

Forum - What's happening in the UK?

— John A Smith, National Coordinating Director for Vocational Training

Summary: *In a publication of the British Government it is stated that in no other developed country has the primary care physician achieved such a central role; it not only recognised the central importance of the GP in the NHS, but also the way in which it has held down the cost of health services as compared to other western countries. Different aspects of preventive medicine, the compulsory 3-year Vocational Training programme, the importance of general practitioners teaching and examining undergraduates, the multidisciplinary practice-based team, the GP's unique position to contribute to the planning and setting of priorities in hospital and health services, and the career earnings of the specialty of general practice.*

In 1986 the British Government published a paper: "Primary Health Care - an agenda for discussion".¹ The Government paper stated: 'In no other developed country has the primary care physician achieved such a central role. It not only recognised the central importance of general practice in the NHS but acknowledged the way in which general practice has held down the cost compared with costs of health services in comparable western countries.'

In March 1987 The Royal College of General Practitioners published Report from General Practice 25 - The Front Line of the Health Service, their response to the Government's papers.²

Any practitioner who is concerned about, and wishes to be involved in a meaningful way in the health care services of this country in the years ahead should read this report. The catalyst which has sparked successful health services have been built on simple and logical principles, and world trends in successful health service systems are evolving along similar basic patterns.

Comprehensive continuing and personal care

To quote from the report: In the United Kingdom there is a comprehensive health service for all. The average number of contacts between patients and general practitioners is about four per patient per year.

'Personal' is the first adjective in the College's job description of the general practitioner. Many of the problems brought by patients to doctors are best understood and best helped by the doctor who knows patients as people, who understands their fears and feelings, and knows the problems in their daily lives.

Personal preventive medicine is now a major feature of a modern health service and it is logical for patients to be offered preventive services in the same place and by the same team that offers them treatment services. Fusing prevention and treatment into comprehensive clinical care is an exciting development of modern practice. General practice is the biggest single provider of personal preventive care, and the evidence shows a growing involvement. General practice provides most immunizations, most blood pressure checks, most cervical smears and most anti-smoking advice; it is the largest provider of contraceptive care.

The registered list system

Patients register with a named general practitioner. It is a unique asset of British medicine and it provides a logical basis for monitoring health problems in defined populations, for planning services to patients, and in particular for evaluating performance and the uptake of services.

This list is easy to analyse by age and sex, using simple record-keeping systems as well as micro-computers, and also by other important characteristics so that general practitioners can relate health problems of all kinds to population characteristics. For example, British general practitioners have the potential to state the percentage of their patients who have been immunized, who have received cervical smears or who have any defined condition.

The report of the Community Nursing Review in England has advocated the neighbourhood as the basic unit of population for nurses. Such a proposal creates two problems. The first is that nurses and doctors will be working to two different populations, which will cause confusion and carry the risk of duplication or omission. The second is that

currently nurses working in primary health care teams can have access to information held by doctors on all patients. The organisation of nurses by neighbourhood could deny them this.

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Research

The Government's discussion document does not contain a section on research - this is significant and regrettable.

The College comments particularly on this subject because it believes that both general practice and primary health care have been seriously under-researched. There is an urgent need for further research both into the diseases that are seen primarily in the community and into the organisation and evaluation of health services, including cost benefit studies of alternative forms of providing care. Studies are needed on the origins of

disease, on the reasons why patients seek and need medical help, on the most appropriate, effective and efficient ways of providing care, and on the prevention of disability.

Education

Improvements in care for patients depend not only upon research but upon education. Education is the key to change and is the only practical way of helping professional people to adopt new tasks and techniques. Education becomes more important in times of rapid change in society particularly in relation to health care. Medical care is never static, new knowledge and new techniques are being

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discovered all the time. The pace of such discoveries is steadily quickening.

The Government's discussion document stated:

"Another landmark in the development of general practice was the introduction in 1981 of

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a compulsory three-year vocational training programme for new entrants. This was a crucial step in maintaining and improving standards of care by specialised training. General practice is a specialty in its own right and is increasingly seen as an attractive career by many of our best medical students."

The College is an educational body and devotes a substantial amount of its energy and resources to education so that the standards of care which patients receive can improve. It organises many

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courses nationally and locally through its faculties. There are educational meetings and small groups of doctors which College faculties have done much to develop and support.

The College introduced the MRCGP examination in 1968. The number of candidates applying for this has risen steadily and is currently about 2000 doctors a year. The pass rate is now about 70 per cent. The number of doctors passing the MRCGP each year now matches approximately the number of vacancies for principals in general practice in the NHS.

In 1985 the College decided:

"to give more formal recognition to sustained performance and continuing professional development as essential factors in making the award of fellowship" (RCGP, 1985a).

Since then the College has started pilot studies of

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fellowship assessment by peer review based on practice visits in four of its faculties.

The Government has stated in its discussion document:

"However, the undergraduate course content varies widely between medical schools and in some, general practice forms only a relatively small part of the curriculum."

General practice is the largest branch of the medical profession and about half of all medical

students will become general practitioners. General practice must therefore form a major component in all undergraduate courses, and students should be specifically examined by general practitioners in every final examination leading to a basic medical qualification.

The College cannot understand how even today doctors are qualifying without being examined by general practitioners and it calls on the General Medical Council (GMC) to explain this and to indicate how quickly the necessary reforms can take place.

The College strongly supports the recommendations of the Mackenzie Report. The principle is simple. University departments of general practice should be resourced at least as well as university departments of medicine and surgery.

The main specialist branches of medicine have been developed substantially through their postgraduate institutes. Many of these are grouped within the British Postgraduate Medical Federation and there are other major institutions outside it such as the Royal Postgraduate Medical School. These organisations have outstanding records in

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postgraduate research and teaching. They achieve this through multi-million pound resources for their staff. General practice needs equivalent provision.

Educational arrangements based on health districts can conveniently be considered as those for vocational training and those for established principals in general practice.

Mandatory vocational training for general practice was introduced by the Government in 1981 with the full support and encouragement of the College. Although overall responsibility rests with the regional adviser in general practice, the implementation and day-to-day coordination of vocational training requires doctors working at district level who are responsible for organising local courses and schemes. These doctors are usually known as course organisers, or in some places, associate advisers.

A sound undergraduate education is extremely important and good vocational training for general practice is essential to prepare doctors for unsupervised clinical responsibility. But these two periods

together occupy only about nine years and general practitioners may practise as principals for over 35 years. The College believes that much more attention now needs to be given to the educational needs of principals and to supporting them through the changes that occur during a lifetime of professional practice. The whole point of continuing education is to influence doctor behaviour in order to provide better care for patients.

One approach is to encourage performance review within practices so that general practitioners and their colleagues are provided with a regular flow of information about practice activity. This enables them to compare their performance with those of their colleagues in as many ways as possible. This can contribute a considerable amount to the quality of care provided, to better practice organisation, and to relevant continuing education.

The practice team

Much of primary care, especially in the management of people with chronic illness and in prevention, requires a co-ordinated approach with a

multidisciplinary team of professionals. To provide primary care services satisfactorily to the practice population, the functional unit of care must be the practice-based team.

The practice team consists of a core of individuals in different professions each working from a base in the same building. In addition there are other

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colleagues who come to the practice building to see the patients of that practice. The core team usually consists of general practitioners, practice nurses, community nurses and health visitors with practice administrators and secretarial and reception staff. In some practices midwives, counsellors and psychiatric nurses may be members of the core team.

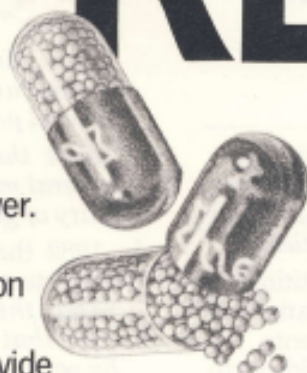
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There is a need for greater recognition of the importance of the multidisciplinary primary health care team, and for wider flexibility of the professions in it.

The roles of nurses in primary health care need to be further developed. Such development is most effective when nurses work as members of practice-based teams rather than in isolation from other primary care professionals. Such an approach makes it practicable to extend the nurses' responsibilities so that, although still working closely with doctors, they can prescribe from a limited range of items and use their professional judgment.³

Most innovation in primary health care nursing in recent years has come as a result of general practitioners and nurses together developing the role of the practice nurse. Working together and planning policies for patients is easier, quicker and less frustrating for practice nurses than for nurses who are managed from outside the practice. For example, some community nurses have been inappropriately restricted by nurse managers in their clinical work.

The further development of the role of the practice nurses is central to the future of primary health care. The College looks forward to the practice nurse acquiring increasing responsibility and clinical independence without the intervention of nurse managers who are based outside the practice itself, and who may not have experience of practice nursing.

The role of the family practitioner committee in the planning of local health services is developing slowly and is recognised by the Government in its discussion document when it states:

"Because of their unique position in mobilizing

The College believes that the most appropriate mechanism for maintaining standards among doctors, is peer review

hospital services for their patients, family doctors are well placed to assess the adequacy of the services and to contribute to the planning and setting of priorities by health authorities."

The College believes that general practitioners should always be involved in the evaluation of hospital services and of clinical departments. As consumers of hospital facilities, they should participate actively in the process of agreeing policies and ensuring their implementation as part of the planning cycle of health authorities.

The relationship between teaching hospitals and local practices has often been unsatisfactory from both sides. As stated previously there is a particular need for strong, well resourced academic depart-

ments of general practice in all medical schools and for local policies to encourage the care of patients by local practices rather than through alternative services such as accident and emergency departments and outpatient clinics, which are likely to be both more expensive and less personal. The overriding aim must be for teaching hospitals to foster and support general practice rather than to take over its responsibilities.

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Modern information technology

The planning of care in practices must be based on up-to-date information about practice activity. Encouraging improvement in standards of patient care is a main object of the College. This depends on knowing what is actually happening in practices and in analysing the performance of doctors and their colleagues. This is why the College is rapidly developing its own information service and is actively encouraging its members to develop information systems within their own practices.

It is the responsibility of the profession to provide the most appropriate methods for collecting information about activity in general practice and to agree on professional standards.

That responsibility should rest with the profession was emphatically endorsed by a special Conference of Local Medical Committees in 1978, which agreed, inter alia, the following resolutions:

"That this Conference approves of clinical audit of professional standards in general practice."

"That clinical audit of professional standards in general practice shall be the responsibility of general practitioners."

"That this Conference believes that audit of general medical services should be the responsibility of general practitioners."

In 1982 the Annual Conference of Local Medical Committees passed the resolution:

"That this Conference fully endorses the principle that medical audit will be carried out only by peer groups."

As a general principle the College believes that the most appropriate mechanism for maintaining standards among doctors who hold unsupervised clinical responsibility and are independent contractors, is peer review. The College does not wish to see supervisory systems introduced in which general practitioners, who form the front line of the NHS,

are controlled by those who have no first-hand experience of the work of general practice. The College will continue to promote peer review, small group discussion, and the evolution of standards for general practitioners themselves.

Career earnings

The College believes that as a matter of principle, able young doctors choosing a career in general practice should not be at a disadvantage in career earnings compared with their colleagues who enter specialist medicine. In 1979 the Conference of Local Medical Committees adopted a policy that:

"the career earnings of doctors who practice the specialty of general practice should be no less than those of doctors in other specialties."

In conclusion, it is stated that as generalists, general practitioners must work as members of multidisciplinary practice-based teams. They must provide a wide range of services to their patients, including preventive services, and in readily accessible ways. To do this, practices will need to be properly equipped, and doctors and practice staff to

be properly prepared for their responsibilities through education and training.

All that is stated above is directly stated or indirectly implied in our own Health Service Facilities Plan. Consequently, if we wish to be in the forefront of health care we must see that it is implemented as soon as possible.

Good health care need not be expensive health care, bad or inadequate health care is always expensive to the patients, to their family, to the community, to the State.

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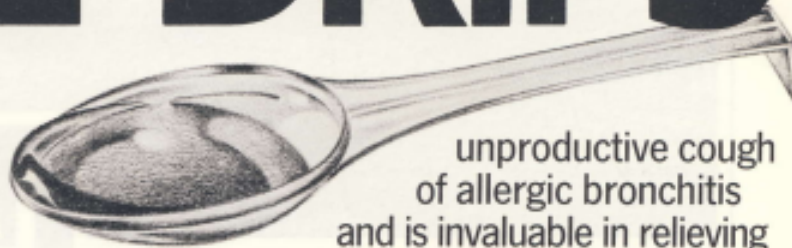
1. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. Primary health care: an agenda for discussion (Cmnd 9771) London HMSO 1986.
2. The front line of the health service, College response to 'Primary health care: an agenda for discussion'. Report from general practice 25. Copies can be obtained from the Central Sales Office, Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1P.V. (Price £5,00).
3. Department of Health and Social Security (1986b). Neighbourhood Nursing - A Focus for Care. London HMSO.

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