

patients experience long waits for very short appointments, are often surprised to see a good and rewarding relationship between patients and GPs, a totally different picture from the increasingly frequent reports of escalating doctor–patient tensions. It would be interesting to investigate how this increased exposure to general practice teaching would finally affect students' career choice in a few years, when enough data is available.

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## What factors influence intention towards a career in general practice?

We read with interest the article by Merrett *et al*<sup>1</sup> on young doctors' attitudes towards a career in general practice and have collated complementary data from students. We surveyed all final-year medical students at Newcastle University, on completion of their rotation in general practice, over the last 2 academic years. Responses were received for 578 students (response rate = 85%). Students were asked whether they intended to pursue a career in general practice and which factors influenced their decision. One-hundred-and-ten (19%) reported an intention to become GPs and 189 (33%) stated it was

one of their options.

We identified a range of themes that positively influenced career intention: specific practice-related factors such as good general practice role models ('*Dr X has shown me how important a good GP can be*'); career-related factors such as work–life balance; and speciality-related factors such as variety of presentations encountered ('*Find general practice an interesting career with good opportunity to see a large variety of patients and build up a good rapport. However, main benefit for me was also the work–life balance*').

Negative influences on GP career intention included stress among GPs, lack of procedural skills, and lone working ('*I feel general practice is slightly exhausting, and there is not as much interaction with other professionals during the day*'). Negative comments from hospital doctors were also cited ('*General practice has appealed to me in the past. However, the berating they get from hospital doctors (for reasons varied and often unsubstantiated) put me off*').

We believe these studies add to the crucial contemporary literature into why an individual may choose to pursue a career in general practice.<sup>2</sup> In addition to the recommendations raised by Merrett *et al*<sup>1</sup> around funding, workload, and respect, we would emphasise the key aspect of positive GP role models<sup>3</sup> and the need to explore the perception of general practice as a lonely career. Finally, we must take seriously the recommendation in the Health Education England/Medical Schools Council report, quoted in the editorial of the same *BJGP* issue,<sup>4</sup> that '*work should take place to tackle undermining of general practice as a career across all medical school settings*'.<sup>5</sup> That work must start now.

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## Berwick's third era

Roger Jones is right to highlight Berwick's relevance.<sup>1</sup> Don Berwick admires the NHS and has high regard for general practice, so we should listen to him carefully.<sup>1</sup> He offers a manifesto for the NHS that differs from the usual tired exhortations to integrate, collaborate, and become patient centred. His argument about eras in medicine is attractive. Era 1 was the period of noble, beneficent, self-regulating professionalism that powered the NHS in its early days. In the compromises needed to launch the new health service in 1948, the political class conceded to the professions the authority to judge the quality of their own work.

Era 2 began when the variations in the quality of care, the injustices and indignities inflicted on people because of class, gender, and race, the profiteering and the sheer waste of Era 1, became inescapable. Era 2 introduced accountability, scrutiny, measurement, incentives, and market mechanisms, and has promoted discomfort and defensiveness among NHS staff, and feelings of anger, of being misunderstood, and of being over-controlled. Managers and the Department of Health in turn become suspicious, feel resisted, and can become either aggressive (creating a culture of bullying) or helpless.

Berwick has nine suggestions for helping Era 3 into being:<sup>2</sup> stop excessive measurement; abandon complex incentives; reduce the focus on finance but increase attention to quality of care; reduce professional prerogative; recommit to improvement science; embrace transparency; protect civility; really listen (especially to the poor, the disadvantaged, and the excluded); and reject greed (it erodes trust). As we have tried to point out,<sup>3</sup> some of these ideas have