TALKING POINT

Closing the gap between GPs and hospitals

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After two years of hospital medicine in the Antipodes I decided to enter general practice as a vocational trainee. During my year I often reflected on this relatively new training and its present and future relationship to medicine generally. I was fortunate to have enlightened and enthusiastic practitioners to teach and encourage me in my practice in rural mid-Wales. This and reasonably healthy, tolerant patients provided a rewarding environment for my first experience in general practice. I became aware of the different perspectives and dimensions of our customers' problems in their social environment, and of the lack of appreciation of these differences. I was alarmed at the widening divide separating hospital doctors from GPs. There is growing indifference, lack of communication, and an unwillingness to share and divide the responsibilities towards patients.

The evolution of general practice and the hospital-based services are well known; their amalgamation under the NHS has been stormy and often characterised by reluctant tolerance. This may have been the consequence of long-established traditions and preservation of vested interests but things are different now. The second half of this century has seen great changes in medicine, which are familiar to all doctors. Fewer "diagnoses" now are tenable without advanced technical intervention. While careful observation by the doctor remains important, it is often only the preliminary to choosing the most appropriate diagnostic techniques.

More training does not equal better doctors

This change underlies many of the ills that divide the profession and the organisation of medical care has not adapted to the technology available, thus making it difficult for the NHS to dispense efficient unified medical care. Current discussions on manpower and medical education make no attempt to solve this problem and little consideration is given to future structuring when training programmes are instituted. A good example of this is vocational training in general practice, which will soon become compulsory for the aspiring family doctor,¹ on the rather naive assumption that more training will automatically mean better doctors and improved patient care. While skills and experience can be gained in various spheres of medicine, all of which are relevant, the ability to function as a "good" GP can come only from doing the job and trying to maintain sufficient interest and enthusiasm to keep in touch. In my view the problem is not that the training is insufficient, in either quantity or quality: it is that for most of his professional life a general practitioner is isolated from the mainstream of medical thought and practice and, more importantly, he finds himself excluded from direct participation in, and commitment to, the rapidly changing face of twentieth century medicine. Three years of formal postgraduate training will not alter this unless the other 40 years of professional life are taken into account. The occasional refresher course or lecture is no substi-

tute for clinical responsibility. I can foresee circumstances worsening as more trained doctors entering general practice with their newly acquired knowledge become frustrated by clinical restraints and their increasing dependence on hospital-based management, with the result that they will be denied any depth to their clinical practice.

There is a great deal of duplication and repetition of work, with the areas of responsibility in which both groups operate not only undefined but showing great variation between individual doctors. Some aspects of this problem have been highlighted by Higgins.² The use of specialist referral and the rates of referral are shown to differ widely and to be based little on morbidity or even the characteristics of particular doctors. Older practitioners with the longest experience tend to refer the least and those with a hospital link the most. Presumably the more experienced are either fully confident of making their clinical decisions without specialist help or have fallen so far behind current thought and practice that they are unaware of available diagnostic exclusions and current treatment. On the other hand, the doctor with close hospital contacts may either lack confidence in his clinical abilities or realise that the more he knows the less he is able rationally to intervene in diagnosis and treatment without definitive investigations. This suggests that the more highly trained doctor should have freer access to a wide range of specialised facilities without intermediate referral, a policy that should reduce the burdens on the hospital service and improve the clinical confidence and capabilities of the GP.

The necessity for such dependence on inpatient management has also been challenged by Forsyth and Logan³ and by Torrance,⁴ who all showed that up to 25% of men and 40% of women patients were considered not to need inpatient care. While such criteria are bound to vary from doctor to doctor, and innately by the nature of illness, it seems that our concepts of hospital management should be reviewed.

Specialisation and communication

Two fundamental changes are needed in our provision of health care to rationalise it and to restore a degree of satisfaction to doctors and the public. Firstly, the trainee general practitioner should be encouraged to spend his "training" period gaining detailed experience of one particular branch of medicine, becoming thoroughly proficient in that area, and then entering general practice with a special interest. In a group practice he should accept a degree of specialisation in the group. This would allow the doctor to keep up to date in his chosen sphere and be equipped to deal with pertinent problems in the practice. If this were combined with freer access to diagnostic facilities the work load of hospital outpatient departments could be cut radically.

The second change is for the specialist to move towards the community and for the GP to move towards the hospital. The specialist should visit the surgery with the general practitioner to review problems, thus enabling the GP to participate directly in the further care of patients. At the same time the GP should have free access to "holding" wards in the hospital where patients could be intensively monitored and investigated for short periods before being admitted for consultant care or returning home. During this time they should remain the

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general practitioner's responsibility with specialist referral if necessary. This would inevitably bring the GP more directly in contact with current medical practice and should lessen the burden on the hospital services. The latter could then function as acute diagnostic and therapeutic units, leaving most of the management to the GP. Similarly, much of the minor surgery, which grossly overloads surgical waiting lists, could be done by suitably trained and interested GPs. This would be appreciated by the patient and provide professional satisfaction for the family doctor.

There is great scope for altering traditional spheres of practice. It is up to the profession—and GPs in particular—to explore the possibilities, using closely monitored pilot

schemes. Resources are limited: it is important to deploy them efficiently and ensure that patients receive competent, caring service while doctors achieve professional fulfilment.

¹ Statutory Instrument 1979 No 1644. National Health Service, England and Wales: *The National Health Service (Vocational Training) Regulations 1979*. London: HMSO, 1979.

² Higgins PM. The GP/hospital interface. *J R Coll Physicians* 1979;13:132-8.

³ Forsyth G, Logan RFL. *The demand for medical care*. London: Oxford University Press, 1960.

⁴ Torrance N, Lawson JAR, Hogg B, Knox JDE. Acute admissions to medical beds. *J R Coll Gen Pract* 1972;22:211-9.

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services at the district level" might, experimentally, be exercised by "an advisory group of experienced NHS officers, who would report to the district health authorities."

Health Service auditors

This is a proposal which should, surely, be eagerly seized on and welcomed. The model for such an inspectorate (the term tends to raise hackles in the NHS but describes the function accurately) already exists—the Health Advisory Service, born as the Hospital Advisory Service in 1969, which covers services for the mentally ill, the elderly, and children in long-term care. This has established the principle and showed the practicability of using peripatetic teams of health service professionals to examine standards and of deriving criteria of excellence and efficiency from the standards set by professionals themselves as distinct from being imposed from the outside. So why not extend the principle and the practice to cover acute services and, dare I suggest, general practitioner services? Furthermore, why not extend the membership of teams to include community physicians and economists so as to ensure that standards of existing services are not raised at the expense of denying access to those whose needs have not been recognised?

Setting up such teams of health service auditors would have several advantages. It would provide members of district health authorities with an expert source of information independent of their own officers. This would be a direct incentive to exhibit

"vitality" in their managerial function rather than being trapped in the quicksands of often dubiously relevant data or meaningless trivia. Similarly, it would permit the DHSS to carry out its inescapable responsibility for the overall operations of the NHS without getting embroiled in interfering in day-to-day management. And, in the context of such an innovation in the "technique of government," the abolition of community health councils might be seen not as a damaging piece of cheeseparing but as part of a fundamental rethink of the problems of running the NHS.

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- ⁵ Hansard, House of Commons, 19 December 1979, col 687.
- ⁶ Royal Commission on the National Health Service. *Report*, Cmnd 7615. London: HMSO, 1979.
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local management was faced with ever-changing and often conflicting advice from the DHSS; local discretion was granted and subsequently withheld with increasing rapidity.

I interpret the new DHSS guidelines as a public declaration that this era of ministerial intervention is now formally closed. The "hot line" between the minister and the unions at national level has been withdrawn. Both management and unions are on their own and they may presume that after this circular they can expect little in the way of sustenance or sympathy from the DHSS. I presume that the meaning of this public declaration is that the abstentionist policy will now have to be adhered to by the Government until a subsequent and equally public decision is taken to change it.

Having been castigated for its lack of confidence in the past and its failure to apply coherent and consistent policies during previous disputes, NHS management is now encouraged by the Government to demonstrate a newly found virility. Some more

seasoned observers might suggest that this document overreacts: regrettably the same lack of experience and confidence in coping with a sustained trade union challenge at the work place can leave management with either the appearance of inactivity and ineptitude or a false sense of purpose where weak intentions are disguised by tough words. They are commonly two sides of the same coin.

References

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