PRACTICE OBSERVED

Good Practice

What is a good GP?

R M BERRINGTON

Honour a physician with the honour which is due unto him.

In the current debate on the future of primary health care GPs may recall this familiar exhortation. Unfortunately, in contrast to recent statements it provides no clue as to how we attain high esteem nor does it mention any reward other than "honour"—but then it is apocryphal.

The government's discussion paper on primary health care suggests that performance indicators for general practice might include personal availability, range of services, preventive activities, attendance at postgraduate courses, and "those aspects of practice indicative of high quality work."[1] Prescribing patterns and hospital referral rates are mentioned in relation to high quality.

Defining a good GP is a dynamic process that takes in patients, government, and the health professions. Government inclines towards hard measurements of effectiveness, efficiency, and economy, the performance related contract, and measurable indicators that are determined outside the profession. Most GPs would prefer self regulation using criteria based on personal care and clinical standards, though many acknowledge the need for accountability on basic standards, such as premises and equipment, staffing levels, accessibility, records, repeat prescription, and range of services. Such features have, of course, been assessed for the past 15 years before the appointment of general practitioner vocational trainers. This might be acceptable to GPs generally if it was carried out by experienced GPs visiting practices, perhaps accompanied by a family practitioner committee representative.

Clinical School, Addenbrooke's Hospital, Cambridge CB2 2QQ
R M BERRINGTON, FRCGP, regional adviser in general practice, East Anglia

High quality care

Defining and measuring high quality care is more difficult. Mechanic asserts that all organisations create formal sets of goals, responsibilities, and ideologies.[2] After discussions with many groups of GPs in the past few years I am sure that general practice is evolving its own, but the process should be developed formatively, using peer review and ideas from patients.

Historically we venerate the dual traditions of clinical competence and compassionate care. In the 1950s Craddock considered that the essential virtues of the good GP were "knowledge, personal care, and wisdom."[3] Since then the BMA family doctors' charter and the intellectual framework supplied by the Royal College of General Practitioners and by vocational training have provided a more detailed profile. Conflicts still exist between science and caring, between the independent contractor status and accountability, and between the holistic and so called reductionist approaches to general practice referred to by McWhinney.[4]

Model GP of the 1980s

The attributes of a good general practitioner are based in education: on knowledge, skills, and attitudes. The frame of reference is continuing personal care in the patient's environment at home, at work, and in the community. A list of priorities was recently drawn up in the East Anglian region.[5] Good GPs may not fulfil every criterion but should at least aspire to them.

Knowledge—Comprehensive knowledge is important to the GP. Clinical medicine, behavioural science, social work, administration, and management are the ingredients of successful general practice. Nowadays, knowledge is acquired in undergraduate, vocational, and, subsequently, continuing education. Performance review will enhance it, as will an appetite for medical publications.

Skills—Knowledge is useless without the ability to apply it. Certain skills must be acquired so that the doctor can exercise clinical judgment and the elusive art of general practice. Arguably the essential ones are: (*a*) To be

a good listener and effective in consultation and interpersonal skills. (*b*) Abilities in diagnosis, in early detection of illness, and in dealing with undifferentiated symptoms. (*c*) A capacity to see the patient's problems holistically. (*d*) Logical decision making and clinical management skills—especially sound economic treatments and sensible referrals for specialist or "community" help. (*e*) The ability to use preventive medicine. (*f*) Effective practice management and team work.

Attitudes—The good GP's approach should embrace: (*a*) Commitment to personal and continuing care. (*b*) Thoughtfulness about and understanding of patients and their problems. (*c*) Desire to develop professionally through continuing medical education and performance review. (*d*) Belief in the value of the primary care team and a willingness to exercise leadership. (*e*) Willingness to observe ethical principles. (*f*) Concern for patients at special risk—the chronically sick and disabled, the elderly, the mentally ill, children, patients with dependency problems, socially deprived people, and the ethnic minorities.

Measurement

Although there is now general agreement on what constitutes good general practice, it is difficult to evaluate the above criteria. Some would be difficult to measure by acceptable scientific methods, even if the appalling lack of resources for research in general practice were remedied tomorrow.

Attempts are being made to measure knowledge by assessing end points, such as the membership examination of the college. These tests offer the opportunity to set standards and provide consistency. Some GPs think that the tests should become an integral part of the certification of the Joint Committee for Postgraduate Training in General Practice.

On the other hand, certain skills and attitudes can be assessed only qualitatively by continuing assessment—for example, the Manchester rating scales for trainees and the "What sort of doctor?" reviews that were recently introduced for principals. We still have no acceptable proof, however, that high scores indicate "a good GP." As Stevens suggested, we can only continue to test such ideas as a prelude to action and pursue a better understanding of general practice by auditing its structure, process, and outcome.[6] More research is needed before pay can be related to hospital referral rates, let alone to Sanazaro and Williamson's five "d's": death, disease, disability, discomfort, and dissatisfaction.[7]

Meanwhile, good GPs should adopt peer review and send signals to the government on how to achieve high quality care and on possible pilot studies in this field.

Politics and the good GP

If the government genuinely wants good general practice it will commit substantial new funds to develop services and education. Management and resources for primary care teams should be concentrated in general practice under the leadership of GPs and under the direct responsibility of the independent family practitioner committees. The present system is divisive, and the recent Cumberlege proposals would compound the problems. A small share of the National Health Service budget is a poor incentive to the good general practitioner who cannot provide services simply for the "honour."

References

1 Secretaries of State for Social Services, Wales, Northern Ireland, and Scotland. *Primary health care: an agenda for discussion*. London: HMSO, 1986. (Cmnd 9771.)
2 Mechanic D. *Readings in medical sociology*. New York: The Free Press, 1980.
3 Craddock D. *An introduction to general practice*. 2nd ed. London: H K Lewis, 1958:2-4.
4 McWhinney I. *An introduction to general practice*. Oxford: Oxford University Press, 1981.
5 Berrington RM. *The next decade, priorities for general practice postgraduate education in East Anglia 1985-1994*. Cambridge: East Anglian Regional Postgraduate Office, University of Cambridge Clinical School, 1986.
6 Stevens J. Quality of care in general practice: can it be assessed? *J R Coll Gen Pract* 1977;27:455-66.
7 Sanazaro PJ, Williamson JW. End results of patient care: a provisional classification based on reports by internists. *Med Care* 1968;6:123-30.

Practice Research

Evaluation of the efficacy and acceptability to patients of a physiotherapist working in a health centre

G I HACKETT, M F HUDSON, J B WYLIE, A D JACKSON, K M SMALL, P HARRISON, JANET O'BRIEN

Abstract

The records of the first 805 patients who had been referred by general practitioners at this health centre to the attached physiotherapist were examined in November 1985, three years after the physiotherapy department was opened. Seventy per cent (549) of the patients had been treated within one week, treatment having started on the same day for 8·5% (67) of the patients. This compares with a mean of six weeks for direct access to a district general hospital that is eight miles away and between six and 13 months for the three nearest orthopaedic consultants who are 13 miles away.

The most common conditions treated were knee injuries (16·5%), followed by cervical (15·5%) and shoulder (13·8%) injuries. Surprisingly, only 9% were back injuries. The non-attendance rate was 2·2%, and only 7% of patients failed to complete treatment. Nearly all the patients were able to attend the clinic, only 4% requiring home treatment. By March 1986, 90 treatments a week were being carried out at a cost of £6·11 per patient. Compared with official hospital figures, this represents a savings of £21 500 a year for a practice of 12 000 patients.

Introduction

Physiotherapy is commonly used for a variety of acute and chronic conditions that are encountered in general practice. These range from acute injuries and postoperative rehabilitation to chest and