

# Improving the general practice discipline through higher degree study

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On Thursday 1 August 1968, I started as Assistant in General Practice in Kirkintilloch, Scotland. I wrote shortly after, *'I feel I have found the job that I will love for the next 40 years.'* That feeling never wore off and nearly 48 years later, I still work part-time in a rural general practice. When asked why I still want to be there, I respond that the relationships, the conversations, the questions, the burdens I encounter, are so utterly fascinating that there is no reason why I should want to do anything else. In these 48 years I have been an 'ordinary' general practitioner (GP) in both urban and rural practices about half of the time, and the other half has been spent as Professor and Chair of academic departments of General Practice, Family Medicine, Primary Care and Public Health Medicine, and Rural and Remote Medicine. I entered the academic world because I believed that it could provide the environment for the discipline of general practice to thrive and that this would benefit general practice through better research, teaching and scholarship. Having achieved two doctorates (one in the solitary struggle of full time clinical practice, and the other supervised by an immunopathologist) I felt higher degree programmes run by academic departments of General Practice had to be a better way to develop general practice scholarship.

Two papers in this issue of the Journal shed light on academic development opportunities for primary care practitioners in New Zealand. The first<sup>1</sup> is an exploration of the business case for a masters degree in primary health care by asking a group of 30 stakeholders (potential students and possible employers of future graduates) whether there is a market for such a programme. The other<sup>2</sup> describes the experience of 70 GPs who have completed a Postgraduate Diploma or a Masters degree in General Practice.

The two studies address quite different propositions. The first is an academic department's

exploration of the market for a degree in Primary Health Care. Only four of the 30 participants were primary care clinicians and three were GPs. The consensus of the group does not reflect any great passion for the discipline of general practice and comes up with the interesting conclusion that such a degree 'might help primary care practitioners move into clinical management and leadership positions,' suggesting that career advancement may be a motive for study. It is allowed that clinical skills development might add value to practice, or enhance teaching and research skills, but adding to the body of knowledge in the discipline is not seen as an issue. Cost and time constraints were identified as the major barriers to study.

The second paper explores the experiences of 70 GPs who have graduated with a postgraduate diploma or masters degree in general practice. The outcomes reported include perceived improvement of medical care delivery, development of critical thinking about medical epistemology, education, research, and personal growth. Graduates increased their engagement in academic and advisory roles, published papers, and some completed doctoral studies. They valued scholarship and enjoyed learning, but felt their qualification had low perceived value within the profession. Perceived costs and time commitments were important barriers to enrolment. Overall, the researchers come up with the encouraging message that completing the qualification had enabled transformative learning that positively impacted graduates' personal, practicing and professional lives. Participants also believed their study had improved their patient care by increasing attention to delivering whole-person care and more astute delivery of scientific- and evidence-based medicine. Improved teaching and researching skills were valued, even by graduates who did not gravitate towards an academic career. Perhaps more importantly, the graduates became active in many other spheres of professional work, carrying

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their learning into community, managerial and governance roles. These outcomes show the value of becoming educated, beyond clinical training. This research provides evidence that a substantial cohort of New Zealand GPs has benefitted from enrolment in higher degree study but also signals a high degree of health sector skepticism about the usefulness of advanced study, and also of barriers confronting those who enroll. Completion of the degrees is also a problem.

The historical context of these two papers spans 30 years in the development of New Zealand academic general practice, from 1984 when the first Department of General Practice sent a questionnaire to all general practitioners (~2000) to gauge their interest in a general practice research degree, to 2014 when another academic Department appears to not feel that GPs as a group are worth consulting. The discipline is now Primary Health Care rather than General Practice and what used to be GPs are now primary health practitioners.

Universities' recognition of General Practice or Family Medicine or Primary Health Care as an academic discipline took place relatively recently in New Zealand, with the first employed academics in the 1970s and the first independent academic department in 1983. Since then there has been remarkable physical progress with four departments, 9 professors, 5 associate professors, 28 senior lecturers and many more clinical and research staff. There is little doubt about the viability of the discipline within the universities: the concern now is the relationship of academic departments with their clinical communities. The Royal New Zealand College of General Practitioners (RNZCGP) fought hard to establish this academic status for general practice but having succeeded, it now seems at a loss to know where academic general practice fits in the grand plan. Conversely, university departments seem unwilling to be solely devoted to the discipline of general practice.

The continuing education of vocationally trained GPs is apparently well organised in a system called Maintenance of Professional Standards (MOPS) administered by the RNZCGP. At a superficial level this is an impressive structure of triennial reaccreditation with points accrued

for professional development plans, approved courses, personal audits, peer review groups, and cultural competence courses. The problem is that there are nearly 4000 students in the class, little academic leadership or supervision, and no stated outcome apart from points accumulation. Unlike the report from Otago, there are no reports of lives being changed or patient care being improved by MOPS.

General practice research explores the edges of the universe of medicine, with respect to individual patients. McWhinney<sup>3</sup> observed few publications in the journals of family medicine and general practice concerning clinical insight and discovery and deplored the lack of clinical research carried out by single practitioners working with their own patients. The paradox is that this kind of research has withered largely because of the development of academic general practice and a cadre of professional researchers.<sup>4</sup> Academics in the UK have disparagingly described such researchers as *'gentleman amateurs working to produce research in a general practice cottage industry'* and clinical research done by individual GPs in their own practices as *'occupational therapy for doctors'*<sup>5</sup> yet questions arising from everyday practice are oxygen to general practice research. Using such questions to create and defend hypotheses as part of Masters or Doctoral study is an essential feature of the general practice academic discipline.

Universities have been described as communities of scholars and it is appropriate that our discipline now holds a proud place in *'the mansion-house of the goodly family of the sciences'*.<sup>6</sup> However modern universities have also become what Newman disparaged: *'a sort of bazaar in which wares of all kinds are heaped together in stalls independent of each other.'*<sup>7</sup> Newman's preferred vision of universities (and mine) was of places of inquiry and interest: *'When a multitude of young men, keen, open hearted, sympathetic and observant, as young men are, come together and freely mix with each other, they are sure to learn from one another, even if there be no one to teach them.'* Perhaps we need to talk about how the universities, the College and the multitude of ordinary GPs can come together to improve the discipline of general practice.

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