General practice: feeling fine, getting better

John Roberts

In the early 1920s Andrew Manson, newly qualified, set out to practise general medicine in south Wales. First he was neglected by an absent principal general practitioner. Then he encountered the ignorance of patients in his miners' practice. Exasperated, he blew up a sewer to alert townsmen to a typhoid fever epidemic. Finally, fed up as a general practitioner, he went off to Harley Street.

When A J Cronin wrote *The Citadel* in 1937 the future for general practitioners was still that bleak. Professional descendants of English apothecaries, they were at the bottom of the medical hierarchy—entrepreneurs who offered little medicine beyond support or else union employees who signed work excuses. Manson's hope for a "compassionate and scientific" general practitioner was only a dream. Medical reform was under way in that decade, and when negotiations between doctors and the government accelerated during the second world war all sides seemed to agree that general practice would fade away into history. Indeed, general practitioners' leaders fought the creation of the National Health Service, suspicious that the government planned to place them on salaries set by local councils, robbing them of their independence and hastening their demise.¹

As often seems the case in British medical politics, the doctors lost the battle but won the war. Primary care has succeeded in Britain. And the latest government reforms have clearly placed the general practitioner in the centre of the NHS.²

British general practice, on its deathbed just 70 years ago, today is robust, feeling well, and doing better. "The family doctor is our strength," said former health secretary Kenneth Clarke, reviewing the government's reforms in October. "The power in the system... goes into the hands of the family doctor. The family doctor's chosen referral pattern will carry the resources [of the NHS]."

The key to the success of general practice is simple and nearly unique to Britain: every primary care doctor has a list of patients whose medical care he or she is solely responsible for. With few exceptions every patient must see his general practitioner to gain referral to hospital and specialist services. As an east London general practitioner said, "The list creates a relationship between my patient and me even before we meet. We know we have responsibilities to one another."

Practice in 1990

The Gill Street Health Centre is tucked away in Docklands. The small waiting room of the four doctor health centre is filled with women, mostly Asian immigrants, and their children. Notices are written in five languages: most are about well child or other clinics, though a few proclaim the doctors' opposition to the new general practice contract and the idea of fundholding. Like many practices in poorer parts of London, the Gill Street Health Centre has patients moving in and out constantly: 40% of its list changes each year. North of London is the Collingham Medical Centre, near Newark. Patients here are England born, mostly in professional and managerial jobs and farming. The large waiting room is subdued, and the

few notices are in English only. Changes on these four doctors' lists usually are through birth and death. There are no political statements because the doctors here support many of the reforms.

The two practices are miles apart, literally and figuratively. But they both represent what has been called "the new, new general practice" in Britain.

Their size—four doctor groups—is a little below average, but both represent true, team oriented primary care: teams comprise the general practitioners, midwives, practice (prevention) nurses, practice managers, health visitors, district nurses, school nurses, social workers, nutritionists, chiropractors, physiotherapists, audiologists, and counsellors. Both practices are in new buildings with architecture that encourages intimacy, patient education, and the use of technology. In contrast with most American doctors' offices, these doctors have one consulting room each, and nurses often have their own offices and treatment areas. Instead of a blood chemistry laboratory or x ray room, they opt for audiology suites. Both practices use computers to study the health risks of their patients.

The focus of care in British general practice goes beyond medicine. For example, during my visit to the Collingham Health Centre a 35 year old woman rang the doctor on call at his home (a circumstance unheard of in America, where patients must go through answering services) with abdominal pain. He met her at the surgery and within 10 minutes decided she needed an appendectomy. He quickly arranged the surgical referral and then spent 20 minutes talking about how she and her husband could put things in order at home, where they had a 4 year old. After her husband drove her to the hospital the general practitioner arranged for a nurse to visit their home the next morning to ensure the child's wellbeing. Most of the 30 minute visit was devoted to a crucial, but non-medical, issue.

The list: key to primary care

Lists are the core of general practice in Britain. At Gill Street each doctor is responsible for about 1500

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GREENHILL

residents, at Collingham about 1700. General practitioners' lists averaged about 1960 in 1989, down 21% from 1950. (However, the number of people aged over 85 has grown by 230% in aging Britain.³) What strikes an American visitor is that the list system ensures that every Briton has full medical care free at the point of delivery. A sixth of Americans forgo medical care because they have no health insurance. Generally, all a Briton has to do is sign up with a general practitioner, though in practice it doesn't always work that smoothly. Several general practitioners said privately that certain types of patients do get refused by some general practitioners: "the dirty, long-haired types who don't take care of themselves." But even such undesirables can claim a legal right to a doctor.

American doctors often argue that the British list system denies patients a choice. Patients are free to change general practitioners, but they rarely do, especially in rural areas, where few other doctors practise nearby. And even those in the cities hesitate to switch. I talked to five patients who admitted dissatisfaction with their general practitioners; none planned to change. "I only need him once or twice a year," one said. "He doesn't talk to me enough, but he seems to be a good enough doctor." Patients seem hesitant to break the relationships implicit in the lists—relationships that often are years long.

The list also creates a population orientation. "The GP is a community oriented doctor: I live in that community, my kids grow up in that community, my friends are that community, I treat that community," says Dr Julian Tudor-Hart. For example, in Dock-

lands about 50 general practitioners have set up a study of cardiac risk factors among their low income patients. They hope to detect a lower death rate from their prevention initiatives. Nearly every general practitioner I interviewed was using his or her list to assess medical effectiveness in some way, from lowering blood pressure levels to improving antenatal care. Special clinics focusing on at risk people (smokers), diseased patients (diabetes), prevention (well child), and patients who do not speak English seem to flow out of the population orientation created by the list. Clinical protocols are becoming commonplace and tend to unify treatment among a community of patients.

And the list system saves money. As general practitioners like to say, they provide 90% of medical care for 10% of the cost. They also serve as gatekeepers for the other 90% of costs. Actually, general practitioners directly account for only 7.7% of the total NHS budget. All family practice services (general practitioner, pharmacy, dental, and optical services) account for 24% of NHS spending. A general practitioner's net pay averages £27 300, well below that of his or her American counterpart, who earns an average of £44 700 (though the pay of the general practitioners I met ranged from £19 000 to £60 000).

However analysed, primary care in Britain is a bargain. For direct general practitioner services the NHS spends about £35 per person per year. In the United States one visit to a doctor often costs that much.

More attention to prevention

The average Briton sees his general practitioner about four times a year; the average American 4.7 (the United States figure includes visits to all doctors). About 15% of the British encounters will be in a patient's home versus 2% in America. About half of all patients over 75 are seen at home, and the new contract requires general practitioners to contact all patients over 75 every two years. In the United States 8% of those over 75 have not seen a doctor in more than two years.⁴ The Briton will get a 7½ minute appointment (the American gets 15-20 minutes), and in three quarters of visits he will get no examination beyond pulse and blood pressure checks.⁵ Temperatures are rarely taken. "Scientifically, taking temperatures makes no sense in the surgery, though personally I still feel a little uncomfortable," said a young rural general practitioner. "But I've never had a case where my taking the temperature would have changed my diagnosis or treatment. Patients know if they have a fever or not."

The average British patient probably won't be told to cut down on sodium. Unless they have other risk factors for cardiovascular disease, they won't have a cholesterol check done.⁶ Especially since the government reforms, however, they probably will be encouraged to visit a well person clinic to discuss habits such as smoking, drinking, and wearing seat belts; vaccinations; and, for women, cervical smears and mammograms.

Preventive care, such as screening and vaccination, has always been central to British primary care, but under the new contract prevention has assumed greater emphasis. In the past, a general practitioner was paid a small fee for each vaccination or cervical smear done. Now, the pay is population based: if a doctor vaccinates 90% of the eligible children on his list he gets a bonus on top of his basic practice allowance and capitation payment. The same applies to cervical smears.

Such targets worry many general practitioners. Those in London, with their rotating patient lists, say

that they will be hard pressed to get 90% of their women patients to undergo cervical smears, especially in their fundamentalist Moslem Asians. They fear that less scrupulous colleagues may simply offer smears to no one, losing a bonus but saving time and money.

Former health secretary Kenneth Clarke discounted the worries. "We will look at that when and if it works out that way," he said in October. "But I have to say that so far, the people hitting the higher targets are coming from all kinds of places. However, I will adjust the level of payments if that turns out to be the practice." On the whole data suggest that British general practitioners do excel at providing vaccinations and cervical smears.

General practitioners also have complained that the targets for vaccination and smears, as well as the requirement to visit patients over 75 every two years, were arbitrarily set by Mr Clarke and other government ministers. Clarke responds that he tried to get medical consensus but general practitioners refused to negotiate. So he took recommendations from the World Health Organisation. At a meeting of general practitioners near Nottingham several doctors voiced a third worry: general practitioners were being made the frontline soldiers of public health.

"All this extra pay for well person clinics, blood pressure checks, and vaccination targets is fine," said one, "but I worry about underlying medical authoritarianism. I feel like a medical storm trooper telling my patients they must come in—or else."

A practice manager in the south west summed up how her colleagues view the targets: "Grab 'em and jab 'em is our attitude now."

Managers of the new marketplace

The medical planners in the government downplay general practitioners' concerns, pointing out that ethical safeguards—as well as efficiency—will grow from the new "internal marketplace." General practitioners are expected to become the major buyers of medical services from hospitals, consultants, and other, as yet unknown, providers. Many speculate, however, that the primary care team's provider functions will increase.

The plan, already in motion, is complex. But at its centre is the budget holding general practice. Certain groups of general practitioners—those with more than 9000 patients—will receive capitation fees and be allowed to shop for other medical services in an intra-

British lead the medical world in information technology

A revolution has occurred in general practice, one that has not been recognised outside Britain and perhaps not even within its shores. It is the computer.

In 1987 when I last visited Britain general practitioners still relied on the Lloyd George system of record keeping: medical records stuffed into a 5×7 inch manila envelope. When I returned in 1990 all five general practices I visited had computers.¹

Most United States group practices have been using computers for nearly a decade—for billing and, latterly, for patient registrations. What is revolutionary is how British general practitioners are using them. At the Lumbard Street Surgery in Newark, for example, each general practitioner had available within a few seconds medical histories, prescription histories, patient risk factors, recall letters, programmes to write repeat prescriptions, drug interaction databases, vaccination and laboratory records, demographics, and prevention reminders—all via the computers on their desks.

The government, through *Working for Patients*, seeks to create "informed consumerism."² For patients this means having information about their general practitioner. For the general practitioners it means having information on patients' illnesses and prescription needs, on the one hand, and knowledge of hospital services, waiting lists, and community services, on the other. Information technology is key to the government's hopes to make an "informed consumer" of the general practitioner. In addition, indicative drug budgets, target schemes, and audit will demand access to patient data much more rapidly than is possible with paper records. The government provided £24m to general practitioners in 1989 for computers. But by late 1990 then health minister Kenneth Clarke was promising from £16 000 to £32 000 a year for budget holding practices to buy and maintain computer hardware. "Reasonable" software, he said, would be covered in full.³

General practitioners are using their computers not only to send letters and appointment reminders but also to track patients' progress. At the Gill Street Clinic in east London doctors call up graphs of blood pressure to show patients their successes—all in less than 10 keystrokes. Computers are tracking entire practices, ensuring that vaccination and cervical smear targets are met. Some general practitioners believe that computers will unify standards of care among general practitioners while preserving clinical freedom.⁴

Computer technology may be a crucial factor in a very new system of medical education. General practitioners working with St Bartholomew's Medical School search

their computer for epileptics among their patients. The computers generate letters, asking patients to visit the surgery for consultation with a Bart's neurologist.

The dean of St Bartholomew's, Professor Lesley Rees, points out the possibilities for medical education. "With patients available so easily, and in situations where they are out of our beds, it provides a much better forum for teaching and learning about disease. . . . Medical education is moving from the hospital to the general practitioner's surgery."

The scientific potential is even greater. Nationwide, the computerisation of general practitioners will build the world's biggest medical database: 58 million patients. If exploited this database will allow epidemiologists to determine precisely the prevalence and incidence of rare diseases, chronic diseases, and occupational diseases as well as to analyse initiatives to alter disease risk factors. Britain may be the first country to be able to analyse an entire population and follow its progress over decades—all through doctors' surgeries, avoiding the problems of sampling and the costs of extra patient interviews.

Several problems, however, will have to be faced before the computer revolution is completed. Firstly, numerous vendors are offering software to general practitioners, making one practice's information unusable to another. Moreover, some software vendors are offering free packages to general practitioners in exchange for their being able to monitor general practitioners' drug prescribing patterns. They then sell the information to drug companies. This leads to a second issue: the right of patients to have their records kept confidential. Patients' paper records have been closely guarded. "We have to figure out some way to keep just anyone from looking over computer records before we go much further," said a general practitioner who is switching from paper to electronic record keeping.

The computer revolution led by general practitioners has not reached British hospitals. They have fallen behind, partly because many big hospitals invested heavily several years ago, when computers were in their early generations of development. The government has also decided to see how general practitioners use their computers before investing the even larger amounts of money that will be required to computerise hospitals.

1 Warden J. GP computers. *BMJ* 1990;301:405.

2 Secretaries of State for Health, Wales, Scotland, and Northern Ireland. *Working for patients*. London: HMSO, 1989.

3 Delamothe T. GP fundholding. *BMJ* 1990;301:1009.

4 Pringle M. The new agenda for general practice computing: a time to exploit the potential for improving patient care. *BMJ* 1990;301:827-8.

NHS market. The hope is that hospitals will respond to money from general practitioners more than edicts from district health managers. Despite the allusion to a free market the general practitioner purchasers will take no financial risks, as purchasers do in a true marketplace. If they shop poorly and lose their money (or if one patient's medical needs exceed £5000) the government promises to bail out the practice. The worst that could happen to the practice would be a return to its pre-budget holding practice style.

To say that general practitioners remain sceptical is an understatement. Numerous polls have suggested that the vast majority of general practitioners are against budget holding. But a few—I was told a growing few—general practitioners have converted and see more good than bad. A young Newark general practitioner thinks the reforms are a major—though painful—step towards a more patient oriented general practice. “First of all, making us responsible for spending money makes us think about what we’re doing, how we’re practising,” he said. “But, moreover, we are moving from a doctor driven system towards a patient driven one. Can it be bad if we deliver what patients want?”

Nearly all agree that the ultimate result of the white paper will be greater consumerism among patients. British patients are well known for their passivity and ignorance of their medical conditions. Fewer than 15% of Britons know their blood pressures, and only about 20% know where their stomach is.⁷ “If you feel well, you are well,” seems to be the accepted attitude.

That may change, according to a scenario that some general practitioners and health economists foresee. It goes like this: the government, by paying bonuses for targets, encourages more people to see their general practitioners for screening and health promotion. Thus, more people see a doctor even when they feel well, perhaps encouraging a subtle doctor dependency. Screening will pick up more disease earlier, which may cost more money in the long run as people are under doctors’ care for longer. And most worrisome is a heightened medical awareness by the public—the “medicalisation” that Ivan Illich described in overdoctored America.⁸

The result, suggested a Nottingham general practitioner, is that health costs will fall for a few years as general practitioners search for and deliver efficiency in medical services then will rocket as patients demand more and more from the NHS.

Another dark theory is “patient grabbing.” Capitation payments have increased, and general practitioners are encouraged to attract more patients. Some general practitioners doubt that bigger lists indicate better care. They also worry that some general practi-

tioners will “dump the sick and grab the well,” who are always more “profitable.”

Yet as they wait for the future most general practitioners I spoke to, whatever their attitudes about the contract and budget holding, said that 1990 had been an exciting year for general practice, one that put primary care medicine truly in the centre of British medicine. Most also admitted that much good will flow from the reforms. For example, budget holding will encourage bigger group practices, which will not only become primary health centres but also increase doctors’ education, simply by there being more doctors around. Audit, helped along by the computerisation of general practice, has already promoted research into patient populations.

And the attitude seems to be reflected in young doctors in training, who are committing themselves to general practice earlier. In 1975 only about one in five new general practitioners had actually trained for their specialty via the three year general practitioner training scheme. By 1985 nearly half were choosing this route.³ I asked a general practitioner trainee why he had chosen his specialty. “Simple,” he said, “General practice is where the power will be in my lifetime.”

For an American visitor general practice represents the best of British medicine. The list system ensures all get a doctor. Vulnerable patients (at least the elderly) are seen regularly, often in their homes. The referral system ensures that specialty services are not overused. General practitioners deal with only a single bureaucracy from above. Health promotion is being made more systematic and is nearly universal, thanks in part to the government reforms. Bigger groups, audit, and computerisation are encouraging self reflection and research in primary care. And general practice training has been overhauled, with much thought being given to the skills a good general practitioner needs for the future. All this is done at cut rate costs. Less than three quarters of a century after Andrew Manson left general practice for Harley Street his dream of the compassionate and scientific general practitioner has come true.

- 1 Cartwright FF. *A social history of medicine*. Longman: London, 1977.
- 2 Secretaries of State for Health, Wales, Northern Ireland and Scotland. *Working for patients*. London: HMSO, 1989.
- 3 Office of Health Economics. *Compendium of health statistics*. 7th ed. Luton: White Crescent Press, 1989.
- 4 National Center for Health Statistics. *Health, United States, 1988*. Washington: US Government Printing Office, 1988.
- 5 Mechanic D. General medical practice: some comparisons between the work of primary care physicians in the United States and England and Wales. *Med Care* 1972;10:402-20.
- 6 Payer L. *Medicine and culture*. New York: Penguin, 1988.
- 7 Boyle CM. Differences between patients’ and doctors’ interpretation of some common medical terms. *BMJ* 1970;3:286-9.
- 8 Illich I. *Medical nemesis*. London: Marion Boyars, 1976.

MATERIA NON MEDICA

The porter's tale

Thirty years ago, in a survey for the Nuffield Provincial Hospitals Trust, I visited a small unit, part of a large hospital for mental diseases. Before the NHS it had been a private mental hospital, whose tradition was maintained by the blue uniformed hall porter at the entrance. Here a striking feature was a very large bronze plaque by the lift, inscribed: THIS LIFT WAS PRESENTED BY MRS PERRIN-TRAILL, IN MEMORY OF HER HUSBAND WHO DIED IN THIS HOSPITAL.

“I think I knew him,” I said to the porter; “he tried to teach me Latin and Greek at school.”

“Oh no sir,” replied the porter, “Mr Perrin-Trail was a very wealthy gentleman: he could not have been a schoolmaster.”

“That’s him,” I said. “He left the school when a relative died and left him the family inheritance.”

Then I heard the porter’s tale. Mr P-T’s room was upstairs and one of his

few remaining pleasures was to sit in the hospital gardens. He became paralysed and getting him downstairs to the garden was too difficult. Mrs P-T’s answer was to donate a lift to the hospital. But by this time it was 1948; the new NHS could not accept a charitable gift. On principle the provision of a lift had to be a national service at the taxpayers’ expense. Mrs P-T was a woman of spirit and determination. She took her lift through committees to the regional hospital board. At last her donation was accepted and the lift was installed. Sadly, Mr Perrin-Trail died before the lift was finished, so he never got down to the garden again. Mrs P-T had the last word. The magnificent bronze plaque reminded them all of what had happened.

“That explains it,” I said. “I did not see why my old schoolmaster should be so strikingly commemorated for dying in this hospital.”

The porter said, “I expect he came here, sir, through trying to teach you Latin and Greek.” — T P EDDY, *Hove, Sussex*