Careers in academic general practice: problems, constraints, and opportunities

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Changing priorities in the NHS have underlined the crucial importance of academic general practice in providing quality training and research to underpin developments in general practice. Unfortunately, several problems and constraints mean that the full potential of general practitioners to make a contribution to teaching and research has not been realised. These issues are examined and recommendations for improvements are made. Obstacles to career development for academics in general practice should be removed. The funding of academic general practice should be the same as for other medical disciplines. Vocational training for general practice should be extended to include research and audit methods, particularly for doctors interested in an academic career. Above all, the long term objective should be to integrate undergraduate and postgraduate general practice to increase the overall effectiveness of teaching and research and hence the quality of service general practice.

Introduction

In accordance with government policy there is currently a move away from expensive secondary care towards primary care. Many patients previously treated in hospital are now being looked after by competent general practitioners in the community. There is also a planned shift in NHS general practice towards a "research and audit culture" and a greater emphasis on preventive medicine.

These new responsibilities have underlined the need to strengthen the training of general practitioners, who make up the largest branch of the medical profession, to ensure the delivery of good quality and cost effective care. There is also an urgent need for research into the relative effectiveness of different patterns of care of patients associated with these changes. These needs in teaching and research point to the crucial importance of academic general practice in improving the quality of those who work in the discipline, creating more opportunities for setting of standards, and education for the benefit of patient care.

The achievements of academic practice in the United Kingdom have been considerable. The Royal College of General Practitioners in 1961 published the first journal of general practice in the world to be accepted into peer reviewed literature through *Index Medicus*, and the first chair of general practice was established in Edinburgh in 1963. The output of research in general practice has been of a high standard. University departments of general practice are making considerable contributions in both undergraduate teaching and research.[1] The regional advisory network has been instrumental in raising standards, especially through the training of new general practitioners.

At the same time there are increasing signs of tension within this system, which has developed in a somewhat haphazard fashion. The overriding need is to integrate teaching, research, and clinical practice. It is doubtful whether existing arrangements are ideal if academic general practice is to meet this challenge. How, for instance, will the profession attract quality candidates into a specialty which needs more secure funding and which has an uncertain career structure? We have explored the problems and constraints currently faced by academic general practice and make some recommendations for remedying the situation. Three interrelated issues are considered: career development in academic general practice; the funding of academic general practice; and the integration of undergraduate and postgraduate general practice. Recommendations are made under each heading.

Career development in academic general practice

There are several obstacles to the acquisition of the appropriate teaching and research skills required of a general practitioner seeking to make an academic contribution. Most vocational training schemes do not give enough support and encouragement to trainees who may be interested in developing projects, audit, and research. As there is not enough time in a single training year to learn methods in research and audit the length of training in general practice should be extended for at least some trainees with good research potential.[2] The difficulty of obtaining advice and guidance in some regions and inadequate funding for relevant courses makes it difficult for young doctors to embark on an academic career, while many established principals often feel trapped within their practices and find it difficult to extend their careers in an academic direction. In the circumstances it is remarkable that so much published research and audit output comes from general practitioners with no formal academic status and little practical support.[3] At the same time one of the consequences of poor academic support is that the number of general practitioners with higher degrees has remained consistently low.[4] This is a cause for serious concern as it limits the ability for applications for research funding and means that there has been a serious shortage of applications from general practice for postdoctoral fellowships.

The lack of protected time to acquire and use research skills is another obstacle for aspiring academic general practitioners, particularly for those who wish to remain predominantly in service practice. Lack of support from partners, particularly since the advent of the new contract, is often a problem.

The gap in earnings between the general practice principal and the junior lecturer or research fellow can be 100% or more.[5,6] One way to overcome this difficulty is for university posts at lecturer and senior lecturer level to be allowed supplementary income from practices to top up any shortfall (as part time principals in practice). Academic general practitioners

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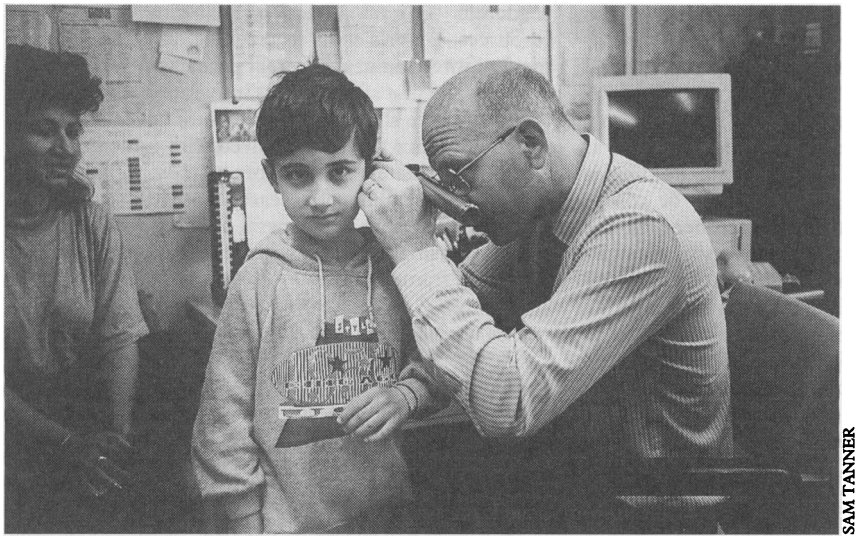
BMJ 1994;309:1270-2



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Caring for patients remains an important part of an academic general practitioner's job

should also be eligible for merit awards on the same terms as other academic colleagues.[7] The long term solution must be for remuneration for academic general practice to be fixed equitably in relation to other branches of medicine.

Academic general practitioners do not usually hold posts solely in university departments or positions in postgraduate teaching but have to integrate these with service general practice. Some ways of incorporating teaching or research, or both, into a career in general practice have been developed.[8] The difficulty has been to meet the three different but equally important objectives of high standards in teaching, research, and clinical competence. Although it is possible to be a good doctor without being a good teacher or researcher, it is not possible to be a good teacher without being a good doctor. Conflicts of interest will inevitably arise, as when a high commitment to practice can lead to a low academic output. A half time "university" general practitioner will have to meet the requirements in terms of academic output to achieve promotion to, say, professor in half the time available to a full time academic. On the other hand, university general practitioners who undertake only token attendance in their practice lose credibility with their colleagues who are service general practitioners.

It is not always easy for doctors to move between academic and service posts in general practice. This problem is unique to general practice because of the difference in structures and contracts between hospital and general practice. The tradition of general practice is to settle down in one place whereas university career patterns typically mean moving for higher posts. Such career moves may act against the tradition of family practice, and continuity of patient care is bound to be affected.

Considerable expansion of part time posts in general practice is needed to give young principals the substantial protected time required to undertake research fellowships. Sessional posts should be provided in practices with promising researchers to give them protected time to undertake research. Only a small number of academic general practitioners wish to proceed to become senior lecturers or associate advisers and ultimately professors or regional advisers. It is important, however, to avoid rigidity in career structures. Opportunities for people to move more easily between roles within the undergraduate and postgraduate sectors need to be developed.

RECOMMENDATIONS

(1) Career opportunities for academics in general practice should be equivalent to those in other disciplines in medicine.

(2) Current obstacles to career development in academic practice should be removed. Policies and practice can merit awards, part time and sessional posts, contractual arrangements, and the remuneration of university general practitioners should be reviewed as a matter of urgency.

(3) The trainee year for general practitioners should be extendable for a small number of volunteers who wish to acquire additional skills in research, teaching, and audit with a target figure of 24 posts in each region.

Funding of academic general practice

The shift in emphasis from cure to prevention and from expensive secondary to more cost effective primary care perhaps justifies a corresponding shift in academic training and funding.[9-12] Increased core funding for infrastructure support is needed as in many academic departments of general practice there is a lack of critical mass which subverts both effectiveness of teaching and output of research[13] and restricts the time available to develop the teaching and research skills of junior staff. One wonders whether much more could have been achieved by departments of general practice if they were as well funded as departments of medicine and surgery.[14] The NHS has indicated a willingness to provide an equivalent of service increment for teaching and research (SIFTR) for general practice to promote better facilities for practice based teaching for undergraduates and postgraduates. There should also be greater support for teaching and research in service practices associated with academic departments and vocational training. At the moment the system for obtaining financial support seems unfairly loaded against those in service general practice. Lecturers and course organisers need proper induction and training programmes to acquire teaching and research skills with protected time from clinical work.[15,16]

In several other respects general practice is less favourably treated than other disciplines. Academic junior lectureships have become available under Department of Health initiatives, but the numbers are not comparable with other disciplines. There are practical difficulties in arranging prolonged study leave for general practitioners in service practice under NHS "red book" regulations; ways of facilitating this should be a priority for family health services authorities. In competing for research funds general practitioners are at a disadvantage compared with applicants from other disciplines who usually have protected time to prepare their protocols and do research. There is also little representation from general practice on the committees which approve support for research grants.

RECOMMENDATIONS

(1) Departments of general practice in universities should be as well funded as departments in other disciplines if they are to respond effectively to current demands.

(2) Funding agencies for research should give higher priority to general practice—the front line of the NHS.

(3) General practitioners undertaking research should have protected time for such work funded in the same way as hospital colleagues.

Integration of undergraduate and postgraduate general practice

The continuing separation of undergraduate and postgraduate academic general practice and the subsequent lack of cooperation is detrimental to the discipline.[17] If the two wings were integrated, resources and skills could be shared, making more opportunities available to intending academics at both the under-

graduate and the postgraduate levels. Many of the skills are generic, particularly in teaching.[18]

Undergraduate departments of academic general practice have a well established career structure which mimics that of other clinical specialties. There are only three postgraduate departments of general practice at the present time, and most postgraduate training is based on the network of regional advisers or course organisers. At the moment most members of the regional network formally hold a university appointment, although in practice they are not integrated into university departments and the pathways for academic development are less clear than for their colleagues in undergraduate education. Regional advisers, course organisers, and general practitioner tutors should be able to develop their future roles within a university structure. Movement between the two systems should be encouraged. For instance, if course organisers were concerned in research as well as teaching they would be able to give research advice to trainees wanting to pursue projects.

A number of practical steps could be taken towards academic collaboration. One would be to offer two year posts in a university department at the end of vocational training. Another, as at Southampton, would be a two year traineeship during which the trainee spends half the time in training practice and half as a lecturer in the university department. Interchange between course organiser and lecturers in general practice and vice versa could be arranged on a formal basis. Course organisers might be appointed as honorary members of university departments at an appropriate level. These are essentially short term measures. The longer term objective should be to achieve a full integration between the two strands so that the potential of academics in general practice is harvested.[19]

RECOMMENDATIONS

(1) The present separation of undergraduate and postgraduate education in general practice should be ended. The objective should be provision of integrated academic general practice, allowing sharing of resources, generic skills in teaching, and the development of interchangeable career pathways.

(2) As the first step towards integration, there should be many more shared links and shared events between general practice advisers involved with undergraduates and postgraduates, so that core academic skills in any university discipline of research and teaching can be developed together. All general practice academics can then increasingly mutually support each other within a university framework.

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(Accepted 22 September 1994)

RELATIVES WHO CHANGED MY PRACTICE

Helping the grieving process

When I was a house physician my consultant insisted that I should see the relatives of patients who died when they came to collect the death certificate. Apart from sharing their grief I initially failed to appreciate the benefit of this encounter. I had one patient, however, with intractable heart failure. His daughter was always complaining to me that her father was not eating enough. One night I was going off duty just as his pulmonary oedema worsened. During the night, shortly before his death, his blood pressure dropped and intravenous fluids were given to try to restore his blood pressure. Next day the daughter accused me of ignoring her earlier complaints because "during the night the other doctor had started intravenous feeding, but it was all too late." I carefully explained what had happened.

After this episode I always asked the relatives if there were any questions or even complaints that they had about their relatives' care. I was surprised how often there were unresolved problems, invariably due to misunderstandings. I also used the opportunity to ask for a postmortem examination. Many agreed to the request and thought that if a future patient could benefit from information provided then the death was not entirely in vain.

Some time later after starting my training in histopathology there was a fatal motor cycle accident on my way to work. Both the motorcyclist and his female pillion passenger were seriously injured and there was little that I could do. I gave my name to the police at the scene, but as I had not witnessed the accident I heard no more. Eighteen months later I received a telephone call from the motorcyclist's mother. She found it difficult to talk but told me that it had taken her all this time to be able to telephone me. She needed to know more details about her son's and his fiancée's last moments. In particular, she needed to know whether her son, who was always sensitive about his fiancée's feelings, could have been aware of her injuries. Did they suffer? I gave her the details she needed to know as best I could.

These two people in particular have helped me understand the nature of the grieving process and how different people approach it differently. Under normal circumstances the doctor caring for the patient is the most suitable person to talk to the deceased's relatives. But as histopathologists we are frequently asked to perform necropsies on patients who have died suddenly and unexpectedly. In these cases we are commonly the only doctor involved in the death and therefore may be the most appropriate person to talk to the relatives. To be of help, however, the coroner's officers must be aware of our availability and willingness to be involved in such discussions. At inquests, where I am the only doctor giving evidence, I always approach the relatives after the proceedings and ask whether they understood my evidence or whether they have any other questions. Frequently they ask about the suffering the deceased might have experienced.—MICHAEL JARMULOWICZ *is a consultant histopathologist in London*