the

18th century. Their education paralleled that of physicians, combining surgical training with the practical experience of treating large populations (Loudon, 1986). The lower fees charged by these practitioners made them the preferred choice of middle class consumers, while patients in the poorer strata of society continued to seek care from healers.

Demand for physicians and dedicated surgeons in this period was increasingly suppressed by competition from general practitioners. This became even more evident with the introduction, in the early 1800s, of the concept of family doctor, incorporating both continuity of care and a “pastoral” role (Loudon, 1986).

5.2.4 The “Legislation” period (1815-1944)

This period of medical education confronted three major health care challenges: the absence of professional regulation, the fragmentation of the profession, and the multiplicity of licensing organizations (Newman, 1957).

The Apothecary Act of 1815 was the first national policy to gather enough momentum to systematize medical education. It set a standard for the Society of Apothecaries of London to regulate apothecary-practitioners across the whole country. Apothecaries were no longer to act as druggists, who were now recognized as a separate category of professional. But they could only practice medicine, in effect signalling the beginning of present-day general practice. The Society of Apothecaries of London and the Royal College of Surgeons of England (1815) were the first institutions to regulate training and practice nationally through examination-based qualifications – the Apothecary´s diploma and membership. New schools were founded and

universities began to take over existing medical schools, a practice which had been widely adopted in continental Europe and America (Clarke, 1966).

The foundation of the General Council of Medical Education (later known as the General Medical Council, GMC) in 1858 reinforced the national regulation of licensing bodies, which now included the universities. The 1858 Act not only created the GMC but empowered it to compile a register of all qualified practitioners in the UK. This was the first medical education policy to apply to all categories of medical practitioner. The Council was responsible for registering all medical practitioners and supporting the merger of medical schools and universities. Despite efforts at consolidation, multiple licensing institutions were still operating in the UK at the beginning of the 20th century.

During this period, the role of hospitals in medical education increased significantly. The progressive separation of medical professions (apothecaries/general practitioners, surgeons and physicians) led to a territorial division in which hospitals were dominated by physicians and surgeons, while general practitioners worked as personal doctors in the community (Tait, 2012). Hospitals also became the increasing focus of specialization and scientific inquiry, to the extent that the GMC in 1865 suggested that students should not apprentice as general practitioners before starting their hospital work (The Lancet, 1864) (Rivett G. , 2015). Until the second half of the 20th century, few schools offered placements in general practice (Goodenough, 1944).

The Flexner (1910; 1912; 1925) and Newman (1918; 1923) reports were particularly influential in promoting scientific medicine in close association with the universities, but they also signalled the importance of

redeeming apprenticeships in medical education. At the end of the 19th and throughout the first half of the 20th century, undergraduate medical education in the UK gradually took on a common format: 2-3 years dedicated to the basic sciences (pre-clinical years) and 2-3 years of clinical teaching. Most of the graduates of this time would enter general practice. The balance between theoretical and practical teaching tended towards the former, which consisted mainly of large group academic lectures. This period ends with the publication of the Goodenough Report in 1944, which is a key document in the current analysis (Clarke, 1966), and is further described in the next section.

In summary, the development of medical education in the UK develops through increasing regulation of medical training and practice. In each of the periods described by Clarke, the foundation of institutions responsible for implementing these conventions constituted a materialization of power. Understanding the origin, function and development of these bodies over time is therefore important in analysing the role they played in the period covered by this study (1940s – 2015).

The “antiquity” period of medical education in the UK was characterized by the absence of regulatory or training bodies. The family, both as a social institution and apprenticeship structure, was the main organizer and regulator of medical practice, largely determining the patient groups to which practitioners offered their services (i.e. wealthy or poorer communities) (Loudon, 1986). The following period of “fragmentation” saw the foundation of medical teaching in universities (Oxford and Cambridge) and local craft guilds for surgeons and apothecaries. This broke the model of traditional family apprenticeships and reinforced the unequal social status of the different

medical professions (practitioners/healers, surgeons and apothecaries, physics).

During the third period of “chaos” and conflict, the associations representing surgeons and apothecaries sought to increase their territorial scope beyond individual towns to cover entire regions. Likewise, the Royal College of Physicians (1518) attempted to exercise national power over all medical categories, though without success. During this time, bishops of the Church of England were also empowered to grant licences to medical practitioners. The Society of Apothecaries of London, a forebearer of the modern college of general practitioners, established a 7-year apprenticeship and the sole right to dispense medications in the city and within seven miles of it (Allen, 1946).

The “legislation” period marked the beginning of present day family doctors/general practitioners. The Society of Apothecaries of London and the Royal College of Surgeons gained national power to regulate apothecaries and surgeons respectively. By the end of this period all medical schools were amalgamated with universities. The creation of the General Council of Medical Education was, however, the most important development of this period, in that a single institution became responsible for the registration of all medical practitioners.

From this narrative account, my understanding is that before the 1940s, medical education and its various divisions (e.g. apprenticeships, medical schools, universities) had a major impact on health care provision. This drastically changed from the 1940s onwards with the foundation of the

National Health Service, at which point the organization of health care began to exert a major influence on the medical education system.

The emergence of general practice as a medical category, with its origin outside universities, coincides with the gradual exclusion of apprenticeships from formal academic medical education. General practitioners gradually consolidated their place in the medical profession, despite not having an academic education.

The term “practitioner” was used to denote certain categories of medical professionals and their educational background throughout the period described. The British practitioner, apothecaries, barber-surgeons and surgeon-apothecaries (medical practitioners) all arose from apprenticeship models of education. Although the latter three allopathic categories were distinguished from “healers”, their struggle for status (from the medieval period to 1421) had repercussions which are felt to this day, most notably in differential perceptions of general practice and hospital-based specialties (Clarke, 1966).

The practitioners described in this section constitute the professional genealogy of the general practitioner, as summarized in Figure 9. The very term “practitioner”, with its roots in “practice”, historically distanced these professions from medical theory and academic education. This distinction continued through the exclusion of general practice from formal medical education by the GMC until the end of the 19th century and was consolidated in the Goodenough Report (1944). I chose the Goodenough Report as the first document to be analysed in the UK segment of this study, as it encapsulates the discourse on medical education and general practice

knowledge that prevailed before the establishment of the NHS, as described in the results chapters.

It is tempting to speculate on the reasons why these two words ("general" and "practitioner") came to define a particular type of doctor. The term "general" triggers associations with the "all purpose" nature of previous professionals, and the "general medicine" of university-educated physicians. The term "practitioner" harks back to the lay or orthodox practitioners and apothecary-surgeons of Clarke's third period, and to the idea of a "hands-on" or apprenticeship (i.e. non-academic) model of education. This combination of attributes contributed to the relative popularity of general practice compared with other career models during the twentieth century.

This account, covering an extensive interval of time, is important to understanding the continuities and discontinuities of general practice and its role in UK medical education. The Second World War had a major impact on many areas of UK society, including health provision and training. And with the foundation of the National Health Service (NHS), medical education became increasingly tied to the delivery of health care, organized by the state as a major welfare measure.

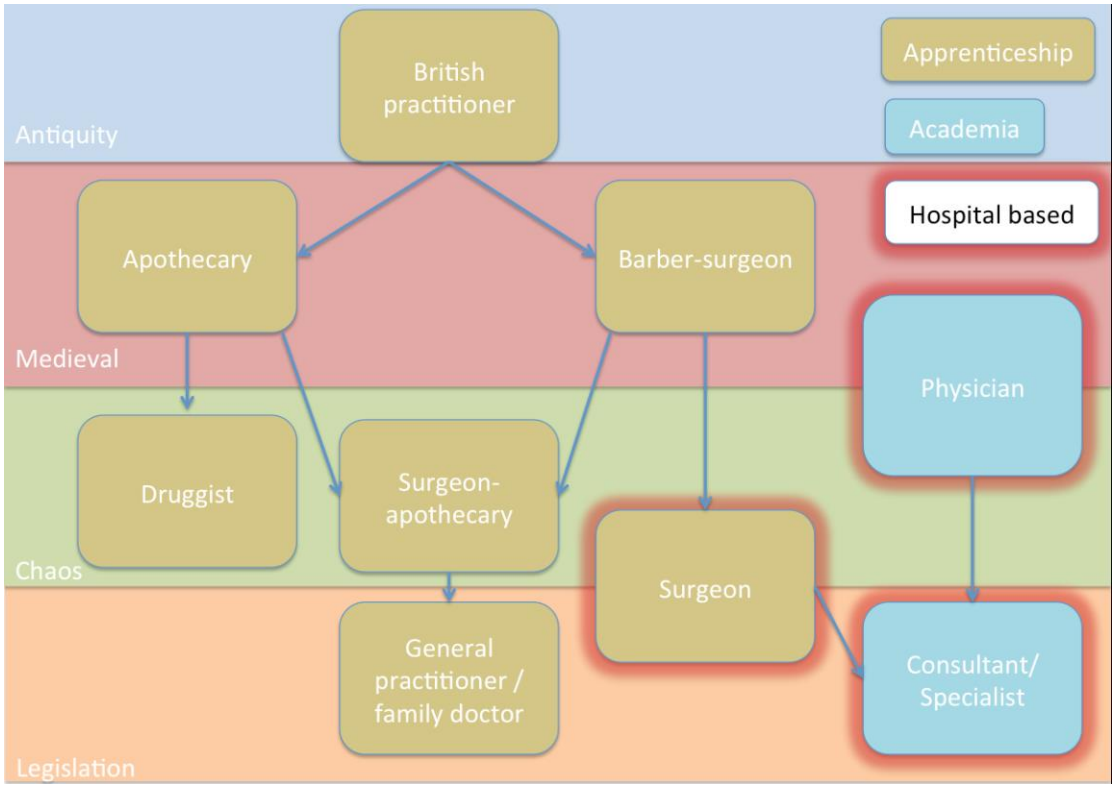


Figure 10. Genealogy of medical profession categories

5.3 Medical education in the UK from the 1940s

This section provides a history of the development of the NHS and related changes in general practice and undergraduate medical education. As described in the previous section, this most recent period of medical education is closely linked to the development of the NHS in the UK. However, few articles and books look at this specific relationship. Most historical texts on medical education in this period address individual policies introduced at different times. The challenge of understanding the part played by general practice in medical education from the 1940s onwards is further highlighted in chapters 6, 7 and 8, which present the results of my discourse analysis.

5.3.1 General practice, medical education and the NHS

This section is divided into sub-sections covering specific periods (decades) in which important medical education policy was published in the UK.

5.3.1.1 The 1940s

The history of the NHS is one of progressive incorporation of state-provided health care during the first half of the twentieth century. Under the Poor Law and Local Government Act of 1929, local authorities were allowed to provide health services to the general public. By the time of the outbreak of the Second World War, the London County Council was running the largest public health service in Britain, including medical schools. After the National Insurance Act of 1911, workers who had contributed through a weekly salary deduction were entitled to receive medical care, plus certain other benefits. But while they were registered with general practitioners, most were not eligible for free medications. The non-working population, especially women and children at this time, did not receive this benefit but instead had to access private medical care or seek help from voluntary hospitals (Rivett G. , 1998).

During this time, many medical and political institutions, including the British Medical Association (BMA) and the Labour Party, called for the creation of a national medical service. In the early years of war, the government had set up an Emergency Hospital Service allowing the injured to be cared for in any UK hospital. Political support for a state-run service intensified in the early 1940s, as local authorities struggled to fund and manage their health care responsibilities. Finally in 1944, despite major resistance from general practitioners and hospital doctors, who were

concerned about losing their independence, the NHS was created through the publication of a White Paper. The service was to be funded by general taxation, not by an extension to the existing national insurance scheme. The National Health Service Act came into force in 1946, creating a single national hospital service to take over the responsibilities of local authorities and voluntary hospitals. Finally, in 1948, after prolonged negotiations, the BMA decided to join the NHS ahead of its launch in July of that year (Rivett G. , 1998).

As part of this climate of health care transformation, the Interdepartmental Committee of Medical Schools, established by the government in 1942 to assess the current state of medical education in the UK, was also responsible for charting its future direction. Its work culminated in the publication of the Goodenough Report of 1944. The report described a medical education system that was neglecting health promotion and illness prevention, the pillars of the future NHS. It recommended the creation of teaching centres, mainly comprising teaching hospitals and general and district hospitals, where students could receive a university-linked education. The report also suggested that all students spend an extra year in hospital wards before registration, providing much-needed manpower for the nascent health system.

In the wake of the Goodenough Report, the General Medical Council and governmental bodies published new policies and recommendations on medical education approximately once every ten years. With the Medical Act of 1978, the GMC gained sole responsibility for assessing and coordinating medical undergraduate and postgraduate

education (Irvine, 2006), although until the beginning of the 1990s it had little control over the implementation of its own recommendations. This was partly because its inspections of schools were “infrequent and far from searching”, but also because it lacked financial resources (MacManus & Lockwood, 1992).

The NHS initially comprised three main structures: hospital services, with separate teaching and non-teaching hospitals; primary care services, run by general practices as independent contractors paid according to the number of patients on their lists; and community services, which were under the control of local authorities. Within a month of its launch, 90 per cent of the UK population had registered with a general practice (Rivett G. , 2015).

5.3.1.2 The 1950s and 1960s

Despite rising costs and ongoing negotiations with medical staff, the NHS continued to expand in the 1950s and 1960s. However, the first major assessment of general practice quality under the new regime, the 1950 Collings report, found that general practitioners were working in unfavourable conditions. Many practised on their own or with just one other partner, in isolation from other professionals. The report also concluded that standards of patient care were poor (Collings, 1950).

The Medical Act of 1950 implemented a key recommendation of the Goodenough Report, requiring all doctors to undergo a pre-registration placement after graduating as a house doctor. In 1956, a subsequent Medical Act strengthened the GMC’s legal duty over medical education through the work of its Education Committee. In 1957, the GMC published the first version of its *Basic Recommendations on Medical Education.* But while this document

was broadly consistent with the Goodenough Report it had little impact on medical school activities (Clarke, 1966).

In 1966, the government introduced better pay and conditions for general practices, and established a maximum list size of two thousand patients. It also provided financial resources for professional development, improvement of practices and the employment of support staff (The King´s Fund, 2011). Responding to criticisms of NHS general practice, the Royal Commission on Medical Education (Todd Report, 1968) endorsed a proposal in the GMC's 1967 redraft of it *Basic Recommendations* that no doctor should enter general practice directly after graduation. From then on, all doctors were expected to undergo postgraduate training. Both documents reinforced the comprehensive care remit of the NHS by proposing that students receive tuition in a variety of clinical settings, including health centres and general practices.

5.3.1.3 The 1970s

The 1970s saw the end of the economic confidence of the previous decade and rising pressure to reduce the costs of public services through a discourse of increased efficiency. The College of General Practitioners, founded in 1953, was granted formal recognition in 1972, giving general practitioners a strong collective voice for the first time (Tait, 2002). It also received a Royal charter, becoming the Royal College of General Practitioners (RCGP). Postgraduate training in general practice became mandatory in 1976, leading to three-year programmes being introduced across the UK. The 1978 Alma Ata declaration highlighted the importance of primary health care, emphasizing health promotion and disease prevention; in

the UK general practitioners' role as the medical professionals working in primary care became increasingly established and valued (The King´s Fund, 2011). In this same period, the Cochrane report, published in 1972, underlined the value of randomized controlled trials in assessing the effectiveness of treatments. This marked the beginning of the evidence-based medicine practised today.

In its 1976 report, *Basic Medical Education in the British Isles*, the GMC published the results of a survey and interviews with 38 medical schools. One of the most striking developments it identified was that most schools were offering a formal attachment in general practice. The report also highlighted the shortage of clinical teachers in certain specialties and the conflict between service and teaching obligations within the NHS (Postgraduate Medical Journal, 1978).

5.3.1.4 The 1980s

This decade witnessed the continuing implementation of the discourse of efficiency in the NHS. The Griffiths report of 1983 recommended that the previous system of management by consensus be replaced by modern management processes, with an increased role for clinicians. The RCGP launched a Quality Initiative in response to the perceived variation in clinical practice across the UK and political pressure to subject public services to greater examination (The King´s Fund, 2011). The Thatcher government, in its final term, introduced the idea of the NHS "internal market" through two White Papers of 1989: *Working for Patients* and *Caring for People*. Under these reforms, implemented in the National Health Service & Community Care Act of 1990, health authorities were no longer responsible for running

hospitals but would instead purchase care from hospitals in their own region or elsewhere. Similarly, general practitioners were to manage procurement funds and purchase care directly for their patients. Health service providers became NHS trusts in a move that stimulated competition but also amplified local variances (Rivett G. , 1998).

University teaching in this period was seen as subordinate to the needs of health care, according to the University Grants Committee surveys of 1986 and 1989 (MacManus & Lockwood, 1992). The priority for clinical academic staff was described as “patients first, research second, teaching third” (McManus, 1989). In the UK, medical research during the 1980s was largely funded by the pharmaceutical industry and health charities, meaning a loss of public control and accountability (MacManus & Lockwood, 1992). The GMC’s (1980) guidance on medical education clearly supported the integration of pre-clinical / basic science in the first year of undergraduate courses and during clinical training. It also encouraged the integration of community and hospital services. However, this document would be less influential than its previous and future versions (the *Tomorrow´s Doctors* series – see below), as there are very few citations in the medical education literature. The same can be said of the Edinburgh Declaration of 1988, released by The World Federation for Medical Education (WFME), which called for the urgent reorientation of global medical education in response to the 1978 Alma Ata Declaration (see Figure 11).

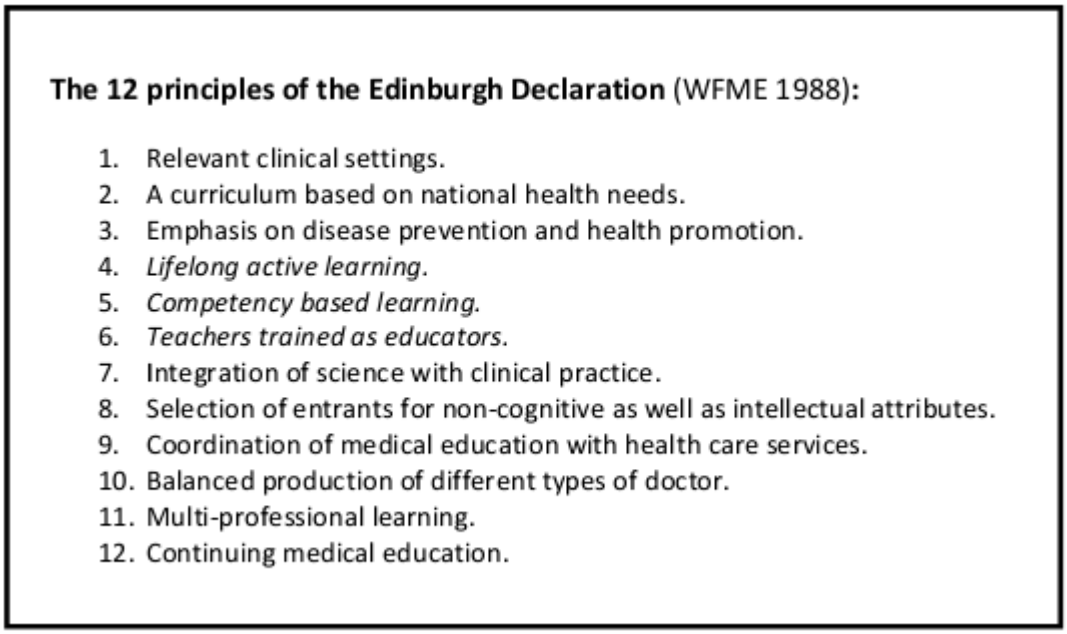


Figure 11. The 12 principles of the Edinburgh Declaration (World Federation of Medical Education, 1988)

5.3.1.5 The 1990s

The trend towards greater scrutiny and evidence-based medicine had been consolidated in the 1990 general practice contract, and elements of performance-related pay were introduced. Overall, general practitioners became more involved in the wider health system, thanks to their new role in commissioning services (The King´s Fund, 2011). Building on the internal market concept, the Blair government, which came to power in 1997, introduced further health market reforms, particularly in its second term. These included the restoration of practice-based commissioning (fundholding), the closure of surplus services, severe economic budgeting, exhaustive service standards and more rigorous clinical and corporate governance (Rivett G. , 1998). An expansion of the Private Finance Initiative

launched by the previous Tory government, gradually opened up NHS services to private health providers.

On the medical education front, the GMC published the first of its *Tomorrow's Doctors (*henceforth *"TD")* series in 1993, with the aim of steering medical school training towards "patient centred" care. Its 1995 ethical guidance, *Good Medical Practice,* broadened this concept of "patient centredness" to apply to all medical professions and laid the foundations for a revalidation process (continued accreditation of doctors) (Irvine, 2006). There were no major governmental initiatives in this period to assess undergraduate medical education, the last being the Todd report in 1968. (MacManus & Lockwood, 1992). To help implement the recommendations of its TD1993 report, the GMC made its Education Committee responsible for liaising with medical schools through visits and reports. From 1995-2001, visits were carried out to 25 UK medical schools. Changes noted in most schools included a reduction in the burden of factual knowledge, the introduction of special study modules and the development of system-based and integrated curricula. Recommendations which had yet to be implemented included the promotion of public health medicine and the development of appropriate assessment schemes.

With regards to community-based teaching, most schools had by this time set up departments of general practice/primary care and were offering early-year placements in general practice (Christopher, Harte, & George, 2002). However, Stephen Higgins (1994), an experienced pre-clinical teacher from the University of Leeds, noted that many departments involved in medical training were not willing to give up their share of the

curriculum. A vast majority of courses were still divided between pre-clinical and clinical years, with the addition of an optional year between these two stages in which students could carry out research into a specific field of medicine.

A notable development in this decade was the creation in most schools of an independent medical education unit/department offering teacher training for academic and clinical staff at all levels (Christopher, Harte, & George, 2002). The GMC's *Good Medical Practice* (2001) report regarded teaching as an important part of medical practice, recommending that all doctors involved in training undergraduates should develop their competencies in this area. This goal was underlined in the second version of TD, published in 2003 (Swanwick, 2009) and became a mandatory requirement in the Department of Health´s *A High Quality Work Force: NHS Next Stage Review* (Darzi, 2008).

The 1990s also saw the rise of medical education bodies like the Association for the Study of Medical Education and the Medical and Dental Education Network. These institutions organized conferences and meetings on curriculum development, teaching innovation and improved assessment strategies (Dennick & Exley, 1997). From these efforts a range of different teaching methods were developed and implemented, including mentoring, computer-assisted learning, competence-based curricula and continuous assessments (Dennick & Exley, 1997).

5.3.1.6 The 2000s

The 2000s confirmed the trend of the previous decades, in which ideas of quality, commissioning, competition and choice predominated.

Several mechanisms of health care quality assurance were implemented (including general practice appraisals in 2002, the Darzi review of 2008, and the Care Quality Commission – 2009). The first national training curriculum for general practice was published by the RCGP in 2007 (assessment for membership of the RCGP has since become compulsory for trainees). Patients were allowed to choose their general practice, introducing competition into primary care, and a range of alternative access points were created, such as walk-in centres. Information technology also played an emerging role in the relationship between health professionals and patients (The King´s Fund, 2011). More recently, an increasing number of practices have joined together to form general practice federations, while maintaining their individual locations.

In 2003, the GMC published a revised version of its *Tomorrow's Doctors* guidance. This reinforced the standards set out in its regulatory document for practising doctors, *Good Medical Practice* (GMC, 1998). It also underlined the need to tackle overcrowded curricula and called for a review of assessment methods (Catto, 2003). This ongoing demand for a reduction in training content would become the subject of dispute between medical school departments, who were reluctant to give up teaching space in the curriculum (Jessop & Johnson, 2009; Webb & Maxwell, 2002). The TD 2003 also elaborated upon the knowledge, skills, attitudes and behaviours expected as outcomes of medical education and clarified the clinical skills to be assessed before graduate students were allowed to work as Pre-Registration House Officers (or Foundation trainees, as they are now known) (Rubin & Franchi-Christopher, 2002).

Another major change in the 2000s was the greatly increased student debt incurred by medical students in England (though not in Wales, Scotland and Northern Ireland). Towards the end of the 1990s, the average fee for the complete undergraduate training was £8,000, most of which was paid by local education authorities. With the introduction of tuition fees in 1998 and “top up” fees in 2004 and 2010, this cost – now borne directly by graduates through a student loan system – had increased to £24,000 by 2010 (Lewington, 2012).

Despite these reforms of medical education, there was little evidence that newly-graduated doctors were any better prepared to face the realities of health care or postgraduate training. Studies revealed, for example, that doctors were continually struggling to update their knowledge and skills (Roberts, 2004). At the same time, the NHS´s move towards a resource-managed health organization required new doctors to develop management skills, which had to be incorporated into medical education policy and curricula (Roberts, 2004). By 2006, however, the British Medical Association´s (BMA) Graduate Student Cohort Study was reporting positive improvements in key skills compared with those of the 1995 cohort (Lewington, 2012).

In contrast to the 1990s, the 2000s saw an increase in government influence over universities and medical education (Department of Health [DoH], 2001, 2002, 2003, 2004). The DoH called for a social medicine commitment, requiring doctors to excel in communication skills, to take a compassionate approach to patients’ problems, to acknowledge the needs of deprived and minority groups, and to include patients in decisions regarding

their treatment (Roberts, 2004). The government's intervention followed a number of medical scandals which revealed the wide gap between professional attitudes and public need (Meyers, 1987; Dyer, 1999; Fenn, 2000; NHS Executive, 2001; Bristol Royal Infirmary [BRI] Inquiry 2001; Royal Liverpool Children's Inquiry 2003). Roberts, in particular, identified a conflict between the stated aim of undergraduate and the vocational specialised practice in health systems (Roberts, 2004). This was demonstrated by the paradoxical demands presented in medical education policies for both patient-centred care and procedural competency, measured by assessments conducted by the Department of Health in 2001 and 2003; (Roberts, 2004).

A significant change in postgraduate training was implemented in 2007 as part of the DoH-led initiative, Modernising Medical Careers. A response to the Chief Medical Officer's recommendation in his report *Unfinished Business* (Chief medical officer, 2002) that fewer NHS patients be cared for by trainee doctors, Modernising Medical Careers replaced the previous Pre-Registration House Officer scheme with a new Foundation programme. Figure 12 below summarizes the differences between the two regimes (Lewington, 2012). The 2009 version of *Tomorrow´s Doctors* adapted undergraduate medical education to the requirements of the new role of Foundation Doctor. But despite specifying three sets of competencies required of the newly-graduated doctor (those of the professional, scholar and practitioner), the GMC made few changes to the guidance contained in its previous version.

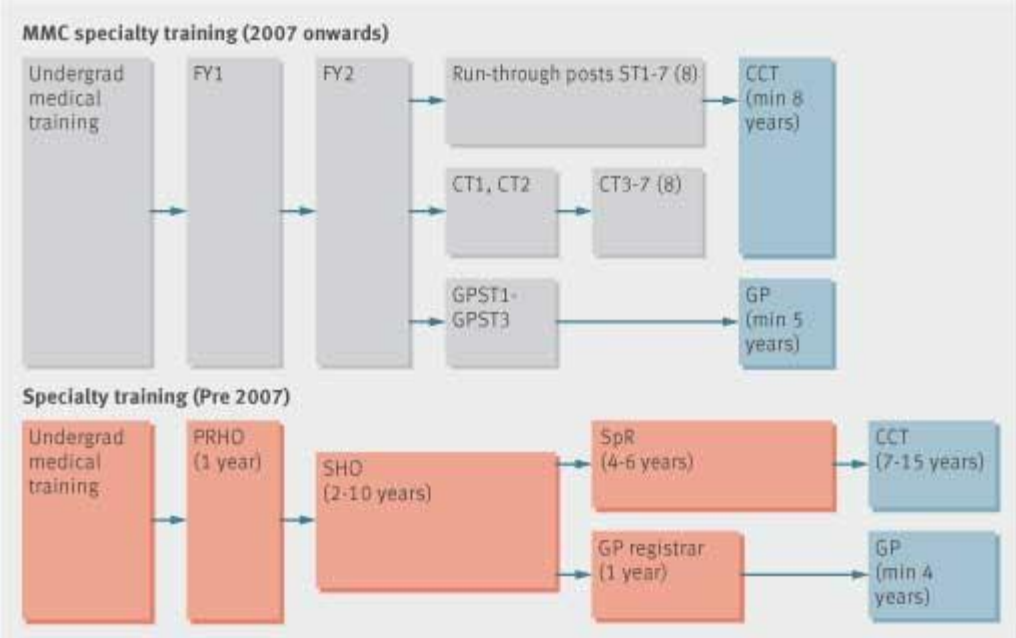


Figure 12. Changes to postgraduate medical education in the UK (Lewington, 2012)

The present requirement for medical students to have contact with patients early in their training, and for more teaching responsibility to be taken on by medical practitioners working in the NHS, in some respects echoes the apprenticeship models of previous eras. At the same time, academic teachers have become increasingly preoccupied with the demands of medical research, paying less attention to undergraduate teaching (Warlow, 2009).

Summing up developments in the period after 1940, MacManus & Lockwood (1992) highlighted a disconnect between the body responsible for funding medical education (the Department of Education and Science) and the major employer of doctors (the Department of Health). It is interesting to note that while judging from the literature a closer relationship existed between the training of doctors and health provision, in reality these were territories ruled by different power structures, with medical institutions and medical schools/universities on the one side and the Department of Health on

the other. There was a particular disparity between the high number of junior doctors finishing training and the much smaller number of consultant positions advertised in hospitals, creating what MacManus & Lockwood (1992) described as career “log-jams”. At the same time a large number of junior posts were needed to satisfy the demands of the service. This signalled to me another point of conflict in UK medical education policy.

In my comprehension of this account, medical education history in the UK has been marked by a series of struggles which helped to shape the development of undergraduate training, e.g. between health provision and academic medicine, between practice and theory, between practitioners and consultants, and between apprenticeships and theoretical teaching. The results chapters describe how these conflicts were expressed in policy documents from the late 19th century to the first decade of the 21st century.

5.4 Conclusions

Significant developments in the regulation of the medical profession in the UK were matched by an increasingly close relationship between medical education and academia. Through this process, general practice was initially excluded from medical education, ironically at a time when general practitioners were the predominant medical carers in the UK. Alongside this, the merger of medical schools and universities signalled the rise of the hospital setting and specialized medical knowledge. This marginalization of general practice described by Digby (1999) lasted until the 1940s, when general practice teaching was reintroduced with the foundation of the NHS. This is a moment of disruption in medical education discourse, and the starting point for the analysis contained in this thesis

The contextualization presented in this chapter was fundamental to my understanding of the history of medical education and the part played by general practice. This historical review also helped me define the timeframe of the study and identify the documents to be analysed in this research. The following chapters describe the results of the analysis of the policy documents in the UK in three different analytic eras. It should be noted that between the publication of the 2009 version of *Tomorrow's Doctors* – the latest document to be analysed – and the completion of this thesis, no other national guidelines for UK undergraduate medical education were published.

6 GENERAL PRACTICE AS PATCHWORK OF OTHER MEDICAL SPECIALTIES IN THE UK

6.1 Introduction

In this chapter, I describe the format of the results section of this study and present the findings for the first analytical period identified through the analysis of policy documents in the UK. The Foucauldian discourse analysis of undergraduate medical education policy defined three different analytical periods in the UK and two in Brazil. These periods are characterized by continuity and discontinuity in the discourse on general practice knowledge, producing the *genealogical* dimension of the discourse analysis. These analytical periods do not have an exact timeframe. I have chosen to present the UK results first, as readers of this thesis are likely to be more acquainted with the historical context of UK medical education. This familiarity will also help readers gain a more immediate understanding of the analytical method used.

The UK results are presented in three chapters (6, 7 and 8), each focusing on a discontinuity of discourse in the documents analysed (which dated from the 1940s to the 2000s) and a change in discursive strategy in undergraduate medical education which directly influenced the characterization of general practice. Chapters that follow (10 and 11) present the findings for the two analytical periods identified in Brazilian policy. The delineation of these analytical periods is not absolute: discursive elements in policies from different periods will co-exist, particularly at the beginning and end of each era. The earlier analytical periods were sometimes confirmed by discursive elements in later analytical periods in which older policies were

referenced. This *a posteriori* reflection on “policy within policy” was useful in consolidating my analysis. In the presentation of the results I have selected extracts from policy documents that illustrate the *transition* between these discursive phases, emphasizing the distinctive nature of the discourse for a specific period. I have used bold letters to highlight certain parts of the quotes which I consider particularly relevant. This highlighted discourse could be seen as complementary and/or substitutive to previous discourses. The discussion chapter (12) correlates the findings for each analytical period and connects these with the current scientific literature. The comparative nature of the study helped map the continuities and discontinuities across the analytical periods and between the different settings.

The presentation of results in each of the five chapters reflects the four methodological tasks described in chapter 4, which form the *archaeological* dimension of the Foucauldian discourse analysis. I have presented these tasks in a specific order. First, I describe the key strategic choices outlined in the documents of each period and the discursive assumptions or truths they contain, in order to describe the discursive object under investigation, i.e. general practice knowledge. Next, I present the formation of concepts that link the object and subject positions to these key strategic choices; these are of fundamental importance in identifying the discursive strategies within the policy documents. Finally, I describe the formation of the object and the subject positions available to general practitioners within the prevailing discourse. These tended to emerge at the same time in textual analysis (i.e. the extracts that helped identify the object also characterized the subject positions), so are presented together. As

described in chapter 4, I also used documents cited by the policy texts as secondary data. Some of these references reinforce or challenge the discursive elements contained in the policy documents themselves.

The order in which these discursive elements are presented in the results chapter does not follow that of the analytical process, and is intended simply to produce a comprehensible account of the analytical procedure and findings. In reality, tasks were conducted simultaneously (although with a particular focus on different tasks at different times) and in parallel with the writing-up process. Within the results, I have aimed to demonstrate the analytical process and allow space for the reader to reflect on this process and the focus of the analysis. I tried to avoid providing a linear argument in the results which would not accurately reflect the analytical process and would create a truncated or smoothed-out version of the analytical findings.

6.2 Three UK analytical periods

This section briefly describes the analytical periods characterized in the analysis of the UK documents. Three different characterizations of general practice emerged from the analysis: general practice as a patchwork of medical specialties; general practice as the internal medicine family doctor; general practice as an uncharacterized medical specialty.

In this chapter, I present the results for the period between the 1940s and the 1950s in which the NHS was founded. Policy documents from this time consolidated a specific discourse on general practice that was prevalent at the end of the 19th century and throughout the first half of the 20th century: general practice as a patchwork of other specialties. Chapter 7 describes a transitional period in the 1960s, 70s and 80s in which general

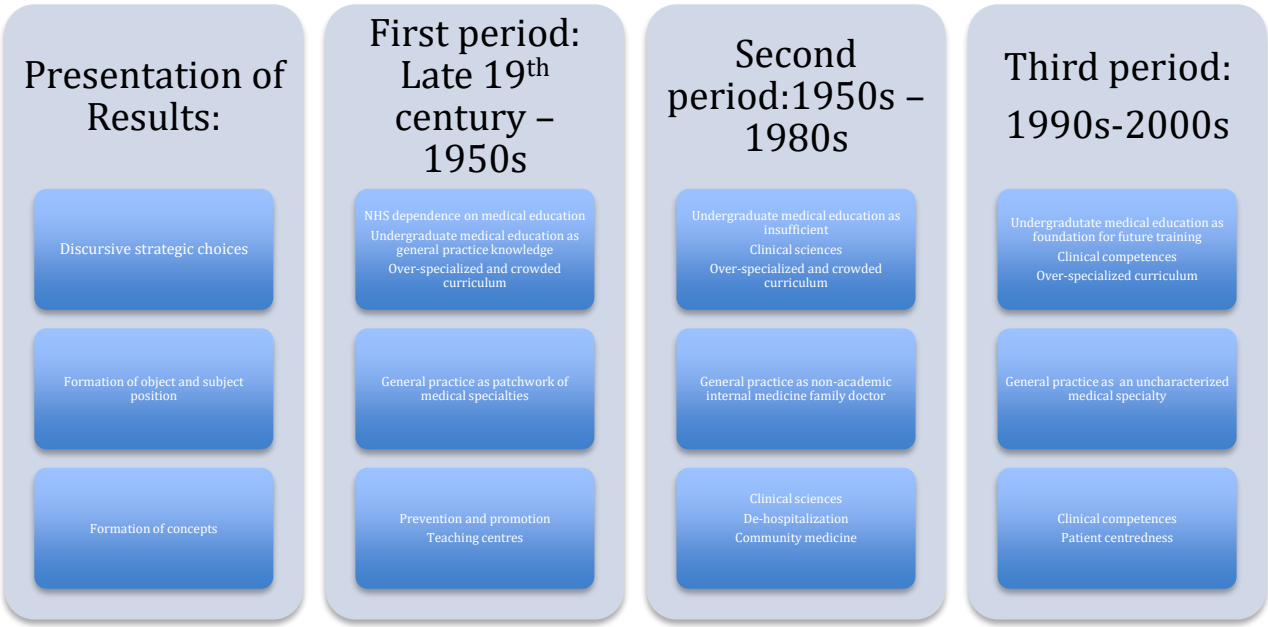
practice began to be seen as a medical specialty practising a clinical science, though without the social, political or academic/scientific status of other medical fields. The final period (chapter 8), spanning the 1990s and 2000s, is marked by a discourse on general practice heavily influenced by the *Tomorrow's Doctors* series of guidelines published by the GMC. These documents characterize the second discontinuity identified by this analysis: general practice is presented as a specialist field of medical knowledge, like any other, but stripped of identifying characteristics by medical curricula which link it instead to a wide range of medical practice and specialties. Table 7 summarizes the three analytical periods for the UK.

Table 7. Organization of the UK medical education policy findings

Discursive characterization of general practice in medical education policy in the UK in 20th century		
Chapter 6 General practice as patchwork of medicla specialty knowledge (Late 19th century – 1950s)	Chapter 7 General practice as family and community internal medicine (1960s-1980s)	Chapter 8 General practice as an uncharacterized medical specialty (1990s-2000s)

Discontinuities in the characterization of general practice knowledge can also be seen in the volume of text devoted to general practice in the policy documents reviewed. Throughout the periods analysed, content on general practice has gradually shifted from undergraduate to postgraduate policy. Table 8 summarizes the organization of the results in each chapter.

Table 8. Summary of the results of the analysis of UK medical education policy



6.3 General practice knowledge as a patchwork of medical specialties

This section presents the discursive elements that characterize general practice knowledge at the time of the foundation and establishment of the NHS in the UK (1940s-50s). First, I present the broader assumption of truths (discursive strategies) and concepts that establish what is thinkable in terms of general practice knowledge at this time. I then present the characterization of general practice knowledge and the subject positions available for general practitioners in this discursive setting.

6.3.1 Discursive strategies supporting general practice as the outcome of undergraduate medical education and as a patchwork of medical specialties

Until the 1940s and 50s, doctors who graduated from basic medical education joined general practice if they did not take up a job or training post in a hospital. This perspective was firmly consolidated and institutionalized by the Goodenough Report in 1944. Produced by a UK governmental committee, the report was a response to the demand for doctors in the Second World War and the need to prepare medical education for the establishment of the NHS (see chapter 5). The committee obtained information on the current status of medical education in the UK through a questionnaire sent to medical schools. It also interviewed members from various institutions involved in medical education: the GMC, the Royal Medical Colleges, the Medical Research Council, the London County Council, local health authorities and voluntary teaching hospitals. No visits to medical schools, universities or hospitals were deemed necessary. The resulting report was by far the most influential of its time and had a significant influence on policy documents produced in the following decade, such as the GMC's Basic Medical Education Recommendations, published in 1957. For this reason, this chapter relies heavily on the Goodenough Report to exemplify the discursive formations described below.

The key strategic discursive choices produced through the analytical process of this research underlined the close relationship between medical education and the nascent National Health Service. However, teaching health services were highly distinguished from other services

focused on the provision of care, especially hospitals. Medical education was expected to take place in teaching hospitals or what the committee called "medical teaching centres" within universities. These centres were part of a strategy to bring together medical schools, universities and the voluntary teaching hospitals, despite acknowledged problems of super-specialization and overcrowded curricula in hospital/university departments. Each of these strategic choices is described below.

6.3.1.1 Undergraduate medical education as general practice knowledge for practitioners in the National Health Service

With regards to the correlation between medical education and the NHS, the Goodenough Report emphasized the dependence of the latter on the former. This discursive strategy is used to justify medical education funding, while maintaining the relative independence of medical schools and university hospitals from the day-to-day operation of the new service. Medical education is depicted as the indispensable basis of a comprehensive and successful health system, but one that had been neglected by the institutions charged with organizing services, as the passage below illustrates:

> "*Properly planned and carefully conducted medical education is the* ***essential foundation*** *of a* ***comprehensive health service****…We think it is advisable to stress the* ***dependence*** *of a successful health service on medical education, partly because current discussions show signs of a tendency to concentrate prematurely on the detailed structure of such a service to the* ***neglect*** *of its* ***essential foundation****…*" (Goodenough, 1944, p. p. 14)

The use of popular concepts from public health policies of the time, like "*comprehensive health service*", suggests a link between the two discursive arenas (public health and medical education). The above text confirms the importance given to medical education in debates on the

establishment of the NHS, but also points to a perceived lack of attention to the needs of workforce development for the new health system.

The policy of the UK government, published in its 1944 White Paper, *A National Health Service*, placed special emphasis on the role of the "*family doctor" or general practitioner.* The Goodenough Report repeats this emphasis to strengthen the association between the NHS and medical education. In the report, medical schools are discursively associated with the future role of graduating students as general practitioners, a topic discussed further in the sections of this thesis on the formation of general practice as a discursive object and its subject positions (section 6.3.2). Medical education gained more importance as it assumed the task of equipping the newly-established health system with general practitioners. This passage of the White Paper reveals the important function assigned to these doctors:

> "*The **family doctor** is the **first line of defence** in the fight for good health; it is to him that every citizen using the new service will look for advice on his own health and the health of his family; and it is generally through him that access will be had to the many other forms of medical care which the National Service will provide.*" (Great Britain, Ministry of Health and Department of Health for Scotland. , 1944)

The position of general practitioners in the NHS is compared to a first line of defence in a war setting. This metaphor highlights the status granted to general practice in the medical hierarchy and in society: that of a lower rank soldier. The task to be accomplished by general practitioners was also delineated: patients were expected to seek guidance, not treatment, and to be referred to other services if necessary. In this way, the White Paper's characterization of general practice was consistent with that of the Goodenough Report. The discursive strategy of establishing the dependency

of the NHS on medical education was structured in the equivalence between recently graduated doctors and general practice.

The main concepts that connected the discursive objects mentioned above (health system, medical education, graduated doctors and general practice) were *health promotion and disease prevention* focused on the wider population (this is further explored in section 9.2.). These concepts were presumed to be absent in both medical education and the health system, which focused more on the pathology of individual patients. Promotion and prevention were portrayed as the basis of a healthy society and of a functioning public health service. These notions were initially associated with the discipline of social medicine, despite a recognition that all of medical practice faced the same challenge, as exemplified below:

> "*To the **neglect of the promotion of health**, medical practice – and consequently medical education – has been concerned primarily with **disease, chiefly as it affects individuals**…A **radical reorientation** of medical education and practice is essential, and we believe that both **medical practitioners and medical students** are ready for it…. Our preliminary steps to be taken are set out later, mainly in the **sections on social medicine**.*" (Goodenough, 1944, p. p. 16)

The concepts of health promotion and prevention were referenced from the government's *White Paper: A National Health System* (1944).The White Paper's emphasis on *"comprehensive health care"* had a varied focus, ranging from treatment of patients to disease prevention and health promotion. Like the Goodenough Report, government policy highlighted the importance of a shift in health care, but did not clarify the concepts referred to, or cite other documents which could define these, as shown below:

> "*The need for a **new attitude** toward health care is perhaps the most important point. '**Personal health** still tends to be regarded as something to be **treated when at fault**, or perhaps*

> *to be preserved from getting at fault, but* ***seldom as something to be positively improved and promoted*** *and made full and robust."* (Great Britain, Ministry of Health and Department of Health for Scotland. , 1944)

Public health policies therefore argued for a change in health care focus from treatment to prevention. Medical education policies adopted the same discursive strategy by linking prevention and promotion to the supply of doctors who would join the NHS in general practice after their undergraduate training.

The "*radical re-orientation*" of health care depicted in the Goodenough Report included a need for appropriate – and improved – financial support for medical schools from government. This policy assigns to the government (and to the NHS) responsibility for funding the provision of general practitioners by medicals schools. The committee went as far as to suggest the amounts of money needed for medical education. These funds were to be allocated to "*building a supply of teachers*" and the "*outlay of teaching hospitals on facilities for teaching and research*". However, its arguments contain a number of seemingly paradoxical discursive strategies. For example, the report highlights the problem of over-specialization and over-crowding in the medical education curriculum, yet at the same time promotes the foundation of teaching centres based in hospitals. These hospitals were the physical institutions that granted power to medical specialties – the same specialities that had lost track of the needs of the general population and become focused on increasingly rare diseases. The paradox of a discourse defending the change towards health prevention and promotion in an educational system based on teaching hospitals was not acknowledged. Moreover, the link between the concepts described

(prevention and promotion) and social medicine reinforced this paradox, as the latter was not part of the hospital system. The document ends with the paradoxical statement that the population should pay for medical education costs, even though teaching services would not prioritize health care but medical education, as exemplified below:

> "*We are confident that the sums named will be regarded as a reasonable price for the **community to pay** for a service vital to the **promotion of national health**.*" (Goodenough, 1944, p. p. 11)

The report called for funding of medical schools and in particular university teaching centres (hospitals). The government would finance the reform of medical education, which would have a close relationship with the NHS. Despite the declared dependence of the NHS on medical education, the converse was not the case. Even though the report argued for financial support from the government, medical education and its institutions were expected to maintain their level of self-determination, as described below:

> "*The **individual freedom** enjoyed by medical schools in **academic matters** is an asset that must be **fully preserved**.*" (Goodenough, 1944, p. p. 25)

The discursive strategy associating medical education with the health system through the provision of a medical workforce was used to justify the funding of medical schools and teaching services, staff and facilities. This last quote also introduces the next discursive strategy, which relates to the teaching services proposed by the report. The main focus of these centres would not be the population served by the NHS, but rather the students being trained, the development of medical specialties and medical research.

6.3.1.2 Teaching services and care-focused services

With its call for the creation of teaching centres, the Goodenough Report envisaged a shared set of objectives for medical schools, teaching hospitals and universities. This discursive strategy defined a boundary between teaching and non-teaching health services to justify special funding of medical education. However, the focus of teaching in university hospitals conflicted with the changes deemed necessary to both medical practice and education towards promotion and prevention.

The teaching centres would comprise parent teaching hospitals and other territorially adjacent non-teaching hospitals ("zone of influence"), including "general practice" hospitals. The latter were general hospitals where general practitioners worked alongside surgical specialties. This "zone of influence" was possibly the first manifestation of geographically organized services in UK medical education. Despite the "close" relationship between specialties, teaching staff would not be expected to take up duties in non-teaching hospitals. Rather, the relationship was to be informal, with teaching hospitals offering continuing and postgraduate training for prospective specialists and refresher courses for general practitioners. Other types of health services (health centres or general practice surgeries) were excluded (mainly absent) from teaching or research activities. These centres were expected to link to general non-teaching hospitals, as exemplified below:

> "*These associations will not be formal; they will evolve in part out of the arrangements made in respect of* ***pre-registration house-appointments*** *and in part out of the provision for* ***refresher courses*** *for general practitioners,* ***hospital appointments for intending specialists*** *and other forms of* ***postgraduate education****.* (Goodenough, 1944, p. p. 53)

The report's discursive distinction between teaching and non-teaching services strengthened the justification of special funding for medical schools and teaching facilities. The population to be treated by teaching services should be commensurate with teaching requirements. So despite the "close" relationship between hospitals in the national health service, only non-teaching hospitals would be expected to focus on the population's health demands. Notwithstanding the 1944 White Paper's declared intention of strengthening the association between health services, the report defined a clear separation of facilities (Division of Publications and Review, Office of the Executive Director, 1944). The passage below illustrates this:

> "*The **number and variety** of patients in the wards and out-patient departments of the teaching hospitals **should be adequate** to provide the students with such clinical experience in the various branches of Medicine…The admission of patients to it must be **selective and controlled** in the interests of teaching.*" (Goodenough, 1944, p. p. 14)

The independence granted to medical schools maintained both the existing balance of power between schools and hospital departments and the hierarchical structures within the schools themselves. The discursive strategy differentiating teaching and non-teaching services supported the preservation of these power structures. The concentration of medical education in hospital-based teaching centres was expected to provide students with an environment to develop their skills in treatment, prevention and promotion. But the committee also acknowledged the challenges faced, particularly relating to over-specialization and an overcrowded curriculum, which served to distance teaching centres from significant public health concerns and the desire for improved promotion and prevention. These problems are described in the following section.

6.3.1.3 Problems of specialization and overcrowded curricula

The Goodenough Report acknowledged the increasing influence of the development of medical specialties on medical education. The phenomenon of overcrowded curricula, resulting from internal disputes between specialties for programme space within medical schools and universities, had been documented long before (in the late 1800s) (Clarke, 1966). This was therefore a discursive continuity within the analytical period. The discursive strategy of policy documents presented overcrowded curricula as a problem in medical education requiring change, not least to accommodate the new policy focus on prevention and promotion, and identified the GMC as the institution with the powers to solve this. It also called for specific changes to medical school teaching, including the addition of a year of house appointments beyond basic medical education. These house appointments were intended to provide trainees with further clinical experience in hospital and specialty based medical practice. The contradictory nature of this position is illustrated by the following extract, in which the report acknowledges that efforts to limit medical curricula had often led to new "additions":

> "*A reorganization of the medical schools and their teaching hospitals will be largely barren of results unless the present* ***overcrowding of the medical curriculum is remedied****…We consider that the GMC is the appropriate body to take the initiative in this matter…We are aware of the* ***numerous attempts*** *that have been made from time to time to revise the curriculum and we know that these have* ***frequently resulted in additions****.*" (Goodenough, 1944, p. p. 148)

This passage uses the discursive strategy of overcrowded and overspecialized curriculum in previous historical periods – along with an acceptance of medical education's ineffectiveness in confronting this problem

– to justify reform. There is an understanding that medical students had hitherto not been prepared for what was being characterized as general practice knowledge. However, in this discursive period there was no space for teaching outside the hospital setting, and no acknowledgment of general practice as a field of knowledge in its own right. Indeed, the analysis of medical education policy across the period covered by this thesis shows that, while this discursive strategy is continuously used to justify modifications in medical education, it has little impact in practice (Whitehead, Hodges, & Austin, 2013).

The Goodenough Report went on to suggest that the various fields of medical education should amalgamate into five domains (pre-clinical, medicine, surgery, pathology and obstetrics and gynaecology), each led by an academic head who would direct the teaching process. In meeting the objective of creating a general doctor with "*a coherently unified knowledge of Medicine*", clinical teachers would consequently have *less* power over training, even though clinical units (or departments) in hospitals would still control medical education. This is illustrated by the passage below:

> "*The **clinical work of the teaching hospitals and the clinical teaching of students** would continue to be conducted on the basis of **clinical units**. The **clinicians** in charge of these units would **retain unfettered responsibility** for the care and treatment of patients; but they would have rather **less independence in the training of students**…*" (Goodenough, 1944, p. p. 149)

It is not clear from passages such as these how responsibility for medical education would be divided between the different actors involved (i.e. medical schools, teaching centres, clinical units). Moreover, considering the dispute of power inside both institutions (medical schools and teaching hospitals), which systematized the over-specialization and overcrowded

curriculum, this difficulty seemed certain to continue. In fact, this discursive strategy was found to be present in the following two periods described in chapters 7 and 8. It resembles the discursive "*pony carousel*" described by Whitehead et al, which has been repeatedly used to justify waves of reform and change in North American medical education (2013).

In summary, the three strategies presented above constructed the main assumptions of truth in the period highlighted in this chapter. These assumptions established the ground rules that delimited the characterization of general practice during this period. According to these assumptions general practice was characterized as a collection of limited knowledge from other medical specialties. Undergraduate medical education was expected to provide a general practice workforce for the establishment of the NHS. General practice knowledge was equated with the final outcome of undergraduate medical education. The majority of students and graduate doctors who did not take up hospital jobs or postgraduate training were expected to join the NHS in general practice as general practitioners. This characterization is described below in a summary of the analytical tasks regarding the formation of object and subject positions.

6.3.2 Formation of concepts: health promotion& disease prevention and medical teaching centres

In order to fully understand the discursive formation produced by the analysis of the documents in this period, I have identified two concepts which played a crucial part in shaping the characterization of general practice. The first concept, health promotion and disease prevention, was a reference by the medical education documents to the public health policy that founded

the NHS. The second was a new concept presented by the Goodenough Report that created an “ideal” medical education setting: medical teaching centres.

As described above, health promotion and disease prevention were acknowledged by policy documents as priorities both for the NHS and for medical education. The deficiencies of a disease-focused medical education were also identified. Despite this, the policy documents did not offer a practical blueprint for medical education in health promotion and disease prevention. Instead the main solution put forward was the creation of medical teaching centres. Precisely how these hospitals, with their wards and outpatient departments, would develop health promotion and disease prevention was not explained, despite the documents’ recognition of the lack of focus on these aspects of health care. Furthermore, the Goodenough Report offers no straightforward definition of the two terms, referring instead to ideas presented by national health services of the time, such as in the NHS White Paper (1944). This reference to public health policy reinforces the connection between medical education and the efforts to establish the NHS.

Health promotion and disease prevention were linked by the report to the discipline of social medicine and to the daily practice of a general practitioner. However, social medicine was not expected to constitute a specific department or body of teachers within medical schools. Rather, the report positioned these themes to be taught by every medical department as part of its clinical curriculum, similar to the teaching of general practice knowledge in university institutions. As a result, prevention and promotion

enjoyed low priority in specialist departments when compared with their main focus of knowledge, as the report highlights:

> "*In most schools, the attention paid to social medicine, the promotion of health and the prevention of disease is **often perfunctory and largely divorced** from the rest of the student's training. If medical students are to be fitted to become **health advisers and members of a national health service**, the ideas **of social medicine** must permeate the **whole of medical education**. A new orientation of medical education, a big expansion in the **social work of teaching hospitals** and radical changes in the outlook and methods of most of the teachers are involved.*" (Goodenough, 1944, p. p. 24)

The aspirational nature of the report's recommendations on social medicine / public health disciplines is further evidence of the "*carousel"* phenomenon described by Whitehead et al. (2013). This is underlined by a reference made in the report to guidance published by the GMC in 1936, which had very little impact on medical practice at the time:

> "*Throughout the whole period of study, the attention of the student should be directed by his teachers (a) to the importance of the measures by which **Normal Health may be assessed and maintained**, and (b) to the principles and practice of the **Prevention of Disease**.*" (Goodenough, 1944, p. p. 167)

Indeed, the Goodenough Committee appeared to admit the limitations of its recommendations:

> "*That these considerations are **essential** in medical practice is so obvious that some may experience surprise that it should be considered necessary to draw attention to them. Unfortunately it is the case that **they do not enter nearly as much as they should** into the thought and practice of a large part of the medical profession to-day, and that in the training of students the attention of both teachers and students is concentrated, as a general rule, on the **stages of diseases seen between the time a patient first appears in hospital and the time he is discharged from hospital**.*" (Goodenough, 1944, p. p. 169)

This passage underlines the internal contradiction between the report's emphasis on the importance of prevention and promotion and its

focus on clinical teaching in a hospital setting. Nevertheless, the document used the discipline of social medicine to introduce the concepts under discussion into medical schools, despite the lack of institutional support (departments or teachers) to implement its recommendations. Finally, in terms of this discursive analysis, it produces a subject position for the general practitioner: bringing social medicine to life in the NHS, as showed below:

> "*The importance of the **promotion** of mental and physical health and of the **prevention** of disease is being **increasingly recognized** by the medical profession and the general public. There is growing support for the view that a **general medical practitioner** should become the **health adviser** of his patients and families and should participate to a greater extent in the conduct of the health services of the country. The evidence received from students bodies discloses encouraging signs that many present-day students **desire to fit themselves for these tasks***." (Goodenough, 1944) p. 165.

The final sentence of this passage again provides a sense that students opting for general practice were different to those seeking specialization. It is positioned as surprising to the authors that students might be interested in general practice at all. One cannot fail to notice the different discourse used to describe students "with the abilities" to enter specialist training and those who "desire to fit themselves" to general practice. The latter gives an impression of students having to adapt to the task, possibly limiting their future perspectives. This is discussed further in the section of this thesis on discursive subject positions (6.3.3.6).

Considering the role of general practitioners in the tasks described above, the report referred to the role health centres might one day play in medical education:

> "*Much profitable teaching can be given in the various clinics which form part of the personal health services provided by local authorities. If **health centres** are established, those in the*

neighbourhood of the medical schools should become important centres for the education of students." (Goodenough, 1944, p. p. 170)

Interestingly, general practice surgeries were completely excluded from the report, although the Committee foresaw a role for community health centres in training undergraduates alongside medical teaching centres. The discursive notion of transforming the latter into health centres or "small hospital-like settings" was still in its infancy. The following chapter shows how this discourse gained importance in the second period analysed.

With regards to the struggle between medical institutions and the government at this time on issues regarding the implementation of the NHS, it is possible to infer that the Goodenough Report tried to provide a partial solution. It proposed that general practitioners should be the main workforce in the public system (although, as mentioned above, without once mentioning general practice surgeries as a setting for this care, or for the training of students) while protecting the role and status of specialists in the medical teaching hospitals / centres described previously.

Despite its detailed description of the role of general practice in medical care at the time, the report characterized a different future for the discipline within the undergraduate training regime, linked less to medical practice and more to social care, as described below:

"*When acting as medical clerk or surgical dresser he (the student) should be required to select one or more patients, and to include the **'social diagnosis'** in the case-study of these patients, in addition to the medical history. Under the **supervision** of the **general practitioner and the guidance of the almoner**, he should **visit the home**, possibly the patient's **place of employment** if a **work doctor** or **welfare supervisor** is employed there, and any assisting agencies.*" (Goodenough, 1944, p. p. 170)

In the paragraph above, the proposed task of the general practitioner as teacher involved the supervision of students in developing a "social diagnosis" of a case. It would not be considered clinical teaching, despite being part of clinical clerkships. Nor would general practitioners be involved in developing the clinical side of teaching. The general practitioner's role could also be conducted by an almoner, underlining its link to the social aspect of health care. The following section explores the characterization of general practice as an object and subject position in the discourse identified by the analysis conducted.

6.3.3 Discursive object and subject positions: general practice as a patchwork of medical specialties

In this section I demonstrate how general practice is characterized within medical education as a patchwork of knowledge from other hospital-based medical specialties. The medical education policy discourse in this analytical period consolidated a view that was common in the UK during the previous 50 years: the final "product" of undergraduate medical education in this area was to be a doctor with general practice knowledge – a general practitioner. In the analysis, I have identified different terms used to characterize the graduate doctor before the term "general practitioner" was established in the report: these included *general doctor, future practitioner, and medical practitioner.* In other words, general practice was delineated as a discursive object in parallel to the identification of the discursive subject positions available for general practitioners, medical students, graduate doctors and specialists.

In this section, the analysis highlights the position of general practitioners as learners, equivalent to the students and the “future specialist trainee”. One could speculate that this was the first time that the field of general practice was delimited in any detail within a medical education policy. General practice was compared to several other specialties and a description of its function in medical practice was outlined, along with the circumstances in which patients should be referred to specialists. This description characterized general practice as a “patchwork” of medical specialties. General practice was also portrayed as practical in nature, distinguished from teaching and research activities and subordinate to other medical specialties. These characteristics of general practice are detailed and exemplified in the following sections.

6.3.3.1 General practice knowledge as the final outcome of undergraduate medical education

This section further describes how general practice is portrayed in the documents analysed as the outcome of undergraduate medical education, despite the conflicts and issues presented in the discursive strategies above: focus on disease vs. focus on health promotion and prevention; teaching vs. non-teaching services; and overspecialized and overcrowded curriculum. These documents did not initially regard the final product of undergraduate medical education to be doctors prepared for general practice: medical students were to be equipped with characteristics that only later in the texts were attributed to general practice and general practitioners. The discursive association of undergraduate medical education with general practice knowledge is structured by a rationale that included the following discursive

elements: a necessary broad understanding of health care; an undisputed medical education dependent on teaching hospitals; an acknowledgement of the limitations of an overspecialized medical education; and a necessary refocusing of specialized knowledge teaching onto general practice. This rationale is further explored and illustrated in the following paragraphs.

The discursive process described above involved the use of concepts that connected the two objects (students and general practitioners), such as *community* and *health promotion*. Medical students were expected, on graduating, to offer the highest provision to the community, as demonstrated below:

> "*The aim of undergraduate medical education must be to **guide medical students** to such development of mind and character as will enable them when qualified to **give maximum service to the community**. It must help a student to acquire a scientific foundation for his professional work, a proper outlook on the **promotion of mental and bodily health**, an adequate knowledge of disease, a **sympathetic understanding of people and their environment**, a sound judgement and the ability to observe accurately, reason logically, and assess the claims of new knowledge.*" (Goodenough, 1944, p. p. II)

As can be observed from the passage above, students' learning and final qualification was associated with a broad understanding of health care that included an understanding of the patient's environment. This is another example of a contradiction or counter-discourse, in that the documents also specified that students' learning was to take place in teaching centres focused on hospital care. Teaching about patients' environments would be restricted to a theoretical perspective, with rare visits to local surgeries, if any. The assumption remained, therefore, that hospitals were indispensable to clinical teaching, as exemplified below:

> "*Medical schools will have to continue to **depend** on groups of hospitals for clinical teaching facilities.*" (Goodenough, 1944, p. p. 54)

General practice was acknowledged as a final outcome of qualification only indirectly, i.e. through the gradual equivalence of the newly graduated doctor and general practitioner. The fact that this could not be stated explicitly hints at an internal struggle and a counter discourse that resisted the equivalence offered (from general practitioners' institutions, for example).

The document explicitly affirms that medical schools were not teaching enough about the health problems confronted by general practitioners in a community, and that students were over-exposed to the concerns of medical specialties. By acknowledging this emphasis on health issues which were not part of a general practitioner's daily routine, but offering no solution to the problem, the committee endorsed the creation of graduate doctors who were unready for general practice and would need further training: an eternal learner. General practice knowledge in this context was characterized as the product of basic medical education; specialist knowledge was "out of place" in this context and should be taught in postgraduate training. The following passage illustrates this:

> "*In the organization and conduct of the training there is **failure** in various respects, to take proper account of the types of **problems that most frequently face practitioners in general practice**. At the same time **undue attention** is paid to certain **subjects that are out of place in a basic course**; particularly one that is followed by a compulsory period of hospital appointments.*" (Goodenough, 1944, p. p. 156)

A newly-graduated doctor, including one entering general practice, should be capable of performing the most common activities of the different

specialties (surgery, obstetrics, general medicine, dermatology and others). This characterized general practice as a patchwork of medical specialties. For every medical specialty described by the report, a specific task was given to general practitioners (see in section 9.3.3), despite the fact that general practice was conceived as a medical practice dealing with prevention, promotion and "mild" health issues. This contradicts the discourse set out in the NHS White Paper (1944), which placed a special emphasis on the family doctor role. General practice knowledge was also expected to encompass the early recognition of common diseases. The passages below illustrate the level of detail in which general practitioners' activities were delineated:

> "*The training of an undergraduate in surgery should be directed to the recognition, early treatment, personal, social and economic effects of those* ***surgical conditions commonly encountered in general practice…***" (Goodenough, 1944, p. p. 29)

The following quote concerning the teaching of dermatology is another example of how general practice knowledge was expected to emerge from the adaptation of the curriculum for a medical specialty:

> "*The major part of the clinical training can be conducted in the* ***out-patient department of hospitals****. This training should be limited to the diagnosis and treatment of* ***common*** *skin diseases, and instruction in the* ***care of the skin****, especially with a view to* ***preventing*** *industrial dermatitis.*" (Goodenough, 1944, p. p. 161)

As observed above, the discourse of this period reinforced the view that medical training should take place in teaching hospitals, and that the teaching of subjects such as prevention and promotion should be left to medical specialties. The report does not, however, describe the teaching of prevention and promotion in the same detail as other subjects, such as surgery or internal medicine. Nor does it recommend specific content for this

training, despite its acknowledged relevance to future graduates. In discursive terms, this could be seen as devaluing its importance.

The above analysis shows how general practice was gradually constructed as an outcome of basic medical education. This was the product (*basic, common and community* - low-cost – doctors for the NHS) to be offered in return for the investment demanded from the government in hospital-based teaching.

The formation of the College of General Practitioners (CGP) in 1952 can be seen as a further response to the increasing importance of general practice in the UK's health system and perhaps also the need for national representation of this professional category. By this time, the role assigned to general practice in the NHS was enormous and overwhelming. The Collins Report, published by The Lancet in 1950, described the low standards of care in general practice surgeries across the UK. Despite resistance from other parts of the medical profession, the CGP was created as a scholastic organisation "to support good standards of practice, education and research" (Tait, 2012). The following section describes the delimitation of general practice's power in medical care provision.

6.3.3.2 Delimitations of general practice knowledge, practice and power: general practice as patchwork of medical specialties

In this section, I present further detail and examples of how general practice in this period was characterized as a "patchwork" of other medical specialties. This finding is based on the following discursive elements: general practice knowledge was to focus on "easily remediable" health issues; "major physical disabilities" were to be acknowledged and referred; general practice

would engage in health education; and deeper specialist knowledge was to be restricted to capable students and doctors trained at postgraduate level to become consultants, teachers and researchers. In this way, the lowly position of general practice and general practitioners within a medical professional hierarchy was implicitly confirmed.

According to this analysis, general practice was defined as a precisely delimited subset of knowledge and practice from the various medical specialties. In obstetric care, for example, the general practitioner was expected to attend a normal labour and make referrals as necessary. Any sort of action in orthopaedics was to be undertaken not by a general practitioner but by qualified orthopaedists. In mental health, general practitioners were deemed qualified to deal with the emotional consequences of physical disorders and the simplest forms of mental illness. This list of delimitations also included skin diseases, surgery, infectious diseases, radiology, chronic diseases, ear and nose problems and paediatrics, as illustrated below:

> "… *(the general practitioner should be able) to recognize and deal sensibly with the psychological aspects of physical illness and with the mild,* ***easily remediable*** *forms of mental and nervous ill-health.*" (Goodenough, 1944, p. p. 168)

Another example in the following passage:

> *"… should be able* ***to recognise*** *when a disorder is one with which he* ***is not fitted to deal*** *and of securing promptly the proper treatment of the patient.*" (Goodenough, 1944, p. p. 156)

Further illustration:

> "*…the distribution (of orthopaedists) will be such that* ***no general practitioner*** *will be called upon to complete* ***the treatment of major physical disabilities****… the training of the undergraduate should be gained in special clinics (for example fracture clinics), and in clinics devoted to the broad problems of rehabilitation…*" (Goodenough, 1944, p. p. 164)

There was an assumption, therefore, that general practice would deal with the basic tasks of medical practice, and that common problems tackled by family doctors were less complex than those presented in a hospital setting. Despite acknowledging the psychological, social and environmental elements involved, the documents present a discourse of *simplification* with respect to the work of a medical practitioner in the community setting. This accords with the document's promise to deliver ready-made general practitioners for the NHS after basic medical training, and its recognition of the health system's dependence on medical education and its funding.

Interestingly, the report made no explicit reference to disputes within medical practice on the division of responsibilities within the newly-formed health service, which extended to the field of education. However, when describing the duties of obstetricians, general practitioners and midwives, such conflicts were documented:

> "*In the conduct of labour**, the pupil-midwife has more technical experience during her training than the medical student**, and it would be **neither wise nor economical to encourage competition between midwife and medical practitioner for the care of normal labour**. The conduct of a normal confinement is the primary and essential obligation of the midwife to the community. The medical practitioner has many others which may be both urgent and exacting.*" (Goodenough, 1944, p. p. 191)

The report thus made clear that midwives should be responsibility for cases of normal labour, with obstetricians taking charge of more serious incidents. In line with the prevailing discourse, general practitioners were cast in the role of non-specialist referrers in post-natal care:

> "*The post-natal period - A general practitioner should be qualified to exercise **general care and supervision in normal***

cases *and* ***to recognize promptly the need for specialist advice*** *or institutional treatment*." (Goodenough, 1944, p. p. 191)

General practitioners' role in the NHS was also regarded as that of health counsellor, as the following passage indicates:

"*If* ***medical students*** *are to be fitted to become* ***health advisers*** *and members of a national health service, the ideas of social medicine must permeate the whole of medical education. A new orientation of medical education,* ***a big expansion in the social work of teaching hospitals*** *and radical changes in the outlook and methods of most of the teachers are involved.*" (Goodenough, 1944, p. p. 29 and 168)

The training of all medical specialties was expected to be accomplished through postgraduate education, even though this was not yet the reality in most hospitals, which carried out this function informally through house-officer appointments. This is demonstrated in the following passage:

"*All parts of teaching or of clinical practice that relate only to the fields of work of the clinical or laboratory* ***specialist*** *should be reserved for* ***post-graduate education****…*" (Goodenough, 1944, p. p. 125)

Similarly, general practitioners were not expected to teach or carry out research. These subject positions (teacher and researcher) were reserved for distinguished medical professionals in specialist university settings. The following passage describes the plans for the University of Oxford's medical school, which was previously responsible for graduate physician training only:

"*The University of Oxford, whose medical school before 1937 was in the main a pre-clinical one, wishes after the war to develop a small clinical school, the aim of which will be* ***to cater specially*** *for men and women students* ***who can be expected to become 'teachers, investigators and consultants, rather than general practitioners'.*****"** (Goodenough, 1944, p. p. 23)

The delimitation of the knowledge and role of general practice in medicine was influenced by an established assumption of medical practice. This assumption strengthened the discourse that excluded general practice

from teaching, research and specialization. General practice, as a field of medical knowledge and medical practice, was thereby characterized as a collage of elements from other medical specialties. This is described in more detail in the following sections, where the subject positions available for general practitioners are identified. These subject positions characterized the general practitioner as the "eternal learner", practical "*in nature*" and subordinate to other medical specialties.

6.3.3.3 General practitioner as "*eternal learner*"

An interesting aspect of the characterization of the role of general practitioner in this period was that of a learner or student, in contradistinction to specialist teachers. Not only were general practitioners described as the products of undergraduate training, they were expected to remain students of hospital teachers and consultants beyond qualification. As described previously, services in the newly formed NHS were categorized as "teaching" or "non-teaching". General practitioners were considered to offer non-teaching services, but to have access to learning opportunities in teaching hospitals as required. The passage below illustrates this:

> "*These associations (between teaching and non-teaching health services)…will evolve in part out of the provision for* ***refresher courses*** *for general practitioners…*" (Goodenough, 1944, p. p. 55)

In this respect, general practice was given a similar subject position to that of a medical student. There was no space in this period for general practice to be taught as a distinct field of knowledge: a state of affairs which dated back to the end of the nineteenth century and the consolidation of medical school and university provision for the training of surgeons and

physicians (see chapter 5). By excluding general practice from university medical education, the ground was prepared for general practice to be constructed as a fusion of the medical specialities included in the academic training of students. The assumption that general practitioners were practical "in nature" flowed directly from this discourse, as described in the following section.

6.3.3.4 General practitioner as "practical in nature"

The discourse of general practitioners as "practical in nature" runs throughout the policy texts analysed within this era. It reflects both the origins of general practice and the presumed character of students who would go on to become general practitioners. The passages below exemplify this:

> "*Such (refresher) courses should be specially designed for general practitioners, should be* ***practical in nature****, and full use should be made of out-patient departments.*" (Goodenough, 1944, p. p. 34)

Further on:

> "*While* ***being primarily practical in character****, the training should give the student a clear understanding of the constantly developing scientific basis of Medicine.*" (Goodenough, 1944, p. p. 43)

This discourse, which is presented as unarguable, is used to justify the exclusion of general practitioners from teaching and research, as can be seen in the extract in the previous section on the University of Oxford's plans for creating teachers, researchers and consultants (6.3.3.2). Teaching and research were to be kept separate from medical practice, notwithstanding the role given to consultants in teaching hospitals, and were therefore not subject positions available to general practitioners. The following extract underlines this distinction:

> "*Besides possessing the requisite qualities and trained skill in their use, the teacher must also be in a position to devote much time and thought to **his teaching duties** and **to scientific inquiry**. **Teaching and research** are great time-consumers. Teachers of medical students must be able and willing to make their educational work their principal interest, or at least one of their **main activities**.*" (Goodenough, 1944, p. p. 41)

The fact that consultants were expected to become teachers and researchers, albeit on the assumption that they would in time relinquish their clinical commitments, produces a contradiction in this discourse. However, the construct of general practice and the subject position of general practitioners are more consistent. The following section describes a further characterization of general practice – that of being subordinate to other medical specialties.

6.3.3.5 General practitioner as subordinate

A discursive continuity is produced in which consultants and hospital-based specialists are valued and general practice is characterized as inferior or of lower status. All other attributes associated with general practitioners (learner, clinically limited, referrer, practical in nature) serve to distinguish this role from the exalted position held by academic consultants in teaching hospitals. Some interesting passages in the Goodenough Report add further dimensions to this assumption of truth. One extract points to a difference between students joining general practice and those taking up specialist training, the latter being distinguished not only by their career choice but also their academic ability:

> "*The basic training should be equally valuable for the student who has the **inclination and ability** to become a specialist.*" (Goodenough, 1944, p. p. 44)

Another passage describes how students viewed learning opportunities in the community. The assumption here is that students learned

less in this setting compared with their hospital training. Due to the medical schools' congested curriculum, when asked to rank learning settings in order of importance, students would often identify community training as their least-favoured option. Learning in the patient's environment was considered unplanned and inappropriate, to the extent that schools in other countries chose instead to simulate this setting within a hospital. While there was recognition that students should be prepared for the possibility of working "outside of the hospital", no consideration was given to the importance of them understanding the patients' environment, as discussed previously. The passage below illustrates the low prominence given to learning in the community:

> "*They (students) now work to a much more **rigid and crowded time-table** and they find that they **may miss** what appear to be **more valuable opportunities of clinical experience in hospital** while they are 'on the district', either attending a labour or visiting their lying-in patients. It is certainly important that the student should learn how to **improvise** and how to conduct a labour satisfactorily in **an ill-furnished house**, but this experience **need not be extensive** and should not replace any considerable part of the **more valuable** training which the hospital labour ward can provide. In some hospitals in Scandinavia and in the United States of America this form of **improvisation is demonstrated by arranging a small room in the hospital on the pattern of a humble domestic apartment**.*" (Goodenough, 1944, p. p. 195)

The perceived need of students to "improvise" in the community setting added to the discourse of the general practice being "practical in nature" (6.3.3.4), while the challenging environment in which general practice training took place was compared negatively to the ideal teaching setting – the university teaching hospitals. This view would be reinforced by the Collins report on the state of primary care in UK in the 1950s (see Chapter 5). But there was a divisive intention too in demanding funding for just one of the two

settings (teaching hospitals) and not even considering the possible advantages of students seeing patients in their own home.

A further indication of the devalued nature of general practice was its exclusion from Appendix 1 of the report, in which the committee estimated the number of clinical teachers needed within university departments to implement the proposed changes. These estimates were divided into pre-clinical, general medicine, surgery, obstetrics and gynaecology departments, excluding not only general practice but other important disciplines associated with prevention and promotion, such as psychiatry and social medicine.

In regard to Foucault's understanding of technologies of the self, described in chapter 4, the subject position constructed for general practitioners in medical education is of subordinate nature. The composition of the committee elaborating the Goodenough Report did not include general practitioners, but mostly academic and hospital-based specialist. General practitioners would only start to assume a stronger and more autonomous position with the establishment of the CGP in 1952, an event implying a further transformation of the subject position available for general practitioners. The description of general practice knowledge as a patchwork of other specialists does not allow general practitioners to define themselves in medical education policy.

6.3.3.6 Other subject positions

This section describes the analysis of other subject positions identified in the policy documents which played an important discursive role in defining the discursive object under study, general practice knowledge, and

the subject positions available to general practitioners. These subject positions include: student, specialist, the patient and the author of policy text.

As illustrated in previous extracts from the policies analysed, students were assigned a passive position in the acquisition of knowledge from medicals schools and teaching hospitals, which would ultimately judge if they were capable or not of undertaking postgraduate training. This discourse placed general practice knowledge at the bottom of a learning hierarchy, the favoured option only of students who were not able to secure a specialist training post.

The subject position of the specialist/consultant can therefore be seen as the inverse of that for general practitioners. As teachers and researchers, consultants were deemed the most valued among medical doctors, able to impart knowledge to others and push back the boundaries of medical theory. General practitioners, by contrast, were depicted as practical, subordinate and “eternal learners”, as described in the previous sections.

The subject positions of people seeking health care from medical institutions (patients) were just as important in the characterization of general practice knowledge. From a teaching perspective, patients in university hospitals were seen as more important than those in the community setting, although the health care of hospitalized patients *per se* was secondary to the goal of training students and extending medical knowledge through research. The admitted patient, in this respect, was less important than both students and research, and unlikely to be understood socially or psychologically until he/she was returned to the community. Patients in a community setting, on the other hand, were considered inappropriate for clinical teaching, belonging

more to the care of general practitioners. These patients were understood to be either a target of prevention and promotion measures, through health advice/education, or of care for common and minor illness. Patients with major problems would be identified and referred to a hospital setting. This description of the patient under general practice care therefore matches the characterization of general practice knowledge itself and the subject positions offered to general practitioners described in the previous sections.

The authors of the documents analysed in this discursive period were representatives of the GMC and of medical schools, in other words mostly specialists involved in medical education in teaching hospitals. General practitioners had no influence in the production of these texts: the institutions representing general practice knowledge were simply not powerful enough at the time to have a voice in drafting medical education policy. This accords with the discourse on general practice knowledge throughout this analytical period.

6.4 Reflections

In this section, I consider how my personal and professional experiences are reflected in the findings in this chapter. As a general practitioner who has worked in both health care and medical education in Brazil, I approached this research with an idealized image of general practice and general practitioners in the UK, given the influence of the NHS and UK primary care structures on the development of the Brazilian health system. I did not expect, in the analysis presented in this chapter, to relate my experience as a family doctor in Brazil to the characterization of UK general practice in this period. The notion of general practice being less valued than

other medical specialties is very much part of the experience of being a family doctor in Brazil.

Having since worked as a medical education researcher in the UK, however, I recognize that this conception of general practice is not an obsolete idea of the past but part of the current experience of medical students and general practitioners. In various encounters with students during teaching activities and conference workshops, I could see how their understanding of general practice echoed some of the discursive characteristics described in this chapter. One student, for example, described how choosing to be a general practitioner was made harder by the resistance of their specialist teachers in hospital placements. A similar picture emerged from conversations with my PhD supervisors and other general practitioners I met during the period of the research, including general practice tutors struggling for equal pay with hospital-based teachers.

6.5 Conclusions

This chapter focused on describing the findings from the first analytical period of this research, in which a relatively stable characterization of general practice as a discursive object of medical education emerged. The analysis of policy documents identified a discourse on general practice in UK medical education that had predominated since the end of the nineteenth century and would continue until the 1950s. General practice was portrayed as a patchwork of different specialties, but with no opportunity to practise in these fields. The general practitioner was depicted as an eternal student who could not contribute to medical education or research. Clinical practice was the domain of hospital-based consultants, while general practitioners were

expected to focus on health education and minor health problems. In the historical context of the foundation of the NHS, the need for general practice knowledge was used as a bargaining chip to improve funding for medical schools and teaching centres. With the gradual establishment of the NHS, however, general practice and its representative bodies would gain in influence and status, marking a discontinuity in discursive characterization which is discussed in the next chapter.

7 GENERAL PRACTICE AS FAMILY AND COMMUNITY INTERNAL MEDICINE IN THE UK

7.1 Introduction

The second analytical period of undergraduate medical education policy in the UK, between the 1960s and 1980s, produced a disruption in what was “thinkable” in terms of general practice and the strategic choices of discourse demonstrated in the previous chapter through the analysis of the Goodenough Report and the RBME of the 1957. General practice in the first analytical period was characterized as a patchwork of knowledge from medical specialties, with general practitioners equated to newly graduated doctors destined to be “eternal learners” of refresher knowledge taught within a hospital setting.

In terms of the characterization of general practice in medical education, the second analytical period marked an important crossroad. Whereas in many parts of the world, the role of the general practitioner was diminishing, in the UK, from the analysis of the policy documents, an effort was being made not only to value general practice more highly but also to transform perceptions of the general practitioner’s role. In the NHS, general practice was proving to be effective in dealing with the majority of health demands, as described further in this chapter by the analysis of policy documents. From the perspective of medical education policy, it was increasingly seen as a medical specialty in its own right, retaining its “practical nature” but regaining some of the characteristics attributed to the role of a family doctor (e.g. continuity of care, personalised care, family approach to health and disease). It also took on characteristics of other medical

specialties, which during this period included the concept of “clinical sciences” – the integration of basic sciences and clinical practice.

The discursive strategies of this analytical period were not static. The dependence of the NHS on medical education was not based purely on the supply of general practitioners to the system, but also on a discourse that sustained the notion of the general practitioner as an *unfinished* medical graduate. This was justified by an increase in medical research and knowledge that would be incorporated into medical practice through the discourse of the clinical sciences. The concept of clinical sciences provided the basis for a discourse of evidence-based medicine in medical education policy. It also reinforced a discontinuity of discourse through which general practice became considered a *bona fide* medical specialty, requiring further education and training. This is clearly expressed in undergraduate medical education policies between the 1960s and 1980s.

The policy documents that were most influential at this time – and which characterized the strategic choices of discourse – were the *Recommendations of Basic Medical Education* (RBME) of 1967, 1976 and 1980 (henceforth referred to as RBME67, RBME76 and RBME80), and the Todd report of 1968 (TR68). The RBME documents were consolidated by the Medical Education Committee of the GMC, established in 1978 to reflect the Council’s expanding role in postgraduate education.

A Royal Commission set up by the UK government in 1965 to review both undergraduate and postgraduate medical education, produced the Todd report (1968). The Commission’s remit was to advise the government on “what principles future development (including its planning and

co-ordination) should be based". Just as the Goodenough Report provided a framework for medical education policy in the 1940s and 1950s, the Todd report best exemplifies the policy discourse for this period of analysis. Many of the examples provided in this chapter are based on its contents, although other documents are cited where appropriate.

The nature of the authorities involved in shaping the discourse for this period tells us a lot about the strategic choices under consideration. The GMC Medical Education Committee was set up by an agency of a government committed to the NHS. General practitioners were not represented on this committee: most of its members were medical school professors in specialist fields such as skin diseases, pathology, anatomy, surgery and internal medicine. As such, the committee represented just one source of learning: the teaching hospital. The characterization of general practice in undergraduate policy was therefore heavily influenced by a hospital-centric view of medical education which, as described later in this chapter, portrayed general practitioners as internal medicine specialists with a focus on the family and community. In this thesis, I refer to internal medicine as the field of medical knowledge which embodies hospital-based (internal) general medical knowledge. In this context, it can be understood as characterizing the "internist" (hospital insider) as opposed to the community general practitioner (outsider), and not only the "internist" as relating to the opposition internal-external diseases as described by Bloomfield (1959).

In the following section, I detail and illustrate with document extracts each of the discursive strategies that structure the characterization of general practice in this period. The strategies highlighted include discourses

on the unfinished doctor, clinical sciences, the “de-hospitalization” of medical education and an overcrowded and overspecialized curriculum. The subsequent sections present general practice as a discursive object and outline the subject positions available for general practitioners in undergraduate medical education.

7.2 Discursive strategies supporting general practice as a non-academic medical specialty

This section presents four discursive strategies which in my analysis directed undergraduate medical education in the period between the 1960s and 1980s. These strategic choices of discourse had an important role in defining general practice and the roles general practitioners played in medical education.

The general discursive strategies of the documents analysed in this chapter have distinct similarities in terms of what is deemed “thinkable” of general practice. I have identified four such strategies: (1) Graduated medical students were considered, after the Medical Act of 1958 (chapter 5), unfinished doctors. Newly qualified doctors were no longer expected to have the knowledge necessary to work as general practitioners. Students would instead be directed to further clinical training in hospitals after basic medical education; (2) Medical education should be clinically based and progressively integrated into the basic sciences, creating the notion of the clinical sciences. This concept produced a further strengthening of the scientific discourse in medical practice which had begun with the merger of medical schools and universities (chapter 5); (3) In response to the growing value of general

practice to the NHS, clinical teaching was increasingly conducted in a range of different clinical settings (i.e. general practice and community), albeit with a continued predominance of the hospital setting; (4) Finally, continued attention was paid to avoiding overspecialization and an overcrowded curriculum (another example of a discursive “carousel”, described in the previous chapter 6). The sub-sections below explain each one of these strategies in turn.

7.2.1 Undergraduate medical education as insufficient

Since the Medical Act of 1958 it was assumed that undergraduate medical education was insufficient training for a medical practitioner. The Act implemented the recommendation of the Goodenough Report (1944) that all doctors should have a compulsory year of instruction after their university degree (house officer year), which later developed into the role of Foundation House Officer. With the introduction of this change, the discourse on undergraduate medical education policy began to portray recently graduated doctors as unfinished and in need of future specialist training. It was no longer possible or desirable to expect a general practitioner to be fully trained and ready to practise by the end of their university course. The same Act limited newly qualified doctors to working under guidance in approved hospitals. This increased the workforce available to NHS hospitals while decreasing the number of doctors joining general practice immediately after graduation (chapter 5).

The RBME of 1967 suggested that the GMC establish a vocational register of doctors who had undergone specific training and reached certain “standard of values”. This specialist register created one more division in the

medical profession, which signalled a different status for the doctors undergoing specialty training. This is exemplified in the passage below:

> "*A **vocational register**, to which a doctor would have access upon the **completion of his training requirements**, would similarly **identify** those doctors who had reached **certain standards**.*" (RBME, 1967 p. 24)

This policy institutionalized the classification of two kinds of doctor: those that had undergone further training and those that had not. This increasingly characterized the newly qualified doctor as unprepared and unfinished. It also reinforced the assumption that medical education was continuous and never-ending (6.3.3.3), and that undergraduate medical education was only the start of the journey. In contrast to the previous analytical period of this research (chapter 6), when the graduating doctor was considered qualified to take on the role of a general practitioner, the notion of "unfinished doctors" characterized recently graduated doctors working in general practice as being insufficiently prepared for medical practice. It also extended the period in which doctors would be under the responsibility of medical institutions involved in undergraduate and postgraduate education. This is illustrated in the following passage:

> "*Graduation has become **neither the end of medical education nor the beginning of the end**, but rather the **end of a beginning…***" (RBME, 1967 p. 22).

General hospitals were still considered the most appropriate context for training, reinforcing the role of consultants/specialists as teachers and the need for further funding to ensure these hospitals were fully equipped for training purposes. The "unfinished doctor" discourse also increased the power of organizations involved in medical education, like the British Medical Association and the Royal Colleges, including the College of General

Practitioners (founded in 1952). The Royal Colleges were expected to draw up guidelines for training in their specialties. The use of the term "*vocational training*" to describe the next phase of medical education emphasized its focus on medical practice and the working environment, exemplified in the passage below:

> "*The time is approaching when it will be necessary to identify programmes of training for each of the* ***vocational branches of medicine (including general practice)****… A great deal must depend upon* ***the views of the Universities and of the Royal Colleges****, which have such* ***important responsibilities in the field of vocational training****.*" (RBME, 1967 p. 23)

The use of the expression "*including general practice*" highlighted an attempt to position general practitioners at the same level as other specialists. However this form of inclusion also characterized a differentiation from hospital-based specialties, echoing the previous status of general practice as something other than a medical specialty. This is further discussed in the next section on object and subject positions.

The "*unfinished doctor*" discourse was reinforced by the Todd report, which introduced the notion of "*a broadly educated man*". The essential purpose of undergraduate courses was to provide "patchwork" knowledge of the specialties, one of which would eventually become the student's choice of career. The discourse from the previous analytical period, which saw recently graduated doctors as an amalgam of medical specialties, was therefore maintained. However, this patchwork of knowledge from different specialties no longer characterized general practice: rather, general practice was now "included" as a specialty field of medical knowledge. This is further described in the sections of this chapter on general practice as a

discursive object and subject position. The Todd report introduces the role of undergraduate medical education as preparatory for future training, as illustrated by the extract below:

> "*At the undergraduate level they require a **common framework of general education**, with provision appropriate to the many **different backgrounds** from which students will be drawn and to the **varying interests** which they will hope to satisfy in their **later professional life**.*" TR68 p. 40.

This consolidated the discourse that undergraduate courses were no longer expected to produce fully qualified doctors or general practitioners. The "*broadly educated man*", in this context, can be understood as someone who is capable of continuing their training through specialist postgraduate programmes. The report also made an attempt to equalize the status of all medical specialties (although the use of the expression "*general education*" could be understood as reflecting the previous equivalence of graduated doctors and *general* practitioners, as described in the chapter 6). The following passage illustrates the discourse surrounding finished and unfinished doctors and the new status granted to general practice and general practitioners:

> "*Yet it remained to **dominate** medical education for nearly **a hundred years** and its influence is felt in the survival of many requirements and practice which could only be justified **if an essential object of the undergraduate medical course were still to produce a safe and competent general practitioner**. We welcome the intention of the GMC to seek changes in the present law so as to **remove the vestiges of this concept**, which in the course of time tended to **consolidate the division**, already apparent in the **mid-nineteenth century**, between the **consultant physicians and surgeons** practising in the **major voluntary hospitals** and the **general practitioner**, **without the access to beds** in these hospitals and professionally considered to be of an **inferior status**.*" TR68 p. 22

The above extract reinforces the discursive strategy presented in the Goodenough Report (see previous chapter), which had itself consolidated a discourse that dominated medical education for approximately a century. There was clearly an intention in the Todd report to change this view and the position held by general practice, despite its repeated use of language that appeared to underline general practice's alien and inferior stance compared with other specialties. Regarding the career expectations of medical students, the report confirmed that all training programmes available were to be led by hospital-based specialties, but that very few doctors would achieve the highest post of consultant. General practice was presented as an option for those who did not want a career as a hospital doctor, or who had taken this path and failed to secure a more senior post, as the extract below demonstrated:

> "*At present virtually any training which junior hospital doctors receive is directed towards the* ***hospital specialties*** *and none to any other branch of medicine. Only a* ***minority will make their ultimate career in the hospital service****, however there are many* ***more doctors in junior hospital posts*** *than can ever hope to become* ***Consultants****, and the only other senior career grade in the hospital service (Medical Assistant) is not popular….* ***Many junior hospital doctors intend from the first to make their careers in general practice or other non-hospital work; others leave the hospital service disillusioned when they fail****, as many must, to obtain an appointment as a Senior Registrar.*" TR68 p.47.

Interestingly, this passage revealed a conflict which can still be seen today. The fact that hospitals offered more posts to junior doctors than to senior staff meant that the goals of undergraduate medical education and the demand for a professional workforce coming from the NHS were effectively misaligned. It was clearly important to NHS hospitals that medical students were obliged to attend pre-registration training programmes, not least

because junior doctors were less expensive and enjoyed fewer rights than their consultant colleagues. But if trainees carried out the majority of the work in the hospitals, the demand for new consultant posts would be permanently limited. Training demands were therefore not the only justification for lengthening medical education; workforce considerations were perhaps also a key factor.

The GMC's 1976 *Recommendations on Basic Medical Education* (RBME76) changed the discourse in a similar way. Undergraduate students were characterized more clearly as having incomplete training, consolidating the "*unfinished*" doctor discourse of previous documents. In addition, general practice was explicitly identified as a career option requiring additional training, thereby consolidating its position as a medical specialty, as exemplified below:

> "*The over-all aim is defined as 'to provide doctors with all that is appropriate to the understanding of medicine as evolving science and art, and to* ***provide a basis for future vocational training****; it is* ***not to train*** *doctors to be* ***biochemists, surgeons, general practitioners or any other kind of specialist.***" RBME76 p.xiii.

The *Basic Medical Education Recommendations* of 1980 followed the same strategy. They underlined the fact that undergraduate courses were not producing medical specialists but preparing students for future training. The notion of medicine as a developing field of knowledge was emphasized in all documents as exemplified (above and below) by the use of terms such as "*evolving science"* and *"evolving discipline"*. This reinforced the "eternal learner" discourse, which justified infinite extensions to the doctor's formal education process, as demonstrated below:

> "*The principal **objective** of basic medical education is **not to train specialists** in any field of medicine or of medical science but to provide all doctors by the time of full registration with the **knowledge, skills and attitudes** which will provide a firm basis **for future vocational training**… The necessary understanding of **medicine as an evolving** discipline must be attained…*" RBME80, p.1.

The 1976 and 1980 policies used very similar wording, such as "*future vocational training*" and "*understanding of medicine as evolving*", attributing a positive and valued quality to the transformations taking place in the medical field of knowledge and allowing little space for a critical perspective of these transformations. The 1980 policy did, however, include an important change, in that it introduced a discourse of competencies based on knowledge, skills and attitudes that would feature prominently in the next period of analysis (chapter 8), characterized by the *Tomorrow's Doctors* series.

The documents during this second analytical period (1960s-1980s) struggled to come up with an agreed name for the newly qualified doctor. The various terms used, such as medical *practitioner* (BME80) and general doctor (*general* surgery, *general* medicine) (TR68), harked back to the previous period of analysis in which *general* practice and general *practitioners* were seen as the end products of basic medical education, as illustrated below:

> "*On completing the period of **basic medical education**, an individual becomes a legally qualified **medical practitioner**.*" RBME80, p. 2.

In summary, the discursive strategy described in this section sets the background for the characterization of general practice as a medical specialty and not simply the end product of undergraduate medical courses. This is further discussed in the object and subject position sections of this

chapter. Besides their emphasis on the interminable character of medical education, the documents specified that medical courses should be clinically oriented, i.e., there was a push towards medical education that was closer to health services – tilting away from university teaching hospitals – and centred on the concept of clinical sciences. This concept would in turn herald a new characterization of general practice, as described in the next session.

7.2.2 Curriculum oriented to the "clinical sciences"

Following a period in which medical schools were integrated with universities (late nineteenth and early twentieth century), special emphasis was given in the second analytical period to clinically-based – as opposed to mostly theoretical – university curricula, which increasingly incorporated the basic sciences. By adding a scientific dimension to the more practical aspect of medical training, this integration created a discourse of "clinical sciences" and signalled the birth of evidence-based medicine, incorporating medical scientific research into daily clinical practice.

The following extract from RBME67 exemplifies the importance given to students' clinical instruction:

> "*The development of **clinical judgment**, through **history-taking and physical and mental examination**, remains the essential of all clinical training. With these methods well learnt and practised the **qualified doctor can enter with confidence on the pre-registration year."*** RBME67, p 9.

The doctor would be valued not simply for his differentiated social status but also for his clinical competence. That doctors were in charge of "matters of life and death" would continue to characterize medicine's privileged place in society. However, one aspect of this power was being

regulated: competence. Patients would not be expected to regard their doctor as a kind of health shaman, as illustrated by TR68 in the following quote.

> "*The very fact that the doctor is concerned with the **most personal aspects of human health**, and indeed with the fundamental matters of **life and death**, will ensure a continuing **high prestige for his profession**; but **the esteem** in which the doctor is held by the **community in general** will be determined much more by his **demonstrated competence than by the mystique of his calling.***" TR68, p. 30.

This competence would eventually be linked to the scientific knowledge necessary for clinical practice, adding an important new characteristic to the discourse on medical education. This scientific discourse did not diminish the importance of clinical teaching and practice: indeed it served to further differentiate the medical practice of educational settings from that of non-academic health services in the NHS. Clinical training was therefore to focus on medicine, surgery and midwifery, a discourse maintained since the nineteenth century. Despite the broadening of the aims of medical education, training was still to take place in the hospital, disregarding the emerging discourse on the need for varied clinical training settings (presented in the following section) brought about by the demands of the NHS. This is exemplified in the passage below:

> "*A section of the Act (1956), which reproduces without alteration some words from the Medical Act of 1886, provides that 'the standard of proficiency required from candidates at a qualifying examination shall be such as sufficiently to guarantee the possession of the knowledge and skill requisite for the efficient practice of **medicine, surgery and midwifery**'. This provision has nowadays to be read in conjunction with subsequent provision of the Act of 1956 (reproducing the Medical Act of 1950) which **limit newly qualified doctors to practise under supervision in approved hospitals.***" RBME67, p.12.

While the focus of medical training in these three fields of medical practice was continuous with that of previous discourses, the idea that the

clinical method should be increasingly linked to science, despite the differing nature of the two domains, produced a discursive interruption. It also required basic sciences usually taught in the pre-clinical stage of a student's education to be integrated with clinical training. The origins of this change can be seen in RBME67:

> "***Clinical method**, which is not entirely identical with **scientific method** although **increasingly becoming an application of it**, is the student's daily occupation*." RBME67, p. 9.

Following this trend, TR68 identified research as one of the essential activities carried out by doctors, alongside their clinical and management responsibilities. Therefore in order to characterize the doctor as a scientist, he/she should also carry out scientific investigations. The passage below confirms this requirement:

> "*The basic attraction of medicine for the young student is the opportunity it offers him of serving humanity in any one of many ways, for example, by **helping the sick or infirm, in advancing medical science by research or by improving the organization of medical care.***" TR68, p. 85.

Scientific research was not reserved for the capable few, as described in the previous period. It was regarded instead as a "general" part of the medical profession, to be gradually merged with other duties of doctors during this period. The term "*medical sciences*" is used in the following passage to define this fusion of basic sciences with clinical practice:

> "*As has been emphasised above, the **essential object of the undergraduate course** is to educate the student to university degree standard both in the **medical science**s and in the **application of these sciences to human diseases.**"*TR68, p. 89.

The most important aim of medical education thus became the formation of medical scientists, rather than medical practitioners. Later on, the

document proposed the creation of a new degree in medical science, the first step towards the integrated Bachelor of Science (BSc) degrees offered today by most UK medical schools.

> "*We believe that a **more flexible course** can be devised which will not only provide the **essential background to the clinical aspects of medical education**, but will also justify the award of a **degree in medical science**; some universities in Britain are already working out proposals on these lines.*" TR68, p. 93.

Medical education was expected to offer students not only a grounding in clinical practice but also research experience, a discursive innovation demonstrated by the following extract:

> "***Certainly** a student should have the opportunity to take part in **research**, if he so wishes: the **value** of contact with research is **very great** and is **not measured by the magnitude of the project or the importance of the results achieved.***" TR68, p. 94.

One of the final expressions of this strategic discursive choice is the suggestion that pre-clinical and clinical cycles of undergraduate courses be integrated. This would impact students in their first contact with patients, but also influence the role played by clinical teachers. While consultants were expected to be involved in the teaching of the basic sciences, there was no mention in the report of basic scientists teaching clinical practice. This could be seen as endorsing a hierarchical configuration in which clinical teachers assumed more importance than their pre-clinical counterparts. It also created something of an academic ladder, upon which general practice teachers, who were expected to teach in practice but not in academia, occupied a lowly rung. The following passage in RBME76 demonstrates this:

> "*These schools are also increasingly aware of the need to relate **early teaching to clinical goals**. At St Andrews, where a new curriculum was introduced in 1974, **medical***

> ***subjects are now taught in Year 1** (**of three) and students receive an introduction to pathology, pharmacology, microbiology, psychology, statistics, and social medicine. Consultants from the nearby General Hospital at Kirkcaldy increasingly help with the teaching of the clinical aspects of anatomy, physiology, and biochemistry**, and students visit the hospital in their third year.*" RBME76, p. 126.

Despite the stated aim of integration, the incorporation described in these documents consisted essentially of an incursion of clinical teaching into the pre-clinical years: the need to teach scientific characteristics of clinical practice merely added value to the latter, while reinforcing the dominance of university-based medical schools and university teaching hospitals, where scientific expertise was produced. It thus created another discursive "*carousel*", as described by Whitehead et al (2013). The passage below from RBME76 provides further evidence of the hierarchical relationship between the clinical and the scientific:

> "*At Nottingham, however, where there is considerable emphasis upon the amount of **clinical experience** received during the **early years**, the respondent said that this was not just intended as a motivating experience: while this aspect was important, clinical experience was also intended to '**leaven'** the often rather **dry preclinical subjects**, and was also giving students a valuable **exposure to the realities of medicine***." RBME76, p. 126.

The use of the word "*dry*" to describe the pre-clinical years implied that students would find the first years of medical education less engaging – further underlining the relative importance of clinical teaching – while "exposure to reality" emphasized the contact students would be expected to have with the NHS service beyond university hospitals, as described in the following section.

The integration efforts of this period took another step forward with RBME80. Despite acknowledging the adverse effect of over-fragmentation of

the curriculum, the report referred to the doctor as a "*qualified clinical scientist*", a nomenclature that formally linked medicine to the world of science. The passage below describes both clinical and pre-clinical teaching as important to this integration:

> "*In achieving such integration and interdisciplinary teaching, however, excessive fragmentation should be avoided. There is no fundamental reason why an* ***appropriately qualified clinical scientist*** *should not teach a part of the course on* ***structure, function and behaviour****, or why a* ***pathologist or morphologist should not contribute to clinical teaching in areas in which he is knowledgeable and competent.***" RBME80, p. 15.

The discursive strategy of the clinical sciences was fundamental to the characterization of general practice as a medical scientific specialty: no longer simply "*practical in nature*" but associated more with internal medicine, a hospital-based specialty requiring clinical scientific knowledge. This discontinuity is further described in the object and subject position section of this chapter.

The integration of medicine with science also encompassed what the documents described as behavioural sciences (psychology and sociology) that had been part of medical education discourse since the nineteenth century. However, in contrast to the "hard" medical sciences (i.e. biochemistry, physiology, microbiology), these subjects did not come under a specific medical specialty or university department; rather, they were expected to be taught throughout the course by medical teachers, in a discourse similar to that identified for prevention and promotion in the previous chapter. This somewhat loose commitment to these fields of knowledge further underlined the pre-eminence of clinical content in the curriculum. During the period analysed by this chapter, the teaching of the

behavioural sciences gradually shifted to general practice, as discussed in the sections on the formation of object, subject positions and concept. The RBME67 offered an example of this discourse:

> "*The council considers that instruction should be given in those aspects of the **behavioural sciences** which are relevant to the study of man as an organism adapting to his **social and psychological**, no less than to his physical, **environment**. Instruction in the **biological** and **sociological** bases of human behaviour, normal **emotional** and **intellectual** growth, and the principles of learning theory should be included.*" RBME67, p. 15.

Although the dominant role of clinical practice within medical schools and university hospitals maintained the special position of these teaching settings during this analytical period, the "*integration*" discourse went beyond curricular content to include the integration of clinical teaching settings, especially those outside the hospital where students were increasingly expected to learn. This discursive development is examined in the following section.

7.2.3 The use of various clinical settings to "de-hospitalize" the student

Notably, this analytical period saw an important change in discourse regarding clinical teaching settings. While the previous period of analysis was characterized by the supremacy of the teaching hospital, the second period began to open the doors of medical education to the outside world. RBME67 explained that in order for the student to achieve a "*comprehensive understanding of man in health and in sickness and an intimate acquaintance with his physical and social environment*" the teaching scenarios should go beyond the hospital and into the community and work environments. The following extract exemplifies this:

> "*He should see the patient at his **home and family, and in school and industry**. He should learn about the **organisation** of medicine, the scope of its **various specialties**, **the role of the general practitioner, and the role of the Public Health Service in the promotion of health**.*" RBME67, p. 9.

As in the previous analytical period, general practice was routinely associated with the NHS and health promotion. However, the RBME67 discourse both broadened the learning spectrum of the student and assigned a new teaching role to general practitioners, as detailed in the section on object and subject positions. TR68 confirmed this trend, but was still heavily influenced by the discourse that doctors should be taught in university teaching centres, as in the period analysed previously. There was an expectation that surgeries attached to, or in the vicinity of, these centres would be more suitable for teaching purposes, in effect creating two tiers of general practice from an educational perspective (i.e. "suitable" and "unsuitable"). TR68 predicted the development of general practice health centres or group practices, a kind of "mini-hospital" setting compared with more conventional home-like practices. This discursive trend is further described in the section on object and subject positions. A further consideration was the amount of time students should spend outside hospitals. The passage below exemplifies this:

> "*In some medical schools undergraduate students are attached for a few weeks to **selected general practitioners**, sitting in at their surgeries and accompanying them on visits; additional time may be spent in this way in an elective period. We think that the **future** will see an extensive **development of health centres and group practices in close association with hospitals**; when they are situated **near a medical school or a university teaching hospital they should certainly contribute to undergraduate education**, especially when they provide an **example of teamwork between doctors and the related social services.** A series of **formal lectures** on the subject of general practice would seem particularly **inappropriate**; much more can*

> *be accomplished by arranging that the student meets family doctors either on an individual basis or in small informal groups.*" TR68, p. 115.

TR68, however, reiterated the "*practical nature*" of general practice, stressing that this type of knowledge was not amenable to formal, theoretical learning. General practitioners should be involved in practical teaching only, in association with teaching centres. In this way a hierarchy of teaching was established which distinguished teaching from non-teaching practices based on their affiliation or otherwise with teaching hospitals. Teaching services were still identified with better qualified staff members (consultants) and, therefore, better quality of care.

In RBME76 this discursive strategy gained more importance. The document acknowledged the widespread use of clinical placements outside teaching centres, including smaller hospitals and community health services. At this time, general practice placements were established in most medical schools in the UK, alongside the teaching of community medicine. This association of general practice with community medicine, linked to the expansion of teaching settings, increased during the 1970s, and is described further in the "formation of concept" section of this chapter. The passage below highlights the emergence of general practice as a place of learning:

> "*A further stimulus to co-ordination has been the* ***increasing reliance*** *of many schools for part of their clinical teaching upon* ***regional ('peripheral') hospitals outside the teaching centre****… Resources for teaching* ***Community Medicine have expanded*** *and teaching in the context of* ***General Practice*** *is now an established part of the programme in* ***almost all*** *medical schools.*" RBME76, p. xv.

Despite a strong discourse of broadening the range of clinical teaching settings, the majority of practical teaching during this period was still

taking place in university hospitals. RBME76 noted that of the 90-144 weeks of a student's undergraduate tuition, only 1-6 weeks were spent in settings outside hospitals, including general practices and other venues.

"Approximate period spent in clinical settings outside hospital	*Number of schools*
1 week	*2*
2 weeks	*9*
3 weeks	*5*
4 weeks	*7*
5 weeks	*6*
6 weeks	*3"*

RBME76, p. 55.

These out-of-hospital (or "*de-hospitalizing")* activities were described as new developments in undergraduate teaching at the time. They were encapsulated also in the notion of "*community activities*", which included social services, primary health care services, general practices and public health local entities. Apart from certain claims for the benefits of community teaching, the justification to *de-hospitalize* students was not particularly clear and could be seen as contributing to an overspecialized and overcrowded curriculum (discussed in the following section). The absence of a clear rationale also served to protect hospital-based teaching from any attempt to undermine its value. This extract from RBME76 exemplifies this discussion:

> "*…the most commonly and enthusiastically reported (*change*) was the development of* ***community activities.*** *The* ***community aspects of hospital illness and treatment*** *are now stressed particularly in seven schools, at all stages of the clinical course… Apart from their intrinsic value they are intended to help students to* ***think always of the family,*** *to '****de-hospitalize****' them, and to give a perspective on the whole clinical course.*" RBME76, p. 64.

Since illness and treatment were still portrayed as belonging to the hospital, the inclusion of community medicine teaching into undergraduate

curricula meant transferring a hospital-centric comprehension of medical knowledge (illness) and treatment (practice) to the community. Documents of this period, however, show little understanding of the differences between these settings. The assumption remained that quality teaching could only be provided in settings attached to teaching centres or by university teaching staff; however the limitations of this perspective were starting to be recognized, as the passage below confirmed:

> "*The **majority** of clinical teaching in many schools is given in units or hospitals **away** from the **control** of the **professor** or senior **teacher** of the subject. Our information is generally limited to that obtained from the schools and their staff: **lack of comprehensiveness in this regard is acknowledged**.*" RBME76, p. 8.

Like other policy statements affirming that general practice teaching should take place in or around university hospitals, this passage demonstrates a degree of ambivalence towards *de-hospitalizing* students. The same ambivalence can be found in the following passage, in which the issue of the status and funding of university hospitals is raised. Echoing the objectives of the Goodenough Report, there was evident concern that teaching centres would lose funding and prestige as a result of the de-hospitalizing agenda. Nevertheless, this major shift was proposed and the advantages of non-hospital teaching recognized:

> "*Whilst a number of schools feared that **health service reorganization** might result in a **deterioration in the relative status and facilities of the teaching hospitals**, a few felt that it had brought very **real benefits** – in particular, bringing the **medical school, the community, and the community medical services closer together**.*" RBME76, p. 130.

As the passage above suggests, this shift in medical education policy coincided with other changes taking place in the NHS at the time. The

NHS was consolidating the role of general practice and other community services in the overall health care system (see chapter 5). Medical schools were therefore adapting to new health policies and trying to protect their privileged teaching centres. The text above highlights the sense of competition for limited funding for teaching venues. An important aspect of this was highlighted by the following passage, where the report demonstrates a divergence of opinion between academic and clinical teachers regarding clinical curriculum, practice and ethics, one of the several conflicts experienced by medical schools in adjusting to new medical care realities and the emergence of alternative perspectives to the scientific version of medicine passed down by medical schools/universities. This difference served to reinforce the distinction between scientific clinical knowledge and the clinical practice of non-teaching health services. The latter included general practice, reinforcing its practical nature and limiting general practitioners to practical teaching. While the policy documents of this period continued to assume that university hospital staff, with their privileged view of medicine, were best qualified to teach, the passage below from RBME76 at least acknowledges the problem:

> "*The **academic department** in another school has found the **NHS staff who teach** most students for at least some of the time **do not share its views** about '**social gynaecology**'. They **disagree** over its role in **clinical practice**, the desirability of teaching it and how much and **what type of problem to teach or to exclude**: ethical disagreements exist too.*" RBME76, p. 668.

The extract above illustrates the kind of conflict medical schools tried to avoid by confining medical teaching to teaching-centres. But the two perspectives of medical practice from this period onwards would eventually

have to confront each other. It could be argued that the pressure on medical schools to use non-teaching health services created a demand from the NHS for doctors who were prepared to tackle the 'non-teaching' reality of health services. In the RBME80, the discourse of broadening teaching settings beyond university was established. The dispute over where the best medical practice took place continued to feature in the policy documents, with a more critical perspective that acknowledged the limitations of both settings. The following passage from RBME80 highlights this:

> "*In order to achieve this objective, it is necessary for a student to acquire knowledge and understanding of: …*
> *The* ***organisation and provision of health care in the community and in hospital****, the identification of the need for it, and the* ***economic, ethical and practical constraints within which it operates****…*" RBME80, p. 7.

In the pre-registration year, doctors were to be offered to health centres but hospital services were privileged. All posts should be under the supervision of a consultant. Despite the discourse of broadening clinical experience, some passages of the policy revealed a continued ambivalence towards community services, which were again excluded from the list of important medical areas, as illustrated below:

> "***Clerkships*** *should be held in* ***Medicine, Surgery, Obstetrics and Gynaecology, Paediatrics and Psychiatry****. The aim should be that the* ***student*** *should be* ***resident in a hospital****, or within a convenient distance from it, for a* ***substantial part of the time*** *spent in his clinical clerkships.*" RBME80, p.20.

Nevertheless, the broadening of teaching settings at least made it thinkable that general practice could be taught as "practical" medical knowledge and that general practitioners could take part in (practical) teaching. The question of how this could be squared with continuing disputes

between medical specialties for curricular time and space is examined in the next section.

7.2.4 Overspecialization and an overcrowded curriculum

As in the previous period of analysis (chapter 6), policy documents of this second period were especially exercised by a discourse of "*avoidance of overspecialization and an overcrowded curriculum*". These two concepts were often presented together as reinforcing and justifying each other, producing a continuity of discourse. In addition, the terms "*general"* and "*basic*" were often used to describe the content privileged in undergraduate education. These words could be a reference to the previous period when the end product of the medical courses was a general practitioner. Postgraduate training in the second analytical period was expected to fill the gaps in undergraduate courses, which were described as incomplete and flawed. The superior status of postgraduate training was thus reinforced. Specialist teachers were also allowed to be more flexible in catering for priority subjects: a consolation for those who were struggling to fit all their knowledge content into undergraduate courses. The excess of curricular content was a symptom of the development of medical knowledge and of the struggle between medical specialties for curricular time and space. The following passage from RBME67 exemplifies this:

> "*In **basic** medical education 'the road of excess' does not lead to the palace of wisdom'. Many subjects have to be taught, and teachers have to ask themselves what **general principles** are implicit in their subjects and what **essential** facts they should give the student in illustration of these principles. The decision to **omit** information is admittedly **hard** for the **specialist** teacher to make. However, the omission of information which is **irrelevant** to **basic** medical education is more acceptable to the teacher when he recalls that its design is founded on the*

assumption that the period of ***vocational training should repair these inevitable omissions****.*" RBME67, p. 11.

The problem of super-specialization is presented in a similar way to the previous period analysed (discursive continuity). Students were not gaining access to the full spectrum of health issues that would be part of their daily work routine. Nevertheless, the documents offered no significant criticism of the model of teaching centres (hospital-based) linked to medical research and postgraduate training, which had a definite impact on the scope of illnesses being addressed (on the wards). The following passage describes the problem:

> *"… a* ***difficult situation*** *is being created because the* ***medical firms*** *around which their* ***clinical teaching*** *is based are becoming* ***increasingly specialized****, and it is consequently* ***now*** *more difficult to ensure that* ***students are exposed*** *to a* ***wide and representative variety of medical problems and cases****.*" TR68, p. 615.

This discursive strategy (overcrowded and overspecialization) was used as a continuous justification for change in different historical periods of medical education (6.3.1.3 and 8.2.4). It was an argument which sensitized and mobilized the medical education milieu, including students, who felt the burden of acquiring so much knowledge. The next example demonstrates the difficulties that students experienced and the struggle among specialties for representation in the curriculum. This is a passage from TR68:

> "*The* ***clinical*** *side of the course has also become* ***overcrowded*** *and* ***indigestible****, in the view of a great many teachers. The* ***growth*** *of knowledge, the* ***increase*** *in specialties all of which want to be substantially* ***represented*** *in the course, and specially the* ***traditional aim of producing a man trained for general practice in the old sense – capable of doing almost everything and hence having had some contact with almost everything*** *– have led to an attempt to achieve an impossible breadth of coverage.*" TR68, p. 90.

The above text seems to blame the characterization of general practice, rather than the competing demands of medical specialties, for the overcrowded curriculum. Also, the allusion to general practice in "the old sense" is mistaken. As the analysis of the previous period revealed (chapter 6), general practice was not characterized as "doing almost everything": on the contrary, it was seen as a patchwork of other medical specialties, responsible only for treating the most common and "simple" illnesses and for prevention and promotion. The passage appears to relate more to a previous discourse on general practice, before the merger of medical schools with universities – perhaps even to a time when surgery and apothecary were practised by the same subjects. The following passage further exemplifies this:

> "*In the past, undergraduate clinical teaching has been based almost entirely on patients referred or admitted to hospitals and only recently has an attempt been made to provide some introduction to the wider problems of sickness in the community.* ***The medical student should understand that patients seen in teaching hospitals represent a highly selected group and that an overwhelming majority of those seeking medical attention are treated in general practice without reference to hospital.***" TR68, p. 114.

The documents of this period offered some resolution to the problems of overspecialization and an overcrowded curriculum. These included the integration of disciplines through teaching cooperation, an approach to health and disease which focused on the human condition, and a shift in teaching methodology away from traditional lecturing and the ward round. These solutions were in accordance with the broadening of clinical teaching settings and seemingly in line with modifications to NHS policies. The following passage from TR68 exemplifies this:

> "***Collaboration*** *in teaching will, however, be the most effective way of removing some of the problems which have arisen from the allocation of time to* ***each discipline separately****, the* ***failure*** *to present health and disease in* ***man*** *as a* ***whole****, and the* ***excessive*** *use of the* ***formal lecture*** *and of the* ***old-fashioned type of open ward round.***" TR68, p. 97.

RBME80 reinforced this view, but with a slight change of emphasis: shifting from teachers' disputes over curricular time and space towards the learning process undertaken by students. The language used referred to the *cognitive* dimension of medical education, in line with the evolving discourse on competences which is consolidated in the next period of analysis (chapter 8). Students should not be overloaded with memory-based learning but encouraged instead to acquire a critical and independent mind-set. This extract from the RBME80 is an example:

> "*We therefore* ***reiterate*** *the views expressed in the* ***Recommendations of 1957 and 1967****, that the student's* ***factual load should be reduced*** *as far as possible, to ensure that 'the memorising and reproduction of factual data should not be allowed to interfere with the primary need for* ***fostering the critical study of principles and the development of independent thought'****.*" RBME80, p. 13.

The next section discusses the concepts that linked the discursive strategies highlighted above with the formation of the object and subject positions.

7.2.5 Formation of concepts: community medicine and behaviour & social sciences

The association between the characterization of general practice and the discursive strategies described in this chapter was constructed through the use of specific concepts. I have identified two in particular: community medicine and behavioural & social sciences. General practice was

increasingly related to these two terms in regards to its role in medical undergraduate teaching.

The use of the term “community medicine” linked general practice to social medicine and created a notion of territorial boundaries between the work of general practitioners and other hospital-based specialists, despite the suggestion that the former should work in hospitals (7.3.1). The concept of community medicine was also able to link the new characterization of general practice knowledge in medical education policy – one that goes beyond the previous patchwork of medical specialty knowledge – to the elementary principles of family medicine (i.e. continued care, family approach, ready availability). This is further described in the following sections on object and subject positions of general practice.

In regards to curricular content on behavioural & social sciences – which medical education policies refer to as sociology and psychology – this was increasingly delegated to general practice teaching, away from the hospital setting, due to its community and family focus. Interestingly, in the previous analytical period, behavioural sciences were expected to be taught by all departments. This tendency returns in the next period of analysis concerning the *Tomorrow’s Doctors* series (Chapter 8). As was the case with the overcrowded and overspecialized curriculum, the discourse surrounding the teaching of the behavioural sciences is thus renewed to justify further change. Despite this, psychology and sociology would rarely receive the same priority in the curriculum as they were granted in policy documents.

The following sections describe the repercussions of the four discursive strategies on the characterization of general practice as a discursive object and the subject position available to general practitioners.

7.3 Formation of object and subject positions: general practice as family and community internal medicine

The characterization of general practice in these documents took a new direction when compared with the documents analysed in chapter 6. However, these changes in discourse were not uniform, and at times conflicted with both previous and developing discourses. General practice is presented as a medical specialty focused on both the community and clinical work. This served to reinforce the territorial boundaries that defined and increasingly separated hospitals from primary care services, despite the integration efforts mentioned previously. The NHS at this time (1960s) faced an important question: would primary care and general practice still have the role played until then? The answer, as described in chapter 5, was “yes”. After the Collins Report’s denunciations regarding the precarious state of general practice in the UK in the 1960s, the NHS’s response was to reinforce the role of general practice in the system (chapter 5). This position was further strengthened by the increased participation of the RCGP in medical institutional decision-making as part of committees producing policies. The documents regarding medical education policy followed this trend. In order to support the difference between medical specialties, general practice became less of a patchwork of other specialists and developed an increasingly specific definition that recognized its distinctive characteristics. These characteristics would establish new boundaries between the medical specialties, which now

included general practice. Through the recognition of general practice's fundamental role in the NHS, the medical institutions involved in medical education policy began to treat general practice as equal to other medical specialties. General practice was presented as a career pathway for all medical students; but in order for it to become a medical knowledge specialty, certain aspects of the clinical sciences had to be incorporated into its definition. General practitioners were expected to become competent scientific clinicians, some of their previous roles would be shifted to other health professionals and the structure of surgeries would change to better resemble hospital-like settings. This discourse would also guarantee a place for general practice in academia. As a medical specialty, general practice would be better regarded by medical students, who would be more likely to choose it as a career path, and medical schools would continue to respond to the NHS's (governmental) demand for qualified general practitioners. The concepts that linked these changes were the notion of "community medicine", "clinical sciences" and "behavioural sciences". Each of these aspects of the characterization of general practice is detailed and exemplified in the following sections.

7.3.1 General practice as a medical specialty: internal medicine

The policies analysed in this period presented general practice as a medical specialty. This was in line with changes to undergraduate medical courses, described in the sections above, which prevented new graduates from working independently as general practitioners (*the unfinished doctor)*. It also accorded with the increasing importance given to general practice knowledge within an increasingly consolidated NHS (*de-hospitalization of*

students). Despite developments in health systems elsewhere (i.e. USA, Russia, Japan), which had seen general practice/family medicine and primary care lose importance, the UK government and society made a deliberate choice to position general practice as a lynchpin of the NHS (see chapter 5). The following passage in RBME67 exemplifies the discourse by which general practice is equated to other medical specialties:

> *"(*Undergraduate medical education is*)…to provide a* ***basis for future vocational training****: it is* ***not*** *to train doctors to be* ***biochemists, surgeons, general practitioners, or any other kind of specialist.***" RBME67, p. 2.

This discourse of general practice as a (new) medical specialty was supported by all the institutions involved in medical education (i.e. GMC, Royal Colleges). Interestingly, as described in the previous section, the expression "*including general practice*" was used repeatedly in the documents when describing medical specialties. The GMC's recognition of general practice as a specialty was exemplified in the following passage from RBME67:

> "*The council (***GMC***) accepts the advice which it has received that* ***all*** *doctors,* ***including*** *general practitioners, will* ***require*** *in the future* ***special and extended*** *vocational training for their chosen careers.*" RBME67, p. 4.

The use of the word "*including*" in RBME67 can be understood as acknowledging the previous *non-recognition* of general practitioners as specialists, described in the previous chapter. The use of "*will require in the future*" also suggests that the status of general practice as a distinct medical specialty was not universally acknowledged at that time, as general practitioners were not yet undergoing vocational training.

Interestingly, the discourse of "*including general practice*" was not present in RBME76, although general practice featured on the list of subjects to be taught. The expression was revived, however, in the 1980 RBME guidelines:

> "*By the time of qualification, the graduate should have **sufficient** knowledge of the structure and functions of the human body in health and disease, of normal and abnormal human behaviour and of the techniques of diagnosis and treatment, to enable him to assume the responsibilities of a **pre-registration House Officer** and to prepare him for vocational training for a specialty (**including general practice**), followed by **continuing education throughout his professional career***." RBME80, p. 6.

The RBME80 incorporated a further stage into medical education by introducing the concept of "continuing education". This discourse of the "eternal learner", familiar to that of the first analytical period, is continued further in policy documents of the 1990s and 2000s, which are analysed in the next chapter. The discourse of equating general practice with other specialties was also present in RBME80, as the following passage shows:

> "*The patterns of the **experience acquired** should be such as to prepare the graduate by general clinical training for subsequent **specialist** training, whether for **general practice or for any other specialty**.*" RBME80, p. 9.

There is a subtle shift too with regards to the promotion of health. In the previous period of analysis, this was very much associated with general practice. Now it was increasingly linked to public health services. As general practice became recognized as one of the clinical specialties, its role in health promotion weakened. The following passage exemplifies this:

> "*He (*the student*) should learn about the organisation of medicine, the scope of its various specialties, the role of the general practitioner, and **the role of the Public Health Services in the promotion of health.**"* RBME67, p. 9.

In the previous period of analysis, students were said to regard general practice as a pathway available to those who could not follow the hospital career trajectory (chapter 6). In the period analysed in this chapter, general practice was presented to students as a "*vocational opportunity"*. It was now expected that students would actively choose to be general practitioners, which had been barely thinkable in previous policy discourse. The following passage in the same document confirmed this:

> "***Finally*** *the student is able to observe* ***general practice*** *as a* ***vocational opportunity*** *for himself.*" RBME67, p. 17.

The same document also recognized that general practice university departments would smooth the student's entry into primary care services:

> "*Such experience is facilitated where teaching* ***Health Centres or Departments*** *of General practice have been created.*" RBME67, p.17.

The two institutions mentioned (teaching health centres and departments) were the means by which the imparting of general practice knowledge came closer to the previous discourse relating to teaching university hospitals. Health centres were described as being modelled on hospital structure and functioning. The creation of departments of general practice in medical schools and university hospitals would further underline the importance of these structures. This can be at least partially attributed to the foundation of the College of General Practitioners in 1952 and its influence on policy- making: a key development in the current period:

> "*A great deal must* ***depend*** *upon the views of the* ***universities*** *and of the* ***Royal Colleges****, which have such* ***important responsibilities*** *in the field of* ***vocational training****. The British Medical Association, the* ***College of General***

> ***Practitioners**, and a number of other bodies are also deeply **interested**.*" RBME67, p.23.

RBME67 mentioned the College of General Practitioners as one of the various institutions which contributed to its recommendations, while TR68 acknowledged the historical division of the medical profession (general practice vs specialists) and the new priorities arising from the reorganization of the NHS at the time. The latter document assumed a strengthened role for general practice in the UK, despite contrary developments in health care elsewhere in the world (5.3.1.2). Nevertheless, general practitioners were expected to acquire additional attributes associated with hospital-based medicine:

> "*The structure of the medical profession in Britain had evolved into a sharply divided form twenty years ago, when an inevitable element of rigidity was introduced by the intervention of deliberate planning for a **new aim**, that of **comprehensive medical care**. One of our central tasks has been to consider **whether the divisions of the past and present are likely to continue in the future**, and particularly to make some judgment on the future **relationship between general practice and specialised medicine**. Other **countries** have adopted **different assumptions** when superimposing planning upon evolution, and we could imagine a number of **alternative ways** in which medical services might develop in this country… (examples in USA, Russia, Japan)…Or something akin to **our present system might remain, in which the general practitioner, while still maintaining his tradition role of family physician, might also play a valuable part in clinical medicine in hospitals and elsewhere**.*" TR68, p.28.

The distinction between general practitioners and consultants was still present in these documents, despite efforts to homogenize the medical profession. Notwithstanding the proposal that they involve themselves in hospital-based clinical work, general practitioners were essentially seen as working in the community. Consultants' posts were described as limited in number and not available to general practitioners, regardless of their

experience and expertise. Nevertheless, the central role of general practitioners in the NHS was acknowledged, as the following passage made clear:

> "*A very substantial proportion of all illnesses, perhaps 90% is dealt with entirely within the ambit of general practice.*" TR68, p. 31.

TR68 questioned the organization of NHS services at the time but accepted that they should be maintained. However, the document offered a different model of general practice. This included general practitioners not only working in health centres or surgeries, but also joining hospital work. This discourse presented characteristics of continuity (role of general practitioners in the NHS) and of discontinuity (incorporation by general practitioners of medical specialties' qualities). The following passage from the report called for a change in respect to the action and value of general practitioners. The term *competence* was closely associated to the discursive strategy of the "*clinical sciences*" presented in the previous sections, as illustrated below:

> "*The very fact that the doctor is concerned with the most personal aspects of human health, and indeed with the fundamental matters of life and death, will ensure a continuing high prestige for his profession; but the esteem in which the doctor is held by the* ***community in general will be determined much more by his demonstrated competence*** *than by the mystique of his calling.*" TR68, p. 30.

While the negative experiences of the USA and other countries were not enough to discredit general practice in the eyes of UK policymakers, as described in the previous quote, the clinical sciences discourse that predominated in the USA was clearly influential in the planning of UK medical education, as the following passage revealed:

> "*We appreciate that in some other countries, and* ***especially in the United States****, the* ***general practitioner is***

> ***said to be fast disappearing and to be losing the respect in which he was formerly held****. On closer examination, however, we think that it is becoming more and more accepted that a* ***doctor should have some advanced knowledge and training, even if in a rather broad field such as 'internal medicine' in addition to the basic medical qualification on which the old-style general practitioner relied.***" TR68, p. 32.

This kind of discourse had a major impact in changing the role and training of the general doctor from general practice in the community to internal medicine. It also reinforced the need for general practitioners to have an "*advanced knowledge and training"* in internal medicine, a university hospital-based specialty. This would guarantee that general practice incorporated clinical sciences knowledge from the university setting. General practice would thus become increasingly valued as a medical speciality – and as a career choice for intelligent and ambitious students in opposition to the frustrated hospital-based former trainees or the insufficiently skilled student described in the previous chapter (6).

The reorganization of the NHS, with its emphasis on the role of non-hospital-based services, meant that the demand for general practitioners during this period was rising, as described above. At the same time, medical schools were increasingly concerned with competition for funding, especially if existing funding was to be shared with the new non-academic teaching services. The discursive association of general practice with internal medicine and further training in hospitals was a strategy to maintain the focus of funding on teaching centres and university hospitals, as exemplified in the second quote presented in page 222 that reads: "*Whilst a number of schools feared that* ***health service reorganization*** *might result in a* ***deterioration in the relative status and facilities of the teaching hospitals…***" RBME76, p. 130.

It would also deliver a huge workforce of trainees to meet projected demand, coordinated by a much smaller number of consultants. The discourse of *competence* and *effective* medical practice and the *clinical sciences* was forging a connection between discursive objects (general practice and internal medicine) and the incorporation of internal medicine knowledge would guarantee the competence and effectiveness of general practitioners moving forward. General practice would no longer be a patchwork of other medical specialties but, through a close association with a traditional medical specialty, become one itself.

The implications of this discourse affected not only general practitioners but also their workplace. General practice surgeries were described by TR68 as inappropriate for "*good practice".* Even the emerging partnerships between general practitioners were targeted as not able to offer an effective medical service, as described in this passage:

> *"…many who have thought **seriously** about the **future** of medicine now accept that the **single-handed general practitioner and the traditional domestic or street-corner consulting-room can have no place in the structure of good practice beyond the present generation**. Nor will the small partnership be able in future to offer the skills and services needed for the effective practice of medicine.*" TR68, p. 33.

The surgeries in which general practitioners worked were expected to develop into health centres, following a hospital-like model. These health centres, if linked to teaching centres, would also be more suitable settings for teaching undergraduate students. Moreover, the document suggested that the health care actions performed by general practitioners should be transferred to a health team. As general practice incorporated the characteristics of a clinical specialty, a significant amount of the duties delegated to the general

practitioner (non-clinical work) could now be transferred to other health professionals. In this way, the hierarchical position of the doctor in relation to other health professionals would follow the same model as that of hospital infirmaries. The changes suggested are illustrated in the following passage:

> "*The introduction of **nurses and health visitors** as integral members of medical practices has made considerable progress in the past few years. There will be problems in defining the kind of non-medical staff who can contribute most usefully to the work of a medical practice (something more than the traditional skills and qualities of nurses and social workers will be required)…we can forecast with confidence a gradually **increasing delegation of a variety of tasks from the qualified doctor to colleagues in other professions**, although of course the **doctor will remain in full charge of the patient's management and treatment and will closely supervise the work of his staff**.*" TR68, p.33.

The report suggested that general practices reconfigure themselves into larger health units with at least six general practitioners and a range of ancillary workers. This would offer local populations a choice of physician and satisfactory emergency care at all times. The doctors working in the suggested setting were expected to become more efficient, but also to acquire further specializations to advance their professional development. There was an assumption, however, that without this additional expertise, general practitioners would not enjoy the same professional satisfaction as their hospital-based peers, as the following extract makes clear:

> "*…and to develop a personal **interest** in a **particular branch or aspect of medicine** which will make a **valuable contribution** to the resources available within the practice as well as **increasing** his own **satisfaction**."* TR68, p. 33.

A further passage from TR68 added to the understanding of general practitioners as lacking the structure and knowledge to accomplish their health care duties: in other words, they were still not regarded as good

enough. This discourse strengthened the view that general practitioners should be trained in internal medicine, in accordance with the discursive strategy of the *clinical sciences*:

> "*Those who by **choice** or **necessity** became general practitioners have often, not surprisingly, felt themselves **inadequately** provided for with regard not only to **clinical facilities** (with which we are not concerned here) but also, particularly, to **postgraduate training**.*" TR68, p. 41.

The document in essence proposed the creation of a hybrid professional, somewhere between a specialist and a general practitioner, equipped with internal medicine knowledge and training. The objective that a general practitioner should have a superficial knowledge of all the specialties was no longer part of the discursive repertoire, as confirmed by this extract:

> *"…the **point has long been passed** at which one person could have more than a **superficial knowledge** of all areas of **medicine**.*" TR68, p. 28.

There was a clear attempt during this period to annul the perceived differences between general practitioners and specialists. This included introducing or institutionalizing general practitioners within hospitals. So while the dominant discursive strategy was to "de-hospitalize" medical students, general practitioners were to be essentially "*hospitalized*". These changes were presented as benefiting both professionals and the community:

> *"…the general practitioners concerned will thus become available, as **Specialists or Clinical Assistants on the staff of the hospital**, for consultation of the **general aspects of other cases**. In this way, the present **hard and fast distinction between general practice and hospital practice** may be expected to gradually recede, to the general benefit of the profession and of the public.*" TR68, p. 38.

Again, however, there was to be some differentiation between future specialists and general practitioners. In postgraduate training, highly

qualified supervisors would be allocated to those training in the hospital setting but not to prospective general practitioners, as described below:

> "*The young House Officer should be under the supervision of a* ***Consultant of high standard*** *who has time to give thought to the most appropriate methods of teaching…*" TR68, p.43.
>
> "*We do not think that the* ***posts or supervisors*** *required in this period of* ***further professional training*** *(*general practice training after two years of training in hospitals*) could be or* ***need to be as highly selected as those appropriate for the trainee during his general professional training****.*" TR68, p. 61.

In conclusion, the characterization of general practice in this period of analysis created a discontinuity from the findings presented in the previous chapter. General practice in this second period was categorized as a medical specialty that epitomized qualities previously associated with hospital-based specialties, most notably the "*efficiency*" and "*competence*" attributed to clinical sciences. General practice would be charged with performing clinical duties relating to diagnosis and treatment of illness and transferring non-clinical tasks to other health professions under medical supervision. But despite all these changes, general practice would not be fully incorporated into the academic world, as described in the following section on general practice teaching.

7.3.2 The principles of general practice: the family doctor

Despite all the changes proposed to general practice and to the role of practitioners in this analytical period, certain principles regarding their role in the NHS and medical education remained. General practice was concerned with health and disease in the community, in people's homes and work environments. General practitioners dealt with health issues that usually

did not require hospitalization and were able to identify diseases in their earliest manifestations, as depicted below:

> "*The student is thus given an opportunity to study the types of* ***illness which do not normally require hospital treatment and the early manifestations of many diseases*** *seen in hospital only at a later stage.*" RBME67, p.17.

Students in general practice placements were expected to understand the existing range of community services. They would also gain direct experience of the general practitioners' role in offering continued care for individuals and families, as shown in the following quote:

> "*He also obtains first-hand* ***knowledge of services available in the community*** *for* ***domiciliary care and the promotion of health****, and observes general practice as a means of providing* ***continuing care*** *of the patient and his* ***family****.*" RBME67, p. 17.

These passages from RBME67 outlined principles that characterized general practice as going beyond the scientific clinical specialty. These principles were intimately related to the role played by general practitioners in the NHS and provided a basis for differentiating general practice from other medical specialties. They were: first contact, individual clinical care, family approach, community medicine, continued care, early diagnosis, chronic disease treatments, multidisciplinary teamwork, and health and social care services networking (RBME67).

These extracts from TR68 also underlined the strengths general practice had acquired during the consolidation of the NHS. They embodied the original motivation for incorporating general practice into the NHS, in marked contrast with public health system models being developed elsewhere in the world, some of which prioritized direct access to specialists without the need for primary care. The following passage acknowledged the importance

general practitioners had gained in the UK's health system as a result of the UK government's deliberate focus on primary care:

> "*We see **no evidence** that there will be a large-scale move in this country towards direct access of patient to 'specialist' in the **narrower sense of the term**; present- day thinking on the importance of the patients' material and social environment, points to the **continuing need for a first-line preventive, diagnostic and therapeutic service** which can deal in **general** terms with the **total medical needs** of the patient and when necessary **guide** him towards the appropriate specialised services; moreover, this **function** needs to be available to **individuals** and whole **families** as far as possible **in the area where they live**, where **personal contact** can readily be made with non-medical agencies able to help.*" TR68, p.32.

The following passage from TR68 brings together the changes proposed to general practice and the principles underpinning them. It recommends that general practitioners serve the clinical and social needs of the population (individual and families) and restates the activities developed by general practice in the NHS:

> *"…general practice should, we think, aim at producing a first-rate clinician in the field of internal medicine, with a good knowledge of preventive medicine and with special knowledge of the problems –both clinical and organisational – associated with family doctoring and with the role general practitioner as 'doctor of first contact in the community'*." TR68, p. 32.

In terms of the student experience, the report continues:

> "*The student must be given an opportunity to see for himself the **impact of illness and death on the family**, and to learn how the **general practitioner meets the clinical, personal and social problems involved**. He should see patients presenting **new symptoms** to the doctor for the **first time**, and learn how **decisions** have to be made at this **stage**. Moreover, he should see how the **doctor-patient relationship** often **differs** in general practice from that in the **hospital**."* TR68, p. 114.

RBME76 followed the same discourse initiated in TR68 relating to general practice, with its emphasis on multidisciplinary teamwork. The

learning opportunities stressed by TR68 were also confirmed in RBME76, but with the addition of a further characteristic of general practice: the management of health services. The extract below exemplifies this:

> "*The last main area in which teaching is concentrated in general practice is that of* ***practice management****. General practice is probably unique in that the general practitioner has a health care responsibility to his patients as well as management responsibilities for his practice.*" RBME76, p. 539.

In RBME80, despite the continuation of the main discursive strategies presented in the previous policies analysed, there were no formal descriptions of general practice. This was a clear sign of the emerging discursive strategies relating to undergraduate medical education policy in the next analytical period, which includes the *Tomorrow's Doctors* series. As postgraduate training programmes became consolidated, the discourse characterizing medical specialties was absorbed into postgraduate training policies. The characteristics of medical specialties which were of interest to undergraduate courses were diffused into the broad goals of medical education as further discussed in the following chapter. The following sections describe the subject positions available to general practitioners in the second analytical period.

7.3.3 General practice teaching: practical teacher

During this analytical period, as described above, general practice began to be introduced into medical curricula in accordance with the discursive strategy of *de-hospitalizing* medical students. At the same time, general practice became associated with social medicine, community medicine departments and (clinical) medicine departments. In terms of medical education, the Todd report did not advocate the establishment of

academic departments of general practice, suggesting instead that related departments take on the job of general practice teaching, as described below:

> "*The aim of the teaching should be to afford the student some insight into the* ***nature of the problems and opportunities*** *in general practice. No department in the medical school is ideally fitted to provide the necessary teaching.* ***Departments of social medicine or community medicine*** *may provide a suitable environment, but there should always be* ***strong*** *links with the* ***department of medicine****.*" TR68, p. 114.

General practice was thus denied equal status with other medical specialties in academia. Nevertheless, the appointment of lecturers and professors in general practice was expected to attract good students to the new medical specialty. This would also guarantee a role for general practice teachers in medical research. Nevertheless, the practical nature of general practice was still identified as an important characteristic of this field of medical knowledge: more theoretical teaching of general practice was seen as unsuitable. Students would learn more about the essence of the discipline through practical placements. Moreover, general practice surgeries involved in teaching were deemed to be better suited to this activity if affiliated with health teaching centres, as illustrated in the previous section. The following extract exemplifies the conflicting way in which general practice was presented as a medical specialty to be taught:

> "*A series of* ***formal lectures*** *on the* ***subject of general practice*** *would seem* ***particularly inappropriate****; much more can be accomplished by arranging that the student meets family doctors either on an individual basis or in small informal groups.*" TR68, p. 115.

RBME76 highlighted the role of general practice in early clinical training in specific schools. This document aligned with TR68 in terms of the perceived practical nature of general practice teaching. In the 1976 document,

general practice teaching was linked to themes such as communication, interviewing and the social and psychological aspects of medicine. The following passage exemplifies this:

> "*A Scottish school (Dundee) links the **early clinical training** with its course in **behavioural science**, organized by the **professor of general practice**. Here the focus is more on **communication**, on **interviewing** and on the themes of **primary care** and patients' **social** and **psychological** background. In one new medical school the **'Early Medical Contact' scheme is supervised by general practitioners** (although students also attend antenatal clinics and birth, as well as the general practice aspects), and students in two other schools have the opportunity to attach themselves to a **general practitioner and to attend his/her surgery as an observer**.*" RBME76, p.44.

Teaching in general practice still found itself in a conflicting position in RBME76 with regards to theory and practice. Although the majority of medical schools in the 70s offered general practice teaching, few offered "*formal classes*" in the subject, and most of the teaching provided was still practical in nature, as described in the quote bellow. During general practice placements, students were effectively absent from medical schools. This demonstrated the rupture between the practical nature of general practice and the academic teaching environment. The following passage illustrates this:

> "*In twenty-six schools (out of 30 with general practitioner teaching in 35 schools) the most significant point at which students are taught about general practice is a separate course given solely on this topic. Sometimes this is a 'teaching' course, with formal classes conducted by medical school staff, interspersed with sessions of clinical experience in selected practices; **but at most schools it consists of a full-time attachment to practises when students are free from formal teaching and are not seen in the medical school at all**.*" RBME76, p. 531.

The passage below confirms the practical nature of general practice:

> *"The very **nature** of general practice determines to a considerable extent the **methods** used in teaching it…Consequently, **comparatively few schools use lectures** to any great extent, **unlike most other courses and subjects**."* RBME76, p. 539.

And this passage emphasizes the lack of scientific knowledge in general practice teaching:

> "*In ten schools **general practice** is a recent introduction to the curriculum, and the point was made that one problem of being a '**new' academic subject is the lack of a sound core of scientific knowledge based on research**."* RBME76, p. 543.

From these examples, general practice knowledge in this period can be characterized as "practical in nature", unscientific and therefore not requiring theoretical teaching. As in TR68, there was a continued linkage of general practice placements/teaching with community medicine, either in the pre-clinical or clinical years. In the pre-clinical years this was related to the teaching of behavioural sciences (sociology and psychology). The home visits supervised by hospital consultants in the previous period analysed were now presented as an activity to be managed by general practitioners. Many other *hospital-based* medical specialties started to integrate general practice teaching into their curricular activities, again with the emphasis on practical tuition, which in early clinical placements was intimately linked to the teaching of the "non-clinical" part of medical practice (i.e. behavioural sciences, communication). The core clinical sciences were still restricted to hospital-based consultant teaching.

Despite efforts to integrate general practice into medical school curricula, the quantity of teaching in this area did not yet reflect the discipline's importance in health care. The majority of clinical teaching was still taking

place in teaching hospitals; in most schools general practice teaching was limited to three weeks or less, as the following passage from RBME76 explains:

> "*Twenty-one courses give full-time attachments to a practice. They are spread over a period of one week in one school, two weeks in twelve, three weeks in two, four weeks in five schools, and six weeks in one.*" RBME76, p. 533.

Notwithstanding the conflicts described in the sections above, general practice departments were being founded in UK universities, although teaching was still also being conducted by departments of community medicine/social medicine and by units within other departments (in some cases by a single professor – RBME 76 p. 534). Despite the report's suggestion that health centres attached to university hospitals should be favoured for general practice teaching, medical schools were actually adopting a range of practices. Certain schools engaged groups of general practitioners for teaching, both close to and distant from the university hospitals. Others also required students to find their own placements. Many schools used a mixture of these models (RBME76 p.535).

Teaching was mostly done in the surgeries or in health centres in small groups and was focused on clinical cases, simulations and communication skills. Despite the recognized importance of general practitioners in the NHS, schools had important difficulties in funding students' placement in the community. In addition, general practitioners involved in teaching were confronted immediately by the conflict between academic and clinical work, as this passage from RBME76 exemplifies:

> "*An additional problem is that of being an academic general practitioner. Most (but not all) respondents felt strongly that it was* ***essential for the teaching general practitioner to***

> ***be actively involved in a practice**, otherwise the teaching lost its **relevance**. However, it is **not always possible for the academic general practitioner with relatively heavy teaching responsibilities to find adequate time to practise**. Six respondents specifically mentioned this as a problem.*" RBME 76, p. 542.

Similarly to TR68, RBME76 acknowledged the need to motivate students to join general practice, as there were not enough hospital posts for every doctor and the NHS was especially reliant on general practitioners. The tension between schools that acknowledged this necessity and others that did not was still evident, as illustrated by this passage:

> "*General practice has met with some **difficulties** in becoming established as an **academic discipline**, and in the past the **majority of graduates** have allegedly wished to enter one of the '**hospital specialties'**. Many graduates **must** enter general practice, however, and seven respondents indicated that **one of the aims of their course was to reassure the undergraduate about the scope and the excitement of medical practice as a general practitioner**. Nevertheless one respondent stressed particularly that his course **'is not designed to recruit students to general practice'**.*" RBME76, p. 537.

The different status attributed to hospital and non-hospital specialties was still an issue in this analytical period. The RBME76 passage above evidenced the huge demand for general practitioners in the NHS. Despite the gradual increase in general practice teaching, by the time of RBME80 this still did not form part of clinical clerkships, despite being listed as a sub-discipline of Medicine and Surgery. This passage in RBME80 confirmed the absence of general practice in the five core medical specialties offering clinical clerkships for medical students:

> "***Clerkships** should be held in **Medicine, Surgery, Obstetrics and Gynaecology, Paediatrics and Psychiatry**, for a total period of not less than 18 months. The aim should be that the student should be **resident in a hospital**, or within a convenient distance from it, for a **substantial part of the time spent in his clinical clerkship**.*" RBME80, p. 20.

The subject position available to general practitioners during this analytic period allowed them to take on a less submissive role and, through the inclusion of family doctor principles in policy documents, to carve out their own niche in the medical education system. Therefore, despite the still prevalent subjection process of characterizing the general practitioner (e.g. as practising internal medicine, not a theoretical teacher or researcher, not producing knowledge), there was a space for general practitioners to be themselves through practical teaching.

In summary, the characterization of general practice as a medical specialty and the broadening of teaching settings allowed the discipline to be formally introduced into undergraduate teaching, albeit with a strict focus on practical clinical tuition, distinguishing it from other specialties. However, this was not the only factor differentiating general practice from other medical fields of knowledge, both in the NHS and in medical education, as the following section explains.

7.3.4 Other subject positions

Other subject positions that shaped general practice knowledge in this analytical period included: the clinical scientist, the de-hospitalized student, the de-hospitalized patient and the policy writer.

The clinical scientist was a product of the merger between clinical practice and the basic sciences. This subject position consolidated the concept of medical sciences as the application of the scientific method and its products to clinical practice and human disease. General practitioners' access to this subject position was enabled by the inclusion of internal medicine in

general practice knowledge. The clinical scientist was, therefore, a hospital-based specialist.

The de-hospitalized student, despite spending most of his or her clinical learning in hospital, would have contact with primary medical care services and the community during the early years of medical education. This outside-hospital activity would focus on social and psychological aspects of clinical practice, including contact with communities and families. Development of the doctor-patient relationship was one of the emphases of early clinical experience in primary care. More important clinical learning would be hospital-based. The de-hospitalized student was allowed to choose general practice as a career pathway, despite the characterization of general practitioners as “practical” and subordinate to consultants and academics (7.3.3).

The position of the de-hospitalized patient considered the person’s home, family and community. The patient had a social and psychological background, an understanding of which was important to developing the doctor-patient relationship and the sort of knowledge students would be offered in general practice teaching. Patients were the target of health care and essentially passive in terms of service delivery. They were not attributed an active role in health promotion or health service assessment, for example.

With regards to the policy writer position, the establishment of the RCGP – alongside the GMC and its medical education committee – offered a position of authority to general practitioners, equivalent to that of other medical specialties. Within governmental committees, however, such positions of authority were still available only to academic medical specialties.

7.4 Reflections

The findings described in this section gave me an insight into the powerful influence of the biomedical discourse in shaping general practice knowledge during this period. I also reflected on the different nomenclature used to describe the specialty in the UK and Brazil. I felt I was closer to understanding why terms like “family” and “community” were not used in the UK. I was surprised by the predominance of clinical sciences in the UK at this time. I had assumed that, given the organization of the public health system, with its strong focus on primary care, general practice would take a broader, more comprehensive, view of health care. The policy documents underlined for me the strong influence of hospital placements, both in undergraduate training and postgraduate general practice training.

In terms of my experience as an international researcher in the UK, I remain intrigued by the short consultations offered by general practitioners in local practices in London (Irving, et al., 2017). Through the current analysis, I reflected that this could be a result of the emphasis on a strong clinical scientifically-based (internal medicine) general practitioner who is able to refer patients to a broad range of services that will treat the social and psychological aspects of illness. In Brazil, the network for social and psychological care is very deficient and family doctors seem to absorb some of this demand to his practice. This is probably not the case for other doctors who did not train as family and community doctors (vast majority), but who work in Brazilian primary care.

7.5 Conclusions

This chapter described the results of the Foucauldian discourse analysis of medical education policy between the 1960s and the 1980s. In this period general practice knowledge was described as a medical specialty that combined traditional principles of family medicine with the clinical sciences of internal medicine, a hospital-based medical specialty. Despite no longer being described as a patchwork of medical specialties, general practice was still heavily associated with hospital-based knowledge. Through the discourse arising from the merger of clinical practice with the basic medical sciences (clinical sciences) and from the "de-hospitalization" of students, general practice became an official part of the medical curriculum. Nevertheless, it retained the characterization of being "practical in nature", not requiring formal lectures or theoretical courses. Rather, general practice knowledge was learned by students mostly in clinical placements. The general practitioner of this period was an internal medicine family doctor who was qualified to take on certain practical teaching responsibilities in undergraduate medical education but was still characterized as a learner of other medical specialties, despite the increased value of the role in the provision of health care in the NHS.

The following chapter describes the third and final period of the UK analysis.

8 CHAPTER 8: GENERAL PRACTICE AS UNCHARACTERIZED MEDICAL SPECIALTY KNOWLEDGE IN THE UK

8.1 Introduction

This chapter presents the findings for the final analytical period of UK undergraduate medical education policy. Between 1993 and 2009 the GMC, through its Medical Education Committee, published three versions of a document entitled *Tomorrow's Doctors* (referred to in this chapter as TD1993, TD2003 and TD2009), establishing national standards for undergraduate medical education. Analysis of these policy documents reveals a discontinuity in discourse concerning the role and status of general practice in medical schools compared with previous analytical periods. General practice knowledge is portrayed as specialist knowledge but is not depicted in detail in the policies, as in previous periods. Indeed, in this discursive era of *competence*, characteristics are not directly attributed to any medical specialty. This is further detailed in the sections below.

The concise nature of these documents means there is comparatively little material for analysis in this period: the passages selected for this chapter are sometimes the only ones illustrating a particular discursive element. Although different versions of *Tomorrow's Doctors* contain specific additions and amendments, overall the documents present a continuous discourse for the period in question in terms of the characterization of general practice knowledge.

As in the previous results chapters, the first section of this chapter outlines the strategic choices of discourse that delimit the *discursive archive* (set of truth assumptions) of this period and the discursive concepts that link general practice to the discursive strategies produced. These discursive strategies produced assumptions of truth that delineate what was thinkable in terms of general practice knowledge in undergraduate medical education of that period. The analysis distinguishes four strategies: (1) undergraduate medical education as a foundation for the future trainee; (2) the development of clinical competence; (3) the transition to patient-centred care; and (4) the continuing problem of overspecialization. Each of these is described and illustrated below.

The second section of this chapter presents the characterization of general practice as a discursive object and subject position. General practice in this analytical period is equated to other medical specialties – and the general practitioner to a consultant – in accordance with a discourse of undergraduate medical education as the foundation for future training. Placements in different clinical settings (e.g. hospital, general practice, community care) are presented as equally important to clinical teaching, with no distinctions in terms of their potential or limitations. General practice is not constructed with features that characterized it in previous analytical periods (7.3), mainly as a consequence of a new discourse on clinical competence. At the same time, certain elements of patient-centred care which previously characterized general practice knowledge are now attributed to medical knowledge and practice as a whole. This leaves general practice as an essentially uncharacterized medical specialty, with no distinct features in

terms of the undergraduate curriculum and no specifically delimited role for general practitioners in medical education.

Table 9. How the findings on UK medical education policy are organized

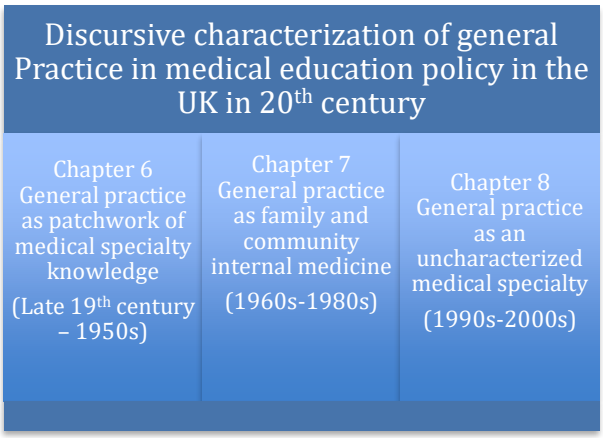
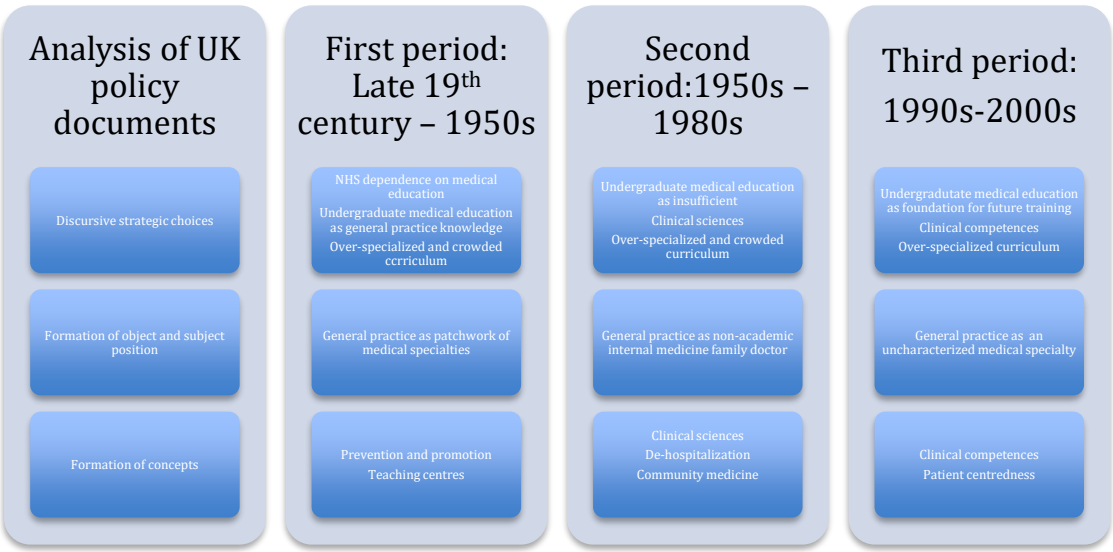


Table 10. Summary of the results of analysis of UK medical education policy



8.2 Formation of discursive strategies and concepts

This section describes the four discursive strategies that underline the characterization of general practice knowledge during the third analytical period. These view the graduating doctor as a future trainee of established

medical specialty programmes and not as an unfinished doctor, as in the previous period. General practice is characterized as a consolidated specialty, with practitioners compared to consultants. The analysed documents, however, abandon the previous expectation that students would decide on their career path during undergraduate studies. This portrays a lower pressure on medical specialty fields to compete for medical students' preferences during this phase of their training and a hides the conflict between specialties over curriculum time and space. It also provides an opening for a new educational discourse on the competences to be acquired by medical students. These are not classified into medical specialties, but presented as attributes of the future trainee to be taught by all medical fields. The medical attributes that characterizes general practice in the previous analytical period are, in this way, distributed throughout undergraduate medical education, while the medical curriculum as a whole no longer reflects divisions of knowledge and power within the medical specialties.

The same discursive strategy of competence is used to promote a patient-centred approach to health throughout medical practice, thus encouraging a more comprehensive attitude towards health care. It also encompasses features that were previously attributed to general practice knowledge, practice and teaching, such as communication skills and behavioural sciences. These were incorporated into medical education policy alongside other principles which emerged from changes to the NHS at the time (see chapter 5). But despite the shift towards a competence-based curriculum (and away from a medical specialty-based curriculum), overspecialization is still portrayed as a problem for medical education and a

justification for change, reinforcing the notion of a discursive carousel in medical education policy.

The main discursive concepts that relate these strategies to the characteristics of general practice during this period are *medical education as a foundation for future training, clinical competence* and *patient-centred care*. These concepts, along with the discursive strategies themselves, are described in the following sections.

8.2.1 Undergraduate medical education as foundation for the future trainee

In the previous analytical periods, the medicate graduate was described firstly as a general practitioner and then as an unfinished doctor. In the more recent set of documents guiding undergraduate medical education, the graduated doctor is presented as the future trainee. This discourse reinforces general practice knowledge as a medical specialty requiring postgraduate training.

The documents recommend that medical specialty career choices be postponed beyond the undergraduate years, thereby further embedding the discursive formulation of the "*eternal institutionalized learner*". While medical schools were expected to avoid pressurizing students to make their decision, the documents do not present a clear justification for this postponement, apart from the impact on the students' career pathway. This educational perspective benefits medical education institutions, by maintaining its justification for funding, and the NHS, which was able to consolidate a massive workforce of medical students and trainees across its services without creating more high-level consultancy posts for doctors who

had completed formal training. The following passage exemplifies the discourse of the medical student as the future trainee:

> "*The undergraduate curriculum is the **first stage** of medical education. It provides a **foundation** for future learning and practice as a pre-registration house officer and beyond."* TD2003, p.4.

The fact that undergraduate and postgraduate training (foundation years) were expected to be flexible enough to allow the students to delay their vocational training choice contrasted with previous periods identified in this analysis, in which students were encouraged to consider their career choice during undergraduate studies. Once postgraduate specialty training became mandatory, there was no longer a need to promote specialization during undergraduate medical education. In a break from previous analytical periods, medical students were no longer expected to take a view of the best specialties to follow, as exemplified in this passage from TD1993:

> *"It must be emphasised that the move towards a **variety of experience** in the undergraduate course is **not** aimed at influencing the time at which **career choices** are determined. This would be **undesirable**, and students would rightly **resist** pressures upon them to decide on their long-term future at the undergraduate stage. Interests developed as students will undeniably influence the specialty choice of some; this happens now. **But undergraduate and, indeed, postgraduate training programmes must retain sufficient flexibility to permit career choice to be delayed until well after graduation."*** TD1993, p. 12.

Undergraduate courses were expected instead to be *flexible,* allowing students to make key decisions later in their professional career. While the nature of this flexibility was not specified, the discourse on competence provided a curricular structure by which career choices could be deferred, as described in the following sub-section. The future trainee discourse incorporates the truth of the need to specialize and establishes the

discursive environment to equate general practice with other medical specialties requiring postgraduate training, as described in the section on the discursive object and subject position. This discourse reinforces the importance of medical education to the public health services, as it prolongs the period in which students and trainees are institutionalized in medical education.

8.2.2 Clinical competence curriculum

The description of the overall goal of medical education does not change from the previous period and could be understood as a discursive continuity between the two analytical periods. The documents analysed in this chapter adhere to the clinical sciences discourse, the significance of social and behavioural sciences and the importance of promotion and prevention. However, the pressure on undergraduate studies to prepare doctors for practice has disappeared and the overcrowded curriculum is no longer a policy preoccupation. Certain features that characterized general practice knowledge in previous analytical periods (e.g. disease prevention, health promotion, family focus) are now disseminated across the curriculum as competences to be developed. Since the GMC documents do not attribute these competencies to any specific field of medical knowledge, general practice knowledge and expertise in this period is uncharacterized.

The guidelines make no mention of competition between medical specialties for curricular time and space, which become subsumed into the notion of competence. However, the concept of competence is not formally defined in any of the *Tomorrow's Doctors,* guidelines*,* which refer instead to "skills", "attributes", "knowledge", "behaviours", "attitudes" and "procedures".

The documents list the educational goals to be developed by medical students but do not attribute or classify these according to medical specialty. No educational rationale is presented for the change from goals or objectives to competences. While medical education during this time produced a lot of research and experience focused on the development of competences, the conceptualization of the latter was disputed and criticized (Hodges, 2011). The organization of the curriculum through this new structure, with its emphasis on preventing early and over-specialization of medical students, centralized power within medical schools, who gained more control over curriculum content at the expense of specialty and university departments. Medical schools were also to direct curriculum content towards the needs of the population, instead of towards specialty knowledge development by university departments. This was in line with the recommendations of international medical education policies, such as the Declaration of Edinburgh (1988), as illustrated below:

> "Ensure that **curriculum content reflects national health priorities** and the availability of affordable resources." Declaration of Edinburgh, 1988.

While policies of this period maintained the curricular emphasis on public health, prevention and promotion, the undergraduate student's skill set changed into a detailed list of procedures to be mastered. The following extract from TD1993 demonstrates the similarity between the overall goals of the analytical periods described in this research. The focus on psychological, biological and social factors and how these affect illness, patient, family and community is repeated throughout the policy documents of this period:

> *"…understanding of the impact of **both psychological factors upon illness and of illness upon the***

> ***patient and the patient's family****; understanding of the effects of* ***childhood growth and of later ageing upon the individual, the family and the community****; and understanding of the* ***social, cultural and environmental factors which contribute to health or illness****, and the capacity of medicine to influence them." TD1993, p. 25.*

Interestingly some of the learning objectives that previously related to medical specialties are now presented as a common ground for medical education and medical practice. In the passage above, for example, educational content previously associated with general practice teaching is no longer referenced as a medical field of knowledge. It is presented instead as important to preparing medical students for further education in postgraduate training (i.e. as the future trainee). Similar goals were outlined in the 2003 version, as exemplified below:

> "*Graduates must have a knowledge and understanding of* ***the clinical and basic sciences****. They must also understand relevant parts of* ***the behavioural and social sciences****, and be able* ***to integrate and critically evaluate evidence from all these sources to provide a firm foundation for medical practice****." TD2003, p. 10.*

This passage provides evidence of another discursive carousel in medical education (defined in chapter 4). Throughout the 20th century, behavioural and social sciences were included in the medical curriculum; however the non-attribution of such content to a specific medical field in the current analytical period left loose in the curriculum, with the continued risk of devaluation. If in the previous analytical period (chapter 7) this content was attributed to general practice knowledge, within the competence curriculum it was not. This discursive strategy produces general practice knowledge that is uncharacterized, as described in more detail in the following sections. Among policy documents of this period, the discursive carousel usually took the form

of a statement that such content should be part of the entire curriculum, as in the passage below:

> "*Such courses (e.g. social sciences) should* ***feature in all curricula*** *and ideally* ***should run throughout the full five years****. Relevant to this theme are matters concerning child development, ethnicity, gender, age, and occupation; so too are the impact of psychological factors on health and disease and issues relating to palliation and the care of the dying."* TD1993, p. 18.

In this way, the discursive strategy of competence-based curriculum in undergraduate medical education policy blurs the conceptual boundaries between medical specialties' knowledge. There is an assumption that these themes (i.e. behavioural sciences) do not require specific training and therefore any medical professional is qualified to provide this teaching. This undermines the educational effort needed to develop knowledge of these specific themes. Likewise, it weakens the importance of general practice in the curriculum, despite attributing these themes to the curriculum as a whole.

Moreover, following the recommendation of mandatory postgraduate training, medical schools were instructed to stop providing a "*fully comprehensive course*" and to allow certain teaching to move to a later stage. The passage below from TD1993 demonstrates this well:

> *"In addition to the pre-registration year,* ***all doctors*** *entering the National Health Service are now required to undergo* ***either specialty training under the aegis of the Royal Colleges through their Higher Training Committees or vocational training for general practice supervised by the Joint Committee on Postgraduate Training for General Practice*** *before they may practise independently.* ***A fully comprehensive course*** *may have been desirable in the days before the development of postgraduate training programmes, but there is now* ***good reason to transfer some of the factual learning previously embodied in the undergraduate course to a later stage****."* TD93, p. 6.

The curriculum discussions of this period, reflected in all documents analysed, can be seen as a response to a competence discourse which dominated undergraduate medical education worldwide from the 1980s onwards (Boyd, Whitehead, Thille, Brydges, & Kupe, 2018), focusing on the need to teach behaviour, skills, attitudes and knowledge. The extracts below exemplify this:

> *"In Good medical practice the GMC states:*
> *'Good doctors make the care of their patients their first concern: they are* ***competent****, keep their* ***knowledge*** *and* ***skills*** *up to date, establish and maintain* ***good relationships*** *with patients and colleagues, are honest and trustworthy, and act with integrity and within the law.'"* TD2009, p4.

And:

> *"Graduates must be able to show that they can meet the following outcomes:*
> *Good Clinical Care*
> ***Know*** *about and* ***understand*** *the following:*
> *Our guidance on the principles of good medical practice and the* ***standards of competence****, care and* ***conduct*** *expected of doctors in the UK."* TD 2003, p 08.

The assumption that specific skills, knowledge, attitudes or behaviours are not directly attributable to a medical specialty weakened the power held by medical specialty departments in terms of medical education content. More power is delegated to the central governance of the medical school responsible to allocate teaching and learning tasks to the departments. It also contributes to the characterization of general practice as a medical specialty (although, like other specialties, with no particular features) equal to others.

In summary, this section presents a discursive strategy that reinforces the reduction of power held by specialty departments. Features that characterized general practice knowledge in the previous analytical periods

were now spread across the curriculum, but with no specific guidance on where or when they should be taught, or by whom. So despite the importance attributed to this content in the policy documents, one could argue that it was in practice devalued by the discourse of this period. In the next section, I describe how patient-centred care is presented as a new competence to be acquired by future trainees. This is described as signifying a new approach to medical care in accordance with modifications in public health policies at the time. Its appearance in medical education policy produced a continued proximity between medical education and public health, while preserving well-established boundaries between the two.

8.2.3 Patient-centredness in medical education

The documents of this period include patient-centredness as a competence to be developed by medical students during their undergraduate studies. This was a response to changes to the public health system policies at the time and renewed a discursive strategy linking medical education to the NHS (6.3.1.1 and 7.2.3). The concept of patient-centred care encompassed some of the features that defined general practice knowledge in the second analytical period (7.3.2). It also confirmed the position of general practice as a medical specialty, albeit one that was uncharacterized in undergraduate medical education policy.

By restating the need for medical education to focus on public health, the documents acknowledge that not enough progress had been made in this area, despite previous policy efforts. The following passage from TD1993 is perhaps a further example of this “discursive carousel”.

> *"Whereas the **focus** of medical education during the **present century** has been mainly on the understanding of **disease processes** as they affect **individuals**, on their **diagnosis** and **management**, there is an evident reawakening of the wider interest of our forebears in the **health of populations**, the **epidemic** and **environmental hazards** that affect them and the means whereby **diseases** may be **controlled** or **prevented**. **Public health**, temporarily lost from the vocabulary, has been firmly **reinstated** as a priority in the planning of medical services in this country and abroad, and the **undergraduate curriculum must reflect this important change of emphasis."*** TD1993, p. 4.

The following passage from the same document similarly positions public health as an important part of the future curriculum: a future which, judging by the repeated prominence of this discourse throughout the 20th century, is destined never to consolidate:

> *"The theme of **public health medicine** must figure prominently in the **curricula of the future**…(it) will be **relevant** to many parts of **the curriculum** and should **not** be seen by the student as comprising the content of a **compartmentalised course."*** TD1993, p.18.

While the NHS is charged with offering medical schools opportunities for practical teaching, it is not seen at this time as having a formal influence on the educational process. The GMC remains in charge of setting the principles of medical education, while universities are responsible for selecting students and delivering an appropriate curriculum. There is an assumption in the documents that these institutions are perfectly adapted to these roles, with no conflicts of interest. The following quote exemplifies these responsibilities:

> *"We (**GMC**), the **universities** and the **NHS** all have **different roles** in medical education. **We** have statutory responsibility for setting standards for **protecting the public**. **Universities** are responsible for **selecting students** into their medical schools and for **providing a curriculum** that will deliver the **learning outcomes** that **we set**. **NHS acute trusts and primary care organisations** are responsible for **making***

> ***available*** *the facilities and practical support necessary for delivering the clinical parts of the curriculum."* TD2003, p.25.

Nevertheless, changes in health care were undoubtedly having an impact on medical education policy. The broadening of teaching environments recommended in the previous analytical period (*"de-hospitalization"* discourse, 7.2.3) is reinforced by the latest guidelines, although with no suggestion of how much time should be spent in each setting. The almost identical passages below from the 2003 and 2009 versions of *Tomorrow's Doctors* emphasize the importance of providing a variety of teaching environments:

> *"**Clinical education** must reflect the **changing patterns of healthcare** and provide experience in a **variety of environments** including hospitals, general practices and community medical services."* TD2003, p26.

And:

> *"Placements should reflect the **changing patterns of healthcare** and must provide experience in a **variety of environments** including hospitals, general practices and community medical services."* TD2009 , p.54.

As well as underlining the importance of public health in medical education, the discursive strategy of patient-centredness constructed a change of focus from disease management to a more holistic perspective of the individual seeking medical care. However, the GMC policies do not present a particular concept of patient-centredness or refer to any other documents or policies in which this term appears. The quotes below from the two latest versions of *Tomorrow's Doctors* exemplify this:

> *"Graduates must be aware of **current developments** and **guiding principles** in the **NHS**, for example: **patient-centred care**…"* TD2003, p.15.

And:

> *"Recognise the principles of **patient-centred care**, including self-care, and deal with patients' healthcare needs in consultation with them and, where appropriate, their relatives or carers."* TD2009, p. 25.

The requirement to deliver a more comprehensive approach to health care teaching (e.g. promotion of health, public health, prevention of disease) is another example of curriculum content previously associated with a specific medical field of practice (in this case general practice) being extended to the curriculum as a whole; in other words, of the de-characterization of medical fields of knowledge and practice. General practice is equated with medical specialties but uncharacterized in terms of its particular features and expertise. The assumption that no special training is needed to develop the capacity for patient-centred care is present throughout this discourse.

8.2.4 Overspecialization

The discourse presented in these documents (TD1993, 2003, 2009) depicts a lessening of conflict between medical specialties for time and space in the curriculum: the overcrowded curriculum discourse in previous analytical periods is therefore discontinued. Overspecialization, however, is still presented as a difficulty and a justification for change. Certain areas of NHS provision which had gained importance in previous decades (e.g. palliative care, care for the elderly) are described as being neglected due to the overspecialized structure of hospitals and its influence on clinical training. The following passage exemplifies this:

> *"Care of the elderly and the chronic sick, understanding of the scope of rehabilitation, pain relief and care of the dying must all receive appropriate priority in a **clinical training that formerly was often biased towards the more***

> ***specialised activities of the teaching hospital****... Medical education must strive to comprehend all aspects of human disorder."* TD1993, p. 4.

The discursive strategies presented above had a direct impact on the characterization of general practice in this third analytical period. The following section describes general practice as a discursive object and subject position in the three versions of *Tomorrow's Doctors.*

8.3 Formation of discursive object and subject position: general practice as uncharacterized knowledge

In this section, I describe the characterization of general practice knowledge in this analytical period. The strategic discursive choices described above were the rules of formation for what was "thinkable" in terms of general practice knowledge in undergraduate medical education policy. I also describe the subject positions available for general practitioners which emerged from the analysis of general practice knowledge in medical education.

The following sub-sections present text from the policy documents to evidence these analytical findings. In a discursive context in which undergraduate medical education is free from disputes between medical specialties, general practice is presented as a specialty requiring postgraduate training, with no reference to previous discursive elements which differentiated it from other medical fields. Indeed, the documents of this period do not characterize any of the medical specialties. This de-characterization produced a major discontinuity from previous analytical periods described in Chapters 6 and 7. The description of specialties is assumed to be the responsibility of the relevant Royal Colleges and their training committees (postgraduate education). Placements in or outside

hospitals are given equal importance. The role played by general practitioners in medical education is not portrayed due to a discourse of competence beyond individual specialties. The characteristics and knowledge attributed to general practice in previous documents are now presented as broad goals for undergraduate students. As an educational outcome, general practice is defined and structured not by undergraduate medical education policy but by postgraduate training policies produced by the Royal College of General Practitioners (RCGP).

8.3.1 General practice as an uncharacterized medical knowledge and subject position

Unlike previous policy documents analysed, the *Tomorrow's Doctors* series does not attempt to define general practice or any other specialty in detail. Previously recognized differences in the ability and status of medical educators from different medical fields are also disregarded. While features such as those attributed to general practice in previous discursive periods continued to inform and integrate undergraduate policies, they were no longer associated with a particular medical specialty. Such attributes or competences, as described in the previous sections, were to be promulgated by all actors involved in medical education, regardless of their field. This repeats the discursive strategies of previous analytical periods, which sought a similar commitment to "redeeming" undervalued fields of knowledge and give them greater prominence in the curriculum (chapters 6 and 7). The "discursive carousel" relating to social and behavioural sciences, public health, prevention, promotion, family and community approaches to health

care continues to exercise policymakers, with the *Tomorrow's Doctors* series placing renewed emphasis on public health.

In this uncharacterized discourse, general practice is equated to other specialties, while general practitioners are seen as having proficiency and governance skills comparable to other medical specialists and consultants, as exemplified in the following passage:

> *"Graduation is an early threshold in doctors' careers. New graduates cannot be expected to have the **clinical experience**, **specialist expertise** or **leadership skills** of a **consultant or general practitioner**.* TD2009 p.5.

Previously omitted from the list of core disciplines in undergraduate education (chapters 6 and 7), general practice is now included in "*the big six"* medical fields, as described in the following passage:

> *"**Clinical placements** must be planned and structured to give each student experience across a range of **specialties**, rather than relying entirely upon this arising by chance. These specialties must include **medicine**, **obstetrics** and **gynaecology**, **paediatrics**, **surgery**, **psychiatry** and **general practice**."* TD2009 , p.54.

Similarly, the various clinical teaching placements are seen as having equal value as learning opportunities for students. No distinction is made between settings in terms of their potential and limitations and no judgement reached on where specific competences should be developed (i.e. in hospitals, general practices or community settings). This discourse confers further value to non-hospital settings, but offers little guidance on the optimal balance of learning opportunities, as the following passages from all three documents demonstrate:

> *"Clinical teaching must adapt to the **changing patterns of patient care in the health service**, not simply as an*

expedient but because education should reflect the realities of ***modern medicine****. Students in future will gain more of their clinical experience in* ***out-patient clinics, in general practice and in community health services*** *than they have in the past. The* ***traditional*** *series of attachments of* ***fixed duration*** *to* ***hospital firms*** *may be replaced by a more broadly based supervisory system which ensures that each student obtains the clinical experience laid down in the curriculum and demonstrates proficiency in the requisite clinical skills."* TD1993, p. 17.

And:

"Clinical education must reflect ***the changing patterns of healthcare and provide experience in a variety of environments including hospitals, general practices and community medical services****."* TD2003, p.20.

And:

"Placements should reflect the changing patterns of healthcare and must provide experience in a ***variety of environments including hospitals, general practices and community medical services."*** TD2009, p. 54.

Despite the increased importance attributed to general practice in the policy documents of this period, its uncharacterized quality in undergraduate medical education policy served to distance it from its role in health care. The subject position of a general practitioner described as equivalent to a consultant or specialist. No description of the role of general practice placements or of the teaching qualities required of general practitioners involved in medical education is emphasized. The characterization of general practice is delegated instead to the postgraduate committees of the RCGP, leaving general practitioners, in effect, to characterize themselves.

8.3.2 Other subject positions

The analysis identifies four subject positions that characterize general practice knowledge in the policy documents of this period. They are

the “future trainee”, the “competent doctor”, the “patient as centre”, and the “author”.

The future trainee position is produced by policy expectations that doctors will defer choices on specialization until these become absolutely necessary (i.e. after graduation). As described below, the future trainee will be a competent doctor who puts the patient at the centre of health care delivery.

The competent doctor, like the future trainee, is not focused on specialty knowledge but is instead defined by knowledge, skills, attitudes, behaviour and procedures. All medical specialties are expected to contribute to the development of these competences equally.

The patient-as-centre position encompasses features such as family and community, together with the social and psychological dimensions of health care. However, the position offered to patients themselves continues to be that of a passive actor in medical education.

The position of “author” in this period is available to general practitioners taking part in the education committee of the GMC, which has absolute jurisdiction over guidance published in this analytic period.

8.4 Reflections

The relative absence of a detailed description of general practice in the documents analysed above – in sharp contrast to the content of publications from the two previous periods – caught my attention. It felt to me as if general practice had gained power in undergraduate medical education during this period while simultaneously being dethroned. I missed a structured definition of the knowledge and role of general practice in undergraduate education and its potential to shape the teaching and learning process moving

forward. The position secured by general practice knowledge as a medical specialty like any other made me reflect on what really differentiates it as a particular field of medical knowledge.

8.5 Conclusions

For this third analytical period, I have analysed the discursive discontinuities produced by the *Tomorrow's Doctors* series of documents published by the GMC in 1993, 2003 and 2009. The discourse of this period positions the graduate doctor as a future trainee who has developed broad medical competences without needing to make an early decision on a career pathway. Undergraduate medical education is described as the foundation for future postgraduate training. The competence-based curriculum discourse shifts power from medical specialty departments to medical schools. General practice knowledge is uncharacterized and its previous features distributed across the curriculum. General practice is equated to a medical field of specialization and the general practitioner to a consultant or specialist. As an uncharacterized field of medical knowledge, general practice's participation in undergraduate medical education is not defined. Thus, the features that characterized general practice previously are given further importance, without being attributed to any specific field of knowledge. And despite achieving comparable status to other medical specialties, general practice is stripped of its distinctive contribution to medical education. This created a contradiction in the discourse.

9 HISTORY OF FAMILY MEDICINE IN MEDICAL EDUCATION IN BRAZIL

9.1 Introduction

This chapter presents a narrative of the history of family medicine in medical education in Brazil. Its aim is to offer some background for the reader and to contextualize the selection and analysis of national undergraduate policy documents, providing a setting for the discussion (in chapter 12) of the results presented in chapters 10 and 11.

9.2 History of family medicine in medical education in Brazil

Similar to the history of medical education in the UK, an important change in undergraduate medical education in Brazil occurred with the establishment, in the 1980s, of a universal health system, the Sistema Único de Saúde (SUS)(see section 9.2.2.1.1). This chapter is therefore organized into two main sections: medical education before the 1980s and medical education after the 1980s.

9.2.1 Medical education before the 1980s

This section describes the period in medical education history before the involvement of family medicine in undergraduate courses, along with the developments that eventually facilitate this change. The sub-sections below cover four different eras: the colonial and imperial era, the birth of Republicanism, the first half of the 19th century and the second half of 19th

century. This time frame is not proposed by my analysis, but the bibliographic references used for this historical account.

9.2.1.1 From colony to monarchy

Brazil's medical education history begins with the foundation of the first medical schools in 1808 by the Portuguese Royal Family, who had fled to the country to escape Napoleon's occupation of the Iberian Peninsula. These so-called Medical-Surgical Schools, based in Salvador and Rio de Janeiro, were part of a wave of institutionalization which also created libraries, theatres, schools and academies (Ferreira, Fonseca, & Edler, 2001).

Before the establishment of medical schools, healthcare was mainly provided by native and religious healers and by charity hospitals under religious governance (Batista, Vilela, & Batista, 2015). Few Portuguese physicians adventurous enough to come to Brazil at this time were professionally active. The concepts of generalist doctor or family medicine did not feature at all in the medical literature. The physicians were mostly Europeans who graduated in European universities.

A month after landing in Salvador (the then capital of Brazil), D. João VI, King of the United Kingdom of Portugal, Brazil and the Algarves (1816-1825), created Brazil's first medical school and military hospital, which later amalgamated to form the first medical college. In 1813, this and a second medical school in Rio de Janeiro were transformed into Academies, with the power to certify doctors in Brazil. These accomplishments helped consolidate the shift in Brazilian status from colony to monarchy (Batista, Vilela, & Batista, 2015). In 1816, the two schools were authorized to use existing charity hospitals for clinical placements. In the 1820s, after other

members of the Royal Family had returned to Portugal, D. Pedro I (D. João VI´s son) declared himself emperor of an autonomous Brazil (Amaral, 2007).

During this time, medical practice in Portugal was greatly influenced by developments in France (the anatomical-clinical model of medicine). This model also had a considerable impact on medical education in Brazil during the nineteenth century, supported by the Imperial Medical Academy (1829-1889), which was the country's main forum of debate on medical education and public health in Brazil (Amaral, 2007).

The political climate in Brazil throughout the 1800s was unstable, with social movements across the country agitating for greater political independence at a national and local level. This period of unrest coincided with the accession of D. Pedro II as emperor when he was 15 years old, ushering in what became known as the Second Brazilian Monarchy (1840-1889). At around the same time, Visconde de Sabóia, a graduate doctor from the Medical School of Rio de Janeiro, was sent to Europe (France, Italy, Austria, Belgium and England) to learn about advances in medical education. His report prompted more funds to be channelled into medical colleges, which in 1854 became Faculties with greater power to consolidate medical training, and would play a significant role in the later foundation of Brazilian universities (Batista, Vilela, & Batista, 2015).

The second half of the 1800s was accompanied by the end of slave traffic, increased exportation of agricultural products (especially sugar and coffee) and industrial development. The resulting population growth led to increased demand for education and health care. There was a recognition too that medical students required more practical training in order to develop

better clinical and laboratory skills, as opposed to the mainly theoretical tuition they were getting from the Faculties (Fonseca, 1995). This was a regular topic of debate at the Popular Conferences in Glória (a neighbourhood of Rio de Janeiro), convened by Professor Francisco Praxedes of the Faculty of Medicine, at which medical issues were discussed with a lay audience. Praxedes defined the state of medical education at that time as precarious (lacking funding and facilities for the study of the basic sciences) and excessively theoretical (Ferreira, Fonseca, & Edler, 2001).

In 1881, the government instituted a period of practical clinical teaching which was divided between surgery, general medicine and gynaecology and obstetrics. Despite the involvement of medical professors in the formulation of the proposed changes, much of the power over medical education was maintained by the national government. There was no intention at the time to expand medical education to other regions. Graduating doctors would most often travel to Europe for further training and the few who returned would work either for the social elite and/or for the charity and military hospitals. From the beginning, medical education in Brazil was mainly theoretical and hospital-based.

9.2.1.2 The Republican period

Brazil became a republic in 1889 as a result of economic, religious, political and military conflicts with the reigning monarchy. Slavery was abolished and there was a rising demand for power by state governments. The educational system, however, continued to reflect Brazil's social class divisions, clearly distinguishing liberal (upper class) from technical (lower class) professions. The opening of a third Brazilian medical school in Porto

Alegre in 1895 (the Faculty of Medicine of Rio Grande do Sul) confirmed medical education as the preserve of the higher social classes, despite epidemics of bubonic plague and yellow fever among the wider populace (Coradine, 1997).

9.2.1.3 The first half of the 1900s and the first medical school boom

The publication of the Flexner Report (1910) marked the end of the dominant European influence over Brazilian medical education. The USA instead became the main source of inspiration, not only on matters of health care and education but in the wider political and economic sphere. The chief impact of this influence was in the creation of universities and the inclusion of the natural sciences in medical school programmes. By 1930, another seven medical schools had opened (making a total of ten). In a trend which continues to the present day, these were mostly located in the richest regions of the country (Southeast and South), (Amaral, 2007).

During the first half of the twentieth century, Brazil's public health efforts were characterized by population-wide campaigns against epidemics (i.e. yellow fever, malaria). Individual medical care at this time was still provided by private doctors or the few charity and state hospitals. Merhy et al. (2011) called this period the "sanitary campaigns era". Its focus was on protecting Brazilian export activities: sanitizing ports where export goods were stored and eradicating diseases that might affect the economy. This sanitary model of health care was mostly based on a military model of control and intervention over individual and social bodies (Merhy, Malta, & Santos, 2011).

From the 1930s onward, medical schools became increasingly integrated with universities and the regulation of medical professional

practice. In 1931, the National Act 19.851 created the university statute, requiring higher education to be delivered by national universities. During the next 20 years, medical schools were transformed into public universities either at state (State Universities) or national level (Federal Universities). This is a similar movement described in the UK at the end of the nineteenth and beginning of the twentieth century (merger of medical schools with universities). By 1950, there were thirteen medical schools in Brazil, all publicly-run and located in state capitals (i.e. in an urban setting) (Batista, Vilela, & Batista, 2015).

The 1920s and 30s also saw the rise of the liberal model of medical care. Employers and employees began to fund medical care provided by self-employed (private) doctors, while health services, organized through a social security system, were offered to workers in urban conurbations and industries. This model of health care continued to expand until the 1960s and 70s when social security was universalized in Brazil. However, virtually all medical care at this time was purchased from the private sector (Merhy, Malta, & Santos, 2011).

9.2.1.4 The second half of the 1900s

During the second half of the twentieth century, the scope, content and management of medical education in Brazil came under increasingly scrutiny, due mainly to the establishment of international and national organizations with an exclusive focus in these areas. Despite the increasing privatization of medical schools and health services, the Pan-American Health Organization (PAHO) supported plans to build a health system and medical education geared towards prevention and public health. At the same time,

healthcare coverage provided by the national social security system increased and eventually became universal. Family medicine and community medicine also made their first appearance in a medical education context through postgraduate training in these fields of medical knowledge in the 1970s. This is further detailed below.

In 1950, the publication of Edward Bridge's book *Medical Pedagogy* inaugurated a global dialogue between medical education and educational science. Three years later the first World Conference on Medical Education (1953) was held in London, organized by the World Federation of Medical Education. Its recommendations included the creation of regional and national medical education organizations and the delivery of a basic curriculum through accredited medical schools (Batista, Vilela, & Batista, 2015). Similar conferences were held in Peru (1951), Chile (1955) and Mexico (1957) with the aim of improving medical education across South America. In 1961, Brazil held its First Conference on Internal Medicine Teaching, funded by the American Kellogg's Foundation. Together with a North American programme to train Family Doctors, this was especially influential in shaping the Brazilian model of healthcare and medical education (Amaral, 2007).

In 1952, medical schools requested a programme to evaluate medical education, funded by the federal government. Despite an acknowledgment from the then president, Juscelino Kubitschek, of the need for such assessment, no action was forthcoming. In 1956, The Brazilian Medical Association (equivalent to the British Academy of Medical Royal Colleges) set up a Medical Education Committee to evaluate medical schools in Brazil. The results of this assessment, though never published (therefore

remained unknown), were handed to President Kubitschek, who demanded action from the Ministry of Education. The National Congress, however, refused to prioritize the Committee's recommendations (Veras, 1981).

During the second half of the twentieth century, the USA, through an international technical committee, provided guidance to the Brazilian government on all areas of public administration. The chief result in terms of medical education was the opening of the system to private enterprise and the expansion of schools beyond urban areas (symbolized by the opening of a school in Brazil´s new capital, Brasília, which had been purposely built in the heart of the country). Between 1950 and 1960, 63 medical schools were created, half of which were private and 37 located in rural areas (20 of them private) (Amaral, 2007). By the 1960s, increasing American influence on medical education had resulted in the creation of teaching hospitals attached to universities and the internal division of medical schools into departments: both a belated response to the 1910 Flexner Report (Almeida, 1999).

The same decade also saw the creation (in 1962) of the Brazilian Association of Medical Education (ABEM), which organized annual conferences on important themes relating to medical teaching, and the Brazilian Regional Library of Medicine (BIREME), which launched South America's first journal of medical education, *Revista Educación Médica y Salud*. A ten-year health plan developed by PAHO in 1963 emphasized the shortage of doctors and proposed an expansion of medical schools in Brazil, which lasted until the 1980s (Pires–Alves, Paiva, & Hochman, 2008). PAHO also encouraged the development of natural science and social medicine disciplines, focused on disease and illness prevention.

During the Military Government (dictatorship) established in the 1960s (1964-1985), the relationship between Brazilian public policies and international interests grew closer, with the aim of creating an increasingly capitalist society. In the field of education, an agreement between the Brazilian Ministry of Education and the USA implemented reforms that privatized universities, including medical schools (Veras, 1981). The same agreement also placed controls on the political activity of university students.

In the 1970s, the first government-funded assessment of medical education was conducted in Brazil. The Committee of Medical Education, established in 1971, interviewed deans, teachers and students and visited 75 (of 76) schools (Rosa, 2001). The committee produced three important documents: (1) *Expansion of Medical Schools*, which charted the uncontrolled rise in the number of medical schools and student vacancies, and the precarious state of these schools; (2) *Medical Instruction and Teaching Institutions*, which discussed the relationship between health services and medical schools; and (3) *Internship and Postgraduate Medical Training*, which proposed changes to the final year of undergraduate courses and subsequent medical training. Rosa (2001) described the government's lack of response to these reports as a clear sign of its political and mercantilist interest in the continued and unregulated expansion of medical schools and student places.

However, the publication of the committee's reports led the board of directors of ABEM, which until then had supported the expansion of medical schools and other government actions, to change its position. In the 1970s and 1980s, it endorsed the Committee of Medical Education findings and recommended that new schools be created only after existing problems

with the medical education regime had been remedied. In the same period, two themes of relevance to the current research were discussed at ABEM's national conferences: community medicine (1975) and family medicine (1977). This was the first time these topics had been addressed in the context of medical training, marking an important step towards establishing family medicine and primary care as educational priorities.

During the second half of the 1970s, government-led programmes to expand health care coverage included PIASS (Program for the Ruralisation of Health and Sanitation Actions - 1976) for rural health services, SINPAS (National System of Pension and Social Assistance - 1977) for the health care of families of workers who had paid for government insurance and INAMPS (National Institute of Medical Assistance of Social Security 1979), a universal social security programme funded mainly by the State but to which employers and employees also contributed. Medical care continued to be predominantly purchased by the state from health care companies in the private sector. These companies enjoyed tax exemptions but were not responsible for covering all medical services: the most expensive and complex procedures (e.g. transplants) were provided by the state in university hospitals. This *liberal model* was supported by the international medical private sector through the supply of internationally produced biomedical equipment (Merhy, Malta, & Santos, 2011).

The main development in the 1970s was the regulation of medical postgraduate training in 1977, establishing responsible institutions and trainers and specifying trainees' roles, rights and duties. In 1975, the first Brazilian primary care project was founded in Porto Alegre (Project of a

Community Health System), creating the first postgraduate medical training in community health and producing the first primary care-led doctors (i.e. comparable with today's family doctor). In 1976, two similar postgraduate training programmes were launched in Recife and Rio de Janeiro, despite the lack of legislative support or jobs at the time (Falk J. W., 2004). These projects inaugurated the *community medicine* model in Brazil, but did little to change the positivist hospital and disease-centred focus of healthcare delivery or the indiscriminate consumption of healthcare products (Merhy, Malta, & Santos, 2011). The liberal model of healthcare in which patients are understood as consumers who demand diagnostic procedures and treatment interventions stimulated the rise in consumption of healthcare products. Family and community medicine were not part of undergraduate medical education at this time.

Despite the government-backed expansion of healthcare, supported by new laws and programmes, the end of the 1970s was marked by several organized strikes highlighting the deficiencies of national public health policy. The following decade saw further social and political turmoil, resulting in the end of the military dictatorship and re-establishment of democracy. During this period, health professionals and academics were active in social movements demanding the establishment of a national health system (Cunha, 1997). These movements consolidated a different discipline in medical knowledge which expanded the understanding of public health: *collective health*.

In order to understand the field of *collective health* and its importance in this historical period and in the second analytical era (chapter

11), I have included a section describing the development of this area of health science as distinct from public health. As described in the following section, *collective health* is a broader field of the health sciences, of which public health is one element.

9.2.1.4.1 Collective health / Saúde coletiva

According to Osmo and Schraiber (2015), the development in Brazil of the field of knowledge termed *collective health* (saúde coletiva) dates back to the 1950s and was consolidated in the late 1970s with the foundation of the Brazilian Post-Graduate Association of Collective Health (Abrasco). In health sciences, collective health was a product of the political movement of re-democratization and the establishment of healthcare as a universal right and a duty of the state. Paim and Almeida Filho (2000) recognized *collective health* as a field of knowledge in the health sciences that integrated the disciplines of epidemiology, healthcare planning and management, and health-focused social sciences. *Collective health* comprised both a theoretical approach to understanding the health sciences and an attitude towards healthcare practice that differentiated it from other fields of knowledge (Paim & Almeida Filho, 2000). These authors describe the conceptual definition of *collective health* as multi-faceted and evolving (Osmo & Schraiber, 2015) (Paim & Almeida Filho, 2000).

To Nunes (1994), the emergence of collective health reflected the broader socio-economic and political-ideological context of Latin America at that time. It is an attempt at epistemological change in health practices and the formation of a health workforce, moving away from the prevailing liberal and disease-centred health care model. The basis of collective health practice

had a dual focus: *preventivism* (focus on health prevention) and social medicine (focus on the health of social groups).

Preventivism was a counter-movement against a disease-centred healthcare model, which was fragmented into specialties and sub-specialties and not cost-effective (Osmo & Schraiber, 2015). An important influence on the development of healthcare in the USA in the second half of the twentieth century, *preventivism* was incorporated into medical schools through disciplines labelled “preventive medicine”, “comprehensive medicine” or “community medicine”. The latter signified an attempt to increase healthcare coverage and relieve social tensions due to socio-economic inequalities. These disciplines favoured a holistic approach to healthcare (Osmo & Schraiber, 2015), rooted in the shared epistemology of collective health and family medicine in Brazil. These common “roots” provided further evidence of the intimate relationship between the disciplines of public health, preventive medicine, social medicine, community medicine and primary care, and their close links to comprehensive care. This relationship is further explored in the second analytic period of Brazilian policy.

The social medicine dimension of *collective health*, which had its origins in the French Revolution and the industrialization of nineteenth century Europe, marked a shift of focus away from individual healthcare towards state involvement in public health problems. Rosen (1983) describes three principles that characterize social medicine: (1) people’s health is a social concern and society should protect and improve the health of its members; (2) socio-economic conditions have a direct influence on health and this influence should be scientifically investigated; and (3) health actions to promote health

and prevent disease should have both a social and an individual dimension. These principles were especially influential during the foundation of the SUS (Osmo & Schraiber, 2015). In 1974, Michel Foucault had delivered a critique of social medicine to the Brazilian academic community in Rio de Janeiro, calling it a tool for subordinating the “lower” (working) classes (Osmo & Schraiber, 2015). Foucault argued that social medicine doctors had to be aware of their capacity to support control of the working classes by higher classes. Following this, the focus of social medicine in clinical practice shifted towards health promotion (including developing people’s autonomy), a comprehensive and collective approach (away from the fragmented, expensive and individual-based medicine) and extending health care coverage (universal health service). Like the preventative approach mentioned above, social medicine links *collective health* to comprehensive care (through its recognition of a socio-economic dimension to illness) and to primary care (through universal access to healthcare).

9.2.2 Medical education after the 1980s

The 1980s were a time of significant change in medical care and education, both in Brazil and internationally, with major shifts towards universal healthcare focused on prevention, promotion and primary care. The impact of these developments on Brazilian medical education is described in the sub-sections below.

9.2.2.1 Medical schools between 1981 and 1996

At the beginning of the 1980s, the vast majority (81 per cent) of health services were provided by the private sector, while the government-funded social security system, which included healthcare, was on the brink of

financial collapse. The continuing conflict between public and private healthcare posed a major obstacle to the expansion of public services. Only public university hospitals were involved in medical education at this time. Medical practice, as described by Amaral (2007), was “predominately curative, technological, specialized, exclusionary and showed no preoccupation with improving the epidemiological profile of the population”. PAHO continued to present a counter-hegemonic stance: in conjunction with the WHO it proposed two alternatives to the community medicine and liberal models – a local health system (based on territorial coverage and focused on sanitary practices) and the concept of “healthy cities”. Although the implementation of these models in Brazil was limited to a few areas, most notably the city of Curitiba, some of their key features would influence the Family Health Programme of the 1990s (Merhy, Malta, & Santos, 2011).

Despite epidemics of dengue fever and HIV/AIDS, medical school curricula of this period were essentially unaltered and therefore no longer reflected the health demands of the population. The creation of new medical schools was halted between 1980 and 1985 following the publication of assessments carried out in the previous decade (9.2.1.4). In 1985 the government established a Medical Education Committee to conduct further inspections of medical schools and, through the Ministry of Health, launched a policy entitled *Medical Education Bases for Reformulation* to fund and regulate medical teaching in hospitals (at that time the Ministry of Education funded more university hospital beds than the Ministry of Health – (Ferreira, 2001). Compared with the boom in medical schools in previous decades,

between 1986 and 1996 just eight new schools opened, the majority of them private and located outside major urban areas.

Political momentum was gathering, however, for the implementation of a primary care-focused health system, led by the national councils of state health and social security departments and influenced by the Alma-Ata Conference Report (1978). At the same time, medical corporations were undergoing major structural changes more favourable to the expansion of public health. There was also a clear expectation that more doctors would be state-employed, giving them additional stability and workers' rights. This political environment was reinforced by the National Movement of Sanitary Reform, part of the collective health discipline, composed of health professionals and civil rights movements, which demanded the establishment of a universal public health system (Merhy, Malta, & Santos, 2011).

In 1981, the National Committee of Medical Post-Graduate Training recognized training programmes in "General and Community Medicine", thereby introducing a second term to describe the primary care field of knowledge (the first being *community medicine*). Coordinators of these training programmes, who had not themselves undergone primary care training (psychiatrists, clinicians, infectious disease specialists, etc.), in turn founded the Brazilian College of General and Community Medicine during ABEM's conference of 1981. The Brazilian GMC recognized this medical speciality in 1986.

During that same year, medical students formed a national body to represent their views in both healthcare and medical education policymaking. Its national conference issued a demand for further assessment of medical

schools and a radical transformation of medical education to deal more effectively with population health issues (Amaral, 2007).

The Brazilian National Health Service (SUS) was eventually created in 1988, uniting all previous public health programmes and creating a dedicated health budget (separate from the funding of social security) for the first time. Importantly, the SUS would be responsible not only for the public health system but also for regulating private services and determining the focus of health professional education, duties that would pit it against private interests in both the healthcare and education sectors. Responsibility over medical education in Brazil never relied on regulatory institutions like the Brazilian National Council of Doctors (CFM). Legislation published in the following years reinforced the regulatory power of the Ministry of Health over professional education.

The implementation of a primary care-led system took place gradually over the following decade, constrained by political disputes on several fronts. Private health organizations opposed the expansion of public healthcare, while social movements resisted the establishment of a selective primary care model targeting only the poorest stratum of the population, as advocated by the World Bank (Merhy, Malta, & Santos, 2011).

The Edinburgh Declaration, published in 1988 at the World Conference on Medical Education, also had a major impact on the medical education professions in Brazil. The Declaration was influenced by the World Health Conference of 1986 (Ottawa), which had emphasized the role of health promotion in national health systems around the world (Batista, Vilela, & Batista, 2015). In Brazil, this prompted a renewed effort during the 1990s to

assess medical schools, supported by ABEM and the Brazilian General Medical Council (CFM). The Declaration, however, went against a Brazilian government proposal to implement a national exam for graduate doctors, which had been recommended by the World Bank's report on higher education reform in Brazil. By supporting the deregulation of medical education, the policy would have promoted the indiscriminate opening of medical schools, especially private ones (Cunha, 1997). The proposed national exam would assess only the quality of students, not the schools themselves. ABEM and CFM opposed this omission, and the proposal was never implemented.

In 1991, ABEM and CFM created the National Inter-institutional Committee to Assess Medical Schools (CINAEM), made up of representatives from medical organizations, universities, medical schools, the teaching profession and student associations. The CINAEM programme developed over the next 10 years, culminating in the publication of the first *National Guidelines for Medical Courses in Brazil* in 2001, which were endorsed by the Ministries of Health and Education. The first phase of CINAEM's evaluation consisted of a self-evaluation questionnaire, which was completed by 78 of the 80 medical schools in Brazil. The results showed that medical courses were divided into two cycles (basic sciences and clinical sciences), curricula were mostly centred on diseases, students did not have an integrated perspective of the body, and health issues were dissociated from their social context. The evaluation also noted that medical teachers were not sufficiently qualified and that medical schools had little incentive to carry out research. The courses they offered mainly consisted of lectures to large groups of

students and had no point of contact with health services outside the university setting (CINAEM 1999).

The second phase of CINAEM's work, from 1993 to 1997, involved an external evaluation of medical schools. Inspectors visited 48 schools in total, nine of which were privately run. Their findings confirmed the results of the first-phase evaluation, but highlighted further deficiencies, including inadequate patient communication skills among students and a general resistance to change among university staff. The evaluation also determined that schools had ceded power to specialized medical departments operating mostly outside the national evaluation process and that the overall infrastructure – particular of university hospitals – was poor.

9.2.2.1.1 The SUS

The initial focus of the SUS leadership was on the decentralization of health services in Brazil. Federal, state and municipal funding was transferred to city governments, who were charged with planning and managing health services in accordance with national policies and local demands (although, paradoxically, most of the postgraduate medical training in general and community medicine at that time had ceased due to lack of funding). The Family Health Strategy (PSF), launched nationally in 1994, and the Programme of Community Health Workers were the main planks of a political strategy to implement primary care, with the aim of extending services to more than 60% of the Brazilian population by 2006. The intention was to replace previous basic health units run by doctors specialized in internal medicine, paediatrics and gynaecology and obstetrics. The PSF was territorially organized (the *local health systems model)* and centred on family

care. Every health team was to be multi-professional – comprising a family doctor, nurse, dentist, auxiliary nurse and 4-6 health community workers – providing comprehensive care integrated with other levels of service provision (the *healthy cities model)*. However, the same criticism levelled at *community medicine* models also applied to the PSF (Merhy, Malta, & Santos, 2011). Overall, the primary care strategy faced serious difficulties in delivering an adequate health workforce, especially trained family doctors.

In summary, this period was characterized by a major shift from a predominantly capitalist, liberal model of health care towards a more heterogeneous structure in which universal and comprehensive healthcare enjoyed increasing space and support. This was evidenced by the establishment of the national health system and by the primary care-led strategy. Primary care-led doctor training, however, had lost momentum, with just one programme surviving from the previous healthcare agenda. The next period of medical education would see the resurgence of family medicine, supported by the changes described above.

9.2.2.2 Between 1997 and the 2000s

The family health strategy continued to expand during the first half of the 2000s, increasing the job market for family doctors. To address chronic staff shortages, the government also created short-term diploma courses, providing faster but lower quality training. In 2001, the primary medical care specialty in Brazil changed its name to “Family and Community Medicine”, in accordance with the Family Health Strategy. Following recognition of the speciality by the National College of Medicine, exams for membership of the Brazilian College of Family and Community Medicine commenced in 2003.

Following ten years of assessments and reports from CINAEM, the first *National Guidelines for Medical Education* were published in 2001, which served to unite the various institutions involved in teaching. The document reiterated the problems highlighted in previous CINAEM reports and proposed several changes designed to close the gap between health demands, public health policy and the medical education curriculum. Later that same year, the government set up a programme to encourage a transformation of medical schools (PROMED 2001 – Programa de reforma dos cursos medicos – and PRÓ-SAÚDE 2005/2007 – Programa de Reforma dos cursos de saúde), offering financial support to those willing to implement the proposed changes. The programmes were not, however, sufficiently resourced to incentivize all schools in Brazil, which by then numbered 128 (59 in the state capitals and 69 in rural areas), half of which were private. In fact only 19 schools, all of them public, were included in PROMED (Batista, Vilela, & Batista, 2015).

In 2003, during the presidency of Lula da Silva, the Ministry of Health set up a department to oversee the education of health professionals. Called SGTES (Secretaria de Gestão do Trabalho e da Educação na Saúde), its goal was to implement the national guidelines for medical courses and guarantee the provision of health professionals through undergraduate and postgraduate training in line with the Family Health Strategy. This was followed in 2005 by a second incentive scheme for medical schools, PRÓ-SAÚDE, covering odontology and nursing and privileging institutions that offered family health and family medicine training programmes. The aim was to consolidate these programmes and steer medical courses towards postgraduate training in family medicine (Batista, Vilela, & Batista, 2015).

By the end of President Lula's second term (2007), 39 new medical schools had opened, bringing the nationwide total to 167. Of these, 89 were in rural communities and 78 in state capitals. This was a "third wave" of medical school expansion, creating a clear majority (98) of private institutions. As with the previous right-wing government, headed by the Fernando Henrique Cardoso, Lula's left-leaning administration provided a major opening for private involvement in higher education. But instead of justifying the expansion as a boost to the economy, the government now promoted it as a way to increase access to higher education (Amaral, 2007).

This period, in short, saw the first links between primary care and undergraduate medical education, together with a significant expansion of postgraduate training in family and community medicine. Policies published during this time signalled a move away from an era in which family medicine was essentially absent, and are therefore of particular interest to the current research. In the next section, I explain how more recent developments have reinforced these changes.

9.2.2.3 The 2010s

In accordance with health policies promoting medical education reform, the government continued in the 2010s to invest in those medical schools and universities following its primary care agenda. This investment was regulated by the PROSAUDE policy mentioned in the previous section and by the so-called PET-Saúde programme, set up in 2010 to promote health professional education in the workplace (Brazil, 2010). ABEM continued to focus on the assessment of medical schools through a body called the Committee of Evaluation of Medical Schools. In 2013, the Mais

Médicos (More Doctors) programme acknowledged the demands of health professionals for additional primary care, especially in remote countryside areas and the outskirts of large cities. The Mais Médicos policy recommended an increase in primary care placements for undergraduates and created a new medical specialty, Family and Community General Medicine. By 2018 it was expected that all postgraduate students would be required to undergo training in this discipline before accessing further training in other specialties (Batista, Vilela, & Batista, 2015).

A new National Guideline for undergraduate medical education, published in 2014, adapted the goals of the 2001 guidelines to those of the Mais Médicos programme. This was particularly evident in the priority given to primary care over other clinical placements.

9.3 Conclusions

Medical education in Brazil began in state-regulated institutions that rapidly converted into universities. The training of doctors therefore took place within a formal model of education. The development of family medicine came later in the history of medical education in Brazil. The first attempts in the 1970s to create a medical field of knowledge dedicated to primary care, i.e. beyond the hospital setting, were frustrated by the lack of governmental support for public health and the dominance of a liberal model of service delivery. The participation of family medicine in medical education was not consolidated in the Brazilian context despite the formal acknowledgment of its specialty status as a field of knowledge.

The history of Brazilian medical education in this period is also dominated by conflicts between private and public healthcare. The

establishment of the SUS gave further impetus to public services in opposition to the private sector and created an expanding market for family doctors throughout Brazil. This has had a positive effect on the consolidation of the specialty and its training programmes across the country (Falk J. W., 2004).

The contextual background of medical education in Brazil, and the role of family medicine within it, helped define the period under analysis in this study, which begins with the establishment of the national health system and the subsequent inclusion of primary care in medical education. It also helped me to identify the policy documents to be analysed in this investigation and to build a clearer picture of the social, political and economic context in which they were drafted. The results of this analysis are presented in chapters 10 and 11.

10 COMPREHENSIVE CARE DISCOURSE IN BRAZIL AND THE ABSENCE OF FAMILY AND COMMUNITY MEDICINE IN UNDERGRADUATE MEDICAL EDUCATION POLICY

10.1 Introduction

The aim of this and the following chapter is to present the results of the analysis of documents covering a period from the foundation of the Brazilian national health service (Sistema Único de Saúde – SUS) in 1988 to 2010. As described in chapter 9, this period saw a significant change in undergraduate medical education discourse with regards to the characterization of family medicine knowledge. Before the creation of the SUS, neither primary care nor family medicine was included in undergraduate medical education. With the establishment of the SUS and an accompanying primary care strategy, the Family Health Strategy (PSF), medical education reforms took major strides towards promoting a national healthcare policy. Table 11 summarizes the results of the analysis.

Table 11. Division of the analytical results of Brazil's medical education policy.

Discursive characterization of family and community medicine in medical education policy in Brazil in late 20th century	
Chapter 10 Family and community medicine's "absent presence" through comprehensive care discourses (1980s–2010s)	Chapter 11 Family and community medicine as collective health knowledge (2010s)

This chapter contains the results of the analysis of documents between 1988 and 2010, a period of a relatively uniform discourse in the characterization of family medicine in undergraduate medical education. I have chosen five main documents published in this period: CINAEM's (Medical Education Inter-institutional Assessment Committee's) Third Phase Report of 1997; the 2001 *National Guidelines on the Medical Undergraduate Curriculum*; the PROMED 2001 policy to incentivize medicals schools to adopt the national guidelines; the PRÓ-SAÚDE 2005/2007 policy, which had a similar focus; and the 2007 guideline on primary care teaching in undergraduate medical education produced by ABEM. These were identified as the principal national policy documents concerning undergraduate medical education published in this period of analysis, as described in chapter 4 (methodology).

As described in chapter 9 CINAEM's assessment of medical education in Brazil was a major mobilizer of reform in Brazilian medical schools. Its Third Phase Report of 1997, which recommended a halt to the opening of new medical schools and an assessment of existing institutions, detailed the progress and limitations of previous phases of reform and set out the direction medical education should follow in meeting the health demands of the Brazilian population. The National Guidelines of 2001 were a key product of this re-evaluation and encouraged a collective effort by medical schools and professional institutions to produce consensus on how medical education in Brazil should be structured and organized. The PROMED and PRÓ-SAÚDE policies were an attempt by the Brazilian government to promote and fund medical schools in implementing the changes proposed by

the national guidelines. However, these later documents also embodied a more radical shift of emphasis towards primary care in medical education. Finally, the ABEM-commissioned document of 2007 was an attempt to clarify the role of primary care in medical education and how teaching at this level of health care could be developed. This was the only document of the period to be written by a single author, Prof. Gastão Wagner, a specialist in public health and preventive medicine.

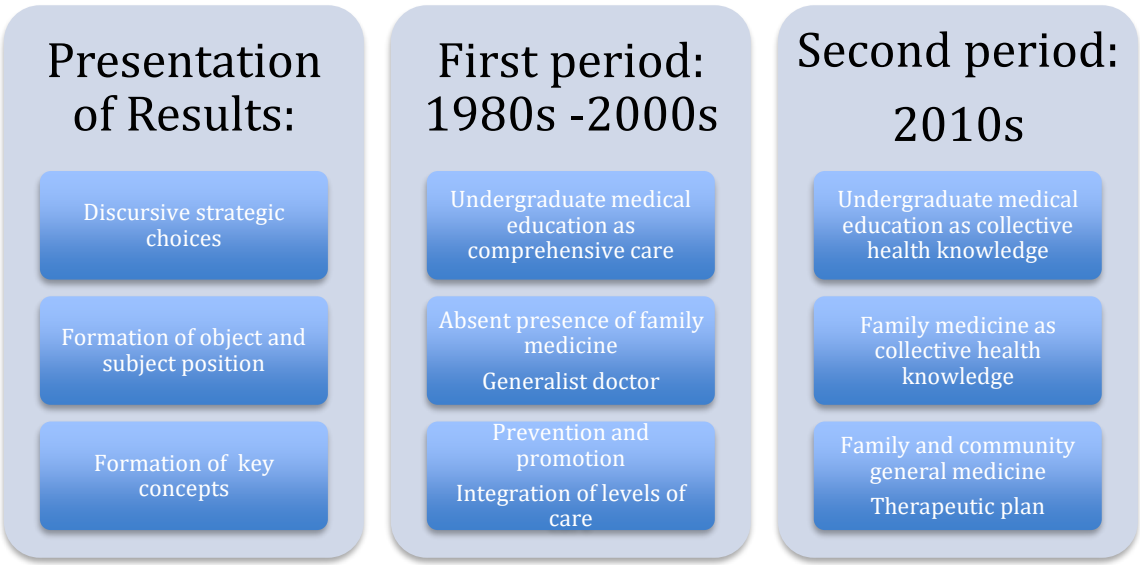
The presentation of the results of the analysis of Brazilian policies follows the same format as that of previous results chapters. I start by describing the overall discursive strategy or assumptions of truths that underpins the characterization of family community medicine in this period and the key concepts that link this strategy to the discursive object. This is followed by a description of the discursive object itself and the subject positions available for family and community medicine in the discourse described (Table 12 summarizes these findings).

It is important to remember that, until 2001, family and community medicine in Brazil was termed “general and community medicine”. In this and the following chapter, I will use the term “family and community medicine” to refer to this specialty in Brazil. While the specialty was recognized by the Brazilian Federal Medical Council (CFM) in 1986, the title of Member of the College of Family Medicine (SBMFC) was only established in 2003, when the Brazilian Medical Association (AMB - equivalent to the UK’s Royal College of Physicians) approved the designation and its qualifying examination. Family doctors in this period chose to exclude the term “general” from the description

of their work. This produced a distancing from the notion of general medicine as a non-specialty, requiring no postgraduate training.

This marks a difference with the UK's history of general practice: in Brazil, the primary medical care doctor is a specialist from the beginning. The term "family and community medicine" instead sought to portray this field of knowledge as a medical specialty – a dimension of the production of power which the current chapter attempts to analyse. However, through the broad and detailed reading of the policies and the coding process, I could find no evidence that this influenced the characterization of family medicine in national policy documents of this period. This is further detailed in the sections below. The influence could only be further explored in the discussion chapter in which I argue that being a specialty field of medical knowledge (requiring further training after basic medical education) could have influenced how family medicine was excluded in this first analytical period.

Table 12. Summary of the results of the analysis of Brazilian medical education policy



I analysed the policy documents in their original language as described in the method chapter (4). I translated the extracts chosen to support the analysis from Portuguese (their original language) to English. I present both the Portuguese and English versions of a quote in the first two examples as a demonstration of the translation process. The quotes thereafter are presented in English only. The knowledge and experience I have gained throughout my academic and professional life in both countries guided me in translating specific terms into their most meaningful equivalent from a UK medical education perspective.

Among the more important of these terms were “comprehensive care” and “generalist doctor”. In Portuguese, the former is termed “integralidade” which, translated literally, becomes “integrality” in English. I opted instead for the term “comprehensive”, which is widely used in UK public health and medical literature. In using the term “generalist doctor”, I firstly wanted to differentiate this role from the concept of general practitioner as understood in the UK. Secondly, I wanted to emphasize the different nomenclature used to refer to the proposed end product of undergraduate medical studies during the analytical period described in this chapter and the medical specialty of “family and community medicine” (or “general community medicine”, before 2001).

In the first section of this chapter, the main discursive strategy identified is that of comprehensive care. This is introduced into medical education through reference to the national public health policy that laid the foundations of the Brazilian national health system (SUS). In this context, comprehensiveness is presented as a counter-discourse to the

biomedical/disease-centred and liberal/private healthcare model that had prevailed in Brazil until that time (see chapter 9). The concept of comprehensive care was explored and expanded by various theoreticians, becoming an all-embracing model of healthcare. Medical education policy described it as including: (1) the integration of basic and clinical sciences; (2) health promotion, prevention, treatment and rehabilitation; (3) a bio-psychosocial perspective of health and illness; and (4) the integration of all levels of healthcare (primary, secondary and tertiary).

Comprehensive care discourse was a fundamental tool in promoting the changes described by the CINAEM report of 1997, including its call for a medical education system that prioritized the healthcare demands of the population as opposed to the demands of the market. The comprehensive care discourse supported the introduction into medical education of discursive elements (key concepts) that were intimately related to the existing medical specialty of family and community medicine, such as: primary care; family and community approach to health care; an emphasis on prevention and promotion; and the integration of primary, secondary and tertiary care.

The following section describes general practice knowledge as a discursive object and subject position. Despite the presence of the key concepts described above, “family and community medicine” does not emerge as a discursive object in this first period of analysis. It is configured essentially by its absence, highlighting a struggle for power in the public health system and medical education between the medical and governmental institutions. Through its absence, family medicine is de-legitimized in the medical education curriculum, although the presence of primary care and its principles

paved the way for its formal recognition in medical education policy in the following decade, as discussed in the next chapter (11). Primary care, whilst clearly identified with public health and social medicine knowledge, emerges as an area of dispute within the medical curriculum. This is further described in this chapter as various field of medical knowledge are described as being involved in teaching in that setting.

The subject positions available for clinical tutors in primary care in this period ranged from public health and clinical specialists, to specialists in family health (with reference to the Family Health Strategy). This served to produce subject positions that could otherwise be attributed to family and community doctors in undergraduate medical education, despite the clear presence, in the policy documents, of discursive elements that characterized it as a medical specialty by professional institutions.

10.2 Formation of discursive strategy and concepts: undergraduate medical education as comprehensive care

This section describes the discursive strategy of comprehensive care and the key concepts that characterize the “absent presence” of family and community medicine in the medical education policy of this analytical period. The discourse of comprehensive care is presented in medical education policies as an aggregate of concepts relating to medical training and care. The most relevant reference to this discourse before its appearance in medical education is in the public health policy clauses of legislation establishing the Brazilian national health system (SUS) in 1988. Comprehensive care is presented as a combination of health services and actions concerning disease prevention and treatment of individuals and

communities at all levels of care (primary, secondary and tertiary), as described in the following quote:

> *"II. Integralidade de assistência, entendida como conjunto articulado e contínuo das ações e serviços preventivos e curativos, individuais e coletivos, exigidos para cada caso em todos os níveis de complexidade do sistema"* Lei 8080 (1988).

> *"II.* ***Comprehensiveness*** *of care, understood as an* ***articulated*** *and* ***continuous*** *set of* ***preventive*** *and* ***healing actions*** *and* ***services****,* ***individual*** *and* ***collective****, required for each case at* ***all levels of complexity of the system****"* Law 8080 (1988).

Comprehensive care discourse incorporates a range of different healthcare dimensions. The first involves health actions and services which go beyond the treatment of diseases, including disease prevention. This followed many international world health conferences (e.g. Alma Ata and Ottawa) and the gradual re-democratization of Brazilian politics, including the active political participation of individuals (health professionals and patients) and collectives in the formulation of health policies. The Alma Ata Declaration (1978) emphasized the role of primary care in delivering universal and comprehensive health services, while the Ottawa Charter for Health Promotion (1986) set a target of health promotion for all by the year 2000. These documents were particularly influential in the foundation of the SUS and the drafting of the CINAEM reports and created a major shift from the then dominant "liberal" model of health care, which focused on diagnosis and treatment.

The second dimension of the comprehensive care discourse produced in the quote above is the need for health care to focus simultaneously on the individual and on the collective (i.e. family and community). Historically, governmental efforts in public health in Brazil were

centred on large-scale campaigns, dictated by the epidemiology of infectious diseases. Medical treatment of individuals was provided mostly by the private sector, co-funded by employers, employees and the government. In the 8080 Law (1988 – leading to the foundation of the SUS), both an individual and collective approach to healthcare are incorporated into the responsibilities assumed by the government through a public health system (see chapter 9).

The third dimension of the comprehensive care discourse characterizes that care at all levels of complexity (primary, secondary and tertiary) should work towards the same goal, namely the maintenance of health for individuals and the population as a whole. This is an important change from the previous model of hospital-centred care, in which treatment took no account of the social context and environmental conditions to which a patient would return after discharge.

From this initial policy definition, the understanding of comprehensive care was expanded and explored in different discursive settings. In medical education, the *National Guidelines for the Medical Curriculum* (DCN 2001) ensured a place for comprehensive care in medical undergraduate policy through a discourse of competence development, but without presenting this as something new or transformative:

> *"Parágrafo Único. Com base nestas competências, a formação do médico deverá contemplar: o sistema de saúde vigente no país, a atenção integral da saúde num sistema regionalizado e hierarquizado de referência e contra-referência e o trabalho em equipe." DCN 2001, p.3*

> *"Single paragraph. Based on these **competences**, the doctor's training should include: the health system functioning in the country, **comprehensive healthcare** in a regionalized and hierarchical system of referral and counter-referral and teamwork. "DCN 2001, p.3*

The discourse of comprehensive care is particularly important for the inclusion of primary healthcare in undergraduate medical education. In Brazil, the implementation of primary healthcare pursued both a selective (offering focused services to e.g. hypertension, diabetes, tuberculosis) and comprehensive model (offering services to all). The selective model is often referred to as “basic health assistance” and the comprehensive model as “primary healthcare”. Both terms appear in public health and medical education policies of this period.

The following five dimensions of the comprehensive care discourse, as presented in medical education policy, enabled the introduction of primary care into the curriculum: (1) integration of the basic and clinical sciences; (2) health promotion, prevention, rehabilitation and a raising of political awareness among medical graduates; (3) a bio-psychosocial perspective of health and illness; (4) integration of all levels of health care (primary, secondary and tertiary); and (5) individual and collective (family and community) approaches to healthcare. These dimensions are key concepts that both differentiate family and community medicine as a medical specialty and characterize its “absent presence” in policy documents which define this specialty (SBMFC, 1986 and 2001). The absence of family medicine in medical education policy, despite recognition of its underlying concepts, demonstrates a denial of its existence and a struggle for control over the medical curriculum. Clinical teaching towards comprehensive care would still be under the aegis of the hospital specialties. In this discursive context, there was no space for a “new” medical specialty that could unite knowledge from both social medicine and clinical practice.

The concepts listed above were, however, fundamental to the incorporation of primary care into medical education in Brazil, which was previously dominated by the university teaching hospitals. The following sections describe these five dimensions and present quotes from policy documents to exemplify each of them.

10.2.1 Integration between the basic and clinical sciences

This section describes the first of the discursive concepts outlined above. In medical education policy in Brazil, the integration of basic and clinical sciences was part of the comprehensive care discourse. The latter was expected to combine the three phases (basic sciences, pre-clinical sciences and clerskship cycles) of the six-year medical education programme in Brazil. According to the CINAEM Report (1997) the basic sciences cycle of the time, with its focus on “a biological individual patient” and “an absolute predominance of biological knowledge content”, had no connection to clinical teaching, while during the clinical cycles, teaching and practice of the clinical interview and physical examination took no account of knowledge from the social sciences, public health and mental health. This distinction between basic and clinical sciences did nothing to promote a “psychosocial” perspective of the patient’s experience of illness. By contrast, the comprehensive care discourse supported the integration of these cycles of the undergraduate course to create a holistic approach to healthcare.

In the national guidelines of 2001, the problems identified by the CINAEM report were addressed through the comprehensive care discourse. The teaching of social, psychological and environmental aspects of health and

illness was expected to inform the clinical development of medical students through a shared focus on the resolution of health problems. The following passage exemplifies this integration:

> *"Art. 5 The training of the physician aims to provide the professional with the **knowledge** required for the exercise of the following specific **skills** and **abilities**:*
>
> *…*
>
> *VI - to master the **basic scientific knowledge of the bio-psychosocial and environmental nature underlying medical practice** and to have a critical reasoning in the interpretation of data, in identifying the **nature of the health problems in medical practice and their resolution**"* DCN 2001, p 2.

The behavioural and social sciences were described as basic sciences that would support medical professionals in understanding health problems and how to solve them. The description of the competences attributed to medical graduates combined the traditional medical disciplines (i.e. physiology of gestation, birth, growth and development) with the dimensions of a comprehensive approach to healthcare (i.e. health promotion), as illustrated in the passage below:

> *"VI - **promotion** of health and understanding of the **physiological** processes of human beings - gestation, birth, growth and development, aging and death process, physical activities, sports and related **social** and **environmental factors**."* DCN 2001, p. 4.

This key concept in comprehensive care discourse was expected to promote the integration (de-compartmentalization) of disciplines both in medical schools and in medical practice through the work of newly-graduated doctors. In the curricular structure, the integration of basic and clinical sciences was constructed by the dissolution of the division between theoretical and practical teaching and learning. One of the proposed actions

to integrate both dimensions was the incorporation of practical teaching from the beginning of the course to connect the theory of basic sciences with the development of clinical skills. As part of this integration process, it was recommended that students attend early clinical placements and take on responsibilities commensurate with their level of training and autonomy. The following passage from the 2001 national guidelines illustrates this expectation:

> *"Art. 12. The structure of the Medical Undergraduate Course should:*
>
> *IV - **promote integration and interdisciplinarity** in coherence with curriculum development, seeking to integrate the **biological, psychological, social and environmental dimensions**;*
> *V - insert the student **early** in practical activities relevant to their future professional life;*
> *VI - to use **different teaching-learning scenarios** allowing the student to know and experience varied life situations, **varied healthcare levels** and work in a multiprofessional team;*
> *VII - foster the active interaction of the student with users and health professionals from the **beginning of their training**, offering the student **real problems, assuming increasing responsibilities compatible with their degree of autonomy**, which consolidates during clinical clerkship before final graduation; and*
> *VIII - link, through the integration of teaching and health services, **medical-academic training to social health demands**, with emphasis on SUS."* DCN 2001, p. 5.

Primary care was considered the clinical setting that united the components described above. Clinical sciences were to be integrated with the fields of public health, social and psychological sciences, taking account of environmental influences on the health of individuals, families and communities. Other arguments used to justify the addition of primary health care to medical education include the broad capacity of primary care to solve health problems and the expansion of Brazil's primary care services as a

strategy to offer universal access to health care. Primary healthcare is presented as a solution to the problem of healthcare access for impoverished populations, a point also emphasized by the governmental policies, PROMED 2001 and PRÓ-SAÚDE 2005. This is demonstrated in the following quote from the 2007 guidelines on primary care teaching, in which primary care is referred to as the "basic health network" (ABS):

> *"WHY TEACHING IN THE BASIC HEALTH NETWORK?*
> *There is a generic curricular recommendation that medical training should offer a range of **different scenarios** for practical teaching. In the same line, it is recommended that the student be inserted from the **beginning** of the course into practical activities.*
> *In addition, if the **basic network** (ABS) is expected to solve **80**% of the population's health problems, if we accept that the interventions in the territory are very complex, and if we add to this the fact that a large part of the Brazilian population lives in poverty, we will have clear technical and ethical evidence that our medical schools should form a **competent professional to intervene in this reality**. In this sense, the **basic network is a potential and necessary field of practice**, in which the various training courses for health professionals should include their students. "ABEM 2007, p. 8.*

The ABEM document proposed that medical education should produce a graduate doctor prepared to practise in primary care, a policy goal which appeared to go beyond the preliminary intention of integrating basic and clinical sciences and theoretical and clinical teaching. The national guidelines of 2001 had also attributed to the newly graduated doctor the capacity to practise mainly in primary and secondary care (as distinct from hospital-based doctors), as demonstrated by the following quote:

> *"II - to act in the different levels of healthcare, with **emphasis** on **primary** and secondary care"* DCN 2001, p. 2.

The introduction of these new teaching scenarios, in accordance with the discourse of comprehensive care, produces a different subject

position for the medical student and graduate: that of a primary care or basic-assistance doctor. This is further discussed in the section on discursive object and subject positions below.

10.2.2 Health promotion, prevention and rehabilitation

This section describes the discursive concepts of promotion, prevention and rehabilitation. These were presented as countering prevailing models of medicine, with the particular goal of expanding healthcare from the dominant "treatment-focused" approach (CINAEM, 1997). The health promotion dimension of this policy required the medical graduate to take a political stance regarding social responsibility and citizenship, as illustrated in the text below from the 2001 National Guidelines. This new emphasis was a response to the political context of the establishment of the national health system (post-dictatorship and re-democratization) and to the findings of the CINAEM report (see Chapter 9). The main focus of the CINAEM results was the gap between medical education and social health demands in Brazil due to the private/liberal organization of medical care, as explicitly mentioned in the 1997 report. The following quote illustrates this wider healthcare discourse:

> *Art. 3 The Undergraduate Course in Medicine has as a profile for the graduate doctor: a* ***generalist****;, humanistic, critical and reflexive training, capable of acting, based on ethical principles, in the health-disease process at its different levels of Health Care, with actions of health* ***promotion****,* ***prevention****,* ***recovery*** *and* ***rehabilitation****, from* ***comprehensive care*** *perspective, with a sense of* ***social responsibility and commitment to citizenship****, as a promoter of the* ***comprehensive health of the human being****."* DCN 2001, p. 1.

As described previously, the comprehensive care approach configured a broad discourse, which encompassed many dimensions. The previous quote exemplifies how the wider approach to healthcare also included “different levels of health care”, turning away from the dominant model of hospital-centred teaching. Primary care is presented as a privileged setting for promotion, prevention and rehabilitation (PROMED 2001 and PRÓ-SAÚDE 2005) while also delivering disease-centred healthcare based on the biomedical model. It was expected that the proximity to the patient’s family and community context would facilitate a shift in the medical paradigm. The primary care setting would also enable the inclusion of patients as politicized subjects in the management of health services as part of the health promotion dimension. The following passage from ABEM’s 2007 document illustrates the link between primary care and a comprehensive approach:

> *"Migrating (medical) education to basic health assistance does not automatically mean migrating teaching into a new **paradigm**. Frequently, the basic health assistance reproduces, under limited conditions, the same **model** (**biomedical**) of health care of **specialized** services.*
>
> ***Comprehensive care** depends on the **reformulation** of the traditional **biomedical** paradigm. In order to do this, it is recommended to understand the subject (patient) in his **family and in his economic, social and cultural context, as well as to involve the users (patients) both in the management of the health system and in the construction of his own health."*** ABEM 2007, p. 8.

The above text illustrates how the discourse of comprehensive care and the key concepts related to it were associated with basic assistance/primary care’s proximity to families, communities and social environment. The advantaged position of primary care with regards to families and communities provided the optimum scenario for the widening of the

healthcare approach. The quote also further justified the inclusion of primary care in the medical curriculum.

The other facets of healthcare (i.e. promotion and prevention) were explicitly associated with both individuals (i.e. patients, citizens, clients) and population groups (i.e. families and communities), thus reinforcing their link to primary care. This intimate relationship is exemplified in the following quotes:

> *"Art. 5 The training of the physician aims to provide the professional with the **knowledge** required for the exercise of the following specific **skills** and **abilities**:*
>
> *I - **promote healthy lifestyles, reconciling the needs of both their clients / patients and those of their community, acting as an agent of social transformation**;*
>
> *…*
>
> *IV - inform and educate their patients, families and community about health **promotion**, **prevention**, **treatment** and **rehabilitation** of diseases, using appropriate communication techniques;"* DCN 2001, p. 1.

And:

> *"The essential contents for the Medical Undergraduate Course must be related to the **whole health-disease process of the citizen, the family and the community, integrated with the epidemiological and professional reality, providing the comprehensiveness of the actions of medical care**."* DCN 2001, p. 3.

In this last quote, primary care is characterized as requiring an adaptation of medical education to the epidemiological and medical professional context of the national health system. This level of integration (medical education and the reality of health care for individuals and populations) produces a counter-discourse to that of university hospital-centred teaching, which is assumed to be distant from the Brazilian health

context in the national health system. The comprehensive care discourse thus becomes a means of subtly opposing the dominant status of clinical practice.

10.2.3 Biopsychosocial model of health care

This section describes the third key discursive concept that links comprehensive care to the absent presence of general practice knowledge. The biopsychosocial model of healthcare is presented as another facet of comprehensiveness. As with the other dimensions of the comprehensive care discourse, the biopsychosocial perspective is presented as a counter-discourse to the dominant biomedical model (CINAEM, 1997). The aim was to provide students with a broader understanding of the relationship between health and illness through the integration of basic and the clinical sciences, as described in a previous section.

Students should be exposed to the patient's psychological (i.e. family) and social (i.e. community) context through primary care in the early years of the course and retain this focus in later years as they move into the hospital setting. Students would not only acquire knowledge about the broader model, but also apply it in medical practice at all levels of care. The passages below illustrate the use of this discourse:

> *"Art. 5 The training of the physician aims to provide the professional with the knowledge required for the exercise of the following specific skills and abilities:*
>
> *…*
>
> *VI - to master the* ***basic scientific knowledge of the bio-psychosocial and environmental nature underlying medical practice*** *and to have critical reasoning in the interpretation of data, in identifying the nature of the problems of medical practice and in their resolution;"* DCN 2001, p.1.

And:

> *"IV – promote integration and interdisciplinarity*

> *throughout the curriculum development, seeking to integrate the* ***biological, psychological, social and environmental*** *dimensions;"* DCN 2001, p. 5.

Describing biopsychosocial knowledge as part of medical practice in this way can be seen as a discursive attempt to integrate basic sciences and clinical work. Early clinical placements in primary care were designed to make students aware of the importance of such integration and take this mode of understanding into hospital settings.

The inclusion of other levels of healthcare beyond university hospitals, especially primary care, would also deliver many of the modifications proposed in the national guidelines of 2001 (PROMED 2001 and PRÓ-SAÚDE 2005). This is further discussed in the following section.

10.2.4 Integration of "all levels" of healthcare

This section describes the fourth discursive concept relating comprehensive care to primary care in medical education policy. The inclusion of other levels of health care (primary and secondary services) in the medical curriculum was another dimension of comprehensive care and put the centrality of university hospitals in question. The national guidelines place no emphasis on where teaching should take place. The three levels of health care mentioned (primary, secondary and tertiary) are given equal status in regard to teaching. However, the newly graduated doctor was described as being prepared to work especially in primary and secondary care. This reinforced the commitment of medical education policy to the national health system's expansion of primary care (through the implementation of the Family Health Strategy) without discursively displacing the university hospitals'

teaching power or the dominance of medical specialties over their field of knowledge and practice. Moreover, the inclusion of “all levels” of care implied an integration between them, so that no health action took place in isolation – a further break from the dominant practice. This discourse guaranteed the presence and importance of primary care and its principles but without explicitly identifying family medicine knowledge as part of the medical education curriculum.

In the following description of the graduate doctor there is no distinction between levels of care where he/she will practice: all are equally important for the student’s learning of the dimensions of comprehensive care:

> *“Art. 3 The Undergraduate Course in Medicine has as its graduate profile a generalist, humanistic, critical and reflexive training, capable of acting, based on ethical principles, in the health-disease process* ***at its different levels of health care****, with actions of promotion, prevention, recovery and rehabilitation to health, from the perspective of integral (comprehensive) care, with a sense of social responsibility and commitment to citizenship, as a promoter of the integral health of the human being.”* DCN 2001, p. 1.

Not only are “all levels” of care included, but health actions are to be cohesive across the public health system. The following quote highlights the expectation that doctors will provide such an “integrated and continuous” practice:

> *“Art. 4 The training of the doctor aims to provide the professional with the knowledge required to exercise the following general skills and abilities:*
>
> *… Each professional must ensure that their practice is carried out in an* ***integrated and continuous manner with other instances of the health system****, being able to think critically, analyse the problems of society and seek solutions to them.”* DCN 2001, p. 1.

The emphasis on primary and secondary care was presented only

gradually in these guidelines, once the equal teaching status for “all levels” had been asserted. This emphasis was in line with the national public health policy of expanding a primary care service that was struggling to fill medical posts under the Family Health Strategy. At the same time, the guidelines protected the power of medical specialties over their professional field, ensuring that doctors would only be allowed to practise after postgraduate training. The following quote exemplifies this:

> *“Art. 5 The training of the physician aims to provide the professional with the knowledge required for the exercise of the following specific skills and abilities:*
>
> *…*
>
> *II - to act in the **different** levels of health care, with **emphasis** on the **primary** and **secondary**;”* DCN 2001, p.1.

In the following quote, the dominance of the comprehensive approach to health care is reaffirmed at all levels of care. The essential technical tools of medicine (history taking, physical examination and therapeutics) and its scientific qualities are directly associated with comprehensiveness of care and again with primary, secondary and tertiary care. The passage below highlights the equal status of these different levels of care and how the merger of the comprehensive care discourse and biomedical (clinical science) discourse would expand the teaching settings in medical schools:

> *“XI* – [students should] *adequately use **semiological** and **therapeutic** resources, validated scientifically.., contemporary, hierarchical.for **comprehensive health care in primary, secondary and tertiary levels of health care**.”* DCN 2001, p. 2.

10.2.5 Individual and collective approach to health care

This section focuses on the fifth discursive concept in the comprehensive care discourse, linking primary care to undergraduate medical education. The collective dimension to comprehensive care was intended to broaden health care action beyond the individual patient to include groups of people, such as families and communities, in a counter-discourse to the disease/biomedical and private/liberal model of health care, as described above.

The expansion of health action targets was consonant with the evaluation of medical education in the 1990s by the CINAEM report (chapter 9). Concluding that medical schools had become distant from the general population's health needs and social demands, the report recommended that doctors not only concentrate on the individual needs of patients but be mindful of the health of families and communities as social groups. Comprehensive care, therefore, focused on both individuals and the wider population (i.e. families, communities). Health actions relating to promotion and prevention gained special importance when considering the health needs of these groups, while actions associated with health education became tools to engage individuals and groups in the process not only of prevention and promotion but also of treatment and rehabilitation. At the same time, medical graduates were to be advocates of social transformation. In both these documents, this is emphasized as a strategy to consolidate democracy. The passage below from the national guidelines exemplifies this:

> *"Art. 5 The training of the physician aims to provide the professional with the knowledge required for the exercise of the following specific skills and abilities:*
>
> *I - promote healthy lifestyles, reconciling the needs of*

> ***both their clients / patients and those of their community****, acting as an agent of* ***social transformation****;*
>
> *…*
>
> *III - communicate adequately with co-workers,* ***patients and their families****;*
>
> *…*
>
> *IV - inform and educate their* ***patients, families and community*** *about health promotion, prevention, treatment and rehabilitation of diseases, using appropriate communication techniques;"* DCN 2001, p 2.

The wider goal of health action also included an integrative dimension: an individual's health/illness was to be considered in a family and communal context, taking account both of psychological and sociological factors. Therefore, students were expected to understand the influence of family and community life on the health of the individual and, through this comprehensive perspective, act not only in the individual's interest but also that of the collective, as illustrated below:

> *"The essential contents for the Medical Undergraduate Course must be related to the* ***whole health-disease process of the citizen, the family and the community****, integrated to the epidemiological and professional reality, providing a* ***comprehensive approach*** *to the actions of medical care."* DCN 2001, p.7.

The guidelines do not associate this collective approach with any specific level of care; a particular emphasis on primary care only features in later documents (PROMED and PRÓ-SAÚDE), which had an important influence on funding of the curricular transformation of medical courses (in 2000). The terms "community" and "family" prepare for a discursive setting in which primary care assumes special importance in medical education. But despite the fact that these same terms were part of the already established medical specialty of family and community medicine, the latter was not

mentioned at all in the policy documents of this period. Nevertheless, primary care is characterized as the most accessible health setting for family and communities, providing the broadest scope of care. The quote below from PROMED 2001 exemplifies this:

> *"The aim is to intervene in the training process so that **undergraduate programmes** can shift the focus of training - **centred on individual and care provided in hospital units** - to another process in which the training is **in tune with the SUS**, **especially with the basic health assistance** (ABS), and that takes into account the **social, economic and cultural dimensions of the population**, instrumentalizing the professionals to face the problems of health and disease of the population, in the **family and community sphere, and not only in the hospital**."* PROMED 2001, p. 5.
>
> And from the ABEM 2007:
>
> *"The comprehensive care approach depends on the **reformulation** of the traditional biomedical paradigm. In order to do this, it is recommended to **understand the subject in his family and in his economic, social and cultural context**, as well as to involve the users both in the management of the health system and in the construction of his own health."* ABEM 2007, p. 8.

In summary, the key concepts described above and linked to the discourse of comprehensive care produced a particular power relation that enabled the inclusion of primary care in medical education. This discursive strategy would in later documents (i.e. after the 2001 National Guidelines) give primary care priority over other levels of care, as demonstrated above.

Despite the emphasis placed on comprehensive care in medical education discourse, government policies on primary care at this time took a more ambiguous stance between a selective model of primary care and a more comprehensive model (see chapter 9). The Family Health Strategy, notwithstanding its multi-professional origins, was organized to deliver specific health programmes for conditions such as hypertension, diabetes, tuberculosis and leprosy. These programmatic actions had specific

quantitative targets that in turn influenced funding. The prominence of comprehensive care in medical education, therefore, also was a counter-discourse against a narrow perspective of primary care, implemented by the government and supported by international institutions like the World Bank. Despite the quantitative expansion of public medical care, this would maintain market demand for a strong private sector. This discursive difference is evidenced through the different uses of terms such as primary health (comprehensive model) care and basic health assistance (selective model) throughout the documents. The national guidelines are the only document to consistently use the term “primary care”, while the subsequent documents are more aligned with the governmental health policies (a selective approach), using the term “basic health assistance” to refer to primary care.

The following sections describe the discursive object of family and community medicine in this setting and the subject positions available, based on the analysis.

10.3 Formation of discursive object and subject position: the absent presence of family medicine in medical education policy discourse

In this section, I discuss the characterization of the discursive object under investigation (family medicine) in the policy analysed between 1980s and 2010. This period is distinct from the other periods analysed in this research, due to the fact that family medicine is essentially characterized by its absence. None of the documents analysed mention family medicine or general and community medicine directly. Despite the specialty being

recognized by the CFM in the 1980s and by the AMB in 2003, when the title of member of the SBMFC was approved, medical education policy did not attribute a specific role to family medicine. Nevertheless, policy documents of this period developed a discourse that enabled family medicine to become part of medical education policy in the following decade (the next analytical period in this research). The discourse of comprehensive care played an important role through the gradual incorporation of key concepts that justified and introduced primary health care into medical undergraduate courses. These key concepts coincided with others of the period, such as those elaborated by the Medical College of Family Medicine in its documents defining family medicine (SBMFC 1986 and 2001). This definition was influenced by those used in different countries (i.e. UK, North America, Cuba) and established the focus of family medicine on primary medical care.

The absence of family medicine from medical education policy in this period can be understood as a result of a struggle between the main medical institutions involved in the development of medical education. Medical educationalists, professional bodies and specialist institutions (i.e. public health, paediatrics) were united during the 1990s in asking CINAEM to assess medical schools in Brazil. Their shared goal was to halt the opening of new medical schools and to understand the situation of medical education at the time. During the elaboration of the national guidelines, however, interests began to diverge. Through the analysis, it is clear that clinical medical specialties retained their traditional role in medical education and that the professional institutions involved in the production of the CINAEM report and the 2001 National Guidelines consented to this. The medical education

institution (ABEM) and the public health specialists, however, were aligned with government strategies contained in publications such as PROMED and PROSAUDE, and with the ABEM 2007 Guidelines on medical education in primary care. Their objective was to expand the coverage of the SUS through primary health care (particularly through the Family Health Strategy).

The gradual importance given to primary care in the policy documents is evidence of the disputed environment in medical education. In the national guidelines all clinical teaching settings are presented as equally important to students' training. This guaranteed that all institutions were represented and had a say in the publication of such an important document. The policies that followed placed a much clearer emphasis on primary care, creating the priorities of the government and of the medical education institution (ABEM) in discourse.

As medical education policy focused increasingly on primary care, subject positions relating to this new teaching environment emerged. Students, teachers, medical professionals and patients were attributed characteristics that reflected the production of power surrounding primary care teaching and the absent presence of family medicine. These subject positions, identified by the analysis, shed light on the conflict among institutions seeking power in the new teaching environment; they also shaped and consolidated the absence of family medicine in medical education policy.

The following sections describe the subject positions available in the policy documents. For medical students an emerging attribution in the policy discourse of this period is that of preparing to practise in primary care as a "generalist". This emphasis may have contributed to the change in the

name of this specialty from general and community medicine to family and community medicine, reaffirming its position as a specialized field of medical knowledge. The subject position of teachers in primary care was attributed to the traditional clinical specialties and to specialists in public health and preventive medicine (a sub-area of public health in Brazil). Gradually, a teaching role was created for specialists in family health who were qualified (to diploma degree level) to deliver the government's primary care strategy (the Family Health Strategy), a reversal of the development of the primary medical care specialty that had begun in the 1970s. In the same discursive approach, professionals working in primary care were described as generalists and were not granted roles in medical schools. Each one of these subject positions is described and illustrated in the following sub-sections.

10.3.1 The generalist medical student and the generalist doctor

The subject position of medical students in this analytical period is associated with a discourse of generalism. This discourse first appears in the final phase of CINAEM as a response to the identification of the early specialization of medical students in medical schools and university hospitals. The CINAEM documents linked this to the organization of medical knowledge in medical schools. The schools were described as segmented into teaching and research departments, producing knowledge that did not necessarily take account of the health needs of the population as whole. Students would often define their career very early in training and limit themselves to clinical placements in the area of their choice. According to CINAEM, graduating

doctors were not prepared to face the reality of the SUS and its expanding primary care provision.

CINAEM's report in 1997 introduced the concept of a "general education" to prepare medical students to work in the Family Health Strategy, which at the time was struggling to attract medical professionals. The generalist doctor is differentiated from the general specialties (internal medicine, general surgery, paediatrics, gynaecology and obstetrics, psychiatry and public health). The former is described as the "fix it all" doctor; able to deal with prenatal care and childbirth, home visits, surgery, wound dressing and disease prevention. This description refers to the position held by the first doctors coming to Brazil from Portugal during the colonization period or those trained by the country's first medical schools, before any kind of specialization existed. It also mirrors the range of activities that characterize family doctors, despite the absence of the latter from the documents. Medical students graduating from medical schools in previous periods were considered by CINAEM to be "pseudo-generalists with a cognitive and skills deficit" (CINAEM, 1997).

The subject position of the generalist doctor, presented as the outcome of undergraduate medical education, is confirmed by the comprehensive care discourse of the national guidelines of 2001. But rather than focusing exclusively on primary care practice, as was the approach of the CINAEM report, the guidelines view the generalist subject position as a way of ensuring equal status to the different clinical teaching settings, as discussed in previous sections.

In the national guidelines, the characteristics of a generalist training are associated with the dimensions described previously in the comprehensive care discourse. The generalist doctor is defined as possessing a set of general skills to be developed by medical students. These include: the capacity to make evidence-based medical decisions; the mastery of communication skills; the commitment to lead multi-professional health teams; the facility to manage health services in terms of workforce, materials and structural resources; and the ability to continuously update his/her medical knowledge. Students were expected to recognize the limits of their general training and skills, and refer patients to relevant health services in the public system as appropriate.

The subject position of the generalist student and doctor also assumes a degree of political engagement; both student and doctor are constructed as agents of social transformation, in accordance with the broad concept of comprehensive care and health promotion.

In the PROMED 2001 policy, instituted by an inter-ministerial committee (Health and Education Ministries), the Ministry of Health takes on the function of directing the workforce formation for the SUS, including persuading medical schools to meet the workforce demands of the national health system. General medical education is, as in the national guidelines, associated with a comprehensive approach to health care. In this regard, this policy supported the medical schools' efforts, directed by the national guidelines, to offer a general training programme, as illustrated by the following quote:

> *"Nonetheless, Higher Education Institutions (HEIs) continue to pursue, as an institutional mission, the* ***terminal***

> ***training of a generalist doctor****. The proposed national curricular guidelines for medical courses point in this direction."* PROMED 2001, p.2.

According to this policy, the medical student should finish the course as a generalist doctor, capable of joining the Family Health Strategy. The PRÓ-SAÚDE 2005 policy reinforced the same discourse but expanded it to nursing and dentistry, the two other professions that constituted the Family Health Strategy workforce.

The decision that graduates should become "finished" generalist doctors for the Family Health Strategy is consistent with the discursive absence of a medical specialty focused on primary care. The Family Health Strategy generated a vast short-term demand for medical workers; therefore, the government could not afford to wait for students to complete an additional two to three years of postgraduate training (after their first six years of medical education) before entering the workforce. The medical education institution (ABEM) aligned itself to the same objective as a way to promote immediate changes to medical schools following ten years of investment in the CINAEM and the publication of the national guidelines. At the same time, other medical specialties (i.e. public health, internal medicine), were battling for space in the curriculum for teaching generalist doctors. As a consequence of all this, family and community medicine was not considered by the policy documents as related to the end-product of medical education or for a teaching role in primary care. The latter is further discussed in the following sub-section.

10.3.2 Specialist teachers in primary care

As policy documents explicitly refocus undergraduate medical education towards primary care (PROMED 2001, PRÓ-SAÚDE 2005 and ABEM 2007), other subject positions are gradually created and depicted. This sub-section focuses on the subject position of teachers in primary care.

The CINAEM assessment describes medical schools' teachers as overspecialized. The "general specialists" (i.e. general surgery, internal medicine, paediatrics) had gradually been replaced by focused specialists, with a huge impact on both teaching and health services, especially university hospitals. Students were taught as if they were to become specialists themselves, and thereby lost touch with the general knowledge of medical practice. This was further complicated by the double role played by the same overspecialized teachers in both public and private health care. By prioritizing their private practices, university teachers gave only limited time to teaching and practice in public institutions. Students would therefore look up to medical teachers who emphasized private practice and not public health or the national health system. The CINAEM report put forward a vast number of suggestions on changing the profile of medical teachers; however nothing is said about the role of the teacher in the specific setting of primary care (CINAEM, 1997).

The national guidelines followed the same trend. No particular mention is made of medical teaching and the learning process in primary care being different to that in other settings. In the PROMED 2001 policy, as the focus of medical education shifts to primary care, specialist teachers were expected to join students in other scenarios beyond classrooms and university

hospitals. This included primary care and the community in accordance with the social demand for health services.

Despite the policies' suggestions for change, most of the "extramural" (outside university hospitals) teaching activities in this period were developed by public health and preventive medicine specialists, as described in PRÓ-SAÚDE 2005. The 2007 ABEM document divided primary care teaching into two parts. In the early years of the medical course, it suggested that teaching should focus on public health and therefore be conducted by specialists in this area. In the second phase, from the fourth year onwards, the focus would shift to the "general specialties", with teaching provided by appropriate specialists. These teachers were expected to join health professionals working to deliver the Family Health Strategy in an effort to adapt clinical teaching to health services in primary care. The "general specialist" teachers were to work with community health workers, promote case discussions with the team, carry out home visits, promote health education activities, and plan health actions with and for the community. The description of the activities to be developed by "general specialist" teachers matched exactly the conceptual role of family and community medicine described in the documents of the National College of Family Doctors (SBMFC, 1986, 2003).

The persistent absence of family medicine in the documents analysed – despite the presence of subject positions that could be attributed to family medicine – says something about the production of power in the medical education environment. The dispute among "general specialists" regarding involvement in primary care teaching prevented the inclusion of

family medicine in the curriculum. In fact, as reported in PROMED (2001) and PRÓ-SAÚDE (2005, 2007), placements in primary care ended up being the responsibility of public health departments. The author of the ABEM 2007 report was a specialist in public health and preventive medicine whose document reinforced the role of public health in primary care teaching.

The teaching role played by primary care practitioners in this analytical period is not clearly described. These professionals were portrayed as specialists not in a knowledge area of the health sciences but in a public health policy: the Family Health Strategy. This is further discussed in the following sub-section.

10.3.3 Generalist family health professionals in primary care

The policy documents which introduce primary health care into medical education regard this learning scenario as critical to implementing the reform proposed by the national guidelines. Nevertheless, health professionals working in primary care are not attributed the same importance when it comes to teaching activities.

The description of these professionals, especially the medical doctor, is the same as that of medical students and graduating doctors: all are depicted as generalist doctors, possessing a general medical education. The final CINAEM report of 1997 makes clear that these generalist doctors are needed to fill the massive number of vacancies envisaged by the Family Health Strategy. This same discourse is continued in documents emphasizing the role of primary care in medical education (PROMED 2001, PRÓ-SAÚDE 2005, 2007 and ABEM 2007).

The closest these professionals get to teaching, however, is through their connections to academic staff (medical specialists) responsible for training medical students. In the ABEM document (2007) a new terminology is invented to describe these professionals: “generalist family health specialists”, a literal fusion of the concept of generalist doctor and the Family Health Strategy. It also produces the exclusion of a specialist in family **medicine** as different from a specialist in family **health.** Further on, the document refers to the predominant role played by university professors of “Public Health and Family Health” in teaching being developed on primary care following the publication of the national guidelines. This new subject position of the university professor in Family Health offers a glimpse of the changes to come in the policy documents published from 2010, described in the next chapter (11). It was a response to the creation of diploma courses run by medical schools in association with city health departments which were intended to open the door to primary care services for medical students. Many of these diploma courses were named to reflect family health specializations (chapter 9). The specialized field of knowledge offered by this discursive formulation was still very much linked to the Family Health Strategy and was not specific to doctors: diplomas were available to all health professionals involved in the primary care strategy (doctors, nurses and dentists). In the second half of the 2000s, residency programmes in family medicine which had been largely abolished in the late 1970s (only two survived), started to flourish again throughout the country. This was another response to the vast workforce demand and a further boost to primary care as a medical specialty. The following decade would also see the gradual inclusion of the role of

university professor in family and community medicine in medical schools and increased participation of primary care health professionals in teaching. This is described in the following chapter.

The policies analysed in this period do not create a subject position for the field of medical knowledge in family and community medicine. In my understanding, the consolidation of family and community medicine as a medical specialty, with a professional institution to represent it (SBMFC), gave enough autonomy to this field for it not to be included as a submissive subject position in policies in this period. Therefore, its exclusion is a discursive process of power. This is further explored in the discussion chapter

10.3.4 Other subject positions

Other subject positions available in the policy documents of this period include the comprehensive patient, the demanding collective and the author.

The comprehensive patient is constructed from all dimensions of the comprehensive care discourse. This subject position is the target of health promotion and illness prevention, treatment and rehabilitation: his/her experience of illness is biological, psychological and social; he or she will have access to all levels of health care (primary, secondary and tertiary) and will be a member of a collective, such as a family and community. Like the generalist doctor, the comprehensive patient is politically engaged and an agent of social transformation, keenly concerned and involved in the formulation of health policies and the management of health services.

The demanding collective is a subject position available for groups of people (i.e. family and communities) targeted by medical care and requiring

actions associated with health promotion and prevention. These collectives are also construed as being politically engaged and agents of social transformation.

The author subject position in this analytic period is attributed to the group of people involved in medical education (i.e. medical schools, ABEM), medical professional institutions (i.e. CFM) and governmental entities. This group is not described as comprising subjects representing a particular medical specialty (i.e. family medicine, internal medicine).

10.4 Reflections

When reading the policy documents of this period for the first time, I was surprised to find no mention at all of family medicine. I felt as if the texts avoided the notion of family medicine through the invention and use of alternative concepts. This was very different to the conspicuous presence of general practice in UK documents. Through my experience as a family doctor in Brazil, I expected the policy documents to present family medicine in much the same way as equivalent publications in the first period of the UK analysis (chapter 6). However this was not the case. The experience of analysing policy from another country and spending time in an overseas (UK) medical education and care environment facilitated the development of a critical and outsider perspective of policy documents with which I had long been familiar. At times I felt the eyes of my Brazilian colleagues watching over me, questioning and criticizing my new perspective. This was evidence of my change of position as a researcher.

10.5 Conclusions

The analysis of the Brazilian medical education policy between the 1980s and the 2000s offered an insight into the characterization of the family doctor in this specific setting. Family medicine is discursively characterized through its absence, the result of a power struggle taking place in undergraduate medical courses during this time. The recently established national health system (SUS) was expanded hugely through a primary health care plan entitled the Family Health Strategy. An assessment of medical schools during this period (CINAEM, 1990s) revealed a gap between medical education and the health demands of the population. The concept of the generalist doctor became the solution to both the workforce demands of the SUS and the need to transform medical education. The discourse of comprehensive care and its various dimensions served as a counter-discourse to the biomedical model which was seen as a problem both for medical education and the expansion of the national health service. Primary care became the setting in which both medical education and health care could be transformed through a more comprehensive approach. The characteristics that defined comprehensive care and primary care paralleled the concepts that surrounded family medicine as a recognized medical specialty in Brazil. But despite this obvious correlation, several factors undermined the role of family medicine in medical education during this period. Firstly, students would not be able to practise in primary care without undergoing postgraduate training, frustrating the government's goal of rapidly filling primary care medical posts. Secondly, postgraduate training for the generalist doctor profile would also reduce the social pressure for

transformations in undergraduate education appointed by medical education institutions involved in the CINAEM and by the publication of the national guidelines. Thirdly, medical “general specialties” (i.e. in public health and internal medicine) were not willing to relinquish space in the medical education curriculum to another medical specialty. Therefore it was more convenient to share the teaching of primary care between these specialties than to accommodate a new, flourishing specialty which would fulfil the brief perfectly. As primary care gained importance in medical education during the 2000s, most of its teaching would be dominated by public health specialists, with other hospital-based specialties showing less interest in straying from their established milieu.

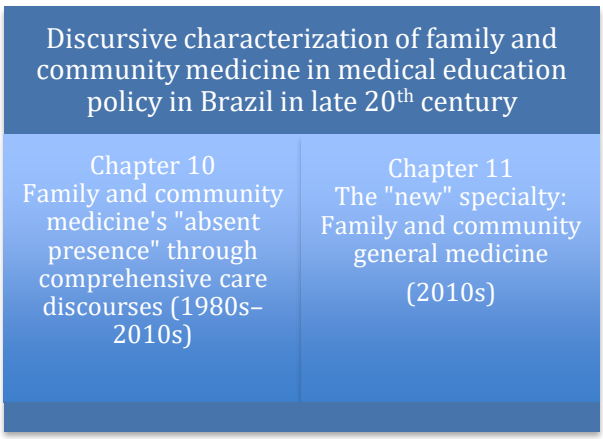
In the next analytical period (chapter 11), a position of specialist in primary care is gradually constructed through different designations, such as generalist doctor, generalist in family health and university professor of family health. This second period is also characterized by a clear insertion of family medicine into medical education policy.

11 THE BRAZILIAN FAMILY AND COMMUNITY GENERAL MEDICINE - A NEW MEDICAL SPECIALTY IN A COLLECTIVE HEALTH DOMINATED DISCOURSE

11.1 Introduction

This chapter presents the findings for the second discursive period identified through the Foucauldian discourse analysis of undergraduate medical education policy in Brazil. This period encompasses documents published between 2010 and 2015. Whilst the previous analytical period (chapter 10) was characterized by the "absent presence" of family and community medicine in medical education, the current period is marked by the emergence of so-called "family and community ***general*** medicine" (Table 13). Introduced into medical education policy from the field of *collective health*, this new term reinforced the comprehensive care discourse (10.2) but also produced a discontinuity in discursive strategy: the discourse of *collective health* is presented as a transformational idea in clinical practice and teaching. New concepts such as *defence of life*, *health care management* and *individual and collective therapeutic plans* were introduced as models and clinical tools to bring about significant change in medical education. The term family and community general medicine may be understood as an additional *collective health* "tool" to assist/encourage this transformation.

Table 13. Division of the analytical results of Brazil's medical education policy



The primary documents analysed in this period were: ABEM's guideline on clinical clerkships in undergraduate medical education (2010); the *Mais Médicos* (More Doctors) government policy of 2013; and the new *National Guidelines for Medical Undergraduate Education in Brazil* (2014). The latter emerged as the most important document of the period due to its detailed description of undergraduate medical education at that time.

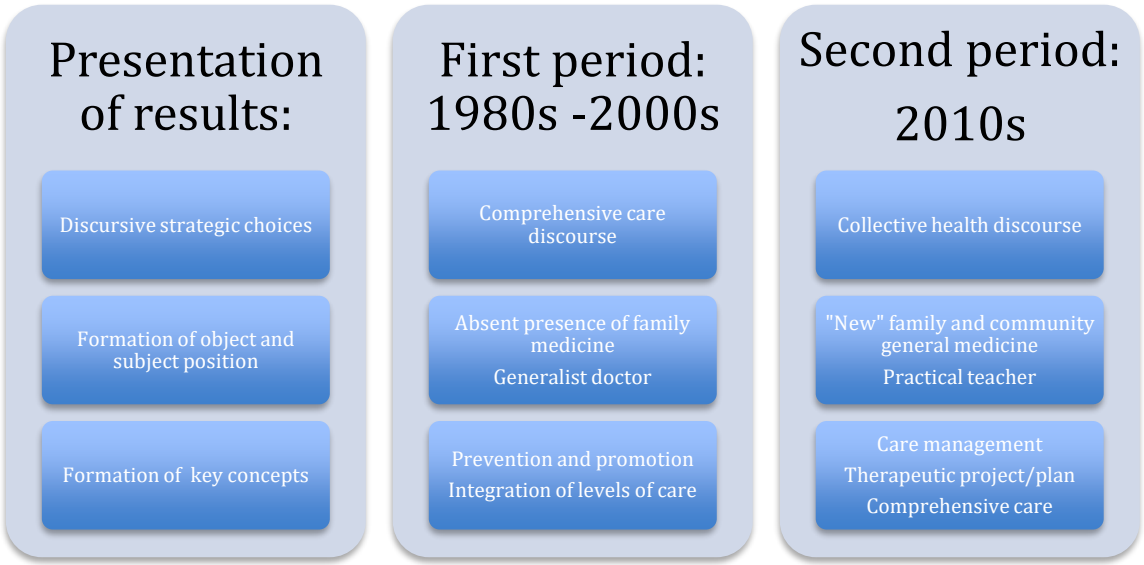
ABEM's guideline on clinical clerkships was developed through a series of workshops at the organization's annual conferences, in which academic teachers, students and clinical tutors participated. The end result was a document listing the competences to be accomplished in each of the five basic medical fields (paediatrics, internal medicine, *collective health,* obstetrics and gynaecology, and general surgery). This document produces a transition between the former and the current analytical periods: primary medical care as linked but not merged to *collective health*. The documents that followed reinforced the role of collective health in medical education and presented the "new" field of family and community general medicine as the locus of primary care. This discursive change differentiated *collective health* from primary medical care and family medicine.

The Ministry of Health's *Mais Médicos* policy (PMM), published in 2013, was a major government initiative to tackle the vast demand for doctors in primary care. The policy dealt with both the immediate provision of doctors in locations with no previous medical care access and changes to undergraduate and postgraduate medical education. These changes emphasized the importance of primary care at both levels of medical education, including longer clinical clerkships in primary care for undergraduate students and mandatory primary care training for other medical specialties. The PMM document created a major shift in medical education policy as it clearly focused on solving the national health workforce problem in primary care. The National Guidelines of 2014 were a continuity of the *Mais Médicos* policy, setting out a more detailed approach to the changes anticipated by the PMM document in undergraduate medical education. While the publication of the first national guidelines (in 2001 – 9.2.2.2) was a response from several actors to a decade of mobilization in medical education after the CINAEM report, the 2014 guidelines consisted mainly of a government-led effort to plug the workforce gap in primary care, entrenching the changes proposed by the CINAEM and 2001 documents.

The next section of this chapter describes the main discursive strategy identified in this period: the collective health discourse as a reinforcement of comprehensive care. The collective health discourse was a development of the field of public health in Brazil which emerged through a process of re-democratization of the country and health care reform, culminating in the foundation of the national public health system (SUS), as described in chapter 9. The collective health field was a political mobilization

of health professionals, academics and the wider population in order to establish the national health system and replace the dominant liberal/disease-centred health care model. The following section also describes key concepts that reinforce the relevance of comprehensive care through the incorporation of collective health ideas that transform clinical practice and clinical teaching. In the previous period, comprehensive care was strategically incorporated into medical education as a way of shifting clinical practice and medical specialties involved with clinical teaching towards the goals set out by the CINAEM report and the national guidelines of 2001. In the new guidelines (2014), different conceptual tools developed by the field of *collective health* propose further transformation of clinical practice and its teaching. The following section (11.2) presents the characterization of the "'new" medical specialty called family and community general medicine, introduced by the Ministry of Health as a governmental entity and not regulated by medical institutions. The section describes how the "new" specialty, which bore all the characteristics of the existing specialty of family and community medicine, marked an attempt by the government to regulate medical education directly and avoid a power struggle with medical institutions.

Table 14. Summary of the results of analysis of Brazilian medical education policy



11.2 Discursive strategy and key concepts: comprehensive care and collective health

This section describes the main discursive strategy that characterized this analytical era, along with related concepts of what was thinkable in terms of family medicine knowledge at this time. This analytical period is characterized by continued investment in the comprehensive care discourse, with an emphasis on theoretical and technical concepts that characterize the *collective health* discourse. As described in the previous chapter, the concept of comprehensive care in Brazil expanded greatly after the foundation of the SUS. The theoretical elaboration of comprehensive care was led by publications in public health and *collective health*. The *collective health* discourse developed theoretical and technical concepts that strengthened the comprehensive approach to clinical practice and teaching. In order to understand this relationship between *collective health* and

comprehensive care, I briefly describe the development of the *collective health* discourse as an elaboration of the field of public health which supports the comprehensive care discourse by demanding changes in clinical practice and teaching towards primary care. Next, I describe the increasing presence of the *collective health* discourse in undergraduate medical education, using examples from the policies analysed. In this context, the "new" specialty of family and community general medicine is presented as yet another tool for transformation. Each of the sub-sections presents a key concept that links the *collective health* discourse to comprehensive care and a transformed approach to clinical practice and teaching, focused on primary care.

11.2.1 Perpetuation of a comprehensive care discourse through inclusion of collective health and an emphasis on primary care

The analysis of the three documents in this period identified a continuation of the comprehensive care discourse, using the same discursive elements that enabled the inclusion of primary care into medical education and portrayed the absent presence of family medicine (Chapter 10). These elements consisted of: (1) the integration of basic and clinical sciences; (2) health promotion and disease prevention and a biopsychosocial model of health care; (3) integration of all levels of health care; and (4) an individual and collective approach to health care.

The 2014 national guidelines, as well as including all these discursive elements, reinforced the existing profile of the graduate doctor, using almost the same wording as the 2001 guidelines. However, by adding emphasis to the notion of social context as a determining factor in the health and disease process, it highlighted the growing influence of *collective health*

in this period, as explored in the following section. The quote below describes the attributes expected of the graduate doctor at this time:

> "*Art. 3º The medical graduate will have a general, humanistic, critical, reflexive and ethical training, with capacity to act at the different levels of health care, with actions of promotion, prevention, recovery and rehabilitation of health, in the individual and* ***collective*** *dimensions, with* ***social responsibility*** *and commitment to: the defence of* ***citizenship****; human dignity; the comprehensive health of the human being; the* ***social determination*** *of the health and disease process.*" DCN 2014, p. 1

The comprehensive care discourse is gradually linked to the discursive elements of *collective health* through a greater emphasis on social and collective dimensions of health care and the use of conceptual and technical tools from *collective health* to inform clinical practice and teaching. This is exemplified in the ABEM guidance on clinical clerkships. The comprehensive care approach is generally attributed to clinical practice as a whole; however it is emphasized in the description of the clerkship in *collective health* – a placement exclusively in primary care:

> *"In the collective health clerkship:*
> *(Students should learn how to)* ***Welcome all*** *health demands from a humane and comprehensive perspective of health care." ABEM 2013, p.2.*

I have highlighted the "*welcome all"* approach because it is an important example of a clinical and managerial tool from *collective health* introduced into medical undergraduate education in this period. The *welcome all* strategy advocates that the health team in primary care should be organized so that everyone seeking help from the service is seen. This first contact will not necessarily be with a medical professional: it could be with any staff member who is able to manage demand and refer patients to the

appropriate health professional(s) in the team. In short, the quote above exemplifies the gradual inclusion of a *collective health* discourse into medical education and its association with comprehensiveness and primary care.

The PMM policy of 2013 further emphasizes the importance of primary care in medical education by requiring that 30% of the time dedicated to clinical clerkships should be spent at that level of care. It also separates the clerkship in primary care from that of *collective health.* This change has the effect of giving more importance to both primary care and *collective heath,* which are now seen as distinct, unlike in ABEM's guideline on clerkships. So both primary care and *collective health* have their own time and space in medical curricula, as evidenced in the following quote:

> *"§ 6 The 70% (seventy percent) of the remaining hours of clinical clerkship will necessarily include* ***essential aspects*** *of the areas of Internal medicine, Surgery, Gynaecology-Obstetrics, Paediatrics,* ***Collective Health*** *and Mental Health, through mainly practical activities where theoretical activities do not exceed 20% (twenty percent) of the total time of each placement." PMM 2013, p. 12.*

The PMM policy introduces the term "family and community ***general*** medicine" into primary medical care teaching (discussed in the discursive object and subject position section of this chapter). In addition, the national guidelines suggest the focus of action of the medical graduate should be on primary care and emergency services. This constructed a discontinuity of medical education discourse towards meeting the workforce demands of the health system.

The contributing role of *collective health* becomes more evident in the text of the national guidelines (2014). The following extract identifies social participation in health care management and teaching – one of the

cornerstones of *collective health* (as explained in the next section) – as an important tool in promoting comprehensive care:

> *"VIII - **Social participation** in teaching and learning about health care services network collaborate to promote the integration of health care actions and services, **providing continuous, comprehensive, good quality clinical practice and responsible care, increasing the access to the health syst**em, with equity, effectiveness and efficiency, based on humanistic, ethical, health and health economics principles." DCN 2014, p2.*

Other extracts provide further evidence of this discursive strategy by referring to the *collective health* concepts explained in chapter 9 (9.2.1.4.1).

The continued development of the field of *collective health* also produced conceptual and practical tools that intervened directly in clinical practice and teaching. These are the key concepts presented in medical education policy as a means of shifting medical practice and teaching towards comprehensive care with a focus on primary health care.

11.2.2 Key concepts related to collective health

The introduction of key concepts from *collective health* into medical education is the major discursive transformation in this analytical period. It paralleled the introduction of a "new" medical specialty, created from the discourse of collective health, to allow government to regulate the supply of labour to the health care workforce. I chose one of these key concepts – the "therapeutic and collective intervention project" – to exemplify the use of theoretical and practical tools of *collective health* to reinforce comprehensive care in clinical practice and teaching.

11.2.2.1 Therapeutic plan/project and collective intervention projects

The therapeutic project and collective intervention project are mentioned in several parts of the national guidelines, although with no formal definition of the terms, or reference to other publications or authors that give further insight into the concepts (the same is true for other concepts discussed here). While a full discussion of the meaning of these concepts is beyond the aim of this research, in the guidelines they are constructed as a comprehensive alternative to the conventional "treatment" phase of medical practice. Although linked in the policy to other important concepts of collective health (i.e. defence of life, care management), they are conceptually dense and distant from the language used previously in medical education policy. The following passage is an example. The concepts of *care management* and "*devices of all technological types"* are presented and associated with therapeutic projects. All these concepts are regarded as contributing to the development of a comprehensive approach to health care:

> *"I – (Students should master)* ***Care Management****, using knowledge and devices of all technological densities, in order to promote the organization* ***of comprehensive health systems*** *for the formulation and development of* ***individual and collective therapeutic plans****."* DCN 2014, p. 2.

Therapeutic projects are not only focused on individuals but also social groups, in line with the *collective health* discourse. In the national guidelines, both health care and health management actions have individual and collective targets, which are seen as equally important. In terms of health care competencies, students are expected to develop and access therapeutic projects and interventions, both for individuals and collectives:

> *“From the Area of Competent Health Care:*
> *...*
> *Art. 10. Health care to Individual Health Needs is composed of two key actions: I - Identification of Health Needs; and II - Development and Evaluation of* ***Therapeutic Plans****.*
> *…*
>
> *Art. 11. Attention to the needs of* ***collective health*** *unfolds in two key actions: I - Investigation of* ***collective health problems****; And II - Development and Evaluation of* ***Collective Intervention Projects****.”* DCN 2014, p.4-5.

Therapeutic and intervention projects are therefore understood as an educational outcome that graduate doctors should be able to practise in a health care setting. The projects themselves should promote the autonomy of individuals and social groups, recognizing their shared involvement in comprehensive care. The following quote from the national guidelines exemplifies this:

> *"II – (Students should promote) comprehensiveness and humanization of care through continuous and integrated medical practice with other health actions and instances, in order to build* ***shared therapeutic projects****, stimulating* ***self-care and autonomy*** *of* ***individuals, families, groups and communities*** *and recognizing the health system users as* ***active protagonists*** *of their own health;"* DCN 2014 p2.

The introduction of these concepts into medical education is an attempt to provide medical schools with technical tools to implement comprehensive care in their clinical teaching. The substitution of *therapeutic and collective intervention projects* for *treatment* exemplifies how the collective health discourse is used to support and entrench the shift in medical education to a different health care paradigm. The presence of family medicine in undergraduate medical education policy in this analytical period follows the same discursive strategy as the concepts introduced from the field of collective health. The “new” term *family and community general medicine* is

introduced, in both PMM and the national guidelines, as the medical field responsible for clinical practice and teaching in primary care. This is detailed in the following section.

11.3 Discursive object and subject positions: family and community general medicine as a government strategy in the collective health discourse

Family and community general medicine is first described in the PMM policy (2013) as a new medical specialty requiring 1-2 years of postgraduate training. The policy makes no reference to the existing specialty of family and community medicine, and does not make clear if the two terms describe the same, or distinct, specialties. It limits itself instead to defining the scope of the "new" specialty differently to that described in postgraduate training policies published by the Brazilian College of Family Medicine (SBMFC) and in resolutions of National Committee of Medical Post-graduate Training. Unlike other forms of medical training, the programme in family and community general medicine was to be directly coordinated by the Ministry of Health rather than by various local institutions and authorities. With regards to undergraduate education, the new specialty is associated with the clinical clerkship in primary care, or "basic assistance" as it is described in the documents (the same term was used in previous national guidelines as an alternative to "primary care" – see 9.2.2.2). This difference speaks to a closer commitment to the national basic assistance policy implemented by the government: the Family Health Strategy. There is no mention of the specialty

in guidelines concerning theoretical or practical teaching in other phases of the medical curriculum.

The PMM policy, despite recommending a longer duration of clinical clerkships in basic assistance, does not mention teaching in primary care as a role of the new specialty. The national guidelines, however, make this explicit:

> *"Paragraph 5: The activities of the **clinical clerkship directed to basic assistance** should be coordinated and directed to the area of **Family and Community General Medicine**."* DCN 2014, p.5.

The PMM policy does not provide a detailed account of undergraduate medical education. Its description of family and community general medicine is limited to postgraduate training, which is more relevant to the needs of the national health system. This description does not refer to existing postgraduate policies on family and community medicine. Instead, it appears to deny the existence of this specialty, as the following passage exemplifies:

> *"Paragraph 6. The training Programmes **in Family and Community General Medicine** shall contemplate specificities of the SUS, such as the activities in the area of **Emergency, Home Care, Mental Health, Popular Heath Education, Collective Health and Comprehensive Internal Medicine** in all cycles of life."* PMM, p. 4.

The "new" specialty's definition is restricted to the needs of the health system, which include the areas described above (emergency, home care, mental health, health education, collective health and comprehensive internal medicine). The discursive strategy of creating new terms and omiting previous nomenclatures is illustrated in the quote above by the use of the expression *comprehensive internal medicine*, a term that does not appear in

any other medical or policy document. The *collective health* discourse seems to have empowered the author(s) to create terminology and concepts to facilitate the government's objectives. The government's power over the new specialty is consolidated in the following passage, which gives the Ministry of Health oversight of all training in the field:

> *"Paragraph 7. The **Ministry of Health** shall **coordinate** the activities of the **training in Family and Community General Medicine** within the scope of the teaching-health services network."* PMM, p. 4.

Despite what is described in the quote above, the Ministry of Health does not coordinate any postgraduate training: the coordination and regulation of medical training is under the auspice of the National Committee of Medical Post-graduate Training, which is part of the Ministry of Education. This is evidence of the wider interest in the newly created medical specialty, which is seen as key to expanding the workforce in primary care. The PMM further advises that all medical graduates should take part in family and community general medicine training before accessing other training programmes:

> *"Paragraph 2 - it will **be necessary** to perform **one (1) to two (2) years of the training programme in family and community general medicine before the other medical residency programmes**, as set by the National Medical Residency Commission, except for direct access medical residency programmes."* PMM, p. 4.

This paragraph implies that the National Committee for Medical Post-graduate Training had made training in primary care mandatory; in fact this had not yet happened.

The national guidelines do not provide further detail of the characteristics of family and community general medicine, apart from assigning to it the role of primary care teaching.

In summary, the discursive object “family and community general medicine” was created in the text to support government efforts to solve a health workforce crisis in primary care. The creation of a new specialty by a governmental entity, as opposed to medical institutions, is a first for the country. By creating and coordinating a medical specialty and its training, the government avoided a power struggle with these institutions, including the SBMFC. This was revoked when the National Committee of Medical Training published the following resolution (2015) equating family and community general medicine with family and community medicine:

> Art. 2º - **Family and Community General Medicine** and **Family and Community Medicine** are considered the **same area of knowledge and the same specialty** being thus **equivalent terms for Medical Training** programs and training of specialists. Resolution no. 1, of May 25th, 2015. Ministry of Education - Secretary of Higher Education - National Committee of Medical Training" 2015, p. 1.

The subject position of family and community general doctor is not directly described by the documents analysed. The only mention of the specialty in this period is linked to practical teaching during clinical placements. The subject positions described in the documents do, however, provide further information on the characterization of family medicine in undergraduate medical education.

11.3.1 Medical student and generalist doctor

The description of the medical student is coherent and consistent with that of the previous analytical period (10.3.4). New graduates are referred

to as generalist doctors with a generalist education. Interestingly, the term *comprehensive education* is used in the national guidelines, reinforcing the discourse of comprehensive care. There is no attempt to treat as equals: the medical student or graduate doctor with family and community general medicine. This consolidates the latter as a specialty area, despite the expectation that newly graduated doctors will work in primary care. This assumption creates two categories of primary care doctor: those with training and those without. Doctors with training are attributed an educational role, as described in the previous section.

11.3.2 Academic professor

The medical school professor or teacher is described most clearly in the national guidelines of 2014, and is characterized as someone who is not directly involved in the delivery of health care services. The guidelines do not associate the teaching role with particular specialties: the professor is not described (uncharacterized) as a specialist or consultant of any kind. It is expected, however, that the professor will facilitate the autonomy of the student and that both will take part in continuous education.

11.3.3 Supervised teaching health professional

Health professionals involved in medical education are described in this analytical period as: (1) providing students with early contact with real health problems faced by the population served by the national health system; (2) participating in continuous education; and (3) being supervised by the medical school's staff. This is perhaps the subject position that best characterizes the role of the family and community general doctor in primary care teaching. The health professional is not expected to take part in other

academic activities, like research, and will defer to academic staff in the co-ordination and management of clinical placements.

> *"§ 1 The **clinical tutorship exercised by professionals of the health service** will have **supervision** of teachers of the Institution of Higher Education (IES)" DCN2014, p. 12.*
>
> *"VIII - foster the active interaction of the student with users and health professionals, from the beginning of their training, providing them with the opportunity to deal with real problems, assuming increasing responsibilities as care and attention agent, compatible with their degree of autonomy, which is consolidated, in the undergraduate, with the boarding school; "DCN 2014, p. 13.*
>
> *"Art. 35. The Medical Graduation Courses should develop or encourage the participation of the **Health Services Network Professional**s in a permanent training and development programme, with a view to improving the teaching-learning process in SUS practice scenarios and the quality of health care assistance, and this program was agreed with the municipal and state health managers in the Organizational Contracts of Public Health Teaching Action. "DCN 2014, p. 14.*
>
> *"II - critical analysis of sources, methods and results, in order to evaluate evidence and practices in the care, work management and education of health professionals, the person under their care, families and caregivers." DCN 2014, p. 11.*

11.3.4 Other subject positions

Patients and groups (e.g. collectives, families, communities) are portrayed as "*active protagonists of their own health*". Part of the work of health professionals and students is to promote the development of this protagonism. Patients are most often referred as "*users*" of the health system. This term is used in opposition to the term "patient", with its connotations of passivity, and "client", which implies a relationship to health care as a business.

The subject positions outlined above provide some flexibility to the subjectivation of students, patients and collectives in practice through the

development of an autonomous and proactive position in learning and health care. The position offered to family doctors is associated with medical education, but restricted to practical teaching and not to theoretical teaching or research in academia. This produces a subjection process in which family medicine is mostly restricted in its participation in medical education.

11.4 Reflections

The creation of a new term to describe a medical field of knowledge focused on primary care was unexpected. As this was a recent policy event, I could follow through social media its impact on family and community doctors. This reaction from family doctors supported the results of the analysis of both analytical periods. For the general community of medical doctors in Brazil the change was not an issue, possibly because they did not see a difference between the new and old entities. In fact, it was very common in Brazil, during my experience in care and teaching, to hear students and other medical professions talk about family and community medicine using different nomenclatures (e.g. family and community health doctor, family health doctor, family health specialist). Their limited knowledge of the specialty and its immediate link to the Family Health Strategy was a possible explanation for this.

For the group of family and community doctors, the creation of the new term / new specialty was met with outrage which was only assuaged after the postgraduate policy made clear the synonymous relationship between the two terms. This was further evidence of the discursive exclusion of a new power group from the medical education scenario.

The identification of the discourse on collective health as a major discursive strategy was unexpected to me. As the concepts used in the policies of this era were personally familiar, and were part of my daily routine as practitioner and teacher before undertaking this research, I could not recognize how the collective discourse had dominated the policy scenario. In fact, it was only during the analytical reading (as a researcher) of the policies (not in the many times I read them before as a professional) that I realized how these policies might be read by medical professions other than those engaged in public health and family medicine. My impression is that they would react to this new terminology in two ways: with indifference (not recognizing the concepts or their full significance) or incomprehension (not understanding what was being said). The dominant role of government in these policies had in effect produced a new vocabulary. This differed from the language used by first national guidelines analysed in the previous chapter, which was a product of a more collective effort.

In regard to the subject position available for family doctors, my personal experience during this period was very different to the norm for medical educators. I had volunteered in the Department of Social Medicine at the UFPE as an academic teacher for four years (2006-2010) before being formally employed in that role. But, along with a group of five other family doctors, I considered myself an outsider. We used a motto to justify our presence in academia in a playful way: "*occupy, produce and resist*". This was a reference to the clarion call of the Landless Workers' Movement, which was occupying vast unproductive parcels of privately owned land at that time. We were thus able to produce a different subject position in practice. The majority

of doctors working in primary care (most without specific family medicine training) did not even consider the possibility of becoming academics. There were also major concerns about what the university could offer in exchange for their work as practical teachers.

11.5 Conclusions

In the analytical period described in this chapter (2010 - 2015), family and community medicine is formally introduced into medical education. It is presented as a new medical specialty, created by a governmental institution seeking to control the training and supply of doctors for the national health service. The new term is one of many introduced into medical education in the context of *collective health*. These terms reinforce the discursive strategy of comprehensive care, which attempts to change the *status quo* of medical practice and teaching in Brazil.

As collective health and primary care gains emphasis and becomes differentiated in the curriculum, the new specialty of family and community general medicine takes on a teaching role in primary care. The characteristics of the new specialty were to be determined by governmental edict, despite the existence of regulatory documents defining family medicine both as a medical practice (SBMFC) and as a postgraduate training specialty (National Committee of Post-graduate Medical Training). The subject position available for this new specialty is focused on primary care and practical teaching. There is no mention of a clinical teaching role for these individuals, who will be supervised by academic staff and required to undergo continuous education.

The policies of this period alienated the established specialty of family and community medicine from developments in postgraduate and

undergraduate medical education and brought medical institutions into conflict with government efforts to fill the primary care workforce gap. This dispute was eventually resolved through a postgraduate policy that equated the two family medicine specialties. However, it underlined the fragile position of family medicine in the medical education scenario. This is further discussed in the following chapter.

12 DISCUSSION

12.1 Introduction

This chapter brings together the results of the Foucauldian discourse analysis of undergraduate medical education policy characterizing general practice knowledge. This discussion interrelates the results described in analytic eras in both the UK and Brazil. I have organized this discussion into three sections. The first considers the discursive institutionalization of general practice knowledge in the academic sector of both countries. The second and third sections focus on the two major discursive elements that were part of the overall discursive institutionalization of general practice knowledge: the discourse of specialism and the discourse of the expansion of medical education.

12.2 Institutionalization of general practice knowledge

> "*I am supposing that in every society the production of discourse is at once controlled, selected, organized, and redistributed according to a certain number of procedures, whose role is to avert its power and its dangers, to cope with changes, events, to evade its ponderous awesome materiality*" (p.216). (Foucault M. , 1972)

In this section, I consider the discursive process by which general practice knowledge is institutionalized by medical education policy in both the UK and Brazil. By institutionalization, I mean the process by which general practice knowledge is incorporated into formal undergraduate medical education within national policies. This institutionalization has influenced the characterization of general practice knowledge in medical education. For

Foucault, this process produces the adaptation of a discursive object to a specific discipline, which in this research is academic medicine.

> *"a discipline is defined by a domain of objects, a set of methods, a corpus of propositions considered to be true, a play of rules and definitions, of techniques and instruments" (222).* (Foucault M. , 1972)

In the policy documents analysed, general practice becomes a domain of academic medicine to a greater or lesser extent. Where it is included in a document, it is adapted to that policy's assumptions of truth and methods. My analysis found general practice to be one of the latest major medical fields to be incorporated into policy on medical schools. The analysis produced different discursive strategies that integrated or excluded certain ways of depicting general practice in medical knowledge. These different strategies characterized a range of concepts associated with general practice, as revealed in the results chapters. As Foucault describes:

> *"for a proposition to belong [to a discipline], it has to fulfill certain conditions, in a sense stricter and more complex than pure and simple truth" (223).* (Foucault M. , 1972)

My analysis shows that changes in the characterization of general practice knowledge reflected a particularly "fragile" discursive position, which became the focus of an important power struggle during reorganizations of health care in the periods analysed. This fragility is evidenced through the vicissitudes of characteristics attributed to general practice knowledge and through the subject positions available to general practitioners. These were more in the nature of a hierarchically subordinate position. In this chapter, I introduce the concept of *discursive fragility* produced in this analysis. By using this term, I want to describe the way general practice knowledge is

fundamentally modified in the discursive eras described in the results chapters. The changes to the description of general practice knowledge, in my analysis, were a response to: (1) the foundation of universal health care systems, which emphasized primary care as an important public health strategy; (2) the impact of these public health systems on undergraduate medical education; and (3) the positioning of general practice as the field responsible for primary medical care; (4) a re-characterization of general practice in accordance with the dominant discourse in each discursive era. Academic medicine, therefore, not only incorporated general practice as a discursive object but also the notion of a public and universal health care system. Despite the relative consistency in the first three points throughout the periods, the last (4) was responsible of major changes to general practice knowledge. In that sense the discursive position of general practice could be understood as fragile because it could not sustain the principles of general practice knowledge as understood by general practitioners and their representing institutions. In the following sections, I discuss the different dimensions of this discursive fragility evidenced in the results chapters.

In the two sub-sections that follow, I briefly revisit the discursive institutionalization of general practice knowledge in medical education in each country. The aim is to connect the different analytical eras to the broader historical context. This process is necessary due to the ahistorical character and positioning of the policy documents analysed. This became clear during the analytic process, which revealed the absence of contextualization of the policy changes proposed by these documents. A similar phenomenon was described by Razack et al. (2014) when studying the discourse on equity and

selection of medical students by universities in North America. This a-historicity gives the impression that medical education policy is sovereign and free from contextual influences. In a third sub-section, I relate and compare the institutionalization of general practice knowledge in both countries.

12.2.1 Institutionalization of general practice knowledge in the UK

This section aims to correlate the findings of the analysis of the UK policies with the broader historical context and the production of power through the discursive institutionalization of general practice knowledge in undergraduate medical education. As described previously (chapters 6, 7 and 8), I identified three discursive periods in the characterization of general practice knowledge in the UK. Each period produces general practice differently, and in this discussion I relate these results to the history of public health policies and shifts in medical education.

This sub-section is divided into three topics. The first (12.2.1.1) is a contextualized review of the analytic eras of UK policy. This identifies two major discursive strategies which are explored in the subsequent two topics: (12.2.1.2) the “academification” of general practice knowledge in the UK and (12.2.1.3) the correlation between general practice knowledge and the NHS-medical education relationship.

12.2.1.1 The analytic periods and the institutionalization of general practice knowledge in UK policy

In the first period of the UK analysis (1940s-1950s), medical education is presented as the solution to the workforce needs of the NHS, a public health policy born of the post-World War II period and the rise of a welfare state. Despite the resistance of medical professional institutions to the

nationalization of medical labour, general practice is depicted as the key workforce to be trained by medical education institutions for the benefit of the national health system. General practice is, however, constructed as a patchwork of medical specialty knowledge, with a focus on prevention and promotion. These discursive elements maintained and reinforced the privileged position held by medical schools, their specialist departments and the university hospital setting. Nevertheless, the NHS gained authority over medical labour through the nationalization of the majority of the medical workforce. This process legitimized the inclusion of general practice, promotion and prevention in the medical discourse of authority (medicalization of society) (Paradis, Webster, & Kuper, 2013). Researchers studying the medicalization of society suggest that the rise of the biopsychosocial model of health care (Engel, 1977), as depicted by the policy documents analysed in this period, increased the influence of medicine over people's daily life, replacing the law and religion as a central pillar of authority (Paradis, Webster, & Kuper, 2013). The inclusion of general practice in medical education could also be seen as producing an expansion of medical authority, given its role as the first point of access to a universal health care system.

In the second period of analysis (1960s-1980s), medical education was seen as inadequately preparing medical students for practice. This coincided with an increase in the production of medical knowledge through the rise of the clinical sciences (chapter 7). The key development in this period was the extension of medical education to include obligatory postgraduate training. At the same time, the clinical science discourse produced a different kind of medical practice, seen as modern, effective and

grounded in scientific investigation. Historically, this was a period of decreasing state funding and rising pressure for cost-effective measures. It was also a period in which the NHS gained strength and the economic benefits of primary care and general practice, compared with more expensive hospital/specialty based-systems, became recognized. General practice was thus positioned as the solution to the majority of health problems of the population, justifying the expansion of medical education beyond teaching hospitals.

In this context, general practice is characterized as a medical specialty composed of features from the traditional and (re)valued role of family doctor and from the clinical sciences, especially internal medicine. This discursive arrangement served to increase the power held by medical education institutions, while at the same time preserving the medical specialty system. The NHS also gained further power over the medical workforce through the inclusion of a broader range of health services, delivered in large measure by an army of part-qualified postgraduate trainees in an expanded medical training programme.

In the third analytic period (1990s-2000s), undergraduate medical teaching became consolidated as an educational foundation for future postgraduate training, providing competence-based tuition to all medical students. This historical period is characterized by a continued enforcement of state austerity measures which strengthened the cost-effectiveness and managerial discourse within the NHS. The moral authority of medicine also came under scrutiny at this time, as for-profit services grew and medical scandals received widespread attention in the media (Paradis, Webster, &

Kuper, 2013). The discourse relating to measurable and verifiable competences endorsed a socially accountable perspective of medical education. Through a competence-based curriculum, medical schools could re-establish public confidence in the end products of medical education. The features that characterized general practice knowledge in the previous analytical eras are described in this period as competences outside the classification of specialized medical knowledge. General practice is acknowledged as one of the most important medical specialties, despite not being ascribed particular medical characteristics. In this discursive constellation, the position of power held by medical education institutions and the NHS is sustained and strengthened. Inside medical schools, however, there was a shift of power. The specialty departments that held a central position in a discipline-based curriculum became less dominant in a competence-based curriculum. As one of these specialties, general practice also lost power.

The analysis also identified two major discursive strategies relating to the incorporation of general practice knowledge in education policy throughout the analytic eras in the UK: the “academification” of general practice knowledge and its association with the NHS-medical education relationship. These are presented in the sub-sections below.

12.2.1.2 The “academification” of general practice knowledge

The shift in general practice knowledge towards a medical academic discourse took place in different phases. General practice was initially depicted in UK policies as devoid of clinical responsibility and focused on prevention and promotion (chapter 6). It was later seen as re-engaging

with clinical matters through the incorporation of knowledge from internal medicine (chapter 7). Finally, it was given equal status with other core medical specialty fields in undergraduate education (chapter 8). There is, therefore, a process of "academification/scientification" of general practice knowledge. In this process, the characterization of general practice adapts to an academic discourse in which scientific knowledge and experimentation are valued more than practical know-how and work experience. This is evidenced by the initial use of discursive elements such as "*practical in nature*" and "*clinical sciences*" along with subject positions such as "*eternal learner*" and "*practical teacher*", which exclude general practice from the academic world (6.3.3.4, 7.3.3). It was through a process of transformation and re-characterization across the analytical periods that general practice knowledge became part of the academic discourse (i.e. *general practice as consultant* – subject position in third analytic era in the UK – chapter 8).

12.2.1.3 Correlation between general practice knowledge and the NHS-medical education relationship

The second main discursive strategy for the incorporation of general practice knowledge into medical education policy involved the repositioning of medical education discourse towards public health policies, whilst maintaining the power of educational institutions (i.e. over funding and defining future doctors' profiles – chapter 6). Through this process, general practice emerged as an important discursive object and concept in forging a strong association between the two main dimensions of the medical field of knowledge: medical care (i.e. NHS) and professional education (i.e. undergraduate courses). In the first analytical period, general practice was

associated with the discursive concepts of "*promotion"* and *"prevention*", which were presented as fulfilling the strategic goals of the NHS. In the second period, the cost-effectiveness of general practice gained recognition in the NHS and some of its most important principles were incorporated into the characterization of the service (i.e. family and community focus, continuity of care). At the same time, the discursive element of "*de-hospitalization*" of medical education expanded clinical placements beyond university hospitals to include other NHS services. In the final period, the characteristics of general practice knowledge were incorporated into medical education as competences to be taught and learned in all undergraduate courses. The discursive concept of "*patient-centred care"* illustrates the connection between NHS policies and medical education through the diffusion of general practice knowledge into education competences.

In summary, the discontinuities in medical education discourse and their associations with the discontinuities in general practice characterization highlight the important role played by the latter as a discursive concept and object in the assimilation of NHS principles into medical education. This unifying role of general practice legitimizes its inclusion in medical education policy, paralleled by the transformation of its characterization through the process of "academification".

The next section discusses the institutionalization of family and community medicine knowledge in Brazil. As described before in chapters 1 and 9, "family and community medicine" is the term used in Brazil for the field of knowledge called general practice in the UK.

12.2.2 Institutionalization of family medicine knowledge in Brazil

The analysis identified two discursive eras (chapters 10 and 11), also embedded in a historical context with consequences for the model of health care and medical education. The first sub-section consists of a review of the analytic eras and their contexts. The second correlates the institutionalization of family medicine knowledge with the SUS-medical education relationship.

12.2.2.1 The analytic periods and the institutionalization of family medicine knowledge in Brazil

In the first period (1980s-2000s), medical education is portrayed as inadequately meeting the health needs of the Brazilian population and requiring more ambitious training goals to reflect the country's health care realities. This period is historically characterized by the process of re-democratization of Brazilian society after 30 years of military dictatorship. During the latter, a liberal capitalist, hospital-based model had dominated health care. In the course of re-democratization, the foundation of the national health system (SUS) focused on the development of universal public health care, which would coexist with the private model.

Medical education policy in this period shifted its emphasis to c*omprehensive care* as a discursive element applying to both the SUS and medical schools. My analysis examined how primary care became seen in policy documents as adhering to the principles of *comprehensive care*. An approach to primary medical care known as general community medicine (later family and community medicine) had already been recognized as a medical specialty at that time by professional institutions but did not form part

of medical education policy in this period. Other medical specialties, particularly social medicine/public health, filled the educational space created by the introduction of primary care. According to Cruz (2004), the departments of social medicine/public health were peripheral to the academic milieu constituted by medical schools. The growing importance given to primary care was an opportunity to change this power structure, despite the absence of family medicine as a formal specialty. This is evidenced by the availability of new subject positions in undergraduate education: students were to become *generalist doctors*, ready to work in primary care; *specialist teachers* were to deliver education at this level of care; professionals working in primary care, *generalist family health specialists*, were to be supervised by *specialist teachers* during practical teaching sessions.

The analysis of policies in this period also identified a shift of emphasis in medical education from a model of private-hospital specialism to one of comprehensive public health. This would give medical education institutions (i.e. ABEM, medical schools) influence over policies without displacing completely the role of specialty departments, which continued to follow the liberal capitalist model of health care. This disputed environment, however, provided no space for the inclusion of any form of primary care speciality in the educational setting.

In the second analytic period (2010s), undergraduate medical education policies continued to emphasize a *comprehensive* model of health care, supported by a *collective health* discourse that was beginning to inspire changes to clinical practice and teaching (11.2.1). This historical moment is marked by a continuous period of democracy in which public policies aimed at

reducing social economic inequality were consolidated across the country. In health care, primary care was vastly expanded through the Family Health Strategy.

Policy documents of this period make clear the distinct role of primary care in medical education compared with other settings (i.e. hospital, polyclinics) and the urgent need to fill medical posts created by the massive expansion of primary care. This is reflected in a proposal to expand medical education by a further 1-2 years of obligatory clinical training in primary care (creating a partially qualified workforce to take on less onerous duties). A "new" government-sponsored primary medical care specialty (*family and community general medicine*) is created to justify extended training in primary care ahead of further specialization, and does appear in medical education policy.

The documents analysed in this period point to a shift in power relations within medical education policymaking. The prominence of a *collective health* discourse and the need for more primary care workers resulted in government agencies (i.e. Ministry of Education, Ministry of Health) taking on wider policy responsibilities, while medical education and professional bodies became less influential in setting the direction of national guidelines. This is evidenced by the exclusion of family and community medicine, a medical specialty recognized by medical institutions, in policy documents and the eventual publication of a postgraduate medical education policy (in 2014) in which it is officially replaced by the "new" government-backed specialty of *family and community general medicine*.

The following sub-section links the institutionalization of family medicine knowledge to the SUS-medical education relationship.

12.2.2.2 Family medicine institutionalization and the SUS-medical education relationship

I have highlighted two major discursive components in the characterization of family medicine knowledge in medical education in Brazil. The first is the initial exclusion and subsequent inclusion of family and community medicine in medical education policy. This goes hand-in-hand with the second: the closer relationship between the SUS and medical education in Brazil. In the first analytical period, the emphasis given to public health (through the *comprehensive care* discourse) allowed no space for a field of knowledge from another medical specialty. Teaching of primary care was therefore left to the medical specialty of public health (*specialist teacher*).

The demand for *generalist doctors* in the SUS in this period did not support the extension of medical education to postgraduate training. At the same time, the change in nomenclature from *general and community medicine* to *family and community medicine* distanced the specialty from the notion of a *generalist doctor* and moved it closer to the concept of a primary medical care specialty in line with the Family Health Strategy. In policy documents of this period, the position held by the *family health generalist* was linked to the concept of the *generalist doctor*. Nevertheless, the discursive elements that characterized family medicine as a medical specialty were now part of medical education as never before.

In this first period, primary care is equated in value to hospital-based care, while the importance of clinical knowledge and specialty

departments is maintained. In the second period this power balance changes towards primary care and, with it, the degree to which family medicine is reflected in policy documents. The *collective health* discourse required a new approach to clinical practice and teaching that could only be supported by a medical subject position that functioned as a clinician (i.e. not just a public health specialist). The creation of a "new" medical specialty (i.e. family and community general medicine), and the proposed extension of medical education to include 1-2 years of postgraduate training in primary care, provided the discursive context for this clinical role. As a concept within the *collective health* discourse, the "new" discipline is isolated from the influence of the existing medical specialty: its characteristics are defined by government policy rather than by medical institutions. Nevertheless, the two fields of knowledge would eventually be aligned by mutual agreement of the various actors, marking the formal incorporation of family medicine into undergraduate medical education policy. This development mirrors power shifts in the wider fields of collective health, social medicine and public health. In chapter 11, I highlighted the involvement of the discourse of family medicine in reforming medical education policy from a disease/hospital/private model to a health/primary care/public model of health care. This is also reflected in the increased social responsibility expected of medical students and graduates – a discursive innovation that would place family medicine knowledge on the frontline of a dispute regarding health care in Brazil.

12.2.3 Institutionalization of general practice knowledge in the UK and Brazil

In this section, I compare the discursive institutionalization of general practice knowledge in undergraduate medical education policy in the UK and Brazil. I have focused on two main differences: the first concerns the predominant discursive polarities that influenced the characterization of general practice knowledge across the discursive practice in both settings; the second is the inclusion of the discourse on competence, which, while present in Brazilian policy, had a much greater impact on the characterization of general practice in the UK. With regards to similarities, I highlight the relationship between medical education and the national health systems in both countries and the role played by general practice knowledge in this. These topics are detailed in the sub-sections below.

12.2.3.1 Discursive polarities: academic and non-academic; private and public

This section discusses the dominant discursive polarities that shaped general practice knowledge in the medical education policy of both countries.

In the UK, a strong body of medical education institutions (i.e. GMC, representatives of medical schools in governmental committees, Royal Colleges) were responsible for a series of policy discourses which reinforced the privileged position both of academic institutions and the scientific approach to medicine. General practice knowledge was similarly shaped by these forces, adapting to both the academic discourse and the dominance of

the university hospital setting (i.e. *patchwork of medical specialties*; *clinical science-internal medicine*; *medical specialty*). Despite shifts in the balance of power, the position held by medical education institutions was stable and dominant across the analytic timeframe. But whereas general practice gained power and status in the first and second period of the analysis, in the final period general practice knowledge diffused into the broader curriculum. This both underlined and devalued the importance of the discipline.

In Brazil, the re-democratization process and the establishment of the SUS (in opposition to the private model of health care) strengthened the public health discourse in medical education institutions (ABEM), medical professional institutions (CFM, AMB) and governmental bodies. The inclusion of primary care in medical education policy was paralleled by the rise of departments and disciplines of public health, which became responsible for teaching primary care-based modules. However, teaching in primary care was essentially composed of non-clinical themes (i.e. health and society, public health principles and organization, management of health care systems); there was no space for a medical specialty, such as family and community medicine that would combine knowledge from both the public health and clinical medical specialties.

In the second analytical period, stronger governmental involvement in policymaking reinforced the discursive strategy of public health through the inclusion of a *collective health* discourse, with accompanying changes to clinical practice and teaching. In this context, the incorporation of family medicine as a discursive element of *collective health* legitimized changes to the delivery of health care services. Family medicine in undergraduate policy

was shaped by an emphasis on a public health/social medicine/*collective health* discourse that was less evident within academic institutions.

This discussion points to an important difference in how general practice is characterized in both countries: an academic/scientific/clinical discourse dominates medical education in the UK, whereas a public health/collective health discourse prevails in Brazil. In the UK, the struggle for power in this discursive field focuses on the tension between academic knowledge and service/practical experience. This is evidenced by the polarization of specialist consultants and general practitioners. Academic knowledge (i.e. science, research, hospital-based learning) is deemed superior to medical practice outside academia. This polarity has also been highlighted by Razack et al. (2014) in a discourse analysis of medical education texts on equity and selection of medical students in North America, which found that medical schools privileged academic excellence to the detriment of medical care. In the UK, the impact of this polarity can be seen in the very term “general practice”, implying the practical application of generalist knowledge as opposed to (and less valued than) specialist academic knowledge. Thus the historical exclusion of general practice from academia, recognized by Clarke (1966) in the early development of this medical field (5.2.4), is still present in its terminology.

In Brazil, the relevant polarity is between private and public models of health care. The mixed character of the health system, in which universal public services coexist with a significant private sector, is an important aspect of this. Primary care comes to the fore as provision of universal public health and comprehensive care, taking precedence over family medicine knowledge

in the policies of both analytical periods. The private-public health care polarity is also evidenced by the social responsibility attributed to medical students and graduates in Brazilian policies. This is described by Cruz (2004) in her discourse analysis of CINAEM documents in the 1990s, which detected a movement in medical education discourse away from the dominant biomedical model in the organization's final (third) phase of recommendations. The politically active positions granted to doctors, health professionals, patients and social collectives was part of this discursive shift. Social responsibility in the policy analysed in this study is a counter-discourse to the profit-focus of the educational process at the time. This is a phenomenon also highlighted by Whitehead, who identified social responsibility as a counter-discourse to the privileged position held by medical doctors and to the private model of health care in North America (Whitehead C. , 2011).

12.2.3.2 Discourse of competence

The predominance of the competence discourse in the final analytical period in the UK can be linked to the increased liberalization of the medical workforce in response to multilateral agreements, such as the Bologna Agreement of 1999, which guaranteed free movement of students and graduates within 29 European countries. This is evident from the references in policy documents to European standards of medical education. The decontextualized nature of the policies excludes evidence of this important influence. In Brazil, where the movement of professionals is not such a priority, the discourse of education competencies in both analytic periods is less prevalent. Its presence in Brazilian policies is associated more

with the discourse of medical education reform, reinforcing the comprehensive care discourse and its focus on public health.

Martimianakis and Hafferty (2013) investigated the association between medical education competences and globalization through a discourse analysis of medical education publications in a number of countries (with a focus on Europe and North America). They identified in these texts a hypothesis that medical practice crossed topographical and social borders (the “universal global physician”). This discourse was linked to definitions of globalization that emphasized the relationships of countries and the movement of populations. The emphasis on the medical education competences privileged the development of shared scholastic principles, reciprocal acknowledgment of qualifications and liberalization of professional practice (Martimianakis & Hafferty, 2013). A less dominant discourse was also identified, linking global competences to international health. This discourse focuses on transforming medical education through a broader political-economic-social model of health care that promotes equality (“global physician advocate”). The authors also make a connection between the development of universal medical competencies and the broader neo-liberal logic of self-governing, enterprising citizens (Martimianakis & Hafferty, 2013).

The incorporation of the discourse of competences into education policy in both countries therefore appears to follow a global trend. However, the policies analysed offer no justification or explanation for the shift to a competence-based curriculum, presenting it instead as a natural and unquestionable progression of medical education. Talbot has criticized this stance, arguing that the criteria-based approach of the competence model of

learning does not allow for a deeper and more reflexive attitude towards professional practice (Talbot, 2004). Talbot's point of view highlights the polarization between academic education and professional experience. The competence-based model's emphasis on the mastery of certain procedures, furthermore, does not take in consideration the complexity of real health care work environments.

12.2.3.3 The relationship between the public health system and medical education

My analysis also identified similarities in the medical education policy of both countries. One example is the way in which the incorporation of general practice in medical education policy parallels the development of the relationship between medical education and public health systems. In both countries, general practice is closely associated with the discursive elements that link these two previously separate worlds (in the UK: *prevention and promotion, de-hospitalization, patient-centred care*; in Brazil: *comprehensive care, collective health*).

This highlights the strategic role of general practice as a discursive field linking medical education with the goals of national health systems in addressing their population's health needs. By combining features from the discourses of primary care and clinical practice, the strategic characterization of general practice knowledge in medical education policy reflects both the development of stronger public health policies and the change in medical education brought about by the nationalization of health services.

In summary, the above sections offer a comparison of the discursive institutionalization of general practice knowledge in medical

education policy in the UK and in Brazil. I have highlighted the discursive polarizations of academic/ non-academic knowledge and private/public models of health care as influencing the incorporation of general practice into medical education in the UK and Brazil, respectively. In both countries, this incorporation is intimately linked to the development of the relationship between public health systems and medical education.

In the following sections, I describe the two most important discursive elements in the institutionalization of general practice knowledge: the specialism discourse and the expanding medical education discourse. I present these two discourses separately due to their specific and individual relevance to the characterization of general practice knowledge.

12.3 Discourse on specialism

In this section, I discuss the role of the discourse on specialism in the characterization of general practice knowledge in both countries' policies. The privileged position of specialist over generalist knowledge is presented differently across the analytical periods of both countries. The emphasis on specialist knowledge is evidenced by the dominance of hospital-based teaching over other health care settings (e.g. primary care). The discursive carousels (6.3.1.3, 7.2.4, 8.2.4) of overcrowded and overspecialized curriculum offer further evidence of the discursive emphasis on specialism, despite the implied criticism of this influence in the policies analysed. Whitehead highlights these discursive repetitions and emphases in her analysis of medical education policy in North America. (Whitehead C. , 2011). The hold of the specialism discourse over medical education is also seen in a bias towards postgraduate training in policy documents. Generalist knowledge

as a discursive element in medical education is valued in inverse proportion to the importance attached to specialism at any given time.

General practice in both countries was initially associated closely with social medicine. But while there was a shift towards clinical specialties in the UK, the link was maintained in Brazil through the inclusion of family medicine in the collective health discourse as a tool for reforming clinical practice.

The question of whether general practice should be considered a medical specialty also plays a role in the transformations analysed. In the first period of UK analysis, general practice was configured as the end product of undergraduate medical education, requiring none of the additional hospital training associated with medical specialties. In Brazil, where family medicine was already a specialty, its absence as a discursive element in undergraduate policy avoided both conflict with other specialties and the need for practitioners to undergo extended training. The *collective health* discourse was instead reinforced by the creation of a "new" specialty under direct government control, beyond the influence of medical institutions (i.e. educational and professional).

This section is divided into three sub-sections. In the first, I discuss the discursive polarities produced by the specialism discourse and the incorporation of general practice knowledge into the medical curriculum. In the second, I examine the role of the specialism discourse in protecting the status of medical professionals. In the third, I consider the fragile position (*discursive fragility*) held by general practice as a medical specialty in undergraduate policy.

12.3.1 Discursive polarization in the specialism discourse

In this sub-section, I characterize two discursive polarities in medical education policy: specialist and non-specialist knowledge (UK); and specialist and generalist knowledge (Brazil).

In the UK, the predominance of specialism was evident in all the analytical eras. In the first analytical period, general practice was recognized not as a specialist area of knowledge but as an amalgam of knowledge from other fields of medicine. The notion that general medical knowledge could have its own distinct characteristics therefore did not form part of the prevailing discourse. By the time general practice became a medical specialty in the second period of analysis, there was no space for any kind of non-specialized knowledge in the medical curriculum. In the final period, the discourse on competence can be seen as signalling a resurgence of general medical knowledge but without recognizing it as such (it is instead regarded as a foundation for specialized knowledge). General practice knowledge is consolidated as a specialty, requiring postgraduate training, and its role in medical education is matched to the role of specialist teachers (consultants). Nevertheless, the focus on competences withdraws from general practice any specific role in medical teaching associated to its characteristics as a field of medical knowledge.

In Brazil, where family medicine was already established as a medical specialty, there was an emphasis on general medical knowledge, described as *comprehensive care*, in both analytical periods. This was evidenced by the subject position of the *generalist doctor*. Despite the important position of specialist knowledge in the teaching of primary care (i.e.

public health, clinical specialties), the discourse of general medical knowledge was maintained in order to reflect the health demands of the Brazilian population. This discourse also played a role in excluding specialty family medicine from medical education policy. To include a primary care medical specialty would reduce the number of generalist doctors working in primary care and underline the need for further compulsory training.

In the second analytical period in Brazil, the compulsory extension of medical training and the creation of a “new” medical specialty would displace the role played by the generalist knowledge discourse. However, the latter is still present and continues to be part of recommended solutions for matching medical education with the population’s health requirements. The importance attached to medical specialties (associated with the private model of health care) is questioned through the discourse of comprehensive care and its emphasis on the public health system. However, in the policy documents the importance of specialism in medical education is dominant and unchallenged, and the position held by specialties is preserved, despite the reinforcement of general medical knowledge. This is evidenced by the inclusion of family and community general medicine as an additional medical specialty in medical curricula in the policies analysed by this research

In the UK, the discursive polarization centres more on the opposition between specialist and non-specialist knowledge. This polarity remains until the final UK analytical period, at which point specialist knowledge in undergraduate medical education policy is replaced by a competence-based curriculum in a response to the discourse of “universal global medicine” (Martimianakis & Hafferty, 2013). This discontinuity can be

seen as a rejection, from both the neo-liberal and social equality standpoint, of a discourse of specialism that grants power to medical professionals.

The specialism/non-specialism polarity in the UK contrasts with the findings of Whitehead in North America, which point to a continued attempt by medical education publications to value generalist medical knowledge (Whitehead C. , 2011). In Brazil, the polarized discourse is concentrated on generalist and specialist knowledge. These discursive polarities do not consider other ways of characterizing medical knowledge. Other publications (scientific, theoretical, professional) present general practice and family medicine as an interdisciplinary area of medicine, incorporating an understanding of different fields of knowledge beyond the medical sciences (i.e. sociology, psychology, geography) (WONCA, 2011). However, the concept of interdisciplinary knowledge does not form part of the medical education discourse in the policy documents analysed. When other fields of knowledge are integrated in medical education policy discourse, they are characterised throughout the eras as a discursive carousel, which is used to justify and perpetuate the necessity of change.

12.3.2 Protective character of specialism

Despite differences in the medical specialism discourses in the UK and Brazil, the position of specialty knowledge in the medical curriculum as described by policy is favoured in both countries. This specialism discourse is particularly important to medical professionals, as it offers protection against external threats. This is evidenced by the privileging of specialist knowledge through the continued extension of postgraduate training and the examination process for specialist accreditations. In this context, the characterization of

general practice as a medical specialty is unquestioned and absolute. Interestingly, general practice in the UK is not included in the specialist register held by the GMC: for a doctor to become a general practioner, he/she needs to undergo specific training and membership exam for the RCGP. In Brazil, family medicine is a medical specialty like any other, with the same prerequisites of postgraduate training and examination.

The sociological literature on professional systems has documented how occupational fields claim authority and protect themselves from other professions. In the medical profession, the specialism discourse grants a monopoly over practical techniques and proficiencies while also regulating, through postgraduate training and membership examinations, the entry of new practitioners to the field (Martin, Currie, & Finn, 2009). It creates an inter-professional (i.e. other health professions) and intra-professional boundary (i.e. other medical specialties). The discourse on medical specialism helped to overcome the presumed threat of de-professionalization and proletarianization following nationalization of the medical workforce. According to Freidson (1984), it has also allowed the rise of a “knowledge elite” that determines guidelines of conduct for subordinate-level doctors.

In the following section, I discuss the particularly fragile position held by general practice knowledge as a medical specialty.

12.3.3 General practice knowledge as a fragile specialty

The predominance of the specialism discourse in medical education policy provided space for general practice to be considered a specialty field of medical knowledge in both the UK and Brazil. However, the characterization of general practice as a specialty appears less secure than

that of other medical specialties described in policy documents. The results of the analysis of this research present general practice knowledge as particularly fragile to exclusion, inclusion and change. As evidence of this discursive fragility, in the first and second analytical eras in the UK, general practice is predominantly characterized as other medical specialties (i.e. patchwork; internal medicine). In the third period of analysis, certain features previously attributed to general practice knowledge (i.e. family approach, patient-centred approach) are subsumed into the competence-based curriculum, to be learned and taught by all.

In a study of patient-centredness, Klingenberg (2013) described how this discursive concept became a justification for change to all health professionals (under NHS policy) and a competence to be developed by all medical professionals and assessed under GMC guidelines. In my investigation, the patient-centredness skills described by the GMC (i.e. understanding the patient's experience, communicating with patients, using patients' expertise, liaising with local institutions) were found to be already part of medical education policy and attributed to general practice knowledge in the second analytical period in the UK. In the third analytical period these skills were amalgamated into a specific competence to be developed by all. This made "thinkable" several arrangements for delivering a general practice curriculum, such as giving less time to general practice and more to other specialties teaching the same content, and allowing greater participation of general practice in the teaching of other medical specialties. In short, general practice becomes less visible in curricular content that differentiates it from

other medical specialties and more visible in teaching provided to all specialties.

Similarly, in the first analytical period in Brazil, family medicine (an established specialty) is excluded and the generalist doctor occupies the space in primary care. In the second analytical period, this field of knowledge is recreated and is composed of specific health services knowledge (i.e. emergency services, mental health services), in sharp contrast to the definition of family medicine proposed by the professional institutions (i.e. CFM, SBMFC) which is aligned with the ones described in chapter 1 and published by the Wonca and WHO.

In my analysis, I associate this discursive fragility with the predominantly *soft technology*-based characterization of general practice, as opposed to the *hard technologies* that guarantee the stability of other medical specialties (i.e. internal medicine, surgery)(see **Table 15**). The concepts of hard and soft technologies in health care were developed by Merhy (2002). Theoretical knowledge, techniques, procedures and instruments are *hard technologies*, while *soft technologies* centre on the knowledge involved in building relationships between health professionals and people in their care.

Table 15 Characterization of general practice knowledge in medical education policy in regards to soft and hard technologies in the UK and in Brazil

	Soft technologies			Hard technologies		
UK	1st period	2nd period	3rd period	1st period	2nd period	3rd period
	Health promotion, Disease prevention, Practical.	Community medicine, Behaviour and social sciences, Continued care, Personal contact, Family approach, Readily available, Early identification of disease without	Patient centredness for all.	Limited knowledge from other specialties.	Internal medicine (clinical science), Diagnostic and therapeutic.	Competences and procedures for all.

		the aid of hard technology.				
BRAZIL	1st period		2nd period	1st period	2nd period	
	(Primary care) Comprehensive care, Health promotion, Disease prevention, Rehabilitation, Biopsychosocial model, Collective approach.		Collective health, Therapeutic project, Collective intervention projects, Popular Heath Education.	NA	Emergency, Home Care, Mental Health, Comprehensive Internal Medicine.	

Most medical specialties are consolidated through the concept of hard technologies, which in medicine are medical procedures dominated by biomedical knowledge (Merhy, 2002). Medical procedures are subject to institutional control, for example regulating access to specific settings (i.e. wards, operation theatres) and tools (i.e. surgical instruments, hospital wards apparatus). They are also more valued socially and academically compared with soft technologies (Whitehead C. , 2011), which are considered easier to learn and master. Hard technology legitimizes the treatment of knowledge as specialized, whereas in the case of soft technology this process is more vulnerable to diffusion between specialties and disciplines and less amenable to institutional control. In this way, general practice knowledge becomes thinkable as “universal”, rather than the domain of a single field of medicine.

According to my analysis, attributing this type of knowledge (i.e. patient-centredness) to all professionals involved in medical education has the effect of dispersing it across the curriculum (as is also the case with the social and psychological sciences). This is evidenced in policy documents by the repeated call throughout the analytical periods for patient-centredness to receive additional attention – a “discursive carousel” which in practice served to highlight its devaluation. Martimianakis (2011) defines this discursive process as a technology of domination, which embraces and, in so doing,

subverts discourses of opposition in order to maintain hierarchies of knowledge. Citing examples such as inter-professional work, interdisciplinarity, equity and social justice in professional situations, she argues that the partial inclusion of such counter-discourses serves to weaken criticism of the dominant discourse, a process she terms “diffusing by appropriation” (Martimianakis, 2011). The same process can be seen in medical education policy regarding aspects of education which focus on soft technologies, as exemplified by the discourse on patient-centredness.

The attribution of certain features of medical practice and knowledge to everyone involved in medical education suggests an inappropriate understanding of soft technologies and an unsuitable use of these technologies in medical education policy. Developing the capacity to appropriately use these soft technologies in medical practice is difficult to verify and assess. Moreover, the full acquisition of these technologies in learning and practice is beyond the scope of formal medical education, belonging more to work experience and personal reflection. It is also influenced by the personal characteristics of each professional and their ability to embrace areas of knowledge relating to the behavioural and social sciences (i.e. psychology, sociology). The characterization of general practice through these soft technologies, and the way in which medical education policy addresses this, places general practice in a particularly fragile position in the educational discourse. **Table 15** summarises the attribution of soft technologies to general practice throughout the analytical periods in both countries.

In summary, the predominance of the discourse on specialism has an important influence on the characterization of general practice knowledge in medical education policy. It polarizes medical education between specialism and non-specialism, and between generalist and specialist knowledge. The discourse of interdisciplinary knowledge is avoided and excluded. Nevertheless, the position of general practice knowledge is particularly fragile compared with that of other, “hard technology” specialties. These findings have been supported by a recent report published in the UK, *By choice – not by chance* (Health Education England , 2016), in which the authors list a series of recommendations aiming to challenge long held opinions about general practice as a less appreciated profession. The following section focuses on the discourse of extended medical education and its impact on the characterization of general practice knowledge.

12.4 Expansion of medical education, medical workforce demands and the characterization of general practice knowledge

In this section, I present the relationship between the discourses of never-ending and expanding medical education and the characterization of general practice in medical education policy. The expansion of medical education in time and space strengthened the importance of medical education institutions in building a workforce for the national health systems in both the UK and Brazil. The nationalized services also benefited from this expansion through the increased control over medical labour, which included a massive growth of less qualified and onerous posts (trainees) and the

maintenance of a smaller number of higher trained, more responsible posts (consultants). The characterization of general practice as a medical specialty in undergraduate education followed this discursive trend, which served the interests of both medical education institutions and national health services.

12.4.1 Time and space of medical education in the UK

In the UK, the discursive transitions of undergraduate medical education (time limited, insufficient, foundation for future training) led to a prolonged period of revision and restructuring, which culminated in general practice knowledge being recognized as a postgraduate specialty and not simply the end product of undergraduate training. This discourse of extended training is intimately linked to the need for an expanded medical workforce following the establishment of the NHS. In the first analytical period, the requirement of general practitioners to consolidate universal health care positioned general practice as the end product of medical education, reinforcing the role of medical institutions and state funding for medical schools. From the second analytical period onwards, the consolidation of the NHS and a general practice workforce led to the inclusion of other health services (beyond university hospitals) in undergraduate education and the transformation of general practice into a medical specialty.

The discursive transition that characterized the spatial expansion of medical education in the UK (from teaching centres to de-hospitalization and the recognition of other clinical settings as equally important places of training) consolidated the importance of both the NHS and primary care/general practice as clinical settings in medical education. The workforce dimension to these changes was also positive for the NHS, delivering an

increase in placements/training posts across all services in both undergraduate and postgraduate education. This discourse shifted the subject positions available for general practice from the “eternal learner” to the “practical teacher” and eventually to the “consultant/researcher”, on a par with hospital-based specialties.

The workforce organization of medical practice in the UK also underwent significant change across the analytic periods. Doctors moved from being autonomous practitioners to employees of the state (NHS). Medical trainees were absorbed into this process as compulsory workers in the public health system. Harrison and Ahmad (2000) have described the decline of autonomy within the medical profession since the establishment of the NHS. They compare the delivery of public sector medical care to a Fordism model of mass production, involving highly specific and routinized work. This decline of autonomy occurs at three levels, the authors claim. At the “micro” level (definition of treatment and work patterns), the increased importance of clinical guidelines and protocols, combined with greater managerialism of health services, gradually deprived doctors of decision-making control. The “meso” level concerns the medical workforce’s relationship to state power. The near absolute monopoly of the NHS over the medical workforce, and the increasing power of government to audit and regulation of medical practice, hastened the decline of professional autonomy. At the “macro” level (i.e. ideology), autonomy is constrained by the continual dominance of a biomedical model which equates ill-health to pathology and treatment to medical intervention. Nevertheless, it is the “macro” level, through biomedical knowledge, that protects the medical profession from

further external interventions. The authors suggest that ideas of a broader perspective of medical care, which might allow for a higher degree of individual autonomy, were rejected as early as the 1940s (Harrison & Ahmad, 2000).

Harrison and Ahmad's reflections on the macro level of autonomy accord with the findings of my own analysis. Most discursive attempts to introduce elements of a different health care paradigm into UK medical education policy have fallen into the discursive carousel trap (i.e. promotion, prevention, public health, behavioural sciences). The biomedical model has, therefore, been the major force in maintaining the power of medical professions in the UK, and in shaping the characterization of general practice knowledge in medical education policy.

12.4.2 Time and space in medical education in Brazil

In Brazil, the time extension of medical education is signalled in the second analytical period, despite the continuation of a discourse of the "ready to work" character of the generalist doctor. The expansion of primary care and its workforce demand was not initially supported by obligatory postgraduate training for all doctors. However, a compulsory period of training was established by a policy on the new primary care medical specialty (family and community general medicine) (Brazil, 2014). This solution highlighted the close relationship between medical education, nationalized health services and the medical workforce. In Brazil, this discursive context was responsible for the inclusion of family medicine in undergraduate policy; it also influenced the elements of the curriculum associated with family medicine, such as the

composition of health service placements (i.e. mental health, emergency), which included some outside primary care.

On the matter of this spatial expansion of medical education, the first analytical period in Brazil was characterized by a de-hospitalization agenda in which primary care became the increasing focus of medical education through a discourse of comprehensive care. Despite the discursive exclusion of family medicine knowledge from policy in this period, the emergence of principles of primary care allowed the *de facto* introduction of the specialty of family medicine into undergraduate education.

The mixed character of medical care organization (private and public) placed limits on government power over the profession in Brazil. Nascimento et al. (2005) have identified the different ways in which doctors participated in the job market in Brazil – as autonomous professionals, employees, civil servants, businessmen and "precarious" workers. The authors characterized this flexible workforce organization as the "Japanese model" (Nascimento, Nascimento, & Carvalho, 2005). The expansion of medical education in Brazil, therefore, was an attempt by the state to further regulate medical workforce production and practice. In this context, the characterization of family medicine as a specialty in medical education policy was a strategic move by government agencies to change their relationship with the professional workforce.

In both the UK and Brazil, the temporal and spatial expansion of undergraduate medical education is influenced by the workforce demand from the national health service. This analysis presents an opposite view to the one described by Whitehead (2011) in her discussion of medical education in

North America. Whitehead describes the institutions involved in medical education (professional and governmental) as preferring a shorter and more effective period of training. In this study, I have highlighted how institutions sought to exercise power over medical education and the professional workforce through an increase in the duration of the training process and the variety of placement settings.

A similar phenomenon has been described in research postgraduate education, where an extension of the period of "study", through temporary post-doctoral posts, allowed the maintenance of a much smaller number of permanent faculty positions (Fochler, Felt, & Muller, 2016). This hierarchical arrangement can be linked to a political and economic context of austerity, which limits public funding for health and education sector while opening up space for the private sector.

The characterization of general practice as a medical specialty is aligned with these changes in discourse. With regards to the discourse on specialism, the increased duration of medical education confirmed the privileged position of medical specialties, which were able to protect their knowledge through longer training. In terms of the spatial dimension, the specialties located within the university hospital setting had to find other means of regulating access to their fields of expertise. This was achieved through the Royal Colleges' membership examinations, which became a professional requirement regardless of where an applicant trained.

12.5 Discursive carousels

During the analysis, I came across elements of discourse that appeared continuously in policy documents, across the eras in both settings,

creating what Whitehead (2011) called a “discursive carousel”. Examples included discourses on the importance of public health, behavioural sciences and a biopsychosocial model of health care, as well as those relating to overcrowded and overspecialized curricula. These discursive elements were referenced either as absences (i.e. public health) or excesses (i.e. specialized knowledge) in medical education. In summary, these discursive elements were presented as problems in medical education and a justification for reform. Their continuous presence throughout the analytical periods evidences the discursive process by which problems are identified but never solved. They also fit the description of Martimianakis (2011) of discursive diffusion by appropriation, considered previously in this chapter, in that they are appropriated by medical education despite producing a counter-discourse to a biomedical model of care focused on the individual, on pathology, and on hospital-based and specialized knowledge.

Another dimension of the discursive carousel identified in this research regards the structure of the policy documents. The policy documents analysed by this research did not contextualize the changes proposed. The historical setting and its influence over the suggestions made are not considered. When read in isolation from their context, as they are presented, policy documents do not clearly present to readers their main influences. They could then be considered a-historical by a lay reader. This is also observed in the lack of references in the policy text to literature outside medical education policy. Most references made were to national health policies. Concepts used are not clearly defined and their epistemic origin in other fields of knowledge is not referenced. A discourse analysis has helped to construct these

associations and references. This structural discursive carousel creates an idea of medical education policy as an absolute field of knowledge that does not relate to or integrate with other areas.

12.6 Conclusions

This discussion chapter summarizes the discursive institutionalization of general practice knowledge in medical education policy in the UK and in Brazil. I have highlighted differences in discursive polarities and similarities in the discourse presented in both countries. I also describe the influence of the discourse of specialism and of the never-ending and ever-expanding nature of medical education on general practice knowledge as a medical field of specialty, and how the characterization of general practice was impacted by medical workforce reorganizations in both countries. In the UK, general practice is characterized by the predominance of a biomedical discourse, whereas in Brazil (as it eventually becomes part of undergraduate policy) it is characterized as part of a counter-discursive element opposed to this biomedical discourse. Table 16 summarizes the findings of this study and the discussion presented above.

Table 16. Summary of the findings of this study and the discussion presented.

UK	First period: Late 19th century – 1950			Second period:1950s – 1980s			Third period:1990s-2000s		
	Strategy	Concept	Object	Strategy	Concept	Object	Strategy	Concept	Object
	Undergraduate medical education as general practice knowledge	Prevention and promotion Teaching centres	General practice as patchwork of medical specialties	Undergraduate medical education as insufficient	Clinical sciences De-hospitalization Community medicine	General practice as internal medicine/ family medicine	Undergraduate medical education as foundation for future training	Clinical competences Patient-centredness	General practice as an uncharacterized medical specialty
	Subject positions								
	GP as eternal learner, practical in nature and subordinate Students capable or not of entering postgraduate training Consultants/specialists as academic and researchers Teaching and non-teaching patients			GP as internal medicine family doctor and practical teacher Clinical scientist De-hospitalized student De-hospitalized patient			General practitioner as uncharacterized consultant/specialist Future trainee Competent doctor Patient as centre		
Discussion	Institutionalization		"Academification" of general practice justified by its role in the NHS (Primary Care) (academic and non-academic knowledge)						
	Specialism		General practice as a discursively fragile specialty, soft technology-based (specialist and non-specialist knowledge)						
	Expansion of medical education		Mass production of medical care (Fordism) through a production line model of medical education (biomedicine dominance)						

BRAZIL	First period: 1980s -2000s			Second period: 2010s		
	Strategy	Concept	Object	Strategy	Concept	Object
	Undergraduate medical education as comprehensive care	Prevention and promotion Integration of levels of care	Absent presence of family medicine	Undergraduate medical education as collective health knowledge	Family and community general medicine Therapeutic plan	Family medicine as collective health knowledge
	Subject positions					
	Generalist doctor/medical student Specialist teacher in primary care Generalist family health professional Comprehensive patient Demanding collectives			Generalist doctor/medical student Family and community general doctor practical teacher Academic professor Supervised teaching health professionals Proactive and autonomous users (patients) and groups (communities, families)		
Discussion	Institutionalization		Exclusion and posterior inclusion of family and community (general) medicine justified by its role in the SUS (PSF) (private and public health care)			
	Specialism		Family medicine as a discursively fragile specialty, soft technology-based (specialist and generalist knowledge)			
	Expansion of medical education		Initial inclusion of medical education to the health care production line to strengthen the public sector (vs the private sector) (public health dominance)			

13 CONCLUSIONS

13.1 Introduction

In this final chapter, I summarize the main findings of this research and their potential implications for policy, education and practice. I also reflect upon the limitations of the research process and my journey as a researcher conducting this investigation. The first section is dedicated to the implications of the characterization of general practice knowledge. The second considers the dominant broader discourses and their implications. The final two sections describe the study's limitations and my personal reflections as a researcher.

13.2 General practice in medical education policy

My research studied the discourses that characterize general practice knowledge in medical education undergraduate policy in the UK and Brazil. Through a discourse analysis, I was able to construct what was "seeable, sayable and thinkable" about general practice knowledge in a specific period of time in both countries. Moreover, I identified the changes to what is thinkable of general practice knowledge in time and place according to the different discursive elements (i.e. statements, objects, strategies) that characterize it in diverse forms. A Foucauldian discourse analysis helped me examine the specific ways of characterizing general practice and the power/hierarchical position attributed to it.

I identified general practice as a particularly fragile field of medical knowledge, seen in the various shifts in its characterization in time and space and its frequent absence in the dominant discourses of each discursive era.

The process of inclusion or institutionalization of general practice knowledge in medical education policy was influenced by the historical context of changes to medical education and the organization of heath care. In the contexts described, the institutionalization of general practice knowledge strengthened the relationship between medical education and the organization of universal health care in both countries. Depending on the predominant discourses, general practice was described differently in the UK and Brazil. In the UK's policies, the predominance of the clinical sciences and clinical competencies discourse steered general practice towards the clinical medical specialty field. In Brazilian policies, general practice was characterized as a clinical field of knowledge in public health and collective health as part of a counter-discourse to the clinical sciences.

The struggle of general practice knowledge, within the documents, to establish itself as a consolidated field of medicine suggests a need for stronger representation of general practice institutions (e.g. RCGP, SBMFC) in medical education policy production and a more critical approach to policy writing, based on an awareness of discourse and discursive elements in use and their implications in terms of power production. Despite the efforts of national and international institutions to define general practice/family medicine as a field of knowledge and practice, undergraduate medical education policy has not fully incorporated it.

The ways in which general practice is made thinkable within the different discursive periods produced in this research excludes other forms of characterization. In light of my findings, I suggest a stronger effort to clearly define general practice knowledge in medical education policy. This definition

should support a distinct position for general practice knowledge in policy and its implementation in medical schools. The key question should be: how can we characterize general practice knowledge as a differentiated field of medicine that is not so susceptible to the power struggles played out in policy production? At the same time, the means of characterizing general practice knowledge should avoid the discursive elements that de-characterized it in medical education policy and consolidated a particular approach to the development and regulation of medical knowledge in each country, as described in the discussion chapter. In this view, there are three ways to portray general practice as a less vulnerable field of medical knowledge. The first is to place stronger emphasis on the role of general practice knowledge in the consolidation of universal health care. This stress on general practice as universal care could shift the balance in the UK from a discourse polarized between specialism/non-specialism to one of generalism/specialism; and in Brazil from a polarization between public/private to one of universal/non-universal care. This discursive element could be further explored and established as one of the central features of general practice in policy documents. As the medical field most accessible to the overall population, general practice plays a major role in translating and offering access to important medical science innovations.

The second approach would be to consolidate general practice as an interdisciplinary field of medical knowledge, rather than a medical specialty. This would distinguish it from other medical specialties and recognize its essential value as described by its national and international institutions. As an interdisciplinary field of medicine, general practice would

amalgamate knowledge and skills from other fields that could enrich its practice in primary care. These other fields of knowledge could include, for example, sociology, psychology, management and other medical approaches (integrative/complementary medicine). However, these fields should not feature through a discursive process of diffusion by appropriation, as was the case in the policy analysed in this study. General practice as a distinct medical field should develop a profound knowledge of these areas and absorb concepts and tools (hard and soft technology) into its practice and teaching. This profound understanding of non-medical fields could form a sub-specialty of general practice that is not shaped by conventional medical specialties (i.e. dermatology, psychiatry, paediatrics), although knowledge from these specialities would still play a part in daily general practice. These sub-specialty fields of knowledge may enhance general practitioners' capacity to develop their role in primary care through comprehensive care, a person-centred approach and health promotion, in a way which is distinct from other fields of medicine.

The third step is to structure general practice knowledge in a way that avoids the appropriation of its particular characteristics by medical specialties that do not have the competence to do so effectively. The incompatibility between these other fields of medical knowledge and the main features of general practice as defined by national and international policies could be recognized. Medical specialties that are in essence structured by a biomedical paradigm (hospital-based, centred on disease management and individual treatment) cannot develop and teach promotion, prevention,

comprehensive care and a collective/community approach, unless there is a major change in the structure of medical specialty knowledge.

13.3 Dominant discourse and general practice knowledge

This research also contributes to broader discussions in medical education and practice beyond general practice knowledge. During the analytical process, I reflected on more general medical discourses that shaped general practice knowledge in undergraduate medical education policy documents. These general discourses are concerned with the main discursive strategies identified in the discussion chapter: institutionalization of medical knowledge, specialization of medical knowledge, and ever-expanding medical education.

13.3.1 Institutionalization of medical knowledge

The institutionalization process through which certain knowledge is legitimized by a particular discourse (in this case by academic discourse) is not impartial or stable. At various times and in various places, different discursive strategies produce a different characterization of discursive objects and subject positions. The “academification” of knowledge in medical education policy leads to the tacit exclusion of other knowledge that is not considered part of the academic discourse. This has been evidenced by concepts like the *hidden curriculum* in medical education publications. What I want to highlight in this section is the creation of a polarity between academic and non-academic knowledge. Academic knowledge is given a more valued position, whilst non-academic knowledge is associated with work activities that do not involve formal education. The development of expertise through

continuous work-based learning involves an educational process that is not formally recognized by medical education policy discourse.

This realm of non-academic knowledge has been conceptualized by theories concerning work-based learning. This includes formal education activities conducted in work settings, like clinical placements and postgraduate medical training. Morris and Blaney (2014) have questioned the disadvantaged status of work-based learning, citing the increased use of "protected teaching time, investment in formal teaching spaces and simulation resources within clinical environments, and investment in off-site development opportunities for trainees and their trainers". The authors highlighted the advantages of work-based learning in developing proficiency through continuous engagement with a workplace team culture, constant supervision and longitudinal relationships with both academic and clinical staff and patients. According to the authors, "longer, integrated clinical attachments offer a range of potential benefits, including enhanced professionalism, more holistic appreciation of the course of illnesses and greater patient-centredness". Students undergoing work-based longitudinal attachments tend to develop a more independent and proactive attitude towards patient care (Morris & Blaney, 2014).

In the polarization between academic and non-academic knowledge, I highlight aspects of informal work-based education that take place beyond the educational setting, for example after medical training. This informal learning process takes place mostly during the later stages of a medical career and generates particular expertise. This is a time when trained doctors continue to improve, adjust and develop in their workplace, assuming

more responsibilities and adapting their knowledge to different circumstances (Morris & Blaney, 2014). The improvement of proficiency through continuous learning in the work environment involves an educational process that is not properly acknowledged by the medical education policy discourse.

Another dimension of general practice that is undermined by academic knowledge is the possibility of a meaningful exchange between practice and theory. This has been well discussed by Ménard and Ratnapalan (2013) who reviewed the application of such “reflexive” models to medicine (i.e. (Schön, 1983; Dewey, 1933; Boud, Keogh, & Walker, 1985; Mezirow, 1991)). Paulo Freire (1996) also emphasized the inseparable character of teaching and a critical perspective of practice and theory, in which a cycle of mutual rectification and ratification is established. In the medical education policies analysed, the privileged position granted to academic knowledge establishes a unilateral process in which knowledge is produced in academia and applied in practice. This discursive construct further evidences the disadvantageous position held by general practice knowledge if positioned as practice-based or experiential rather than academically-generated. A greater emphasis on the practice-theory cycle could move medical education closer to the real context of medical practice and acknowledge the value of professional development beyond formal education. General practice knowledge would also gain higher status and recognition if it were characterized as a practice-based academic discipline in which theoretical constructs were intimately linked to health care practice.

13.3.2 Specialism

The predominance of the specialism discourse was also highlighted by this analysis as a discursive strategy to protect the medical field of knowledge and profession from internal and external pressures for change. With regards to professional status, the specialism discourse has protected medical workers from deprofessionalization and proletarianization. The specialism discourse in medicine privileges a reductionist and biomedical perspective of human health phenomena and care. Reductionism is associated with philosophical ideas that describe phenomena in ever simpler or more fundamental terms. The biomedical model is associated with an emphasis on disease management, physical processes, individual diagnosis and treatment, and hospital-based interventions. The emphasis on the specialism discourse in medicine consolidates a particular positivist scientific paradigm while excluding the possibility of the emergence of other scientific paradigms (i.e. constructivist or transformative).

As with the academic discourse, the specialism discourse, present in policy from both countries, creates a unidirectional focus of medical development towards specialized knowledge (reductionist and biomedical). The problem of overspecialization in medical education and practice has been widely discussed and forms part of the “discursive carousel” identified in this thesis. In my findings, it was presented as problematic in both countries across the discursive eras studied. Medical education literature has widely discussed how a focus on ever-smaller parts of the human body or on specific diseases allows specialist doctors to lose contact with the patient as a whole. The protection for medical professionals afforded by overspecialization has

allowed them to secure a particular slice of the market of health care demand, and also discouraged new medical graduates from pursuing general practice. The costs of an overspecialized health care system have also been criticized, while the effects of overspecialization on medical care have created the need for quaternary prevention that focuses on avoiding harm caused by medical intervention.

In the specialist discourse, general knowledge, which is closer to other fields of knowledge relating to human health and care, is less privileged. This contact with other fields of knowledge creates the possibility of interdisciplinarity and transdisciplinarity and opens up the possibility of a complex understanding of reality, in contrast to a reductionist view. Edgar Morin (2014) has highlighted the importance of a continuous movement between general and specialized knowledge in order to (re)contextualize or reframe the latter in relation to a complex perspective of understanding reality. According to Morin, the whole is “more and less” than its parts: more because the person under care, for example, has certain qualities and properties that cannot be found in, say, organs or body systems; and less because the whole person cannot, like an organ, be transplanted and maintain its unity. Morin reasons that a smaller unit of a particular system can only be understood from a systemic perspective, as part of a whole. He proposes a “trinity” made up of the whole, the part and the whole in each part (Morin, 2014). From this perspective, the cycle between general and specialized knowledge offers a possibility of restructuring medical knowledge and profession. The findings of my research highlight the absence of such a paradigmatic perspective in medical education policy. The inclusion of such an understanding of

knowledge would strengthen the importance of disciplines such as general practice, which could potentially restructure and reframe specialized knowledge by relating it to a broader scientific context.

In both countries, the discourse of specialism dominated the characterization of general practice knowledge. It also regulated the medical profession in the context of the establishment and consolidation of universal national health services. The expansion of the training period and of the clinical settings (beyond university hospitals) of academic medical education reinforced the discourse of medical specialism and created a structure for state regulation of the medical profession. This is further discussed in the following section.

13.3.3 Expanding medical education

The prolongation of medical education and its expansion throughout the health system has added another dimension to medical knowledge and professional corporatism. This discursive strategy has strengthened the academic and specialism discourse and expanded it in time and space as part of a strategy of creating a compulsory continuum between undergraduate and postgraduate medical education. This continuum creates a further strategy of protecting medical knowledge from change and innovation brought about by different discourses, paradigms and rationalities, as it becomes ever more difficult for individuals to sustain an opposing view to a dominant discourse for the duration of the educational process.

The expansion of medical education has also created a different organization of medical work. Unlike other work structures, the production of medical care has been organized to include the education process. Medical

students and trainees are increasingly immersed in the production line of medical care. In an industry in which the increasing dimension of specialization is prevalent, the most “reasonable” solution for education is to continuously expand. The model of organization of medical work resembles the Taylorist and Fordist models, with their specialized workers and measures of efficiency (Nascimento, Nascimento, & Carvalho, 2005). However, in the medical profession, and especially in hospital settings, the majority of tasks are carried out by a workforce in training, which is an economic necessity of longer formal education. However, this structure or model of work organization, which could be called “traineeism”, does not reflect the reality of general practice/family medicine in the two countries under study, due to the vast number of services needed to offer universal access to health care and the frequent shortage of qualified practitioners. This dominant discursive strategy in the policy documents analysed needs to be further explored in terms of its advantages and disadvantages (e.g. quality of health care provided by trainees; cost-effectiveness). The prolonged, demanding and compulsory nature of medical education makes it difficult for students and trainees to look outside the established “truths” of medical knowledge. Further studies could provide deeper understanding of the theoretical, practical and ethical implications of structuring the production of medical care and medical education in this way.

The discursive constellation constructed through this analysis strengthened the institutions involved in the production of medical education policy: the medical professions, medical academia and the (state-run) health care systems. Longer training processes and specialist exams and

memberships increasingly protect the medical profession from external and internal drivers of change. Academia is continuously involved with the medical profession and medical care throughout the training period, while governmental institutions regulate access to employment in a nationalized health system via the medical education pipeline. In this sense, general practice knowledge is treated as a medical specialty, shaped by prolonged training and a specific clinical discourse in each country. A discursive strategy that considers and values work-based education, as discussed previously in this chapter, would produce a completely different educational scenario.

13.4 General practice and predominant medical discourses

This research has identified three major discursive strategies in medical education policy through the characterization of general practice knowledge. As described above, the predominant discourses in medical education policy weaken the position held by general practice knowledge in relation to other medical fields. A policy that strongly values the reflexive cycle between academic and practice knowledge and the theoretical movement between general and specific knowledge could potentially reposition general practice knowledge in undergraduate medical education. These paradigmatic changes to the predominant discourse in medical education policy could potentially have repercussions in terms of medical practice. The characterization of general practice knowledge in future policy documents could reflect this paradigmatic shift in order to produce stronger, more stable and authoritative thinking in this major area of medical knowledge. If associated with the more specific characteristics suggested in the beginning of this chapter (general practice as universal health care, general practice as

interdisciplinary knowledge, and the avoidance of appropriation by diffusion), it could also strengthen general practice knowledge as a whole.

In Foucault's *Birth of the Clinic*, the author characterizes the discontinuities in medical discourse from the salvation of souls to the observation and treatment of human bodies (the medical gaze). In the policies analysed in this research, the predominance of the medical gaze remains, but with different emphases identified through the discourses of clinical science, standardized medical practice and medical education through the development of competences. In parallel, a different perspective has developed, that of a biopsychosocial model of care, with emphasis on prevention and promotion, comprehensive care and patient-centredness. The nationalization of the medical workforce has also influenced the medical discourse towards an "industrialization" of medical education and care in both countries. At the same time, discourses of specialization, efficiency and competence have been reinforced. From this perspective, general practice has a privileged position to develop a paradigmatic transformation of medicine and make it accessible to the population.

13.5 Limitations

Foucauldian discourse analysis, like any other method, has its limitations. This sub-section focuses on two of these: (1) the time period established by the study and (2) the selection of documents. My choice of time period was concerned with both the characterization of general practice and the comparison between countries. With this in mind, the establishment of both national health systems was an important event that restructured what was thinkable of general practice knowledge in undergraduate medical

education. In accordance with my historical background relating to general practice in medical education, this event in both countries can be considered a major discursive discontinuity. After this decision, I tried to map all national policy documents on undergraduate medical education and include them in this research. As described in the methods chapter, I excluded other policies on postgraduate training and public health, analysis of which would probably have yielded different findings.

Another limitation regards the analysis itself. A Foucauldian discourse analysis is quite a singular activity, taking account of the mutual influence of researcher, researched and social context. The analysis was an interactive process: a continuous movement between the categorization of texts, discussions with supervisors and the writing up of results, with frequent unawareness of what was about to emerge and numerous iterative and critical comparisons of completed findings and analysis. Usually, I only became fully able to articulate the nature and implications of the results of the analysis during the process of writing a chapter. I cannot claim that another researcher attempting this investigation would have established the same timeframe and set of documents or identified the same discursive elements and processes.

The restriction of the data set to national undergraduate policy documents was an important limiting factor. The characterization of general practice knowledge could have been complemented by research publications, textbooks and curricular documents, to mention just a few. From my broad understanding of the history of medical education in both countries, I decided that policy documents were the key to understanding the discursive context in each of the periods described and to developing a critical stance towards

other texts in the same settings and periods. Perhaps the features attributed to general practice knowledge in undergraduate medical education policy were different from the characterization constructed by general practitioners themselves through their representative institutions and documents. This difference has been in my mind throughout the research process and has been important for me to identify the characterization produced in the policy documents analysed.

The question of how the researcher and the object of research are shaped by the investigative process is crucial to the Foucauldian approach to discourse analysis and perhaps a limitation in itself, as one analysis cannot reproduce another. The development of a critical view of this mutual influence is imperative. In this sense, my thesis is a product of a discursive tradition and associations of power that offer a specific “truth”. My analysis has been shaped by my experience as a family doctor in clinical practice and in medical education. I have made a point of identifying and analysing any assumptions and claims that have emerged from my previous experience through the reflexive sections in each chapter. The presentation of my results and of the extracts taken from the texts is intended to clarify my investigative process, my engagement with the texts and the production of analytical findings from the textual analysis. Returning to the full policy documents in later stages of the research confirmed my findings, but also challenged my decisions on the most illustrative sections, given the abundance of relevant material in certain documents. My interaction with research supervisors and presentations in conferences and workshops provided important additional feedback on my reflections and conclusions.

Another limitation was the focus of the analysis on general practice knowledge. In this study, I did not aim to produce a comprehensive historical analysis of policy documents or of the characterization of general practice knowledge. Throughout the analysis, I came across many different discursive objects that triggered my attention and curiosity (e.g. behavioural sciences in medical education, characterizations of the patient). Focusing on these other discursive objects could have produced different discursive strategies and concepts. Nevertheless, the emphasis on the chosen discursive object of this research enabled the production of a cohesive and thorough analysis.

13.6 Reflections

While at the outset of my research, I was unsure what to expect from the analysis of policy documents from the UK and from Brazil, I am aware that I harboured certain preconceptions. These included an idealized perspective of general practice and the NHS in the UK, which was a recognized model for the Brazilian health system and family medicine. I also did not expect to find such a vacuum in Brazilian policy on family medicine. As the research process progressed, I was able to give up on my assumptions and accept the findings of the emerging analysis and to produce a critical curiosity.

The research I have undertaken is distinct from previous studies in several respects: first, it focuses on the discursive characterization of a specific field of medical knowledge (general practice); second, it analyses medical education policy documents in a historical frame; third, it adopts an unusual and critical approach to medical education research (Foucauldian discourse analysis) to examine what is thinkable and unthinkable within this

field; and finally, it compares policy from two countries with specific similarities and differences, allowing a critical engagement between the two. I hope my description of the method is clear and helps other researchers understand my particular approach and perhaps replicate it in future studies.

The approach to Foucauldian discourse analysis used in this research considered the many ways in which it has been used in medical education research and other fields, especially in the analysis of policy documents. I have emphasized the characterization of general practice knowledge through the different discursive elements produced in the analysis. The discussion and conclusions are also focused on this main element and pay less attention to subject position and discursive concepts, for example. The latter are used as evidence of the characterization of the main discursive object under study. A different focus of analysis could have provided more information on the discursive elements, but this was not a priority of my research. There are many findings which I am extremely curious to develop further, but for this thesis I had to maintain the focus on answering the research question.

Through this analysis, I have also highlighted the predominance of certain discursive strategies and how they have shaped medical education and practice. These strategies were particularly important to the characterization of general practice in the policy documents, but they also limited general practice to a specific, paradigmatic understanding of medical education and medical care. An equally important dimension of the analysis consisted of identifying what has been excluded from policy discourse and from medical education.

In my development as a researcher, I had to re-examine my preconception of general practice and family medicine in the UK and Brazil, respectively. I was both an outsider and an insider in each country. I have undergone no formal medical education in the UK, apart from the current PhD. At the same time, my position as a patient in the NHS and as an honorary professional in primary care health services has given me an insider's perspective. In Brazil, I am an insider, since it is my home country and the place where I studied and practised medicine for fourteen years. Nevertheless, the four years spent away have given me some distance to look back at my experience and develop a critical perspective.

From my experience of living, studying and working in each country, I was able to reflect on the relationship between the discourses on general practice found in medical education policy and medical education and health care reality. As an example, the research department of primary care at University College London, where my PhD programme is based, is situated inside a university hospital (Royal Free Hospital). My very location, therefore, evidences the predominance of specialism and hospital-centred discourse in academia, reflected in the high social status of my department and its members and its proximity to political and financial decision-making. Most of the department's undergraduate teaching is based in the hospital, while its placements are in primary care services around the UK. In Brazil, I am one of two family medicine professors based in the social medicine department of the Federal University of Pernambuco. The department and most of its teaching and placements are based outside the university hospital. Interestingly, neither of these universities (UCL or UFPE) offers a primary

care or family medicine teaching service or have plans to provide such a facility.

Another example of the relationship between this analysis of policy and everyday experiences comes from clinical practice. In the UK, I have seen how general practitioners are instructed to conduct a short clinical consultation, standardized through protocols, during which patients are expected to report a single complaint. This could be seen as evidence of the influence of a predominant biomedical discourse on general practice. In Brazil, trained family doctors (only a small fraction of the doctors working in primary care) use tools from psychology and sociology, such as the family intervention approach and family risk and vulnerability scales, to formally address these dimensions of clinical practice. This difference is perhaps further reflected in the name of the specialty in each country (general practice in the UK; family and community medicine in Brazil).

Another point of contact between the current analysis and my personal experience concerns the crisis in recruitment in both countries. Graduate avoidance of general practice is reflected in the fragile position of general practice in medical education policy. I have no intention of proclaiming a direct cause-effect relationship between the two; however, it is important to emphasize the devaluation of general practice knowledge in this regard.

During my research journey, it was a particular challenge to connect and relate the bibliographic references for the two countries. I moved back and forth between these to make sense of and relate my analytical findings to the existing field of knowledge. In this effort, I gained further knowledge of authors developing medical education research in the UK and

elsewhere; I was also able to present the work of authors from Brazil who have helped me understand the world of medical education.

The results of this research have surprised me in terms of the relationship between discursive practices across the two countries. I now understand how the general practice academic community in both countries can learn from each other's developments. The way in which general practice has been shaped by dominant discursive strategies in each country provides useful information for future reflection on policy development. The clinical dominance identified in the UK, for example, possibly had a major influence on the academic consolidation of general practice. In Brazil, the collective health approach to family medicine has strengthened its counter-discursive position in shaping clinical discourse, but at the same time made it more difficult to achieve consolidation in the academic realm. And as described in the previous section of this conclusion, I have outlined some possible changes to the characterization of general practice that could differentiate and enhance its position in relation to other medical fields of knowledge.

The methodological development of my study was especially challenging due to its subjective and constructive nature. I was particularly influenced by studies from the few medical education researchers (e.g. Whitehead, Hodges, Park, Klingenberg) who have attempted to conduct Foucauldian discourse analysis in different settings (e.g. North America) and using different data sets (e.g. published articles, polices, curriculum). The development of my own approach involved a return to Foucault's work in order to critically reflect on current uses of discourse analysis under his influence.

The use of policy documents to produce the discursive elements described in my research was instructive. Before this research, I had no critical framework for reading policy documents. Some of the discursive processes I came across in this research, such as appropriation by diffusion, the discursive carousel, internal counter discourses and paradoxes, have equipped me with particular knowledge in the use of discourse which I can use to critically understand social life as a whole (e.g. politics, research, education). This knowledge also exemplifies what Morin describes as the actions of *homo sapiens demens*, which is the product of human rationality/awareness and madness/unconsciousness (Morin, 2014). Since undertaking this research, I have read and listened to words in a completely different manner, informed by discursive concepts relating to power, history and knowledge. One of my hopes for this thesis is that it will motivate other academics and professionals to develop similarly critical stances in their own way.

I believe that this research and its findings produce one more piece in the puzzle of understanding the position held by general practice in the medical field of knowledge and how to tackle a number of problems faced by universal health care systems and medical education. Policy documents are not a-historical or decontextualized and have the power to promote stability or change. More attention should be paid to policy production in general and the representation of general practice knowledge in particular. The latter should be emphasized to value its peculiarities in time and space and its special relationship to universal health care.

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15 APPENDIX

15.1 APPENDIX 1: Scope literature review of medical education research using discourse analysis and policy documents

The following list of articles comprises the studies found in the scope review presented in Chapter 2 of this thesis. These were the studies that used discourse analysis (not only Foucauldian discourse analysis) in medical education research. The list is divided by the database (e.g. Medline, PubMed) researched. Seven studies were identified as using Foucauldian discourse analysis. These were identified in Chapter 2. This list could help researchers interested in discourse analysis in medical education in future research.

Medline:

1. Discourses of student orientation to medical education programs. Ellaway RH; Cooper G; Al-Idrissi T; Dube T; Graves L. Medical Education Online. 19(1):23714, 2014 Jan.
2. Are patient-centered care values as reflected in teaching scenarios really being taught when implemented by teaching faculty? A discourse analysis on an Indonesian medical school's curriculum. Claramita M; Sutomo AH; Graber MA; Scherpbier AJ. Asia Pacific Family Medicine. 10(1):4, 2011 Apr 25
3. Setting the standard: Medical Education's first 50 years. Rangel JC; Cartmill C; Kuper A; Martimianakis MA; Whitehead CR. Medical Education. 50(1):24-35, 2016 Jan.
4. What supervisors say in their feedback: construction of CanMEDS roles in workplace settings. Renting N; Dornan T; Gans RO; Borleffs JC; Cohen-Schotanus J; Jaarsma AD.
5. Unravelling medical leadership]. [Dutch] <Medisch leiderschap ontrafeld. > Voogt JJ; van Rensen E; Noordegraaf M; Schneider MM. Nederlands Tijdschrift voor Geneeskunde. 159:A9123, 2015.
6. Learning about gender on campus: an analysis of the hidden curriculum for medical students. Cheng LF; Yang HC. Medical Education. 49(3):321-31, 2015 Mar.
7. Equal, global, local: discourses in Taiwan's international medical graduate debate. Ho MJ; Shaw K; Liu TH; Norris J; Chiu YT.

8. Seeking inclusion in an exclusive process: discourses of medical school student selection. Razack S; Hodges B; Steinert Y; Maguire M. Medical Education. 49(1):36-47, 2015 Jan.
9. Supervised learning events in the foundation programme: a UK-wide narrative interview study. Rees CE; Cleland JA; Dennis A; Kelly N; Mattick K; Monrouxe LV. BMJ Open. 4(10):e005980, 2014 Oct 16.
10. Can physicians be replaced with gynecological teaching women to train medical students in their first pelvic examination? A pilot study from Northern Sweden. Grankvist O; Olofsson AD; Isaksson RM. Patient Education & Counseling. 96(1):50-4, 2014 Jul.
11. Are we all on the same page? A discourse analysis of interprofessional collaboration. [Review] Haddara W; Lingard L. Academic Medicine. 88(10):1509-15, 2013 Oct.
12. Power in clinical teachers' discourses of a curriculum-in-action. Critical discourse analysis. Graham J; Dornan T. Advances in Health Sciences Education. 18(5):975-85, 2013 Dec.
13. Narrative, emotion and action: analysing 'most memorable' professionalism dilemmas. Rees CE; Monrouxe LV; McDonald LA.
14. Discourse(s) of emotion within medical education: the ever-present absence. McNaughton N. Medical Education. 47(1):71-9, 2013 Jan.
15. Scientist or science-stuffed? Discourses of science in North American medical education. Whitehead C. Medical Education. 47(1):26-32, 2013 Jan.
16. Captive on a carousel: discourses of 'new' in medical education 1910-2010. Whitehead CR; Hodges BD; Austin Z. Advances in Health Sciences Education. 18(4):755-68, 2013 Oct.
17. Dissecting the doctor: from character to characteristics in North American medical education. Whitehead CR; Hodges BD; Austin Z. Advances in Health Sciences Education. 18(4):687-99, 2013 Oct.
18. Six ways problem-based learning cases can sabotage patient-centered medical education. MacLeod A. Academic Medicine. 86(7):818-25, 2011 Jul.
19. Differences in medical students' explicit discourses of professionalism: acting,

representing, becoming. Monrouxe LV; Rees CE; Hu W. Medical Education. 45(6):585-602, 2011 Jun.

20. Assessment of professionalism: recommendations from the Ottawa 2010 Conference. Hodges BD; Ginsburg S; Cruess R; Cruess S; Delport R; Hafferty F; Ho MJ; Holmboe E; Holtman M; Ohbu S; Rees C; Ten Cate O; Tsugawa Y; Van Mook W; Wass V; Wilkinson T; Wade W. Medical Teacher. 33(5):354-63, 2011.
21. Caring, competence and professional identities in medical education. MacLeod A. Advances in Health Sciences Education. 16(3):375-94, 2011 Aug.
22. Medical professionalism: conflicting values for tomorrow's doctors. Borgstrom E; Cohn S; Barclay S. Journal of General Internal Medicine. 25(12):1330-6, 2010 Dec.
23. So you think I'll survive?": a qualitative study about doctor-patient dialogues preceding high-risk cardiac surgery or intervention. Schaufel MA; Nordrehaug JE; Malterud K. Heart. 95(15):1245-9, 2009 Aug.
24. Excellence in clinical teaching: the core of the mission. Hekelman FP; Blase JR. Academic Medicine. 71(7):738-42, 1996 Jul.
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25. Caring, Competence and Professional Identities in MedicaL Education. MacLeod, Anna. Advances in Health Sciences Education, v16 n3 p375-394 Aug 2011.
26. Learning about gender on campus: an analysis of the hidden curriculum for medical students. ACheng, Ling-Fang; Yang, Hsing-Chen. Medical Education. Mar2015, Vol. 49 Issue 3, p321-331. 11p.
27. The More It Changes; the More It Remains the Same: A Foucauldian Analysis of Canadian Policy Documents Relevant to Student Selection for Medical School. Razack, Saleem; Lessard, David; Hodges, Brian D.. Advances in Health Sciences Education, v19 n2 p161-181 May 2014.
28. Collaborative diagramming during problem based learning in medical education: Do computerized diagrams support basic science knowledge construction? Leng, Bas De; Gijlers, Hannie. Medical Teacher. May2015, Vol. 37 Issue 5, p450-456. 7p.
29. Power in clinical teachers' discourses of a curriculum-in-action. Critical discourse analysis. Graham, Jennifer; Dornan, Tim. Advances in Health Sciences Education.

Dec2013, Vol. 18, Issue 5, p975-985. 11p.

30. Seeking inclusion in an exclusive process: discourses of medical school student selection. Razack, Saleem; Hodges, Brian; Steinert, Yvonne; Maguire, Mary. Medical Education. Jan2015, Vol. 49 Issue 1, p36-47. 12p. Making sense of feedback experiences: a multi-school study of medical students' narratives. Urquhart, Lynn M; Rees, Charlotte E; Ker, Jean S. Medical Education. Feb2014, Vol. 48 Issue 2, p189-203. 15p.
31. Making Sense of How Physician Preceptors Interact with Medical Students: Discourses of Dialogue, Good Medical Practice, and Relationship Trajectories. van der Zwet, J.; Dornan, T.; Teunissen, P. W.. Advances in Health Sciences Education, v19 n1 p 85-98 Mar 2014.
32. Making sense of how physician preceptors interact with medical students: discourses of dialogue, good medical practice, and relationship trajectories. Zwet, J.; Dornan, T.; Teunissen, P.; Jonge, L.; Scherpbier, A. Advances in Health Sciences Education. Mar2014, Vol. 19 Issue 1, p85-98. 14p.
33. Using Online Digital Tools and Video to Support International Problem-Based Learning. Lajoie, Susanne P.; Hmelo-Silver, Cindy; Wiseman, Jeffrey. Interdisciplinary Journal of Problem based Learning, v8 n2 p60-75 Oct 2014.
34. Dissecting the Doctor: From "Character" to "Characteristics" in North American Medical Education. Whitehead, Cynthia R.; Hodges, Brian D.; Austin, Zubin. Advances in Health Sciences Education, v18 n4 p687-699 Oct 2013.
35. Medical students' first clinical experiences of death. Kelly, Emily; Nisker, Jeff. Medical Education. Apr 2010, Vol. 44 Issue 4, p421-428. 8p.
36. Captive on a Carousel: Discourses of "New" in Medical Education 1910-2010. Whitehead, Cynthia R.; Hodges, Brian D.; Austin, Zubin. Advances in Health Sciences. Education, v18 n4 p755-768 Oct 2013.
37. Setting the standard: Medical Education's first 50 years. Rangel, Jaime C; Cartmill, Carrie; Kuper, Ayelet; Martimianakis, Maria A; Whitehead, Cynthia R. Medical Education. Jan2016, Vol. 50 Issue 1, p24-35. 12p.
38. What supervisors say in their feedback: construction of CanMEDS roles in workplace

settings. Renting, Nienke; Dornan, Tim; Gans, Rijk; Borleffs, Jan; Cohen-Schotanus, Janke; Jaarsma, A.; Gans, Rijk O B; Borleffs, Jan C C; Jaarsma, A Debbie C. Advances in Health Sciences Education. May2016, Vol. 21 Issue 2, p375-387. 13p.

39. The simulation game: an analysis of interactions between students and simulated patients De la Croix, Anne; Skelton, John. Medical Education. Jan 2013, Vol. 47 Issue 1. DOI: 10.1111/medu.12064.
40. Flower power: the armoured expert in the CanMEDS competency framework? Whitehead, Cynthia R.; Austin, Zubin; Hodges, Brian D. Advances in Health Sciences Education. Dec 2011, Vol. 16 Issue 5, p681-694. 14p.
41. Equal, global, local: discourses in Taiwan's international medical graduate debate. Ho, Ming-Jung; Shaw, Kevin; Liu, Tzu-Hung; Norris, Jessie; Chiu, Yu-Ting. Medical Education. Jan2015, Vol. 49 Issue 1, p48-59. 12p.
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15.2 APPENDIX 2: Outputs from Study

Papers published in annals of events (abstract)

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2. BARRETO, V. H. L .; PARK, S .; RAIT, G. Qualitative study on the management of teaching in health teams In: 12th Brazilian Congress of Family and Community Medicine, 2013, Belém. 12th Brazilian Congress of Family and Community Medicine. 2013. v.1. p.1294-1294 Additional references: Brazil / Portuguese. Means of disclosure: Digital medium. Home page: [http://www.cmfc.org.br/index.php/brasileiro/issue/view/3/showToc]

Presentation of work and lecture

1. LIMA BARRETO, V.H .; PARK, S. Discourse on general practice in medical education, 2017. (Conference or lecture, Presentation of Work) Additional references: England / English. Means of disclosure: Other; Location: Royal Free Hospital; City: London; Event: General Practitioner Tutor Conference University College London; Sponsor: Department of Primary Care / University College London

2. LIMA BARRETO, V.H .; PARK, S .; RAIT, G. Foucauldian discourse analysis of medical educaiton policy, 2017. (Conference or lecture, Presentation of Work) Additional References: Great Britain / English. Means of dissemination: Digital media; Location: Warwick University UK; City: Coventry; Event: IX SAPC Conference; Facilitator / Funding Facilitator: SAPC

3. LIMA BARRETO, V.H .; PARK, S .; RAIT, G .; PELLETIER, C. Discourse analysis of general practice in medical undergraduate education, 2016. (Communication, Presentation of Work) Additional references: Spain / English. Means of disclosure: Other; Location: Barcelona; City: Barcelona; Event: AMEE 2016; Sponsor: AMEE

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Additional references: England / English. Means of disclosure: Digital medium. Home page: http://www.ucl.ac.uk/igh/events/grand-symposium; Location: University College London; City: London; Event: UCL Institute for Global Health Grand Symposium; Facilitator / Financier: University College London

7. BARRETO, V. H. L .; PARK, S .; RAIT, G. Qualitative study on the management of teaching in health teams, 2013. (Congress, Presentation of Work) Additional references: Brazil / Portuguese. Means of disclosure: Digital medium. Home page: http://www.cmfc.org.br/index.php/Brazil/article/view/400; Location: Convention Center; City: Belém; Event: 12th Brazilian Congress of Family and Community Medicine; Inst.promotora / financiadora: Brazilian Society of Family and Community Medicine

15.3APPENDIX 3: Details of policy documents committees

In this appendix, I describe the composition of the committees that produced the policy documents that constitute the data set analysed. This could help future research projects and researchers interested in medical education policy. Below is the list of documents analysed in this research study. The documents that constituted institutional reports named the members of the committees in the documents themselves. The documents that constituted guidelines did not name the members of the committees. For some of the later documents, the institutions involved in their production not always had information about the committees readily available. It is important to highlight that the analysis for this thesis focused on policy texts as a social practice. It did not specifically aim to analyse the meaning *behind* those texts, such as particular assumptions about authorship. Nevertheless it is important to highlight that very few general practitioners were part of the committees.

Brazil	**United Kingdom**
(1997) CINAEM 3rd Phase	(1944) Goodenough Report
(2001) National Curriculum Guidelines for Medical Undergraduate Courses	(1953) Basic Medical Education Recommendations
(2001) PROMED (Program to incentive changes in medical schools)	(1968) The Todd Report
(2005) Guidelines for Medical Education in Primary Health Care	(1976) Basic Medical Education Recommendations
(2005, 2007) PRÓ-SAÚDE (Program to incentive changes in health undergraduate courses)	(1980) Basic Medical Education Recommendations
(2011) Undergraduate Clinical Clerkship Guidelines	(1993) Tomorrow's Doctors
(2013) More Doctors (Mais Médicos) National Policy	(2003) Tomorrow's Doctors
(2014) National Curriculum Guidelines for Medical Undergraduate Courses	(2009) Tomorrow's Doctors

Documents from the United Kingdom

(1944) Goodenough Report

This document is signed by the Sir William Goodenough (chairman); Sir John Stopford (vice-chairman); Prof T. R. Elliot; Dr A. M. H. Gray; Prof James Hendry; Prof A. V. Hill; Sir Wilson Jameson; Prof J. R. Learmonth; Sir Ernest Pooley; and Dr Janet Vaughan.

Sir William Macnamara Goodenough, 1st Baronet DL (1899–1951) was a British banker. He served as the Chairman of Barclays Bank from 1947 to 1951.

Lord Stopford was introduced in the House of Lords on 10 March 1959. He was made Professor of Anatomy at Manchester University in 1919, aged just 31, and was vice-chancellor of the university from 1934 until 1956. He held many positions on professional bodies in the field of health care, becoming a Fellow of the Royal Society in 1924.

Thomas Renton Elliott FRS[1] (11 October 1877 – 4 March 1961) was a British physician and physiologist. He studied natural sciences at Trinity College, Cambridge, specializing in physiology. He joined University College Hospital as a junior staff member in 1910, and eventually became first professor of medicine and director of the medical unit at Gower Street.

Dr Gray was Physician of the Skin Department at University College Hospital. He was also appointed Physician for Diseases of the Skin to the Hospital for Sick Children Great Ormond Street.

Archibald Vivian Hill (26 September 1886 – 3 June 1977), known as A. V. Hill, was an English physiologist, one of the founders of the diverse disciplines of biophysics and operations research. He shared the 1922 Nobel Prize in Physiology or Medicine for his elucidation of the production of heat and mechanical work in muscles.

Sir Ernest Henry Pooley, 1st Baronet GCVO (20 November 1876 – 13 February 1966), was a British arts administrator. Pooley was educated at Pembroke College, Cambridge. He was knighted in 1932 and made a Knight Commander of the Royal Victorian Order (KCVO) in 1943. From 1946 to 1953 he was Chairman of the Arts Council of Great Britain. He was created a baronet, of Westbrook House in the Parish of Tillington in the County of Sussex, in January 1953.[3] He was further honored when he was made a Knight Grand Cross of the Royal Victorian Order (GCVO) in 1956.[4] He published The Guilds Of The City Of London in 1947. Pooley died in February 1966, aged 89, when the baronetcy became extinct.

Sir James Rögnvald Learmonth KCVO CBE FRSE FRCSE (1895–1967)[1] was a Scottish surgeon who made pioneering advances in nerve surgery.

Dame Janet Maria Vaughan, DBE, FRS (18 October 1899 – 9 January 1993) was a British physiologist and a distinguished haematologist and radiation pathologist, academic, and academic administrator. From 1945 to 1967, she was Principal of Somerville College, Oxford.

Sir Wilson Jameson GBE KCB (12 May 1885 – 18 October 1962) was a Scottish medical doctor and the ninth Chief Medical Officer of England 1940 - 1950. He also trained in law and was called to the Bar in 1922. He was appointed Dean of the London School of Hygiene and Tropical Medicine in 1931.

(1953) Basic Medical Education Recommendations

The committee or its members are not mentioned in the document.

(1968) The Todd Report

Members of the Commission

The Rt. Hon. The Lord Todd, D.Sc., F.R.S. (Chairman)
Alexander Robertus Todd, Baron Todd OM PRS FRSE[1] (2 October 1907 – 10 January 1997) was a British biochemist whose research on the structure and synthesis of nucleotides, nucleosides, and nucleotide coenzymes gained him the Nobel Prize for Chemistry.

The Rt. Hon. The Lord Platt, M.D.,F.R.C.P.

Robert Platt, Baron Platt, Bt., MD, FRCP (16 April 1900 – 30 June 1978), was a British physician. Platt specialized in kidney disease research, but he is remembered for the 1940-1950s Platt vs. Pickering debate with George White Pickering over the nature of hypertension.

Sir Edward Collingwood, C.B.E., Sc.D., F.R.S.
Sir Edward Foyle Collingwood CBE FRS FRSE DL LLD (17 January 1900 – 25 October 1970) was an English mathematician and scientist.

Sir Brian Windeyer, F.R.C.P., F.R.C.S., F.F.R.
Professor Sir Brian Wellingham Windeyer KBE, FRCS (7 February 1904 – 26 October 1994) was Professor of Therapeutic Radiology at the Middlesex Hospital Medical School, University of London, from 1942–69, Dean of school from 1954–67 and Vice-Chancellor of the University of London from 1969–72.

Sir Peter Medawar, C.B.E., D.Sc., F.R.S.
Sir Peter Brian Medawar OM CBE FRS (28 February 1915 – 2 October 1987) was a British biologist born in Brazil, whose work on graft rejection and

the discovery of acquired immune tolerance was fundamental to the practice of tissue and organ transplants.

Professor A. G. R. Lowdon, B.E., F.R.C.S.E.

J. R. Ellis, Esq., M.B.E., M.D., F.R.C.P.

Miss Josephine Barnes, D.M., F.R.C.P., F.R.CS., F.R.C.O.G.
Dame Alice Josephine Mary Taylor Barnes, DBE (18 August 1912 – 28 December 1999), known professionally as Dr Josephine Barnes, was a leading English obstetrician and gynaecologist. She was the first female president of the British Medical Association, 1979. Barnes was also active in the Women's National Cancer Control Campaign with cancer screening.[3]

Professor G. M. Carstairs, M.D., F.R.C.P.Ed.
George Morrison 'Morris' Carstairs, FRCPE, FRCPsych (18 June 1916 – 17 April 1991) was a British psychiatrist, anthropologist, and academic. He was Professor of Psychological Medicine at the University of Edinburgh from 1961 to 1973, President of the World Mental Health Organization from 1968 to 1972, and Vice-Chancellor of the University of York from 1973 to 1978.

G. F. Dixon, Esq., M.A.

Professor Andrew W. Kay, M.D., Ch.M., F.R.C.S.
Sir Andrew Watt Kay was regius professor of surgery at Glasgow and an archetypal Scottish academic surgeon. Known by surgical trainees worldwide through his book *A textbook of surgical physiology* (Edinburgh/London, E & S Livingstone, 1959), written with R Ainslie Jamieson, Kay stood alongside many other surgical giants from north of the border.

N. M. Parry, Esq., F.R.C.S., F.R.C.G.P.

Professor J. R. Squire, M.D., F.R.C.P.

Professor R. M. Titmuss, C.B.E.
Richard Morris Titmuss CBE, FBA (1907–1973) was a pioneering British social researcher and teacher. He founded the academic discipline of Social Administration (now largely known in universities as Social Policy) and held the founding chair in the subject at the London School of Economics.

T. M. Wright, Esq.,

D.Phil. Professor F. G. Young, D.Sc., F.R.S.
Frank was elected F.R.S. in 1949 and was Croonian Lecturer in 1962 (72). He was elected an Honorary Fellow of the Royal College of Physicians in 1974. He was Banting medallist of the British Diabetic Association (1948) and the American Diabetes Association (1950) and received the Upjohn award of the Endocrine Society, U.S.A., in 1963. He was Linacre Lecturer of St John's

College at the University of Cambridge in 1977 and he gave 12 other named lectures at universities at home or abroad. He was awarded Honorary Degrees by the Catholic University of Chile (1950) and by the Universities of Montpellier (1959), Aberdeen (1965) and Rhodesia (1975). He was knighted in 1973.

J. N. R. Barber, Esq.

Mrs. E. M. Chilver, M.A.
Elizabeth Millicent "Sally" Chilver (née Graves; 3 August 1914 – 3 July 2014) was principal of Bedford College, University of London from 1964-1971 and Lady Margaret Hall, Oxford from 1971-79.

Professor C. M. Fleming, C.B.E., M.D., F.R.C.P.Ed.

Professor G. Wilson, M.D., F.R.C.P.

Secretary MR. M. W. HODGES

Assistant Secretary IR. W. G. HAMMERTON

(1976) Basic Medical Education Recommendations

The committee or its members are not mentioned in the document.

(1980) Basic Medical Education Recommendations

The committee or its members are not mentioned in the document.

(1993) Tomorrow's Doctors

The committee or its members are not mentioned in the document.

(2003) Tomorrow's Doctors

The committee or its members are not mentioned in the document.

(2009) Tomorrow's Doctors

Tomorrow's Doctors (2009) Review Group

Professor Michael Farthing (Chair) GMC Education Committee QABME Team Leader
Professor Michael J. G. Farthing (born 1948) a British physician, medical researcher and academic administrator. He was the Vice Chancellor of the University of Sussex (2007-2016), having succeeded Professor Alasdair Smith in September 2007. Prior to his appointment as Vice Chancellor at

Sussex, his academic career was in Medicine, specialising in Gastroenterology.

Dr Joan Martin GMC Council GMC Education Committee
DR JOAN MARTIN, who has died aged 102, was appointed an MBE in 1985, largely owing to her contribution to the Girl Guide movement and her work teaching disabled children to swim: she had set up the Kensington Emperors Swimming Club for disabled children in 1955.

Professor Debbie Sharp GMC Education Committee
Professor Debbie Sharp, who founded the Centre for Academic Primary Care in the 1990s, has been awarded an OBE in the Queen's Birthday Honours list.

Mr Alan Hartley Chair of GMC Patient and Public Reference Group

Ms Elaine Brock, Mr Graham Bruce Public members of GMC Patient and Public Reference Group

Dr Mike Watson Director of Medicine, NHS Education for Scotland - Postgraduate Education

Professor Tony Weetman Medical Schools Council GMC Education Committee QABME Team Leader - Medical Educators & Schools

Sam Leinster Medical Schools Council QABME Team Leader - Medical Educators & Schools Professor

Prof Derek Gallen Postgraduate Dean Wales Conference of Postgraduate Medical Deans (CoPMED) UK Foundation Programme Office - Medical Educators & Schools

Dr Ed Neville Chair of Academy Foundation Programme Committee - Medical Educators & Schools

Mr Ian Noble BMA Medical Students Committee - Students

Dr Johann Malawana BMA Junior Doctors Committee - Junior Doctors

Professor Allan Cumming Medical educationalists Scottish Deans' Medical Curriculum Group - Educationalist

Mr Rob Slack GMC Council GMC Education Committee GMC Registration Committee - GMC — internal consistency & integration

Dr John Jenkins GMC Council GMC Standards Committee PMETB - GMC — internal consistency & integration

Representatives of Chief Medical Officers:

Dr Donal O'Donog hue Director, Renal Services - England

Professor Michael Harmer Deputy Chief Medical Officer for Wales - Wales
Dr Aileen Keel Deputy Chief Medical Officer for Scotland - Scotland
Dr Paddy Woods Senior Medical Officer for Northern Ireland - Northern Ireland

Documents from Brazil

(1997) CINAEM 3rd Phase

Roberto Xavier Piccini
Technical Team Coordinator
Researcher
Dr Piccini has a medical degree from the Federal University do Rio Grande (1976) , specialization on Labour Medicine at the Pontifícia University Católica do Rio Grande do Sul (1978) , specialization at Education from Federal University de Pelotas (1985) , master's on Epidemiology by Federal University de Pelotas (1993) and medical training in Internal Medicine at the Grupo Hospitalar Conceição (1979) . Currently is a teacher of Federal University de Pelotas.

Edmundo Gallo
Researcher
Holds a medical degree from the Federal University do Pará (1984), Master in Collective Health at Fundação Oswaldo Cruz (1991) and Doctor in Sciences at Fundação Oswaldo Cruz (2009). Former Secretary of Health in Belém-PA city (1997-1999), General Secretary and President of the National Council of Health Departments in Brazil (1997-1999), Director of Investments and Strategic Projects at Ministry of Health in Brazil (2002-2005) and international organizations and government agencies consultant.

Luiz Augusto Facchini
Researcher
He holds a medical degree from the Federal University of Santa Maria (1979), a master's degree in Social Medicine, the Universidad Autonoma Metropolitana Xochimilco, Mexico (1986) and a PhD in Medicine: Medical Sciences from the Federal University of Rio Grande do Sul (1994). He completed postdoctoral studies in International Health at the Harvard School of Public Health, in the United States (1997). He is a full professor in the Department of Social Medicine and Postgraduate Programs in Epidemiology, Nursing and Family Health at the Federal University of Pelotas.

Rogério Carvalho Santos
Researcher
He holds a PhD in Preventive and Social Medicine from the State University of Campinas (2005), a Master's Degree in Collective Health from the State University of Campinas (1998), a graduate degree from the Federal University of Sergipe (1993), a Medical Residency in Preventive and Social Medicine from the University Estadual de Campinas (1996). He is currently an effective professor of Collective Health at the Department of Medicine at the Federal University of Sergipe. Has experience in the area of Medicine, with emphasis on Public Health Management.

(2001) National Curriculum Guidelines for Medical Undergraduate Courses

Signed by Arthur Roquete de Macedo President of the Higher Education Chamber. The committee or its members are not mentioned in the document.

(2001) PROMED (Program to incentive changes in medical schools)

The committee or its members are not mentioned in the document.

(2005) Guidelines for Medical Education in Primary Health Care

Gastão Wagner de Sousa Campos

Holds a medical degree from University of Brasília (1975), master's at Collective Health from University of São Paulo (1986) and doctorate at Collective Health from University Estadual de Campinas (1991).

(2005, 2007) PRÓ-SAÚDE (Program to incentive changes in health undergraduate courses)

Ana Estela Haddad

Graduated in Dentistry at the University of São Paulo (1988), Master Degree (1997) and PhD in Dentistry at the University of São Paulo (2001). Professor at the Department of Orthodontics and Paediatric Dentistry, School of Dentistry, University of São Paulo. Advisor for the Minister of Education (2003-2005), took part in the development of the University for All Program (PROUNI), and on the development of the National Sistem of Evaluation for High Education (SINAES). Diretctor of Manegment of Education in Health, at the Ministry of Health(2005 up to 2010), responsible for programs as Pró-Saúde, Telessaúde Brasil and for the coordination of the National Comission of Multiprofessional Residency.

Benedictus Philadelpho Siqueira Bertoldo

Cruise Grande Arruda

Gustavo de Faria Oliveira

Jaira de Medeiros Belizário

José Paranaguá de Santana

Bachelor in Medicina (1974), master in Tropical Medicine (1980) and doctor in Health Sciences (2012) from University of Brasília. Experience in Public Health and International Cooperation in Health.

Maria Auxiliadora Córdova Christófaro

Maria Inês Barreiros Senna

She holds a degree in Dentistry from the Pontifical Catholic University of Minas Gerais (1986); Master's degree in Public Health, Epidemiology concentration area, Faculty of Medicine of the Federal University of Minas Gerais (2000) and PhD in Education (2010), area of concentration Public Policies of Education, Faculty of Education of UFMG. She is an associate professor at the UFMG School of Dentistry with experience in public health, epidemiology, teaching-service integration and health education. Has interest in university teaching and curriculum development in undergraduate education and evaluation of policies and programs of health and higher education.

Regina Celes da Rosa Estela

She has a medical degree from the Escola Paulista de Medicina (1963) and a doctorate in medicine from the Escola Paulista de Medicina (1968). Shee is currently an associate professor at the Federal University of São Paulo. She has experience in Medicine, with emphasis on Human Resources Training in Health, and research in the field of biochemistry (Peptideos Vasoativos).

Rogério Carvalho dos Santos

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(2013) More Doctors (Mais Médicos) National Policy

The committee or its members are not mentioned in the document.

(2014) National Curriculum Guidelines for Medical Undergraduate Courses

Signed by Erasto Fortes Mendonça, President of the Higher Education Chamber. The committee or its members are not mentioned in the document.