Risk factor weightings

Randall et al suggest that an error may arise through using weightings derived from men seen 18-20 years ago. The Dundee score is based on data of similar age to that of almost all other British* and American scoring systems.† Risk assessment must be based on historical comparison (unless it is spurious), and for that reason it will take a similar length of time to know whether the error actually exists.

Unifactorial versus multifactorial assessment

The Dundee score will not categorise everybody with one risk factor as being at high risk, and Randall et al imply that individual risk factors should be considered in isolation. That idea is outmoded. For every person identified by exceptional levels of one risk factor there are many more with moderately raised levels of two or more factors who are at the same or greater risk because risk factors interact multiplicatively.‡ §

Cigarette smoking is equivalent to adding 20-40 mm Hg on to diastolic blood pressure or 1-3 mmol/l on to serum cholesterol concentration. These concepts can be shown on the Dundee risk-disk, but what they imply is that the multifactorial approach is not a second best approach to save work but the only valid one for managing cardiovascular risk factors.

After three decades of obsession with one dimensional algorithms for diastolic blood pressure, doctors have finally got the multifactorial message.‖ Lipidologists are belatedly beginning to do so. You cannot treat one risk factor and take account of the others without a valid scoring system which takes account of their interaction.

The established protocols for unifactorial risk assessment and modification are too naive. Simplistic, one dimensional, black and white algorithms must now incorporate the three dimensional solid state, and full colour, of multifactorial management.

Conclusion

The action plan and Dundee coronary risk-disk are a multifactorial approach to cardiovascular risk factor management. They form a necessary progression from the unifactorial approach and reflect the epidemiological evidence, cost effectiveness, and the latest clinical teaching. A change from tradition is required and this will not suit everybody, but many users welcome the interactive approach and the apparent motivating effect of the Dundee rank. So far the disk seems more popular than the action plan. Many practices are using it without a formal protocol. There is a perceived need for educational exchange. The OXCHECK analysis is of value, but its deviations from the Scottish study, which included 50 times as many practices, are unexplained.

The opinions expressed are those of the author and not the Scottish Office Home and Health Department, which funded much of the research.

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Partners in Practice

The primary health care team: history and contractual farces

John Hasler

It is not possible to state precisely when the concept of a team in primary health care became a reality. As with so many developments its progress was slow and its start unrecognisable. Before the arrival of the NHS in 1948 most general practitioners were in single handed practice, often with their wives as their only support—receptionists as such were uncommon. There were no attachments of district nurses and most doctors practised from their own houses. While there had been occasional ideas about a more progressive approach to primary medical care, these had been sporadic and had had little general effect. General practitioners saw their role as reactive and their potential role in prevention of disease had not yet dawned on most of them.

In this article I examine subsequent developments in three phases: from the inception of the NHS to the doctors' charter in 1966, from then to the new contract in 1990, and the present.

The '50s were difficult times for general practice. Removed from the hospital service and operating in a financial arrangement where any money spent on staff or premises directly reduced their income, many general practitioners looked with some envy on their specialist colleagues as the hospital service and technological advances took shape. But the frustrations had their positive effects, the most notable of which was formation of the College of General Practitioners, which attracted some of the ablest minds of the day. Some of these people turned their thoughts to starting primary care teams. As money was scarce, buildings often inadequate, and the potential of nursing work in general practice largely unrecognised, the theme at this stage largely concerned the attachment of district nurses and health visitors.

ATTACHMENT OF NURSING STAFF

The first reports of attachment of local authority nursing staff, who were then working in geographical areas under the control of the medical officers of health, appeared in the '50s and early '60s. But it was not all plain sailing. It took men of vision to see the possibilities, and Ian McDougall, county medical officer of health for Hampshire, a stalwart enthusiast for attachment schemes, once recalled how he had been
History of the practice team

Before 1948
• General practitioners usually worked single-handedly

1948-66
• Formation of the College of Practitioners encouraged able thinkers to advocate a team approach in primary care
• The first local authority nursing attachments were made in the 1950s, but many medical officers and general practitioners were wary.

1966-90
• The 1966 Family Doctors’ Charter enabled employment of practice staff—70% of the costs were reimbursed
• The role of practice nurses expanded and their number increased
• Practice managers were employed to help with management and administration
• An increasing number of other health care professionals became involved in primary care

1990 onwards
• The workload created by the new general practitioner contract has increased the need for practice nurses and practice managers with proved managerial skills. As their roles expand these members will have a higher profile and may become partners or members of executive boards

accused by some of his colleagues of dismantling their empires.

Many general practitioners were equally wary of the new developments. In a survey carried out by the Wessex Regional Hospital Board in 1964 less than half of general practitioners wanted health visitors attached, and this fraction was as low as a quarter in another survey in the previous year conducted by the medical care research unit of Manchester University. One of the problems was that many general practitioners were not entirely clear what health visitors did and, furthermore, in a survey conducted by the Royal College of General Practitioners only a minority of doctors were interested in prevention. In a survey in 1966 nearly half the doctors had difficulty in contacting district nurses and most doctors were ignorant about district nurses’ qualifications and the help they could give. By the middle of the ‘60s it was becoming clear that although the new developments in teamwork were beginning to be accepted, something much more radical was needed if real progress was to be made.

1966-90

The 1966 Family Doctors’ Charter provided the contractual framework within which many of the new ideas circulating in general practice could take effect. It stimulated the development of new, larger buildings and made employment of staff by general practitioners a realistic option because 70% of their cost was reimbursed. The number of receptionists and secretaries began to increase. The most important development, however, was the employment of nurses.

PRACTICE NURSES

There were two reasons why the employment of nurses was an obvious step in the evolution of primary health care. The first was that in many practices (including those considered relatively advanced in the mid-‘60s) most routine nursing work on the premises was done by the doctors: this included giving injections, performing venepuncture, and applying dressings. It made no sense at all to continue in this way. The second reason was that in the mid-‘60s, when there was a sporadic development of attachment of district nurses and health visitors, even in practices that had district nurses there were limits within which they had to operate. The number of district nurses who worked in practices and health centres was always limited, and still is today.

Most publications at the time were concerned with routine nursing procedures, although two papers in the late ‘60s described nurses carrying out assessment visits to patients requesting a visit by a doctor, an idea which never really caught on, especially as the number of visits (particularly to patients with chronic illness) slowly fell.

The rise of the practice nurse continued unabated and training requirements began to be recognised. So, too, was the need for general practitioners to be better informed about their responsibilities as employers. Much of the thinking at the time revolved around how much time the nurse could save the doctor until it gradually became apparent that time was not so much saved as better spent, with patients gaining more comprehensive care.

EXPANSION OF NURSES’ ROLE

As the number of practice nurses steadily grew, the range of their work increased. The first significant development was the recognition of their role in prevention. While health visitors have always worked primarily in this subject, their role was often limited in scope, either because their range of work was restricted by their employers or because there were simply not enough of them and mothers and children came first.

As a result practice nurses moved into coronary artery disease prevention and other areas such as cervical cytology, well man clinics, and well woman clinics.

The second and later development was in the follow up and monitoring of chronic disease, especially asthma, diabetes, and hypertension. It seemed that nurses generally did better than doctors when it came to checking that guidelines were being followed and were better at educating patients, and much follow up came to be organised in clinics by nurses.

Training courses were set up, both in higher educational establishments and in the private sector, of which perhaps the best known was that run in the Asthma Society Training Centre in Stratford upon Avon.
PRACTICE MANAGERS

During the 1970s and 1980s it became increasingly clear that just as doctors were not always the best people to provide all the clinical care, so it was not appropriate for them to be heavily involved in practice management and administration. As the number of receptionists and secretaries grew in parallel with the number of nurses, as buildings were enlarged (stimulated by the cost rent and notional rent schemes), and as the use of computer systems spread, the work involved in supervising and running the practice became more complex. Partnerships began to appoint managers to deal with much of this workload, although the extent to which doctors delegated responsibility varied considerably from one practice to another.

OTHER HEALTH PROFESSIONALS

An increasing number of other professionals gradually became involved in primary care, who, while not always forming part of the core team, nevertheless extended the range of services in an important way. Some of these were staff employed by the health authority, such as dieticians, speech therapists, chiropodists, and community psychiatric nurses, and others were employed directly by the doctors, such as counsellors.1

PATIENT PARTICIPATION GROUPS

Patient participation groups were established in several practices in the 1970s; these were made up partly of patients and partly of health care professionals. Their function varied slightly from one practice to another but in general they enabled patients to influence such things as appointments systems, access to practice services, and facilities in the building.

The present

At the end of the 1980s primary medical care was disturbed by another contract for general practitioners. Some of the new arrangements reflected developments from the previous decades, such as the concept of health promotion activities.

The new contract importantly did not interfere with the principle that although the general practitioner was responsible for ensuring that the contract was fulfilled, any work considered appropriate could be delegated to others, whether or not they were employed by the doctor. Thus the concept of teamwork was retained. However, the guarantee of 70% reimbursement for all staff up to a ceiling amount was removed, creating a measure of uncertainty for the future.

But the contract had other effects. Much of the new work, such as new registration, three yearly health checks, and health checks for those over 75 and the payment for special clinics stimulated further increases in the number of practice nurses. The new paperwork, especially in fundholding practices, encouraged practices to employ new administrative staff: some practice manager posts were advertised at a salary of over £20,000 a year. A book on practice management was into its second edition within 18 months and another had received orders in excess of 1500 even before it was published.2

The future

Already there are some clear questions about the future for primary care health teams.

NURSES

The primary health team has always had a highly complicated managerial structure, chiefly because the attached members are employed not only by an external body but one which, in England and Wales, is not the authority responsible for contracting with the doctors. Furthermore, the fact that some family health services authorities will not pay for clinic sessions done by attached staff has put pressure on some practices to substitute practice nurses for attached nurses, creating frustration and anxieties for attached nurses. There is already a debate about whether attached staff should be employed by the family health services authorities or, even more widely, by general practitioners.3 Clearly if general practitioners employed the attached staff roles and boundaries would be looked at anew. More delegation of work by doctors is virtually certain, especially regarding prevention and supervision of patients with chronic disease.

MANAGEMENT

Many practice managers are still only administrators, but the new breed of manager is more skilled and has higher expectations. Some practices are already exploring ways in which managers (and nurses) can become partners or members of executive boards. Because of their central role in primary care practice managers are now routinely members of the visiting teams who approve training practices in the Oxford region.

Fundholding has enabled practices to buy in the services of other health care professionals such as physiotherapists and psychologists.

Conclusion

In the end what makes a successful team is not merely the quality of the individual members but how they work together. In recent years an increasing number of educational activities have been devised to promote effective teamwork, and many groups now organise whole days away from the practice, when they can share aims and devise better ways of working together. The potential for new ways of delivering primary care has never been greater.

This series has been edited by Dr Mike Pringle.

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