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Enriching Careers in General Practice

A career structure for general practice

Stuart Handysides

This is the fourth in a series of articles examining ways to increase fulfilment from a career in general practice

Training for general practitioners usually provides little experience in research, business management, or dealing with chronic disease. It is these areas that could provide scope for further training after becoming a general practitioner principal and provided career goals. Formally recognised research practices, perhaps with one partner coordinating research but all participating, and district research facilitators could increase both the quality and the quantity of research in general practice.

Recognising the different skills of doctors in the partnership and referring patients to the most appropriate partner will improve care for patients as well as provide career development. Further training could be aimed at filling gaps in the practice's pool of skills. Good management skills are becoming more important as practice teams get bigger and fundholding spreads. Some doctors may wish to become full time or part time managers and the idea of accredited courses for management has been raised.

Vocational training for general practice in Britain is considerably shorter than the training for a hospital specialty. It uses progressive educational methods and the mentor relationship with a trainer but offers few opportunities for research,¹ limited training in the business side of general practice, and little experience of the management of chronic diseases.² In 1968 the Royal Commission on Medical Education advocated a five year vocational training,³ and the Royal College of General Practitioners has recommended two years in general practice.⁴ This goal is now approached by Denmark,⁵ but in the Netherlands training takes two years, although it is due to increase to three later this year.⁶ The number of general practitioners with higher degrees is lamentably low: only 50 out of 3041 MDs were awarded to general practitioners between 1973 and 1988.⁷

Increasing the length of training to give time for research will not in itself create goals or prevent isolation of general practitioners, but it could provide one way to build a career structure for at least some

general practitioners. In this article I examine the possibilities for providing career goals through clinical practice, management, and research and discuss the processes for accreditation and reaccreditation of general practitioners.

The academic career path

Few non-clinical academic appointments exist for general practitioners.⁸ A vocationally trained general practitioner can become a lecturer. Lecturers spend about half of their time in clinical work (as a partner or assistant) and half in research and teaching and work towards a higher degree. Senior lecturers need experience in research and teaching, and a higher degree. They usually do the same mix of clinical and academic work. Professors do less clinical work to allow more time for the administrative tasks of leading the academic department.

A recent report of a working party of the Association of University Departments of General Practice recommended the development of a post called academic registrar in general practice. The post which is being piloted at the University of Southampton, would last for two years. The registrar would spend half the time training in general practice and half in research, working for a master's degree.⁹

Academic posts in general practice are rare. In 1988 only 391 out of 6551 medical academic posts were in general practice. There was one paid post per 161 general practitioners, compared with 0.43 academic posts per consultant.¹⁰ Rachel Rowsell is the first holder of a lecturer post in Bristol. The department has two half time equivalent senior lecturers and another who works two sessions, but it is set to expand. Her job has three strands: to increase experience in general practice, to develop skills in teaching undergraduates, and to work for a higher degree. Like other lecturers I talked to, she felt tensions between the academic and service components of her job, "It feels impossible to do both justice, and you don't feel valued in either. The clinical demand is always there, but university appointments committees are interested in research

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achievement and quality of teaching, not in how hard I have worked for my practice and patients."

Paul Little, senior research fellow at Aldermoor Health Centre in Southampton, agreed that there is too much to do, "The clinical sessions always run over and the research and teaching get eaten into." He told me that the financial rewards are less than normal practice but that the real problem is lack of tenure, the threat of having to move on after two to three years.

Judith Ridd, another research fellow at Aldermoor, was not looking for security and she said there were fewer hassles about practice finances in an academic post. She has recently returned from maternity leave and is delighted to be able to combine academic and clinical work as well as looking after her baby. With her husband organising his career as well, her future is uncertain: "I hope to obtain an MD and retain links with Aldermoor. However, I may need to move and my academic background might be threatening to some practices." Aldermoor is indeed no ordinary practice, with only three out of eight doctors on a mainly clinical track and Southampton university's department of general practice literally above the shop.

Linking town and gown

Every medical school in the United Kingdom now has an academic department of general practice.⁸ Their remit is to teach undergraduates and do research. A separate structure organises vocational training and continuing medical education: regional advisors are linked with universities through the postgraduate deans rather than departments of general practice. This division sanctions the idea of academic departments being ivory towers and does nothing to develop a research culture in mainstream practice.¹ Academic departments need to draw service general practitioners into research through links with course organisers and general practice tutors if they are to achieve a reasonable output.⁹ General practitioners will benefit from the challenge of research and the support of working in collaboration.¹¹

Kieran Sweeney, a general practitioner in Exeter, says that he originally saw himself as a fully committed service general practitioner. The influence of his partner, Denis Pereira Gray, professor of general practice at Exeter, led him into research. He told me, "I think it's important to continue to be a primary care doctor to retain credibility, the benefits of clinical practice, and humility. There is a danger of becoming remote, detached from human predicaments. But we need equality of opportunity for research and development in general practice. As things are you can't develop a research strategy, because funding is ad hoc." He is spending one or two sessions each week on work towards an MPhil.

The proportion of original papers that had been written by service general practitioners and published in the *British Journal of General Practice* fell in the 1980s from a half to a third.¹² An editorial that accompanied this observation said that more papers were being submitted from academic departments and that referees were blinded to the author and source of papers to reduce bias. It warned that a two tier journal might develop if allowances were made for "poorer quality papers by non-academics."¹³ Roger Jones and John Spencer, of the department of primary health care at Newcastle upon Tyne, acknowledged that the infrastructure for research by general practitioners outside university departments was inadequate.¹⁴ They were wary of the "every practice a research practice" idea, but said, "What is needed is a climate—culture overstates the issue—in which inquisitive people with good ideas and energy can at least think about researching their questions with a

reasonable prospect of getting some time, money, and support to do so."¹⁴

As medical audit advisory groups develop experience and doctors become accustomed to welcoming facilitators into their practices, a new role—that of research facilitator—could emerge. Such a person, working in a district or family health services authority, would help practitioners to turn their ideas into researchable questions, link practices with similar ideas to build projects big enough to have statistical power, and generate momentum to see projects to their conclusion.¹⁵

An academic plan for general practice

The Royal College of General Practitioners' academic plan for general practice is for there to be 12 training posts in every region, each offering, for example, day release one day a week for three years.¹⁶ In addition, at least 12 practices in each region should be formally recognised as research practices, based on the quality of their previous research and organisation.¹⁰ These research practices might be analogous with training practices, with one partner coordinating research activities but all participating.¹⁵ The association of university departments of general practice regards this as "the linchpin of future moves to broaden the academic base of general practice."⁹

All general practitioners now have to examine their activities as a contractual requirement. Julian Tudor Hart, general practitioner and researcher, sees a possibility for "the birth of a new kind of clinical and social imagination, which no longer regards research as a minority option. Our great opportunity is not the recruitment of a few more professionals, but the accession of 30 000 absolute beginners."¹⁷

Clinical career structure

It is easier to envisage an educational or a research hierarchy than a clinical one. Patients come to see a general practitioner because they feel ill. They expect to see a doctor who is capable of doing what they think general practitioners do. People ask to see the top specialists, but we don't expect them to say it about general practitioners. Nevertheless we ask each other's advice and recognise that in the course of our training we have shown greater aptitudes in some areas than others, and hope that our partners have picked up the bits that we missed along the way. Market forces in medical practice aim to replace the naive, trusting attitude of patients with an inquiring, evaluative one already possessed by some well educated patients.¹⁸ We can no longer say that we do our best and our patients like us. We have to show what we do, how much, and how well it works.¹¹

The goals in such a system are to demonstrate performance, to attract patients, and to inspire "brand loyalty" to a particular surgery or doctor. How long it will be before most patients are able to make informed choices about quality of care can only be guessed. The recommendation to general practitioners is to get ready now.

The Hertfordshire faculty of the Royal College of General Practitioners assesses its resources by periodically surveying its members' particular interests and skills. Partners may know each other's strengths and limitations, but it may be helpful to review the resources of the partnership and team to ensure that a comprehensive range of skills can be provided. This need not undermine personal lists, any more than referral to a hospital specialist does. If my partner does a particular task better than I do, say minor surgery or child health surveillance, patients requiring these skills are best served by seeing my partner.¹⁹ The number of

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Minor surgery—another of general practitioners' roles

partners who need to possess particular skills depends on the organisation of the practice and its demography, the demand for the skill, and whether it will be needed urgently or out of hours. As more people develop a skill each may use it less often.

Core competencies and special clinics

All general practitioners need certain competencies and standards, but other skills can be offered by one or some of the partners or other members of a practice team. Vocational training should equip general practitioners with all the core competencies, and they could develop other responsibilities in a structured way during their career.¹⁹ Modules of higher training could be designed for clinical practice, communication, epidemiology, management, quality assurance, teaching, and research.⁴ The team member with a special skill might teach other members of the team or act as a resource for internal referrals. The size of the practice and demand for the skill would determine whether a dedicated clinic was likely to be a more efficient way to deliver care.

The learning and preparation for fellowship by assessment, a clinically based higher degree, and the work that goes into teaching members of the team or other colleagues all add to the clinical structure of a general practitioner's career. The British standard 5750, although mainly a management standard, can be applied to clinical aspects of practice organisation and serve as a goal in clinical practice (Jacqueline Tavabie, personal communication).

Career goals in management

The attitudes of general practitioners to management and their personalities determine how much they do themselves and how much responsibility is given to a practice manager.^{20 21} For some it may become a job in itself, as the managing partner, fundholding partner, coordinator of a consortium of fundholders or non-fundholders, or as an advisor to a family health services authority. The idea of creating fellowships for graduate courses in management and administration has been mooted.²²

General practice fundholding has provided the opportunity to develop services to complement and even replace those traditionally offered by hospitals. The business of managing the fund, of developing a team that is capable of administering it, and the

rewards of being in control at a time when so many general practitioners have felt control slipping away have made fundholders among the most buoyant of doctors in recent years.²³ Complaints about a two tier service have continued and later waves of fundholders have joined through resignation rather than enthusiasm.²⁴

Fears are expressed that when most general practitioners have become fundholders they will hold all the responsibilities but none of the perks that the first fundholders had. Rather than a pot of gold the fund may become a means of cash limiting general practitioners and they will lose their position as advocate for individual patients.²⁵ The counter argument is that general practitioners are in a better position to make rationing decisions than anyone else and that by good stewardship now can delay the need for rationing. Fundholders have told me about savings they have been able to make without loss of care and of improved services they can offer.

Non-fundholders are not standing still either. Some group together and can exert enough muscle to influence the policies of provider units. At practice level Abdollah and Jacqueline Tavabie, in Orpington, have asked local providers to quote lead times for responding to referrals. They give their patients written instructions to contact the practice if they have not heard within that time. If providers do not meet their obligations they are prepared to send their patients elsewhere.

Accreditation and reaccréditation

Career structure requires assessment—and this is likely to become a periodic requirement for general practitioners. The Royal College of General Practitioners launched its quality initiative 10 years ago²⁶ in response to concerns about poor standards of care, doctors' lack of accountability, and finite resources.²⁷ The initiative's aims were that general practitioners should be able to say what services they provide, define specific objectives for care of their patients, and monitor their progress towards achieving their goals, but it has had limited success.²⁸ Irvine attributed the prescriptive nature of the 1990 contract to the profession's failure to regulate itself.²¹ This introduces the distinction between formative assessment, performed for the educational benefit of the person being assessed, and summative assessment, performed to protect the public against a substandard doctor.

In 1992 the General Medical Services Committee canvassed all general practitioners on the subject of accreditation and reaccréditation.²⁹ Although half the respondents agreed with the statement that the vocational training certificate issued by the joint committee on postgraduate training in general practice was sufficient proof of competence to practise, a third disagreed. Over 40% believed that a system of accreditation was long overdue, and half believed it would improve the standards of care. Two thirds disagreed with the statement that once a basic level of competence is acquired no further reappraisal is necessary for the rest of a doctor's professional life. Doctors involved in training and young doctors were more likely to agree the need for accreditation and reappraisal than others. The conference of local medical committees in 1992 asked the GMSC to set up a task force to look at reaccréditation.

In a survey of general practitioners in Cleveland early in 1993, three fifths agreed that reaccréditation should take place, and almost three quarters thought the GMSC and local medical committees should set it up.³⁰ They thought assessors should be appointed by the local medical committee. Clinical knowledge, clinical skill, and prescribing practices were the three

topics for appraisal mentioned most often. The most favoured interval between reaccreditation was 10 years or more, and two thirds of respondents thought reaccreditation should be a part of continuing medical education.

Vocational training certificate or college membership?

Since 1981 new principals in general practice have needed to have a vocational training certificate. The certificate is issued by the Joint Committee for Postgraduate Training in General Practice in response to statements of satisfactory performance from four hospital consultants and the general practice trainer. Some regard it as no more than a certificate of attendance, although the three professional bodies concerned have acknowledged that the certificates represent a professional judgment of quality.³¹ Concern has continued, however, and the college and the Committee of Regional Advisors in General Practice in England have agreed that "all future principals in the NHS should hold the MRCGP."³² Members of the Royal College of General Practitioners are less likely than other practitioners to have repeated reprimands or be erased from the register, fewer are found in breach of their terms of service—particularly repeatedly, and at least one defence organisation offers them discounts on indemnity.³²

Reaccreditation: voluntary or compulsory

The General Medical Services Committee task group on reaccreditation, chaired by Laurence Buckman, had to steer a course between what is acceptable to the profession and what the Department of Health will regard as worth while. Laurence Buckman believes the proposals have nothing to do with policing medical standards: reaccreditation means no more than that doctors are capable of working to a particular standard, not that they do."

The task group preferred the idea of voluntary reaccreditation and proposed both practitioner and practice based schemes. Practitioner reaccreditation might be a more sophisticated arrangement for obtaining the postgraduate education allowance: a general practice tutor and practitioner would discuss and agree the educational needs of a practitioner and develop a five year plan. Practice reaccreditation might also occur, perhaps five yearly, using assessments similar to those used for approving training practices, and successful practices could qualify for a performance related allowance. Unlike practitioner reaccreditation, practice reaccreditation would require new money to fund it and to act as an incentive for developing standards.³³

One fear is that having been made to jump through hoops of the government's devising we may devise hoops of our own to try to avoid further hoops being imposed. Several sources have indicated enough disagreement between the college and the GMSC on both end point assessment of vocational training and reaccreditation to fear that the government may take the initiative and impose its own standards on the profession.

Building morale through education

This article has been about education in its widest sense, and the goals that the profession can provide to

retain general practitioners' interest. Building morale is about "finding the subject interesting, keeping in touch with it, and having outside interests," said Denis Pereira Gray. Using the model of vocational training, practices could build clinical and managerial structures into partnerships. We need more academic posts and we should build sufficient flexibility into our practices so that established principals are not inhibited from taking time out from their service commitments.

Marshall Marinker acknowledges the benefits of a career that dips into different fields. "I know this flies in the face of continuity of care, but is continuity as important for patients as it is for doctors? Personal care has survived the development of primary health care teams and doctors changing." Perhaps we have to avoid overcaring, and look to our own needs. General practitioners, like other doctors, fear overwhelming work and not being good enough.

Robin Fraser, professor of general practice at Leicester University, said, "You can always improve. Undergraduate medical education needs to be reformed so that doctors learn to think, develop an attitude of self learning, and acknowledge the fact that no one can know everything. We have to know our own limits, and they will be different for different doctors."

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