The figures should be seen as indicative rather than absolute values and probably underrepresent the direct loading on tissue actually experienced by debilitated and emaciated elderly people, who have less fat and muscle to dissipate the forces transmitted. Secondly, the instruments available cannot measure indices of shear and friction, which are believed to increase the damaging effects of pressure on the microcirculation[10] and are probably important in patients treated by appliances like traction.

As the onset of sores is concentrated at the beginning of admission to hospital prophylaxis should begin then. A significant reduction in the incidence of pressure sores would ensue if all high risk patients were treated on low pressure support systems from arrival at hospital until mobility is restored and danger of sores diminishes. Secondly, many complex factors determine the rate of a patient's progress through treatment facilities, but if this were accelerated it could only benefit sick patients with major injuries.

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For Debate . . .

The doctor, the patient, and their contract

I The general practitioner's contract: why change it?

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The publication by the government of *Primary Health Care*, although presented as setting an "agenda for discussion," represents the opening stages of a debate which will persist throughout 1986.[1] The government has chosen the issues on which views are to be sought, although there is an invitation to raise other matters. The profession therefore has a unique opportunity to influence the pattern of primary health care for decades to come.

The discussion document covers a wide range of issues, and this article and the two that follow cover only part of the ground. They are concerned almost exclusively with the general practitioner's contract and its relationship to the quality of care.

This first article discusses the existing contract against the background of the changes in medicine and society which have taken place since the negotiation of the GP's Charter in the mid 1960s, and asks why appreciable changes should be made. The second article explores in detail the form which a performance related contract might take. Finally, the third article examines some of the potentially more radical options which the government might have chosen.

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Achievements

General practice has changed out of all recognition since the beginning of the National Health Service. Collings described a poorly equipped, poorly motivated, demoralised profession engulfed by demands for health care to which general practice in 1950 could scarcely respond.[2] Today most practices are well equipped, group practice has become the norm, and many premises are purpose planned. Several thousand practice nurses are playing an increasingly active and extended part, and most community nurses and health visitors are attached to practices. Planned preventive care—for example, child care surveillance—is becoming common, and in some district health authorities about three quarters of all the cervical smears are taken in general practice.[3] General practice is the largest single source of immunisations, family planning advice, care for the common acute problems, care for the mentally ill, and care for the elderly. The vast majority of all consultations are handled within the primary care team, and only about 5% of consultations lead to hospital referral.[4]

Today general practice has become the single most desirable career choice for medical students.[5] Some 1500 young doctors take the membership examination of the Royal College of General Practitioners each year, and there is no shortage of applicants for places on vocational training schemes, practice partnerships, and vacancies. For several years the BMA has had a policy that career earnings in general practice should be comparable with those in other branches of medicine.

These achievements are all acknowledged in the government's discussion document, which considers that the present contractual arrangements have made an important contribution to both the quality and cost effectiveness of our health care system. It refers to the benefits of the independent contractor status and to the tendency of the present system of fees and allowances to provide an inducement to the general practitioner to run the practice with proper regard for cost effectiveness. If the present contract for general practitioners has produced such good results, why change it?

Shortcomings

It would be dangerous to become complacent or for the profession to rest on the evident laurels of its own public relations exercises. General practice may be a British success,[6] but there is another side to the story. There are evident failures to provide even basic services in some parts of the UK. Patients sometimes find it difficult even to register with a general practitioner.[7] In other places patients find it hard to choose or to change.[8] The Acheson report documented deficiencies which cannot be defended: "In 11% of single handed practices in inner London, the telephone was not answered in any way."[9] About a fifth of Britain's children have not been immunised against polio, diphtheria, and tetanus, and two fifths remain unprotected against measles and pertussis.[10] Many of the complications of maldescent of the testes might be prevented if maldescent were routinely sought by general practitioners.[11] In many practices the medical records do not include basic information about the patients' key data about past and present illnesses or health risks.

This variability is of increasing concern both to government and the profession. Crombie has shown that variations in performance depends more on the doctor and his or her attitudes than on the characteristics of the patient, such as age, sex, or social class.[12] Metcalfe was not able to correlate performance with measurable characteristics of the doctor, such as age, size, and location of practice or place of basic medical education.[13] The evidence suggests that such cost and quality sensitive components of care as frequency of doctor-patient contact, laboratory investigations, prescribing, and referral to hospital are subject to very large variations which relate only to individual habit and choice. For example, referral rates to hospital vary between 2% and 24% of consultations. Irvine has called this variability "the outstanding characteristic" of British general practice[14]: anxiety about it was a major stimulus to the recent policy statement *Quality in General Practice* from the Royal College of General Practitioners.[15]

Society

The general practitioner's contract is in essence a contract with society. Society too has changed out of all recognition since 1948, when the contract was first drawn up. Our citizens are far better educated than they were 40 years ago, a much larger proportion of them now undergoing higher education. There are changes in communication technology and developments in the media which have resulted in far more public awareness about health, and about the possibilities of health care. In 1948 there were two domestic BBC radio programmes: now multichannel cable television is imminent, and already half of our citizens use video recorders. As a result of this explosive increase in information technology people increasingly want to know how and why health problems arise, and what options are open to them for prevention and treatment. They want to share in their own care. There is a demand for more information about practices in order to make and exercise a more informed choice of doctor.[8] These societal pressures show in the formation of new organisations and groups: the Patient's Association, community health councils, patient participation groups, the Patient's Liaison Group of the college, and the College of Health are all examples.

There have been profound demographic changes. Fifteen per cent of our population is now aged over 65 years. This compares with 11% in 1948. One in two of the people over 65 are now aged over 74 years. This compares with one in three in 1951. The advent of reliable contraception has accelerated changes in the role of women, and this is already affecting patterns of family life and child rearing. Long term unemployment has now reached unprecedented levels. Our inner cities are decaying, and new towns, housing estates, and tower blocks have engendered new problems in the attempt to solve older ones. Even had the profession not changed since 1948 (and it has changed profoundly), changes in society presage changes in the contract.

Resources

Most NHS resources go into the hospital service. Between the years 1950 and 1980 the number of doctors in general practice rose by 20% and the number of doctors in the hospital service rose by 400%.[16] None the less, the discussion document notes that the cost of the family practitioner service has doubled in cash terms in the past five years and increased by about a quarter in real terms. The number of general practitioners is rising by about 1·8% a year. The nature of the "cost-plus" contract—that is, the achievement of target net income plus the reimbursement of expenses—puts considerable pressure on public expenditure. The present contract, with its absence of any substantial accountability, makes it difficult to convince government or colleagues in the hospital service that expenditure on primary health care represents value for money. Indeed, it may sometimes seem that there is an open ended expenditure on the family practitioner services, and that this expenditure purchases a very uncertain service. It is defined in the *Regulations* of the NHS Act 1977 as "to render to their patients all necessary and appropriate personal medical services of the type usually provided by general practitioners."[17] General practice is what general practitioners decide to do.

This contrasts with other developments in the NHS. In the hospital and community health services there is a move towards defining standards and setting targets by which the achievement of an individual or the organisation may be judged.[18] If in the future general practice is to retain its share of NHS resources, let alone increase that share, we may expect a demand for much more explicit evidence about value for money.

Furthermore, the present contract does not provide a direct return to practices on their investment in resources. To provide effective preventive care and follow up of chronic illnesses practices require good staff supported by computer based information systems. The introduction of computers into practices in the 1980s parallels the introduction of ancillary staff in the 1960s and may require similar adjustments to the contract.

Contracts

In the middle of the nineteenth century and before, standards of professional performance were achieved largely by intraprofessional control. The system of guilds and colleges had as a major function the protection of the profession, trade, or craft from outside competition. As a byproduct these professional institutions defined and maintained standards. This system has served society well, and we may expect the royal colleges and similar organisations to continue to fulfill this function. But the changes in society to which we have referred make it inevitable that the medical profession, like other professions, must now expect to become publicly accountable. Over the coming decades we can expect the contract between profession and society to serve the purposes of this accountability. Contracts will therefore need to define more closely the relationship

of the doctor with the individual patient and with the practice population. They can be expected to specify the services which will be made available and to indicate the standard of those services. They may include statements about the obligations on the providers of those services, and perhaps also about the obligations on the patients who receive them. The rewards for meeting the contract may be spelt out as well as the penalties for failure.

If, however, primary health care services are to be developed sensitively in response to the needs of a rapidly changing society at large, and to the needs of local communities in particular, the contract will have to be flexible, leaving room for creativity, experiment, and risk taking. Ideally, a contract should stimulate initiative and endeavour among doctors, it should generate a competitive motive to improve, and in a variety of ways it should reward both those who have succeeded in achieving the agreed goals and those who continue to strive to achieve them. Contracts will need to enable the profession and society to respond to developing public policy in health care. These are the criteria against which we should seek to judge the performance of any future contract.

Change

The contract of the mid 1940s was essentially a political arrangement to get the profession into the new NHS. Donabedian categorised the elements of health care under the headings of structure, process, and outcome.[19] The contractual negotiations in the mid 1960s were about structure. They reduced the impediments to the provision of modern premises and staff. It can be expected that contractual negotiations in the mid 1980s will be about process and so focus on quality of performance in general practice. Experience so far suggests a 20 year cycle in the negotiation of contracts. Perhaps the negotiations around the year 2006 will be about outcome.

There is a Chinese symbol indicating two connotations of change—danger and opportunity. The government has proposed major contractual changes in primary health care, and there is now a risk of concentrating on the dangers to the relative exclusion of opportunities. Both must be examined. We believe that the opportunities of a new contract should be recognised and seized upon for the benefits of both patients and their doctors.

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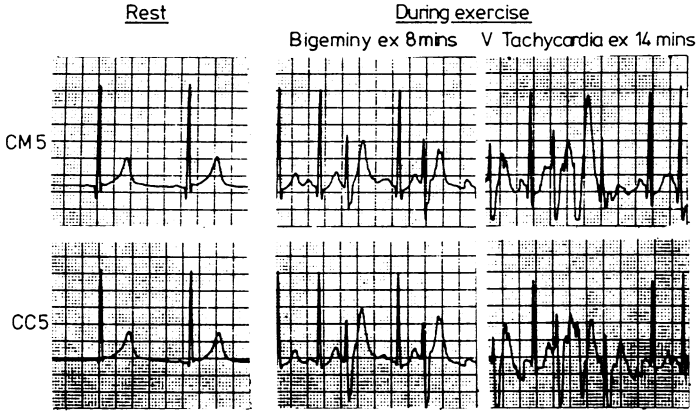
This is the first of three articles.

A healthy middle aged non-smoking man has developed symptomless extrasystoles on exercise. What investigation and treatment, if any, are advised?

Irregularities in cardiac rhythm are well described in athletes both during exercise and at rest. During sleep nodal bradyarrhythmias may develop, with beat to beat pauses of three seconds or more. During exercise supraventricular (nodal) ectopics are common. These may be so frequent as to alternate with each normally conducted beat and are nearly always benign. Ventricular ectopics are also common during exercise, the problem being



that these may not be benign. The figure shows the exercise tests of a world class athlete. At the end of a standard Bruce protocol, when his heart rate had reached the target of 120 beats a minute, several nodal ectopics are seen. When exercised at the level to which he was accustomed in competition, however, ventricular ectopics begin to appear and become so numerous as to occur in runs, resembling ventricular tachycardia, an arrhythmia normally regarded as being highly malignant. Non-invasive investigation including gated thallium angiography failed to show any evidence of coronary artery disease and the athlete is still competing. The development of symptomless extrasystoles during exercise is likely to be benign but it would be reasonable to conduct an exercise test to gauge the frequency and origin of the ectopic beats. Runs of ventricular ectopics probably require further investigation.—M HARRIES, consultant physician, Harrow.

Symposium on the athlete heart. *Journal of the American College of Cardiology* 1986;7:189-243.

What treatment is advised for typical psoriasis confined to the fingernails in a girl of 8?

Psoriasis of the nails at any age is difficult to treat, largely because the site of the infection is protected from topical agents by the overlying nail. Dithranol and tar, of such value on the skin, have virtually no place. Topical steroids, such as the scalp lotions, may only occasionally be of some help in psoriatic onycholysis or subungual disease of the nail bed. Repeated injections of steroid into the posterior nail fold, under the nail matrix, or under the nail bed (according to the part of the nail affected) are used enthusiastically by some,[1] less so by many, and are unlikely to please an 8 year old. Systemic psoralens and ultraviolet A (PUVA) treatment may certainly influence psoriasis of the nails[2] but would not be justified in isolated infections. Treatment with topical PUVA, topical fluorouracil, and radiotherapy are seldom effective enough to warrant the problems entailed. Systemic drugs such as methotrexate and etretinate can improve nail psoriasis but could hardly be justified for an isolated nail dystrophy, certainly in a child. Many authorities are sceptical about the value of any form of treatment for psoriatic nails at any age, apart from the avoidance of undue trauma.[3] It is often a disease capable of surprising remissions and relapses. I would be even more sceptical about treating a child.—R H CHAMPION, consultant dermatologist, Cambridge.

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