PRACTICE OBSERVED

Organising a Practice

The single-handed doctor

M HAMID HUSAIN

For over 10 years I have practised single-handed in a small suburb of Rotherham. Professionally, this has been the happiest and most rewarding decade of my life. It has also turned out to be the most daunting and challenging period that I can remember, demanding total devotion to the care of patients and requiring a sense of vocation that I never could have imagined before.

The most satisfying aspect of a single-handed practice is, of course, the opportunity it provides for continuity of care for the patients and for developing close relationships with them. It is possible to acquire over time a knowledge of patients that extends far beyond their medical histories. Not only do I know all my patients who are diabetics, have hypertension, are disabled in some way, or have taken an overdose at some time in their lives, but I am often also aware of their personal circumstances and their domestic problems, their attitudes and personalities, their fears and obsessions. After a while one recognises not just their faces but their voices too. It is not at all unknown for my patients to phone me for advice or to request a home visit without giving their addresses or sometimes without even mentioning their names. I shall always remember the morning at 2.30 am when a harassed voice on the phone shrieked, "It's Bert, doctor." "Come quickly, Margaret is in a pool of blood." And then he put the phone down. I had to think quickly of all the "Berts" in my practice until the high-pitched voice of one whose daughter was Margaret came to mind. With a doctor-patient relationship of this nature it is obviously easier to establish a rapport and develop mutual confidence and respect. The patients feel less inhibited during consultations and are able to discuss their worries, anxieties, and problems—sometimes of a very personal nature—in an atmosphere of trust and relaxation. Their respect and consideration for the doctor is reflected by making less than the average demands upon him outside normal working hours.

Rotherham, South Yorkshire S60 3HE.
M HAMID HUSAIN, MR, MRCP(S), general practitioner

Freedom plus some problems

The doctor who works single-handed has total freedom in planning and organising his programme. One does not need the approval of a partner before purchasing an extra stethoscope or electrocardiograph for the consulting room. It is possible to take a night off, provided one is prepared to pay for it, without having to worry whether it will be agreed by a partner—or the partner's spouse, for that matter.

There are problems, of course—big problems. The obligation to provide cover round the clock for over 2000 patients throughout the year can never be underestimated or ignored. It requires conviction and courage, everlasting patience, a sense of responsibility and commitment, and a special temperament, not just from the general practitioner but from spouse and family too. It is impossible to run a single-handed practice satisfactorily without the support and understanding of one's family. One of the most tedious features is to have to be near a phone all the time. Although the messages are usually received by the staff at the surgery during office hours, it is invariably a spouse who gets lumbered with answering the phone in the evenings and at weekends, thus interfering with personal life and social engagements. The strain on the family of being "chained" to the practice may indeed be enormous.

COVER

THE ONUS for providing adequate cover at all times for patients remains with the general practitioner. Furthermore, he is responsible for the actions of those who stand in for him, unless the locum in charge happens to be a principal in general practice. Unlike some of my rural colleagues, with whom I have every sympathy, I at least have access to a competent deputising service run by Aircall. Subscribing to them each month—rather like an insurance premium—gives me the option of calling on their services at short notice should my wife suddenly have the urge to go to a concert. Although it reduces my income,

Saving money on staff salaries is counter-productive, but economy may be made by using the phone at peak times, reducing the heat when the surgery is not in use, and buying stationery, medical supplies, and other stock in bulk. Making a budget for the anticipated expenses for the coming year is a salutary and worthwhile exercise and helps one to keep under review the outgoing expenses. Many practices fail to provide for tax and are surprised to be faced with a huge bill, which always arrives at the most inconvenient time. When cash flow is poor there is less money available for capital expenditure on essential equipment for the surgery.

There is therefore more to running a practice than conducting surgeries. The Medical Practices Committee is unwilling to

appoint any doctor, however qualified, to a single-handed vacancy unless he or she has had experience as a principal. Young doctors who have completed vocational training are increasingly on the look out for suitable practice opportunities and there are pressures on the committee to relax the present directives.

Despite the problems, the responsibilities, and the inevitable encroachment on my family and social life I have never regretted practising alone. It has taught me many things, tested my patience, and tried my stamina, but it also has invigorated and rejuvenated and has given me something much more important—fulfilment.

Paying General Practitioners

Salaried service—a basis for the future?

JOHN ROBSON

Ever since the beginning of the National Health Service there have been suggestions that the standard of primary care might be raised if general practitioners were paid salaries instead of remunerated as independent contractors. Most GPs have disagreed strongly with this suggestion and their representatives have consistently opposed the idea, but it has been proposed again recently, particularly in discussions on dealing with the problems of inner city primary care. Accordingly, we have asked one author, Dr John Robson, to make the case for a salaried service and another, Mr Michael Lowe, to oppose it.

For the past 30 years many doctors in Britain have been paid a salary. With the exception of Finland, it is only recently that serious discussion on a salaried service has begun in other Western countries. Moves towards a salaried service have now taken place in Canada, Sweden, after the Seven Crowns Reform in 1967, and more recently in Italy and France.¹ The alternative has been a variety of fee-for-item-of-service and capitation payments, each of which has produced its own problems—an increase in the number of procedures performed, extended lengths of stay in hospital, high prescribing rates. Paying the general practitioner for each patient on his list (capitation), as done in Britain, Denmark, and the Netherlands, has certainly been superior in this respect to paying a fee for item of service, as done in Belgium, France, Germany, and Italy, with prescribing rates double or even triple in Italy.

No system of payment by itself guarantees good practice, but there is much to suggest that a salaried service that is appropriately weighted for work is least open to abuse. It is the framework within which quality of care for whole populations may most efficiently be developed.

Equity and the 1966 package

Average medical incomes in Britain have lagged behind those in Europe—a multiple of 2.7 that of the average manual earnings.

London E14
JOHN ROBSON, MR, MRCP, general practitioner

for men, compared with 6:1 in Germany and 7:0 in France.² This mainly reflects a considerably lower expenditure on health services in general in Britain, though the decline in the differentials that separate the traditional professions from the rest of the working population has contributed. To take comparable groups together—barristers, army officers, solicitors, clergymen—in 1913-4 their earnings were 3.7 times that of the average manual wage. By 1960 the ratio had fallen to 2.5, and it continues to decline. What has been most striking in Britain though is the reduction of differentials within the profession. The ratio of a consultant's income to a general practitioner's has fallen from around 6:1 in 1913-4 to 2:1 in 1955-64, until now the income of a consultant and a general practitioner is broadly comparable.³ In contrast, differentials between specialists in Europe, the United States, and Canada have remained considerable. In Canada otolaryngology, orthopaedics, and plastic surgery are at the top and medicine, paediatrics, psychiatry, and general practice are at the bottom of the net income ladder, with a highest to lowest ratio of 1.74.⁴ In Britain equity within the profession has been associated with the moves towards salaried status, and for general practitioners the main step was taken with the 1966 package. Between April 1960 and April 1970 retail prices rose by 46.7%, the average net income of GPs by 103%, and that of consultants by 62%.⁵

But the question is how, and not how much, doctors are paid. It took almost 20 years for us to realise what hospital doctors had gained by salaries—free premises of a minimum standard, free access to a range of facilities, free provision of support staff maintenance, nursing, technical, administrative, and not least medical—and the guarantee of a continuous increasing income. The illusion of independent contracting crumbled with the edifice of the voluntary hospitals. Clinical autonomy came to rest upon guaranteed access to planned resources. The creeping independence of the provider societies, the rattle of collecting tins, and the more grotesque variations in the quality of care were consigned to history.

For general practice the demand for quality was not pursued with quite the same enthusiasm. Salary and a planned structure were all right for the hospitals, but Lord Moran felt that capitation fees would be more suitable in general practice for "unless there is adequate incentive . . . to keep men on their

this service at least maintains my sanity and gives me the satisfaction of contributing to the pool of practice expenses, which are subsequently reimbursed by the Revenue Body to all general practitioners.

Not having partners to share the work load means that one has to plan well in advance for holidays and to budget for the locum fees, which are fairly expensive and have to come out of one's pocket. Good, reliable locums are not easy to find, and there is always the fear of someone letting you down at the last moment. I have a very satisfactory commercial arrangement with a local colleague who deputises for while I am away. On BMA business or short holidays, it is a shame that the National Health Service does not make adequate provision for the sickness of general practitioners, and single-handed doctors are the ones most at risk. The locum allowance is much lower than the cost of a substitute. A single-handed doctor needs to make ample arrangements for sickness insurance—and this cannot be emphasised too strongly. Financial considerations may also deter a single-handed doctor from attending postgraduate courses, and the attempts of the General Medical Services Committee to obtain a fair deal for single-handed doctors are welcome.

ISOLATED?

The professional isolation of single-handed general practitioners has, in my view, been considerably exaggerated. I think that those who care about standards would go to any length to keep their high, whether working alone or not. Monitoring the progress of my patients and keeping regular contacts with consultants helps me to re-evaluate myself. To say that isolation, such as may exist, may be removed by a doctor joining a partnership is to show total ignorance of the realities. I have known of partnerships where the individual doctors hardly speak to each other, let alone meet and discuss daily problems in the practice.

Organising the practice

If the needs of patients are to be properly met the single-handed doctor must be a good organiser and administrator as well as clinically competent. He needs to know about and have a fair for financial matters. On his shoulders rests the responsibility for organising the practice so that all the patients on his list have an opportunity for consultations and access to all the medical and paramedical services they need. Providing suitable services for the community is, after all, the raison d'être of general practice.

Having adequate and well-furnished premises with proper investigative and treatment facilities is, of course, mandatory in any good practice. A general practitioner has to be available for at least 20 hours (spread over surgery sessions and home visits) of a normal working week to claim the basic practice allowance. The practice commitment of a single-handed doctor is naturally much higher than this. The actual number and duration of consultations held is determined by the work load and type of additional facilities offered—for example, antenatal, cytology, and well-baby clinics.

STAFF AND COLLEAGUES

Competent, compassionate, reliable, and responsible secretarial staff are the backbone of a practice, and I simply cannot understand some of my colleagues who manage without them in the interest of economy when 70% of the salaries of the equivalent of two full-time staff will be reimbursed to each principal. When properly trained the staff can ensure that the surgeries are run and the patients are seen in an orderly fashion and that the case records are kept tidy and stored safely. Apart from my wife, who, of course, is married to the practice (and

thank God, finds that relationship bearable and helps with the reception and clerical work at a small consulting room at the back of my house, most single-handed doctors still have them). I have two other super women at my medical centre. In addition to their obvious duties, they check that the centre is well stocked, that ambulances for the patients are booked in time, that the age-and-sex register is kept up to date, that all new patients have been registered, and that no temporary resident has left the surgery without signing the form, and they keep me informed of the messages received from the patients at the surgery so that I can plan my work to attend to urgent calls quickly without interfering with the routine surgeries and clinics. Investing in a radiotelephone has enabled me to keep constantly in touch with my secretaries while I am driving to visit patients.

Working alone places an additional responsibility on the general practitioner when deciding to what extent to investigate patients, how long to treat them, and, more importantly, when to seek further specialist help. Good basic training, experience, self-confidence, as well as awareness of one's limitations and the ability to communicate and liaise effectively with hospital doctors, community nurses, health visitors, midwives, social workers, psychiatrists, assistants, occupational medicine officers, and the regional medical officer are all essential if the patient is to get the maximum advantage from the NHS.

A single-handed doctor must assume leadership of the primary health care team and should be able to coordinate the activities of all the medical and paramedical staff under his guidance. Keeping close contact with others connected with health care is helpful in monitoring the health of patients. Although I do not see my nurse, health visitor, or midwife every day I do know that I would be immediately informed if they were unhappy with the condition of any one of my patients. It is possible to be in complete control of one's practice and yet be receptive to the suggestions and ideas of others. A general practitioner who becomes paranoid about his own ability and importance and listens to no one is doing a disservice to himself, his colleagues, and, above all, his patients.

Running a business

Let us not forget that general practice is after all a business and depends for its efficient running on a healthy cash flow. Although some payments—for example, basic practice allowance, capitation fee, seniority and social security allowances—are automatically paid at quarterly intervals by the family practitioner committee (FPC) the general practitioner has to make regular claims for the item-of-service payments, such as maternity, immunisation, and cervical cytology, and for the reimbursement of rates and rent of the premises and of the salaries of the ancillary staff. I usually delegate the responsibility of completing the appropriate FPC forms to one of my secretaries, while checking periodically that all the claimable items have been sent to the FPC by the target date. A single-handed doctor has to know the "red book" thoroughly to appreciate what allowance or fee he is entitled to and how to apply it. It is not widely known that the FPCs are usually prepared, when requested, to send the practice a monthly advance on account for most of the quarterly allowances. The administrators of the local FPCs are usually very knowledgeable and helpful, happy to give guidance if one only cares to approach them.

It is obvious that the cash flow does not just depend on money coming in. One has to keep a vigilant eye on the outgoing expenses, making every attempt to reduce the operational costs to the minimum compatible with maintaining decent standards. The main items of expense are, of course, those of staff salaries, rates and rent, heat and light, insurance, telephones, stationery and equipment, and maintaining the car. Since these cannot be shared in a single-handed practice, the doctor's net income is reduced. I estimate that we will over 65% of my gross income is accounted for by expenses.

toes . . . a whole-time service would be an incalculable disaster."¹⁴

Unsurprisingly from the BMA Bevan excluded the salaried option from the new Bill and the premises—the health centre that was to have been the "cornerstone" of the new service—were curtailed by ministerial circular on the grounds of cost.¹⁵ It was no wonder that GPs felt they had gained little more than an increased number of patients on their lists. But the solace sought in becoming independent contractors and the vagaries of payment by capitation became a millstone, acknowledged in deed if not in fact. It was a status that could not be reconciled with either the economics of efficient practice or the aspirations for quality held by most practitioners. If in 1945 they had reached into the past, then in 1966 it was very different. The proposals, which included substantially increased basic allowances, the payment of rent and rates, additional support staff, supplements for out-of-hours work, and seniority payments, were supported by over 17 000 GPs. Only 2000 voted against.¹⁶

Half a century of shopkeeping in the Lloyd George tradition had finally convinced the government and profession that there was little hope of adequate premises or staff if the only source of funds was the income of practitioners in a fluctuating private market. Any senior doctor in the inner cities can testify to the treachery of work done on the basis of health care. The devastating effect of capitation, with its single-handed practice, competition for patients, concentration in densely populated areas, high list sizes, and substandard premises—still in use today—has been inescapable. The move in Britain towards a salaried service and the original charter included a salaried option, meant a rejuvenation in the quality of resources and the local organisation of care. There was never any doubt that when a formal career structure was established the vocational trainees would be salaried. What other option could have been seriously contemplated?

Gaps in provision

One foot, however, remained stuck in the past, and 1966 has proved to have been an unsatisfactory halfway house. Important parts of care have continued to fall below an irreducible minimum standard. The present system of incentives, particularly in sparsely populated areas, has proved to be insensitive to the needs of doctors and their patients. Most importantly, the remnants of independent status are proving an increasing obstacle to the development of primary care.

In the recent studies of primary care in inner London, access was evidently a problem for the 10 to 15% who were not registered with a GP. Fifteen per cent of the premises fell below the minimum standard acceptable for providing general medical service, and in some areas the figure was 80%. Twenty per cent of principals did not employ support staff of any kind.¹⁷ There is no reason to suppose that the findings would have been very different in Liverpool or Manchester, though access at least might have been better in industrial South Wales or the North.

While a few may prefer to practise without any staff, the condition of premises suggests that there are still financial deterrents to providing minimum facilities. Even for those who do not wish what evidence we have of the quality as employers? Do our receptionists have agreed forms of service or nationally agreed pay scales? How many are formally trained for the work they do? Despite the verbiage, the team approach is not recognised in the present contract, and payment takes little real account of it. At best, attachment of staff is nebulous and co-ordinated strategies primordial. Where they have been started—for example, computerised immunisation schemes—the initiative has mainly come from outside general practice.

If the organisation on weekdays is sometimes vague, what of the rest? Some form of out-of-hours cover for those who are not shared in a single-handed practice is certainly desirable, but subcontracting to the deputising services has all the worst features of the building trade—a high turnover of casual labour,

no training requirement for the job in hand, no agreed scale of charges, and no generally agreed monitoring of either utilisation or performance.

The next step

For the future, contracting or subcontracting independently seems even more anachronistic. The trend is towards interdependence—with secretarial staff and receptionists, with nurses, midwives, health visitors, and all the other ramifications of comprehensive primary care. It is towards continuous anticipatory and preventive care.¹⁸ Experience both here and abroad has shown that such a strategy cannot be rationally organised on a basis of either capitation or item-of-service payments. Where are the very substantial resources, acceptable facilities, staffing, and equipment required for these programmes now proposed by the Royal College of General Practitioners to come from? Good primary care that is well organised is not cheap. Contractor status has been a licence for underfunding in which both capital and staffing rates have lagged further and further behind the hospital sector, and there is no sign that this trend is slowing. In 1971-8 the number of hospital doctors increased by 30.2%, and general practitioners by 19.8%. Independent status has permitted governments legitimately to disclaim responsibility for the problems of provision in a fourpenny service. If free primary care is to be a reality, then the equipment we made available would there be any empty places? The offer has never been made.

As yet we have little idea of the sort of structures of control that will integrate local needs with national standards. So far at least we have escaped the clumsy apparatus of cost control that has proliferated in Europe and the USA. Free from utilisation review, tissue review committees, professional service review, and the additional bureaucracy protecting consumer and paymasters, consultants in Britain are the envy of their colleagues abroad. The rounds of committees on which they sit are a measure of the control they have retained rather than a measure of externally imposed constraints. If primary care in the future is to be a diminishing backward then the issue of control can be safely ignored by governments. If, however, there is to be a real expansion of the primary sector then the basis of control will be refashioned from without if not done from within. Most doctors would prefer to be answerable to their peers and to their patients than to the officers and clerks, yet our experience of audit and patient participation groups is in its infancy.

If appropriately weighted salaries, a planned structure, capitation, consultation rates, out-of-hours provision, and other indicators of presented needs—then a salaried service could be a sensitive index of the effort expended and the needs met. By removing the final financial barriers to the change takes place and provision of staff and premises, a salary can provide minimum facilities without penalty. Most importantly it can provide a framework for the clinical quality can be developed.

The widening gulf between what is now possible and what is in fact done has highlighted the inadequacies of the present system of payment and organisation of primary care services. As long as the system is based on the distribution of income, likely to hurt us into the void by the centrifugal force of the rhetoric. Here is a proven a workhorse for doctors, expensive for the country, and bad for patients. It is increasingly being rejected by the collecting tins of the profession.

There now seems to be real ground in Britain on which to develop a salaried service. In conjunction with expanded resources, it has become a measure of necessity if the delivery of care is to be improved. It is to be hoped that the "salaried provision" or for selected groups—for new entrants to practice, for those working from health centres, for those who cannot

leakage should not occur.—Useful hints to householders are that all houses should be supplied with a stop-cock, so that in case of severe frost, or in the event of repairs, the water can be easily turned off; without having to hunt for the regular official, and causing general inconvenience. The stop-cock should be placed in a convenient position, and the water-cistern should have a properly fitted cover. It is advisable, when practicable, to provide a separate system for the storage of water for fire purposes, and to have a separate stop-cock for the fire-cistern and the water-closets. The frictional parts of all sanitary fittings should be kept regularly oiled. The seats of water-closets should be loose or fixed with hinges, so that they appear to be loose, but are really fixed. The fittings should be the same as at sea. It is of great importance that all pipes and fittings should be securely caulked at sea. To prevent the bursting of pipes in severe frost, the water should be turned off at the main, and the pipes should be covered with straw, or other material, and the water-cisterns and pipes thickly bolted, or, casing them in sawdust, will generally prevent the freeze from freezing. NB.—The pipes burst in the case of a stop-cock being placed in a position where the water is frozen. Water will rarely freeze if it is kept slightly running from the tap. In order to secure clean and wholesome water for drinking and cooking purposes, all water cisterns should be cleaned out at least