The future of the College

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THE four papers on "What Kind of College?" (March 1978 *Journal,* pp.142-160) make sad and sombre reading. If he had read them, Oscar Wilde would surely have said, "You are a member of a College that does not dare to speak its name". Irvine, Metcalfe and McCormick indicate that in numerical terms the Royal College of General Practitioners is not representative of general practitoners. None has reasoned why and, much more importantly, none seems to have recognized that the College has a real potential to become representative within the foreseeable future. When this occurs, and we have no doubt that it will, the College must have a central, national organization, able and willing to be consulted and express opinion about any aspect of general practice. Resuscitation of a fragmented body will be infinitely more difficult than its prevention.

Professors D. H. H. Metcalfe and J. S. McCormick

The saddest of the four papers is the one by Metcalfe and McCormick, for it expresses most pungently the undesirable supersedure of research and teaching above good patient care. They say, "Academic medicine is concerned with teaching, research, and a high standard of care of patients' interests". Clearly they have their priorities wrong. They proceed, at unnecessary length, to advocate "a shift of emphasis to a purely academic role" (for the College), an objective which our founder members would surely not accept. Metcalfe and McCormick have a concept of research in general practice in association with other interested bodies which would result in recommendations. There is not the slightest indication of the manner by which such recommendations could or would be implemented. The greatest current failure of academic departments of general practice is their insistence on producing 'reports' which, though carefully researched, have no realistic expectation of implementation, even by college members. Some are only remotely connected with patient care. There is a danger of becoming too immersed in academic medicine and forgetting that the primary purpose, for all of us, is to sustain good patient care, accepting or rejecting recommendations, be they from consultant colleagues, Royal Colleges, the Department of Health, or whoever, according to our perception of a particular patient's needs.

Dr D. H. Irvine

The paper by Irvine is the least helpful. It advocates a fragmentation of the College and particularly of the MRCGP examination. It is unhealthily long and at times confusing. It is clear that during his term of office as Secretary of Council, he became sensitive to opinion or pressure exerted by faculties. During a term of office as Secretary to the North-West England Faculty, it was often the task of one of us to bring to the attention of Council the strongly held views of the Faculty Board on several issues. This was done in no less a vigorous and aggressive manner than is indicated in the minutes and correspondence of our founder faculty members. Much of faculty opinion was accepted and respected by Council. Faculty influence seemed to be ineffective only when it did not accord with views expressed by other faculties. This is democratic. This is good. This is the way to continue.

Irvine expresses concern about the large volume of written material which burdens the Secretariat of Princes Gate and he has undeniable recent experience. A good secretary should, however, remedy the defects of his organization during his term of office.

Irvine suggests better records and information retrieval systems. How do such systems permit us to ask important questions such as, "How did you get on with the specialist in the clinic?", "How do you feel about your husband being in jail?", "This pain in your back is really not important; why have you really come to see me?". These are three questions which we have put to patients during recent surgery sessions. No efficiency of

previous records or retrieval system would even allow these questions to be asked. Most certainly the management in each instance was independent of esoteric records and computers. In determining the care of our patients we do not believe that it is of the slightest importance to have previous knowledge such as our patients' 'smoking habits', 'frequency of occurrence of acute tonsillitis', 'ethnic origin', or 'marital status'. Such information has relevance only in the context of a consultation and should be elicited at that time. The only demonstrably valuable current result of good data record achievement in the NHS is that which is used on an individually non-judgemental basis to record the cause of maternal death. Such intense investigation is impossible for 1·2 million consultations per year. Any compromise must fail to achieve any desirable objective.

The most telling of Irvine's statements is, "I must stress that I am not advocating the construction of an elaborate, fixed job definition (for general practitioners) because this would be hopelessly prohibitive and quite impracticable". We interpret this to mean that it cannot be done. He may well feel that possession of an MRCGP is an important prerequisite of the application for trainer. Is this universally and conveniently practicable or merely an easy option? Is it honestly realistic? Is this a model which our College has either the right or the audacity to promote? Some members of our College have a degree of audacity. We doubt, however, that it has universal suffrage.

Irvine's concept of a regionalized examination procedure for the MRCGP rubber-stamped by Council is the most horrendous of his suggestions. Every higher examination has its critics, who are mostly those who fail. We should certainly not be diverted from our present examination purpose by a crop of complaints. As with any other examination, there is room for continued review and improvement but this should take place in conformity with the current collegiate membership rather than by the impressions of the few or extraneous comments. A matter of this seriousness surely merits discussion at an annual general meeting of the College, where the views of faculties can be collectively heard.

The narrower the medical discipline becomes, the more likely idiosyncratic behaviour is either dangerous or brilliantly innovative. The obstetrician who would today consistently undertake upper segment caesarian section is an example of the former, while the orthopaedic surgeon who consistently performs joint replacement surgery is an example of the latter. The wider the medical discipline then the more likely it becomes for the idiosyncratic to behave with minimal danger or genius. General practice is a wide discipline and each idiosyncratic general practitioner attracts an idiosyncratic list of patients. The total population becomes dispersed, often by choice, among a broad spectrum of doctors. This is a counter-argument to the view of Irvine that "The success of general practice will depend almost wholly on the extent to which we can hammer out a cohesive discipline which is understood and accepted by every general practitioner and most patients".

The job each of us has to do is to apply knowledge, skills and attitudes to our patients. Because general practice is a broad discipline we *can* afford to permit doctors and patients to have complete freedom of behaviour and to select each other accordingly. The College should strive to perpetuate this objective rather than impress conformity of expressed behaviour. The most prized possession of general practice is its conjoint flexibility. Its most untrustworthy enemy is to be described as a 'specialist'.

Professor M. Marinker

Marinker seems to us to make the most cogent and succinct arguments. He confines his report to the activities of Council with particular reference to the dangers of inbred oligarchy or intellectual nepotism. We like, in particular, his suggestion "to give a larger number of the most able people in the College an opportunity to contribute directly to decision-making". Marinker advocates a greater number of committees, most of whose members would be derived from outside Council and who would also have the advantage of youth. He advocates an early start on a fifth report as opposed to a new edition of *The Future General Practitioner—Learning and Teaching* (Royal College of General Practitioners, 1972). This seems to us to make considerable sense and the burden of its preparation could be distributed among a wide spectrum of opinion within the College. If there is an argument for regionally (or faculty) orientated groups to undertake committee functions, supported by Council, then Marinker has made it. He does not, quite properly, mention patient care and therefore cannot be accused of getting his priorities wrong. He seems to us to have adhered most closely and most concisely to the centre of the question "What kind of College?".

Dr A. Donald

The most valuable and acceptable of the four papers to us is the one by Donald. He has placed the proverbial finger so frequently and so accurately on many of the College's current problems. Not least, he has shown that the College is in a process of evolution rather than revolution. He has also emphasized that evolution is not merely a process but that it also has structure and outcome.

We would challenge his thinking on three points. First, he has summarized the activity of members of the College in the development of the primary health care team. He states, "Imaginative research might well have been rewarding in this field and offered a practical link with education". The Manchester Multidisciplinary Workshop has recognized the truth of this statement

and is agreed that educational research to remedy interdisciplinary relationships begins at the level of the undergraduate. The Manchester University Departments of General Practice and Nursing are collaborating in the preparation of such research. However, the difficulties of securing precision as well as a useful outcome cannot be underestimated and it may well be 10 years or more before any real fruits of such research are borne. An indication of this research has not previously been made public and perhaps those of us concerned should have at least advised the College of our intended activity. The only currently compelling reason to do so is in regard to financial support!

Secondly, we would question that "Council has become remote from the faculties". It is in our view more true to say that faculties have become remote from the College, undoubtedly because the faculties have, like Council, been undergoing an evolutionary process involving a lessening of responsibility and activity in research and education which were the major primary platforms of the founder faculties. Practice organization, which promised well, has not been universally developed at faculty level. The Council practice of setting up a small number of research centres must contribute to this.

Thirdly, we feel that Donald's misgivings about the credibility of the College examination are misplaced. Any examination which plays no part in the securing of employment but continues to attract a substantial number of candidates can hardly be described to bear incredulity. The best estimate we have been able to obtain for 1977 membership of the four Royal Colleges (excluding those who have resigned or died) is: Royal College of Surgeons (UK), 9,640; Royal College of Physicians (UK), 9,300; Royal College of General Practitioners, 6,453; Royal College of Obstetricians and Gynaecologists, 5,480.

Bearing in mind the essential requirements of some fellowships and membership of the other Colleges for professional advancement (Members with an MRCOG are often also FRCS), these numbers suggest that the newest of the Royal Colleges does not have a disreputable record. The most encouraging view expressed by Donald is that he believes "We should pursue excellence in the provision of patient care—if we discover some truths along the way, so much the better".

Reference

Royal College of General Practitioners (1972). *The Future General Practitioner—Learning and Teaching.* London: *British Medical Journal.*