PRACTICE OBSERVED

Conference Report

The future of general practice: more elderly, less money, and scattered computers

RICHARD SMITH

Earlier this month about 300 general practitioners deserted the daily worries of their practices and motored up from Cornwall to the Hyde Park Hotel, took the overnight bus from Port Talbot, or cycled in from Brixton to contemplate the future of general practice at the Royal College of General Practitioners' annual symposium. Even if that future did look more bleak than bright (but then the future always does), and even if there was much nigh on incomprehensible talk of "liveware versus software," "paradigm shifts," and "Illich options," it must have been delightful to have been in London—for when the talking was over, or even before it was over, there were the theatres, the fine restaurants, and the dens of iniquity for which London is famous. Many of those at the conference must have jumped at the opportunity to "eat, drink, and be merry" for there seemed to be agreement that quite likely "tomorrow we die" en masse.

The possibility that general practice might not have a future was touched on briefly. One reason that it might not have is because maybe none of us have a future. Professor Metcalfe put the probability of there being a "thermonuclear exchange" in the next 20 years at 50%, while Dr Julian Tudor Hart thought it inevitable if doctors didn't get their heads deep into the muck of politics and change the course of our society. But, nuclear obliteration apart, the feeling was that primary care would be around in 20 years' time, and maybe it will have to expand considerably if there is to be a shift from hospital care to community care. Professor Alan Maynard, professor of economics at York, sounded a warning note, however, when he pointed out that community care might well turn out to be more expensive than institutional care and it might be necessary to

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about the future is necessarily scarce, is that there will be the end of the century by many more old people and fewer younger people to support them. By the year 2000 there will be a 16% increase in those aged 75-84 and a 61% increase in those over 85, whereas those aged 65 and 74 will decline by 13%. After giving these figures, Professor Acheson pointed out that all was not gloom because improved pension schemes should mean that the elderly of 2000 should be better off than the elderly of 1981, and also the elderly of the future should be less dependent. He reminded the meeting that general practitioners have a large part to play in ensuring that dependency rates do fall—for instance, by being more effective in managing hypertension and so reducing the incidence of stroke.

Although he emphasised that every effort should be made to keep the elderly as independent as long as possible and with their own possessions about them, Professor Acheson sounded ominously like a chairman when he said that, on the future it might be necessary to "concentrate the elderly" to be able to cope. This statement was especially ominous because it followed Professor Maynard's observation that the elderly might have to be cared for in institutions simply because they were cheaper.

Other social changes

Other social changes that Professor Acheson touched on were that family stability might fall further over the next 20 years, leading to more people living alone and more single parents. Single people use health care resources more than those who live with others, and so here was another factor leading to rising demand. Professor Acheson also spoke briefly, as he was expected to do, about inner cities, saying that he thought that depopulation, with the poorer and more dependent being left behind, would continue—at least in London and on Merseyside—until the end of this decade. He did, however, insist that he was "pleased" by the government's recent response to his report of two years ago on inner city primary care. Some of those at the conference thought that the response had been inadequate and that Professor Acheson was being uncharacteristically politic because of the difficulties of his new position.

Perhaps general practitioners should be grateful that any money at all has been earmarked for inner cities because another theme of both Professor Acheson and Professor Maynard was that money was going to get progressively shorter and that the era of uncontrolled financing of general practice was over. Those who doled out the money were going to become much more concerned about how it was spent, and Professor Maynard said they were going to want to know which activities gave best value for money. General practitioners, he said, would have to take a leaf out of Mao Tse-Tung's red book and start studying hard—particularly economics and how to minimise costs and maximise benefits. In the fight for money with hospital services and others, they would have to be well armed with economic ammunition or they would go to the wall. Neither Dr Tudor Hart nor Sir George Goddard, a past Chief Medical Officer, were happy with this view of the economics of health care. Dr Tudor Hart didn't like the idea of his practice in south Wales being stripped down to some sleek, efficient, monetarist machine that employed few people while 40% of his village was unemployed, whereas Sir George thought that reducing everything to money terms was shortsighted. All were agreed, however, that general practitioners would have to become more canny about resources. Dr Tudor Hart advised everybody at the conference to go home and employ as many ancillary staff as the reimbursement scheme allowed because the government would "plug that loophole soon."

The theme of people versus technology and efficiency ran right through the conference, and Professor Metcalfe made some doctors' blood run cold by describing a high technology future in which every aspect of general practice would be computerised. But he tried to make it clear that he thought that imaginative and

imaginative use of computers should mean more freedom for doctors to do what they were best at and an improvement in the doctor-patient relationship. Linking together two themes on which the college is very keen—computerisation and the doctor-patient relationship—was a marvelous sleight of hand, but much of the audience remained sceptical. Yet Professor Metcalfe was very persuasive that "civilised hardware" (printers that don't deafen you, and screens you can see), and "advanced software" (the artificial intelligence type—really smart machines) that would prompt, remind, and correct the erring doctor, together with information being shared between doctors and patient would lead to a new dawn of both being happy with their machines and their relationships.

The idea that patients should be given access to their records was one that came up time and time again, and many doctors were clearly strongly attracted by the possibility. Others were worried that medical problems might result, but the end impression was that patients will by the end of the century have much better access to their records—be they on computer or in a Lloyd-George envelope. This sharing would fit together well with another expected development of patients taking much more responsibility and interest in their own health. This was a theme advanced enthusiastically by both Dr M A C Dowling from the World Health Organisation and Mrs Anne Richardson from the Policy Studies Unit, and it had a welcome effect of inevitability about it.

Written records were discussed much less than computers, which is perhaps to be expected at a conference concerned with the future, but at the same time this emphasis illustrates one of the great problems of general practice. While 300 general practitioners were sitting in a hotel in London arguing about the possible benefits of complete computerisation, many of the other 24 000 were out in what the Americans expressively call the "boondocks" practising with records that are utterly inadequate for modern general practice. Similarly, while college members are being called on to audit their practice and participate in the "quality initiative," a good many general practitioners are simply grinding their teeth and bearing it. The question of how the college could help to raise the standard of general practice right across the board came up several times, but people didn't really get their teeth into it.

A question that provoked more discussion was the future of the relationship between doctors and nurses. Miss Sue Mowat, director of nursing in Tower Hamlets, thought that health teams hadn't come up with the goods and that "teams" should be replaced by "groups" where conflict was minimised and it was recognised that each member had distinct skills. She was worried, too, that the work and status of district nurses were being undermined by practice nurses. In contrast, Dr Tudor Hart thought that district nurses were so constrained in what they could do by the nursing hierarchy that their contribution to the care of general practice patients was very limited. This statement was applauded, and, although many doctors clearly get on well with their nurses, all is by no means well with the team group concept. It is hard to imagine that teams groups will disappear from general practice, but most doctors need to go into making them work better.

How to change

The conference appropriately devoted much time to considering the education of future general practitioners. Professor David Morrell looked at the whole process from A levels to retirement and found some sad deficiencies. He started by saying that we needed much better ways than three good A levels of selecting medical students. He then suggested that medical training should have stated objectives, and he offered the conference some: two central ones were that future general practitioners should be better at changing, and evaluating both their own standard of practice and the claims of researchers and drug companies. The abilities to change and evaluate were at the

moment, he thought, sorely lacking. He thought, too, that more of vocational training, and particularly the first year, should be spent in practice rather than in hospital. Dr Dowling was also keen that more medical training all round the world should be done in the community. He made the interesting statement that in many developing countries doctors are the major obstacle to raising health standards. This couldn't help but remind me of Ivan Illich's statement in 1975, which seemed outrageous at the time, that doctors were the main threat to health in the modern world. Yesterday's heresies may be today's establishment wisdom. Professor Morrell concluded by saying that more thought needed to be put into continuing education, particularly into supporting young principals, if a doctor were off the rails in the first few years of practice he was unlikely to return.

The college obviously has an important part to play in attempts to raise education standards, but Dr John Hasler, the retiring secretary, saw it as able to do very much more as well. He reminded the conference of the recent creation of the patients' liaison group and of the "quality initiative," and then went on to

What Annoys Me Most

The telephone

OLIVER SAMUEL

What annoys me most about general practice? It's the damn telephone of course! I've spent my whole professional life entangled in a love-hate relationship with that penetrating, persuing electronic intruder. I really should have paid greater respect to my elderly senior partner who refused to have a phone in the consulting room. His marvelously patient wife took phone messages in the kitchen and only ever summoned the doctor to the instrument if it was absolutely unavoidable. This she did by banging heavily on the wall that divided the living room from the small surgery at the side of the house. The doctor then had the option of not hearing the signal or taking so long to come through to the phone that only the most persistently importuning caller had the opportunity of actually speaking to him. Patients quickly learnt that they had a much better ally in the doctor's wife, and if the matter could actually be dealt with over the phone then she would cope with great courtesy and expedition. As soon as I took over the practice I had a phone installed on the desk and it has been downhill ever since.

As a medical student and then as a junior houseman I remember a surge of self importance in having a phone by the bedside ready to summon me in a flash to lifesaving deeds of great skill and critical importance. The glamour didn't last very long, as in my last job I had to share a bedroom with a colleague who was on duty those nights that I was off. In a busy one in two rota this meant interruption night after night until we could stand it no longer and threatened to quit unless we were housed

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say that he wanted the college to do more in helping its members to manage time and handle change, to do more research into cost effectiveness, to encourage more responsible prescribing, to adopt a higher profile in the media, and to be more political and improve relationships with the government, the civil service, the General Medical Services Committee and the local medical committees. Such an energetic programme can perhaps be advocated more easily by somebody who is finishing his spell in office rather than just starting, but Dr Hasler has been a very successful secretary. In any case if progress is to be made within the profession the college will need to go hand in hand with the General Medical Services Committee and its local committees.

So will this conference have fitted those who attended to face the future in a more intelligent way? I think it must have done, and I think that individuals and groups both large and small have more to gain by following Miss Pritchard's advice and setting time aside to consider the future—even if at times such consideration can be very painful.

separately. In almost no time I had become so sensitised to the telephone that I would wake and reach for the instrument even when the phone was ringing in the house next door. Curiously, after our first daughter was born my wife reacted similarly to the first sign of any baby whimpering anywhere in the street. I never ever heard the babies, but those phones. . . .

Surely I am not the only sufferer from paranoid telephonic tinnitus being got at by the telephone bell wherever I go. I suspect that our local hospital is exclusively staffed by telephonic telephone operators. They probably spend all morning huddled in the rest room, drinking tea, and trying not to notice the ringing. Funnily enough though, I have actually been into the switchboard room at the hospital and met the supervisor and some of the staff. Face to face they all seemed friendly, concerned, hard working people doing their best with rather inadequate equipment. An astonishing change in my perception took place when I discovered that those brisk disembodied voices actually belonged to real people who get frustrated in the struggle to contact doctors who don't answer their beeps or staff who won't pick up their extension no matter how long it rings. From the exchange it seems clear that the real sufferers are at the other end of the line and they have plenty of witnesses to prove it. It is disturbing the way that the people you only know over the phone turn out to be completely different when you actually meet them for the first time. It is as if you are only then seeing the real person. Yet on the phone some people seem astonishingly unimpaired and able to demand attention and become angry, laconic, hysterical, or pathetic in a way that they would never risk in a face to face confrontation. There seems to be a professional quality to a conversation with someone who cannot be seen or touched, see how anyone can feel. Small wonder that the Samaritans are so effective in helping lonely people who need to talk anonymously with a friendly voice.

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Relentlessly pursued

My trouble is that I feel too accessible, too exposed, to anyone who wants to talk to me on the phone. I find it impossible to leave a ringing phone unanswered as it really might be important. So I resent it when my patients discover that they can quickly and easily cut through the tedium of waiting at the surgery to see me by just giving me a ring when they feel like it. I'm not busy. I don't want to trouble you doctor, I just need a word of advice. "I didn't want to take up your time, so I thought I'd just have a few words." The requests are perfectly reasonable, but it is nice that they have been put so consistently. How can the callers realise that I have been relentlessly pursued by such trivial interrupting telephone calls all my life. Even when they matter, I resent being pestered by them. They transform me from being a kind and considerate Dr Jekyll into brusque and evil temper as I struggle to deal with their maddeningly disembodied voices. They reach out and distract me during meal times, when I

am in the bath, trying to read, or asleep in bed. I find it almost impossible to give a patient sensible advice on the phone, as all my experience dictates that having heard the story I need to see and examine the patient before I try to decide what to do. As I resent the phone calls I can hardly take a proper history over the phone anyway. I really don't see how anyone can feel confident of a telephone diagnosis when the information is electronically filtered and can be perceived only by one of the five senses normally engaged during a real consultation.

Although I couldn't possibly work without one, I have very mixed feelings about phones and I think them a very poor substitute for actually meeting, either for professional or sociable purposes. Why then do my children spend hours on the phone moaning desperately at friends they have only just left and are due to meet again very shortly? Damn it, don't they know I'm on call? For God's sake get off the line, someone might be trying to get through to me.

Practice Research

Evaluation of screening for hypertension in general practice with an automatic machine

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Abstract

An automatic device for measuring blood pressure was used to screen all patients aged 30 to 65 years registered at a health centre. Of those who were eligible, 58% attended. Patients with previously recognised hypertension were more common among the attenders than among the non-attenders. High readings obtained on the automatic device possibly deterred some patients from reattending for follow up measurements of blood pressure. Although the device is quick and easy to use, the logistic challenge of formal blood pressure screening is considerable. Hypertension was discovered in 12 patients (mean diastolic pressure > 100 mm Hg). Retrospective analysis of their medical records showed that a third had had an abnormal blood pressure reading noted during the past 10 years and no further action had been taken, and almost three quarters had attended their practitioner during the previous year without having a blood pressure measurement recorded. One year after the screening procedure two fifths of the newly discovered hypertensive patients had defaulted from follow up and treatment.

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Automatic devices are not a short cut to the discovery of occult hypertension. Case finding by routine measurement of blood pressure at surgery visits is more efficient.

Introduction

The availability of automatic devices to measure blood pressure has rekindled interest in screening populations for occult hypertension. One such machine was temporarily installed in a local health centre to screen the patients in the practice. We have investigated the practical problems posed, the range of people attracted by the offer of automated blood pressure screening, and the subsequent response of newly discovered hypertensive patients to their problem. Furthermore, we attempted to compare the efficiency of automated blood pressure screening in the community with case finding by the routine measurement of blood pressure at unrelated health centre attendances.

Methods and results

PRELIMINARY WORK

The Prestwich Health Centre has 13 000 patients on its list, who are shared among four practices and five general practitioners. It had been decided to screen all those aged 30 to 65 years: 5367 patients (42% of the practice population) fell into this age group. Because of the large numbers it was thought essential to prepare a computerised age-sex register—a time consuming procedure, taking more than 200 hours of secretarial time. Roughly 6000 letters were sent to patients during the study: an explanatory letter with the invitation to have a blood pressure check and then a second letter to all those with a high initial reading. The computerised record allowed all correspondence to be automated.