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Partners in Practice

Caring for the future

Martin Lawrence

This is the fourth of a series of articles focusing on the current tasks and functions of the primary health care team

We live in a time of massive change. Primary care is no exception. Having practised in a relatively stable structure since 1948, general practitioners have been affected in the past five years by various government initiatives.¹⁻⁸ One thing is certain, the general practitioner is no longer going to be left to practise independently and in isolation. The demand is for accountability—to patients with needs, to a profession dedicated to assuring quality, and to a society which sets targets for effective and efficient care, where possible justified by research. The three areas of accountability are interrelated and the key to satisfying them is partnership.

Patients as partners

It is 40 years since Collings described a practice which had to lock up and bar the door "to stop the patients coming in,"⁹ and since the 1966 charter general practice has had the time to evaluate care from a patient orientated standpoint.¹⁰ Byrne and Long described "doctors talking to patients"¹¹; Pendleton *et al* emphasised the need to consider patients' ideas and concerns¹²; but only by 1985 did Tuckett *et al* acknowledge that the consultation is as much the patient's as the doctor's.¹³

Direct assessment of patients' views and needs has been more difficult to achieve.

Patient participation groups were officially recognised in 1972.¹⁴ They were established with four main objectives: to provide feedback in the planning and evaluation of services; to work with the practice in providing health education for patients (for example, in open meetings or by staffing a patients' library); to act as a safety valve for the transmission and discussion of complaints; and to provide social support (for instance, help with transport for infirm patients). Evaluation of the groups emphasised their enthusiasm but noted that only small proportions of patients participated in the groups.¹⁵

Community health councils were established in 1975 to provide the patients' viewpoint in planning of the health service. While there was no clear structure for them to use in their early years, the increased role of family health services authorities in planning services has now enabled community health councils to be represented, and many medical audit advisory groups are working with the councils as representatives of patients' views.

The importance of patients' views in audit of care is emphasised by the new contract and encouraged by family health services authorities and medical audit advisory groups. Evaluation is difficult, not least because patients tend to be oversupportive, even in the face of inadequate care,¹⁶ and instruments for eliciting views are currently scarce, usually not well validated,

Needs for research and development

- In future it will be necessary to base care on targets and guidelines justified by research evidence
- Adequate tools are required for assessment of patients' needs by the primary health care team
- Research on developing criteria for referral to hospital will enable the development of jointly agreed guidelines between primary and secondary care for the management of common conditions
- There is a need for a mechanism to ensure that the results of research carried out by academic departments are reflected in practice

or overcomplicated. Several bodies, both private,¹⁷ charities,¹⁸ and academic bodies,¹⁹ are currently attempting to correct this deficiency.

Assessment of need

Closely allied to the objective of eliciting patients' views is that of assessing need. Patients are able to criticise the care they are receiving, but it is difficult for them to formulate an unmet need. Any assessment by primary care teams is likely to be partial, owing to lack of expertise in developing instruments for assessment and time and incentive for applying them. To integrate this type of assessment with that of public health physicians would be more informative and realistic.

An example would be the assessment of elderly people. As imposed on practices in the general practitioners' contract this is probably ineffective, but carried out by using the advice of community geriatricians and established tools for assessment^{20 21} it could provide a valid and reliable assessment of need.²²

Partnership in the primary health care team

Total quality management implies that each part of any service is examined by the person concerned with a view to improvement. The primary health care team is ideally placed to undertake such a process.

Consider the management of diabetes. Common failings (with possible solutions) are: inability of patients to make and remember appointments several months ahead (a receptionist can be responsible); deficient review of housebound patients (the district nurse can be involved); feet are not examined (the practice nurse's protocol can be adjusted); glucose control may be poor (the doctor must review the patient's management). At each stage a person from a different discipline knows best how to resolve a problem, what targets are attainable, and what to monitor in order to evaluate success. Practices are

Department of Public Health and Primary Care, University of Oxford, Radcliffe Infirmary, Oxford OX2 6HE
Martin Lawrence, regional health authority lecturer in general practice

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learning to work as teams, gaining benefit both in efficiency and morale.

Teamwork in primary care extends far beyond the practice group: district nurses, midwives, community psychiatric nurses, and social workers are developing their own professionalism and cooperating on equal terms. This broad based primary care team, with members exercising their professional capacities, offers a much wider range of care to patients but has a major potential for disharmony unless working procedures are defined. Who, for instance, should advise schools on pupils' smoking—the health visitor, the social worker, the psychiatric nurse, the health education officer, or the general practitioner? Without careful planning areas of community health promotion will be missed as each member of the team leaves it to somebody else: 30 years ago Balint described the same situation in medical care as "the collusion of anonymity."²³

Working together also implies learning together,²⁴ which leads to mutual respect and full use of special skills. Many practices already arrange "away days"; increasingly, attached staff join in.

Partnership with the family health services authority

Traditionally general practice has operated in an environment with minimal management. This has changed suddenly to a situation where family health services authorities have a very powerful management role. Indeed, all three estates of the law are vested in the authorities—they interpret the rules (legislature), decide whether practitioners have complied (judiciary), and have considerable discretion over payments (executive).

General practitioners' responses tend to be defensive—yet both they and the family health services authorities have the same objectives of better quality care, and family health services authorities and the former family practitioner committees have a long tradition of supportive management of general practice. The uneasy partnership has good reason to flourish.

Arrangements for quality assurance provide an example of a benefit of this partnership. Medical audit advisory groups have an explicit obligation to maintain confidentiality but to provide family health services authorities with the general results of audit.²⁵ Family health services authorities themselves have a remit to improve quality in their areas. There is increasing cooperation—although the constraints of confidentiality leave the authorities to identify and police

unacceptable practice, which they can do both by disciplinary procedures and by using the incentives of discretionary payments.

Partnership and discussion are particularly important if practices are to ensure that their clinical views and particular circumstances are respected. Family health services authorities may issue guidelines, but practices need to agree and adopt precise protocols; and whereas criteria of care can be suggested externally, practices should develop their own standards—as the only external standards that can be imposed are minimum ones. Such practice development with support from the authorities is a key way of improving quality of care. Groups of practices supported by their authorities are working together to influence district health authority purchasing contracts and applying pressure for improving standards. This type of partnership shifts the engine driving quality improvement firmly into primary care.

Partnership with hospitals

The purchaser-provider split can increase the strain between hospital and primary care. General practitioners can shop around for cheaper and better contracts, hospitals can cut costs by reducing prescribing or earlier discharge. There is equally opportunity for cooperation. Fundholding has turned the disincentive to do work in the practice into an incentive, so consultants can reduce their load by developing guidelines jointly with general practitioners, freeing their beds and expertise for more needy cases. Follow up of patients who have had grommets inserted, direct access to hearing aid services, and injection of joints or varicose veins are examples.

Closer cooperation can further increase efficiency. Extensive work is being done on developing criteria for referral, and this will develop into jointly agreed protocols for management of common conditions, which saves patients excessive travel or periods in hospital and doctors the frustration of disagreeing on management.

Emergency work is a grey area between hospital and primary care. Many patients attend the accident and emergency department as their primary care service and some attend for a second opinion. If patients appear to be using the service inappropriately then it is necessary to understand their unmet needs rather than merely to redirect them. For general practitioners to work in accident and emergency departments may be one way of cooperating to solve the problem.²⁶

Improved electronic communication will further ease joint management as information will be passed instantly; but problems of confidentiality will have to be faced before a joint record is acceptable between hospitals and primary care.

Partnership in research and teaching

Karl Popper said about Oxford philosophers that they are so busy polishing their spectacles that they never get round to putting them on.²⁷ But much change in medicine seems to be introduced by people who are unaware that spectacles are available. The new general practitioner contract was introduced after minimal consultation—but since its introduction there has been a rush of academic papers questioning the justification of many of its clinical demands.^{28 29}

General practice academic departments are poorly resourced but generate extensive research which should inform current practice. If adequately funded—and the recent provision of tasked money, which is analogous to the service increment for teaching (SIFT) will go some way towards this—they would still need a mechanism to ensure that the results were reflected in

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Primary health care workers such as midwives are developing their own professionalism

practice, politically, through education and across disciplines. At present academics in primary health care are divided, between university departments, regional advisers, the royal colleges, schools of nursing, and so on. Joining these groups into institutes of primary health care, perhaps in one or two universities in the first instance, would develop synergy of effort, ease dissemination of results, and provide a focus for consultation. Such an academic partnership would provide the evidence on which the activities of practical partnerships could be based.

Conclusion

In caring for the population in the future it will be necessary to coordinate the work of professionals and managers, nurses and doctors, employed and self employed, and primary care and secondary care. With such large groups it will be necessary to base care on targets and guidelines justified by research evidence. Patients should benefit from a broadly based primary care team, consulting as appropriate for secondary care services. *The Health of the Nation* encourages health workers to believe that this may take place in an environment which is increasingly health conscious.³ The reward will be a dynamic approach to health based heavily on primary care.

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A PATIENT WHO CHANGED MY PRACTICE

Controlled adhesions and more patient years

Mrs A was 57 when she was treated for a strangulated femoral hernia in 1966. Gangrenous ileum was resected but she reobstructed twice, and at the third laparotomy within one month a kink was shortcircuited by ileo-ileostomy. Over the next five years she suffered recurrent bouts of partial obstruction, and in May 1971 she had to have a fourth laparotomy when I straightened all adhesive kinks and performed Noble's suture-plication. Obstruction recurred and three weeks later laparotomy revealed dense generalised adhesions. I elected to perform gastrostomy and formed an enterostomy on the lowest accessible loop of small bowel. The patient was fed intravenously for five weeks and slowly recovered, but within three months subacute obstructive episodes reappeared. On 2 September 1972 Mrs A was readmitted with persistent pain and a large hot swelling over the lower abdomen: when incised this yielded a copious and persistent small bowel fistula.

Another operation seemed unavoidable but all too likely to fail in giving lasting benefit. Fortunately, I had recently come across the 1956 paper of White.¹ Faced with a similar case in 1949 he had freed all adhesions and then threaded a Miller-Abbott tube down the whole length of the small bowel, leaving it in situ for 12 days. He theorised that adhesions would certainly reform, but believed that the intrinsic stiffness of the tube would hold the small bowel in smooth curves, so these "controlled adhesions" would form in a favourable pattern. White reported this patient to be well six and a half years later and Baker had also found this method helpful.²

At the sixth operation on Mrs A on 8 September 1972 there seemed to be complete obliteration of the peritoneal cavity, but the whole small bowel was eventually freed,

120 cm of the blind ileal loop with the fistula was resected, and ileoileal anastomosis performed. Adopting Baker's suggestion, a Miller-Abbott tube was introduced through a high jejunostomy and threaded down so that the tip, with balloon inflated, lay in the caecum.² The bowel was carefully replaced in the abdomen in open curves. The tube was removed three weeks later when Mrs A was eating normally.

It seemed reasonable to conclude that it was the intubation which had enabled Mrs A to enjoy a smooth recovery, and we felt justified in proceeding to use it in other patients. Franklin Medical cooperated in producing an 18 Ch Foley-type catheter, 300 cm long, which was a great improvement. As we gained confidence in the method we also used it in patients with multiple adhesions who presented in their first episode of obstruction.

A preliminary report was made in 1978,³ and in 1985 we reviewed other reports and our own results.⁴ We had then operated on Mrs A and 16 more patients with recurrent adhesive obstruction. They had survived for a total of 103 patient years without any further obstruction: 13 of these years were contributed by Mrs A. We believe this method is now of proved value to patients with a particularly troublesome legacy of laparotomy.

—PETER F JONES, *emeritus clinical professor of surgery, Aberdeen*

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