BMJ LONDON, SATURDAY 16 NOVEMBER 1991

The RCGP approaches 40

Much left to do

In 1845 a campaign for a college of general practitioners foundered after several years of controversy and debate.[1] More than a century later, in October 1951, the *BMJ* published a letter from John Hunt (later Lord Hunt) and Fraser Rose calling for "suggestions and comments" about the possibility of forming a college of general practitioners.[2] Forty years ago this month a cautiously supportive editorial appeared in the journal.[3] The college was formally founded around one year later despite the opposition of the presidents of the existing royal colleges.

In its almost 40 years of existence the Royal College of General Practitioners has grown to have some 16 000 members (about half of all general practitioners). It has contributed greatly to the development of general practice and can justly claim a large share of the credit for the relative strength of general practice in the United Kingdom. As well as its contribution to the development of vocational training the college has had a substantial input into research, particularly through its research units. As the college approaches middle age it is appropriate to ask whether it is still needed and what its function should be.

Despite the gains considerable problems still exist. These include the need to overcome what the Sheffield faculty of the college has referred to as "the College's unpopularity with its own membership." Some believe that the college has been run by an élite that is out of touch with its members. This perception was amplified by the negative reaction of rank and file general practitioners to the new contract of 1990 and the feeling of many that the college had not been forthright enough in its opposition to the contract despite its written rejection of the government document *Working for Patients*.[4] Several ways exist for minimising such tensions in the future. Circulating the draft of the college's development plan for the 1990s[5] to all members was an important step. The faculty system also needs strengthening, with more resources put into the periphery. (This process has already started but needs to be accelerated.)

The college's clinical and research division has produced a policy document to ensure that research will remain a high priority among the future aims and objectives of the college.[6] Awarding training fellowships to young principals is a step towards improving research skills in general practice. Compared with the considerable resources devoted to research in hospital practice, however, the sums of money are minuscule. On average only three of 30 000 British general practitioners gain an MD each year.[7] At the same time the funding provided by the NHS to hospital senior registrars to support research is equivalent to 600 whole time research posts.[8] A determined effort should be made to ensure that those who wish to develop and use their research skills while continuing to practise in the community are given adequate opportunity to do so. Less than one fifth of research from primary care published in the *BMJ* and *British Journal of General Practice* in the mid-1980s was funded from government sources.[9] The college should be agitating for a fairer slice of the cake from the Department of Health's new research and development division.

The wide gap in the burden of ill health between the upper and lower social classes in the United Kingdom[10] is unacceptable, and college activity has often been weakest in areas of greatest deprivation, including the inner cities. The college is seeking to redress the balance by setting up an inner city task force. From this initiative should come a strong commitment to reduce inequalities, particularly as evidence exists that the uptake of preventive care by deprived patients can be enhanced by a well organised and resourced campaign by primary care teams.[11] Strengthening the faculty structure should enable the college to have a greater impact at a local level. Particular effort must go into tailoring continuing education programmes to the needs of those who work in the most difficult circumstances, whether in inner cities, other deprived areas, or rural isolation. The concept that planned medical education largely ends after vocational training needs to be replaced by career-long development.

More women and members of ethnic minorities should be recruited into positions of leadership and working parties. Traditionally the college has been male dominated, but this period is probably drawing to a close: the college now has more female than male members in the 25-33 age group.[12]

Much of the college's work is focused on setting standards and education, and little direct attention is given to patients. In the recent draft of the college's development plan only one of the nine major objectives mentions patients directly. Clinical topics should be given greater attention in the future. In addition, the voice of the patient in the NHS has always been muted, and the college, which has taken a lead among the royal colleges in setting up a patient liaison group, could do more to improve the public understanding of what doctors do and the need for scientific evidence to back changes in treatment, prevention, and the organisation of practice. This will require a higher profile public relations strategy.

The college also needs to look more actively beyond the United Kingdom's borders. In developing countries health professionals at the front line need training.[13] As part of its concern to narrow health differentials between rich and poor the college could promote policies to increase the inadequate sums spent by Western governments on development, particularly on the provision of primary care and education.

Pressure is growing to develop clear standards and guidelines for the management of common medical problems and to devise ways of monitoring the effectiveness of care. In these developments the respective roles of specialist and generalist will need clarifying. The Conference of Medical Royal Colleges and Faculties already meets regularly, and there is cross representation on several committees. The possibility of forming a unified "national college" was raised in 1845 and was revived in 1973 with the suggestion of an academy of medicine bringing together all specialties.[14] Closer working relationships between specialists and generalists will certainly be necessary to make the best use of limited resources. This implies more joint educational and research initiatives. In 1950 Collings, in an influential report, portrayed a situation of widespread demoralisation and perfunctory care and stated that "the overall state of general practice is bad and still deteriorating."[15] His article provided a stimulus for reform. A similar survey today would no doubt show a great deal of progress, but considerable improvements are still needed.

ANDREW P HAINES

Professor of Primary Health Care,
University College and Middlesex School of Medicine,
Whittington Hospital,
London N19 5NF

1 Hunt JH. Past attempts to found a "College of General Practitioners" one and a half centuries ago. In: Hunt JH, Pinsent RJFK, eds. *A history of the Royal College of General Practitioners.* Lancaster: MTP Press, 1982:1-5.
2 Rose FM, Hunt JH. College of General Practice. *BMJ* 1951;ii:908.
3 A college of general practice [editorial]. *BMJ* 1951;ii:1076-7.
4 Royal College of General Practitioners Council. *Summary statement on "Working for patients."* London: RCGP, 1989.
5 Royal College of General Practitioners. *RCGP college development plan. A draft for circulation.* London: RCGP, 1991.
6 Royal College of General Practitioners Clinical and Research Division. *Research in general practice. A development plan for the 1990s.* London: RCGP, 1991.
7 Williams WO. A survey of doctorates by thesis among general practitioners in the British Isles from 1973 to 1988. *Br J Gen Pract* 1990;**40**:491-4.
8 Gray DP. Research in general practice: law of inverse opportunity. *BMJ* 1991;**302**:1380-2.
9 Iliffe S, Haines A. Developments in British general practice. *Fam Med* 1989;**21**:169-70,175-6, 229-30.
10 Delamothe T. Social inequalities in health. *BMJ* 1991;**303**:1046-50.
11 Marsh GN, Channing DM. Narrowing the health gap between a deprived and an endowed community. *BMJ* 1988;**296**:173-6.
12 McBride M. Meeting on women doctors and the RCGP. *RCGP Connections Issue* 1991; No 33:5.
13 Frontline doctor [editorial]. *Lancet* 1991;**338**;155-6.
14 Sellors TH, Hill J, Richardson J, Himsworth H, Hunt J, Wright R, *et al.* An academy of medicine. *BMJ* 1973;i:737.
15 Collings JS. General practice in England today. A reconnaissance. *Lancet* 1950;i:555-85.

Auditing necropsies

Learning from surprises

"Much can be learned about the living from the study of the dead," states the introduction to *Autopsy and Audit*, a report from a joint working party of the relevant royal colleges.[1] But currently much of this opportunity is being lost. Now that each district health authority has a medical audit committee the time may have come to change this. The working party's report should help: it provides convincing evidence of the usefulness of necropsies in medical audit. The report reviews the many studies showing that about one in 10 cases coming to necropsy have pathological lesions that would have materially altered clinical management had they been identified before death.

The working party expressed concern about the fall in hospital necropsies, a trend that is occurring world wide.[2] Necropsies are performed on about one in four people dying in England and Wales,[3] 90% of these at the request of a coroner. Although the number of necropsies performed after obtaining a relative's permission has fallen considerably over the past 20 years, coroners' necropsies have fallen by only 6·6% in the past decade.[4] For the purposes of clinical audit an adequate number of coroners' and non-coroners' necropsies need performing to a consistently high standard.

For the purposes of audit the joint working party recommends that whenever a necropsy is performed the relevant clinicians should receive a summary of significant lesions as soon as possible, usually within two days of the necropsy. A complete report should be dispatched within three weeks. A paper in this week's journal by Whitty and colleagues shows just how far below these standards some hospitals are falling (p 1244).[5]

According to the joint working party, all necropsies should be accompanied by histological examination of the tissues, although this is sometimes not possible for coroners' cases, where histological examination may not be considered necessary to establish the cause of death. The counterargument—that histological examination is always required to give a precise cause of death and to define other contributing diseases—has not yet been tested. Histological examination of the hearts of children who died after cardiac surgery provides a good example of this: myocardial necrosis is present in 40% of cases but is visible to the naked eye in a much smaller proportion.[6]

The report suggests that the responsibility for obtaining permission for a necropsy should lie with the consultant in charge of the case and that members of the clinical team should be encouraged to attend either the actual necropsy or a presentation of the important findings. In practice, both of these objectives will be difficult to achieve. Putting aside constraints on time, there is the problem that non-pathologists find necropsies distasteful: in a survey of 41 undergraduates 35 expressed "personal distaste" for necropsy.[7]

Many undergraduates and junior doctors have never attended a necropsy and therefore have little insight into its value in investigating disease. Perhaps the answer is to provide good facilities for demonstration, both within and outside the mortuary. Hospital clinicopathological and mortality conferences are good forums for showing photographic or video material from individual cases in aesthetically acceptable surroundings in which the audit and scientific value of the necropsy can be fully appreciated. All medical undergraduate teaching courses should seek to provide these facilities.

If the scientific validity of the necropsy as a form of audit is to gain universal acceptance it is important that the necropsies themselves are properly performed and audited. As pointed out in a recent paper in this journal the necropsy, like any other scientific investigation, is not immune to error.[8] This paper suggested that the sensitivity and specificity of clinical