TALKING POINT

The RCGP: an inside view

BRIAN D KEIGHLEY

An acutely embarrassing experience has led me to wonder why it is that an organisation with such laudable aims as the Royal College of General Practitioners should stimulate antagonism from so many doctors, especially GPs. At the 1980 LMC Conference dinner one speaker mentioned the college. This reference was met with hisses and boos from all sections of the banqueting hall despite the presence as a guest of Dr John Horder, the college president. Probably the inhibitive effect of good manners was diminished on this occasion by a well-known and free-flowing social lubricant. The question remains, however, as to why a sizable minority of these GPs who represent their peers medicopolitically should react with such hostility, an emotion which I have found echoed by other doctors from all parts of the country.

Founded in 1952 by a small group of enthusiastic doctors, the college describes its *raison d'être* in a small booklet entitled *Aims and Activities*. I will list these aims and try to isolate why a proportion of potential membership is alienated.

The first aim is to encourage and maintain high standards in general practice.

I have never met a general practitioner who did not think, according to his own lights, that he was achieving and maintaining high standards in his own practice. But at the drop of a hat these same doctors can produce horror stories about some other doctor's lapsed standards.

Perhaps one of the central causes for antagonism towards the college is the threat an individual doctor feels to his own professional self-esteem, a threat that cannot easily be dismissed as intraprofessional jealousy, as when the criticism comes from outside—such as a jibe from a hospital consultant. A criticism from within a GP's own peer group is more important and upsetting. The doctors active in the college's affairs have slowly become used to these challenges to their standards but should also understand if others resent them.

The second aim is to foster good relationships and understanding of mutual problems between general practitioners and other members of the medical profession.

Good relationships stand the greatest chance of being established when there is mutual respect and a kindred spirit between two parties. This cannot be the case when there are doctors in the college who imply that there are two classes of doctor or that the college holds a monopoly of good clinical standards or wisdom. Any senior office bearer of the college would deny that this idea is generally held. Nevertheless, the comment I most often hear from non-members is that the college has a "holier than thou" attitude to other doctors. It may or may not be true that this attitude has currency at Princes Gate but the fact remains that many doctors believe it.

Understanding in any academic discipline has its basis in language. Jargon is the bastard of language and means little to those who have had nothing to do with its conception or propagation. Much of the college's jargon has been generated by its predilection for slavishly following educational theory and is thus a borrowed jargon. But despite attempts to talk in

plain English the jargon persists and has become the medical equivalent of a music-hall joke.

Greatest successes

The third and fourth aims are to promote the necessary understanding of domiciliary and community care of the family in undergraduate education; and to promote and set standards for vocational training of young doctors before they become principals in general practice.

Few doctors carp at these laudable aims, and it is in these two areas that the college has had its greatest successes. The one main criticism that I have heard about vocational training is the tendency of GP teachers to forget that their students are no longer undergraduates, that they are doctors in their own right and often have valid opinions about practice. Though these GP teachers are not college representatives, young doctors will judge the college on their attitudes and actions.

There may also be antipathy from those doctors who make a late switch in career from hospital to general practice. With the impending introduction of vocational training regulations they may rightly think that the college has played a major part in closing a door which was previously open to them.

The fifth aim is to advise and assist in the continuing education of established general practitioners.

This is the crux of the matter. This is where most hostility is generated. Advice and assistance is all very well, but what I think the college fails to realise is that increasingly it is being called on to offer what is considered to be authoritative advice and assistance to Government departments. The structure of general practice in Britain can be likened to that of the Church of Scotland: each general practitioner is entitled to his own view and own method of practice so long as it does not stray too far from the consensus of his peers. That consensus, and its bearing on relationships with the Government, has long been mediated by the democratic structure of local medical committees and the GMSC.

The authoritative position of the college could be seen by some as the imposition of an episcopacy, whereby the "bishops" of general practice are afforded a position of power and influence rather like that of the Church of England's bishops. The senior officials of the college are, of course, elected by their peers. But their peers are all college members and the college is not yet representative of all general practice. The college can surely not deny that it seeks a position of influence when decisions are taken about general practice, albeit from the best of motives. It must not be surprised, therefore, if at times doctors whom it does not represent directly think that it is taking too much power to itself.

The MRCGP examination, the method by which the college measures the success of continuing education, also produces antagonism, especially among those who have failed it. It is to the college's credit that nearly all examiners have taken and passed this examination, even if they joined the college before it was introduced. There seems to be a great deal of confusion in the college as to the purpose of the examination. To some it is a basic test of competence, and yet it often seems to be unable

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Primary health care in London

BMA proposals

A document on primary care in London has been prepared by the BMA Secretariat, modified and approved by the craft committees and the Executive Committee of the Council, and submitted to the Primary Health Care Study Group of the London Health Planning Consortium. A BMA delegation, comprising Dr Michael Gilkes (CCHMS), Dr John Marks (GMSC), Dr Alan Tranter (CCCM), and Dr John Dawson (BMA under secretary), met the study group on 19 November to discuss the BMA's proposals. The action proposed by the BMA in the document is set out here. Copies of the full document are available from the BMA Secretariat.

The BMA believes that after discussion with the PHCSG the following action should be started by the Association or its craft committees to affect positively the present access to primary care services in London.

The BMA should initiate discussions with the RCN to support the efforts of the college to provide better terms and conditions of service for community nurses working in inner-city areas. The aim of this action, probably achieved by negotiation with district health authorities, would be to increase the recruitment and retention of skilled nursing staff in unattractive areas with a consequent effect on the recruitment of "suitable" general practitioners. Methods of strengthening the present liaison between GPs, community nurses, and other primary health care staff should be explored.

The BMA should negotiate an agreement across London with the GLC and local authorities for a more consistent attitude to the provision of premises and sites for primary care centres. Research should be carried out into the use of buildings that are expected to depreciate in value, defined life premises, to establish their suitability for inner-city primary care.

Waiting lists, classified simply by specialty and hospital, should be made available on a regional basis to GPs. The cross-

boundary patient flows detailed in *Acute Hospital Services in London*¹ indicate that people are prepared to travel to obtain treatment, however inconvenient this may be.

Information about waiting lists is transient and will be updated at frequent intervals. GPs require access to accurate information at the time of referral but do not need sheafs of paper cluttering their surgeries. This service could be provided ideally by PRESTEL. Either the NHS or the BMA would act as a central or regional information provider to PRESTEL with responsibility for gathering and collating up-to-date information. Access to this data could be restricted to authorised terminals through the use of a closed user group.

FPCs have difficulty in distributing up-to-date lists of doctors and this should be rectified. The procedure for registering with a GP should be more widely publicised and consideration should be given to the difficulties experienced by people who have trouble in using the system. This might be carried out by the BMA through the medium of the CHCs.

The BMA should discuss with the Medical Practices Committee the criteria used for the appointment of principals in inner London areas. The present pattern of appointments appears likely to perpetuate current deficiencies and may even produce a greater decline in standards of access to care.

The remuneration of GPs might be modified to produce changes along the lines of those proposed in the report of the joint GMSC/WGMSC working group on underdoctored (underprivileged) areas (27 September, p 884). In this context, the GMSC should seek to implement changes that will allow the unlimited use of deputising services in London.

¹ Department of Health and Social Security. *Acute hospital services in London: a profile by the London Health Planning Consortium*. London: HMSO, 1979.

Talking Point—continued from previous page

to measure the well-known basic competence of established doctors. On the other hand, many young doctors who have recently completed vocational training seem to be able to pass it with ease, but their basic competence can still be in doubt.

The college has reacted to this criticism by exploring ways in which the examination might be made more suitable for the established doctor. But while the current position remains confused the college must acknowledge that the examination is regarded with suspicion, especially by established doctors. Rightly or wrongly, many believe that it will in time be put forward as a criterion for becoming a GP principal or GP trainer and the examination is resisted for this reason alone. Many doctors find the idea of the college fellowship repugnant and think that it has little to do with the bread and butter work that they do every day. They think perhaps that it is another symptom of the élitism that is being encouraged by the college.

The sixth aim is to encourage and conduct research in and into general practice and to assist and advise those who wish to undertake such research, whether general practitioners or in other organisations with similar objectives.

This activity is restricted to a minority of GPs and undoubtedly has added to the total sum of medical knowledge. Some wonder, however, how much of this research is worth while and are happy to leave it to the enthusiasts while wondering how they find the time.

To study and encourage the improvement of the organisation within general practice in its widest aspects is the seventh aim.

To most GPs this means either improved patient care or more money, or both. I think little heat is generated by this activity.

Lastly, the RCGP aims to issue publications on general practice and related subjects.

The best advertisement for the college is, or should be, the house journal, the *Journal of the Royal College of General Practitioners*. The journal often has interesting articles, but just as often it has articles of limited interest, full of esoteric jargon, which are a poor stimulus to interest in college membership. Looking through the correspondence columns I see I am not alone in this view.

I believe in the college and its aims for general practice. I should not have joined it otherwise. It distresses me that so many non-members are actively antipathetic. Much ill will is generated by ignorance and indifference. Some of the criticism, however, is valid, and it would be an arrogant organisation that did not recognise this. For the college to go forward it has to take the rest of the profession willingly with it. If this is to happen attitudes within and without will have to change.

I have offered no solutions but only a personal view as to why there might be problems. Perhaps it is time that some of the scientific endeavours of the college should go towards identifying these problems more formally. When valid criticisms are isolated and positive action taken the college can look forward to an exciting and prosperous future with its house very much in order.

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