NO HOLDS BARRED Margaret McCartney

Dementiagate

I'm wondering if this is Dementiagate, a defining moment when the UK public discovers the ugly truth about how most GPs are paid. The news from NHS England, that GPs were to receive £55 for each new diagnosis of dementia, has been met with widespread condemnation and disgust.[1]

NHS England wants GPs to identify potential dementia patients through screening in those supposedly at risk, including people over 60 who smoke, drink too much, or are obese.[2] But this is hugely problematic because such screening has not been shown to be accurate, effective, or useful.[3]

Who do doctors work for? For patients? How many things do we do because we are paid to, rather than because they benefit patients? Incentivised health checks have taken doctors' time away from sick people and redistributed it to healthy attendees. We spend hours filling in anticipatory care plans, even though evidence is scant that they will improve patients' quality of life.[4] And waiting times get longer as we are diverted by time consuming, bureaucratic nonsense.

How many things do we do because we are paid to, rather than because they benefit patients?

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The general practice contract has become an unfunny joke. We are mostly small businesses, contracted wholly to the NHS. We are not simply paid a wage and expected to get on with our work. Rather, we are paid separate sums for each service rendered: flu vaccines, cervical screening, referral management, fitting contraceptives, and so on.

We pay for staff, running costs, premises, ourselves; and we have to chase contract payments. For example, we are currently being denied payment for palliative care meetings last year: the contract said "three monthly"; we had meetings every three months; the health board now says that it meant every 12 weeks.

Financial instability poses the risk of running primary care into an era of unbridled, market oriented medicine, in which multinationals get short term primary care contracts, consumers must become "buyer beware," doctors and patients lose long term relationships, and our most vulnerable citizens miss out.

Worse still, we risk losing our patients' trust, and being mistrusted is a miserable way to practise medicine. I'm not alone in being frustrated and demoralised by political micromanagement and the misery of the tick box contract. The natural position of patients and doctors is on the same side. But politicians have pushed their own self interest between us—targets, to meet meaningless election pledges.

Doctors cannot change this on our own: we need patients to advocate change for us. Let's hope Dementiagate is the catalyst.

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BMJ BLOG OF THE WEEK Sanna W Khawaja

What can we learn from the locum?

Sanna W Khawaja has recently completed her foundation training in Manchester

When recounting the tale of my first ever shift as a bona fide doctor, the line "I was on call with a locum SHO and a locum Reg" tends to get the perfect reaction: sympathy and kudos. I follow "The Locum Doctor" on Facebook and have made many a witty (some would disagree) joke with a "locum" punchline. The newspapers also love a bit of locum bashing. Yet here I am, taking a gap year and I am "the emergency department (ED) locum."

I have now spent the past month working in a number of different EDs and urgent care centres around the north west, as well as in the Midlands. It has been a refreshingly different type of learning. As headlines about A&E waiting times, GP failures, missed diagnoses, and hospital closures dominate the pre-election news, I am seeing firsthand, around the country, what the NHS is capable of and what it is doing well. We don't often hear about that anymore, do we?

My ED as an FY2 did handovers properly, as should every department. There was a 30 minute overlap of night and day shift, allowing for a handover of the whole department. Despite being bleary eyed and desperate to get home, I look back now and understand the value of the consultant's debriefing: "Any problems overnight? Any lessons learnt? Could the shift have gone better?" But, as a weekend locum, I'm not sure where to take these suggestions.

In the Midlands, I saw how a well staffed rapid assessment unit phenomenally reduces time to referral—all the patients I saw had already had basic and relevant investigations. Moreover, having a doctor assigned to this area keeps it safe: ECGs were reviewed on arrival, and patients received adequate analgesia before being seen.

The locum doctor can act as an impartial clinical observer, seeing what works and what doesn't

A custom made pro forma for minor road traffic collisions is a quick and safe way to see and adequately document this common presentation, which has the potential to lead to legal proceedings. This is being done well in urgent care centres in the Pennine Trust, why not in the A&E minor injuries unit at the same trust?

I have (and have observed) different ideas that I think EDs could share with each other—all coming from the perspective of a clinician who knows firsthand what makes a difference on the shop floor. I just don't know where to take these ideas. To my knowledge, there isn't much of a platform available for the locum to feed back to the employer. I propose we create one.

The Francis Report highlighted the role of junior doctors as the eyes of the hospital. Rotating through specialties, a junior doctor is well placed to pick up areas that need improvement. I believe the same applies to the locum doctor, who can act as an impartial clinical observer, rotating through different organisations and seeing what works and what doesn't. I can't help but feel that the solution to many of the problems faced by EDs in the UK is akin to a large jigsaw puzzle—and through my work I have seen many departments holding different pieces. Now, more than ever, we need to start speaking to each other. This ED locum, for one, is keen to join the conversation.

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Fire the Medical Schools Council if you want more GPs

Hospital doctors are over-represented in medical schools' representative body, and it shows, writes **Richard Wakeford**

Labour has announced plans to recruit 8000 more GPs if elected—but without saying how. And the prime minister has promised to provide seven day access to a GP by 2020 if the Conservatives get in—also without saying how. But the NHS needs more GPs immediately.[1]

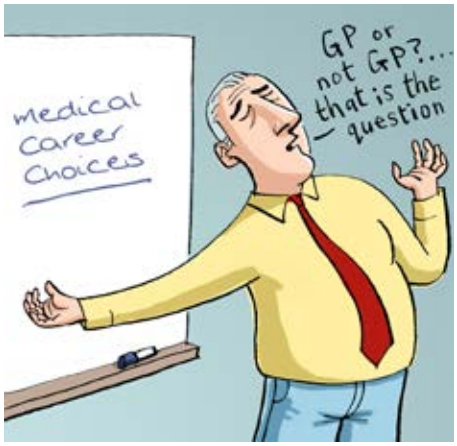
We need at least half of UK medical graduates to become GPs, said a report on student numbers by the Health and Education National Strategic Exchange last year,[2] as did the recent GP Taskforce study commissioned by the government.[3] Recruiting foreign doctors may help, but international medical graduate trainees are not necessarily equivalent to domestic ones.[4 5]

UK medical schools are not recruiting anything like enough students with this career inclination: from the sparse data available, a report from King's College London showed that only 11% of new medical students planned a career in general practice,[6] and research from Aberdeen backed this up with a figure of 13%.[7] Even when they graduate—after five or more years to reflect on career opportunities—less than a quarter of doctors entering the foundation programme intend to enter general practice training.[8]

Recruitment websites

Why are medical schools attracting so few would-be GPs? I reviewed the recruitment websites of all 33 publicly funded UK undergraduate medical schools. These noted in general terms the variety of career opportunities, the generic need for particular skills (empathy and listening were commonly mentioned), and the importance of medical schools in providing role models for their students. These sites attested their research and general rankings by the often selective use of various league tables, and none referred to the only hard published measures of graduate quality—the performance data on the membership exams for the Royal Colleges of Physicians of the United Kingdom[9] and the Royal College of General Practitioners.[10]

Many of the websites offered positive commentaries by students or had worthy initiatives to widen access. Most of the schools provided videos specific to medicine, and almost all attested to the social attractions of the institution, referred to the (sometimes "famous") hospital and its "wards," and offered the possibility of "research." A few mentioned general practice, though not at length—except the Brighton and Sussex website, which includes a video on the interaction between one practice and the school.[11]



MALCOLM WILLETT

How can a representative body comprising only 6% GPs be entrusted with directing undergraduate medical education, and selection into it, when the country needs 50% of doctors to enter general practice?

More typically, a slogan would assert "superb teaching and research facilities," with a picture of a surgeon in an operating theatre. I received no general impression that half of all medical students would end up becoming GPs. Indeed, I saw this only in the small print on one school's website, which said that "approximately half of all UK medical graduates work in general practice."

Who directs these medical schools' policies? All 33 publicly funded schools are part of an independent parent university and notionally determine their own policies on recruitment, education, and assessment. However, their activities must respond to the requirements of the regulator, the General Medical Council, and the NHS.

On its own website, the Medical Schools Council says that it "represents the interests and ambitions of UK medical schools as they relate to the generation of national health, wealth and knowledge acquisition through biomedical research and the profession of medicine."[12] One of its aims is to "explore proactively the role of the doctor in the future and to pursue educational solutions for workforce requirements involving doctors."

So, who makes up the Medical Schools Council? Of 33 members representing undergraduate medical schools just two are GPs, the rest mostly clinician scientists. One is pictured on the council's website wearing blue scrubs. These people are conflicted: they are responsible for delivering appropriate medical graduates to the NHS, but they also have responsibilities (and loyalty) to their own—largely hospital specialist—disciplines and colleges. How can a representative body comprising only 6% GPs be entrusted with directing undergraduate medical education, and selection into it, when the country needs 50% of doctors to enter general practice?

In their GP Taskforce report Simon Plint and colleagues recommended a "professionally led marketing strategy to target a wide range of audiences, including the general public, to promote an accurate and positive image of general practice."[3] This should include "the promotion, central coordination and funding of provision of work experience in general practice for secondary school students."

Obliterative change

Radical solutions to the workforce problem must include considering retention as well as recruitment—and the inevitable reform of the undergraduate curriculum. Certainly, primary care should take up more curriculum time than it does now, although necessary breadth will mean that medical students inevitably encounter far more scientists and hospital clinicians than GPs in their training. This should not mean that schools should be directed by members of these groups, however—or that arrangements for recruiting students should be devised to their gratification. Without a complete reorganisation of student recruitment, patients will be left badly served by medical schools that will continue to produce too many graduates inclined to hospital specialties and research.

Medical schools must act, and the Medical Schools Council's membership requires obliterative change. This is urgent because of the training time lag. If the NHS is to survive, we need creative recruitment whereby at least half of new medical students—not an eighth—want to become the GPs of the future.

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Competing interests: I have been an academic assessment adviser to various medical and dental bodies, specialist as well as generalist, since 1984, and I was training programme director for the West Cambridgeshire GP Specialist Training Programme from 2005 to 2011. I'm also an ageing patient anxious that he may not have a GP to consult when he needs one.

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