Letters

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Brexit

I and other doctors are deeply disturbed by a motion passed in a RCGP Council meeting, namely that *'the public should have a final say on the Brexit deal, including the options of accepting the deal, rejecting the deal, and remaining within the European Union'*.

This is a clear departure from the College's politically neutral stance. I believe this has set a dangerous precedent for the RCGP and that this motion is contrary to the College's charity status enshrined in law.

The RCGP, as a charity, is obliged by law to be sufficiently balanced and neutral in its approach. It is essential that patients and doctors can have faith in charities such as the RCGP, and a level of conduct and integrity on the part of RCGP is required to maintain this faith.

RCGP members and indeed the public do not require the RCGP Council to represent their political views, nor are they elected to do so, yet the College is making a perverse argument of making an 'exception' to the neutral standards that are expected of it.

The College acknowledges that it has a diverse membership of over 52 000 members yet it does not incorporate the views of those paying subscriptions to it who may have voted for Brexit and has entirely sidelined them. Equally there are those in the remain camp who may also feel that the referendum result must be respected as it has been voted for through the democratic process and the College should remain neutral and respect that process. I can see no evidence of the RCGP Council adequately reflecting on either of these viewpoints, which run contrary to its motion.

I do hope the College will reconsider its stance and maintain neutrality, as the concern is that the RCGP is being used as a vehicle for advocating views of a particular elite political faction that opposes Brexit at all costs. Members of the public are increasingly feeling alienated and the RCGP cannot allow itself to be seen as part of an elite that wishes to overturn/subvert the Brexit referendum result.

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RCGP response

The purpose of the Royal College of General Practitioners is to *'encourage, foster and maintain the highest possible standards in general medical practice'* — in doing so, ensuring that the care we deliver to patients is good and safe.

It is the view of RCGP's governing Council — elected by our members to reflect and represent their diverse views — that Brexit in any form would likely be harmful to the NHS, and undermine our ability to do this.

After almost 2 hours of debate during which any member of Council who wanted to speak was given the opportunity to do so, a significant majority voted, first, that the College should move to oppose the UK's forthcoming exit from the EU, and, second, that the public should have a final say on the Brexit deal; in essence to support a second referendum.

The strong feeling on this second issue was that at the time of the 2016 referendum the public voted without full and impartial information about the impact Brexit will have on the NHS.

I understand that Brexit is a polarising issue, and that some members may not agree with our decision to take a stance, or the stance we are taking, but the decision to debate this issue was not taken lightly and only after seeking legal advice regarding our charitable status.

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What is the root cause of the GP workforce crisis?

Chantal Simon and colleagues write perceptively about Generation Y[1] but can we blame medical graduates for being cautious about committing themselves to general practice? Trying to see things through their eyes I spot three big hazards for potential GPs.

Specialist medicine is growing very fast. The number of hospital medical staff has grown substantially from 87 000 in 2004 to 113 500 in March 2017. Within that figure, the number of hospital consultants has risen by more than half — up from 30 650 in 2004 to 47 816 in March 2017. This contrasts with the slow erosion of the GP workforce and the rapid reduction in district nursing. The scientific developments on the near horizon — 'precision' medicine, AI data-mining, bacteriophage therapies, biome modification, and so on — are emerging within specialist disciplines. General practice might have much to teach about integration of health and social care, but we are not promoting it as the contribution of our discipline to medicine's further development. The gravitational pull of hospital-based specialisms seems likely to increase.

The collectivisation of general practice seems likely to create many salaried posts but future fewer partnership jobs. Being a locum or opting only for salaried posts make sense in such an unstable environment, especially when there is a buyers' market and some locums can command high salaries. The highest I have seen so far was £200 000 for a year's commitment to eight surgeries a week. And of course part-time sessional work is flexible, eases childcare arrangements, and promises work–life balance.

As a discipline we do not always help this situation. Matthew Dunnigan argued cogently that the repeated exaggeration of GP consultation rates by RCGP leaders, starting in 2014, may have created a disincentive for new graduates to enter general practice.[2] The estimated consultation rates are no longer discussed in public, but general practice is described as being under pressure, stressed, challenged, and close to collapse. GP workload is described by the BMA as *'so unmanageable it is affecting the delivery of safe patient care'*.[3] Medical graduates may well ask why they should join a discipline that is presented in such a light by its own leaders.

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Prescribing parkrun

A fantastic and inspiring article on the power of prescribing parkrun.[1] Our practice based in South London has recently signed up as a parkrun practice and reading the success stories of how parkrun has transformed patients' lives is exactly why we joined this initiative.

There is something for everyone at parkrun and the examples used show the vast range of health benefits it can have from cardiac rehab and weight loss to reducing social isolation and mental health problems. For a GP surgery it helps to form closer links with the local community, as well as health promotion for staff.

The main barrier we have had to overcome is convincing patients and staff that it is not just an event for 'runners' but is inclusive for all. That Saturday morning buzz can be had by walkers, joggers, and volunteers, who are essential in running the events. Colleagues and patients have said that it can seem quite intimidating on the first visit and I would encourage parkrun to continue to focus on inclusivity and breaking down these barriers to involvement.

We are fortunate in our practice to have volunteer health champions who run a 'Couch 2 5K' programme from the surgery twice weekly. Our hope is that patients can then graduate from the couch to a full 5 km parkrun. We have started to see small success stories already, such as an overweight patient who previously had never run, managing a steady jog and even a short sprint when she had thought she had been left behind!

As a GP trainee at the start of my career it is great to hear from the author that parkrun and all the associated health benefits *'is the best medicine I can prescribe'*. I know that exercise for health will always be part of my health promotion at work.

If you have never given parkrun a go, I would strongly encourage you to sign up to your local event, print your barcode, and walk, jog, volunteer, or run! I guarantee that you will feel the buzz and see the smiles all round, whatever the weather.

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Are we propagating the inverse care law as GPs?

Watt[1] is right to acknowledge the disconnect between the political rhetoric of addressing health inequalities and the reality of limited healthcare provision in areas of greatest need. He has however failed to acknowledge the role that we as GPs have in propagating the inverse care law. Recognising our influence as GPs in workforce planning, policy, and medical education is important in addressing the gaps in provision. Bespoke resilience training,[2] leadership, and pastoral support would improve job satisfaction in disadvantaged settings, rather than limited-efficacy 'golden handshakes'.[3] Offering academic GP training in disadvantaged communities presents another means of supporting GP recruitment and raising the profile of academic general practice. Directing research towards Cinderella specialties, that is, mental and public health, presents an opportunity for an upward cycle of community health understanding, engagement, and improved health outcomes.

As recognised in the editorial by Blythe,[4] integration of a proactive GP curriculum in undergraduate medicine is essential, encouraging recruitment and incorporating social accountability in health care. This should go beyond taught theory, with hands-on participation in health promotion and research projects in disadvantaged communities.[5] Achievement will necessitate more research-active practices outside university cities, and greater collaboration with third-sector organisations. Experiencing a 'Tudor Hart' positive impact will challenge students to consider working in such areas. In contrast, the status quo of increased practice workload in disadvantaged communities risks negatively impacting on GP trainers' ability to engage and inspire medical students.

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Teaching general practice

Andrew Blythe's recent editorial on teaching general practice reminds us of the opportunities to teach diagnostic reasoning, the management of uncertainty, and therapeutics, which appear under-taught in many schools.[1,2] There is also an opportunity here for a patient safety focus in consulting, in terms of discussing diagnostic reasoning, how diagnostic errors arise, and how to manage diagnostic uncertainty more safely.[3–5]

The World Health Organization states that *'Trainees would benefit from explicit*