General practice and the College:

60 years on

Sir Denis Pereira Gray.

In 1952 the state of general practice in the UK and the rest of the world was dire. Specialist medicine was advancing rapidly, Lord Moran would soon describe GPs as having 'fallen off the ladder', and Sir Arthur Thompson stated that general practice was 'outmoded'. GPs had no training for their job, no body of scientific knowledge, no journal or college of their own. There was not one professor of general practice in the world and one-third of new GPs left their practices, many emigrating.

In this crisis, Rose and Hunt^{1,2} called for a college but Sir Russell Brain³ wrote for the then-three English medical royal colleges stating that there would not be a college for GPs! A steering group of five GPs and five consultants, with chairman Sir Henry Willink, decided otherwise and founded the College of General Practitioners secretly on 19 November 1952.⁴ This was a unilateral declaration of independence by generalists from specialists.

GIVING GENERAL PRACTICE A VOICE

The 60th anniversary of this event is a time to review the successes and failures of general practice and its college. The balance sheet is strikingly positive, with many successes — several leading the world. In 1953 the College published the *Research Newsletter*, the predecessor of the *BJGP*. In 1961, under the editorship of RMS McConaghey, a Council member, *The Journal of the College of General Practitioners* became the first scientific journal of general practice in the world to be included in *Index Medicus*. The discipline of

general practice was born.³ The next year, the College bought 13–14 Princes Gate,⁴ a headquarters comparable with other Colleges. In Edinburgh 1963, Richard Scott, another Council member, was appointed to the first chair of general practice in the world.⁵ The same year, Annis Gillie, Council, chaired the report *The Field of Work of the Family Doctor*, starting to value general practice publicly.

In 1965, the College started the examination for membership (MRCGP)⁶ and, the same year, it called for specific (vocational) training for general practice.⁵ It gave evidence to the Royal Commission on Medical Education,⁶ which faced a fundamental question: was general practice a discipline or not? The College evidence, powerfully supported orally, was convincing and the Royal Commission⁷ endorsed postgraduate training for general practice, equivalent to other medical disciplines. By 1977, parliament mandated vocational training in the NHS Act, a triumph for a College that had only one-third of GPs as members.

Countering this minority position, the College worked well with the British Medical Association's GPs through the Joint Committee on Postgraduate Training for General Practice, which Ekke Kuenssberg invented as Council chairman. In a remarkable two-way partnership with the regional advisers (directors of GP education), a new, UK-wide system of GP training developed; this included mandatory training in teaching for trainers, time-limited trainer approvals, and dismissing some established trainers. Major research contributions to medical education followed⁸ — general practice led in medical education and the lead has continued. By 2008, general practice had the most satisfied junior doctors in training⁹ and the fewest number, out of all branches of medicine, who reported being bullied.¹⁰

Simultaneously, general practice research developed progressively. The College's research units developed the tools for practice organisation, such as the age-sex and morbidity registers and the biggest-ever survey of oral contraceptives. Hope-Simpson showed a single virus caused both chickenpox and shingles; follow-up work won a Nobel prize. Slowly, GPs gained hard-won university chairs until, eventually, there was a GP professor in every undergraduate medical school, as well as some postgraduate ones. With over 100 GP professors in the UK, GP research has never been better and ranks highly internationally.¹¹

The College's overseas faculties became Colleges and the international wing, which was established in 1981, has been a resounding success — and the MRCGP international especially so. In the same year, the College was the first medical institution to establish a centrally-placed patient group.

In its first 40 years, the College was a faith organisation built by those believing in general practice and knowing its value for patients. In the 1990s, research showed that general practice/primary care alone, among the medical specialties, could both substantially increase life expectancy in populations and also reduce socioeconomic disadvantage.^{12,13} Starfield and colleagues showed the huge contribution general practice/primary care makes to health systems.¹⁴ As a result of much international research showing the importance of primary care, China is now training 300 000 GPs.

By the 1990s, GPs were democratically elected to all the leadership positions in the medical profession including the presidency of the General Medical Council, as well as the chairmanship of the Academy of Medical Royal Colleges, the BMA Council, and the Medical Postgraduate Deans. In the 21st century, British GPs

"College members can be proud that their support and subscriptions have empowered their leaders to take many imaginative decisions ... but this is no time for complacency."

"A diamond anniversary is a time for pride and reflection. General practice and its College can celebrate these 60 years, but there is still much to do."

ADDRESS FOR CORRESPONDENCE

Sir Denis Pereira Gray

St Leonard's Research Practice, 9 Marlborough Road, Exeter, EX2 4TJ, UK.

E-mail: denis.pereiragray@btinternet.com

became the best-paid medical generalists in the world outside of the US, and College diplomacy enabled academic GPs to receive distinction (clinical excellence) awards (D Pereira Gray, unpublished data, 2000). With over 46 000 members, the Royal College of General Practitioners now has the largest membership and, with £33 million in 2011, the biggest annual income of all the medical royal colleges. General practice now stands within the medical profession as *primus inter pares*.

In these 60 years, general practice has made remarkable progress, with the College its most important institution. College members can be proud that their support and subscriptions have empowered their leaders to take many imaginative decisions. The College is celebrating its diamond jubilee by moving into magnificent new premises — possibly the best College home in Britain — but this is no time for complacency.

The College has inevitably made mistakes. Abolishing its research committee was an error, sending the wrong signal, losing a precious place at the top table in the medical research community, and discouraging generalists conducting research outside of universities. Abandoning Fellowship by Assessment, after more than 300 members had worked extremely hard and paid highly for it, lost the leading incentive for career development in British general practice and surrendered a huge commitment to patients, as well as the chance to influence values and standards of clinical care separately from the state.

LOOKING TO THE FUTURE

Both for the profession and its College, large problems remain, especially in terms of developing training for general practice in depth, quality, and length. It is absurd that GP training is shorter than consultant training when early diagnosis is harder than late, when the problems presented have the widest range of any branch of medicine, and the mix of physical, psychological, and social factors encountered are the most complex. With increasing general practice responsibilities, more skills are needed,

particularly for older people with multiple morbidity. More epidemiological, paediatric, and psychological skills are also needed.

Only 17 per cent of male medical students choose to go into general practice as their first-choice career, despite it being the most clinically interesting branch of medicine, with the richest patient-doctor relationships. New ways are needed to inspire medical students. Could every medical student be adopted by a supportive general practice? Could general practice better deploy its leaders within the medical schools?

Thousands of patients cannot get to see the GP of their choice even though doing so increases patient satisfaction and significantly reduces hospital admissions.¹⁵ Many general practices do not yet have an effective patient group. And there are those who do not value general practice because of pockets of unacceptable care. Only when high-quality clinical care in general practice is consistently delivered nationwide will this be solved. In general practice, no man is an island.

A diamond anniversary is a time for pride and reflection. General practice and its College can celebrate these 60 years, but there is still much to do.

Sir Denis Pereira Gray,

Consultant, St Leonard's Research Practice, Exeter, Past President, RCGP, and Past Chairman, Academy of Medical Royal Colleges.

Provenance

Commissioned; not externally peer reviewed.

DOI:10.3399/bjgp12X657044

REFERENCES

1. Rose F, Hunt J. College of General Practice [letter]. *Br Med J* 1951; **2**: 908.3.
2. Rose F, Hunt J. College of General Practice [letter]. *Lancet* 1951; **258**(6685): 683.
3. Pereira Gray D. *Forty years on — the story of the first 40 years of the RCGP*. London: Atalink, 1992.
4. Fry J, Pinsent RJFH, Hunt JH. *The history of the Royal College of General Practitioners: the first 25 years*. Lancaster: MTP Press, 1983.
5. Royal College of General Practitioners. *Special vocational training for general practice. Report from general practice*. No 1. London: RCGP, 1965.
6. Royal College of General Practitioners. *Evidence of the College to the Royal Commission on Medical Education. Report from General Practice*. No 5. London: RCGP, 1966.
7. Royal Commission on medical education Chairman, Lord Todd. London: HMSO, 1968.
8. Murray E, Jolly B, Modell M. Can students learn clinical method in general practice? A randomised cross-over trial based on objective structured clinical examinations. *BMJ* 1997; **315**(7113): 920–923.
9. Goldacre MJ, Davidson JM, Lambert TW. The first house officer year: views of graduate and non-graduate entrants to medical school. *Med Educ* 2008; **42**(3): 286–293.
10. Paice E, Smith D. Bullying of trainee doctors is a patient safety issue. *Clinical Teacher* 2009; **6**(1): 13–17.
11. Glanville J, Kendrick T, McNally R, *et al*. Research output in primary care in Australia, Canada, Germany, the Netherlands, UK, and the United States: bibliometric analysis. *BMJ* 2011; **342**: d1028.
12. Shi L. The relationship between primary care and life chances. *J Healthcare Poor Underserved* 1992; **3**(2): 321–335.
13. Shi L. Primary care, specialty care, and life chances. *Int J Health Serv* 1994; **24**(3): 431–458.
14. Starfield B, Shi L, Macinko J. The contribution of primary care to health systems and health. *Millbank Q* 2005; **83**(3): 447–502.
15. Bankart MJ, Baker R, Rashid A, *et al*. Characteristics of general practices associated with emergency admission rates to hospital: a cross-sectional study. *Emergency Med J* 2011; **28**(7): 558–563.