

LETTERS

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HOW TO INCREASE GP NUMBERS

MSC plays its part in inspiring students to value generalism

The Medical Schools Council (MSC) values medical schools’ autonomy over student selection, curriculums, and staffing.¹ It is a complex combination of these and other issues, including role models and perceptions of how rewarding a career might be, that contributes to medical students’ career choices.

Doctors find specialties attractive or unattractive for many reasons.² This is why recruitment strategies to medical school must recognise students’ diverse interests and aptitudes. Simon Stevens recently stated, “we need to tear up the design flaw in the 1948 NHS model where family doctors were organised separately from hospital specialists . . . GPs themselves say that in many parts of the country the corner shop model of primary care is past its use by date.”³ The *Five Year Forward View* emphasises flexibility, with doctors undertaking different roles as patients receive integrated care closer to home.⁴ This aligns with the General Medical Council’s *Tomorrow’s Doctors*, which requires graduates to have a broad foundation from which they can specialise later.

Priorities for MSC include ground breaking work on widening access,⁵ fitness to practise, assessment, and understanding the evidence base for selection to study medicine. MSC works with colleagues across the health and higher education sectors to select the best students to study medicine, so that high quality patient care can be provided as part of the present and future workforce, including general practice. Members of MSC head their respective medical schools, each of which has an education lead, several of whom are primary care physicians. Education teams drive admissions and selection, with input from a range of medical disciplines, including general practice, and the public.

GPs play a central role in the medical workforce. MSC will continue to play its part, working with Health Education England and others to inspire students to value and select generalism.

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Competing interests: I am chair of the Medical Schools Council, dean of the faculty of medicine, University of Southampton, and a professor of obstetrics and gynaecology.

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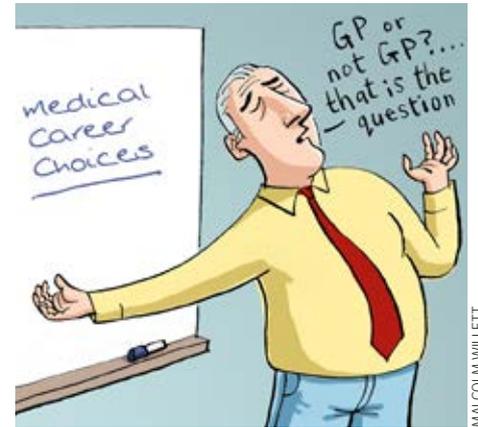
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Making careers in general practice more attractive

Wakeford argues that “conflicted” medical school councils have adversely affected the recruitment of medical students likely to become GPs.¹ Although the academic ethos of a medical school is important in determining eventual career paths, many other influences affect career decisions before, during, and after undergraduate training (N Munro. Postgraduate attachment to general practice: influence on future career intentions [DPhil Thesis]. Sussex University, 2011). Even in countries with sophisticated primary care systems where generalists and specialists have similar earnings, only about a quarter of recent graduates profess an initial interest in general practice.² The failure to fully recruit to UK general practice training this year after an unprecedented third round of selection suggests serious problems with the career itself.³

In countries like the US, where more than three quarters of doctors specialise, efforts have been targeted at selecting school leavers intent on a career in general practice. The reasons why this policy does not translate into equivalent numbers of GPs include factors that attract students away from primary care towards specialties during training, such as positive experiences during placements, career earnings, status, and academic eminence. In addition, factors within medical schools, including denigration of general practice by undergraduate teachers and medical student peers, detract from this career path.⁴

It is unclear whether recruitment is influenced mostly by the training system itself or by current perceptions about UK general practice. Small changes to the system may have little impact if the root cause lies in the reputation of the career in both professional and public eyes. Only through improved understanding of the career drivers in medical students and young doctors, and inclusion of these in more enticing



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and interesting career structures, can primary care have any real prospect of attracting half of all new doctors to its ranks.

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The NHS is responsible for the crisis in GP recruitment

In attacking medical schools, Wakeford is aiming at the wrong target.¹ Medical schools could do more to promote general practice as a career for their graduates, but the current recruitment and workforce problems in NHS general practice in the UK are not caused by the actions of medical schools.

Newly qualified doctors are not applying for general practice training schemes and established GPs are retiring early because GPs’ working conditions have deteriorated substantially in recent years. The volume and complexity of their work has increased, and many general practices have seen large reductions in their practice budgets.²

The Department of Health and NHS England (and their equivalents in the devolved nations) are responsible for this, not medical schools.

Medical schools do have a role in promoting primary care, but the current problems in UK primary care can be rectified only through a fairer funding mechanism for general practice in which both workload and population health needs are taken into account.³

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Increasing GP numbers is not that simple

The lack of primary care representation on the Medical Schools Council and medical school websites is interesting.¹ However, this is just one aspect of a complex problem and does not explain, for example, the variation between medical schools in the proportion of graduates entering primary care.

The GP Task Force Report and research papers have called for studies on why this difference exists.²⁻³ What role does selection to schools play (nature) and what role do the schools themselves play (nurture)? Do we take truly undifferentiated “stem doctors,” as they have been described, and mould them during their time at medical school, or do these students already have strong preconceived ideas? Many studies have looked at factors that influence choice of specialty.⁴

We know the recruitment figures. What we don't know is why 11.2% of Cambridge graduates were appointed to GP training in 2012 compared with 38.5% from Keele.⁵

Investigation into the differences between the “worst” and “best” performers in terms of producing future GPs will probably shed light on how we can improve recruitment, and seems less radical than firing the Medical Schools Council.

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Competing interests: None declared.

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Author's reply

Cameron states that the Medical Schools Council “values medical schools' autonomy over student selection, curriculums, and staffing.” Of course. Just as the Country Landowners Association values foxhunting. Since Brotherton's 1967 recommendations it has been accepted that, for undergraduate medical education, “identity lies not in the path, but in the goal.”¹ Doubtless the proposed National Licensing Examination will clarify the goal for medical schools and widen the path.

The problem's nub is that arrangements for undergraduate and postgraduate medical education are not inter-articulated. Medical schools are not encouraged financially to recruit and train towards NHS workforce needs. There need to be introduced feedback loops based on workforce requirements into their funding stream and feedback loops based on analyses of graduates' subsequent performance (on recruitment tests for specialty training, for example) into their curriculums. Medical schools also need feedback from major specialty examinations as to any details associated with differential graduate performance, such as Membership of the Royal College of General Practitioners (MRCGP) and Membership of the Royal Colleges of Physicians.²

Absence of articulation and feedback has led to 25% (about 1000/year) of UK graduate applicants to GP training being regarded as “unappointable” and rejected by the selection system (data provided by Health Education England after a Freedom of Information request). This scandalous situation results in local education and training boards recruiting international medical graduates who collectively cause considerable additional costs and difficulties, such as failing the MRCGP Clinical Skills Assessment at eight times the UK graduates' rate.³

I criticised medical schools' recruitment approach on their websites, which clearly and universally focuses on careers other than general practice. Of course there are many reasons for the shortage of GPs, as other correspondents note, and research is needed (as urged in 2012⁴), but recruitment, the start of the educational process, has fundamental importance.

If the medical schools continue this unguided behaviour, they will be failing the taxpayer, the medical profession, and patients. Perhaps at the annual residential meeting on 26-28 November the Medical Schools Council may reflect on this?

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ATLAS OF CARE

Discrepancies between data on various PHE websites

O'Dowd reports on the atlas of care, the new Public Health England (PHE) *Healthier Lives* online tool.¹ In using the tool we have encountered fundamental discrepancies between data on the various Public Health England websites, including *Healthier Lives* and *GP Fingertips*.

As an illustration, within our local clinical commissioning group (Dorset), the proportion of patients with diabetes in whom the last glycated haemoglobin (HbA_{1c}) was less than 7.5% (59 mmol/mol) in the preceding 15 months (Quality and Outcomes Framework (QOF) 26 for diabetes) is recorded as:

- *Healthier Lives* website: 56.6%
- *GP Fingertips* website: 66.4%.

Should the *GP Fingertips* data be correct, then our clinical commissioning group would rank 12th out of 211 groups rather than 162nd.

In response to our query, Public Health England attributed the discrepancies to the use of exception reporting, specifically: *Healthier Lives* uses QOF intervention rates that include exceptions, whereas *GP Fingertips* uses QOF achievement rates, which GP payments are based on.

Exception reporting is used to exclude patients from QOF payments for various reasons—clinical and other—although all patients have a working diagnosis of diabetes.

The use of QOF as a tool for incentivising quality in primary care remains contentious.² But our main concern is that from a population health outcomes perspective, the inclusion of exceptions more accurately reflects the quality of care delivered. Failure to consistently analyse and display the ranking for any given clinical commissioning group can have important local “political” repercussions. The publication of metadata and adoption of

consistent analytical standards would go some way towards resolving this problem.

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MAMMOGRAPHY SCREENING

Advanced breast cancer rates and screening effectiveness

Swedish trials on mammography screening of women aged 40-74 years indicated that two to four rounds of screening could significantly reduce the risk of being diagnosed with and dying from advanced breast cancer.¹ Because stage at diagnosis is independent of treatment efficacy, the trials concluded that the introduction of screening in general populations would be reflected by a reduced incidence of advanced breast cancer and mortality from breast cancer.¹

However, De Glas and colleagues show that mammography screening of Dutch women aged 70-74 years has only a modest influence on the incidence of advanced breast cancer.² US, Australian, and European studies in communities with a long history of screening and a high participation rate, where women have attended more screening rounds than in the Swedish trials, report similar findings for advanced breast cancer, including very large or metastatic cancer.³⁻⁵ The quasi stable incidence of advanced breast cancer over time is not compatible with screening having a major role in the reductions in breast cancer mortality seen in most high income countries.

This situation contrasts sharply with that seen for colorectal and cervical cancer screening. Marked declines in the incidence of advanced forms of both these cancers, as well as mortality, are seen where screening is widespread, which agrees with results of randomised trials. For breast cancer, the discrepancies between trial results and epidemiological data can probably be explained by the Swedish trials overestimating reductions in the risk of advanced cancer and of cancer death associated with mammography screening.

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Competing interests: None declared.

Full reference details on thebmj.com.

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thebmj.com Letters by Tabár, Kopans, and De Glas and colleagues.

FEAR IN OVERDIAGNOSIS

Beware of medicalising the fear of uncertainty and death



MATHILDA HOLMQUIST

I strongly second Heath's call for clinicians to be more tolerant of uncertainty, and agree with her that this requires courage, particularly given the prevalent culture of blame.¹

Nobody could disagree with the recommendation that people should be screened for their potential to benefit from risk reducing interventions "only when medical care is appropriate and will produce more benefit than harm." Most clinicians are well aware of the harms of swapping Sontag's "good passport" for a provisional "at risk" one.²⁻⁴ The snag with Heath's recommendation is that defining and evaluating "benefit" and "harm," and hence deciding when "medical care is appropriate," requires more than just courage and certainly more than just statistical facts: it requires a complex weighing up of preferences. Like her, I would prefer to avoid preventive drugs. I am aware that this inevitably colours the way I talk with patients about screening but try to keep this to a minimum, because the conversation should centre on the patient's

preferences, not mine. Some well informed people choose screening; I am concerned that Heath's strongly expressed preference might well translate in practice into a new version of "doctor knows best."

We need to acknowledge that helping individual patients to make decisions that are right for them, in the way that they want to make them, is a complex and difficult task. Trying to help people not to fear death is a major additional challenge. As Heath says, doctors may well not be the best people to meet this challenge. In attempting to meet it, we should beware of increasing the medicalisation that Heath criticises, by extending the remit of "healthcare" to encompass yet more aspects of human life.

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Risk factor medicine as driver of fear and overdiagnosis

Heath is right to argue that we have to face up to our fears of uncertainty if we want to limit overdiagnosis and overtreatment.¹ I think that one major driver of these fears comes from the development of medicine that is based on the identification and treatment of risk factors and from blurring of the boundaries between risk and disease.² Indeed, being at risk of disease is increasingly confounded with having the disease itself.³ This is one reason why the diagnostic criteria for several conditions have been widened, thereby increasing the proportion of individuals who are potentially worried by their health. Admitting the limits of what risk factor (predictive) medicine can offer at an individual level could help prevent several of these problems.^{4 5}

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