THE present medical undergraduate curriculum seems to give the impression that general practice is the most benign form of practicing medicine — ideal for those students who prefer not to play around with research, teach or be burdened with hospital administration. However, the growing pressure of financial and bureaucratic reform, together with results from studies in the primary care setting, indicate that academic general practice is arguably the way forward.

Current perceptions of general practice are not as glamourous as an academic career in a speciality. Presently, more academic student doctors are directed towards hospital practice, whereas those with less academic and more clinical interest are suggested general practice. Creating a new breed of proactive GPs heavily involved in research and medical education, may change this. Recognising that GPs may have such skills, combined with the economic and management sagacity required to manage a practice, may be the next step in primary care.

So how would I implement this? The first step would be to assess the way we train undergraduate doctors, progressing later to changes in the vocational training scheme. Although postgraduate education is undergoing major restructuring with a suggested 2-year foundation programme,[1] its effects on GP training have yet to be seen. As for undergraduate education, the contents of a core curriculum in medicine are as hotly debated as the formation of foundation hospitals. Of course, due to the exponential increase in medical advances and central government involvement, it is both necessary and important to revise teaching content continually.

When we look at the additional roles of the modern day physician, we can group them broadly into three categories: *a*) research *b*) administration and *c*) teaching. These roles should also apply to doctors outside the hospital setting, that is, general practice, but junior doctors heading for a career in general practice receive little encouragement to indulge their academic interests.

Assessing each of the roles, we see how much GPs can and have contributed, and perhaps suggest ways of improving current undergraduate and postgraduate medical education to reflect the growing demand for a more dynamic type of GP.

Research in general practice

Many students and indeed doctors are unaware of the considerable contribution and achievements of academic general practice in the UK. In fact this contribution is relatively recent: the Royal College of General Practitioners (RCGP) published the first peer reviewed journal of general practice in 1953 and the first Chair of General Practice was established in Edinburgh in 1963. Subsequently, the output of research in general practice has been of a high standard and university departments of general practice are making a greater contribution both in undergraduate teaching and research.

Indeed, there are now established research centres, for example the Department of Family and Community Medicine at the University of Toronto, which predominantly focus on primary care and community health and have successfully combined clinical practice with research.[2]

Although the Culyer report[3] and the National Working Group report on research and development in primary care[4] have made a series of recommendations to support and encourage research in general practice, there remains a considerable shortage of academic GPs.

It is difficult to understand why more junior doctors are not entering academic general practice, especially considering that the Medical Research Council (MRC) published a topic review of research in primary care in 1997, identifying key areas for future research.[5] In November 1998, around £12 million of funding (to be spent over 5 years) was made available as a joint MRC and Department of Health call for research proposals.[6] Although this may partly be due to ineligibility for merit awards, it is important to identify reasons why such influential changes affecting the practice of modern medicine, are not filtering through to the undergraduate curriculum.

This is reflected by the fact that very few intercalated BMedSci/BSc degrees offered by medical schools are orientated to primary care, community health or general practice. The same can be said for the brief audit or research projects undertaken by undergraduates that are compulsory in many medical schools.

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Although most MBChB degrees integrate general practice as one of their clinical attachments, very few are exposed to the research and audit element of primary care. Many GPs may argue that it is in general practice that such skills can best be taught due to the variety of medical conditions encountered in primary care and their long-term management. The greater need for self-appraisal as a result of the direct effect of decisions on practice budgets also makes the process more reflective.

Suggestions for improvement, therefore, include widening the scope for intercalated degrees, small projects and audits in primary care offered by medical schools. Experience in research methodology will be essential in both hospital and community practice and a placement in academic general practice may provide this. Such a placement may be at a university department or with individual practices with an interest in research.

Administration in general practice

Administration has become as much a part of medicine as patients, but nowhere except in general practice do a doctor's management decisions directly influence the quality of clinical practice. Therefore, it is necessary to review mechanisms in place to aid future GPs in handling such pressure.

Mintzberg identified 10 roles for the manager: figurehead, leader, liaison, monitoring, disseminating, spokesperson, entrepreneur, disturbance handler, resource allocator and negotiator.[7] Each of these roles is more than applicable to the modern day GP and at a time of increasing financial monitoring and budget control, the roles of entrepreneur and resource allocator become ever more dominant.

The General Medical Council (GMC) document *Management in health care — the role of doctors* states: 'Doctors make an important contribution to the management of health services. All doctors have some responsibilities for the use of resources; many will also lead teams or be involved in the supervision of colleagues. Recent changes in the NHS, such as clinical governance, will make doctors' roles as managers more extensive and better defined'.[8]

The similarities of Mintzberg's characteristics of managers with the modern-day GP, and the expectations of the GMC, mean that many GPs have considered studying for a Masters of Business Administration (MBA) or equivalents. The value of such a qualification is arguable but there are recognised advantages such as transferable skills, enhanced work performance and career progression.[9] Take into consideration that 87% of healthcare decision making takes place exclusively in primary care, and the argument in favour becomes more compelling.

The unique business aspect of general practice is rarely, if at all, a focus in teaching at both undergraduate and postgraduate levels. Consequently many newly qualified doctors entering general practice find themselves ill-equipped to deal with non-medical staff management and the responsibility of controlling large finances. In order to ease this difficulty and boost the efficacy of primary care, I suggest mandatory undergraduate education in business, financial and personnel management.

Atun identifies the advantages of this; 'management training early in their careers will enable medical students to appreciate important managerial and organisational issues that affect patient care.[10] Taken further, these skills could be more widely offered as an intercalated degree, following the example set by London Business School and Imperial College who offer a joint scheme. Many international universities, for example Yale University Medical School in Connecticut, have already taken this initiative further — integrating management and medicine in an MD–MBA programme.[11]

At postgraduate level, the suggested restructured 2-year foundation programme could incorporate, for example, 1 day each week in management training. This could lead to a formal examination by the RCGP and the award of a specialist MBA in healthcare management.

It may be argued that interpersonal skills acquired at medical school and the self-financial management of studying away from home should be enough for potential GPs. However, I feel more formal tuition is necessary, as exemplified by past acceptance that communication skills can be acquired rather than taught and present focus on teaching these in the undergraduate course.