Organisation and education

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OF the surveys of medical care which emerged in 1972, three are of particular interest to the British general practitioner. The first—a special issue of the *International Journal of Health Services* provides a view of primary medical care in a wide range of countries. The second, the *Milbank Memorial Fund Quarterly* (Wolfe and Badgley) for April, 1972 focuses on " the organisation, work and payment of the doctor, particularly the family doctor " in the setting of a consumer-sponsored clinic in Saskatoon. The third, relating general practice to the total practice of medical care in Britain, is the " Grey Paper "—*Management Arrangements for the Reorganised National Health Service* (Department of Health and Social Security, 1972).

This trio should be read widely by members of the College since they raise important issues—professional, organisational, and educational. It is plainly naive to suppose that features from the health care system of one country can be usefully transposed into another. Yet familiarity with other systems of medical care can usefully stimulate us to look more critically at the assumptions and features of our own—not least at the aims, problems and limitations of its organisation.

Primary physicians in search of a role

Organisation is concerned with delivery systems—with the translation of (limited) resources into priority objectives. In the not-so-far-off days of the 1930s, the objectives and priorities of primary care were easily defined—as, indeed, they are today in developing countries. Not so now, however, in the affluent societies of the world. Here, as the pages of the *International Journal* illustrate, the priority roles of the primary physician are often confused and ill-defined.

The roots of this uncertainty lie in the dramatic changes which have occurred in the health needs of both individual and family. Clinically, the burden of the acute infections and of malnutrition has been supplanted by that of the chronic degenerative diseases; the psychiatry of the psychiatrists by the ubiquitous stress reactions, the neuroses, alcoholism, addiction and suicide. Society has imposed a demanding mobility on the individual, and new pressures on his family; it has created as many environmental problems as it has solved; and has added to these the burdens of increasing population and age.

Simultaneously, a combination of both scientific advance and (in Britain) of developments in social policy has greatly increased the range of domiciliary care. There have been strong centrifugal trends in medical care away from the hospital and into the community.

In such circumstances preventive medicine and the promotion of health become as important as the management of disease and the assumption readily arises that the primary physician's role encompasses any and all matters affecting health. Indeed if the promotion of health *is* as important as the care of curable disease, then there are few aspects of an individual's life which are not of concern to the general practitioner.

This is a far cry from the world of James Mackenzie and of William Pickles. And it is not surprising that the primary physician often seeks the security of a traditional,

disease-centred role; or contracts out of decisions on role by accepting demands rather than needs as the basis of his day-to-day business.

Either response is inadequate. Until he has defined his role clearly he cannot define the organisation best suited to it. For a generation in Britain the general practitioner has been concerned with his status: he might now, profitably devote the same concern to his role.

Good and bad organisation

Organisation is 'good' or 'bad' precisely insofar as it helps or hinders the process for which it is the vehicle. In this it is *effective* or *ineffective* according to the extent to which it achieves its objectives at all: it is *efficient* or *inefficient* insofar as it achieves (or fails to achieve) those objectives with the minimum waste of resource.

Organisation may thus be highly efficient yet abysmally ineffective; or effective in spite of inefficiency. It is interesting that while in Britain criticisms of health care organisation are preoccupied with efficiency and very little concerned with effectiveness, North American medicine is much more concerned with effectiveness than efficiency. This is seen not only, at individual level, in a concern to develop clinical audit; but also at a national level in criticisms of gross maldistribution of care. Britain has lessons to learn here.

Role of organisation

Wolfe and Badgley—concerned at the maldistribution and consequent ineffectiveness of much primary care in the United States of America—have no doubts about the role of organisation. To them it is of predominating importance. " Our central thesis " they write, " is that the framework of medical practice—whether the doctor works by himself or in a group, and how he is paid—determines what the doctor does and how he does it ".

This is only partly the truth. Legislation and organisation are more effective in determining what individuals do not do, than in motivating what they do. Organisation may proscribe some activities: and may create, or remove, disincentives to others. It may determine priorities and the distribution of resources: provide a pattern for their deployment and the matching of resources to needs; may help or hinder the co-ordination of a complex exercise; and provide for monitoring and assessment. In short, it may determine the environment of medical care. But it cannot provide, or order, the attitudes, skills and knowledge which determine the content of that care. This is the prerogative of education. Or, as the Grey Paper expresses it, in its opening paragraph: " Success . . . depends primarily on the people in the health care professions who prevent, diagnose and treat disease. Management plays only a subsidiary part, but the way in which the service is organised can help or hinder the people who play the primary part " (DHSS, 1972).

Organisational issues in primary care

Four organisational issues of importance in primary medical care run like strands through the pages of the *International Journal of Health Services*. Each has lessons for Britain.

1. Availability and maldistribution

" It is occasionally salutory to remember " wrote McLachlan in 1966 " that to the sick person what matters most is that the best possible medical care should be available as a continuous process relevant to his disease."

Availability, however, is not only determined by the total resources available but also by their distribution. Australia has a perennial problem created by the migration of experienced practitioners towards the social, educational and cultural attractions of urban centres. In Swedish cities it is sometimes difficult to find a doctor between Friday

evening and Monday morning. And nowhere is maldistribution more dramatically seen than in the USA.

" As the inner cities of the USA have become filled with the poor, the physicians have fled to the suburbs, with the middle classes of which they are part. . . . Producing more physicians will not put them into ghettoes or into rural communities. There are 127 physicians per 100,000 population in Los Angeles but 38 per 100,000 in the Watts area. In the poverty area of Baltimore 100 general practitioners care for 550,000 people in the slums and the great majority of these physicians are over the age of 60 ". (Wolfe and Badgley, 1972).

By comparison Britain is a comfortable, complacent society to live in. But have we no lessons to learn? A recent report (Sidel *et al.*, 1972) clearly demonstrates that we have. It is possible that, looked for with the same thoroughness, situations similar to that in Camden might be found in other British cities.

2. Deployment—matching resources to needs

In reading the pages of the *International Journal of Health Services*, it is clear that there is not a country that does not believe itself short of doctors. A vivid illustration of this is the Carnegie Commission's recommendation in 1970 that the 10,800 new students entering medical schools in the USA should be increased by 50 per cent to 16,400 by 1978 (Wolfe and Badgley, 1972).

It is the commonly held assumption that " physicians will continue to constitute the primary profession responsible for the provision of personal health services " which—perhaps more than any other factor—has led to this belief.

This assumption has never really been true. A hierarchy of consultation exists—family, neighbours, pharmacist, nurse, health visitor, osteopath, doctor and doubtless others. This hierarchy has represented the skills necessary to achieve the desired outcome. The much-felt shortage of doctors in primary care bespeaks a ' shift to the right ' in this hierarchy, the cultural sophistication of society often demanding the attention of a doctor when the skill of the nurse would achieve equal results.

A critical reassessment of role, based on community morbidity is necessary in primary care. It is foolish to train an additional *a* per cent of doctors, if *b* per cent of nurses would achieve the same result: or *c* per cent of specialist diabeticians when *d* per cent of properly educated general practitioners would provide care of the same standard. This situation is one which has perforce been explored most diligently where the discrepancy between obvious needs and available resources is greatest. The work of Morley in Nigeria and of Geiger in Boston are two such examples. In countries in which the discrepancy is less obvious, however, squandering of resources continues. We have many lessons to learn here. At the level of individual practice the same holds true. Wise delegation is both difficult to learn and contrary to the innate conservatism characteristic of medicine.

3. Co-operation and co-ordination

For effective deployment, co-operation and co-ordination are essential.

" The paramount requirement " wrote Kenneth Robinson (Minister of Health, 1968) " is that all the different kinds of care and treatment that an individual may need at different times . . . should be readily available to him. This requires the closest collaboration between the doctors, nurses and other workers who give him their help. It also requires close collaboration between those who provide and administer the various services to which all these workers belong."

Here, traditional professional boundaries too often become walls. Wolfe and Badgley describe the situation at the Saskatoon Clinic thus:

" It was not unexpected, then, that the staff nurses frequently had sessions, including luncheons, at which they reviewed procedures and ' bitched about their doctors ' and about other problems of staff work . . . The doctors, too, regularly had ' bull ' sessions at which they spoke freely, sometimes critically, of their co-workers."

A similar comment on interprofessional relationships in British general practice was made by Verby (1972).

" I noted the general practitioners generally had difficulty (in) including the other professionals and workers in discussions of mutual interest. The other professionals projected their inability to relate by removing themselves from the room when the general practitioner entered. An interesting phenomenon, quite common wherever I went. My personal impression is that both the general practitioner and other professionals were mutually insecure and unable to develop comfortableness in their interpersonal relations."

The lessons to be learned are of critical importance. The practitioner must have clear concepts of his own role; and an equally clear comprehension of his colleagues' roles. He must develop new attitudes; and base his leadership not on authoritarianism but on a critical understanding and use of his colleagues' distinctive skills. This can only be achieved by sustained interprofessional discussion. This without doubt is one of the most important self-educational tasks which general practice in Britain faces—for unless new attitudes are learned no amount of reorganisation will achieve the desired results.

4. Monitoring and assessment

In almost every country, medical care remains one of the few activities into which society is willing to pour money with very little attention to the efficiency or effectiveness with which that money is applied.

Since the day of its inception, the National Health Service has lacked any adequate assessment of its services at regional or community level. There is no reason to suppose that priorities of need, or the problems of maldistribution, deployment and co-ordination of resources, are identical in different communities in Britain. Indeed, there is plenty of evidence—both direct and indirect—that the opposite is true. In the absence of adequate systematic operational research at regional and community level, changing needs will continue to be inadequately met, and misapplication and reduplication continue.

Transatlantic contrasts are striking. In the USA, medical care now forms the largest section of the American Public Health Association and among university medical faculties there is a wealth of talent devoted to the epidemiology of medical care. Yet the vast administrative complexity of that nation inhibits application. In the compact society of Britain (where operational research originated) administrative complexity is much less, yet operational research in medical care remains unsystematised and inadequately developed.

Thus, a major criterion of success or failure in British Health Service reorganisation will be the degree to which it enables monitoring of needs and resources to be developed at regional and community levels.

Monitoring of medical care is not, however, solely a matter for regions and communities. It requires development at the grass roots level of individual practice; for it provides the only adequate basis for the continuing education of the general practitioner. Until he knows what he is (and is not) doing he cannot know what he needs to know; and his continuing education remains haphazard—at best a matter of hunch or inclination. This is the real contribution which clinical audit offers him. So, both he and the College, must now address themselves to the development of practical methods of audit.

Professional responsibilities

Reading these accounts of organised care abroad recalls the remark of a senior Israeli physician that the pattern of medical care is not built on needs, but on history and vested interest.

Precisely because Medicine is one of the most respected of professions it is one of the most powerful. Corporately, physicians are in much the same position as the board-room technocrats described by Galbraith. As the system becomes more complex and sophisticated, the shareholders—still nominally in control—defer more readily to the technocrats' priorities and decisions. " Industry sets the pace; decides what people want and then ' accommodates the consumer to the goals of the technostructure and provides a climate of social belief that is favourable to this result.' "

Thus the profession has considerable corporate responsibilities in the shaping of medical care. Its record in this—both recent and past; both in Britain and abroad—has not always been good. If, as Fry asserts, general practice has " become an important and dominating branch of medical care " with " an important voice in medical planning and administration " it will need to turn new attention to these responsibilities.

As its first principle, the Grey Paper proposes that " the health care professions should be integrally involved in planning and management at all levels." This is wise. Whether it proves a creative or a stagnant provision will depend, mainly, on the attitudes and wisdom of the physicians involved and on the pressures brought to bear by the corporate profession they represent.

The future

These three papers provoke reflection on the College's future role in two areas.

1. Research and development

First, in the research and development of organised primary care. For many years the practice organisation committee of the College has introduced and fostered valuable studies into the organisation of primary care. These, however, have often focused their attention on the work of the practitioner rather than on his community's needs; and been concerned with efficiency rather than effectiveness.

A new emphasis on studies of effectiveness is needed. On the one hand, at regional and community level—in terms of community morbidity and special needs; the availability, development, and co-ordination of primary care resources; and deficits of care. On the other hand, at the level of individual practice—in the development of methods of clinical audit and operational monitoring.

By virtue of its Faculty structure, the College is well placed for such a role.

2. Education and training

Second, in education and training, the College has a major role. Organisation is but the vehicle of care. It is attitudes, ways of thinking, skills, and knowledge which determine the content of that care.

During the past 15 years the College has devoted much critical thinking to the necessary content of vocational training for general practice. It has, however, devoted much less both to undergraduate education, and to the continuing training of established practitioners.

Yet undergraduate medical education is the substrate on which all else is built: and general practice has much that is distinctive to contribute to it—not only in terms of concepts, modes of thinking and professional attitudes, but also in content, and a fresh understanding of the basis and limitations of clinical method. Such education plainly remains the prererogative of University Faculties: and the College's contribution

is necessarily an indirect one. Nevertheless that contribution did not die with the birth of university departments of general practice.

The tasks associated with continuing training are of a different order. The only rational starting point for such training is the educational needs of the individual practitioner. In the USA major attempts have been made to develop methods of clinical audit from which such needs could be defined and programmes planned. In Britain by contrast reliance is still placed on more haphazard provision. The College will need to direct a new attention to this.

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