Simpson and Ballard set a good example.[5] Their study highlights how tests do not always measure what they set out to measure; in this case decision making in the orals. Swanwick and Chana raise interesting issues on the high validity of evidential, locally-based assessment, suggesting ways of enhancing the reliability.[6] If we believe the published literature,[11] the task in hand is challenging.

The danger of current change is the impetus with which is it taking place. The new approach may not lead us to the Holy Grail for a test that accurately predicts future unobserved practice; but we do face a major change in philosophy. Assessment programmes designed to ensure education is efficiently and appropriately delivered are replacing the examinations that are known to be reliable but are at times lacking in validity. We need well-designed research to support or refute this new rationale.

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Making general practice fit for the 21st century

For some while it has been customary to argue that good primary care is an essential part of an effective, comprehensive system of health care. Barbara Starfield's work comparing the systems in different countries has supplied convincing objective evidence to support the contention, where countries with poor orientation towards primary care have worse health outcomes.[1] The same relationship has been found when comparing the different US states,[1] and on a more local scale, mortality rates in English hospitals have been found to be closely related to the supply of GPs in the area.[2] Policy experts observing from countries lacking such systems, most obviously the US, bemoan their deprivation in this respect.[3] Older doctors and patients lament the passing of the familiar family doctor, who through long knowledge of the patients became a family friend. The difficulty with this vision is that such long-term commitment has become unusual, and erodes through the mobility of both patients and the needs of doctors for career development and adherence to the European Working Time Directive. So unusual that it is now unrealistic to plan a system on the basis of long-term relationships. Worse is the risk that constructing a system on the basis of such relationships sets it up to fail. It is worth taking stock to define what the task should be now, and how we can set about achieving it.

First and foremost, doctors working in primary care have to practise medicine to a high degree of technical competence. It is easy to dismiss this, or regard it as a truism. But truisms are often true. It has been customary to take technical excellence for granted, either by assuming its universal existence among all primary care doctors, or through fear of what we might find if we looked a bit harder. However, we know that there have always been doctors working in primary care whose practice would not, if tested, reach an acceptable standard. One of the benefits of a robust system of revalidation, when it is in place, is that it will tell us whether such doctors comprise 0.1%, 1% or 10% of the total. Technical competence demands two added dimensions. First, doctors all have to keep abreast of a discipline that changes constantly, with the appearance of new diseases (and the disappearance of some old ones), development of new diagnostic tests and techniques, and a constant supply of new therapies. Second, doctors working in primary care should continue to aspire to be good generalists. One of the strengths of primary care is to have enough expertise across all areas of medicine to relieve patients of any anxiety that they need to decide the appropriate specialist to deal with their problem. Also the last thing patients want is a primary care doctor who can say as specialists can (and sometimes do), 'Sorry but this problem is outside my area of expertise'. Because the idea of excellence which turns its face against specialism is so alien in our culture, the insistence that primary care has to remain rooted in generalism is a vital message to get into the heads of policy makers. This is especially true right now in the UK, with developments pulling in the opposite

direction: the creation of GPs with special interests, a contract offering doctors the opportunity to opt out of particular clinical areas, and the trend towards part-time working.

Modern general practice implies expertise in areas beyond purely medical competence. GPs have to practise within a defensible ethical framework. There is the principle of justice, implying respect for the wide range of cultural sensitivities encountered, and attention to the cost-effectiveness of decisions and how they impinge on the rest of the system. There is also the requirement to respect patients' autonomy, with the need to involve them, as far as they wish, in decisions affecting their health. In passing, it's worth pointing out that the need to promote shared decision making is both more high-minded, more truly respecting of patients' autonomy and more complex than the meretricious choice of provider so assiduously promoted by policy makers in the UK. These extra dimensions can feel as if there are numerous invisible observers in the consulting room looking over our shoulders. Not just the medical experts but also a panoply of ethicists, anthropologists, economists, and management consultants.

Providing care of high technical quality has become easier with electronic access to up-to-date information, in the form of primary research, systematic reviews and guidelines. Decision support, both electronic and delivered by other means is following close behind. Standard GP systems already provide prompts and alerts, and such aids will become more sophisticated, delivering individualised data on prognosis, and risks and benefits of different treatments.[4] What's more, either because of such assistance or despite it, there is convincing evidence that standards of technical care are improving, and have been doing so for some time before the introduction of the 2004 contract.[5]

Which leaves a question mark hanging over personal care. Because in the past it was felt to be such a permanent feature of primary care we may have taken it for granted. Patients have always valued personal continuity of care,[6–9] but others, most notably policy makers, have assumed that immediate access is more important. However, recent research on changes to access,[10–11] together with the more dramatic press coverage shortly before the recent UK election has confirmed its importance. The more that the value of trust is recognised to lie at the heart of effective health care,[12] the more important personal care becomes. If patient-centred care is to become anything other than an empty slogan, it will require much better personal care, with doctors being more sensitive to the personal agendas that patients bring to shared decision making. So, with long-term personal continuity slowly eroding, and no longer to be assumed, the central task of primary care in the coming years will be to find ways of delivering personal care in the context of much shorter, more intense, relationships between doctors and patients. Different models are being proposed for personal care, and the evidence for what works in routine primary care is, as yet, scanty. For future researchers the vital criteria follow from the arguments put forward here: it has to be an approach that is not based on long-term relationships, that can be deployed in relatively short encounters and that facilitates shared decision making.

Accomplishing this task will involve everyone with any influence on primary care. Clinicians themselves will want to assess their own abilities more than they do at present, and it may become a regular part of appraisal. Those responsible for postgraduate education (and assessment) will wish to develop methods to help doctors learn the necessary skills. The work to date on shared decision making has so far indicated that the skills can be learnt and deployed,[13] but that does not guarantee that they will be applied in all consultations.[14] It will certainly be a long learning process for most of us, patients as well as doctors. There is, as has been shown in the past, coherence in teaching, assessing and maintaining professional attitudes, and the vital first step is to accept that such attitudes are essential. This approach will also demand longer times for consultation than the 10 minutes that is now the UK norm, and planners will have to be convinced that patient-centred medicine requires long term investment.

David Jewell
Editor

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