SUPPLEMENT

TALKING POINT

Inner London general practice—is there a solution?

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It has been asserted for many years that general practice around the London teaching hospitals has not been as good as in other parts of the country. A study of inner London practice has shown that the general practitioners there are on average older and more of them are overseas graduates than is so for GPs outside London. A greater proportion are single-handed and fewer work with attached nurses and health visitors. Few of the doctors practise from purpose-built premises and many accept inadequate premises in which to work.

The problems of inner London doctors have been largely ignored for two decades. The London teaching hospitals were the last to provide open access facilities for their general practitioners for laboratory and X-ray services. They were the last to co-operate in creating vocational training schemes and even now some even resent a half-day release for their senior house officers. They have lagged behind the rest of the country in providing postgraduate centres and, in many cases, do not understand the role of general practice in the districts for which they are supposed to provide secondary care. Many of the inner London boroughs have failed to see the need for purpose-built surgery premises in new housing estates and have sometimes obstructed planning permission for doctors wishing to develop their own premises. Now, at last, the problems are attracting some attention and a special sub-committee of the London Health Planning Consortium appointed by the Department of Health and Social Security has been asked to look into the problems of inner London general practice.

Four years ago the district administrator at St Thomas’s Hospital and I visited a random 60% sample of the doctors in our district to try to identify ways in which the teaching hospital could help to solve some of their problems. Three years ago the Royal College of General Practitioners set up a working party under the chairmanship of Dr Brian Jarman to collate all the routinely collected statistics about the populations of inner London and the medical care provided for them. I served on this working party. Its findings indicated the high level of sociomedical problems in inner London, such as single-parent families, solitary elderly people, mental illness, suicide, non-accidental injury, and alcoholism. They also confirmed the problems of high mobility in inner London populations emphasised by other workers and the special problems presented by commuters and visitors to London. The relative importance of these problems varies in different London boroughs.

In our visits we became aware of the isolation of many doctors not only from their colleagues in general practice but also from the specialists in the district and from their nursing and health-visiting colleagues. We were impressed, too, that many of the doctors were content to accept this unsatisfactory state of affairs and did not question whether it could be improved. Few of them realised that they might be able to influence matters through their local medical committee, the district management committee, or the district management team. Indeed, some were unaware of the existence or function of these bodies.

Accepting second best

Many of the premises we visited were totally inadequate to develop primary care based on the concept of the primary health care team, and many of the doctors who were Asian immigrants saw no way to improve the position. We came away with the overwhelming impression that the doctors had been lulled into accepting the second best and we wished they would rise up and demand better premises and closer links with nurses, health visitors, and their specialist colleagues. At the same time, we were aware that nursing officers in inner London were often opposed to the concept of the primary health care team and many local authorities were uninterested in providing the type of accommodation likely to promote a team approach. Many of the doctors were anxious about moving into health centres, in which they would cease to have any say in the appointment of paramedical staff and would also almost certainly have heavier overhead expenses. In addition, they thought that the authorities providing health centres failed to realise that in a densely populated area a move of even half a mile from their practice premises could threaten their livelihood because it would separate them from the centre of a small practice population.

Providing general practitioner care in inner London presents a great challenge to the medical and allied professions. That this challenge has been largely ignored by the profession and left in the hands of elderly and immigrant doctors, unsupported by the nursing profession, the local authorities, and, indeed, the elected representatives of the profession, is worrying.

Need for firm policy

We desperately need a firm policy for primary care services in inner London. Some people have suggested that the solution lies with the accident and emergency departments of the teaching hospitals. The logistics of such a solution renders it unrealistic. In the St Thomas’s district, for instance, the...
general practitioners undertake about 4000 consultations each day, with around 10% of these in the patients’ homes. Do the accident and emergency departments really believe that they could cope with this work load? It would surely lead to the unacceptable dilemmas from which the Americans have been attempting to escape for two decades. Primary care in an inner city, where the emphasis is on sociomedical problems, needs a well-organised primary health care team consisting of doctor, nurse, and health visitor, and possibly social worker providing continuity of care. This approach has been eminently successful in other parts of the country where the sociomedical problems are much less arresting.

Why has this concept not been adopted in London? There are several reasons: there has been no definite guidance from the profession’s leaders and the Department of Health that it is the ideal pattern of health care for inner cities; suitable premises have not been made available; many nursing officers in inner London reject the concept of the primary health care team; many of the immigrant doctors are not aware that this is the pattern of care to which British general practice is committed; and many of the older doctors do not wish to change their traditional patterns of care.

It is time that those in authority recognised that the solution to the problems of inner London general practice does not require a revolution. All London needs is to adopt the pattern of care which has proved successful in other parts of the country and which is admired by visitors from all parts of the world. Can this be achieved? It can and has been achieved in London by doctors prepared to fight against the bureaucracy and antipathy in the capital. There are some excellent group practices with attached staff scattered thinly through the inner London boroughs. Such a pattern can be realised much more widely if those in positions of power are prepared to state unequivocally that this is what they wish to achieve and to support their strategy with the necessary money. This means that the medical planners at district level, local authorities, family practitioner committees, the Medical Practices Committee, and the community nursing services must agree a policy and pool their resources to achieve their objectives.

Extra finance essential

The Department of Health and Social Security must make an unequivocal statement concerning its objectives and be prepared to make extra finance available to achieve them. The local authorities must consider the provision of primary care services in all their new building programmes, must be prepared to make good these services in the many new estates where they have failed to provide adequate premises, and must be prepared to give planning permission for development designed to achieve the expressed objectives. The nursing services must make a commitment to attaching nurses and health visitors, where possible, to general practitioners to produce the health care teams. They will also need to keep in reserve some nurses and health visitors to cope with the mobile sections of the population who do not register with GPs, and where necessary their establishment must be increased to cope with these problems. The Medical Practices Committee must look hard at its criteria for admitting new doctors to practice vacancies and give priority to doctors vocationally trained in London with a commitment to the primary care team concept.

General practice in inner London may be a hard and at times depressing occupation but a well-organised primary care team can greatly enliven the work. There are 12 medical schools in London where the students are increasingly exposed to highly specialised, high-technology medicine. Where are these students to learn about the common problems in medical care, the effect of illness on the individual, and the resources in the community for coping with the disability produced by illness? General practice in the districts of teaching hospitals provides an ideal place for this aspect of undergraduate education.

General practitioners in the shadow of the teaching hospital should no longer be seen as poor relations. They have a vital part to play in undergraduate education. They can provide the general medical experience which is now lacking in the London teaching hospitals. In return, they will be stimulated by the young critical minds of those who work with them in their practices.

This is the vision of one department of general practice in a London teaching hospital where 20% of the GPs in its district are committed to teaching undergraduates. Four practices are committed to the teaching hospital’s vocational training scheme. Six principals in its district have research fellowships in the department of general practice and are undertaking original research, and a senior research fellow has been appointed to establish links with the doctors working in the teaching hospital district and to study their special educational needs.

The problems presented by general practice in inner London are challenging. They need no revolutionary solutions, just a firm commitment by those in authority to the concept of the primary health care team. Such a team is ideally suited to provide the continuity of care for the sociomedical needs of those living in London. Well-endowed departments of general practice in each teaching hospital could make a real contribution to the education of their undergraduates and to the general practitioners in their districts.

References

(Accepted 27 November 1980)

Junior Members Forum

Allocation of resources in health care

Lancaster University, 4 and 5 April 1981
Chairman: Dr Stephen D Horsley

The first day of the forum will be a symposium on the allocation of resources in health care. The speakers will be

- Dr Gerard Vaughan, Minister of State for Health
- Mr Roland Moyle, formerly Minister of State for Health
- Dr Malcolm Forsythe, regional medical officer, South-east Thames RHA
- Professor Roy Calne, professor of surgery, Cambridge

The second day of the forum will be devoted to medicspolitics. The forum consists of elected or nominated BMA members (or associate members) from all disciplines who are under 40 and within 12 years of provisional registration. Any member who would like to attend should contact their regional office.

The symposium has been given limited approval under section 63 of the Health Services and Public Health Act for GPs in England and Wales.