Out of Hours
Academic general practice:
a viewpoint on achievements and challenges

Service general practice is supported by three academic systems: the Royal College of General Practitioners (RCGP), university general practice, and the GP deaneries. Having been privileged to hold senior posts in all three branches of academic general practice simultaneously, I offer a highly personal, helicopter view of its achievements and challenges and the big questions of our day.

ACHIEVEMENTS

Service general practice. Service general practice has evolved in one lifetime from a singlehanded, untrained service, like my grandfather's and father's, working from home, into a vocationally-trained, multidisciplinary service mainly in purpose planned premises, with world-class computing. No British profession has evolved faster while retaining such high patient/client satisfaction.

RCGP

The College turned general practice from a craft into a discipline. RMS McConaghey, a service GP, established the College *Journal* as the first scientific journal of general practice in 1961,[1] before there was a professor of general practice in the world. The College still edits and publishes the *British Journal of General Practice*.

The College Council crossed the boundary into universities, providing the first professor of general practice in the world,[2] the first GP professor in Canada, England, Ireland, and the first in a postgraduate university department. It created vocational training, steering it into law. It established the Scientific Foundation Board, a rare GP/primary care-focused research fund.

College leadership identified four young GPs, who, 30 years later included the first GP president of the GMC and the first GP Chairman of the Academy of Medical Royal Colleges (AMRC). Is this happening today?

The College established the first patient group in any British medical institution. Initially, salaried academic GPs were excluded from the NHS distinction award scheme, through blatant discrimination. GP professors complained bitterly, but were helpless. I solved this problem with the help of the Joint Consultants Committee (JCC) and the AMRC, only because I was the first GP Academy Chairman, a member of the JCC, and of the Department of Health (DH) national, distinction awards committee. I shamed policy-makers saying that it was easier for an academic GP to receive a knighthood than a distinction award! Collaboration across organisational boundaries succeeded. The clout of the College achieved the reform.

In the 20th century, the RCGP was probably Britain's most innovative medical organisation. It now has the biggest membership and the biggest income of any medical royal college.

University general practice

The world's first professor of general practice came at Edinburgh in 1962.[2] Britain still leads, with general practice/primary care publications ranking among the world's best.[3] Academic general practice has developed training programmes for academic clinical fellows and masters and doctoral training for them, generating excellent applicants for senior university posts. I became the first Professor of General Practice in the South Western region: now, happily, there are 10 GP professors there, one a medical school dean.

GP deaneries

General practice deaneries started in 1972.[4] The Regional Advisers in General Practice (RAGPs) created a new UK-wide GP postgraduate training programme in only 10 years. Vocational training led British medical education, requiring GP trainers to be trained to teach, be paid to teach, and be appointed as trainers with limited tenure with re-approval subject to review and trainee reports.[5] No other branch of medicine has matched this. GP educational processes now lead British medical education.[6,7] The RAGPs crossed organisational boundaries: four initiated GP university departments and seven led the RCGP as Chairs of Council. They produced the only GP president of the GMC.

CHALLENGES

RCGP

The RCGP, despite its flying start, has gone off the boil, now inspiring GPs much less. The College proposed GP training equal to specialists in 1965,[8] but failed to achieve it in 50 years. Hospital consultants receive 2 years longer training than GPs, who need it more. The 2015 RCGP Blueprint document ignores this longstanding policy.[9]

The College recently made two unforced errors. It abandoned its Research Committee, although that Committee's deputation to the House of Lords helped break Oxbridge's resistance to GP departments.[10] That Research Committee met the Medical Research Council (MRC) regularly discovering that only 7% of MRC funding then went to general practice/primary care. The College surrendered for nothing a place at the top table of British medical research.

The second mistake was abandoning Fellowship by Assessment (FbA),[11] despite over 300 loyal members paying about £800 and working hard for it. This Europe-leading quality assessment system included patients as assessors and was envied by the specialist medical royal colleges, none of which could match it. By keeping only a money-making Fellowship and abandoning the Fellowship which benefited patients, the RCGP stepped backwards towards a membership machine, rather than, as a registered charity, acting in the public interest to improve patient care. This abandoned professional standard-setting delivering it to the State.

University general practice/primary care

The successes of university general practice have come at a high price. Most serious is reducing clinical work with patients to only 1–2 weekly sessions. GPs need to build working relationships over time to learn the hopes, fears, and expectations of their patients. Patients rarely have as personal doctors GP professors who may not be available 6 days a week. Most academic GPs are not managing partners, employing staff, managing budgets and personal lists, so they cannot fully understand the organisations they work in. In general practice alone, senior academics are usually clinical assistants working under the supervision of managing partners.

A professor of surgery can operate weekly maintaining consultant status and credibility with fellow consultants: GP professors rarely have managing partner status or equivalent clinical credibility. Ministers and civil servants control the research agenda and academics respond to their 'calls'. A learned profession needs independent funding to research its own agenda.

Citations are university currency but miss clinical impact. My most cited research[12] showed that patients' attribution of symptoms significantly influenced GPs diagnosing depression. Despite over 400 citations, in 16 years not one patient has benefited: a clinical failure! We need more

implementation. Research-active hospitals are common: research-active general practices are rare.

The purpose of medical schools

Medical schools behave like research institutes. A big question is what are medical schools for? They exist to produce the doctors the nation needs.[13] While the NHS now needs half of all postgraduate training places for GPs,[14] only 19% of medical students view general practice as their first-choice career.[15] One medical student told a Vice-Chancellor that she had only met inspiring GP literature[16] in the last fortnight of her 5-year course. 'Why?' she asked: 'have I not been shown such articles or been taught the theory of general practice?'

The serious undersupply of GPs (21% increase versus 76% increase in consultants since 2000),[17] has pressurised general practices excessively, reducing the attractiveness of the clinical environment for students.

Despite excellent research, medical schools collectively are failing. Too few medical students learn how interesting and rewarding general practice is and it is under-represented in academic posts. Future specialists rarely learn about how general practice influences them and health systems. Some medical schools deny the discipline of general practice by not teaching its theory systematically or examining general practice enough. The SAPC survey[18] found some medical schools allocating <4% of their teaching budget to general practice. Is Government getting value when paying medical schools about £30 000 per medical student, when these institutions are not producing the doctors the nation needs?

Why are BScs in general practice so rare? Now the DH has recognised generalists as the central medical discipline and half of postgraduate medicine, why do medical schools, like Bristol and Exeter, not offer MScs/MPhils tailored for generalist doctors and nurses? Medical schools and the NHS should monitor the percentage of practising GPs and primary care nurses in their region with higher university degrees compared to hospital doctors and nurses in the same area. There are more consultants in my local hospital with doctorates than all the 2500 GPs in Devon and Cornwall. Is service general practice drifting towards an academic desert?

Departments of General Practice/Primary Care are vulnerable. As multidisciplinary research groups and research centres grow, they are usually organ or system centred. General practice/primary care departments are needed to provide balance with whole-person medicine. They have halved in 10 years.[18] They need support to promote generalist identity with stronger staffing with academically-qualified, clinically-respected, generalist doctors, nurses, and social scientists.

How many GPs should have university appointments? I suggest the yardstick is the proportion of consultant geriatricians, which in England is 4.7%.[19] With about 2500 GPs in Devon and Cornwall for a level playing field with specialists, the number with university posts should be about 118. There are currently about 20 GPs with significant university posts. Including the deanery's leading teachers and course organisers only roughly doubles this. Are we ambitious enough?

GP deaneries

Postgraduate deaneries were originally within medical schools, funded by the DH. Despite their success, the medical schools missed the big picture, charged high overheads, and killed the golden goose.

In 1994, the Civil Service nationalised the medical postgraduate deans and GP advisers, making them civil servants. I declined to sign, becoming the last independent postgraduate dean in generalist or specialist practice in England. My case went to the Medical Director of the NHS, who did not force my resignation, but waited for my retirement.

The strategic weakness of the deaneries is that, while they have authority and resources, they are politically led; their staff must obey ministers and senior civil servants, and may not criticise them. The logical response was wrapping deanery colleagues with support from professionally-freer colleagues in the RCGP faculties and universities. It hasn't generally happened: deaneries, faculties, and university departments are relatively separate. Specialists do better. Full-time GP directors, as medical managers, are vulnerable to replacement by those who cannot be GP role models.

GP training schemes are run by course organisers, mostly without higher university degrees, research competence, or publications.[20] How can they enthuse trainees with a deep understanding and love of the literature of general practice?

A big question is whether general practice is now reverting to a craft?

General practices as learning organisations. In my practice, three managing partners have obtained MDs, five partners achieved master's degrees, the nurse practitioner an MSc, an attached midwife an MSc, and a practice-based district nurse a BSc, another managing partner gained FbA of the RCGP. Our practice manager led us to Investors in People. A current managing partner is completing an EdD. Three partners became professors. A key question is how to scale up intellectual skills in general practices, as learning organisations. It can be done.

ADDRESS FOR CORRESPONDENCE

Sir Denis Pereira Gray,
Alford House, 9 Marlborough Road, Exeter EX2 4TJ, UK.
E-mail: denis.pereiragray@btinternet.com

A funded plan

When the College's mortgage ends, it will have about £2 million surplus a year. This could transform general practice/primary care, but only if the College returns to an academic course and if real collaborations across academic organisations are built. A wide-ranging strategic plan is needed for our discipline.

CONCLUSIONS

Fifteen years ago I was simultaneously working in all three branches of academic general practice, as a deanery Director of GP Education for the South Western Region, a university professor at Exeter, the RCGP President, and Chairman of the AMRC. No-one had held those posts together before and probably no-one ever will again. I offer three conclusions.

First, those organisations were mutually supportive with much collaboration. Today, GP academic organisations are much more separate, with less mutual understanding. Secondly, success means identifying and solving the difficult questions of the day. Each of these systems has great achievements, but they all face major challenges, so they should work together to maximise the strengths and minimise the weaknesses. General practice has previously achieved much by *collaborating across organisational boundaries*. It now needs to do so again.

Sir Denis Pereira Gray,
Past Chair of Council and President, RCGP and; Emeritus Professor; Consultant, St Leonard's Research Practice, Exeter.

Edited text from the keynote lecture at the regional conference of the Society of Academic Primary Care on 5 March 2015 in Birmingham.

REFERENCES

1. Pereira Gray D. McConaghey memorial lecture 1988. The emergence of the discipline of general practice, its literature, and the contribution of the College Journal. *J R Coll Gen Pract* 1989; **39(323):** 228–233.
2. Fry J, Pinsent RJFH, Lord Hunt of Fawley. *A history of the Royal College of General Practitioners: the first 25 years*. Lancaster: MTP Press,1983.
3. Glanville J, Kendrick T, McNally R, *et al*. Research output on primary care in Australia, Canada, Germany, the Netherlands, the United Kingdom and the United States: bibliometric analysis. *BMJ* 2011; **342:** d1028.
4. Department of Health and Social Security and the Welsh Office. *Appointment of regional advisers in general practice*. Circular HM(72)75. London: DHSS, 1972.
5. Pereira Gray D. Minimum standards for training.Selecting general practitioner trainers. *Br Med J (Clin Res Ed)* 1984; **288(6412):** 195–198.
6. Goldacre MJ, Davidson JM, Lambert TW. The first house officer year: views of graduate and non-graduate entrants to medical schools. *Med Educ* 2008; **42(3):** 286–293.
7. Paice E, Smith D. Bullying of trainee doctors is a patient safety issue. *Clinical Teacher* 2009; **6(1):** 13–17.
8. College of General Practitioners. *Special vocational training for general practice. Report from general practice no 1*. London: CGP,1965.
9. Royal College of General Practitioners. *A blueprint for building the new deal for general practice in England*. May 2015. http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/PPF/A-Blueprint-for-building-the-new-deal-for-general-practice-in-England.ashx (accessed 2 Oct 2015).
10. Royal College of General Practitioners. *Evidence of the Royal College of General Practitioners to the Select Committee on Science and Technology of the House of Lords*. London: HoL,1995.
11. Royal College of General Practitioners. *Fellowship by Assessment. Occas Pap R Coll Gen Pract* 1990; **(50):** 1–52.
12. Kessler D, Lloyd K, Lewis G, Pereira Gray D. Cross sectional study of symptom attribution and recognition of depression and anxiety in primary care. *BMJ* 1999; **318(7181):** 436–439.
13. Inglehart JK. Institute of Medicine report on GME — a call for reform. *New Eng J Med* 2015; **372(4):** 376–381.
14. NHS Health Education England. *Securing the Future GP Workforce. Delivering the mandate on GP expansion. GP Taskforce final report*. March 2014. http://hee.nhs.uk/wp-content/uploads/sites/321/2014/07/GP-Taskforce-report.pdf (accessed 2 Oct 2015).
15. Lambert TW, Goldacre M. Trends in doctors' early career choices for general practice in the UK: longitudinal questionnaire surveys. *Br J Gen Pract* 2011; DOI: 10.3399/bjgp11X583173.
16. Heath I. Divided we fail. *Clin Med* 2012; **11(6):** 576–586.
17. Iacobucci G. General practice needs investment to provide enhanced services, says BMA. *BMJ* 2014; **348**: g3285
18. Harding A, Rosenthal J, Al-Seaidy M, *et al*. Provision of medical student teaching in UK general practices: a cross-sectional questionnaire study. *Br J Gen Pract* 2015; DOI: 10.3399/bjgp15X685321.
19. Fisher JM, Garside M, Hunt K, La M. Geriatric medicine workforce planning: a giant geriatric problem or has the tide turned? *Clin Med* 2014; **14(2):** 102–106.
20. Pereira Gray D. Two sides of the coin. *Postgrad Educ Gen Pract* 1993; **4:** 85–88.