PRACTICE OBSERVED

Reflections on Practice

Reconstruction of general practice: failure of reform

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Thanks to the protection provided by the National Health Service Britain has preserved its corps of general practitioners, and this is probably the main reason why its health costs are among the lowest in the world. But general practitioner care is offered within a restricted range of services, and the development of programmes that reach beyond the hospital tends to narrow it further. Many general practitioners think that the skills that they have acquired are not being fully used.

The BMA has devised a programme to reverse this, giving general practitioners the opportunity to perform clinical procedures that might bring them closer to the hospital world from which they are separated. The Royal College of General Practitioners has proposed a different programme that is designed to keep general practitioners at work in the community focusing on prevention. Neither programme has made much progress because the government has failed to provide the financial inducements needed for success. In the present economic climate it appears that no change stands a chance of acceptance unless it holds out the prospect of lower costs or a more efficient service.

In this two part paper I argue that the way out of this morass is by employing nurse practitioners. Nurse practitioners working in primary care teams could relieve general practitioners of routine work, enabling them to develop skills not fully used. In the process the quality of care might rise, and that would enable the profession to deal with a problem that it has been reluctant to tackle. There is every reason to expect the government to react favourably because the savings in costs generated by employing nurse practitioners could be used to finance inducements that are designed to extend the range of general practitioner care.

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Failure

General practitioners working in the National Health Service are independent contractors who rarely recognise that a reciprocal relationship exists between them and the health service: to a large extent both depend on the survival of the other. It is hard to see how the restricted range of general practitioner care in Britain could continue without the financial security provided by the health service. But it is just as difficult to see how the health service could maintain the principle of universal coverage (its most distinctive feature) without general practice.

Where the survival of general practice is concerned we need only look at the experience of other countries to see what might happen. Elsewhere general practitioners and specialists have invaded each other's sphere to sustain a viable practice. This applies particularly to my own country, the United States, where general practitioners have been exposed to the full force of specialist competition. As a result few general practitioners remain, and those who do have to offer a wider range of care than general practitioners in Britain.

Without the security of the income and the ease of referral that is provided by the health service British general practitioners might be forced to follow the same course. Undoubtedly, few patients would be willing to pay £10 or £15 for a private consultation if the doctor whom they see is unable or unwilling to carry out procedures such as suturing a simple laceration. But the next time they go directly to a doctor who can satisfy their needs even if they have to pay a few pounds more. It is also doubtful if the ethical restraints imposed by Britain's referral system would stop them because doctors who compete in private practice find it difficult to be fastidious.

The health service, however, also owes much to general practice. Despite the twin principles of free access for patients and universal coverage, British health costs are among the lowest in the world. This never fails to astonish my American friends. But one of the main reasons for it is clear: far fewer patients undergo costly hospital care in Britain than in America. Having preserved the largest corps of general practitioners in the world,

Few general practitioners seem concerned about this. Indeed, they appear to be less and less willing to deal with the social and emotional problems that lie at the heart of personal care—the most startling finding to emerge from Ann Cartwright's last survey of general practice in 1977.¹ General practitioner leaders may be in danger of losing their sense of direction because the whole strategy since the royal college was formed has been based on the principle of personal care. Indeed, in 1960 Sir Theodore Fox, then president of the College, thought that this element was essential to preserve the family doctor: the general practitioner would survive as a personal doctor or not at all. He and his disciples in the College of General Practitioners maintained that general practitioners had to keep their distance from hospital medicine.²

Strategies for reform

That strategy seems to have failed, but the general practitioner has nevertheless survived, thanks to the protection provided by the health service. Where does that leave general practice? Denis Pereira Gray, the erstwhile editor of the college's journal, hopes to reverse the tide. By emphasising the need for personal care and home visits he wants to push the profession back to the principle Fox pronounced.³ "This strikes me as hopeless. The tide is moving strongly in the direction of impersonal care, swept by the general practitioner's understandable desire for a normal family life and a longer life expectancy. It makes more sense to accept general practice as it is and mould it in the direction it wants to go."

The first point is that, despite the inroads made on the range of services, the general practitioner still has much to do. No matter how far the hospitals reach out, the need for health care outside the hospital is broad enough (embracing roughly 70% of patient demands) to keep the general practitioner and his team busy for years.

The main problem facing general practice lies not in the quantity of work but in the kind that is offered. Clearly, the BMA does not think it is sufficient to interest and challenge the general practitioner, even while halting general practice as "a British success," it deprecates the "wasted skills."⁴ And Dr Alastair Donald, a leader of the Royal College of General Practitioners, described the British general practitioner as being "overworked but underemployed."⁵

Minor surgery school

Two rival schools of thought have emerged on the direction in which general practitioners should go. General practitioner leaders in the BMA want to reverse the inroads made by hospital medicine. In 1979 they produced a new charter that was designed to undo outreach programmes across a broad front: general practitioners were to be given financial incentives to undertake minor surgery, screening tests, and surveillance of chronic ailments.⁶ They had much support while Dr Gerard Vaughan was in the Department of Health and Social Security, but since then their proposals have been largely ignored and failed to arouse much enthusiasm from the profession or backing from organisations outside it.

By having general practitioners undertake work that is now done in hospital costly services may be saved and patients spared long waits in outpatient departments.⁷ There is every reason to encourage general practitioners to offer services that their counterparts in other countries provide, and which, indeed, some in Britain have already begun to do. But from the point of view of the prospect is fraught with danger. Many doctors have forgotten the techniques: as one consultant so delicately put it, "Most general practitioners don't know their ass from their elbow when it comes to suturing."⁸

of this school, acknowledges that it will take 30 years to make British general practitioners prevention minded,⁹ and the decline of the personal element in medical care will increasingly impede medical effectiveness. How can doctors hope to influence the smoking habits of people they hardly know?

Some who support the prevention campaign see their best hope in the development of a salaried service, preferably under the local authority.¹⁰ There is much logic to their argument, for it is clear that many preventive activities take time and can be promoted more fully through salaried employment. Furthermore, since there are often social and environmental factors to consider close links need to be forged with the social services, making a municipal administration desirable. This line of thought dates back to the creation of the panel system in 1911, but many attempts to realise its aims have been frustrated by the profession's fear of a salaried service under the direction of the local authority.¹¹

In the face of such obstacles it is hard to understand why the leaders of the Royal College of General Practitioners have not considered an alternative programme. They seem to fear most any move that will carry general practitioners closer to hospital medicine, so much so that it might be fair to describe their proposals as the "keep general practitioners busy in the community" school. For them, almost any activity will do as long as it leaves general practitioners free from entanglement with consultants. This apparently includes even the arcane therapies of alternative medicine, for in 1980 the former research adviser of the college, Robin Pinsent, was allowed to use the college journal to promote the cause of homeopathy.¹²

Like the BMA, the college has thus far had little success with its proposals. In 1981 the two organisations joined forces to realise one aim that was common to their programmes—paediatric surveillance—but the DHSS refused to supply the financial incentive needed to implement it. In the present economic climate it is clear that no programme stands a chance of success unless it holds out the promise of lower costs or a more efficient service. If one accepts then the government may be forced to take the crude step of applying the same cash limits to the family practitioner service as it has imposed on the hospitals. It has already proposed restrictions on prescription drugs, and though cash limits have been ruled out in 1985, they may come in 1986.

100 YEARS AGO

The physiology of food has formed the subject of many a learned and able discourse or dissertation; but Dr. Lauder Brunton's Lettersonian lectures will, if we are not mistaken, stand out conspicuously as forming an almost unique exposition of the subject. The lecturer has not only presented a clear and complete account of known facts with regard to the general physiology of food-taking with which Dr. Brunton prefaced his first lecture, but which should on no account be left unused by any practitioner. In the second lecture, we are anxious to direct particular attention to that portion of the discourse which treats especially of the physiology—we might say the pathophysiology—of fasting. It is refreshing in these days of a rampant, and in many respects, a false, physiology to find a physiologist so well-informed and practical as Dr. Brunton, not only preaching a doctrine that will be of the greatest use to the general practitioner, but also making a soundly made and well-illustrated case for it. The method of the majority in regard to the principal meal of the day is not either laid in itself in an urgent need, perhaps in these days of a rampant, and in many respects, a false, physiology to find a physiologist so well-informed and practical as Dr. Brunton, not only preaching a doctrine that will be of the greatest use to the general practitioner, but also making a soundly made and well-illustrated case for it. The method of the majority in regard to the principal meal of the day is not either laid in itself in an urgent need, perhaps in these days of a rampant, and in many respects, a false, physiology to find a physiologist so well-informed and practical as Dr. Brunton, not only preaching a doctrine that will be of the greatest use to the general practitioner, but also making a soundly made and well-illustrated case for it.

Marsh's comparative study of general practice supports this because he found that whereas 83% of general practitioners in Canada undertake suturing of simple lacerations, only 44% of general practitioners in England do so.¹³

Furthermore, many general practitioners do not have the facilities or equipment needed for the work, and it is doubtful if the surgeries of some doctors, particularly in inner cities, would meet the health standards required. To make a success of this programme considerable retraining would be needed, combined with the periodic inspection of surgery premises. In addition, item of service payments not only require much paperwork but would probably have administrative controls to prevent abuse, like those now used to reduce excessive prescribing. How many general practitioners would be willing to accept such conditions? Perhaps that, together with a reluctance to use any sort of surgical instrument again, explains why the profession has failed to show much enthusiasm for the minor surgery school.

Furthermore, this has disturbing implications for the whole health service. Item of service payments now cover only a small proportion of remuneration to general practitioners, but this programme would extend such payments substantially and that might lead to a demand for patient contributions to prevent abuse, as is done with prescriptions. The free, universal health service might be undermined and the nation end up with a mixture of private and public insurance. The dental service, which is based entirely on item of service payments, appears to be moving strongly in this direction. Perhaps that is why these with an interest in private practice are strongly attracted to this school, but they do not realise how suicidal the realisation of their aims would be for general practice.¹⁴

Prevention school

The Royal College of General Practitioners hope to arouse the general practitioner's interest in prevention rather than cure. Whereas the BMA programme would bring general practitioners closer to hospital medicine, the college programme would ensure that they stay away from it. College leaders have issued paper after paper on prevention, and they have received much support outside—from the Socialist Health Association on the one hand and the College of Health on the other. The campaign has assumed the nature of a religious crusade reminiscent of the one waged earlier for health centres.

No one can deny the desirability of the concept of preventive medicine. Laymen as well as doctors should do all they can to avoid the onset of illness. But anyone who tries to devise practical methods to prevent disease soon realises that it is a subject of great uncertainty, particularly where exercise and dietary habits are concerned. If doctors cannot agree on what is safe to eat then how can laymen know what to avoid? Medical effort should be concentrated on proved methods—like rubella immunisation and smear tests for cervical cancer, which are likely to be the only preventive activities for which the government will provide financial incentives. And here is the most serious weakness of the college programme. Though the leaders fully recognise the need for financial reward,¹⁵ they appear to rely mainly on education and exhortation to realise their aims. This, it seems, is not only because of the difficulty of establishing suitable incentives where most of the work is concerned but is also because of antipathy to the principle of item of service and the belief that prevention should be an inherent part of general practice.

If Britain's immunisation record is any indication of success then even item of service payments do not seem sufficient to arouse general practitioners' interest in prevention.¹⁶ Once again it is startling to find that the US with its depleted corps of general practitioners has gone much further with immunisation, with screening tests, and with many other techniques aimed at reducing heart disease.¹⁷ John Florde, the leading proponent

of this school, acknowledges that it will take 30 years to make British general practitioners prevention minded,⁹ and the decline of the personal element in medical care will increasingly impede medical effectiveness. How can doctors hope to influence the smoking habits of people they hardly know?

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British managers to satisfy roughly 70% of patient demands in the community (50%, is usually cited, but more and more people use the hospitals each year).¹ In America, on the other hand, not only do expensive specialist treatments for coughs and colds but too often they find a reason to admit patients to hospital beds. Thus, the American public is over-treated, over-drugged, over-protected, and—most least—over-charged.

Without the screening protection provided by general practice Britain's hospital admission would rise, and with that might come cries to contain the costs incurred. The nation might then decide that it cannot afford to offer "free" care to everyone. Something like the insurance system that existed between 1911 and 1948 might return, accompanied by a resurrection of insurance agencies akin to the approved societies that the profession so detested.

Problems caused by the division in British medicine

Nevertheless, despite the savings in costs, this division in British medicine is becoming harder and harder to sustain. Its most obvious weakness is its failure to provide continuity of care, and this has implications for finance as well as for quality of care. Patients who enter hospital pass into the hands of a separate corps of doctors, who for the most part must rely on letters to learn what happened before. Too often this leads to needless duplication of work. But when the patient is sent home there may be long delays before general practitioners learn what happened in hospital.

Advances in medical technology make it increasingly difficult to live with this communication gap. Patients who suffer from kidney disease may die because general practitioners are not aware of facilities in hospital for dialysis.² Meanwhile, patients who manage to secure dialysis treatment shift endlessly between hospital and home, with the doctors concerned often not knowing what the other is doing.

In Scotland, where the profession has always been less sharply divided, the problem has been recognised and a start has been made to close the gap. A few years ago a joint committee was formed by general practitioners and physicians to integrate patient care, and a group in Lothian has produced a blueprint for managing hypertension in general practice.³ The need is no less strong in England and Wales and extends to health problems that are less affected by technological development. Yet across most specialties one searches in vain for any meaningful move towards integration south of the border.

Indeed, the distance between the two branches of the profession in England and Wales appears to grow wider and wider. Despite the recent attempt by leaders of the Royal College of General Practitioners to promote cooperation rather than conflict they seem anxious to avoid contact with consultants, particularly on the critical topic of continuing education, out of fear that this will impede their efforts to establish general practice as a specialty on a par with hospital medicine.⁴

Meanwhile, consultants have become increasingly disturbed by the growing number of patients who turn up at accident and emergency departments with conditions that general practitioners could have treated. Together with other experiences, this undermines their confidence in general practice and prompts them to hold on to outpatients long after discharges might have been safely arranged. Since inexperienced junior hospital doctors are normally left in charge of such patients, needless tests are often performed.⁵

Financially, even more disturbing are the duration of bed stays in Britain and the difficulties in getting appointments for day surgery. Roughly 3% of hernia operations and 20% of all operations are performed in outpatient departments compared with a potential estimate of 40% to 80%.⁶ This greatly inflates the cost of hospital care. With the largest corps of general practitioners in the world Britain should be ahead of everyone, but the statistics show that the US, even with its

depleted corps of family doctors, has gone much further in this direction.⁷ The attitudes of consultants appear to be largely responsible for the slower British advance because, as one general practitioner put it, "Most hospitals prefer to see day surgery as an extension of their role rather than as a 50-50 partnership with general practitioners."⁸

Reaching beyond the hospital

Another disturbing development in attempting to overcome the handicap of their distance from and lack of confidence in general practitioners is that consultants reach out into the community and sponsor their own network of facilities. This seems to have started with obstetricians (with community midwives based in hospital) and then spread to paediatricians (home nurses) and surgeons (stoma nurses). Nearly every specialty has joined in so that everything from "casualty to child guidance" is covered.⁹ Direct access clinics are particularly common for the treatment of asthma, diabetes, hypertension, epilepsy, and arthritis.

Thus, there is a serious breakdown of the referral system, coming not from private practice (where it has always been violated) but from within the protective framework of the health service. No one knows how far the "outreach" programme has extended: a study initiated by the International Hospital Federation will be published this year. It appears that it has progressed further in emergency care. Not only do patients of all ages in inner city areas resort more and more to accident and emergency departments, but hospitals in places such as Nottingham find that most of the children whom they treat for acute illness are brought directly by parents without contacting their general practitioners.¹⁰

Erosion of general practitioner care

The effect of all of this has been to remove more and more care from the general practitioner, which Dr John Ball has aptly called "clinical drift."¹¹ This is not a new development: it simply reinforces one that began in the nineteenth century.¹² Much of the earlier transfer of care was inevitable because of the advance of medical science: many aspects of care became too specialised for general practitioners and had to be referred to specialists. This applied particularly to surgery, and no one in Britain wants to see major operations performed again by general practitioners. We need only look to America to be reminded of the damage such a development would cause.

In Britain more than in other countries care has moved away from general practice, and this includes minor surgery as well. Few general practitioners now do very much with their hands as far as treatment is concerned. The practitioner exception is simply reinforced by the fact that in the nineteenth century.¹³ Much of the earlier transfer of care was inevitable because of the advance of medical science: many aspects of care became too specialised for general practitioners and had to be referred to specialists. This applied particularly to surgery, and no one in Britain wants to see major operations performed again by general practitioners. We need only look to America to be reminded of the damage such a development would cause.

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