sense is precisely what has eroded the trust of our patients and opened us up to justifiable claims of professional arrogance in dismissing alternative approaches to health care. Nobody is arguing that these are not more effective when applied at a population health level, but this should not preclude GPs from applying our professional common sense in tailoring sensible and safe lifestyle interventions for our patients.

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REFERENCE

1. Nunan D, Blane DN, McCartney M. Exemplary medical care or Trojan horse? An analysis of the 'lifestyle medicine' movement. *Br J Gen Pract* 2021; DOI: <https://doi.org/10.3399/bjgp21X715721>.

DOI: <https://doi.org/10.3399/bjgp21X716213>

The academic triad in general practice

Reilly *et al*'s article on GP scholarship¹ is important and we warmly support it. They rightly state that academic general practice should be 'integrated and accessible to grass roots GPs'. Secondary care has long had its teaching hospitals and long trumpeted the academic triad of good service for patients, teaching, and research all in the same place. GPs should seek to replicate this triad.

We report that our practice obtained the Investors in People award and has been twice rated outstanding by the Care Quality Commission. For educational development, since 1987, seven different GP managing partners have received higher university degrees. A nurse practitioner and an attached midwife obtained master's degrees and an attached district nurse a BSc. A medical student won the Quintiles prize for women in science while at the practice. In a typical year, over 40 medical students receive teaching in the practice.

There is a designated research room for research designed and conducted within the practice, and for 10 years running the practice has employed three successive postdoctoral research fellows. There have been 22 practice-based publications in peer-reviewed medical journals, as well as four in educational and policy publications, in the last 5 years. Our systematic review²

of continuity of doctor care and mortality, in *BMJ Open* in 2018, was designed and conducted entirely within the practice, involved two medical students as co-authors, and has an Altmetric score of 2421, with 250 citations and over 87 000 downloads.

We offer this example as evidence that the academic triad can be built in general practice. NHS GP care, the teaching of medical and postgraduate students, and active research can all occur simultaneously in a single general practice. What is needed now is what teaching hospitals have had since 1948 — public recognition and reasonable financial support. Both the Royal College of General Practitioners and the Department of Health have responsibilities to ensure a level playing-field for general practice.

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REFERENCES

1. Reilly J, Reeve J, Machin A, Lyness E. What is Wise GP? The intellectual and scholarly challenge of general practice. *Br J Gen Pract* 2021; DOI: <https://doi.org/10.3399/bjgp21X715853>.
2. Pereira Gray DJ, Sidaway-Lee K, White E, *et al*. Continuity of care with doctors — a matter of life and death? A systematic review of continuity of care and mortality. *BMJ Open* 2018; **8**(6): e021161.

DOI: <https://doi.org/10.3399/bjgp21X716225>

Behavioural determinants of health: individual versus societal responsibility

Nunan *et al* draw our attention to the emphasis of so-called 'lifestyle medicine' on behavioural determinants of health and the responsibility of individuals for behaviour modification.¹ While it is important to address the leading behavioural determinants of premature mortality in England, namely tobacco use/unhealthy diet/alcohol and drug use/physical inactivity,² the authors rightly highlight the importance of considering the wider determinants of health.

An important point being made here is that overemphasis on health behaviours and individual-focused interventions (intentional or unintentional) may actually increase health inequalities and draw attention away from the main drivers of poor health, namely the wider socioeconomic and environmental determinants of health. As the Marmot reviews have shown us, differences in socioeconomic status are associated with dramatic differences in rates of premature mortality and disability; the 2020 review reported a 12-year difference in healthy life expectancy at birth between the most and least deprived regions of England.³ Moreover, a recent cross-sectional study of 2.5 million premature deaths in England found that one-third of these deaths were attributable to socioeconomic inequality.⁴

Clearly, a balance must be struck between individual responsibility and wider societal/governmental responsibility. It is important not to minimise individual responsibility for one's own health or create a false dichotomy between individual responsibility and societal responsibility; both are important and should be advocated for simultaneously. Nunan *et al* provide a useful framework regarding ways to integrate 'individual-level interventions' with 'public health interventions' to address key modifiable risk factors. In doing so, the authors remind us of the importance of national policy in improving the nation's health and reducing health inequalities, by placing some of the responsibility at the feet of governments and national public health organisations.

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