

Academic general practice — present state and future trends

IT is now over 10 years since the last major review of academic departments of general practice.¹ The new Mackenzie report² from the Department of General Practice at the University of Edinburgh is a valuable source of information about the dramatic developments which have taken place in the last decade. By the end of 1986 general practice will be represented as an academic discipline in all UK medical schools; the majority of departments are now independent, although some operate within other departments, for example community medicine. The departments have developed in various ways with specific arrangements chosen according to local factors and opportunities. However, common patterns of operation have emerged and are worthy of further comment.

A university department can be based on its own practice with each member providing a service commitment. The practice is similar to any National Health Service practice but has fewer patients per doctor. The practice is often situated in a socially disadvantaged area of a large city. This particular model seems to give the academic doctor more credibility with his fellow general practitioners and with his clinical colleagues within the medical school. The demands of practice, however, leave little time for teaching and less for research and such departments may be less productive in terms of publications.

The members of departments of general practice which do not have a university practice usually have a defined commitment to a local practice and potentially more opportunity for academic work. This pattern of working can enable the department to be closely integrated into a number of different practices and so extend the working base and increase the clinical resources for teaching and research. A perhaps less satisfactory arrangement is where some universities employ a local general practitioner on a sessional basis, the doctor continuing to work in his or her own practice. This situation occurs mainly in London with the doctors involved having to spend almost all of their time on teaching and administration, thus leaving little opportunity for research.

In the Mackenzie report² Professor Howie argues that there is a critical level of staffing which is vital if a department is to be active and productive. Four full-time medically qualified personnel with one social scientist are suggested as the minimum required for a department which has not only heavy undergraduate teaching responsibilities but also demands placed upon it for postgraduate and continuing education. The new departments of general practice in Liverpool and Nottingham are of interest not only because of the way they are funded but because they are on a scale similar to practice-based departments, without the responsibilities and demands of a practice to run.

The university general practitioner has a job description which is many-faceted. He is involved in patient care, teaching, examinations, research and administration within his own department. He also needs to be able to relate to the general practitioners in his region. Horder³ has highlighted the problems facing academic general practitioners in dividing their time adequately among these different aspects.

While the contribution of university departments of general practice to teaching and research is well-recognized^{4,5} there are

difficulties in convincing academic specialists of the worth of research which is often behavioural rather than cellular in character.⁶ More than any other doctor in academic work, academic general practitioners have problems of identity in that they need to maintain credibility with both service general practitioners and with specialist academic colleagues. Traditional performance indicators of grant money acquired and publications in refereed journals have a restricted relevance in the setting of general practice.

Funding

There is great variation in the way departments of general practice are funded. Money from the University Grants Committee can be supplemented by bequests, research grants or health authority funding. A novel scheme is developing in south-west England where the general practitioners have set up a trust to help fund a proposed department of general practice in Bristol and the existing department in Exeter. The main source of funds initially will be 12 of the 13 health districts in south-west England and general practitioners from the area will be asked to co-vent money to the trust. Their expected commitment will be related to their seniority and involvement in teaching. This initiative is attractive and deserves success.

Universities are experiencing severe financial problems and the low fees paid to service general practitioners who teach are unlikely to increase in the near future. Continuing facilities for teaching undergraduates are dependent on the good-will of the general practitioners involved; teaching usually takes place in small groups or one-to-one and this is very demanding of time.

In teaching hospitals there is a substantial NHS contribution to teaching costs. This subsidy is rationalized using the SIFT formula (service increment for teaching) in England and Wales and ACT (addition for clinical teaching) in Scotland. There is no parallel in general practice but an equivalent system is urgently needed and could make a major contribution to the funding of departments of general practice.

Career structure

This is another problem facing the academic general practitioner. In contrast to the independent contractor status of service general practitioners, he is a salaried university employee. Movement between service and academic general practice is difficult both in career and financial terms. The young doctor who has just completed vocational training and becomes a lecturer earns less than he would if he decided to become a principal. This fact has important implications for recruitment in departments of general practice. The universities have been sympathetic to this difficulty and have generally paid lecturers in general practice above the levels paid to equivalent staff in other clinical disciplines. However, universities will quite reasonably hope that applicants for senior lectureships might have a higher degree and a number of research publications: credentials which are unusual in service general practitioners. Conversely, practices may be wary of taking on as a partner a doctor who has previously worked in an academic department because they may doubt the individual's commitment to the routine of service practice.

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The future

Despite its present problems academic general practice can look forward with cautious optimism. The major support for academic general practice must come from general practice itself — from general practitioners, the local medical committees and the Royal College of General Practitioners. Members of departments of general practice must strive to work hard to earn the good-will of those bodies whose support they seek. Equally those who wish to be critical should be sure that the grounds for their criticism are informed ones.

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The problems of audit and research

A PART from the intrepid explorers of the past, Vasco Da Gama and Christopher Columbus for example, few sailors would embark on a sea voyage without consulting the charts which are available. Yet that is what many general practitioners have done, not only embarking on a career without any formal training but also attempting to deal with many conditions that never presented in the hospital environment in which they were taught. The recognition of this omission is now enshrined in the Vocational Training Act 1980. The presence of new and enquiring minds in many of our practices forces us to question our everyday activities and to ask ourselves what we are doing and why. Faced with a young and clever colleague challenging a particular course of action, our temptation is to reply that experience tells us so. But experience may be no more than making the same mistake for 20 years.

The general public and the profession are increasingly aware of the wide variation in the performance of general practitioners — differences in consulting, prescribing, investigation and referral rates that are not accounted for by the demographic or social class characteristics of our practices or by the range of conditions which have been seen.¹ The recent policy statement from the Royal College of General Practitioners concludes that 'setting standards and assessing quality of care through performance review should become part of everyday clinical practice'.² Many doctors are now seeking to monitor, evaluate and, if appropriate, modify their clinical behaviour or practice organization; accounts of these studies are often published under the heading of 'practice audit'. Criticism has been made of the shortcomings of audit when compared with research and, while medical audit and performance review should not be allowed to develop in an uncritical way, it is important to understand the different roles of audit and research.

Logical thought is common to both audit and research and so is the need to define the purpose of the study and control the field of observation. To a large degree we are still dependent in medicine on uncontrolled clinical experience. Thus, the difference between audit and research lies not in the critical approach to our activities but in the relevance of the findings to other situations. Research provides information which has relevance and value beyond the particular circumstances of the study. In contrast, audit aims to provide precise information in a particular setting which enables rational policy decisions to be made.

When reporting any audit review, a clear statement should be made about the conclusions which can be logically drawn from the data presented, and the assumptions which are made without a firm basis of evidence. Sources of error include insufficient knowledge of the spontaneous course of the disease under scrutiny, random variation within a small number of cases, placebo effects and clinicians' bias. The doctor's memory is also

biased because he cannot easily forget a case which had novelty value, whereas he can easily overlook the mundane. An audit should attempt to record honestly what occurs, and recognize the limitations of the methods employed. In this way conclusions drawn from the evidence presented will be cautious but realistic. It is often the method employed in audit exercises which is of interest to others rather than the results of the study.

Audit is limited, audit is local, audit is parochial, nevertheless it should be carefully executed and honestly reported. Research on the other hand sets out to answer a specific question with some certainty and implicit in this is that the answer may be extrapolated to other similar situations. Research is therefore more formal and rigorous, more critical of denominators and hypotheses. Research requires care in the selection and randomization of subjects and controls. Clarity of purpose, avoidance of speculation and accurate recording are all necessary in research. The language is the same, it is only the syntax that differs. In audit we make comparisons, notice the difference, worry about protocols, recording methods and the use of definitions and record the results. So do researchers, but at a different level of resolution. Failure to recognize the different scale of rigour required is to confuse the two. Audit is more like a descriptive account of a journey between two points, research sets out to map that journey.

Trainee general practitioners are encouraged to undertake projects in audit because learning to think is as essential a component of a doctor's education and training as the acquisition of facts.³ The trainee or student is not seeking to discover new treatments for disease but to observe and comment on the situation as he or she finds it. Frequently the methodology is imaginative or even flawed, but the presentations and debates which follow are always valuable and help to clarify questions about general practice.

If we regard audit as the starting point for generating questions rather than supplying answers then we shall see it in its true perspective. The message is: present the data as carefully as possible, draw reasoned and tentative conclusions and enjoy the discussion that follows. From this many research projects will grow.

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