

A murky future for academic primary care

THE MacKenzie 2 Report, *New Century, New Challenges*, highlights accomplishments and challenges for Departments of General Practice.¹ Academic general practice has come far in a generation — a fourfold increase in the number of professors and expansion of non-clinical staff, teaching commitments that represent 9% of all undergraduate teaching in United Kingdom medical schools, and successful, funded, and important community-based clinical research. Along with these well-deserved pats on the back, the report addresses some of the looming obstacles to continued success and offers suggestions about the direction and cost of future academic general practice.

Issues for academic general practice in Britain and family medicine in the United States couldn't be more similar, in some cases, and more different in others. Results of a study of departments of family medicine in the US, published in 2000, points out that threats to departments also represent threats to primary care education and clinical practice.²

The most important similarities on both sides of the Atlantic are the demands on academic departments brought on by increased involvement in medical student education. The predicted growth by 42% of medical student enrolment in Britain between 1998 and 2004 will overwhelm senior and junior academic staff and community general practitioners without concomitant increases in academic posts. In the US, the problem is not more medical students — numbers have remained constant since the surge of 'new' medical schools in the 1970s — but more curriculum time for family medicine. Student education is the least financially rewarding of all the activities of academic departments of family medicine. Student education in primary care is not well supported by medical schools. Instead, it relies heavily on a 30-year history of support from a federal programme for academic family practice, a programme that the Bush administration seeks to eliminate.

Most departments — in the 70% of US schools that have departments — are being asked to assume major responsibility for community-based ambulatory education, paralleling the evolution of academic general practice outlined in the MacKenzie 2 report. No other discipline knows how to teach in communities as well as family doctors, and grudging recognition of that fact from medical school curriculum committees has put academic family medicine in a lead position for primary care education. However, we are being asked to lead for free. Medical schools in the US are having financial crises, which now find deans commencing their annual reports to the faculty with a list of reasons why there will be no increased support for education. Departments of family medicine in the US often feel like the new junior partner in a practice, thrilled at last to get the job and arriving full of energy, only to find they have been left the key to the office and a note from the senior partners wishing him or her well, saying they will back after their summer holiday.

The expected growth in student enrolment in the UK is creating justifiable concern among heads of university departments of general practice, that the already thinly spread

resources will be thinned even more by additional educational demands. More junior positions might be added, but the shortage of current senior leadership positions compared with other academic disciplines will only worsen. Growth in medical education will require senior leaders to divert their time and energy towards curricular and institutional leadership and away from important aspects of academic departments, such as mentoring their junior faculty and expanding research programmes. Increasing demands without increasing resources results in the zero-sum game of shifting existing resources to student education and away from the other responsibilities. Zero-sum games never give satisfying results, but dropping one of the central missions for academic departments would be a disaster.

If one were to ask all heads of general practice departments to rank their department priorities in order, I suspect the answer would be medical student education, followed by research, and clinical care, with a varied relationship to trainee education. Ask chairs of family medicine departments in the US the same question, and they would answer: clinical work, residency (trainee) education, medical student education, then research.

For academic family medicine, increasing clinical demands have unalterably changed the jobs of academic physicians. At a recent meeting of department chairs, one member presented, to the many heads nodding in agreement, his approach to an 80% clinical/20% teaching job he is selling to his junior faculty. Without any serious time for scholarship, his plan will assure that his junior faculty will remain junior for their entire careers.

Fully 40% of the operating budget of my department now comes from clinical work, up from about 20% a decade ago. Most academic family medicine departments derive at least one-third of their budgets from clinical work, a percentage that is rising rapidly. We use our clinical income to subsidise our academic work and much of that academic work is medical student education. We are engaged in our own zero-sum game and the *absolute necessity* for US family practice is clinical care, which can only increase as other sources of support decrease. The chief fear from all this is that, at the end of this decade, academic departments will resemble a beehive in winter, with the busy workers — after first booting out the drones (i.e. the 'unproductive faculty') — spending all their energies supplying honey for the Queen and her court. I haven't decided who the Queen is at this point but it will most definitely *not* be the department chair. Chairs are the beekeepers, using smoke to avoid being stung.

The single challenge underlying all of the separate challenges outlined in the MacKenzie 2 Report is how to link the clinical work of general practice in the Health Service to academic departments of general practice. Academic general practice will never rely as heavily on clinical income to support other activities as we do in the US. However, in the UK, the RCGP, the National Health Service and academic departments can benefit if each of the entities is willing to explore new relationships that bridge long-held positions relating to

education and clinical practice. We have had some experience in the US with this process.

The American Academy of Family Physicians, which had previously confined itself to clinical practice and political issues, has for the past five years put substantial funding for research in academic departments and created an independent research and policy centre. Academic departments are working more with the practising community on quality improvement and clinical initiatives, best exemplified by the Patient-Oriented Evidence that Matters (POEMS)³ and Clinical Inquiries, which bring evidence-based medicine to the practising physician. And the residency programmes, which in many cases have functioned as quasi-independent entities governed by their own accrediting body, have moved towards closer affiliation with academic departments and student education programmes as important components for future resident recruitment. All of the family practice organisations are collaborating in educating the public and policy makers about current threats to family practice education and clinical practice. A sense of interdependence and mutual need exists now in US family practice, in part because the arms-length relationship that had existed previously cannot be financially or intellectually sustained.

The Keystone III process in October 2000 created a four-day intergenerational conversation that has proved enormously productive as family medicine moves into an era of more with less.⁴ Rather than finger pointing, teaching and practising physicians are now working to find how to do better with what we have and be nimble enough to deal with what comes next. (special Keystone III issue found at

<http://stfm.org/fm2001/apr01/toc.html>)

New Century, New Challenges captures the important future issues for academic general practice, but how these issues are viewed by the other stakeholders in general practice in the UK is less clear. The solutions for general practice, both academic departments and the practising community, will be worked out in the context of history, funding, and the NHS. However, reading the MacKenzie 2 Report made me realise how much general practice and family practice should talk with each other, as we struggle with similar challenges in the next decade.

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Racism and general practice — time to grasp the nettle

RACISM is firmly on the agenda.¹ The murder of black teenager Stephen Lawrence at a bus stop in south London on 22 April 1993, and the subsequent tenacity of his bereaved parents have, after inordinate delays, resulted in far-reaching policy changes. The appointment of Sir William Macpherson to conduct an inquiry into the matters arising from Stephen's death was announced in July 1997, and the final report of the inquiry was published in February 1999.² This triggered a national debate, and the government's principle response, the Race Relations (Amendment) Act,³ came into force on 2 April 2001, almost exactly eight years after Stephen Lawrence was murdered. The implications for patients, GPs, other members of primary care teams, and the Royal College of General Practitioners, are huge. In this editorial we are concerned with those that arise in response to the racism experienced by GPs and other health care professionals.

Racism, in general terms, consists of processes, attitudes or behaviours which disadvantage or advantage people because of their colour, culture or ethnic origin. Subtle, covert racism is as damaging as its more overt form.² Macpherson defined institutional racism as: 'The collective

failure of an organisation to provide an appropriate service to people because of their colour, culture or ethnic origin'. The inquiry report pointed out that this might occur through unwitting prejudice, ignorance, thoughtlessness, or racist stereotyping. Coker presents compelling evidence that institutional racism exists in the National Health Service (NHS).¹

In October 1991, two orders under section 71 of the Race Relations Act, as amended, were laid in parliament. The first order⁴ brought an additional 300 public bodies within the scope of the statutory general duty to promote race equality, including the Royal College of General Practitioners. The second⁵ imposed specific duties, which came into effect on 3 December 2001. Health authorities, NHS trusts, and primary care organisations, are all subject to these specific duties and are required to prepare and publish race equality schemes. Paradoxically, during the same months, the aftermath of the terrorist attack on the World Trade Centre in New York on 11 September 2001 and heightened political rhetoric around the issue of immigration, served to intensify the fears of many immigrant communities.⁶

Most of the responders to Bhopal's editorial⁷ in the *BMJ*

last year reported personal experiences of institutional racism. Some noted that abusive and oppressive attitudes within the NHS are not confined to issues of race or ethnicity, and that there is a culture of ignoring or condoning this. In his editorial, Bhopal concludes that addressing racism and addressing oppression are linked.

Many GPs have their own experiences. Ours lead us to disagree with Decker when she suggests that discrimination against non-UK graduates occurs only on the basis of race as defined in terms of physical features alone.⁸ Those who speak with a different accent may belong to 'audible' minorities, as opposed to 'visible' minorities, and may also be subject to discrimination. Those who combine both audible and visible differences may be doubly disadvantaged.

Discrimination by patients: zero tolerance

It is completely unacceptable for health professionals to discriminate against patients on racial, ethnic, or religious grounds.⁹ The reverse is less clear. Most ethnic minority health professionals have experienced abuse or discrimination by patients,¹⁰ and many feel themselves to be much more vulnerable to patients' complaints. Dadabhoj¹¹ reports a disturbing lack of support within health care institutions, where managers and senior staff appear to expect health professionals to take racism and prejudice in their stride. Our view is that racism is unacceptable, whatever the context, and that any colleague subjected to racism should be actively supported. We have a duty to challenge patients who do not wish to be seen by particular health professionals or staff because of their ethnicity. Ultimately, we should expect patients to choose between accepting racial equality and leaving the practice list. This may appear extreme, but to do otherwise is to allow the dignity and rights of our colleagues to be eroded, and may well fall short of our duty under the new legislation. In exceptional circumstances, allowances may be made for patients who are prone to express verbal abuse as a result of psychiatric illness or cognitive impairment. In general terms, however, there should be a policy of zero tolerance of racism, in the same way that there are policies in relation to violence and verbal abuse, allowing health professionals to withhold treatment from patients except in life-threatening conditions.

Discrimination within the professions

There is a notable lack of GP trainers and undergraduate tutors from minority groups. In a recent group of about 20 aspirant GP trainers in an area including the Midlands — the second largest conurbation for ethnic minorities — not a single participant was from a minority ethnic group. This is undesirable, both pragmatically and as a matter of principle. Black and ethnic minority GPs and their patients should become much more part of the mainstream of general practice. One reason for this under-representation is that more minority GPs are single-handed. This is, of course, a result of discrimination in the past, when doctors filled single-handed posts in deprived and isolated areas that were spurned by others. Given the disproportionate number of minority GPs in small practices, we should question whether persistently negative attitudes towards small practices are in part based on racism, especially when there is no evidence

that such practices by their nature deliver worse or more costly care.^{12,13} Positive action has been taken and could be implemented more widely; locum or assistant support can be given to enable GPs in deprived and ethnic minority areas to become trainers and tutors. Extended primary care teams can be organised around groups of small practices. Roving facilitators from regional postgraduate centres, university departments, or Primary Care Trusts, can help develop and maintain information systems and libraries.

Non-UK graduates

It is reasonable to assume that providing adequate GP training to non-UK graduates requires, on average, more work than training UK graduates with similar work experience. Non-UK graduates are made up of heterogeneous groups, including refugees, economic migrants, and doctors who are interested in looking beyond their national horizons and who are attracted by the NHS and the UK. The higher rate of failure of the summative assessment video examination and the written and oral parts of the MRCGP examination¹⁴ among non-UK graduates¹⁵ may merely reflect the difficulties that such doctors experience in adapting to the language and medical culture of the UK.

Many non-UK graduates will simply be on a steeper learning curve and do well with the right educational support. Assuming that everyone who is motivated to become a GP is an asset to the UK, there should be a fuller acknowledgement of the challenges faced by non-UK graduates. Additional, protected teaching could be offered on cultural aspects of communication with patients of diverse backgrounds and about communication with colleagues, other health professionals, and managers in the vast, often hierarchical and top-down NHS.

The RCGP

The College has made some moves towards addressing institutional racism within general practice. Its Council accepted a position paper by Joshi and Pringle¹⁶ and has adopted a plan of action. Progress has also been made in the MRCGP examinations with regard to issues of ethnicity and discrimination.¹⁶

Following its fiftieth anniversary year, the College is in a prime position to focus attention on these issues, and to promulgate a broad policy of fostering human dignity through the promotion of human rights.¹⁷ GPs could be encouraged to write open references about registrars, other doctors, and practice staff — the system of secret references is, arguably, a mechanism that can perpetuate prejudice and submission. The College could continue to commission and promote educational materials, such as the *Valuing Diversity* teaching pack,¹⁸ to be used at courses, within practices, and in undergraduate education.

In an era when professionals have become tired of top-down directives, it is essential that there is a sense of ownership of efforts to tackle racism and prejudice. The College's quality initiatives¹³ appear to be acceptable to the professions within primary care, and they all incorporate criteria that explore equal opportunities, prejudice, and racism. The Quality Team Development programme,¹⁹ with its open nature and emphasis on systems, rather than on individual

culpability, may offer particular opportunities to encourage and monitor progress.

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'I saw a great star, most splendid and beautiful': headache in primary care

THE Abbess Hildegard of Bingen was inspired by her migraine equivalents.¹ Headache is the most common symptom reported by women.² Like Hildegard, most people who experience headaches do not consult a doctor; nevertheless, they may experience considerable functional impairment. In the United Kingdom, migraine alone accounts for about 18 million working days lost per year.³ Researchers are currently revising a rubric for headache diagnosis.⁴ This differentiates headaches that are secondary to organic disorders from those it classifies as 'primary'. The two main types of primary headache identified are tension-type and migraine. In the revised edition, headache that recurs half the time (and is associated with substantial use of medication), will receive more emphasis. To be judged useful, specific diagnoses need to have predictive value in describing the natural history of the condition or response to treatment.⁵ Evidence from Canadian primary care suggests that symptom severity, but not specific diagnosis, predict outcome.⁶

In Denmark, Rasmussen described the one-year period prevalence of tension headache in adults as 63% in males

and 86% in females⁷; for migraine it was 6% in males and 15% in females. Daily or near-daily headache affects almost 5% of the population⁸. It is difficult to find good evidence on incidence, and estimates vary. The prevalence per 100 000 person years at risk for consulting with headache and migraine in UK primary care is 2420.⁹ It is likely that consulting patterns are affected by co-morbidity. Some patients with headache have symptoms of depression.¹⁰ In disorders in which psychological and somatic symptoms co-occur, psychological distress may predict consultation frequency more closely than physical symptoms do.¹¹

Both specialists and generalists agree on the primacy of the history in diagnosis, and there is a systematic review on the diagnostic value of specific aspects of the history.¹² A functional enquiry includes visual symptoms, nausea and vomiting, as well as symptoms of depression. The Canadian group found that resolution was associated with patients stating they had been able to discuss their headache and related problems with the doctor fully.⁶ Asking about the patient's ideas, concerns, and expectations is important; Fitzpatrick and Hopkins interviewed patients referred to neu-

rologists with headache not owing to structural causes, and found that 60% had fears about serious organic disease.¹³

A role of the GP is to marginalise danger. In the absence of prospective studies, guidelines are based on retrospective evidence of patients with a diagnosis of brain tumour.¹⁴ The risk of raised intracranial pressure increases when headache is new, severe, occurring for the first time in middle age, changed from a previous pattern, or accompanied by new-onset seizures, papilloedema, cranial nerve palsy or progressive, subacute neurological deficit.¹⁴ Many doctors have not had postgraduate training in neurology, and lack confidence in their ability to elicit some of these neurological signs.

There is little evidence about how GPs make decisions on the investigation and referral of neurological problems. In the NHS they probably weigh up social and medical factors, and the probable time course of the patient's illness, in the context that access to investigations and specialist advice is controlled by a historically separate, hospital sector. For example, an elderly person with a headache history that is suggestive of temporal arteritis will initially receive an erythrocyte sedimentation rate/C-reactive protein (ESR/CRP) test; a child with headache and possible meningitis will be seen urgently at the nearest hospital. There are situations in which the doctor could reduce uncertainty by using computer tomography or a magnetic resonance scan. In many Western countries, all doctors access scans directly and there is evidence to support the hypothesis that GPs use direct access appropriately.¹⁵ Selection for referral to secondary care on the basis of abnormal symptoms and signs makes the prevalence of disease (and abnormal test results) higher in hospital settings.⁵ The evidence that positive findings are as common from scans requested in primary as in secondary care,¹⁵ needs replication. It is worth systematically testing open access to scans for GPs, as waiting to see a neurologist, and then waiting for scans, mean that patients queue twice.

Without 'red flag' signs, the diagnostic yield of scanning for headache is low, even in the hands of specialists.¹⁶ Nonetheless, most neurologists have occasional experience of patients with brain tumours who did not fit the usual pattern. Scanning may reduce physician and patient uncertainty. It is not clear whether negative scans have a positive therapeutic effect on patients, or whether they perpetuate a cycle of somatic concern and psychological distress, and this is being investigated.

Experts suggest that medical management of headache and migraine needs to be tailored specifically to the diagnosis, and if this is achieved then management will be more effective.¹⁷ There is comparatively little evidence to support or refute this assertion. Probably most headache management is self-care and 98% of medical management takes place in general practice.¹⁸ There is evidence that mild to moderate tension headache and migraine both respond to aspirin and non-steroidal anti-inflammatory agents, so exact diagnosis may be not so important.^{19,20} Tryptans are effective and expensive remedies for moderate to severe migraine.²¹

A child is not a 'little adult' and headache in childhood requires consideration on its own. Diagnosis and referral pathways are, for example, different for children. This

month's *BJGP* includes a qualitative study of children who reported to the school nurse with headaches, which included migraine.²² Some complained of excessive noise in the school. On the one hand it may have been real, on the other hand this may have been a feature of sensory hypersensitivity typical in migraine. The children also reported conflicts in the family, difficulty with some school subjects, and insecure relations with classmates. Parents like me may view this as usual too. However, there is interesting evidence that children with migraine fear their teacher and failure at school more than children with non-migraine headache, and families of children with migraine report unhappiness more often than families with non-migraine headache.²³

Several of the children in the study reported mothers with headache also.²² In a population study of headache in children of a similar age, both a positive family history of migraine (46% in relatives, 18% in the mother), and environmental factors (such as being unhappy at school and home) played a role in predicting migraine.²⁴ This evidence supports quite different research paradigms. On the one hand there is active search for genetic causes,²⁵ such as the rare subtype that causes familial hemiplegic migraine. On the other hand, headache can be explored as an unexplained physical symptom. A psychiatric study found that headache is the most frequent symptom in children who are referred for emotional and behavioural disorders.²⁶ Either way, headache is a major cause of disability,^{3,22} with great potential for qualitative and quantitative research and the evaluation of interventions in primary care.

Even though only about 2% of patients with headache are referred each year, it is such a common condition that it accounts for up to a quarter of new patients seen by neurologists.²⁷ There are approximately 350 neurologists, who work full or part-time in the UK.²⁸ Before waiting list data was forced down, the median waiting time for a routine neurology appointment was 28 weeks.²⁹ Small shifts in the location of headache management at the interface between primary and secondary care will have important consequences, both for people with headache and for patients with other neurological symptoms.

Chronic pain management is challenging, and the relative absence of a physician with an interest in this common condition increases the scope for mixed messages. The question of whether complex interventions, such as cognitive behaviour therapy, physiotherapy, counselling, and alternative treatments can help, has been relatively neglected and deserves more trials.

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