Editorial

GENERAL PRACTICE IN BIG CITIES

Organising good primary care in big cities is more difficult than arranging good specialist care. Difficulties arise all over the world, because of factors such as the high cost of urban land, overcrowding, poverty, and a mobile population. Impersonal relationships are common and threaten general practice particularly. Doctors providing primary care in the community face great difficulties, as do local governments, however organised.

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"EVERYTHING flows, nothing is stationary", said Heraclitus in 513 BC. He was proposing a theory of matter, but he might well have been describing life in an inner city today. Traffic flows, people flow, and even doctors flow. How can continuity of care be maintained?

Young families flow out of the city to the suburbs and the old are left behind, either because they cannot or will not move. Most of their moves, except those of the favoured few to sheltered housing, are for the worse. The elderly make few new friends, their young married children are increasingly further and further away and are now able to provide their help only in a monthly dose of a whole day, rather than the much more preferable two daily ten-minute visits. If they do decide to take the plunge and live with a married daughter, mild dementia—in Hodgkin's phrase "the privilege of old age"—may lead to the breakdown of the daughter and to a social crisis. The city doctor may then find himself welcoming back his old patient to the familiar tune of "Something has got to be done!"

Young people flow into the city as students, apprentices, nurses, secretaries or squatters, often just to get away from home. They usually live in flats, frequently registering with a doctor only when they need care. General practitioners have particular difficulty with this group, with their sexual entanglements, their legal wrangles with authority, and their abuse of drugs. In the old rented property in the middle of cities gather the ghettoes of racial minorities, the objects of prejudice for many people, and often having fearsome family problems.

Planning policy in many parts of central London seems unproductive. Although many old houses are pulled down, no new buildings may appear for as long as ten years. Local deprivations occur and the old borough of Southwark, which in Dickens' time was the teeming home of thousands of people, now contains not even one pharmacy. The needs of the population are inadequately met even on new estates, where there are often no corner shops, no social clubs, no bingo halls, and no planned premises for modern health care.

The motor car is banned to protect children playing near their back door, so doctor and district nurse may have to walk half a mile to get to patients. Should there be an urban equivalent of the rural practitioners' extra payment for those who live more than a specified distance from the nearest road?

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Deputising services are changing the face of urban general practice. One consequence is that they enable an ageing single-handed practitioner to remain on his own and postpone retirement. Forming groups is difficult, particularly in difficult economic times, and buying new premises may be impossible at current interest rates, particularly if there is a large gap between what the partnership proposes and the district valuer disposes. As population clearances proceed, areas may suddenly become " restricted " and partners may not even be replaced until a colleague dies or some new estate is completed.

Should one allow well-satisfied patients moving further away to stay on the list? How does a general practitioner balance the time lost sitting impatiently in traffic jams covering a scattered practice of patients he knows well against that which he saves in a compact high turn-over practice with much poorer doctor-patient relationships?

London, the biggest city of all, may have the greatest need for health centres. It has the fewest. The South-east Thames Regional Health Authority has only 3·7 per cent of its practitioners in health centres, while at least four regions of the country have provided health centres for more than one fifth of all their practitioners.

Simultaneously, the big cities often have the lowest proportion of directly attached health visitors and district nurses, thus making it even more difficult to make the primary health team work. Tudor Hart (1971) has described the inverse care law: in the big cities perhaps there is a perverse care law as well.

Almost four years ago this *Journal* drew the analogy between the concept of vulnerable groups of patients needing special care in general practice and the idea of vulnerable areas of general practice also needing special attention. Four years later the problems are getting worse. Just as vulnerable patients may not receive remedial therapy in time, so complications and crises are beginning to develop in general practice in the big cities.

The scale of this problem is considerable. Fry (1975) has already shown that a fifth of the general practitioners in England practise within 50 miles of Charing Cross, yet as yardstick after yardstick appears, London is shown to be deprived. We have already pointed out that it has four of the five regions with the fewest number of trainees, four of the six regions with the fewest number of practitioners in health centres and the London medical schools have the fewest number of departments of general practice.

Something has got to be done! We remain convinced that three general principles still apply: the provision of modern premises, the need for attachment of well-qualified staff, and the development of strong representation of primary care in every university medical school.

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