Specialization in general practice*

JULIAN TUDOR HART, FRCGP, DCH
General Practitioner, Glyncorrwg, Wales

SUMMARY. Ideas about general practitioner specialism may have been hampered in the past because of the three models of general practitioner specialism—in the hospital service, the fee-earning specialoid or the general practitioner obstetrician—none of which is satisfactory.

However, general practitioner specialism can be justified in guaranteeing standards by concentrating groups of patients, accepting responsibility, and planning care. Medico-political changes may be needed to achieve improvement in clinical standards.

Introduction

THE need to reconsider our attitudes to this subject became apparent when the cautious proposals of the Court Committee (1976) for limited paediatric specialism were rejected, both by the College and by all other bodies representing general practitioners, without serious counter-proposals to improve the quality of service to children, or evidence to discount the Committee's criticisms of the existing service. This rejection may have been more instinctive than rational, and we should perhaps re-examine the question.

Points of departure

Prevailing attitudes to general practitioner specialism derive on the whole from the three models of which general practitioners have experience: the general practitioner in hospital, the fee-earning specialoid, and the general practitioner obstetrician.

General practitioner in hospital

The old senior hospital medical officer grade, the clinical assistant, and the proposed hospital practitioner grade specialize either as modified consultants or as ancillaries to consultants. Like consultants, they either have an episodic relationship with referred patients, or a continuous relationship with long-term clinic attenders. All of them take the general practitioner away from his own practice community. They may solve some of the problems of hospitals, but there is little evidence that they improve the quality of general practice. The only major experiment in combining hospital specialism with general practice has been at Livingston: the specialoid role developed there does not appear to have become generally popular.

Fee-earning specialoid

The fee-earning, direct access specialoid has taken over most of the primary care market at the expense of the general practitioner in all countries with fee-for-service earnings, whether private or insurance based, with or without government support. The fee-for-service system is the historical point of origin of consultants in the UK who began as general practitioners to the rich, but developed differently as they came to monopolize hospital care. Fee-for-service encourages investment in equipment, accommodation, ancillary staff, and a visibly active approach to diagnosis and treatment (which may or may not be relevant to improved outcome).

Strict enforcement of specialist registration might encourage formal postgraduate education. It has supported high professional earnings in France and Germany, for example, but has proved very costly. For this reason alone it is hardly a feasible option in Britain as an across-the-board system, but it could develop as part of a two-tier system (a barebones public service plus a quality private service), if central funding for the NHS were to be curtailed further and private practice encouraged. In most countries it has led to serious imbalances in distribution of doctors between town and country, and between rich and poor areas. It tends to disrupt continuity of care, encourages wasteful competition for the market in 'hard' medicine and surgery, accelerates flight from responsibility for patients whose problems do not correspond with the categories of the classical specialties, and fails to provide the continuity necessary to effective anticipatory care.

General practitioner obstetrician

The general practitioner obstetrician is probably the model most of us had in mind when we first considered

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the Court Committee's proposals. The obstetric list created a system of postgraduate training whose content was determined by hospital rather than general practice requirements, and a two-tier system of item-of-service payments designed to penalize but not exclude all obstetric practice without full hospital training. This coincided with a general shift of deliveries from the home to the hospital. This system was bitterly opposed at its inception, mainly on the (now untenable) ground that it denied the general competence in all branches of practice hitherto conferred by the qualifying examination. It seems doubtful whether six months of resident obstetrics is necessary for competence in antenatal care with consultant support, which has become the sole content of general practitioner obstetrics in many if not most areas. If general practitioner specialism of other kinds were to be recognized formally in the future, the College would probably demand a more active role in determining the nature and content of training.

The problem

If specialism is considered functionally in terms of the requirements for effective anticipatory care, models quite different from any of these may appear feasible. Traditionally, specialism has been justified by its answer to two main functional problems:

1. The scope of medical science is now so vast that no single person can master all its necessary diagnostic and treatment skills.

2. Specialized skills and equipment can be attained, maintained, and economically used only by concentrating problems of particular kinds, so that uncommon problems become everyday events.

To these I think we should add a third problem which is rarely stated:

3. Medical care appears easier to the doctor if responsibility is limited to parts of patients and parts of their problems. Fear that our colleagues will evade the heaviest, most ambiguous, burdens of general practice by flight into a more comfortable, as well as profitable, specialism underlies much of our traditional hostility.

Of these three, only the last is relevant to current problems. Episodic support from hospital-based specialists is available everywhere in district hospitals and in super-specialist departments in regional units and teaching hospitals. It is in the nature of primary care that one kind of medical scientist should be retained who specializes in (a) the initial presentation of illness at a stage commonly preceding precise definition, and (b) the integrated, continuing care of cumulative problems of patients throughout their lives. Forms of general practitioner specialism that impede either of these essentials are a contradiction in terms.

All three are highly relevant to hospital specialism and essential to episodic handling of diseases which, in

the current state of knowledge, demand complex skills and equipment for diagnosis or treatment. Providing that hospital specialists can act against a background of integrated, continuing care by a general practitioner, their specialism need not separate the solution of clinical problems apparent to the doctor from problems apparent to the patient, or the needs of long-term anticipatory care.

Because this background of good general practice is often either not present or not recognized, much hospital outpatient work is not specialized in the traditional sense. It deals with the initial assessment and long-term follow-up of the common presentations of common diseases, which is well within the competence of general practitioners who have been vocationally trained. This is a grossly uneconomic use both of hospitals' and patients' time. Substantial savings in time for both would be possible if the long-term care of, for example, diabetes, hypertension, chronic obstructive airways disease, chronic suppurative otitis media, epilepsy, and rheumatoid disease were normally conducted in general practice. General practitioners should be concerned with specialism at the base, not the apex of medicine: the two are entirely different, and most of our problems have originated in failure to recognize this.

This would demand fundamental changes in the relationship of general practitioners to hospital specialists (Horder, 1977). Where follow-up of referred patients is required, the job of the specialist would become the definition of a plan for continuing care, suggesting to the general practitioner the nature of the monitoring required, and the criteria for re-referral in each case. Consultants would have to accept more responsibility for appropriate continuing education of general practitioners in their own catchment area, and for assisting in designs for follow-up in general practice geared to local and to individual needs.

Such changes can occur only if a critical number of general practitioners and specialists accept such wider responsibilities. Even so, there must be a more or less prolonged period of overlap, during which hospital specialists continue to undertake much work that should properly be performed by general practitioners. Some specialists will still be slow to recognize the readiness of growing numbers of general practitioners to work in this new way, but few practices are presently organized for efficient follow-up and the rapid recognition of default.

Real demands for specialism in general practice

The real demand for specialism in general practice is of a different nature from hospital specialism. All general practitioners have to care for a few people with rare conditions, but these cannot be concentrated to any great extent simply by doubling or trebling the population at risk. The general practitioner who has, for example, a patient with haemophilia must become proficient in his care, helped initially and from time to time by a specialized hospital department: his experience will not be improved by caring for the haemophiliacs in a population of 10,000, 20,000, or even 100,000. Patients are able and willing to travel long distances for necessary procedures the risk or complexity of which really do require centralized teams and equipment, and it is pointless to duplicate these in general practice.

The justifications for specialism in general practice are principally:

1. To guarantee standard sets of data for diagnosis and follow-up of common conditions by concentrating problems of the same kind at a predictable time and place, so that work can be planned and supporting staff and equipment can be deployed effectively.

2. Within medical groups, to apportion responsibility for leadership in planning and development of routines for care in certain important topics, so that these groups can look to their own 'experts' (I prefer the word 'activist'), and use lateral as well as vertical referral in cases of doubt.

The expected number of patients may justify concentration in regular mini-clinics for hypertension, diabetes, chronic obstructive airways disease, epilepsy, rheumatic diseases, contraception, antenatal care, immunization, developmental assessment in infancy and early childhood, and geriatric screening. All of these demand monitoring of a set of variables, support by ancillary staff with at least some special training, the use of equipment otherwise not often used, and giving patients information, often in written form, that can rarely be given within the unpredictable diagnostic mix of a normal session. All of them can also help by bringing patients with common problems together, so that they get to know and educate one another. Such mini-clinics can systematically reshape custom and expectation, improve compliance, and reduce the gap in knowledge and expectations between care givers and care receivers.

The number of such patients is too great to permit specialization within groups of more than three or four doctors, unless clinics are held more than once a month. The proposal is not that each clinic be conducted only by one doctor within a group, but that one doctor (the activist) should accept responsibility for overall design, training of staff, keeping up with the literature, and maintaining a close relationship with the relevant hospital department.

Maintenance of continuity

Such mini-clinics would involve one general practitioner seeing the patients of another. This would disrupt continuity of care unless there were:

1. A structured record system that clearly summarized the patient's main problems and current treatment, that permitted easy entry and retrieval of monitoring data, and allowed ready connection of current decisions with

those made previously. It is doubtful whether records of this quality can be attained without general use of A4, and a longer consultation time to use it.

2. Agreement within the group to accept common terminology and common plans of sequential treatment.

Material requirements of general practitioner specialism

General practitioner specialism on these lines will not develop unless:

1. The present economic disincentives to it are removed and replaced by a system of payment to general practitioners that encourages them both to accept and to perform more responsible work, currently delegated to hospital outpatient departments.

2. List sizes are reduced so that general practitioners have more time for their patients, for practice planning and administration, and for continuing education.

3. All practices (rather than the present 15 per cent) employ their full complement of office and nursing staff.

4. Attached nurses are made available not only to assist in running general practitioner clinics, but to help in their administration, including home visits to defaulters.

5. DHSS support is given for the modernization of records wherever general practitioners are prepared to implement this.

Systems of payment

An unmodified capitation system encourages minimal service to the largest possible list. This effect is limited by professional conscience and public expectation, but these vary widely. Possible modifications of the system are:

1. To limit list size, granted an adequate supply of medical staff, to 2,000 or 1,500, which would give more time.

2. To augment individual capitations for care of specified groups, as at present for the elderly.

3. To augment individual capitations for specified long-term function, as at present for conception control.

4. To pay for specified individual items of service, as at present for cervical cytology.

All but the first two of these increase administrative costs centrally, and paper work at the point of service. Capitation for specified long-term function has the advantage that the data recording required for full claims overlaps at least to some extent with that required to plan patient recall and verify follow-up. Item-of-service claims are irrelevant to delivery of the service itself, and may well impede it. Experience with cervical cytology has been salutary in this respect: most conscientious general practitioners are doing many smears for which they cannot claim, and completing the forms takes almost as long as the procedure itself. Augmented capitations for specified long-term functions would probably be the most effective way of financing clinics in general practice, staying closest to our present traditions. Pricing would depend on estimates based on precise, standardized definitions of those at risk which, though arbitrary, would have advantages in encouraging diagnosis in a common language, allowing valid pooling of experience. Prevalence data would have to be obtained using these same definitions. All this is within the capacity of our research resources. It appears inevitable that the traditionally complete dissociation between negotiating terms and conditions of service, and the definition of clinical standards, will come to an end in these circumstances. The College may have to concern itself with means as well as ends.

Reference

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Cimetidine for anastomotic ulcers after partial gastrectomy

In a randomized double-blind multicentre trial, 15 outpatients with endoscopically proved anastomotic ulceration after Billroth I or Billroth II partial gastrectomy received cimetidine, 1 g daily over eight weeks, or a placebo. All patients also received antacid. The ulcer healed completely in all seven cimetidine-treated patients and in one of the eight placebo-treated patients ($p < 0{\cdot}01$). Ulcers not healed during the double-blind phase of the trial were all subsequently healed on open cimetidine treatment. There was a trend toward improvement of daytime symptoms in favour of cimetidine ($p = 0{\cdot}06$), and night time symptoms were significantly relieved during the initial four weeks of cimetidine treatment ($p = 0{\cdot}02$). We conclude that cimetidine, 1 g daily, promotes healing of anastomotic ulcers after partial gastrectomy.

Reference

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