HEALTH, EDUCATION AND GENERAL PRACTICE

Papers prepared for a discussion meeting
held on 30th October 1985,
together with a summary of the discussion

Edited by George Teeling Smith

Office of Health Economics
12 Whitehall London SW1A 2DY

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The Office of Health Economics was founded in 1962 by the Association of the British Pharmaceutical Industry. Its terms of reference are:

To undertake research on the economic aspects of medical care.

To investigate other health and social problems.

To collect data from other countries.

To publish results, data and conclusions relevant to the above.

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Preface

This booklet is based on a meeting organised by the Office of Health Economics and chaired by Sir John Butterfield at the Ciba Foundation on 30th October 1985. The meeting was a follow-up to a similar more general OHE discussion held at Cumberland Lodge in June 1984, whose proceedings were published under the title 'A New NHS Act for 1996?'

The present booklet contains the nine prepared papers on which the 1985 discussion was based, together with a shorter contribution from the Chief Medical Officer at the Department of Health and Social Security which he presented at the meeting. The final chapter is a summary of some of the main points raised in the discussion. There is a foreword by Sir John.

These proceedings cannot pretend to offer a definitive account of the best way in which general practice should develop under the National Health Service in the years ahead. However, it does provide an optimistic view of the potential for general practice and some 'signposts' as to how general practitioners and their team can best help to promote the good health of the population.

The booklet points out there are many different ways in which individual general practices are organised, and it expresses regret that more has not been done to evaluate the effect of those differences. There is no crisis in general practice but this does not mean that no improvements are possible. The steady advances in organisation and performance which have taken place over the past twenty years can be expected to continue largely as a result of internal pressures, and in response to realistic expectations from better informed patients. These advances will continue to take many different forms; the pathway forwards in general practice is a broad avenue rather than a narrow gangplank.

Incidentally, the conclusions from the 1985 meeting form a sharp contrast to those from an earlier meeting organised by the Office of Health Economics in 1963. This was held at Magdalen College, Oxford and was entitled 'Incentives in General Practice'. The record of that meeting (which was unpublished) referred to the 'present criticism and dissatisfaction amongst general practitioners'. The opinion was expressed in 1963 that 'it would be wrong to expect an "operation bootstrap" to raise the standards within the profession itself'. The response was, of course, the 'New Charter' for general practice a few years later, from which much of the subsequent improvement has flowed.

There are still isolated pockets of poor practice, and various ways were discussed at the 1985 meeting to deal with this problem. But these isolated instances must not be allowed to detract from the overall positive and optimistic picture which emerges for the development of general practice in Britain in the 1980s and 1990s.

George Teeling Smith

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Foreword

General practice has responded well to the difficult times it faced in Britain 20 years ago. Since the early 1960s financial and other motivations have been introduced to stimulate higher standards. Given the steadily improving environment for general practice which has therefore existed in recent years the great majority of general practitioners have shown themselves to be well intentioned people, determined to do a good job for all their patients.

In addition, general practitioners have demonstrated an ability to criticise their own performance, and this self criticism has contributed greatly to the improvement in standards of practice in the past two decades.

For the future, it is essential that even if there are to be more financial rewards to encourage better standards of care there must also be a real motivation amongst all the professions which make up the general practice team. This motivation is possibly most important of all because there must be a subtle mixture of compassion with medical skills in general practice. Compassion is hard to measure, but it can easily be recognised both within the caring professions and by those who are to benefit from it. It brings its own rewards to those who exercise it. Medical skills and compassion will be the most important elements in ensuring that general practitioners remain in demand and that general practice continues to develop and improve its performance in the promotion of health in the widest sense.

John Butterfield

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New horizons in health care

George Teeling Smith

In June 1984, the Office of Health Economics held a meeting at Cumberland Lodge for which the late John Vaizey proposed the title 'A New NHS Act for 1996?'. He suggested that Beveridge's original plans for the Health Service, embodied in the 1946 National Health Service Act, were no longer relevant to the health care problems of the 1980s and 1990s. Fifty years on from the date of that original legislation, he felt that fundamentally new concepts should be introduced into the organisation of health care in Britain.

The introductory paper for that meeting looked back, over the history of the National Health Service, and described the ways in which the situation had changed since 1946. The present meeting is a follow-up to the Cumberland Lodge discussion, and will concentrate more especially on the changing role of general practice in the future. It is therefore appropriate for this paper to look forward, rather than to look back. It spells out the effect of continuing advances in medical technology, and suggests a pattern of development in general practice which is perhaps a little different from some people's concept of the future role for the general practitioner. In this picture of the future, general practitioners emerge primarily as specialists in diagnosis, and in 'micro-community care' for their patients. In this role they would refer more of their patients for treatment to very highly specialised units, each of which dealt only with the precise diagnosis from which the patient was suffering. The present paper explains the logic behind this proposed change in the organisation of medical care for the future.

The emerging pattern

Both the cost and the benefits of medical care are continuing to increase as a result of three fundamental factors. The first is the dramatic progress in medical technology. The second is the resultant ageing of the population, as more and more causes of premature death are eliminated. The third factor is a consequence of the first two. This is the increasing expectation of both the professions and the public that an ever-widening range of diseases should be either preventable or effectively treatable. Once again, as the late Lord Vaizey pointed out, the consequent rising expenditure should not be seen as a 'problem', any more than rising expenditure on consumer goods or foreign holidays represent a 'problem'. The recent expansion of effective medical care brings benefits which are often substantially greater than those which could be obtained from many alternative uses of the same resources.

Given these three underlying factors influencing the expansion of the health services, there are four areas in which developments may be particularly relevant to the future. The first is in antenatal, perinatal and infant care. This can be seen most dramatically in the care and survival of premature babies in the technologically most advanced hospitals. It is now possible to keep alive babies born three or four months prematurely, and at the same time greatly to reduce the risk of such babies being left with residual damage. In the future, it is probable that routine antenatal screening for normal babies will further reduce the incidence of handicapped infants, suffering, for example, from disorders such as spina bifida or Down's syndrome.

The second major area for development is in the prevention or control of chronic progressive disease in adults, and particularly in the elderly. Already 'routine' availability of hip replacements, for example, has greatly reduced the suffering and disability among the elderly. Treatment for diseases such as Parkinsonism can be expected in the foreseeable future, and the scourge of senile dementia may also be eliminated.

The third focal area is in the more precise identification and the avoidance of risk factors which are responsible for premature mortality in middle age. Cigarette smoking, of course, is already well recognised as a problem in this connection. But other behavioural factors are likely to be identified in the future, for example, as causes of cancer and heart disease. There will then be an educational challenge to find ways of persuading people to avoid the newly identified risks.

Finally – and in many ways most conspicuously – there are the continuing developments of 'high tech' medicine for the treatment and cure of diseases in children and adults. Renal dialysis, brain surgery and heart surgery are all much publicised examples. Despite the currently fashionable criticism of the use of resources for the further development of 'high tech' medicine, there will undoubtedly continue to be progress in such technologies. Advances in diagnostic techniques and in biochemistry will go hand-in-hand with ever more heroic surgery. It is quite unrealistic to suggest that there could ever be a moratorium on advances in medical technology in the broadest sense.

The future potential for the development of medical care has been underlined by discussion of 'a second pharmacological revolution'. The past forty years has seen the conquest of the bacterial infections, and many of the diseases caused by malfunction of the body's intercellular (or tissue) biochemistry. The next forty years can be expected to see a corresponding conquest of the 'intracellular' diseases, such as the virus infections and the cancers. The whole range of autoimmune and 'slow virus' disorders are likely to come under control. This will enormously extend the scope for the prevention or treatment of the chronic diseases, and will, incidentally, add to the numbers of very elderly in the population.

Apart from such technological developments, there is also likely to be a wider application of existing procedures. Britain falls far behind the United States, for example, in providing heart surgery or renal dialysis, particularly amongst people in their sixties and seventies. At the other extreme in the age range, the healthy survival of premature babies with a birthweight less than one kilogram at present depends on the availability of a local specialist premature baby unit. Such facilities must be expected to expand until survival of such babies becomes routine, wherever they are born.

Another important development which will extend the benefits of medical care in the future will be improved epidemiology. This will range from better monitoring of adverse reactions to multiple medication, through to the identification of causes of rare diseases.

Finally, it is implicit in what has already been said that better public education and more sophisticated and effective methods of achieving changes in behaviour must play an important part in the improvement of public health.

The organisational response

Against that background of continuing improvements in medical care, it is possible to suggest an organisational structure for health services in Britain which would maximise the benefits which could be achieved. To a large extent, this involves a return to the pattern of medical care which existed for the middle classes in Britain before the introduction of the National Health Service in 1948. One of the criticisms which has been levelled at the National

Health Service so far is that it tended to be developed on the basis of 1911 'panel' medicine, rather than an extension of middle class medical care to everyone.

In this new structure, the general practitioner in the 21st century would first and foremost be a superb diagnostician. This was the skill of the best of the general physicians in the early decades of this century. In those days, the physician's diagnostic expertise was largely an art. He could sense a particular odour from the patient, and connect it with one he recalled in a previous case. The appearance of the skin, the manner of gait or pattern of speech of the patient might be equally significant. It is said that some of the greatest diagnosticians could often identify their patient's diseases as they walked from the door to the physician's desk.

In the latter half of the 20th century the great diagnosticians no longer have to depend on such intuitive skills – although these may often still help. They have an array of highly sophisticated diagnostic instruments at their disposal – either directly or indirectly – ranging from the electron microscope to the most advanced analytical tools of the biochemist. The general practitioners of the future must be masters of the art of calling upon the most appropriate tests to make as precise a diagnosis as possible of their patients' problems. It is quite wrong that 'difficult' cases should invariably be sent to hospital for diagnosis.

The general practitioners' diagnoses will not, of course, always involve high technology or biochemistry. It is just as important for them to understand their patients' social circumstances. If a back ache is due to a marital problem, for example, there is nothing positive that the X-ray machine can tell the doctor.

This leads on to the second role which general practitioners must continue to develop. This is the long-term support for their patients, both in a purely medical context and in a socio-medical sense as well. Once a patient's condition has been diagnosed and appropriate treatment has been initiated, in a way that will be discussed later, the general practitioner should usually accept responsibility for continuing supervision of the patient's well-being. Too often, at present, continuing care of the patient is taken over by the hospital out-patient department. This is usually unnecessary, costly, inconvenient, and often inappropriate. In many cases the treatment, and the emerging pattern of the patient's disease can more appropriately be monitored by the general practitioner in the community setting, with only occasional referrals back to a specialist unit.

The third role for the general practitioners is in health education and micro-epidemiology for the patients in their practices. They need to persuade their patients to adopt a healthy life style and to watch for early signs of deviation from good health. Partly, this links back to their diagnostic role, but in addition they must watch for signs of obesity, excess stress, abuse of alcohol and other harmful patterns of behaviour. In this way, they could supplement their traditional curative activities with a truly preventive approach towards their patients.

All of this puts extra responsibility on the general practitioners. To compensate for this, the other proposed development in general practice tends to shift responsibility onto the medical or surgical specialists. Too often, at present, general practitioners have been persuaded that they can make just as good an analysis of the patient's condition as any expert, and can therefore assume full responsibility for their initial treatment, once a diagnosis has been made.

It is here that the future role of the general practitioner needs, perhaps, to be questioned. If a patient is suffering from arthritis, or diabetes, or asthma, or bronchitis, or hypertension, or cancer, or schizophrenia, or alcoholism or drug abuse, for example, it can be powerfully argued that – once the diagnosis has been made – they should in many cases see a specialist in that particular disease. The general practitioner cannot be a Jack-of-all-Trades. He cannot possibly know as much about diabetes, for example, as a doctor who sees nothing but diabetics of every possible sort and suffering from every nuance of the problem. This is already recognised with the cancers, and with drug abuse, for example. Only the most cavalier of general practitioners would expect to handle such cases on their own. It can be argued that the logic which applies to cancer applies equally to diabetes and arthritis.

In the recent Office of Health Economics study on 'Back Pain', a strong criticism which emerged was that the specialist practitioner often saw the patient too late. Whereas effective therapy might have been instituted when the symptoms first emerged, once they had been present for many years, the condition had become intractible. It is often only at that stage that the general practitioner or the patient feels he must at last call in expert advice.

Asthma and bronchitis provide another example of the occasional benefit which can be obtained from highly skilled specialist analysis and treatment at an early stage. A full exploration of all the causal factors can often lead to a much more precise definition of the disease than would be possible in a general practitioner's consulting rooms. Once again, a specialist who sees nothing but bronchitis and asthma is likely to make a better therapeutic judgement than a doctor who sees only a few cases.

In all these situations, the plea for specialist examination of the patient once a diagnosis of a serious and complex condition has been made is a direct reflection of the best type of middle class medical practice from the 1930s. Few general physicians, for example, would have expected to treat a private patient with an intractible skin disease on their own. They usually called in a dermatologist for a second opinion. The dermatologist, in turn, probably had an honorary appointment at the Skin Hospital, where he had an opportunity to see every type of skin problem, and to evaluate fully all of the alternative treatments available to him. It was only once the specialist treatment had been initiated that the generalist once again took charge of the patient's continuing care. In this sense, exactly, the National Health Service general practitioners of the 1990s would become the equivalent of the general physicians of the 1930s. Their status would be correspondingly enhanced.

As a corollary to this development, there is a strong argument for more highly specialised treatment centres within the National Health Service. This is, of course, already the emerging pattern, but it needs to be encouraged further. The best treatment will always be that provided by a centre of excellence specialising in the particular disease.

Incidentally, there is no need for all of these specialist units to be grouped together within a District General Hospital. Individual specialist treatment centres, with or without hospital beds, could sometimes be geographically separate from each other. Common services, such as bacteriology laboratories, would still be provided on a central basis. Possibly, if the philosophy of this paper were to be accepted, the concept of a necessarily comprehensive District General Hospital could eventually become obsolete, together with the concept of the 'general physician' or the 'general surgeon'. The historical role of the generalist

would be largely absorbed into general practice, and the general practitioners in turn would work in collaboration with a whole range of highly specialised disease treatment centres. One of their new skills would be always to select the most appropriate and efficient treatment unit for each particular patient, often selecting between competing centres within the same speciality. Sometimes this could involve the choice of a treatment centre some distance from the patient's home. However, this again is not a new principle. More affluent members of society have always in the past been prepared to travel, if necessary even to a different country, to obtain the very best available treatment for their disease.

This general proposal might perhaps appear to imply that the process of diagnosis and therapy could in the future be separated. This is not true: diagnosis and therapy form a single indivisible process. An essential feature of the proposed relationship between general practitioners on the one hand and skilled specialists on the other is that they should share the whole process of diagnosis and therapy for the patients' illnesses. There should be a positive and close interaction between the new style of diagnostician – general practitioners and the therapeutic specialists. If patients, for example, have been incorrectly referred to the wrong specialist, the general practitioners must be given a full explanation as to why their diagnosis was faulty. In this way the specialists collectively will play an essential role in the performance review of the general practitioner's activities. In more positive ways, also, the general practitioners will learn from the specialists in relation to the continuing care of the increasingly prevalent chronic conditions.

Conversely, the specialists will learn from the general practitioners about the interaction between physical abnormalities and social circumstances: thus the learning will be a two-way process.

Hence, the fear of a dichotomy between the processes of diagnosis and therapy in the present proposals is misplaced. What should be built up instead is the sort of relationship which existed between the 1930's general physician and the more specialised doctor who was called in for a second opinion. Each respected the other for their own particular role in creating the maximum well-being for their patients.

In order to complete this picture of the future, it is important also to emphasise the need for more long-stay hostels for the chronically infirm and for more hospices for the dying. Here, again, the general practitioners would refer their patients directly to the appropriate institution. In this way, the doctors-of-first-contact would maintain their central position in the medical orchestra consisting of many different facilities, each appropriate for different types of patients.

The economic implications

Finally, it must be said that none of this will be cheap. There will certainly be savings from the elimination of wasteful 'general hospital' care and unnecessary outpatient after-care consultations. There will also be savings as some of the long-term chronic diseases such as Parkinsonism can be controlled. But in general the scheme outlined proposes overall improvements in the quality of care; and in any situation improvements imply higher costs.

The British National Health Service is one of the cheapest in the developed world. But in many places its cheapness shows. In approaching the new horizons of health care which are envisaged in this paper, the shortcomings of the existing health service would be largely overcome. This must mean an increase in health care expenditure in one form or another.

This raises a political consideration. The Social Democratic-Liberal Alliance and the Labour Party are both committed further to increasing National Health Service expenditure. The Conservative Party, on the other hand, would probably like to see the major growth in health care expenditure taking place in the private sector.

None of the proposals in this paper prejudge the issue as to which of these approaches is preferable. Some of the new-style general practices and some of the specialist units could lie in the private sector, forming part of a more flexible arrangement between public and private medical care.

However, the important point is that – whichever political party is in power – better health care can only be achieved at the expense of higher health care budgets. Whether the money comes from private funds or public funds, there is no doubt that it is needed if the new horizons in health care are to be approached in the decades ahead.

General practice today

Nicholas Wells

The fortunes of general practice have fluctuated from one extreme to the other over the past 40 years. At the inception of the National Health Service (NHS) the prospects for this particular sector were not very promising. New developments at that time had, according to Rhodes,[1] 'tended to take nearly everything into hospital and convert GPs into sorting clerks directing patients appropriately to specialist departments'. Subsequently, in the 1950s, the rigid remuneration system did not provide funds for much needed innovations, such as the employment of ancillary staff, or investment in more suitable practice premises.

The inevitable decline in morale was reversed in the mid-1960s with the advent of the 'Doctors' Charter'. This initiative led to reform of the system, introducing various work-related payments and realistic financial inducements towards progress. Today, general practice is the most popular career choice of medical students – more than 50 per cent become family doctors – and opportunities exist for continuing innovation. It has been suggested, for example, that the ever increasing significance of general practice in treating disease and promoting health could involve this sector in becoming the budget-holder for the rest of the NHS.[2] Against a background of such potential for development, the objective of this paper is to examine the current state of general practice and thus to provide some indication of its state of readiness to meet the challenges of the future.

General practice today

Contemporary general practice has many attributes. Family doctors treat around 90 per cent of all episodes of ill-health presented to the NHS. Care is provided 'on demand', without long waiting lists – over 70 per cent of consultations take place within a day of the patient seeking help. It is also extremely accessible in that an estimated 75 per cent of patients live within two miles of their doctors' surgeries. In addition, continuity of care is facilitated in general practice – a survey by the Office of Population Censuses and Surveys (OPCS) found that over three-quarters of 4,000 plus respondents had been registered with their general practitioner for over five years.[3]

As a consequence of these and other qualities the public has a high overall regard for the service. The OPCS study found that 76 per cent of the interviewees were either favourably or very favourably impressed by the approachability of their family doctor and 84 per cent considered their doctors' surgeries to be either efficient or highly efficient. Research undertaken at the behest of the Royal Commission on the NHS also found high degrees of satisfaction among individuals most frequently in contact with the service: the elderly and the parents of young children. Thus between 80 and 90 per cent of both groups indicated that they were able to see their doctor as often as they wished and that they were accorded sufficient time and attention.[4]

In addition to its popularity with consumers, it is claimed that general practice is the most cost effective element of the NHS. In support of this contention, it is pointed out that health care costs in the UK are among the lowest in the developed world. This achievement is attributed to the relatively low numbers of patients treated in the expensive hospital sector – less that 2 per cent of all episodes of ill health are dealt with in hospitals – and this in turn is a reflection of the success of primary medical care as an effective 'screen' and source of treatment. In reality, however, shortcomings in available data imply that it is not possible scientifically to test the hypothesis that, on the basis of international comparisons, family doctors in the UK generate decisive economic advantages for the nation in terms of low secondary health care costs. Nevertheless, it is almost certainly the case that such savings are generated.[5]

At the same time, evidence of cost effectiveness is drawn from comparisons of the costs of care provided by different sectors of the NHS. The Family Practitioner Services comprise the General Medical, Pharmaceutical, General Dental and General Ophthalmic Services and in 1982 accounted for £3,237 million, or 22.4 per cent, of total NHS spending. The cost of the first of these subgroups – the services provided by general practitioners – amounted to £1,003 million, or 6.9 per cent, of NHS expenditure. This sum may be linked to estimates of the demands placed on general practice revealed by the General Household Survey. The latter indicates that in 1982 males and females consulted their GPs 3.5 and 5.0 times respectively. Application of UK population data to these rates yields a total of 241 million consultations for 1982. It may therefore be estimated that each consultation cost £4.16 in that year.

The total cost of treatment in general practice should also take account of the prescriptions of pharmaceuticals. In 1982 the cost of the Pharmaceutical Services – including drug ingredient costs and dispensing fees – amounted to £1,469 million. This sum implies a pharmaceutical cost per consultation of £6.83. Thus the total expense generated by a GP consultation in 1982 may be calculated to have been £11.

Of course, this estimate has to be treated with caution. The overall cost of general medical services will cover items of practice other than consultations although the latter, coupled with the 'peripheral' workload to which they give rise, will clearly constitute the principal element. In addition, there are the inevitable distortions inherent in averaged data. Nevertheless, the figure is useful as a broad order of magnitude estimate for comparison with the costs arising in other sectors.

Comparison might be drawn in the first instance with accident and emergency departments. The report by Coopers and Lybrand[6] on the Cost Effectiveness of General Practice drew attention to the findings of a study suggesting that 'general practice type cases' accounted for between 3 per cent and 30 per cent of cases in accident and emergency units. Data from the 1983/84 Health Services Costing Returns indicate that approaching 80 per cent of accident and emergency attendances take place in either large acute hospitals (over 100 beds) or in those classified as mainly acute and that the average cost per attendance is £16.50. Inflating the 1982 GP consultation cost to 1983/84 prices yields a revised estimate slightly in excess of £11.50. Consequently, where appropriate, GP care could avoid 30 per cent of the costs that would be incurred in an accident and emergency department.

There is perhaps greater scope for substitution – both currently and potentially – between care provided by GPs and that delivered by hospital outpatient departments. The cost per attendance in the latter setting for the same types of hospital as those specified above was £22.41 in 1983/84. Consequently, a transfer of responsibility to the general practitioner could, in suitable cases, save about 50 per cent of the costs incurred by an outpatient attendance.

The foregoing arithmetic is based on simplistic assumptions, fails to take account of considerations such as capital costs and would not therefore persuade economists of the cost effectiveness of general practice. Instead, convincing evidence requires detailed examinations of specific examples of therapy/care provided in different settings and

these must of course incorporate appropriate measures of outcome. Nevertheless, primary medical care would appear to be a highly economical service – in treating 90 per cent of all episodes of ill-health presented to the NHS it consumes only one-sixth of the latter's total resources. It is also popular with patients. Against this background Metcalfe[7] has written that 'in many ways, general practice has never been so good as it is today, nor has the trend in improvement been so steep. The stimulation afforded by vocational training has been enormous; there is exciting progress on many fronts, from patient participation groups and practice computers to well-woman clinics and peer reviews ....'

An alternative view of general practice

In the same article, however, the author went on to record that 'there is ample evidence, anecdotal and from formal research, that a significant minority of GPs' behaviour can only be described as unmotivated, unprofessional and technically incompetent.' And Hart[8] has argued that although general practice in this country compares favourably with its counterparts abroad, in absolute rather than relative terms it is a 'disaster area'.

The latter observation may be regarded as somewhat extreme, nevertheless contemporary practice is widely acknowledged to suffer a number of major failings. Criticism has been levelled, for example, at the apparent reluctance among some family doctors to assume responsibility for the treatment and monitoring of patients with various chronic diseases. In this context, a randomised study of the care of type II diabetics found that only 14 per cent of the patients allocated to GP care had been reviewed at least once a year compared to 100 per cent for the hospital group.[9] Focusing on hypertension, random samples of men over 20 years of age in London found that in 1982 between one-half and one-third had not had a blood pressure reading taken by their GP for over 10 years. In addition, nearly half of all treated hypertensives had been started on medication following only one measurement of this unstable condition and two-thirds had not undergone investigation of any kind.[10,11,12,13] The failing of GPs to occupy and develop areas of clinical responsibility they had hitherto claimed as their own has been associated with the development of direct access clinics for the treatment of conditions such as asthma, diabetes, hypertension, epilepsy and arthritis.

A related form of this so-called 'clinical drift' has also been observed in the context of accident and emergency (A and E) treatment. Available evidence indicates that A and E departments are seeing increasing numbers of patients who could have been treated by GPs. A study in 1982 found that 85 per cent of people attending hospital emergency rooms had referred themselves without prior contact with a GP or deputy and that in 39 per cent of the cases the conditions were neither an emergency nor the result of an accident.[14] Such findings reflect a number of factors, including the problem of accessibility of GP advice at the time of need. More generally, Wilkes[15] has suggested that the growing percentage of self-referrals may also be a function of diminishing respect for the filter of general practice.

Family doctors have also been criticised for insufficiently involving themselves in disease prevention and health promotion activities. General practice provides an excellent setting for preventive medicine. Practically everybody is registered with a family practitioner and two-thirds of the population seek help from this source at least once each year. Over a five-year period this proportion rises to 90 per cent. Furthermore, there is evidence of the efficacy of GP endeavours in this field. Russell and his colleagues,[16] for example, have suggested that via advice, the provision of information leaflets and warning of follow-up, each general practitioner might hope to achieve 25 committed ex-smokers in his or her practice each year. The General Household Survey indicates that cigarette smoking – which is believed to be a major factor in the deaths of 100,000 individuals each year in the UK – remains a habit for more than 15 million people.

Yet these findings appear to have had only a limited impact. Thus Jamrozik and Fowler[17] found that although three-quarters of GPs claim to initiate discussions about smoking with basically healthy patients who persist with the habit, fewer than two-thirds state that they make a record of their observations. Furthermore, audit of clinical records reveals that less than one-third of GPs who are accredited trainers do in fact make a note of smoking behaviour.[18]

A study seeking to discover patients' views on the role GPs should play in health promotion also generated discouraging findings. Wallace and Haines[19] sent a questionnaire to 3,452 patients aged 17–70 years who were registered with practices in North West London. They found that high proportions of the respondents considered that their general practitioner should be interested in matters such as smoking, fitness and weight (Table 1). However, much smaller proportions considered that interest was actually shown by the GP (Table 2) even though the need for involvement was clear from the high percentages of respondents who considered themselves to have weight (42 per cent), fitness (41 per cent), smoking (59 per cent) and other problems. The findings of this stuy led the authors to conclude that 'greater participation by GPs in health promotion would be well received by most patients and that currently there may be considerable discrepancies between patients' expectations and the perceptions of their general practitioner's interest in these areas of preventive medicine'.

Criticism of modern general practice embraces a range of other issues. Concern has been expressed, for example, at the fact that GPs do not have to retire and that one GP in 40 is over 70 years of age (1981 data). Questions have been raised about the acceptability of the physical premises of some practices and the absence of arrangements for inspec-

Table 1 **Patients' views on whether their GP should be interested in selected health related problems**

	Weight problems		*Smoking problems*		*Drinking problems*		*Fitness problems*	
	Per cent of men	*Per cent of women*	*Per cent of men*	*Per cent of women*	*Per cent of men*	*Per cent of women*	*Per cent of men*	*Per cent of women*
Should be interested	81	85	79	81	77	81	72	73
Should not be interested	13	8	15	11	17	13	19	16
Don't know	6	7	6	8	6	6	9	11

Source: Wallace and Haines 1984

Table 2 **Patients' perceptions of their GPs' interest in various health related problems**

	Weight problems		*Smoking problems*		*Drinking problems*		*Fitness problems*	
	Per cent of men	*Per cent of women*	*Per cent of men*	*Per cent of women*	*Per cent of men*	*Per cent of women*	*Per cent of men*	*Per cent of women*
Have seemed interested	47	48	54	48	44	38	41	36
Have not seemed interested	20	19	16	16	21	19	22	20
Don't know	33	33	30	36	35	43	37	44

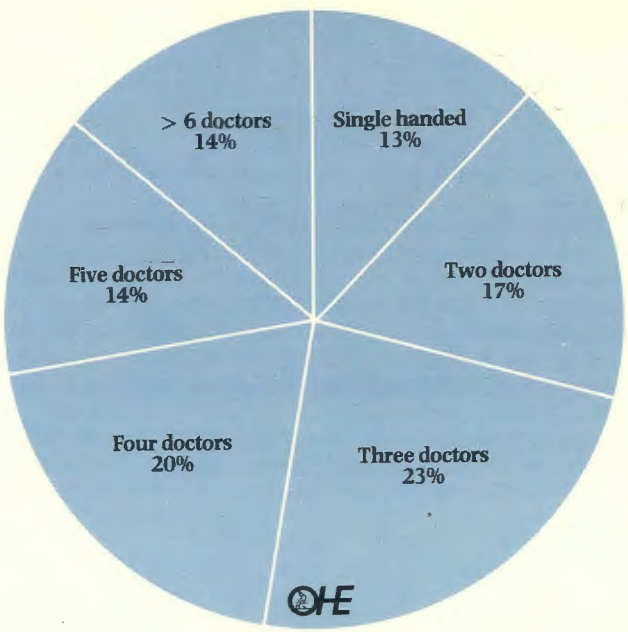
Source: Wallace and Haines 1984

tion on a regular basis. There is disquiet at the decline in home visiting. The General Household Survey shows that the overall ratio of surgery to home consultations fell by 23 per cent between 1974 and 1982. And there are serious doubts about the adequacy of family doctor training. Hart[8] has commented that the system of medical education in the UK 'is still designed to produce community physicians only as a by-product, an afterthought following a core curriculum designed by and for specialists.' And Wilkes (1984) has point out that 'the national figures of attendance by GPs at approved educational sessions are pathetic' and that it has been argued that 'the only achievement of vocational training has been to make some good practices rather better'. Clearly these and other observations have important implications for the standards of quality and competence in general practice.

The objectives of general practice

The preceding two sections have illustrated sharply divergent aspects of contemporary general practice. Neither view can be taken to be representative of the family doctor service as a whole. It would of course be unrealistic to expect a large group of individuals to be homogenous in either expertise or motivation. Furthermore, the circumstances facing each individual doctor vary considerably. Practice size is one such variable – in 1982, 13 per cent of unrestricted principals operated single-handedly whilst 14 per cent worked in practices with 6 or more doctors (Figure 1). They also serve patient populations which differ markedly according to age or socio-economic grouping and, as Tables 3 and 4 make clear, such characteristics are a major influence on workload patterns. Ease of access to

Figure 1 **Proportional distribution of unrestricted principals by size of practice, United Kingdom, 1982.**



Source: OHE Compendium of Health Statistics, 1984.

Table 3 **Doctor consultations**
(a) Percentage of persons who consulted a GP (NHS) in the 14 days before interview, by sex and age
(b) Average number of GP (NHS) consultations per person per year, by sex and age

All persons **Great Britain: 1982**

Age	*(a) Percentage who consulted GP (NHS) in the 14 days before interview*			*(b) Average number of consultations per person per year*		
	Males per cent	*Females per cent*	*Total per cent*	*Males No.*	*Females No.*	*Total No.*
0– 4	21	20	20	7.2	6.4	6.8
5–15	9	10	10	3.0	3.0	3.0
16–44	8	16	12	2.2	5.2	3.7
45–64	13	16	14	4.1	5.1	4.6
65–74	15	17	16	4.9	5.5	5.3
75 and over	19	18	19	6.3	6.0	6.1
TOTAL	11	15	13	3.5	5.0	4.3

Source: General Household Survey 1984

Table 4 **Percentage of persons who consulted a GP (NHS) in the 14 days before interview and average number of consultations per person per year, by sex and socio-economic group, 1982, Britain**

Socio-economic group	*Per cent consulting*		*Average number of consultations*	
	Males	*Females*	*Males*	*Females*
Professional	9	12	2.5	4.0
Employers and managers	11	13	3.4	4.5
Intermediate and junior non-manual	10	15	3.5	5.0
Skilled manual and own account non-professional	12	15	3.6	5.0
Semi-skilled manual and personal service	13	17	4.0	5.4
Unskilled manual	11	17	3.5	5.6

Source: General Household Survey 1984

support and secondary services supplied by other sectors of the NHS is a factor that will differentially affect family doctors practising in different parts of the country. Against this background, it is of little surprise that patterns of care show immense diversity. Thus prescribing rates per 100 consultations have been found to vary from less than 60 per cent to more than 80 per cent, laboratory test rates from less than 1 per cent to more than 10 per cent and referral rates from less than 3 per cent to more than 15 per cent whilst average consultation times range from five to nine minutes.[20]

At the same time an unequivocal verdict on the current performance of general practice is not feasible because of the dearth of appropriate information. There are no data to indicate the nature of the services being supplied by different GPs, the scale on which provision takes place, and the effectiveness of these services in improving the health of the community. In the absence of these measurements not only is the present state of general practice unknown but it is impossible to determine what the optimum working pattern might be.[21]

Despite these uncertainties, the existence of such wide variations in general practice in the NHS has created considerable pressure for reform. In reponse the Royal College of General Practitioners launched in 1983 what has become known as the quality initiative. Among other recommendations, it has been proposed that GPs should describe their current work and be able to list the services provided for patients in their practice. In addition, GPs should define specific objectives for the care of patients and monitor the extent to which these targets are being met. A subsequent document, published in June 1985, has reiterated the need for reform placing particular emphasis on the importance of appropriate training for general practice.[22] Furthermore, it argues that 'unacceptable levels of performance should be reflected in a doctor's remuneration'. At the present time 'there is no obvious link between remuneration and performance so that the poor doctor is protected . . . and the good doctor . . . is no better off. The system fosters mediocrity and protects the status quo.'

The present paper has, highlighted several areas where greater involvement by family doctors would widely be considered desirable. Thus the management of chronic diseases such as diabetes, hypertension, asthma and epilepsy might be brought back into the domain of general practice. The extension of anticipatory care and health promotion activities is another key objective. Improvements in the monitoring of practice populations are also a pre-requisite of better quality primary health care. Such surveillance is not only essential to the practice of anticipatory care and achieving the high levels of vaccine acceptance needed to protect the community against infectious diseases but it also provides excellent material for research purposes. Utilising general practice data, epidemiological studies, management reviews of specific diseases and other investigations could promote a more effective use of available resources. Finally, benefits might be expected to flow from an increase in the number of general practitioners undertaking minor surgical procedures: patient convenience would be enhanced and pressures on hospital waiting lists reduced.

Discussion of the means of achieving these and other targets within the overall objective of improving the quality of general practice does not fall within the brief of this paper. Instead, potential solutions are the subject of other presen-

Table 5 **Some future influences on general practice**

1. Demographic changes. Projected population estimates indicate that the number of persons aged 75 years and over in Britain will increase by 17.1 per cent between 1983 and 1998. This growth will add 19 new elderly patients to each general practitioner's list (assuming the number of GPs remains constant). Over the same period, the population aged 0–4 years will rise by 13.3 per cent, adding a further 15 children to the average list. The significance of these trends lies in the fact that both age groups consult their GPs on half as many occasions again as the rest of the population and that, in the case of the elderly, 51 per cent of consultations require a home visit (compared with 13 per cent for persons under 75 years of age).

2. Public expectations regarding the quality of primary and other health care services are likely to continue to become more demanding.

3. Increasing use of the general practitioner as a source of guidance on seemingly contentious and confusing health matters and, eventually perhaps, on alternative or complementary sources of treatment.

4. To some extent the workload of general practice may be lightened by community pharmacists assuming a more substantial role in the management of minor illnesses. This trend will be fostered by the strategic aspirations of the pharmacy profession itself but may also be strengthened as a consequence of initiatives designed to curtail prescribing at NHS expense and to lift present restrictions on the availability of some medicines (by altering their status from POM to 'pharmacy only').

5. The continuing evolution of information technology has important implications for investing in the computerisation of general practice.

6. Sustained pharmaceutical innovation should enable general practitioners to manage some diseases more efficiently but contemporaneously may increase workloads by transferring to this setting care that had hitherto been the responsibility of other sectors or had simply not been possible to provide at all.

7. Economic and social variables – for example, high levels of unemployment and the diminishing stability of the family unit as suggested by the rising incidence of divorce – have potentially significant implications for personal health and may place increasing pressures on the primary health care service.

tations to this meeting. As a concluding comment, however, it should be emphasised that consideration of these options must pay close attention to their overall and intersector resource implications and the extent to which they are capable of accommodating change (Table 5) for these two factors will be key determinants of both their acceptability and likely success.

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Public expectations

Katharine Whitehorn

What does a patient expect? It depends on the patient. One patient, who has seen too much TV on an empty stomach, may expect an ambulance clanging through the night – drama, lights, blood transfusions – and all for a simple bout of flu. Another, one of nature's optimists, of the tiresome sort that says he's never had a day's illness in his life, may march in expecting a simple prescription to cure him of cancer, heart failure and the Oedipus complex; while a third, a frequent visitor to doctors' surgeries, may crawl into the consulting room with no higher expectation than to be made to feel apologetic for taking up his time at all plus a prescription for something that she could just as easily, and nowadays probably as cheaply, have bought across the chemist's counter.

In other words, what you *expect* depends on what has happened to you before. So let us start with hopes instead.

The first hope is so extremely simple that it would seem insulting to mention it – except that it is often an area of difficulty for both the doctor and the patient. The patient hopes to see the doctor soon. Working out that the time has come to consult a doctor is not the obvious matter that it may seem; a conscientious mother may anguish for hours or even days about whether the change in a toddler's appearance is worth 'troubling' the expert; a man who has been brought up not to ask advice (which is most of them) has to cross a real psychological barrier before he goes to place himself in the hands of another man or even, heaven help him, woman. So when they have finally come to that decision, they want to see the doctor *now*. I've often heard GPs grumbling, as well they might, when someone rings them up in the middle of the night about a condition which has actually been dragging on for days; but what has often happened is that it is at that bleak moment at three in the morning the patient at last cracks, gives in, thinks he can't cope alone any longer. A doctor shouldn't ever underestimate what the simple knowledge that 'we've sent for the doctor' can do to help a patient get through the night. The doctor may know there's not a lot he can do when he gets there; but for the family, his actual arrival is what counts. GPs, I am sure I don't need to tell you, are a great deal more to us than just the sum of their treatments.

So how can that hope be fulfilled or diverted? Patients have to learn, I think, how to use a group practice, and the more of them realise how to go about it, the better this situation may become. Anybody knows that in the kind of emergency where there is blood all over the floor or someone's turning blue in the face, you don't waste time trying to find the doctor with the kindest smile, *any* doctor will do. And most patients, too, would be prepared to wait for a favourite doctor if it's all part of a long, continuing saga and there's not a lot of point in starting all over again with earnest young Dr Thing. It is in the in-between area that patients have a lot to learn, and nobody's going to teach them but doctors.

'I want to see the doctor' – but would the nurse do? Sure, if it's just a question of getting out the ear wax, or seeing if your blood pressure's up again. But the degree to which the patient will consent *not* to see the doctor, but to see the nurse, will be a measure of the extent to which the *doctor* has made it plain how much responsibility the nurse can have. If he refers to her as wise, as knowing a lot more about some situations than he does, as being a very valuable colleague, patients will be much more happy to see her than if he always implies that he is a very busy man, that only the most important complaints – or complainants – are worthy of his attention, that trivial matters can perfectly be dealt with by her.

So we suppose that a patient feels happy about approaching the practice; that he doesn't mind being steered in the direction of the nurse if he has learned to trust what she can offer; that he doesn't feel so scared of wasting the doctor's time that he waits until he's really desperate, at a totally unsuitable hour, before he finally cracks and screams for medical help. He arrives; he sits there; and he waits. And waits. And waits. I've long held the theory that the medical profession must believe that waiting has a high therapeutic value, since it is the *only* treatment that you are absolutely sure to get whatever it is that is wrong with you. I've heard all the arguments about emergencies, and people taking a bit longer than you expected them to do, and receptionists getting kind-hearted at the wrong moment and stacking up too many patients, and so on and so forth. I think, all the same, that a bit more realism about how long a patient does take can help; and I was much struck by an article I read by a doctor who said that yes, he *did* sometimes spend five minutes sitting in his consulting room doing a bit of paperwork while he waited for the next patient; heaven knows, there was always enough paperwork to do; and he didn't see why it should be taken as an absolute matter of course that patients should *always* wait for the doctor and never doctors for patients. I don't want to labour the point, because first of all hospitals are far worse than GPs about this, and secondly because there are other more important things to say; but I do find it odd that some of the best brains in the country should apparently be unable to solve a problem that is within the grasp of every half-way competent hairdresser.

Before we leave the question of access, there is one more person to take a look at, I think; and that is the receptionist. In the group practice I go to (which is extremely well run on the whole) there tend at any one time to be two receptionists: one of them is full of sympathy, really seems to care, and before you know where you are, you're agreeing that yes, of course, Tuesday fortnight will do fine. The other is sharpish; naughty little children we are to be ill at all, well, the Great Man *might* manage to give you a few seconds of his extremely valuable time . . . by the time she's finished she's turned me into Indignant Ratepayer demanding my rights, insisting on seeing the doctor AT ONCE – and put my blood-pressure up ten points as well.

It *is* a tricky one, this matter of the receptionist. As group practices proliferate, this gatekeeper does become more and more important: every horror story you ever hear about babies with earache being given an appointment the following week and so on, nearly always comes back to a receptionist with a power complex, and I imagine that before I've got to the end of this sentence somebody will be mouthing the word 'training'. But I most emphatically do not believe that's the answer. Train them and you immediately do two things. You exclude, slap off, all the sensible, excellent, returning married women who are at present one of the pools from which so many of the best receptionists are drawn – and common sense is not something you can really train into someone, in any case. And once they're trained, they'll form some sort of gang – professional body, association, trade union or whatever – and it will become progressively more difficult ever to get rid of a bad one. But I would like to beseech doctors, in the name of their patients, to take notice of what their receptionists are doing; to keep a close eye on them; even occasionally to ask patients, not necessarily in a way derogatory to the lady behind the desk, how they've been treated: to regard the behaviour of the gatekeeper, in short, as part of *their* business. She is the first front you show to the world, and even

if she's only as important as your brass plaque, it makes sense to make sure she's bright.

So now we come to the consultation itself. You've all heard *ad nauseum*, I'm sure, the extent to which a patient will clam up if he's terrified; that a doctor who doesn't welcome her, or who goes on writing on a pad as she comes through the door, immediately puts the patient on the defensive and makes her forget half the carefully marshalled points she was going to try to make. With all the work that's been done video recording medical students so that they expose their interviewing techniques to the ridicule of their fellow students, there can't be many doctors who don't know perfectly well that the patient expects to get the doctor's attention, at least for all of the 4½ minutes his busy schedule allows.

What may be less known, because there doesn't always seem to be much sense to it, is the extent to which a patient expects to be examined. I had a great clutch of letters about various malfeasances of diagnosis, particularly connected with women in middle life, just about all of whose problems from 34 to 70 are put down to the Change by a certain sort of doctor; the phrase that kept on and on recurring was 'he didn't even examine me'. I've read some extremely funny explanations by doctors, of the reasons their hearts sink at the thought of wading through all Mrs Troublefudge's underwear and corsets and cardigans, but there it is: the doctor may think he can deduce the full story from learning when it all started, looking at the patient's demeanour and packing them off thankfully to a hospital for an X-ray and a blood test, but patients cling to the belief that a doctor will have a better idea of what is wrong with them if he can actually bring himself to look.

Do patients, who have been examined, and whose ailment has been pin-pointed, invariably expect a piece of paper to take away? Whenever it's suggested that the nation's drug bill is too big, or that having half the population on valium can't really be a good thing, you get a tit-for-tat of accusations: doctors just give you a prescription; patients aren't happy till they get a prescription (as a matter of fact I once developed a theory that paper was our sacred substance in this culture, and that till some had been exchanged – a ticket on a bus, a programme at a theatre, a handout at a conference – no transaction could be considered properly sanctified. It could be that).

I don't think, myself, that patients necessarily hope for a wonder drug every time. But they do expect the doctor – or nurse, or whatever, to *do* something. And that is the tricky one; for often enough there isn't anything much you can do. You can pass the patient on, in some cases; that just postpones matters. Sometimes there really is a drug that will help a great deal. Just occasionally it can be marvellously dramatic: my GP is a sort of osteopath as well, and has been known to click people's backs into place with one shrewd wrench of his muscular arms. But we all know that most troubles for most people aren't like that. The way GPs cope with – what is it, 90 per cent – of our illnesses on such a tiny fraction of the money is not by dishing out expensive tests and scans and treatments but by just keeping the situation ticking over.

In the matter of economics, I am prepared to admit that patient hopes and expectations take, alas, very little account of the reality. If your husband or your son is sick, you want him saved at any cost – and any TV programme knows that you can drum up support for anything that is supposed to be life-saving – a dialysis machine, a facility for bypass operations, even that absurd bubble for the total-allergy patient – in a way that you simply can't for the things which merely make people's lives bearable, like pain killers and invalid carriages and kits for preventing bedsores. You and I know that there is no way on earth that everybody can be cured of everything forever, but there does exist at the back of the minds of too many patients the view that somehow, some way, enough money could make them all live for ever.

This is not just a question of whether it's NHS or private; you can scarcely open a paper without reading of some toddler whose family is raising a vast fund to take him to Australia, or America or Timbuctoo – and usually for an operation they do rather better in Sheffield. There is this wild hope that everybody should have an entitlement to everything all the time; tell the average patient that in that case you'd have everybody living to be a hundred and ten, with two-thirds of the population engaged in looking after them, and he will just look mulishly back at you and go on asking for eight days' intensive care for his ingrowing toenail. I'm sorry to say it, but though I think ordinary people do to some extent understand economics as citizens, they don't when they are thinking of themselves as patients. And that is the only kind of explanation I can think of, for what I have always thought was about the greatest insult you could pay a GP: the suggestion that he would give you better care if you were paying him twenty quid a time.

A patient does hope that the doctor will explain what is wrong with him, and what is to happen next. Obvious? Not at all. If the ones who write to journalists are anything to go by, half our doctors still don't really think patients have any sort of right to total information, which I think is disgraceful; and also a very lively doubt as to how much of the information is understood, with which I have a great deal more sympathy. They ran some tests a while back to see whether those doctors who had been trained by the video techniques I mentioned earlier actually did retain any significant skill in interviewing, and were gratified to discover that they did: they were far better than others at getting information out of patients. Unfortunately, they also did some tests to see who was any good at imparting information, and found that all the groups they tested were uniformly terrible; in particular, it appears that a patient only takes in, at most, the first four things you say to him – which suggests that you'd better not start with your golf score and work up to his dosage. The wretched GP has to try and hammer in the few things that matter – if necessary making them write it down, and *always* – may I suggest? – asking them not only if there are any other questions, but what he thinks you just said. After every article I write there is always one letter from a reader who supposes that I said the exact opposite of what I have actually been trying to say, and it could well be the same is true even of doctors.

More and more patients feel they ought to have a right to a say in the management of their own illnesses – what about that phrase, by the way? Management of an illness? Who is the poor sap surrounding the illness, the office or factory floor in which all this 'management' is to take place? I think at conferences like this, we tend to talk as if there was usually only one thing that ought to be done with a patient, and so the main problem is getting him to do it; 'patient compliance', I believe it's called. But of course that's not the case. Even when you are quite, absolutely, entirely certain that there can be no doubt whatsoever about the diagnosis – and is that quite as common as we all pretend? – there may be still alternative ways of coping with it. Maybe the best thing is a medicine – but maybe there are two ways to administer even that, pills or injections – or even suppositories, if you're French. Maybe it's a

choice, of a sort, between getting on a waiting list for an operation, or seeing if things can be dealt with without.

Maybe – and I accept that this may be the hardest thing of all both for doctor and patient – the best thing may be to do nothing, to wait and see what happens; and there may be some element of risk in that, which the patient may or may not be willing to take. I am reminded of two friends of mine – I admit these stories are in the realm of specialist medicine, but that's only to make it more dramatic – one had cancer of the jaw, and the doctors were quite adamant that most of it had to come off. She was very far from sure she wanted to go on living with half a face, since her life comprises running a million-dollar budget in a children's programme at work, and a highly unrewarding husband at home; so she backed off; in the end, luckily, she found a more skilful doctor who managed to remove much less of her face and she's still going strong four years later. But she was allowed to make her own decision.

The other was a lady who runs her own business which, being to do with food, is heavily angled on the tourist season. She had had one hip replacement with great success, and was due to have the other done. Her particular surgeon was into a new technique, not just for bunging in a prosthesis and leaving it at that, but for a far slower technique where the bone is supposed to grow around the implant. She was told, in spite of her pleas, that since she was on his list she was to have the slower operation. He simply wasn't prepared to discuss her life condition at all, and she was on crutches for weeks and weeks, with the added gall of being in the same ward as other people having the conventional operation and walking away in half the time. She wasn't allowed to make her decision.

So what has that got to do with what people expect of their GPs? Just this: that a GP is supposed to know, what hospital doctors often forget, that not only is the diseased part surrounded by a person, but that the person is surrounded by a life. GPs know perfectly well that half the time you're ill because you're miserable, even if they also know perfectly well that the other half you're miserable because you're ill. They, and only they, can really think out the situation in a patient's life; to realise, for example, that if you can cure the symptom of bed-wetting even briefly, the child may get totally better, because whatever was worrying him originally, it's now the bedwetting itself that's causing the anxiety. The GP may know that a patient is over-eating because she suspects her husband is playing around, but that if he can give her hope about controlling the obesity, she may recover enough confidence to win back her husband – or perhaps the energy to boot him out of the home and start again, who knows.

I believe that a respected colleague at this conference is to suggest that as medicine gets more and more complex, the major role of the general practitioner will increasingly be to serve as a kindly and sophisticated referral agent to doctors with more specialised talent. I would like to submit, with great respect, that the exact opposite is the case.

Disease is indeed getting more and more complicated – but mainly because most of the old-time simple diseases are now under control. It is indeed the case that specialists in hospitals can become adept at chasing up ailments that a GP couldn't know about because there may only be about ten of them a year in the whole country. But that is not where the action lies. The action lies in the question of *why* people get ill – or perhaps why some get ill and get quickly over it, and others get ill unto death.

There's one school of thought which puts the whole thing down to unhealthy habits like smoking and drinking and eating meat, or eggs – or whatever it is this month. There's a school of thought which puts it down to something more subtle even than lifestyle, the balance of happiness and unhappiness, ability to cope or tendency to go under.

There's certainly a growing demand from patients for more involvement, more sense of autonomy; it is the old-fashioned patient and the old-fashioned doctor who don't want to discuss anything except The Disease – and I'm sad about it, frankly, because I may say that I personally far prefer the garage approach to medicine; indeed I only wish one could unscrew the afflicted part and put it in for servicing as one might a machine. But there it is. The whole patient and the holistic approach is increasingly seen as crucial; and this is where the GP scores and the specialist comes a poor second. It's interesting, I think, that in America, where you used only ever to go straight to the specialist (and with some pretty ludicrous results, the man in charge of your lower half meeting the man in charge of your upper half for an unseemly demarcation dispute somewhere around the middle of your diaphragm) the idea of the whole-person doctor is increasingly coming back, even in that very heartland of mechanical medicine. And that trend should be looked at in conjunction with the increasing popularity, here, of the various fringe practitioners, some of whom are now respectable, some not. People get from them something that they do want from their orthodox doctors – considerable attention; they get a very personal involvement in the management of their own problems; and the one thing your friendly neighbourhood chiropractor absolutely does *not* do is to write you a chit to go and see some other medicine man in a huge, terrifying hospital with a waiting time of four hours or ten months.

Far from wanting their GP to do less, I think most patients would like them to do more. Things like X-rays and blood testing and simple pathology are, I believe, done regularly in a doctor's own clinic on the continent, and whether that could be done here is partly economics; and also, I suspect, part of the power struggle between hospitals and general practice, in which struggle I am wholly on the side of the practitioners. I think patients are even coming to realise more and more that the only people who can get some sense out of the hospitals are often the GPs, when they try; and I would also say that to diminish the general doctoring function to a matter mainly of diagnosis is to dig your own graves, as well; since it is in the field of diagnosis that the computer is likely to have most impact on the honest jobs of doctors.

The challenge of the future, as I see it, is how to combine the efficiencies of things like group practices and health centres, sophisticated testing, computer diagnosis and so forth, with that autonomy which a patient wants and needs in his own care; to combine competent medicine with that respect, and certainty of respect, that we will never be able to *count* on getting from a stranger; with that involvement in our own illness and his own health that comes from not only knowing we can trust the doctor; but more importantly still, knowing that the doctor will trust *us* to do the best we can with our own lives.

General practice and health promotion

Godfrey Fowler

Introduction

For many reasons, health promotion and disease prevention are now fashionable – at least as concepts. International bodies, Government, the public and even health professionals have rediscovered 'prevention'. There are many reasons for this. Recognition of the limited ability of medical treatment to 'cure' the modern diseases of our time, awareness that the law of diminishing returns applies to such treatments, economic difficulties and suspicion of 'high technology medicine' have all given impetus to a pendulum swing back to prevention, an activity which accounted for the major improvements in health which preceded 'modern medicine'.

The term 'health promotion' is often used to describe the whole range of activities – environmental, economic, social, legislative and educational, as well as health services – whose aim is the pursuit of fitness, well-being and the prevention of disease. For present purposes, however, health promotion will be used in the somewhat narrower sense of health education, health maintenance and disease prevention.

The general practice challenge

General practice bears a major share of responsibility for furthering health promotion. The job definition of the general practitioner[1] clearly identifies his health educational role and a number of Reports from the Royal College of General Practitioners.[2–7] have identified some of the major tasks for primary care in health education and preventive medicine. There is broad agreement on many of the issues and the debate is not so much about what to do but how to do it.

In a wider context, the Alma Ata Declaration listed health promotion as the first of eight primary health care activities essential to the achievement of 'Health for all by the year 2000'.[8]

Encouragingly, it appears that many general practitioners identify health promotion as an important task[9, 10] and that the majority of patients expect their doctors to ask them about their smoking, drinking, exercise habits and weight.[11]

But it seems that patients consulting their doctors and expecting advice often get prescriptions instead[12] and research based on analysis of video-recorded consultations indicates that many opportunities for health education and prevention go begging even when patients consult with lifestyle-related illnesses.[13, 14]

It is no surprise, therefore, that general practice records contain little information about such things as smoking and drinking habits, dietary habits or weight, exercise, or even blood pressure measurements.[15]

The opportunity

Yet the potential of general practice for health promotion is unrivalled. It has access to virtually the entire population; about three-quarters of patients consult their general practitioner at least once a year (and virtually all do at least once every five years) and almost a million people cross the thresholds of surgeries and health centres every weekday. They come with problems, expecting advice and receptive to it. They are of all types, unselected by age, sex, social class or any other characteristic than the fact that they are asking for help. These general practice 'illness interviews'[16] are an important opportunity for health education in those most likely to need it yet least likely to seek it.

Communication is one-to-one, a method of health education which is recognised as the most successful,[17] especially when the communication is a two-way process. Yet a further attribute is the 'credibility' of general practitioner advice; 'of the various sources of health information available to the public, it is the general practitioner who is most trusted and whose advice has the most impact'.[18, 19]

A variety of studies have investigated the effectiveness of general practice as a setting for health education, using group and individual methods, and of the general practice consultation as a medium for it. The most rigorous of these studies have concerned anti-smoking advice in ordinary consultations and have demonstrated that, counselling against smoking in everyday practice, general practitioners have an important, sustained effect.[20, 21] Further studies are needed to explore the effectiveness of their advice on other aspects of lifestyle and behaviour.

Some deficiencies

There is, however, a substantial gap between potential and achievement – and a variety of reasons for this. Some argue that the average 6½ minute consultation is the major constraint or that patients don't want it. But undoubtedly much of the responsibility for the failure to incorporate health promotion into health care rests with medical education. Basic medical education remains almost entirely hospital based with undue emphasis on organic pathology, advanced disease and acute medical care. 'Salvage' is rated highly: health promotion and disease prevention are considered unexciting – and impracticable anyway. The reorientation of medical education to include the knowledge, skills and attitudes necessary for the performance of a health promotional role poses a major challenge and University Departments of General Practice must be in the front line in responding.[22]

One of the most serious charges against medical education has been its failure to recognise the need for teaching of communication skills although, thanks largely to Departments of General Practice, the majority of medical schools now provide some oppportunities for students to learn relevant skills.

Important advances in understanding of doctor-patient communication, particularly in relation to health education, has derived from the work of behavioural scientists, including sociologists, psychologists and anthropologists who have provided new insights into the process of doctor-patient communication.[23, 24]

The medical model of health education which assumes that information changes attitudes and thence behaviour is too simplistic. The importance of the patient's health understanding (attitudes, health beliefs, expectations and the extent to which health is under the individual control) in determining health behaviour is now more widely appreciated. Such factors, and the need for patients to be involved in decision making and implementation, must be taken into account when giving health education advice, particularly that relating to 'positive health'. Patient satisfaction and subsequent compliance are very dependent on such an approach.

Above all, greater general practitioner involvement in health promotion requires the adoption of appropriate attitudes. One of the basic obstacles remaining is what Julian Tudor Hart describes as 'The shopkeeping inheritance'[25] – the concept of the GP as a 'symptom swatter', or at least having a role limited to the management of disease.

Doctors also need to be more supportive and less authoritative and prescriptive.

The primary health care team

But the major change necessary for general practice to respond more effectively to the health promotion challenge is a 'spreading of the load'. Primary care teams are increasingly a reality. Not only does the team offer the benefit of additional skills, but it also provides an answer to the frequent complaint of GPs that there isn't enough time. Emphasis on a team approach may be an important factor in reorientating the pattern of work of a practice from one which is dominated by patient demand and doctor response to one in which a proportion of initiatives are taken by the practice and particularly by members of the team other than the doctors.

Since the practice attachment of district nurses and health visitors began in the 1960s, there has been a steady growth in primary health care team membership and an important development has been the increase in the number of nurses employed directly by GPs to work in the practice treatment rooms. Initially, these nurses found themselves employed on treatment tasks only – delegated to them by the doctor. But many now have an extended role and are taking on a health promotion and preventive medicine one. In some practices, nurses run well-women or well-men clinics[26] in which, not only are they active in preventive procedures but also in health education, advising patients about smoking, diet, exercise and so on. One interesting recent development is the concept of a 'facilitator of prevention in primary care'.[27] This person, employed by a District Health Authority (or perhaps Family Practitioner Committee) helps a number of practices to reorientate the work towards health promotion and prevention. This includes training practice nurses in appropriate methods and helping practice teams – GPs, nurses, health visitors, practice managers, secretaries, receptionists, and others – to change the pattern of their work. This may include the receptionist offering to the patient attending the practice for any reason an opportunity to see the nurse (there and then or on a planned subsequent occasion) for a 'brief health check'. This may include recording of blood pressure and weight, enquiry about smoking habit and the offer of anti-smoking advice, discussion of diet, exercise and so on. Patients respond enthusiastically to such initiatives – much more so to this 'opportunistic' approach than to written invitations.

One of the inducements for employment by general practitioners of practice staff is the 70 per cent reimbursement of salary (by the DHSS through Family Practitioner Committees) which is currently available. Although each GP may employ up to two whole-time equivalent members of staff on this basis, less than one in six doctors currently reaches this ceiling, and the average is only just over one whole-time equivalent staff member per GP. There is therefore much untapped capacity for employment of many more practice nurses – a resource not only underused but the net cost of which to the practice is also very cheap.[28]

The use of leaflets

Criticism of what some may see as a plethora of leaflets exhorting people to change their behaviour is common; and there is a good deal of scepticism about the usefulness of such literature. Some of this is undoubtedly justified, but appropriate leaflets properly used are certainly effective.[20] But in spite of this evidence of effectiveness, it appears that literature is rarely used by GPs[9] though some enthusiasts not only use such literature extensively but have often produced it themselves.[29]

A co-ordinated approach

In any field, debate by 'experts' about details carries major responsibility for conflicting advice and consequent inaction. This is nowhere more true than in health promotion. But in spite of continuing disagreement about the 'small print', there is now substantial consensus agreement on the major issues. If primary health care teams are to capitalise on the opportunities for health promotion created by patient-initiated contacts (and the majority of primary care contacts are of such nature), it is important that the approach is co-ordinated and the advice simple and consistent. Endorsement by the doctor of advice-giving by other members of the team may be particularly important and the exemplar role of health professionals equally so.

Although particular emphasis should be placed on the individual patient contact, group activities in the practice may have a part to play and may usefully supplement the one-to-one approach. Slimming groups, stop smoking groups, exercise groups, yoga classes, etc, may have a part to play in the overall health promotion strategy of a practice as long as they are seen as supplementary to, and not as a substitute for, the incorporation of health promotion into the everday work of the practice.

Support services

In the field of medical treatment, general practice has the back-up of a substantial secondary and even tertiary care system. In health promotion, the support system is minimal and, even where it exists, hardly used. The Health Education Council is undoubtedly seen by many general practitioners as a national organisation with no relevance to them; its role is seen to be largely confined to conducting national campaigns. Decentralisation of some of the Health Education Council's activities, basing them at Regional level, might not only enhance the 'agenda setting' role of such campaigns but also encourage increased awareness of the HEC amongst GPs. The current programme of establishing HEC-funded academic posts, including the new Professor of Health Education in Wales,[30] is an encouraging development which will help to broaden the base of the Health Education Council.

Likewise there is an urgent need for the establishment and maintenance of closer links between Health Education Units and general practice. Although grossly underfunded and few in number, Health Education Units are an important source of health education expertise, information and literature. A few such Units already relate closely to some practices on their 'patch' but this is very much the exception rather than the rule. Some Regional and District Health Authorities have taken major initiatives in establishing Health Promotion Teams and in developing local programmes. Sadly, these teams do not universally include primary care representation (a serious deficiency). The newly independent Family Practioner Committees have many challenges to face but amongst these must be included the encouragement of health promotion in primary care. Collaboration between Health Authorities and Family Practioner Committees is particularly vital in this context and the 'facilitator' initiative referred to above is an example of such collaboration.

Conclusion

In spite of the considerable gap which presently exists between health promotion potential and achievement in general practice, there are grounds for optimism. But

closing the gap will depend on translation into action some of the rhetoric and lip service which health promotion currently attracts.

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Variations in hospital referrals

Donald Acheson

I am most grateful for a chance to speak about an aspect of primary care which tends to be overlooked. It is the relationship betweeen primary and secondary care, in particular the pattern of referral of patients to hospital by general practitioners, the variation in referral rates and the reasons for these.

Figure 1 shows that in England in 1984 one in six people attended hospital as a new out-patient. One in five went to an Accident and Emergency Department, and one in seven became an in-patient. Of the eight million or so new out-patient attendances more than half were referred by general practitioners, the rest by hospital doctors who were seeing patients referred by other consultants, or were follow-ups of patients after discharge from the ward. While the total cost of the general medical services in 1984 was £980 million, the expenditure on acute out-patient services in England was very little less – £920 million. Total hospital running costs were £7,489 million.

There are clearly material costs each time a general practitioner refers a patient to hospital. Each clinical decision has economic consequences. In this country doctors sometimes seem unaware of this, although in countries which operate billing systems, like the USA, there are now very considerable pressures to ensure that those people who take such decisions are aware of the costs they are generating. However, it seems that there are factors not fully understood which doctors take into consideration when referring patients to out-patient departments. For instance, a Scottish study showed that patients who lived within three miles of the hospital were twice as likely to be referred to out-patients as those who lived at a greater distance.[1] Our own work on the likelihood of hospital admission also confirms that the nearer you are to a hospital, the more likely you are to become an in-patient.

Figure 1 Hospital Patients, England 1984

	% of population	
New out-patients	18%	(1 in 5)
New in-patients	13.5%	(1 in 7)
New A & E attendances	21.7%	(1 in 5)

Figure 2 New out-patient attendances 1984

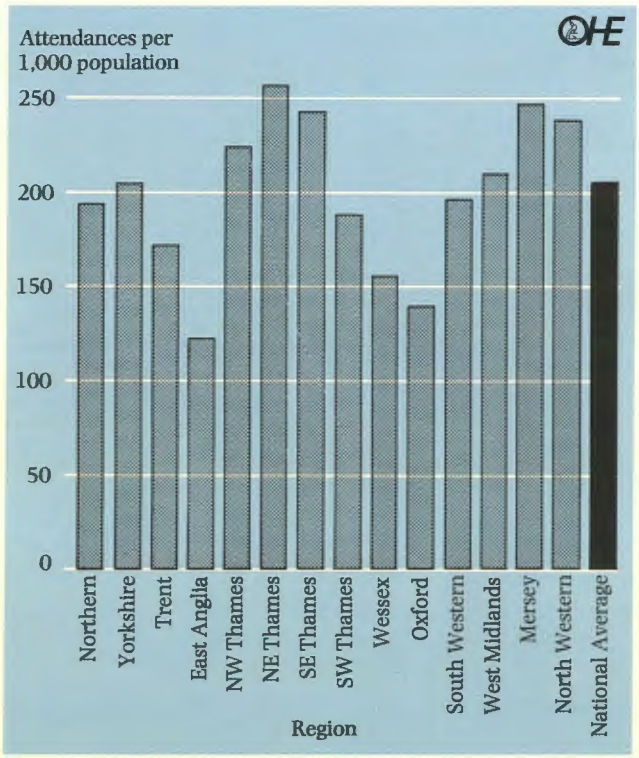


Figure 2 shows the variation in new referrals to out-patient's departments per thousand population by region for 1984. The number of new referrals has risen only slightly over the last two decades from 160 per thousand in 1964 to 180 per thousand in 1984. The number of doctors in practice has, however, also been growing – the effect being that each individual family doctor is now on average referring fewer cases than twenty years ago.

While the national average was 180 per thousand including cross referrals from consultants the highest regional rate was 225 and the lowest 154; in other words roughly one in four of the population of North East and South East Thames is referred annually, against one in seven of those living in Wessex. There are also variations in out-patient attendances by district and speciality, and significant variations can be found in the same speciality between districts.

At regional level the London regions are significantly above national average, and within each region one tends to find high rates in the conurbations and lower rates in rural areas. Oddly, this does not correlate with whether or not a hospital is a teaching hospital. Non-teaching hospitals in the middle of a conurbation have referral rates quite as high as the teaching hospitals. Although the West Midlands has a major conurbation at its centre, it has a comparatively low rate, which is probably associated with a long-standing shortage of hospital facilities which is only now being remedied.

National in-patient data reveal that an average of 131 admissions per 1,000 occur annually. The data currently available are relatively crude and do not enable us to determine how many cases are due to GP referrals, either urgent or routine, or are direct admissions from the emergency services. Since they only relate to each new in-patient episode, they do not associate multiple admissions for individual patients. However, when compared with out-patient referral rates the variation by region is less with the three lowest regions, Oxford and SW and NW Thames having an annual figure of between roughly 116 in-patients per year compared to North Western with the highest figure of 149. As could be expected, in general regions with higher out-patient referral rates have higher in-patient rates as well.

Figure 3 deals with Accident and Emergency attendances and in many ways reflects the contents of the previous Figure with a high rate of attendance in heavily populated conurbations. The West Midlands, however, makes extensive use of its Accident and Emergency services.

So far the Figures have referred to the hospital side of the equation, but the variations found in referral rates between individual general practitioners are far greater. One study puts this as much as 25-fold. All the research which has been undertaken confirms that wide variations exist within regions, districts and individual partnerships where close colleagues may behave in quite different ways.

Figure 3 **New A & E attendances 1984**

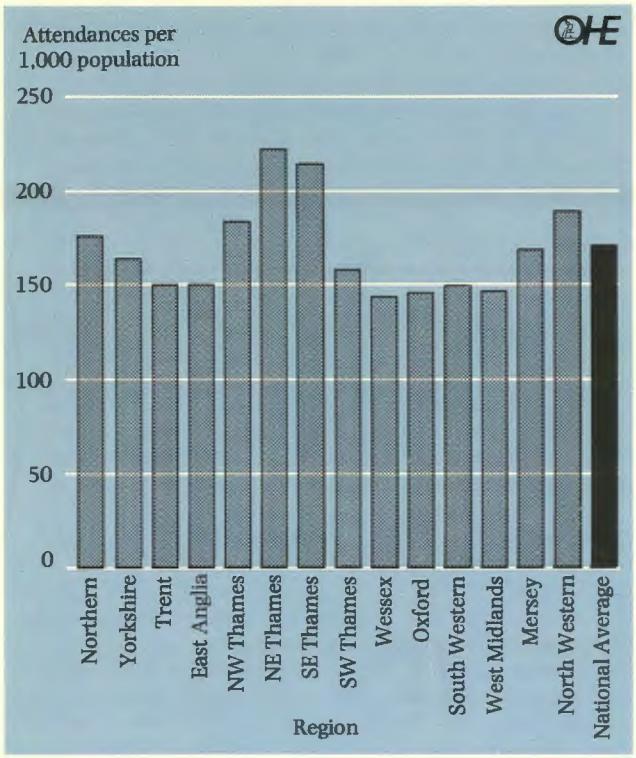
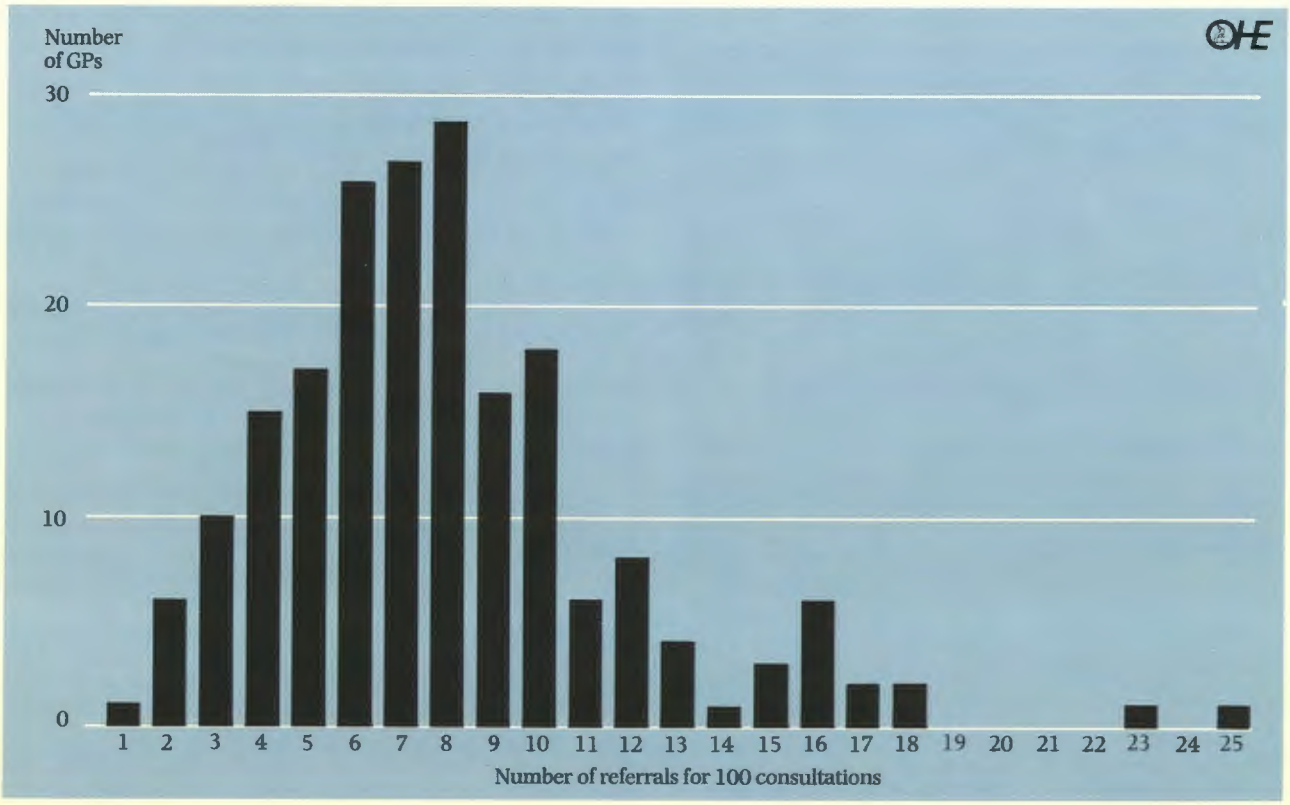


Figure 4 is derived from a recent survey of variations in general practice, undertaken by the Department of General Practice at Manchester University.[2] One of the areas examined was the referral pattern of local general practitioners, all in the urban area. 199 doctors participated and you can see how referral rates varied between one in 100 patients seen to one in four! This result is not entirely unexpected, for it accords with other evidence available such as Dr Crombie's study in 1984 which reported a difference in the referral rate between 6 and 22 per cent,[3] and an earlier study by Scott with rates of between 0.6 and 26 per cent.[4] This variation is hard to explain. Much work has been done in this area by Robin Dowie at the King's Fund and by Professor Brian Jarman.[5, 6] They have looked carefully at all measurable indices without finding any explanation. The age, sex, social class, problems and attitudes of the patient reveal little and neither has any correlation been found with the age, sex, training, locality or list size of the referring practitioner. The statistics probably reflect the innate habits and attitudes of general practitioners, and to some extent the tradition of hospital use which exists in an area. For many years some patients in inner city areas have turned to the hospital as a source of help in an emergency rather than to their GP.

Nevertheless we cannot ignore variation rates which may be 25-fold, for this has enormous implications for hospitals and for the costs of their services. One must ask whether some patients are receiving too much care – any form of medical procedure carries a risk as many studies have demonstrated. On the other hand, are patients who need specialist services being denied access because the doctors fail to respond to the needs of their patients?

Figure 4 **Referral rates of 199 GPs (Manchester, Salford & Trafford)**



This is an issue which I would like to see pursued further. There is an opportunity-cost to every unnecessary referral. Also, of course, there may be a cost to the patient of failure to refer. If we are to obtain the best from our health service we cannot afford to permit management by 'gut feeling'. We should be making doctors more aware of what they are doing, the costs of doing it, and challenging them when the variation in practice seems exceptional. I suspect that this is an educational matter, and it is not going too far to say that the health of the community depends on doctors learning more about how they themselves practice.

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The primary health care team

Ian Tait

Summary

In this paper I argue that the primary health care team can no longer be thought of as ancillary to the role of the general practitioner in our NHS but is becoming a powerful justification for his continued existence. The changes demanded of British general practice today, if it is to fulfil its full potential within the NHS, will, to an increasing extent, require that a number of people with varying professional and personal skills work together to achieve mutually agreed objectives for the care of a practice community. Our family doctor tradition, preserved by the structure of our health service, offers us a stem onto which we can graft an effective and extended system of community based general medical care: moreover a familiar one that has a 'human face'. This is I believe what our patients want and need. If this is so we should have nothing to fear for the future of the general practitioner, but it is a future set in the context of the primary health care team. All members of the team will need to develop new skills, new attitudes, new relationships and new ways of working together. It is now time to define what changes are needed, and how to achieve them. Because of his tradition of independent authority the doctor has a particularly important and, perhaps, difficult part to play in this process of change.

The team in primary care – historical background

Honigsbaum[1] has suggested that the main reason for the survival of the British general practitioner is the protection provided by our National Health Service. He points out that in systems of medical care where open competition between specialists and general practitioners is accepted, the tendency has been for general practice to disappear. Whether this would happen in Britain we do not know. But Honigsbaum is certainly right in pointing out that the structure of our health service has given to general practitioners a necessary and protected role as the patient's personal doctor, responsible for the provision of primary and continuing medical care. Indeed it is doubtful whether the true extent of the responsibilities given to general practice were fully recognised when our health service was introduced. It was often seen at that time as having its chief purpose as a filtering and referral agency for the all important hospital service – more in the nature of a civilian version of the casualty clearing station than the essential basis for a comprehensive health care system. Certainly the majority of the GPs at that time viewed their new role within the health service as unsatisfactory and unfulfilling, and even degrading. They regretted their past and despaired of their future. Collings[2] was one of the first to report on general practice in the NHS and to point out both its great potential value, and the troubled reality of its current state. In his influential paper – 'General Practice in England Today', he wrote 'In the course of this study I sought opinion from men long established in practice and from young men trying to enter it or make their way in it. The same sense of hopelessness pervaded both generations.' In his report he was at pains to point out that his primary purpose was to draw attention not to the present faults, but to the future potential of general practice. In his own words 'It is an appeal not to throw away what is good in general practice and relegate that part of medical care to the slag heap, but rather to use, reinforce, and bring up to date those good elements. General practice as we know it could if we wished, be converted into general practice as we like to imagine it.'

These words are as totally appropriate now as they were in 1950. We still have to achieve 'General practice as we like to imagine it'. In his recommendations Collings revealed a quite remarkable insight into the future role and needs of general practice, for my purpose I will quote two of his recommendations:

Firstly, and most importantly, he was long before his time in recognising the central place of general practice in the functioning of our health service. He saw that specialist medicine based on the hospital should be a background support and not the basis of our health service. I can do no better than quote him:

'We must reverse our thinking on hospitals and specialist services (medical and ancillary); instead of thinking how far we can build them up, we must consider how far we can dispense with them. For both human and economic reasons we should work from two premises:

1 As many people as possible should be kept out of hospital.

2 That the medical care of patients should be integrated not fractionated.'

Secondly, he was amongst the first to give public expression to the view that if general practitioners were to fulfil their potential role within the health service they would need to work in 'partnership' not only with other doctors but also with other professionals and ancillary staff.

A general recognition of this fact sufficient to begin to change the face of general practice was slow to develop. The reasons for this are complex but rested chiefly on the tradition of isolation of general practitioners and on their suspicion of local authority health services, and also on the financial disincentives to any improvements in their premises, equipment, or staffing induced by the 'pool' system of payment.

But changes did eventually occur with initiatives being taken sometimes by forward thinking GPs themselves, sometimes by external authorities or agencies.

In the following section of this paper I have selected some events or indicators that serve to chart the development of the primary health care team. Their relevance is generally self-evident but they are not intended to constitute an inclusive list of all the important events; rather they illustrate the importance of individual initiatives followed up by significant responses in health service policy and administration.

1948 NHS Act gave general practitioners a secure role as the primary and personal physician for all patients, responsible for their referral to hospital when necessary and for the life-long integration of their medical care.

1950 Collings Report (amongst others), revealed the inability of general practice to meet the demands made on it, but also recognised its potential importance.

1953 Foundation of the College of General Practitioners. During the early years of the college working parties produced and reported many new ideas for the development of general practice. Amongst these the concept of the GP working, and needing to work, with professional colleagues of other disciplines was advanced repeatedly.

1955–63 Slow increase in 'trial' schemes including the attachment of nurses and health visitors to general practice. Progress was limited by the guarded response of the majority of general practitioners.

1965 Ministry of Health gives official encouragement to the development of health centres owned by local authorities and leased to general practitioners with accommodation provided for local health authority staff.

1966 The Family Doctor's Charter negotiated and accepted. This laid the financial basis for the employment of ancillary staff by general practitioners. The resulting recruitment into general practice of receptionists and secretaries demonstrated to doctors the value of working with supportive staff, and changed their attitude to the attachment of nurses and health visitors.

1967 Conference of Health Visitors, General Practitioners, Midwives, District Nurses and Medical Officers of Health.[3] The term 'The team' seems to enter the professional vocabulary from around this time.

1968 Ministry of Health gives official encouragement to the attachment of health visitors, district nurses and midwives to general practice (Health Service and Public Health Act 1968).

1973 BMA set up panel to study and report on development of 'Health Care Teams'. Its report entitled 'The Primary Health Care Team' was published in 1974.

Sir George Godber opening the Middlesbrough Health Centre could remark that in 1954 only two practices in England and Wales had health visitors attached, and that in 1973 it was hardly respectable not to have one.

1975 onwards GP Finance Corporation and Cost Rent Schemes offered by Family Practitioner Committees provided finance to allow GPs to develop their own purpose-built practice premises which could include accommodation for employed and attached staff.

The present situation

The norm in general practice today is for the doctor to be in a partnership of variable size (3 to 5 most commonly). There is virtually always a support staff of receptionists, secretaries and sometimes a practice manager. Many practices also employ one or more practice nurses. The Community Health attached staff will normally include a district nursing sister, a health visitor and a nurse midwife. Some practices, though not yet the majority, have an attached social worker, and more rarely other professional staff such as clinical psychologists, counsellors, psychotherapists or physiotherapists.

In general it would be fair to say that in general practice today there are a lot of people around who are concerned in one way or another with patient care; whether they constitute a team is another matter, and one which we must now consider.

The term 'team' seems to have come into existence to describe an ideal rather than a reality. To a large extent I think that this is still true. The GP has been described as the leader of the team – more recently as the co-ordinator, but as Titmuss[4] has written talking of leadership in community care 'Let us remember that we do not make progress by substituting one big word for another. What seems to me to be essential is a careful and authoritative enquiry which would aim to define, describe, and classify the many different components of responsibility. Such an enquiry would have to take account of responsibility which relate, first, to the ascertainment and diagnosis of social and medical need, secondly, to the initiation of action to see that these are met, and thirdly, to continuity of action to see effective and co-ordinated use is made of the services available.'

The essence of this statement points to the need to define the task and then to decide who does it and how. In doing so it points also to the chief reason why, in spite of a dramatic increase in the size of the primary health care team, there does not seem to have been corresponding growth in the work achieved or the services offered. If we are to form a truly creative primary health care team a number of conditions will be needed to be achieved.

1 We must define the role of the team in relation to the total functioning of the health service. Such a definition must be explicit and agreed, not only by general practice, but by district and regional health authorities and by social services departments.

2 We must describe the specific tasks we wish individual members of the team to carry out.

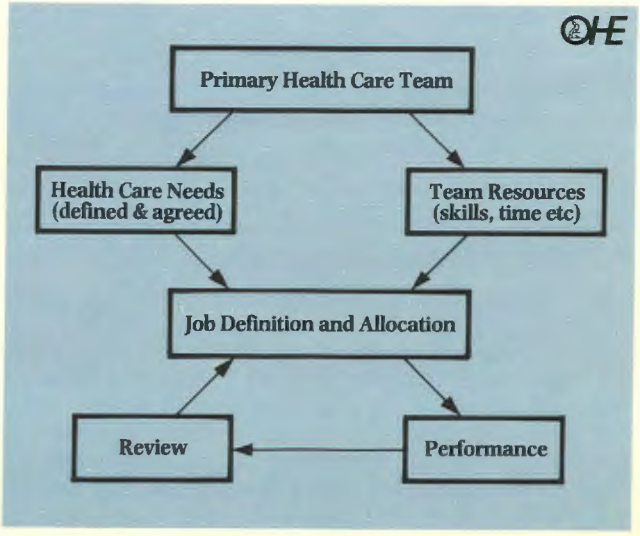
3 We should examine the resources both human and material available to the team. In this process we should press for the greatest possible flexibility in the use of the human skills both actual and potential possessed by members of the team. In this respect we need to be more task orientated and less role dominated. If someone can show that they are capable of doing a job, let them do it.

4 We must develop systems of shared leadership which encourage leadership from the right person at the right moment, and the capacity for all members of the team to respond to it.

5 We must develop effective ways of communication that are neither obsessively time consuming nor frustratingly curtailed, nor distorted by the inevitable quirks of our individual personalities. In this respect we should remember Butterfield's Law[5] 'All fragmentation of responsibility carry attendant communication problems'.

6 Finally all members of the team must be prepared to be assessed and sometimes criticised (of course constructively!) by their colleagues. A process doctors will, I suspect, find more difficult than most.

We could express this process diagramatically:



I have suggested that the future of general practice lies in its developing partnership with other professionals within the setting of the primary health care team. Further I would submit that only in this way can it continue to justify the faith and power placed in it, whether wittingly or unwittingly, by the creators of our health service. In this context it should be noted that it is already being challenged by the extension of hospital based services into the community. This may sometimes be desirable, but is nevertheless a fragmentation of medical care, and it should not happen merely because primary care appears unable to do the job. The primary health care team now needs to define the areas where new initiatives are required. It needs to demonstrate that it can indeed do the job.

Some of the areas where an extension of the traditional range of work of the GP is now badly needed and where the help of the team will be essential are for instance:

1 'Opportunistic' health screening and health education integrated with day-to-day medical care taking place in the surgery.

2 Better supervision of care in chronic disease.

3 Development of agreed protocols for the shared care of certain conditions with hospital departments (eg, diabetes, hypertension, asthma, acute and chronic psychiatric conditions and dementia in the elderly).

4 Development of systematic performance review for important aspects of practice activity both clinical and organisational.

5 Special health education aimed at specific 'at risk' groups.

6 Development of patient self-help or support groups.

7 Practice based counselling for problems such as death and dying, bereavement, situational crises, family and marital problems. A number of psychosomatic problems are also eminently suitable for treatment by counsellors attached to primary health care teams.

The list is already daunting and could be much longer. It is quite obvious that no single members of the team could cope with all these tasks effectively; they must be shared. The initiative and therefore the 'leadership' will need to be taken by different members of the team at different times and for different purposes.[6]

We recently devised categories to form the basis for a practice 'at risk' register. It fell neatly into an alphabetic form:

A Aged and alone

B Battering or violence in the home

C Care of the chronic sick at home

D Drug abuse (including smoking and alcohol)

E Employment problems related to health

F Family or marital strife

G Grieving or bereavement

H Housing problems related to health.

No-one with a knowledge of general practice could deny that these problems are everyday occurences in our practices, and that people falling into them often require help and supervision. But what kind of help and from whom? It is simply not realistic to think that the doctor could offer a significant contribution by himself; he has neither the time nor the training. But what about the primary health care team – well perhaps but who, and when, and how, are still very much unanswered questions.

Our next task, if the team is to become a functioning reality is to start to be able to ask and answer these, and many other questions. To do so will, I believe, require a greater sense of freedom and autonomy in the team. You cannot have a team some members of which are following instructions from a different coach or even the other side. To achieve this autonomy for the team will I suspect require changes in the way professional groups educate and organise themselves and exercise their power, and no-one should expect that to be easy.

One thing is certain: there is no way in which the general practitioner can meet the expectations of our society today other than in effective partnership with a range of complementary professional colleagues – whether or not you choose to call it a team is of little consequence. The important thing is that we continue to develop our own ways of working together. They will necessarily be different from those existing in hospital, or the social service department, or anywhere else; and, let us dare to say it – none the worse for that.

Leadership and the primary health care team

I have left to last a consideration of the nature of leadership in the primary health care team. Traditionally the doctor feels himself to be the leader of the team, but he has often little idea of what this really entails. In attempting to clarify this issue I think it is helpful to try to differentiate between – 'Authority', 'Leadership', and 'Management'. What do these concepts mean in the setting of the team, and what do they mean in terms of lines of command, the initiation of action, the definition of objectives and the setting and maintenance of standards?

Authority establishes a line of command. In the setting of his own surgery the doctor feels a natural sense of authority. Patients tend to invest this in him; to some of the team he is an employer, with the authority that that implies. Other attached members of the team are dependent on him for space, and other resources. This natural authority, resting as it does on a valued if exaggerated idea of his independence, is being eroded by many factors, but it is a tradition that is defended by most GPs, implicitly if not explicitly. It is likely to continue to exist, if only in the negative form of an extensive power of veto.

Leadership is, I like to believe, a more logical process and is best thought of in relation to specific tasks or objectives, which involve a number of people – a team if you like. Effective leadership initiates and sustains positive contributions to the task from any or all members of the team. There is an important complementary quality to leadership which might be called 'followship'. Good leadership is often made by good 'followship' – ie, by a positive response to the act of leadership. This is not just a passive process. Both are needed if the team is to be effective, both will need to be exercised by different members at different times.

Management. The idea that professional managerial skills should be applied in general practice is quite recent. Its encouragement by the Royal College of General Practitioners and by such bodies as the King's Fund is interesting and hopeful. Doctors are not on the whole good managers, if only because there is seldom time to be both a good doctor and a good manager. Practice managers have been accepted in many practices and have assumed surprisingly wide responsibilities and powers, relieving doctors of managerial tasks they had too little time to do properly

themselves. Good management is a catalytic activity. I believe it is a new factor in general practice which should be able to create the kind of organisation and methods of work within the health care team that will encourage the leadership needed for its future development. If so they are needed now.

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Changing workload and continuing care

David Wilkin

The most important and widely recognised 20th-century demographic change has been the shifting age structure of the population. The total number of elderly people increased from 2.1 million in 1891 to 9.7 million in 1981 and is expected to reach 10.3 million by 1991. As a proportion of the total population the elderly made up 6 per cent in 1891 and 18 per cent in 1981. At least as important from the point of view of morbidity and needs for health services is the increasing proportion of elderly people over the age of 75 years. In 1891 only 19 per cent of pensionable age were over 75 years, but by 1981 this figure had reached 32 per cent and is expected to reach 37 per cent by 1991.[1] One of the consequences of increased life expectancy is that more people are at risk for longer periods of time of suffering from a chronic illness and associated disability. The Economist Intelligence Unit[2] estimated that there had been an annual increase of 0.9 per cent in the numbers of disabled people and Wilson[3] showed a projected increase in the total number of handicapped people of 26 per cent between 1968/69 and 2001.

Distinctive feature of chronic illness

It is not only the size of the problem of chronic illness which makes it worthy of special attention in a discussion about future patterns of health service provision. It is also those features of chronic illness and its management which make it different from acute illness. In a health care system developed primarily to meet the needs of the acutely ill, it is important to examine the distinctive features of chronic illness and to assess how well the services are meeting the needs of these patients. Gerson and Strauss[4] have offered a useful discussion of the distinctive features of chronic illness which is worth summarising here. They suggest ways in which chronic illnesses differ from acute:

1 Chronic illnesses are long-term. The time scales for the treatment of acute illnesses usually span days or weeks, but chronic illness usually spans a number of years. Health care tends to be organised around relatively brief and discrete illness episodes, rather than long-term management of incurable conditions.

2 Chronic illnesses are uncertain. Not only is prognosis uncertain, but treatment and its effects may be uncertain as new drugs, surgical procedures, therapies, etc, are experimentally applied. Also, many chronic illnesses are inherently episodic in nature, periodic flare-ups being followed by apparent remissions or quiescent periods.

3 Chronic diseases require proportionately large efforts at palliation. Relief of symptoms and their effects on patients' lives can be more important than progress towards overall treatment of the condition.

4 Chronic diseases are multiple diseases. A single condition often leads to multiple chronic diseases as a result of systemic degenerative effects, greater susceptibility to other diseases and side effects of treatment.

5 Chronic diseases are disproportionately intrusive. The need to adjust to treatment regimes and the limitations on activity imposed by the illness imply an often radical reorganisation of the patient's life style, commitments and activities.

6 Chronic diseases require a wide variety of ancillary services. In addition to medical services chronic illness sufferers will often require social, psychiatric, educational, legal and financial services.

7 Chronic diseases imply conflicts of authority. There is a constant process of negotiation over the precise characteristics of the treatment regime, the interpretation of new symptoms, compliance, palliation, etc. This negotiation occurs between patient and professionals and between different professionals.

8 Chronic illnesses are expensive. Even where expensive technologies are not used, the need for routine monitoring, long-term drug use and extensive professional input makes caring for chronic illnesses expensive. But costs are not limited to services. The costs to patients and their families are often very high.

Patterns of care for chronic illness

At the same time as demographic changes and changes in the pattern of morbidity have been taking place there has also been a gradual shift of emphasis in policy with regard to the balance between primary and secondary care. This is most clearly apparent in the pursuance of policies of community care for people who are suffering from chronic conditions (eg, mental handicap, phsyical disablement, the elderly who are physically and/or mentally infirm). In part this has been prompted by humanitarian concerns that those suffering from chronic disabling conditions would experience a better quality of life if they remained living in their own homes, receiving care from local services rather than from large impersonal institutions. However, it can also be interpreted as a response to the escalating costs of providing hospital based care for an increasing number of people with chronic illnesses. The development of both the ideology of community care and the reality reflect a continuing tension between humanitarian values on the one hand, and crudely financial or organisational concerns on the other. Nevertheless, whatever the reasons, the past two or three decades have seen an important ideological shift which has emphasised the role of primary care in the management of chronic illness. In this shift, public and professional attitudes towards primary health care and general practice in particular have become much more positive. The recognition that health problems of the late 20th century require prevention, education and care, at least as much as treatment and cure, has lead in turn to a recognition of the key role played by general medical practice. It is arguable, however, that although some changes in practice have occurred these are by no means as dramatic as is sometimes implied in references to the shift from hospital to community.

Table 1 **Consultations and number of patients consulting per 100 population for selected chronic conditions (derived from 2nd National Morbidity Study 1971/72)**

ICD No	*Disease or condition*	*Consultations*	*Patients consulting*
240–246	Thyroid disease	10.0	3.3
250	Diabetes mellitus	19.3	4.7
274	Gout	4.3	1.6
290–299	Psychoses	28.1	6.3
300.0	Anxiety	79.4	36.2
300.4	Depression	107.6	36.2
345	Epilepsy	9.1	3.0
390–398	Rheumatic heart disease	4.4	1.2
400–404	Hypertension	22.3	20.2
400–414	Heart disease	53.0	4.7
430–438	Cerebrovascular disease	19.3	4.8
491–492	Bronchitis and emphysema	37.8	11.4
493	Asthma	31.9	9.6
712	Rheumatoid arthritis	16.8	4.5
713–Rem 713	Osteo-Arthritis	58.2	24.6

Table 2 **Annual prevalence of certain long-term diseases in a general practice with a population of 2,500 (Source: derived from Fry 1979)[20]**

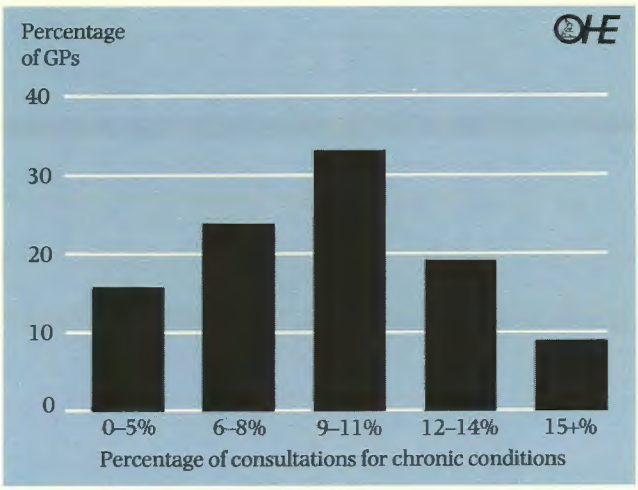
Disease	*Persons per year*
Chronic rheumatism	100
High blood pressure	100
Chronic mental illness	460
Coronary artery disease	50
Chronic bronchitis	35
Asthma	30
Diabetes	20
Epilepsy	10

Table 3 **Actions take during consultations for selected established chronic disease**

	Rates per 100 consultations		
	Prescription	*Laboratory investigation*	*Consultant referral*
Diabetes (N = 304)	76	14	5
Thyroid disease (N = 170)	74	18	7
Epilepsy (N = 177)	77	3	6
Ischaemic heart disease (N = 910)	74	1.5	4
Hypertension (N = 2346)	81	1.5	1
Asthma (N = 652)	80	1.2	5
Chronic obstructive disease (N = 521)	83	0.8	4

Our knowledge of the management of chronic illness in general practice is derived largely from the National Morbidity Studies supplemented by numerous small scale studies conducted by individual GPs in their own practices. Table 1 shows the consultation rates and patients consulting rates for selected diagnoses from the 2nd National Morbidity Study.[5] Whilst there is room for debate over which of these conditions might legitimately be described as chronic, it is nevertheless evident that long-term conditions made up a substantial part of the consultation workload in general practice. Table 2 provides an estimate of the annual prevalence of selected long-term diseases for a practice of 2,500 patients. This suggests that a substantial proportion of the total registered population will suffer from at least one long-term illness. The General Household Survey reports that 28 per cent of males and 31 per cent of females had a long-standing illness. However, global figures like those from the NMS and GHS conceal the considerable variation between doctors in the relative contribution of chronic illness to their total workload. Figure 1 shows, for 200 GPs who collected data on consultations in our own study of the process of care in urban general practice,[6, 7] variations in the proportion of total consultation workload accounted for by chronic illness. The range was from 1 per cent of consultations to 25 per cent. Even leaving aside these extremes, it is apparent from Figure 1 that the part played by chronic illness in total workload was extremely variable. Since the participating GPs were practising in similar areas it is unlikely that such wide variation can be accounted for by differences in the registered populations of different doctors. It appears that some GPs chose to devote much more time than others to the management of chronic illness.

Figure 1 **Consultations for chronic illness as a proportion of all consultations**

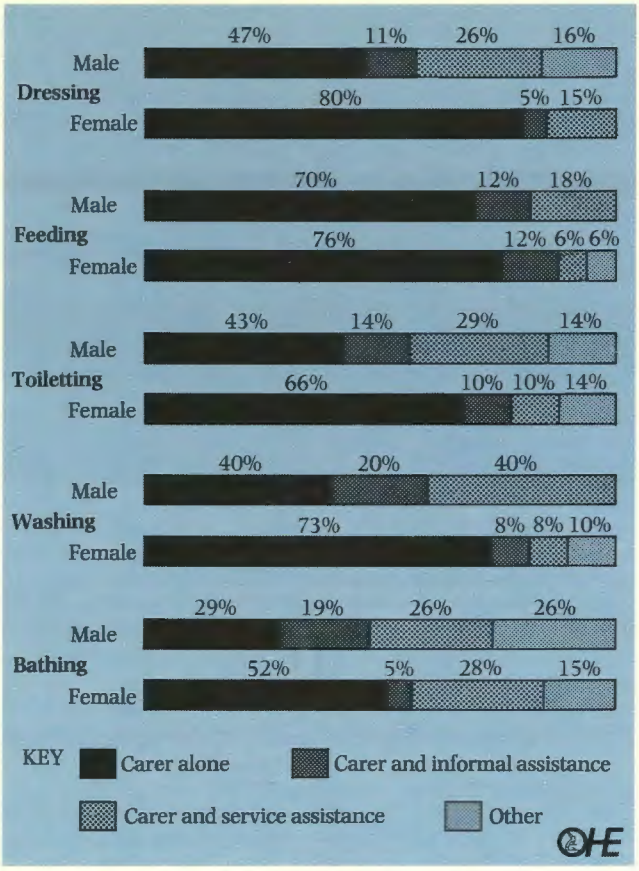


Note:
Consultations for the following diagnoses are included: Diabetes, thyroid disorders, gout, Parkinson's disease, epilepsy, multiple sclerosis, heart failure, valvular heart disease, cerebro-vascular disease, asthma, chronic obstructive airways disease, rheumatoid arthritis, osteo-arthritis, schizophrenia, dementia, other psychoses.

Our knowledge of the pattern of care provided by GPs for their chronically sick patients is limited to relatively crude data on significant 'events', such as the issuing of a prescription or the ordering of a laboratory investigation. Evidence from our own study for selected diagnoses is shown in Table 3. 'Event rates' are calculated per 100 consultations. Although prescribing rates might appear to be high, the average for established patients with these conditions was only 80 per cent compared with 89 per cent for new presentations of minor self-limiting conditions.[8] Few cases were investigated by GPs. The overall laboratory investigation rate for these conditions was 3 per cent, as against 4 per cent for all diagnoses. Whilst there is no universal agreement on the details of a monitoring policy for chronic conditions, it seems safe to say that the investigation rates for IHD, hypertension and epilepsy were very low. Relatively few patients were referred to consultants, but the referral rates to nursing and social services were lower still. Out of more than 5,000 consultations for the conditions shown in Table 3, only 11 referrals were made to nurses and 5 to social services departments. Lastly, it should be noted that there was enormous variation between GPs. Our data are insufficient to show variations for specific diagnostic categories, but overall prescribing rates ranged from less than 50 per cent to more than 90 per cent, laboratory investigation rates from less than 1 per cent to more than 12 per cent, and referral rates from less than 2 per cent to more than 15 per cent.

Despite the fact that the chronic sick make up a substantial and increasing part of the work of general practice, the care received from GPs is only a small fraction of the total care needed, and for many conditions much more care is provided from other sources. Chronic illness, by its very nature, generates needs for a wide variety of different forms of care. Where the illness gives rise to disability and disability to handicap, the need for medical care often becomes secondary to needs for many other forms of care (eg, social, functional, emotional, etc). In a study of 255 elderly people referred to geriatric, psychiatric and social

Figure 2 **Receipt of informal and service assistance with personal care tasks by sex of carer**



Source: Charlesworth, Wilkin and Durie (1984)[21]

services, we examined the relative contributions of different sources of support to personal care.[9] Figure 2 shows that, for those elderly people who needed help with those activities, informal carers provided most support. This was particularly true of women carers who constitute the mainstay of informal care in the community. The role of service support in managing the consequences of disability was relatively small. In the same study we examined the pattern of services provided in an 8 month period following initial referral. Table 4 shows the proportions of elderly people suffering from organic mental illness who received a variety of community and hospital based services. Whilst it is clear that the GPs continued to provide a substantial input after referral, these elderly people were also in contact with a wide variety of other services. These observations indicate that care is very much shared between informal networks and services between different services. It is, however, rarely co-ordinated and still less collaborative.

Good practice in the management of chronic illness

Hasler and Schofield[10] provide an excellent and up-to-date guide to good practice in the management of chronic illness for the general practitioner. Specialist authors deal with each of the major chronic diseases from diabetes to psychological problems. In each case, the chapters contain specific advice to GPs on diagnosis and assessment, treatment options, long-term management and health education. The

Table 4 **Percentages of elderly patients suffering from an organic mental illness having contact with selected services over an 8 month period**

	Percentage of patients having one or more contacts N = 60
General practitioner	77%
Community nurse	60%
Geriatric inpatient	43%
Geriatric outpatient	20%
Psychiatric inpatient	25%
Psychiatric outpatient	37%
Hospital social work	45%
Area based social work	53%
Home help	40%
Residential care	17%
Voluntary organisations	18%

emphasis is upon practical management which takes full account of the social, environmental and behavioural constraints which affect patients. Thus, for example, discussing the management of epilepsy, Lawrence[11] provides detailed advice on drug therapies and goes on to emphasise the importance of providing counselling to the patient and support to the patient's family. All of the authors emphasise the importance of regular follow-up and good records. Each chapter concludes with a performance review checklist which includes the need to have a practice policy for the management of each condition, identification of all patients suffering from the disease and methods for following-up patients on treatment. The GP is also alerted to the existence of patient associations and self-help groups which might provide additional support. Hasler and Schofield[10] themselves emphasise the importance of practice organisation in effectively managing chronic illness. They offer suggestions for improving record systems, setting up disease registers and recall systems, developing health education and making the maximum use of all members of the primary health care team. In short, this book provides an excellent summary of what general practice could and should achieve in the management of chronic illness.

However, one is left with the feeling that there is an enormous gulf between the standards advocated by the leaders of the profession and the pattern of care provided by the average GP. The nature and complexity of the needs of patients suffering from chronic illnesses and the wide range of potential sources of help in meeting these needs suggests that the management of chronic conditions requires a very different approach from that normally employed in the treatment of acute illness. A comprehensive knowledge of the patient and of the complex network of informal supports and formal services is required. Medical needs and the doctors who meet these are often only a small part of the total picture. The continuing nature of chronic illness requires a negotiated control of treatment and care which is not usually characteristic of care in medical settings. This process of negotiation should involve patient, informal carers and service providers. But the diversity of service providers makes this difficult to achieve unless there is some focal point.

The care manager role

The job of providing the links between service providers and between services and informal support networks might best be described as a chronic illness care manager. The basic elements of the role can be summarised as follows:

1 Collection of information for initial assessment
The establishment of an effective long-term management plan for many chronic illnesses requires a comprehensive and systematic initial assessment. This assessment will commonly include general health status, functional capacity, lifestyle, social circumstances and environment as well as the requisite technical tests and examinations. The type and amount of information required will vary for different conditions.

2 Negotiations of care regime with patient and other professionals
It is essential that one individual accepts responsibility for co-ordinating the efforts of the various service personnel who may provide care, and that the patient should be able to negotiate with one person, rather than having to cope with each separately. The care manager should be a focal point for the primary health care team and be available to provide advice and counselling to patients. It is essential that this process be one of negotiation between patient and service providers rather than an imposition of professional control. This may involve the care manager in negotiations with other providers on the patient's behalf.

3 Referral to appropriate individuals and agencies
In order to function adequately the care manager would need to be able to make referrals both within the primary health care team and to outside agencies. He or she would establish a wide knowledge of local service provisions and be able to make appropriate referrals in consultation with the patient and with other professionals. Such referrals should include hospital based services which are normally the province of the GP.

4 Education
Health education with respect to chronic illness should be the responsibility of the care manager. This should apply both to individual patients and to educational messages directed to the practice population as a whole.

5 Routine monitoring
Routine tests both for individual patients with established chronic illness and for screening purposes could be organised and conducted by the care manager. These would include blood pressure, urine tests, blood samples, etc. Where screening or case finding procedures are used the care manager should be responsible for ensuring that patients identified receive appropriate follow-up.

6 Practice organisation
A key component of effective management of chronic illness is the maintenance of an efficient record system. The care manager should ensure that comprehensive and up-to-date information is recorded and available to other professions providing care. At the practice level, disease registers and patient recall systems need to be established and maintained. The introduction of micro-computers into general practice should provide an opportunity to develop more efficient systems for the management of chronic illness.

In order to be effective it is essential that the care manager be based in the primary health care team. This is where most care for chronically ill patients is provided and it is the only base from which to mount a care system for a well defined and known population. But who should undertake this role? It should be apparent from what has been said already that it is not a role which can simply be added to the existing responsibilities of any member of the primary health care team. Even in smaller practices it would require a substantial additional input. Hasler and Schofield[10] imply that the GP provides the appropriate focal point for co-ordinating and managing continuing care for chronically ill patients, using other members of the primary health care team and consultants as appropriate. I want to suggest that the GP is not the best person to undertake the sort of role envisaged in this paper. There are a number of reasons for this:

1 Competence Some of the elements of the job are outside the sphere of competence of many GPs, (eg, design and administration of assessment instruments, management of record systems and recall systems).

2 Tendency to medicalise Many GPs tend to take a relatively narrow view of the problems presented by chronically ill patients. Problems which have very large social, economic and environmental components are treated as if they were solely medical.

3 Insufficient time Most GPs do not have sufficient time to be able to provide the input required for effective management of chronic illness.

4 Cost Even if ways were found of providing GPs with the time and additional training necessary this would be an extremely inefficient use of a very expensive health service resource.

5 GPs do not want to do it There is little evidence that the majority of GPs really want to develop their role as care managers. On the contrary, Pendleton[12] showed that both doctors and patients experienced most dissatisfaction in consultations for chronic illness.

In terms of existing members of the primary health care team, there seem to be two professional categories who might be expected to develop the role of care manager. Firstly, and most obviously, nurses (district nurses, health visitors, practice employed nurses) might be expected to be willing to develop such a role. Similar schemes developed in the USA have usually been explicitly designed for nurses.[13, 14, 15, 16] Additional training would be necessary, particularly in the fields of counselling and administration of record systems. With perhaps slightly more retraining, existing practice administrators might be considered as a second category of potential recruits. Not only do they have intimate knowledge of practice record systems but they also have close working relationships with all members of the primary health care team. It should be remembered that practice administrative staff already act as a point of first contact with the practice for patients and that there may be scope for extending this role.

Whoever fills the post of care manager it is important to develop the role in such a way as to retain the advantages of the flexibility which general practice has. Within broad outlines it should be possible to develop the role to suit the needs of the particular practice, the members of the primary health care team and the background of the person appointed. The development of a set of criteria for cases to be referred to the care manager, powers of decision making and scope of activity should depend on the particular circumstances and be subject to renegotiation. It would be important to establish agreed criteria for routine management, health education, case review, etc. Posts might best be financed in the same way as ancillary support in general practice (ie, employed by the practice but supported by FPC reimbursement). However, it should be emphasised that the care manager is not ancillary to medical staff and that this would need to be recognised at the

level of remuneration. The proportion of the total cost which might be met out of the income of the practice would need to be considered. The employment of a care manager might be expected to relieve pressure on other members of the practice, particularly the doctors, and thus enable them to care for a larger number of patients in total. There is some evidence from American studies that practice nurses can undertake work normally undertaken by physicians.[17, 18] Even if there was no reduction in the workload of other practice staff the pressure to reduce list sizes to cope with the increasing burden of chronic illness would be substantially reduced. To the extent that the introduction of care managers would involve additional resources, it would be essential to link these to indicators of performance. At present, additional payments for patients over 65 and reimbursement for practice staff are not directly linked to performance.

A key feature of any development should be the establishment of effective record systems to permit the identification of chronic ill patients and routine checks to review performance. These might be developed in such a way as to facilitate the collection of routine information for the Family Practitioner Committee. It should be possible to ensure in this way that reimbursement of salaries for care managers was linked to the achievement of agreed criteria for the management of chronic illness.

Conclusions

I have argued in this paper that chronic illness differs in most important aspects from acute illness, and that its management therefore requires a very different approach. Existing patterns of care for chronically sick patients are, at best, extremely variable, and in many cases inadequate. There is a high level of agreement between GPs and specialists concerning the components of good practice, but, unfortunately, there is little evidence that these standards are widely applied in general practice. Many GPs feel that only through a reduction in their present workload would it be possible to provide a higher standard of care for chronically ill patients. Such feelings are translated into calls for further reductions in the average list size. However, our own evidence[19] suggests that the relationship between workload and list size is by no means simple, and that further reductions in list size below the present average (approx 2,100) will not necessarily result in more time being made available to patients in general or chronically sick patients in particular.

I have suggested that the effective management of chronic illness in a primary care setting might best be achieved by developing a new role of care manager. If we recognise the different needs of those patients suffering from long-term diseases which are not amenable to treatment and cure, there is a strong case to be made for alternative sources of care. This is not to suggest that care should be removed from a general practice setting, rather that the role of the primary health care *team* should be strengthened. The changes proposed would substantially alter the roles of existing members of the team. This could not be achieved without challenging existing status hierarchies, responsibilities and decision making powers. These are not challenges to be undertaken lightly, but it is difficult to envisage how any great improvement in the care of chronic illness might be achieved if they are not tackled. Hopefully, the long awaited Green Paper will provide an incentive to open up debate on such issues.

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Changing patterns in general practice education

Marshall Marinker

Summary

I shall begin this review by looking at the different but complementary tasks of training and education, and suggest that there is a dangerous imbalance in favour of training over education, particularly in the medical school. By suggesting that the development of academic general practice can be understood as a freedom movement within medicine, I shall trace the recent history of the subject and show that accepting dependency and vulnerability is an inevitable and desired outcome of so called independence. Lastly, I shall suggest that the future development of training in and for general practice must bring together a number of aspects of medicine which hitherto have not always appeared to be intimately connected: the care of patients: the processes of learning; research; ethical values and medical politics. All of these are subsumed in the idea of medical audit: the setting of standards and the monitoring of performance.

Introduction

The present meeting is planned as a follow-up to the discussions at Cumberland Lodge some two years ago. We were then speculating on 'A New NHS Act for 1996?' In my own contribution[1] to that meeting I made the assertion that medical education was perhaps 'the strongest and most insidious impediment to the further development of general practice'. Let me try to summarise some of these impediments.

There is a major and widely recognised gap[2] between the General Medical Council's intentions for basic medical education and the reality of what is taught and experienced in the medical school. Much of this teaching is driven by the service and research pre-occupations of specialist departments. Attempts at integration, at presenting a coherent picture of medicine are lost in a curriculum bargained for like a series of composite motions at a political congress. The support which the National Health Service gives to the university medical school is almost entirely confined to enhancing the resources of specialist departments in the teaching hospital. Logic of course suggests that the National Health Service would wish to see a medical education designed to enhance the effectiveness and efficiency of generalist primary care. The fact that this does not happen, that precisely the opposite happens, is not a matter of bad faith or bad judgement. It is simply that almost all the traditional links between the National Health Service and the university are fashioned to strengthen the teaching hospital.

Despite the excellent and still relevant arguments of both the Todd and Merrison Reports,[3, 4] we have still failed to produce a postgraduate general professional training. How close the profession is to abandoning this concept was made clear in the General Medical Council's discussion document on basic specialist training.[5] General practice, however, in its three-year vocational training schemes has produced an admirable model of such generic training. Most future specialists would benefit from such experience. But by the same token it is folly to regard as adequate a three-year training period, only twelve months of which is spent in the discipline for which the training is intended. Vocational training, much of which is concerned with remedial teaching, now provides a minimum pre-requisite for entry into general practice. Indeed the Royal College of General Practitioners accurately describes its MRCGP examination as an assessment of the content of vocational training, not of the performance of a general practitioner. The college argues, therefore, for a period of higher professional training during the early years as a principal.

The theme of my earlier paper[1] was the accelerating change in bio-technology, in the structure and function of society, and in the nature of the medical profession. If medical education seeks to accommodate to and to accomplish these changes, reform will need to be radical, and on a wide scale. Precisely because general practice is unencumbered by the massive structures of the universities and their teaching hospitals, precisely because vocational training for general practice is so much briefer, less rigorous and less technical than that for the hospital specialties, the opportunities for experiment and growth are great.

So far I have carelessly used the words training and education as though they were synonyms. But they are not. Indeed it was misleading to suggest that any system of medical education could actually impede the development of general practice. It is the predominance of training over education in the medical school and beyond which impedes change.

Education and training

Training is concerned with learning to perform specific tasks. We are trained to diagnose thyroid disease, how to prescribe for the condition, how to monitor its progress and so on. We extend the idea of training from a preparation for specific tasks to preparation for a defined role. For example we talk about vocational training for general practice.

We cannot, however, train or be trained for an undiscovered task, or for a role which has not yet evolved or been invented. It is education which prepares us for the unexpected. It is education which allows us to create new tasks and new roles. Education is concerned with the development of both our intellectual and our moral capacities. It can stimulate us to use our creative imaginations, and to subject that imagination to rigorous examination. It can also compel us critically to examine the moral component of our actions. It allows us to identify the moral questions posed by the profession of medicine, and gives us some understanding of the human values implied by the answers.

Wright[6] suggests that education provides the major component of the undergraduate phase of the doctor's learning, and that training provides the major component of the postgraduate phase. Our experience so far in vocational trajning for general practice suggests that this model may be misleading. Current vocational training is much concerned with modifying the attitudes of the trainee – in particular attitudes to the pursuit of diagnosis, the goals of treatment, the expectations of the doctor/patient relationship and the commitment to the community. These changes in attitude are matters not of training but of education. Unless we can both prepare doctors for the changes to come, and prepare them to take part in the creation of these changes, those whom we now seek to educate will become the servants of an ungovernable bio-technology, and the reluctant functionaries of a dispirited medical bureaucracy.

The superstructures of medical education, our knowledge of diseases and therapy, our skills in decision taking and communication, the relationships which we form and the ethical dilemmas which we recognise, all rest on a massive bedrock of values and beliefs which for the most part are only implied by medical teachers. So powerful are the changing patterns of general practice education, that this bedrock of values and beliefs becomes increasingly exposed and compels exploration. For decades the tech-

nical dimension of training has been at the centre of our concerns. Now the ethical dimension of medical education will challenge us increasingly, and will force a re-arrangement of our educational priorities.

1945–1985

The starting date of my modern history is almost arbitrary. It predates by three years the inception of the National Health Service, and by seven years the self-conscious renaissance of general practice marked by the establishment of the College of General Practitioners. But 1945 was the year in which the British Medical Association formed a committee under the chairmanship of Henry Cohen to report on the medical school curriculum. There were twenty-one members of the committee, three of whom were general practitioners. Of the seventy-eight luminaries acknowledged in the published report, two were general practitioners. I do not quote these figures in order to question the quality of the report. I do so only to remind the reader of the assumptions about general practice made by the medical establishment not so very long ago.

As for general practice as a component of the undergraduate medical curriculum, 'The Training of a Doctor'[7] gives serious consideration to this novel idea and even explores two possibilities. The first is that general practitioners might themselves become members of the teaching hospital staff and so teach about general practice aspects of the patients encountered there. The second was that medical students might actually visit general practices to receive instruction. Both of these ideas were rejected: the first on the grounds that 'it may be difficult to find a sufficient number of really suitable general practitioners who had developed the broad outlook desired and to have in addition the ability and inclination to teach'; the second on the grounds that 'the demand made on the practitioner would be severe . . . and in busy times it would be a drag on the practice'. The clinching argument was that 'a great part of the value of a good general practitioner lies in the wisdom which comes from long experience; experience teaches slowly and wisdom cannot be rapidly communicated'.

I quote these exclusions and rejections of general practice in the medical school only as historical facts. These were the understandable views of the times, and here I am concerned only to remind the reader again about the rapidity of change. In many other ways the Cohen Committee Report was forward looking, reformist and remains relevant to us now. The idea of university chairs of general practice and a Royal College might have seemed bizarre to the writers of that report: and yet I believe that the educational approach of all our current university departments of general practice and every educational policy of the Royal College, are consonant with the spirit of 'The Training of a Doctor'. The reason for this may not be hard to find. In 1945 the rise of specialism in the teaching hospital had not yet been matched by the decline of generalism. And it is the spirit of generalism in medicine, the intellecutal discipline of the generalist approach, the scale of values implied by it, which inspired the Cohen committee and continues now to inspire the academic development of general practice.

In 1950 a second committee chaired by (then) Sir Henry Cohen considered 'General Practice and the Training of the General Practitioner'.[8] There were thirty-three members of this committee, and this time nine of them were general practitioners. They recommended a three-year period of training, but specified only one year in resident hospital appointments. They recommended that any general practitioner who had been in independent practice for not less than five years should be permitted to train.

Nothing was said about the quality of the trainers, nor of the teaching practices. By contrast it was recommended that hospital appointments should take place 'predominantly in hospitals of the Regional Hospital Boards'. And yet this report contains statements which we might look for in vain in the dry documents of contemporary reports. Commenting on the general practitioner's reading, the report states 'communion with the great poets and dramatists and philosophers can bring, as can no other medium, consolation and mental refreshment after the day's toil and can firm the practitioner's faith in the human spirit'. Many of their recommendations sound avant-garde by the limited standards of today's rigid, conformist and hospital orientated three-year vocational training schemes.

These two BMA publications stand like sentinels at the beginning of the modern history of general practice. In some ways we are only now catching up with some of their ideas. In the decades which followed their appearance, general practice and perhaps even more important thinking about general practice has changed dramatically. I want to suggest that already this accelerating modern history can be described in three epochs. All historical classifications are untidy, arbitrary and general. They are marked by changes in social conditions, the march of technology, the development of institutions and the force of individual personalities. I call the first epoch Colonialism, the second Separation, and the third Independence.

Colonialism

The structure and intentions of the National Health Service rest on important assumptions about general practice. In order to contain the high cost of hospital/specialist services, the majority of health problems must be dealt with effectively and efficiently by an open access, low technology, high quality generalist service in the community. But the coming of the National Health Service both created and revealed a low ebb in the self-image of general practice. I have called this epoch Colonialism because so much of the literature of the time reveals general practice as a difficult to govern colony, distant from the motherland of the teaching hospital. The renaissance of general practice, including the building of a college and the drive to create a university presence, resembled nothing less than the attempt to build a Westminster (Palace and Abbey) on some distant wild terrain.

In many ways the scene was set by the report of the second Cohen Committee. In considering the general practitioner as a postgraduate student, the committee report urges 'organised instruction' (by his specialist colleagues). In support of this the report lists a series of complaints. The dermatoloist writes '. . . (the practitioner) seems unable to recognise the elementary lesions which are the very foundation of all dermatological diagnosis'. The pathologist writes 'the majority of general practitioners are unacquainted with modern methods'. The ophthalmologist and the venereologist make similarly damning statements.

And what defence was voiced from the colony itself? Most of the quotations from general practitioners reveal self-doubt, plead exhaustion and beg for a spell of leave back home. One general practitioner writes of the need to keep 'up to date' as medical science advances, 'either by reading or by attendance in hospitals', and the imperative 'to keep his clinical outlook up to the same high academic

standard that it should have been when he left hospital'.

Most revealingly, one writer hopes that organised instruction will provide help 'particularly in the drudgery of dealing with the vast amount of common, minor and chronic illness'. Much of the general practice literature in the 1950s reflects this colonialist approach. Journals like *The Practitioner* carried the good news from hospital to general practice. The epoch is dominated by assumptions about the future of specialism. Again the report of the Cohen Committee is revealing. In looking at the advantages of the clinical assistantship, the report notes that it 'may also be the means of bringing to the notice of his specialist colleagues and teachers a first class general practitioner who aspires to specialism'.

Even the contemporary architecture of medical education gives the game away. Instruction was to take place in the new Postgraduate Medical Centres which had excellent library facilities and a large lecture theatre designed for the showing of slides and the holding of clinico-pathological conferences.

Of course, as in any colony, independence movements were stirring. In respectable Sloane Square, John Hunt and his colleagues were forming the College. In bohemian Belsize Park, Michael Balint and his colleagues were talking radically about a different sort of education, and a different sort of research. In 1957 Balint[9] described the relationship between the general practitioner and the consultant as 'the perpetuation of the teacher/pupil relationship. The general practitioner looks up with ambivalent respect to the consultant'.

This ambivalent respect was the hallmark of the colonialist era. When it came to an end much was gained and yet something also was lost. As with so many post colonial states, in the early years of separation there was a conspiracy to deny the virtues of the occupying power.

Separation

The independence movement was spectacularly successful. In the course of the 1960s and 1970s general practice became an attractive career, in terms of status, morale and even financial rewards. The Royal Collge of General Practitioners became a powerful partner in the government of medical affairs. University departments of general practice, or at least precursor units, were established in almost all the university medical schools. Regional advisors were appointed throughout the UK, an upwardly mobile population of course organisers and trainers developed vocational training to the point when it would be made mandatory. Looking back, there is something almost breathtaking about this epoch. It is in this epoch of Separation that we first begin to experience the pressures of acceleration.

There were two major springs of change in general practice education. Both derived from new departures in research. First the development of techniques for measuring morbidity in general practice led to the National Morbidity Survey.[10, 11] These quantified for the first time the spectrum of medical problems encountered in general practice. This was a very different spectrum from that encountered in the hospital.

The second point of departure was not quantitative but qualitative. Published work from the early Balint seminars suggested dimensions in the doctor/patient relationship, aspects of night calls, asthma, school absence, patients on long-term medication which were of an entirely different order from anything hitherto discussed in medical education or research.

These two influences are most sharply revealed in what was the most influential publication of this epoch, 'The Future General Practitioner: Learning and Teaching'.[12] This publication set the seal on a distinctly general practice approach to clinical medicine. In earlier reports the curriculum for vocational training was largely described in terms of specialist subjects: gynaecology, paediatrics, minor surgery, psychiatry and so on. It is difficult now to recapture the sense of surprise, sometimes of outrage, when the diagnosis and management of diseases were relegated by the authors of this report to only one of five areas of knowledge, skills and attitudes. Human development; human behaviour; medicine and society and the management of the practice were given equal weight. It was not that 'The Future General Practitioner' set out to suggest that clinical medicine was no longer central to the work of the general practitioner. Quite the contrary. It was simply that the clinical medicine experienced by the general practitioner was subtly different from that experienced in the context of the teaching hospital.

Although addressing the tasks of vocational training 'The Future General Practitioner' was much more concerned with education than with training. It may be a matter of more than anecdotal interest that the twelve goals of vocational training were actually derived from a similar list of goals devised in 1970 for a course in general practice at St Mary's Hospital Medical School. Indeed much of the content of 'The Future General Practitioner' was derived from the perceived shortfall between the goals of basic medical education, and what was actually being achieved at the time. The second Cohen Committee had already predicted this dilemma for general practice. The report stated 'only when the undergraduate curriculum is re-modelled . . . can postgraduate education take its true place in the practitioner's life'.

Not only the content but also the methods of teaching and learning were changing. The general practitioner's consultation now became both the subject and location of the doctor's education. Increasingly the experience of the trainer/trainee/patient relationship was explored in small group discussion. This was the epoch of the Manchester University trainers courses,[13] and the London Teachers Workshop[14] soon to be followed by scores of highly individual trainers groups around the country. In the early 1970s the Nuffield Project[15] would deeply influence the development of regional advisers and course organisers.

There are two facets of this teaching and learning which caused much concern at the time, and which now deserve special comment. First, language; second, the relationship with specialists.

In common with other separatist movements, this one seemed to need to develop its own vocabulary and imagery. In part this reflected a need to find descriptions for aspects of professional work which hitherto had been either ignored or simply taken for granted. As a pre-condition for critical thinking, the familiar must sometimes be made to seem unfamiliar. Unfamiliar language can therefore be helpful. Also because a separatist movement needs to signal its separateness, a private and esoteric language can create the necessary shibboleths. The behavioural scientists and the educationalists were on hand to oblige. Much of the literature of those decades speaks to us in the stilted language of these social and behavioural scientists.

As we become more confident now about our subject, that rhetoric sounds increasingly like the jargon of a misspent youth. There was, however, a price to be paid. Many of the opponents of the new separatism, many general practitioners who themselves longed to return to the old

colonial status, found it easy to attack the ideas by simply attacking the jargon. It was, however, the ideas which mattered, and which have survived the temporary assaults on the English language.

It is unusual to bring about a revolution without excess. We were, I believe, excessive in our zeal to separate from our specialist colleagues. There was of course something exhilarating about routing the redcoats. In consequence, something valuable in the traditional teaching of medicine, not least in the often crucial contribution which can be made by specialists, was temporarily lost. But this may have been an essential pre-condition of breaking free.

'The Future General Practitioner', the London Teachers Workshop and the Nuffield Project are only a dozen years away. Yet already they seem to have acquired an antique patina. We have entered the third modern epoch.

Independence

There is danger in coining the term Independence for the current epoch. The printed word cannot be relied upon to do justice to the sense of irony and uncertainty which should accompany it. When freedom fighters form a government they become accountable in a new sort of way. Most revealing of all, the experience of independence forces us to see just how inter-dependent we really are. This will certainly be true in general practice as we begin to create a new relationship with one another, with our specialist colleagues, with colleagues in nursing and social work, with patients and with government.

The epoch has still to discover its own identity. Landmarks have already been created, but it is still too early to judge their importance. However, the roots of this new independence can be traced back to three major influences. The first was the publication two decades ago of a symposium on The Team,[16] followed by a number of important multi-disciplinary workshops in primary health care, held at Cumberland Lodge. The second, the growing influence of Avedis Donabedian's scholarship of medical audit,[17] and its impact on health services research in general practice. The third, the habit of visiting (in less cautious times the word might have been inspecting) general practices as a means of selecting trainers, and later as part of regional visits by the Joint Committee for Postgraduate Training in General Practice.

All of these influences began to focus our attention on the practice as a functioning unit and on the services which it provides, their quantity and quality. This has had a transforming effect on general practice education. In place of a preoccupation with behavioural objectives we began to specify the tasks which the practice must accomplish for the individual patient, and for its community of patients. Whereas before we had organised these objectives into broad areas of knowledge, skills and attitudes, now we became interested in specifying competences and the professional values which underpin them. When we came to talk about methods, the emphasis shifted from small group discussions and personal tutorials to the setting of standards and the negotiating of policies. As for assessment, in place of multiple choice questionnaires, problem oriented essays and *viva voces*, we now become interested in audit, in the monitoring of our performance.

Items of medical audit began to replace behavioural objectives as the gold standard of general practice education. This was not simply the adoption of another fashionable language. In a sense it could be said that in the recent past the perceptions of social psychology, sociology and educational psychology did nothing to change the practice of medicine: they simply served to describe the already familiar in a new language. The perceptions of medical audit do far more than this: they actually transform the practice of medicine itself.

The consequences of this shift of focus are only now becoming apparent. For example, the Joint Committee in its guidelines to those who visit teaching practices, enjoins the visitors to concentrate on the quality of the clinical work, programmes of anticipatory care and organisation in the teaching practices. Apprenticeship is thus seen as having a new authenticity, and this redefines the trainer/trainee relationship.

But the perceptions of medical audit spell also the end of the general practitioner's isolation. If we are going to elaborate good clinical standards, general practitioners and their specialist colleagues must work together. Indeed, all the members of the primary health care team will need to become involved in the setting of standards, the choosing of priorities and the monitoring of performance. We now have to move beyond the past rhetoric of team work to a new and perhaps painful reality. In all of this general practice will become an increasingly pro-active service. To what extent it can also continue to be a demand led service, still remains to be seen.

What are the important publications of this current epoch? The long-awaited government Green Paper on the Family Practitioner Services may still prove to be the key document. But there are already a number of rival claimants. The recent publication of the College's 'What Sort of Doctor?'[18] experiments describes and elaborates a framework for performance review, and a methodology based on the practice visit. This challenging form of audit has already been accepted by general practitioners in the Oxford Region, as part of the process of trainer selection. There is of course a strong motivation: the position of trainer carries considerable status within general practice, and it has been calculated that a trainee may be worth some £10,000 per annum, to his/her training practice.

The College's 'Quality Initiatve'[19] stated that all general practitioners should create and monitor standards of care, and should inform their patients about the range of services which the practice provides. Within two years this was followed by 'Towards Quality in General Practice'[20] whose policies now unleash a new political imperative. Among many re-statements about the College's intentions in education and research, this document gives a new emphasis to the development of standard setting and performance review. The College is pledged to further research into more reliable and valid tools for the measurement of performance. Henceforward, performance review will be developed as a major framework for continuing medical education. It is to be seen as an integral component of patient care. Measures of performance are to be used in assessment for both membership and fellowship of the College. Most radically, the College urges the DHSS and the GMSC to devise a new generation of NHS contract for the general practitioner, which will link performance and rewards.

It is this latest element, adumbrated in my 1996 paper,[1] which points the most intriguing future. If such a contract is negotiated, time and resources for continuing medical education will be seen at last to be inseparable from time and resources for the care of patients. If the rewards are substantial (as they should be) this mode of continuing medical education will become self-financing. Monetary rewards alone will not engender the changes which we seek. In industry money is regarded as an indifferent moti-

vator, but an important 'hygiene' factor. Devising realistic and relevant goals for health care, and demonstrating that these goals have been achieved will satisfy the intellectual and moral ambitions of a generation of general practitioners increasingly confident of their role. That is the power of a performance sensitive contract.

We have, I believe, embarked on a perpetual vocational training for general practice. It is the practice itself which becomes the subject of this study, and the place where it is studied. No single teaching method will suffice, and it is unlikely that one will predominate. Personal study, perhaps computer assisted learning, will enable the individual doctor to remain informed about current standards. Small group work, not least case discussion, will allow an exploration of those policies which are suggested by the results of good empirical research; they will highlight the value of logical argument, and they will pin-point those decisions and actions which to date can only follow on belief.

A number of initiatives point the way ahead. For example, a study of clinical standards in general practice, now being carried out in the Northern Region[21] will seek to demonstrate the value of standard setting by small groups of general practitioners, and will include an evaluation of the contribution that can be made by specialists. Currently proposals are being drafted for studies of 'What Sort of Doctor' as an instrument for change in general practice. Project work in vocational training has been given an important impetus by the College's Syntex Awards. The scale on which these projects are being carried out is impressive: for the past two years there have been over one hundred prize winning projects to be assessed for national awards. The quality of this work is encouraging.

Leadership

A new generation of leaders will be required, as this new epoch unfolds. These new men and women will, for example, need to break free from many traditional assumptions: for example, the assumption that medical education and medical politics are separate activities. The MSD Foundation has developed a Leadership Course[21] designed for general practitioners, who are beginning to provide professional leadership both locally and nationally. The Foundation has already been commissioned by ten UK regions, and offers an intensive two-year programme of personal and group development, aimed at enhancing the contribution of the course members to the quality of primary health care.

In preparing and resourcing these courses two major areas of concern have emerged. The first related to the competencies of performance review. Elsewhere[22] I listed these as:

1 determining what aspects of current work are to be observed and measured;
2 measuring present performance and trends;
3 determining priorities in terms of what is to be changed;
4 negotiating these priorities with colleagues, including colleagues in other health care professions, and with client groups;
5 developing specific standards of care: this will include an evaluation of the results of good empirical research and logical argument where objective evidence for choices is scant or absent;
6 negotiating these standards with colleagues;
7 monitoring and controlling these standards;
8 deciding about the frequency of review;
9 deciding about the range, categories and numbers of standards to be subjected to medical audit;
10 deciding about intra-professional and public accountability;
11 exploring the values which underpin our choices: these values will touch on public and private morality; the personal and public cost of health care; specific cost effectiveness; the quality of life and so on;
12 resolving the many conflicts which arise from the expected variety of values expressed and beliefs held.

These tasks require not only a penetrating search of the literature of general practice, but the development of a strong critical faculty. For example, in deciding upon a clinical standard, the groups have to distinguish between opinions based on the results of good empirical research; opinions based on the application of scientific principles and logic, and opinions based on opinions. It is not only critical thinking, however, which must be developed. The imagination must also be developed, so that new structures and functions can be created in general practice, to meet new and unforeseen situations.

The second area of concern revealed by the foregoing lists of tasks, is the emotional cost. The pursuit of these new professional goals can set up turbulences in the relationship between the general practitioner and his family; between partners within the same practice; between practices and between doctors and other members of the primary health care team. Marriages, partnerships and even professional organisations can all show the strain.

In particular the problem for general practice partnerships can be formidable. Essentially it seems that partnerships are created in order to share resources, to achieve time off and to divide the profits of the enterprise. Some partnerships are also real friendships. Others are marriages of convenience. Some appear to be playgrounds, others are battlefields. But the introduction of performance review transforms the partnership into a learning group. A number of new instruments are being introduced, which can help to bring about this transformation. For example, the construction of a practice annual report not only summarises performance, but invites the members of the team to be explicit about what it is they are trying to do and about the direction in which they wish their practices to move. And this is only the beginning of the story.

I suggested earlier that the experience of independence brings a realisation of interdependence. The Northern Region study suggests that consultants and general practitioners can form a new relationship, very different from the pupil/teacher relationship described by Balint. By the same token, the two years of preparatory work for the ill-fated Primary Health Care Unit in the Open University, showed those of us involved that general practitioners, nurses, health visitors, social workers and educationalists could work creatively together. In the future the MSD Foundation intends to experiment with programmes which simultaneously involve all the health care professionals concerned: consultants, general practitioners, nurses, health visitors, social workers other therapists working in the hospital and the community.

Conclusion

The tasks of performance review break down the boundaries between the care of patients in general practice, education and research. Furthermore, performance review

makes explicit the moral values which underpin the doctor's decisions, and throws a searchlight over the politics of his medical institutions. Just as the doctor patient relationship can never be emotionally neutral, so medical education can be neither morally nor politically neutral.

The changing pattern of general practice education has mirrored in its apparent urgency the accelerating changes in medicine and society. What now becomes clear is that the forward thrust of these educational processes may be obstructed by the very institutions which they are designed to serve.

In the university medical school, general practice attempts to perform an integrating function, to recreate the teaching of general medicine as a whole discipline. But this kind of education cannot be realised within the present structure of the medical school. It is not simply that, compared with almost every other clinical subject, general practice is starved of resources. It is that the present departmental structure of the medical school and teaching hospital enforces a specialist approach to basic medical education. Even were new resources to be found for departments of general practice this would not be enough. The medical school itself must change. To make a contribution of the same sort as departments of gynaecology or psychiatry or orthopaedics now make to the present undergraduate curriculum, would be to betray the true mission of general practice in the university.[23]

In postgraduate education the situation is no less radically challenging. In order to recast continuing medical education as perpetual performance review, general practice itself must change. Partnerships must become more open, more mutually and publicly accountable and must take seriously the creation of new standards of care. By the same token, relationships with nurses, health visitors and social workers will have to undergo a fundamental change. These colleagues must also be brought into true partnership. They must take a full part in the creation of standards, priorities and policies. What this will mean for the future size of groups, for the contractual status of all members of the team, or for the terms of accountability in the nursing and social work hierarchies, is beyond the scope of this paper.

General practice, not because of the particular virtue of its practitioners but because of the logic of its position, is moving to the centre of health care. Inevitably it will move to the centre of medical education. But to do so it must be prepared to change its structure and function as radically as, in the recent past, it has changed its ideas about learning and teaching. These are the tasks and prizes of the decade ahead.

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Appendix

Framework for the MSD Foundation leadership courses

Tasks

For general practice to develop, we believe that the following tasks must be accomplished:

i *Priorities* must be proposed and chosen, which will enhance the quality of primary medical care.

ii *Standards* must be constructed, negotiated and monitored.

iii *Others* must be influenced both to resource and carry out similar tasks.

Strategies

In order to accomplish these tasks, a number of strategies can be employed.

i *Intellectual development* of general practice, including the development of ideas and models, empirical research and teaching.

ii *Bargaining* with other professionals and other involved groups.

iii *Politics*, in order to engender and accelerate reform.

Skills

In order to make and pursue these strategies, there is a need for a variety of skills. These include:

i *Communication* (including speaking, listening and counselling).

ii *Small group membership and leadership.*

iii *Organisational development*, crucial to the emergence of a more effective and humane general practice.

iv *Management* of self, others, resources, crises and, of course, of change itself.

New technology

Paul Grob

There is a nice story that, long before the miners' strike, an elderly Yorkshire miner put in a very late claim for compensation. The judge admonished his counsel by saying 'No doubt your client is aware of *vigilantibus et non dormientibus jura subveniunt?*' To which counsel replied 'In Barnsley M'Lud they speak of little else!'

Now it would be untrue to say GPs and district managers speak only of the opportunities created by the new technology but perhaps they should!

It is suggested that innovations in information technology can provide many solutions to problems that have bedevilled the NHS since its inception in 1948. The NHS, the largest civil employer in the world, 'grew like Topsy', and in doing so failed to develop an effective system for obtaining and synthesing management data; consequently many management decisions are based on inadequate and out-of-date statistics. These 'guesstimates' may be good, bad or indifferent but they cannot be demonstrated to be 'fair', and so there is often a sense of deep resentment within the NHS personnel because they cannot see the logic as to why resources are not coming their way. Furthermore, recognising the vulnerability of this decision-making process, vested interest groups realising that the decisions are influenced by 'decibels', mount noisy vociferous campaigns to demand a disproportionate share of limited resources leaving other areas, like care of the elderly, to go by default.

Consumerism has risen within the last decade in the NHS, unfortunately instead of the 'customers' sharing the problem of resource allocation, what has so often happened, because of the inadequacy of hard data for decisions, there has developed a polarisation between what is perceived as local needs, and what district authorities are trying to achieve. 'Keep open the cottage hospital at all costs' is a so familiar cry, often assisted by the medical profession shroud waving.

We do not know, except in broad terms, the specific cost of a particular operation or treatment, patterns of morbidity within a community, or even how GPs spend money from the public purse. All these facts are really essential if we are to have a cost effective health service which maximises benefit and minimises waste, and allows doctors and allied personnel to assess how well they are doing.

Paper-based information gathering systems suffer from the problems of cost, and the sheer inertia of handling large quantities of information which has to be processed and analysed all within a reasonable time scale. Now to have identified a problem does not mean a solution has been found, but computer networks (this is now a very expensive procedure), are amazingly good at gathering data from the 'coal face' sending it via the telephone lines to big mainframe computers which will analyse and digest such information with consummate ease. Pilot studies in which some 400 GPs in the SW Thames are linked to the mainframe computer at Surrey University have been very encouraging. They have produced valuable data on a whole spectrum of activities ranging from adverse drug reactions, prescribing habits, referral rates to hospitals, to the very latest pattern of morbidity in the community.

In information gathering, computers have created the first of many paradoxes; they can undoubtedly provide a very effective information management system, essential for cost effective decisions, but unfortunately when virtually all existing monies are already 'bespoke' simply to keep the ships afloat, there is an understandable reluctance to embark upon any additional expenditure.

It is vital not to 'oversell computers', as has often happened in the past usually by salesmen grinding axes, but to be aware of the opportunities created by the new technology and use the machines appropriately. Because of the multiplexity of tasks which can now be computer controlled, there is a tendency to make them perform tasks, rather like performing bears in a circus, which are completely inappropriate, and done so much better the old-fashioned simple way.

All computers should carry a Government health warning as they can be extremely harmful to your mental and financial well-being. More daft ideas are perhaps pursued in the name of computerisation in the health services than in any other field.

In the late 1970s when we first started to become aware of the amazing potential of information technology to improve patient care and management decisions in the NHS, a number of guidelines were produced to keep our professional and financial sanity. These are offered in the hope that others who tread this path may learn from our mistakes.

Firstly, beware the technological imperative – just because something can be computerised, it does not mean it should be computerised. Computers must do things better, not just differently. One has observed dedicated amiable people slaving away to try and make their systems work, whereas if they expended a fraction of the time and money on a simple modficiation of their existing work pattern, the achievements would be comparable. There is a magic about seeing computers perform – the 'Hornby effect' of mechanical toys – which can mesmerise and enchant. The fact that the machine is running your programme and processing data can be very seductive indeed and obscure the fact that there is no real progress.

Let computers do well what they do well, and let humans behave similarly.

Computers are extremely good at sorting out lists quickly and efficiently, so in the field of general practice let them produce a master patient index. This generates the facility to reach our 'at risk' groups of patients for BP check, cervical cancer screening, etc. A computerised repeat prescribing system is also an extremely good use of the new technology. However, it can be argued that one of the least productive furrows to plough is to try and computerise the narrative, the day-to-day records of general practice. Computers are good at classifying hard information – 'Patient A has diabetes' but so often patients present 'grey data'. They may, and it seems frequently do, feel 'any old how', which may mean genuinely suicidal, or requiring time off work to attend the local football derby. A persuasive argument can be advanced to improve general practitioners' records, but this does not mean they should then be computerised.

In the same vein, computers are not the American cavalry, ready to rescue us from our imminent demise under a sea of paper. If you have an inefficient record system, it could be disastrous to computerise. Many have found that the necessary steps to improve the system, prior to computerisation are all that is really needed. Computers can take small man-made mistakes and convert them into enormous expensive blunders of unrectifiable complexity.

But people's possible correct caution about computers is often intellectualised into a rejection of the whole subject, by saying 'I don't understand computers', as if this was sufficient; most of us don't understand our televisions or telephones, but that doesn't stop us using them quite effectively. I always encourage newcomers to play chess or

whatever with their new machine to establish a healthy working rapport.

Then there is information overkill. Having set up your electronic information system, you can interrogate and manipulate the data in a way hitherto undreamed of, and quickly can find yourself trying to cope with yards of computer print-outs, drowning in facts.

Thus free-standing computers can manage a master patient index and all that flows from it, but real progress is made when you link these together and an effective information system is generated.

However, it is extremely important to realise that because the technology required to run a big free-standing practice computer is different from an information gathering machine, the costs are radically different. The former system will start at between £5,000–£8,000 whereas an effective information gathering micro is in the range of £200–£600. It is firmly suggested that micros must stand on their own two feet both medically and financially and when GPs perceive their worth, they will buy them. At the moment it is probably *not* cost effective to install large practice-based micros given the financial climate of general practice, but information about how we work and what we prescribe is an extremely valuable commodity in all senses.

The Anderson report[1] is full of good ideas and common sense, suggesting as it does that the logical next step is to computerise the FPCs. The concept of small practice-based micros being able to access a large patient database held by the FPC has enormous possibilities. But to be critical, what a pity this thinking was not appreciated three years ago when the impetus of Information Technology Year in 1982 could have provided resources for these next essential steps. Perhaps the best thing to do about the design of the 'Micro for GPs' scheme is to draw a veil over the whole sorry project.

As part of an expanding research programme into information technology applications, at Surrey University, we are examining the opportunities created by linking GPs with the Family Practitioner Committee and the local district general hospital. This programme has also examined a number of different facets of information capture relevant to the NHS:

(a) Morbidity data for health care planning

Some 120 general practitioners make a weekly record of a selected number of diseases encountered in their practices. The study is in its tenth year, and the morbidity database is the largest of its kind in the world, and has been of considerable value in delineating morbidity trends and has been used as an early warning system to predict outbreaks of infectious diseases thus enabling prospective investigations to be mounted when required.[2] These data can also be used to show patterns of acute paediatric and chronic adult morbidity, which should be the starting point for assessing general medical support services. (Figures 1–3).

In addition, computer-based patterns of bad housing, smoking and eating habits will be extremely valuable in monitoring not only specifically targeted health education programmes, but also can be used to 'fine tune' community resource allocation at district level.

Figure 1 **Incidence per 100,000 for whooping cough for the mean of non-epidemic years from July 1975 to June 1984. Also the incidence for the period from 4 July 1984 to 2 July 1985**

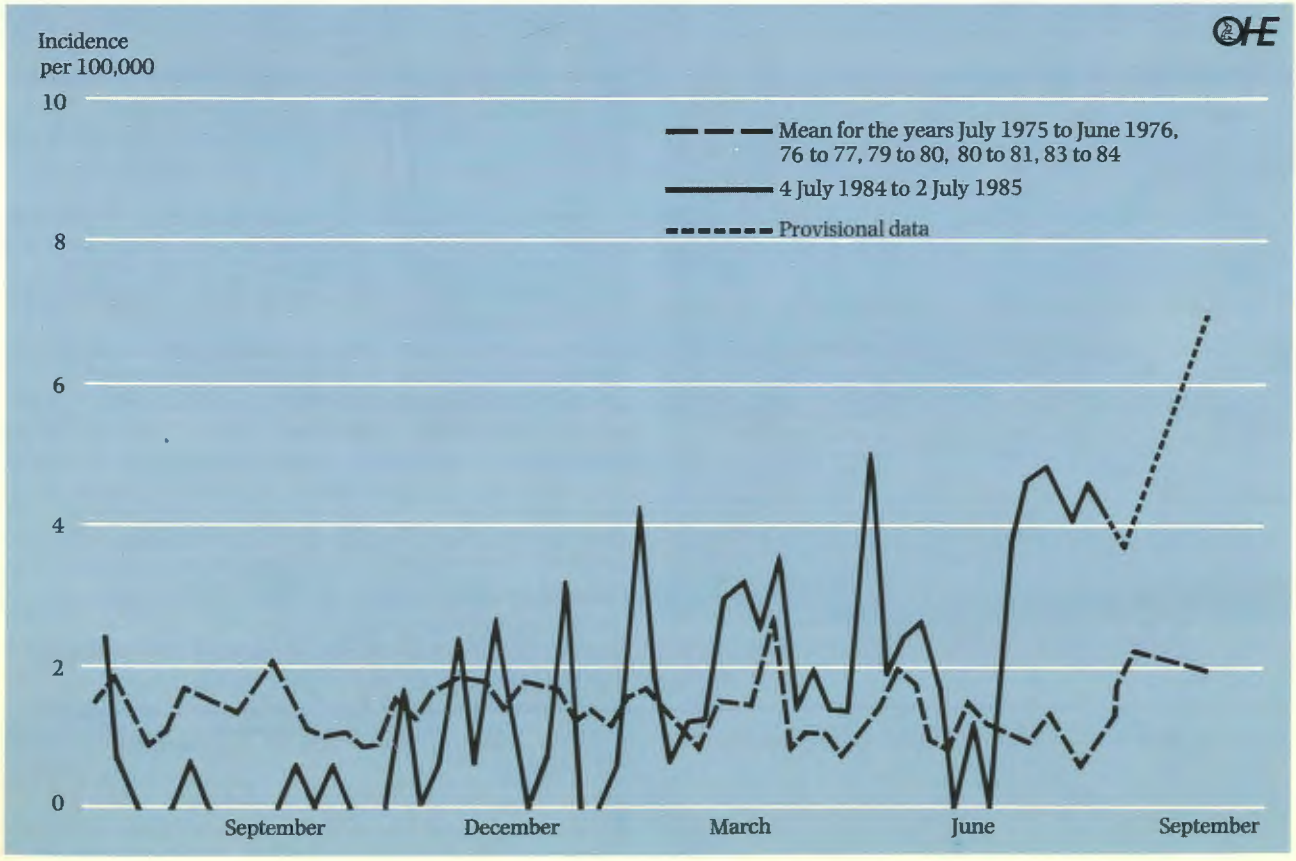


Figure 2 **Incidence per 100,000 for whooping cough for the period from 2 July 1975 to 2 July 1985**

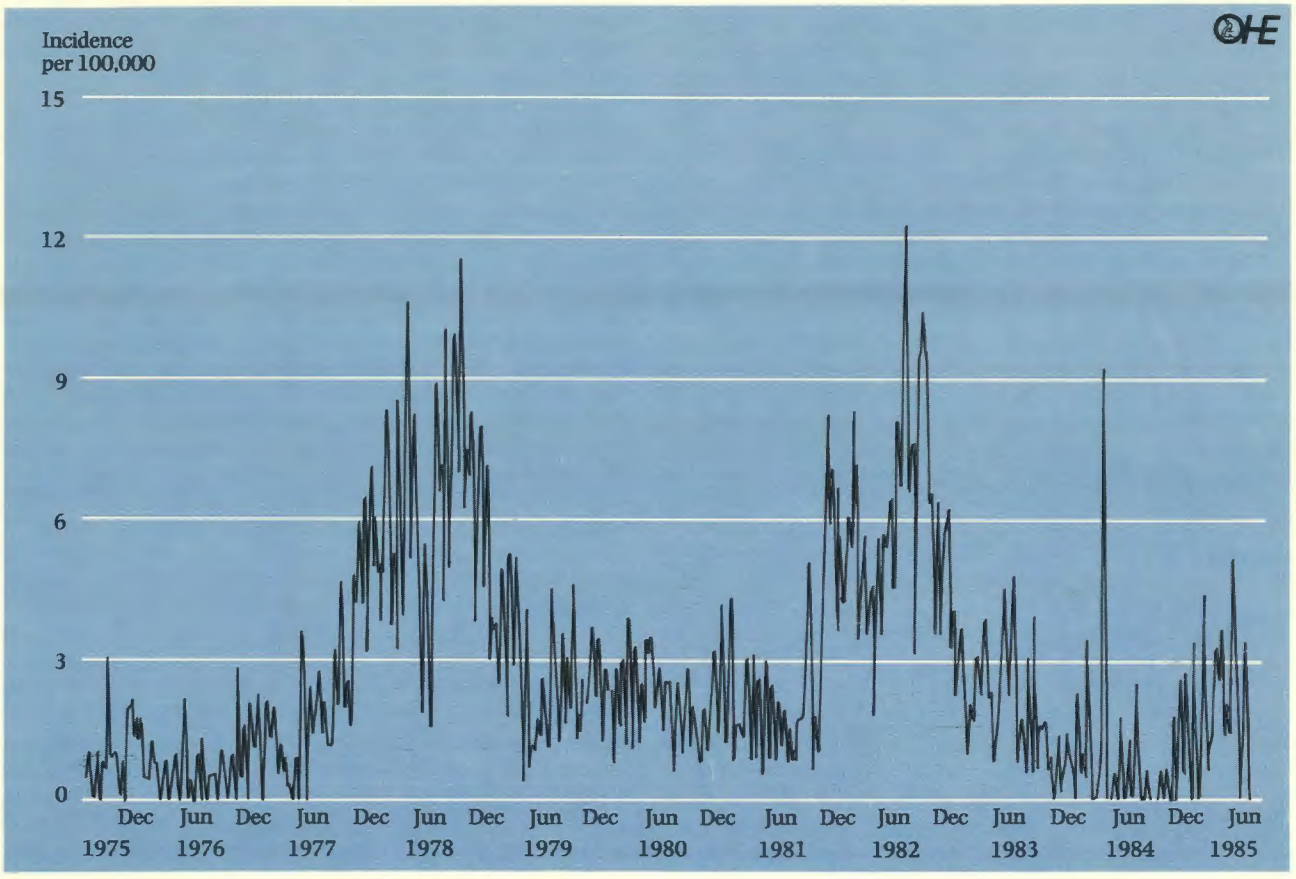
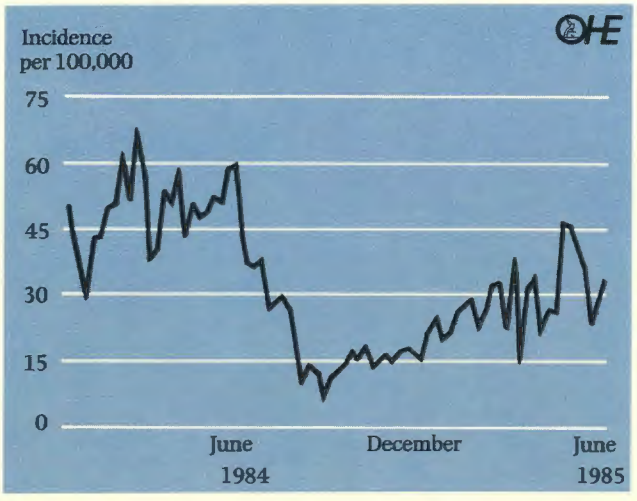


Figure 3 **Incidence per 100,000 for children's infectious diseases for the period from 4 January 1984 to 2 July 1985**



(b) Adverse drug reaction reporting

The paper-based 'Yellow Card' system is acknowledged as being slightly less than perfect, and this should be an area in which progress can be made, it is interesting to speculate at the lack of progress in this field.

Bearing in mind that communications are a two-way process, computer networks are an excellent method of providing feedback to participating doctors about their performance, thereby maximising their co-operation and their learning effect.

In a recent study[3] with a hundred interested general practitioners, 36,470 consultations were analysed, – an adverse drug reaction (ADR) was observed in 1.7 per cent of their consultations. Significantly only 13 per cent of the ADRs, which should have been reported were notified to the Committee for the Safety of Medicines whereas 90 per cent of observed ADRs were reported within the study by this group of well-motivated practitioners. This discrepancy provides food for thought and needs further research.

(c) Electronic clinical drug trials

The University of Surrey has undertaken a large number of big multi-centre clinical studies which have shown the cost-effective nature of this type of information gathering exercise. This activity has been the driving force in developing computer networks in this country.

(d) General practitioner education and self-audit

For the past three years 90 training practices in the SW Thames region have been engaged in self-audit exercises

using micro-computers. Any efficient system of health care must be able to tell its participants 'how they are doing'. Without this knowledge the motivation for changes or improvement is almost non-existent.

There are only three major areas in which GPs spend sizeable amounts of money in the provision of health care. Their prescribing habits (£50,000–£70,000 per GP per annum), their use of pathological services and X-rays, and their referral rate to hospitals – this latter 'gatekeeper' function has a marked influence on hospital costs, and paradoxically is usually completely beyond the influence of the hospital. Audit exercises using micro-computers have been extremely effective in telling participating doctors how they compare with their peers, this must surely be the first step to practising at a 'conscious level'. Once an individual can perceive if he is a high, average or low user of these services he can start to reflect if changes are required. GPs have always been responsible, that's part of the job, but the idea of accountability, giving 'best value' for money is something new, and requires these data on performance feedback.

If the above arguments have validity it is reasonable to ask, how much progress have we made in this field if it's that important. The rather sad answer is, that although some progress has been made, we should have done much better. It is perhaps worthy to reflect that the log jam is essentially human, not related to machinery. In fairness it must be recognised that the 'status quo' has enormous influence and power, over what can happen in the future. But it could be said that officialdom is to technical innovation what Herod was to infant welfare!

There is the natural fear of the consequences of the unknown especially in the uncertain climate of medical employment. Cost is often advanced as a reason for inactivity, but to do nothing does not cost nothing. For example, in the field of information about drug safety, (because in the mid-seventies there was inadequate information about both the safety and the efficiency of the whooping cough vaccine), this Government has had to spend millions of pounds in research and publicity to refute dubious counter arguments on the vaccine's safety. Running parallel with this uncertainty of hard data we see a rise in litigation, as the problems of legally untangling cause and effect are debated in the courtrooms. In the USA, whooping cough litigation is not about medicine or even about the law, but it is about the redistribution of wealth. The most recent award to a 'vaccine damaged' baby was 21 million dollars, and the cost of the vaccine has risen from 4 cents per shot to 2 dollars 90 cents, to account for the pending litigation encouraged by contingency-fee lawyers.

Another often quoted reason for inactivity is the rapid rate of technical advances, when should you join the computer bandwagon? This is only partially true, what has tended to happen is that a market leader like IBM produces a personal computer which has certain specifications and sells for about £3,000. There are then a flood of 'me-too' look-alikes, with similar facilities and are slightly cheaper. This remains the 'state of the art' until a breakthrough is made, as has recently happened. The sagacious Japanese have produced an 'IBM personal computer look-alike' for about £700, this will then persuade the original market leaders to release their Mark 2 or 3 models for about £3,000 but with a vastly improved range of capabilities, giving more 'bangs per buck' as they say in the trade and the whole cycle starts over again, restabilising at the level of the improved machine.

Another more subtle impediment to progress is, as 'information is power', people do not like sharing power. The morality of this is open to debate, but it must be recognised that when a computerised information system is introduced into an organisation there is a definite power shift towards those in the organisation who are closest to the information source; these are usually computer literate younger ambitious executives. This in itself can introduce an interesting dynamic.

All these problems are not original to information technology or computing but have been recognised for many years, as barriers to what might loosely be called progress.

Machiavelli in his treatise on political problems in fourteenth-century Renaissance Italy said:

'. . . and it ought to be remembered that there is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success than to take the lead in a new order of things.

Because the innovator has for enemies all those who have done well under the old system, and lukewarm defenders in those who may do well under the new.' – *The Prince*

In summary therefore an argument can be advanced for developing an effective computer-based information system for the NHS. This should enable more cost effective and visibly fairer and better decisions to be made, thereby improving the quality of patient care, and raising morale within the NHS at a time when farsighted leadership as opposed to effective management, is what our service essentially requires.

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Performance incentives in general practice

Alan Maynard

'It is not hard for one to do a bit of a good. What is hard is to do good all one's life and never do anything bad, to act consistently in the interests of the broad masses, the young people and the revolution, and to engage in arduous struggle for decades on end. That is the hardest thing of all!' – Mao Tse-Tung

After the reforms in the 1960s the British system of primary care settled back into a torpidity from which it has only recently begun to stir. The well-intentioned reforms of two decades ago and the changes which have taken place in the organisation and funding of the primary care system since have had effects which have not been evaluated systematically. Primary care is an expensive 'black box', consuming about 24 per cent of the NHS budget in 1984–85, which some doctors assert, in the absence of any evidence, is 'cost effective'[1] and a 'success'.[2] However, some influential sections of the medical profession are now recognising that fundamental changes in attitudes, evaluation of practice and behaviour are needed urgently.[3] Continuous revolution with systematic evaluation of change is essential if the supply of primary care services is to meet the changing and complex demands for care in an ageing society. As Mao indicated this process is arduous but unavoidable if policy goals are to be met at least cost.

What is the nature of the problem?

Before it is possible to discuss performance incentives it is necessary to identify the defects of the existing system of primary care. However, the indentification of 'defects', presupposes the existence of some ideal system of primary health care. Some characteristics of such a system will be outlined after an exploration of some of the characteristics of the existing system.

i what can the consumer get?

The National Health Service (General Medical and Pharmaceutical Services) Regulations of 1974 state that the general practitioner is 'to render to their patients all necessary and appropriate medical services of a type usually provided by general medical practitioners'.

This general definition of the GP's contractual obligations has not been supplemented with any agreed definition of what are 'necessary and appropriate services of a type usually provided'. Individual GPs have interpreted their remit in a manner consistent with their interests, influenced at the margin by the payment system. Thus some GPs provide hypertension clinics and care for diabetes but not all do so. Immunisations and vaccinations services are available but the extent to which practitioners provide these and other services seems to vary within and between Family Practitioner Committee (FPC) areas. Fundamental procedures like the creation of age-sex registers for practices often tend to be absent with perhaps only 30 per cent of GPs having this basic practice management tool.

Whilst the consumer can switch between GPs she finds it difficult to do so. The migrant patient within or from outside an area finds it difficult to get meaningful and systematic information about the characteristics of alternative GPs. Advertising is 'unethical' and local Family Practitioner Committees, who employ the doctors, typically provide little information to the public and monitor practice in a haphazard and superficial manner.

Typically the patient depends on luck in choosing her GP. She can search the market and interview receptionists and GPs but this process is time-consuming and can be counter-productive if the GP intelligence network identifies a potential 'trouble-maker'. Thus rather than the GP reflecting the tastes and preferences of the patient, practice times, visiting activities and service provision reflect the tastes and preferences of the GP. The professional arranges the patients' life rather than the GP providing those services required at a time and place convenient to the consumer, and the patient knowing of no alternative accepts the package of care offered with gratitude!

ii what can the producer get?

In 1984 there were 29,137 unrestricted principals at work in general practice in the United Kingdom. The majority of these (23,640) work in England and the stock is growing at nearly 2 per cent per year. The net target income for such doctors is £23,440 for 1985–86 and typically the total gross income (from all services) can be in excess of £30,000 by the age of 30. General practice is seen as an attractive career option for medical graduates as it offers high incomes sooner than a hospital career and permits practitioners to work in an environment untrammelled by cash limits and relatively unevaluated by the local employers (FPCs).

During the last two decades, not only has practice income grown, there has also been an expansion in the scope for the delegation of tasks. Thus the growth of health centres and the increased levels of 'latching on' district nurses and health visitors has offered the possibility of improved quantity and quality of service. Whether such an outcome has been achieved is unknown. Policies have changed but there has been no systematic evaluation of their effects. What is meant by a collaborative primary health care team? How does it work? How does it effect the division of tasks between actors? How much do alternative combinations of actors cost and what are the effects of these alternatives on service delivery? The literature offers some subjective evaluations of differing experiences but there have been few attempts to randomise patients between experimental and control groups (randomised control trials) and analyse the costs and benefits of alternatives.

At the same time as the number of 'collaborators' with GPs has increased, average list sizes have declined to about 2,100 patients per GP in England. There is BMA pressure to reduce the list size to about 1,700 and the manpower forecasts appear to accept these in an uncritical manner. Yet criticism there should be: why is it that people like John Fry argue that he can manage, with some delegation of tasks to collaborators, a list size of 4,500? Is his behaviour or that of his colleagues inefficient?

The scope of on-the-job leisure generated by more collaborators and lower list sizes is considerable. Whether the Manchester results, with some GPs having only 15 hours patient contact time per week, are typical only further research will reveal. However, in theory (and it can be seen from casual empiricism too) on-the-job leisure may be a characteristic of some parts of the FPS system. Furthermore, when patients tardily complain, this problem is difficult to rectify. Disciplinary action by the local FPC medical services committee may get reversed by the Secretary of State and even when upheld imposes minor fines which usually seem to fail to change behaviour.

So the producer can get a quiet life with generous remuneration. The minority(?) of GPs who indulge in on-the-job leisure will typically not be called to account and the idle and the workaholic alike can evolve service patterns which reflect their interests and their convenience.

iii what does the taxpayer get?

The taxpayer gets the bill and is bombarded with rhetoric by the medical profession and the Government, of all com-

plexions, that the primary care system is cost effective and the best in the world. Policy making, initiated by Government and usually (but not always) sanctioned by the medical profession, is *ad hoc* with no clear definition of policy goals and an absence of system-wide strategy even to pursue the weak goals that are articulated.

With the budget open-ended and determined by the suppliers (GPs), expenditure can and does over-shoot public expenditure targets. Furthermore in the recent past FPS over-runs have been funded by cuts in the cash-limited hospital budgets. The Treasury cannot control expenditure because practitioners are self-employed contractors and as such they can, if the pay settlement is meagre, augment their incomes (and, by so doing, increase our tax payments) by increasing their activities for fees per item of service.

The occasional attempts to control expenditure are usually weak. Apart from moral-suasion ('be reasonable chaps!') about expenditure generally, the usual specific controls are applied to the drug budget. This policy is fraught with difficulties because on the one hand the Government seeks to ensure the prosperity of the pharmaceutical industry with the use of the Pharmaceutical Price Regulation Scheme (PPRS) which guarantees a rate of return on historical capital, and on the other hand it seeks to reduce drug costs to the NHS. Thus in 1984 the debate about limit lists was seen by the Minister as an economy measure aimed at controlling costs and as an assault on profits by the drug industry. In the event there is evidence that GPs, instead of prescribing cheap harmless herbal remedies are now giving branded and generic products which may cost as much or more. There are many ways to skin a rabbit and the limited list option should have been tried, tested and compared to alternatives in a careful experiment.

The taxpayer gets an uncertain deal. The budget is open-ended and the benefits (in terms of GP activities and the effects of these activities on outcomes) are uncertain. Like other parts of Government expenditure (eg, education, defence, and law and order) much is spent but little effort is made to ensure that the expenditure gives value for resources. Although the rhetoric of the time favours quite rightly 'value for mony', the efforts to evaluate practice are meagre and inadequate.

iv what are the objectives of policy?

Whilst deviant producers (GPs) can consume on-the-job leisure there is a growing awareness within the profession that all is not well and the 'golden era of peace and plenty' is drawing to a close. There is an urgent need to evolve policy targets which the GPs, the patients and the State can pursue with an agreed strategy. Some plausible short-term targets could be:

i annual re-contracting by patients where possible, with all consumers each year being offered the choice of alternative practitioners;

ii detailed statements by practitioners about the timing, location and nature of services offered;

iii enhanced public encouragement and funding of 'experiments' in general practice (see below).

Clearly there are no easy solutions to the problems of general practice. One man's cost is another man's benefits and thus attempts to control expenditure and define agreed patterns of care will impose costs on practitioners which will be rejected by some. In the limit, the Government has to decide whether it will continue to be the passive bank clerk who pays the GPs or the careful buyer of practitioners' services. Can she/he who pays the piper call the tune or at least define the score?

Better incentives?

There are many ways in which the general practice market could be reformed and incentives improved so that practitioner performance is related more closely to patient demand. Each of these reforms needs careful specification and evaluation in experiments.

Alternative 1

Current policy seems to be directed at encouragement of GPs to set their house in order along the lines, for instance, of the Royal College's Quality Initiative, and the reform of the FPCs.

Ignoring the problems of collaboration with other parts of the health sector generated by the 'hiving off' or independence of FPCs, they seem poorly designed to control expenditure and practice. The FPCs are price takers (prices are set each year by the Review Body) and ciphers who pay the producers their due. Potentially FPCs have a useful data set but typically their operations are Dickensian with people using quill (biro) and bundles of paper which ended up piled in heaps on the floor! Cautious investment in computerisation is under way, with Central Government attempting to design system solutions for hard and software in its usual slow and cumbersome manner.

If this data stock could be mechanised and extended, practices could be monitored. Again extensive local experiments with careful evaluation would seem sensible rather than the slow evolution of system-wide solutions. The selection of 10 or 15 FPCs who would be given total freedom to spend their administrative budget, together with scope for borrowing to computerise now and pay back in five years, would be useful ways of 'letting a thousand flowers bloom', ie, using diversity to illuminate the costs and benefits of alternative practices.

Two other reforms could be associated with the liberalisation of Central Government control. Firstly the employment contract should be revised with the ultimate objective being (and this needs to take place in the hospital system too) the replacement of the present 'job for life' contract with a contract for six years with 3 year reviews and rolls-forward.

A second reform could be the identification and prohibition of introduction of all new practices and drugs until they are proved, by trials, to be cost effective. The 1968 Medicines Act controls 'quality, safety and efficacy' and could be extended to costs and all new therapies so that only activities *proven* to be effective *and* least cost would be introduced and used.

Alternative 2

The preceding package of proposals (alternative 1) could be augmented by budgets for some items of GP activity. For instance five years ago (in Medeconomics) the present author advocated the institution of drug budgets for GPs. Thus each year the GP would receive say £30,000 and all drug expenditures would be charged against this income. If the GP spent less than £30,000 in the year, she would be better-off. If she spent more, her income would be reduced. There are many potential problems (eg, particularly expensive cancer drugs) but once again experimentation seems merited. Why not design and carry out an experiment and 'confuse' policy discussion with facts rather than often self-interested rhetoric?

Another budget innovation might be the introduction of capitation fees for the services of a pharmacist. Thus consumers might select a pharmacist and 'sign up' with her. She would keep the patients' pharmacology records (contra-indications, cross effects, etc) and have the power

to re-write the GP's prescription. What effect would such a mechanism, which led to the monitoring of GP prescribing, have on drug costs? Again some experimentation might generate some answers to this question.

Alternative 3

It was the present author who, at the OHE meeting at Cumberland Lodge,[4] proposed budgets for GPs. This idea was discussed in the meeting's proceedings by Marshall Marinker and George Teeling Smith. Basically the proposal is that each patient has a per capita value which is translated into the GP's income when the consumer selects and signs on with her GP. Thus the GP generates her income by competing for patients and she uses this income *not only* to finance primary care but also to 'buy-in' hospital and other services as needed. Such services could be bought in from the private or the public sector whichever is cheapest.

This arrangement would create a market in care with the GP and his partners seeking to maximise her return (income less expenditure) by monitoring the use of services and their costs. Any attempt to cut costs at the expense of quality would lead to the loss of patients and hence income. The GP would monitor and minimise the use of hospital services because the hospital's income is the GP's expenditure! By giving the GP the budget she is given an incentive to manage resources efficiently. Careless use of drugs, diagnostic tests or hospital care would impose a direct opportunity cost on the GP. Activity would have to be monitored and peer review quick and effective if costs were to be minimised. A partner's absence on the golf course would have clear cash-flow effects and incentives such as this would ensure internal review and strenuous efforts to meet the demand of consumers.

Is there evidence to substantiate such conclusions? There is interesting evidence from the United States where Maoism has been adopted on a wide scale! For instance, one version of a 1,000 flowers blooming is the Health Maintenance Organisation (HMO) movement which typically exemplifies such incentive structures. Careful experimentation has shown[5] that the HMO is cheaper than alternative forms of care and that, for instance, hospitalisation costs may be up to 40 per cent less. Further evidence has been summarised by Luft[6] and Enthoven[7] although interestingly, the relative advantage of HMOs seems to be declining as competing organisations cease to be passive and begin to use their buying powers to control the price, quality and quantity of care provided by practitioners and hospitals. Clearly individuals and institutions have to be monitored continually to identify their costs and benefits.

It is curious that some of these proposed innovations are seen as threats to the National Health Service. The present author's views on the NHS are set out clearly elsewhere[8] and the introduction of HMO-like budgeting systems are not necessarily a threat to the service's existence. Such mechanisms would change the service, reducing existing perverse incentives and making possible the existence of public finance of care but wholly private provision. Such an outcome would be dependent on the private sector being more efficient in providing care and it is not obvious that a competitive internal NHS market system would generate such an outcome.

Conclusion

There is a need to reform radically the pattern of primary care in the United Kingdom. At present it is a 'black box' with perverse incentives which reward hard work and idleness in a similar fashion. There is a need to illuminate the contents of the black box by careful research such as that carried out in Manchester. Equally there is a need to experiment with alternative patterns of reform (eg, particular forms of alternatives 1 to 3 above) so that the incentives for practitioners to perform efficiently are increased. Any such reform requires more information about performance, which can only come from evaluation, and the creation of greater uncertainty for providers. Labour, even miners or academics, should not have a 'job for life' and a necessary condition for greater efficiency in the hospital sector and general practice is the radical review of doctors' contracts.

The implementation of reform will be an arduous task as Mao noted, in particular because such reforms will be opposed by professional associations, the income of whose members will be threatened. However, as Adam Smith argued, such corporate activities might not be in the interests of the consumer:

'That pretence that corporations are necessary for the better government of the trade, is without foundation. The real and effectual discipline which is exercised over workmen, is not that of his corporation, but that of his customers. It is the fear of losing their employment which restrains his frauds and corrects his negligence. An exclusive corporation necessarily weakens the force of this discipline.' – Adam Smith (1776).[9]

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Some issues from the discussion

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The discussion of the first paper centred on the organisation of general practice and the role of the general practitioner. It was agreed that the general practitioner should be a superb diagnostician, although it was questioned whether a return to the best of 'middle class general practice' from the 1930s was in fact desirable. There was more agreement that the role of the 1980s general practitioner should mirror that of the general physician of the 1930s.

This raised the question of the extent to which general practitioners actually needed to refer cases to specialists for treatment. It was forcefully pointed out that for the common ailments such as skin disease, hypertension or bronchitis it would be totally impossible to seek specialist advice in the majority of cases. Thus in clarification of the proposals in the paper it was pointed out that an essential element of the general practitioner's diagnosis was a decision as to whether specialist advice was needed; in the majority of cases the general practitioner could indeed deal with the patient very satisfactorily on his own.

There was also a proposal that general practitioners themselves should specialise, for example on paediatrics, or gynaecology or geriatrics. This is of course, already done in many larger general practices, but the merits of this arrangement were not universally agreed. It was suggested that such fragmentation of general practice interests could lead to a 'disease oriented' service rather than a true 'health service'.

It was also suggested that the desire and need for specialist referral from general practice was a reflection of the current patchy quality within general practice itself. If all general practitioners could attain the levels of expertise of the best many fewer referrals to hospitals or specialists might be required. And as the facilities for diagnosis in general practice improved, fewer cases would need to be referred to the specialist. For example, more 'dipstick' type of diagnostic tests were now being developed, and those should enable the general practitioner to decide more accurately exactly what treatment was required by the patient and to monitor drug metabolism.

However, there was general agreement that both hospital practice and general practice, would benefit if hospital specialists were to spend more time in general practice. For example, a specialist could both teach and learn a great deal if he spent a day a month within general practices in rotation.

Turning more specifically to the current state of general practice and the public's expectations from it, the discussion of the next two papers focused on the dichotomy between the overall public satisfaction with the service and the professional concern over its shortcomings. It was suggested that the public needed to be educated to expect higher and better standards of primary health care under the National Health Service. A sharp contrast was drawn between the attitude of the American Health Maintenance Organisations, on the one hand, which tried to attract patients and many British general practices, on the other, which seemed almost to discourage their patients from consulting. In particular the attitude of some receptionists in general practice contrasted sharply with receptionists in situations where the objective was to attract and satisfy customer demand.

Indeed, one participant suggested that the accessibility of general practitioners could be 'awful' in some cases. Thus within the overall picture of public satisfaction with general practice in Britain, there were indications that some people found shortcomings among team members if not the whole team. Professional journals, for example, received letters of complaint from individual patients. Clearly this represented the tip of an iceberg of wider dissatisfaction. This should be a matter of serious concern for general practice.

More specifically, it was suggested that general practitioners were too ready to hand over control of their patients to hospital consultants or registrars. Examples were quoted where this had had appalling consequences. Instead, general practitioners should be more willing to dictate to hospitals the way in which their patients should be treated, if not in clinical at least in management terms. The impression emerged from the discussion that it was often hospital outpatient departments which caused confusion, inconvenience and even inappropriate long-term treatment of patients. One speaker even suggested that outpatient departments should be abolished. Overall, it was agreed that general practitioners needed to use their position as the referees to hospitals to ensure that their patients were handled more sympathetically and more efficiently. They must not allow hospital consultants to keep patients under their control when they should be referred back to general practice.

In the same vein, it was felt strongly that patients' well-being could be enhanced if general practitioners had some hospital beds under their own control. This was beginning to happen again, after it had been virtually eliminated by the introduction of the National Health Service.

Once again, however, the variable quality of care within general practice was mentioned. The proper extension of responsibility of general practitioners at the expense of hospital consultants required a good basic standard of skill and expertise among the practitioners. This could not always be guaranteed at present.

In this connection, the motivational effect of a practice undertaking postgraduate training of new practitioners was mentioned. It seemed clear that 'training practices' were particularly anxious to raise the standards of their care and of their management efficiency.

Finally, in relation to public expectations, it was suggested that 'do-it-yourself' medical booths could sometimes provide a convenient and acceptable alternative to formal primary medical care. Such booths were becoming more common in the United States, and could not only relieve the workload of general practice but could be popular to the public.

The third general area for discussion covered the role of the practice team and the importance of 'health promotion' in general practice. There was much debate as to whether the doctor should always assume the role of practice manager, or whether the management of the practice should not be handed over in reality (rather than in name alone) to a professional manager. This could be a lay person, or someone from one of the other caring professions in the practice team.

Certainly, whoever was to assume the management role needed more training than they had generally received in the past. Their role also needed to be clearly defined, as did that of each of the other members of the practice team. This was particularly important in organising the continuing care of the chronic sick.

It was suggested that personal relationships within the practice varied greatly. In some cases everyone was on christian name terms. In others the relationship remained strictly formal. One problem was that the senior doctors in a practice often needed to 'unlearn' the approach to medicine which they had been taught and under which they had been brought up. There were also indications that demarcation disputes between the different disciplines could act

against the interests of the patients. A spirit of genuine co-operation was needed, and one way to promote this was to ensure that the rewards for good work (whether material or psychological) should be shared throughout the team rather than being awarded to the doctors alone.

One recurrent theme arose in the discussion of the practice team and health promotion. This was the need for experiment and a variety of approaches. For example, ancillary staff could be either employed in the practice or attached to it. And – most importantly – there needed to be proper evaluation of the outcome of the alternatives. The failure to evaluate the performance of differently organised practices was described as nothing short of a scandal. The National Health Service should have provided the ideal framework for this sort of evaluation, yet it had practically never been carried out.

This applies both to the differences in practice organisation and in the different approaches to health promotion. It was suggested that there should be organised 'clinical trials' of types of organisation, in the same way as there are controlled clinical trials of different treatments. One problem in carrying out such trials with methods of health promotion is that changes in behaviour are inevitably slow. No one can expect suddenly to get widespread acceptance of new patterns of more healthy behaviour; it takes time for people to realise the importance, for example, of giving up smoking or changing their diet.

In general, it was emphasised that proper use of the practice team could allow the general practitioner more time for each consultation. Both the doctors and other members of their team would therefore be able to spend more time on health promotion. However, one consideration was that, in order to employ staff of adequate calibre and experience, it might be necessary to pay more than was permitted under NHS guidelines. Thus raising standards and developing health promotion was not only a question of organisation but might also be a question of money.

Discussions on the introduction of modern information technology into general practice raised the question of the quality of the data itself. Some practices which had acquired microcomputers had not at the same time raised the standards of accuracy of their practice data. In many cases this problem could be solved by training members of the practice team other than the doctor to collect and process the data. In addition, it was suggested that in the evaluation of care small very precise studies could be much more valuable than huge less well controlled investigations.

As the discussion of the various individuals' papers progressed it became more diffuse, partly because a more complete and therefore wider picture of the problems of general practice emerged. At this stage a number of recurrent themes dominated the discussions. Some of these have already been mentioned, but because of their importance they are referred to again below. The following list of topics is by no means exhaustive, but it covers most of the central issues.

Variation in quality

A clear picture emerged of extremes in quality of general practice with a spectrum of performance between the very best and the very worst. The latter most often seemed to occur in the inner city areas. As examples of the variation, it was pointed out that a considerable proportion of doctors who qualified as general practitioners nevertheless failed the Royal College of General Practitioners membership examination. The best practices would routinely take patients' blood pressures and discuss their smoking habits, for example, but these things were not done in less excellent practices. One problem, however, was that patients themselves seemed unable to judge between good and bad general practices. Some of the practices which would be judged 'the worst' in objective terms were very popular among those on the doctors' lists.

General improvements in standards

Nevertheless it was clear from discussions that overall standards of general practice had improved dramatically in the past two decades. General practice now attracted many of the best medical graduates, and at the other extreme the worst general practitioners were being eliminated by the natural process of retirement or death. This raised the question of whether retirement should not be compulsory, for example, at the age of 70. Many people felt that it should.

One positive example of the rising standards of general practice was the fact that a practice could not now be permitted to become a 'training practice' unless it operated an age-sex register.

The situation in general practice as a whole could not yet be regarded as entirely satisfactory, but it was steadily improving.

The problem of poor practice

The most serious problem was clearly still the existence of a small proportion of practices which by any objective standards were attaining unacceptably low standards of medicine. It was uncertain whether this problem could be solved by the use of 'a stick' as opposed to the 'carrots' which had helped to raise the standards of practice generally. One view was that the problem was self-limiting, and that it had to be accepted for a few more years until the passage of time had eliminated the past inheritance of poor standards. Another view was that Family Practitioner Committees should be much more active in using pressure to eliminate the problem, by motivating inadequate doctors to raise their standards, or by active persuasion for such doctors to take 'early' retirement if all else failed. It was suggested that if some practitioners were shown how low their standards were compared to the best, they would themselves accept the logic of withdrawing from active practice unless they felt able to change their methods.

Lack of information and evaluation

The data on variations in hospital referral rates presented by the Chief Medical Officer had underlined the lack of information to explain variations between practices. There were enormous variations in practice, but these tended to be studied only in local *ad hoc* investigations, and there was a serious lack of national statistics. More importantly, where statistics did exist there had been little or no attempt to explain variations, or to evaluate differences in terms of patients' wellbeing. The scarcity of carefully controlled experiments, properly evaluated, was one of the greatest indictments of the organisation of general practice under the National Health Service.

Lack of definition of good practice

Leading on from this, there was a lack of precise definition of what constituted good practice. The general principles of good practice had been excellently spelled out, but these had not been widely translated into specific guidelines. One participant suggested that this was inevitable, because the

existence of precise guidelines would merely allow malevolent critics of general practice to show how far short of the guidelines individual practices might be falling.

More constructively, it was suggested that general practitioners and their team could never do everything which might ideally be desirable. Hence, individual practices concentrated on what they did best and on the aspects of care which interested them most. This was a logical situation which made much better use of human resources than forcing every general practice into a fixed pattern of behaviour laid down on purely theoretical grounds.

Even though individual practices varied considerably in the services which they provided, the great majority of practitioners seemed to recognise the basic essentials of good practice.

'Health services research in disarray'

Nevertheless, the discussion returned repeatedly to the problem of lack of evaluation of the effect of differences between generally accepted 'good practices'. It was argued that this was because health services research in Britain as a whole was in disarray. The transfer of responsibility between the Department of Health and the Medical Research Council had lead to difficulties. There seemed to be a lack of clear leadership in the evaluation of the patterns of organisation of health care as a whole, and this situation was mirrored in general practice.

Scope for internal audit

One vital conclusion seemed to arise from the lack of concensus about the 'correct' organisation of general practice and the lack of overall evaluation of the outcome of health care. This was that for the present the best method of improving standards of general practice would be 'internal audit' rather than assessment imposed from outside. The majority of general practitioners were becoming increasingly aware of the need to develop and apply the principles of good practice. Thus they could safely be trusted to motivate themselves to raise their own standards. The principles of 'audit' or 'peer group review' were accepted as part of the *internal* process of raising standards. To some extent the acceptance of 'internal audit' would offset the disadvantages following from a lack of systematic assessment of different patterns of care.

Methods of motivation

Thus in terms of overall health policy, what the National Health Service needed to do was to identify ways in which general practitioners could be motivated to improve more rapidly their own standards, so that all approached the performance of the very best. This did not necessarily mean financial incentives. The motivation of being allowed to become a 'training practice' (which does also carry a financial reward) has already been mentioned. There could be other ways of recognising excellence when it developed in a particular practice.

Conclusion

General practice is like the Curate's Egg – good in parts. It is occasionally excellent and occasionally unsatisfactory, but generally improving rapidly. However, one aspect of the problem facing it is the need to define exactly how successful different practices are being in promoting health and preventing the unnecessary use of expensive hospital facilities. The second part of the problem is to decide how best to motivate the 'average' general practitioner to emulate the 'best'. A final, but relatively small and shrinking problem, is how to deal with relatively 'bad' practices. For the future, this last problem may remain only in some of the inner cities, as one feature of their much more widespread social malaise.

The steady improvement in the standards of general practice since the mid-1960s give grounds for encouragement. There is no massive problem to be tackled, as is sometimes suggested. The priority now must be to find ways of promoting an even more rapid improvement in the standards of general practice in the years ahead. There is unlikely to be a single formula to achieve this. The morale of general practice needs to be raised by gaining acknowledgement of the improvements which have already been made. There are no grounds for complacency, but equally no grounds for alarm.

The last word must be left to Professor Paul Grob. General practice, he said, is not facing the fate of the *Titanic*. It is more like the *Marie Celeste*, in need of guidance and direction – and perhaps, I might add, a little more manpower!

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