EDITORIAL

Lessons from abroad

GENERAL practitioners have an understandable tendency to be concerned with day-to-day problems and are therefore conscious of the restrictions imposed by social and geographical circumstances. Ideas do not recognize national boundaries. Progress in our discipline requires more than parochial pragmatism; our orthodoxy may be heresy elsewhere. Change in primary medical care is a normal process to be encouraged, and a view from a different country may be the catalyst required to effect the change.

This month sees the first issue of *Family Practice*—an international journal published by Oxford University Press. Although wholly independent of any national body, *Family Practice* has a close, albeit informal, relationship to the World Organization of National Colleges, Academies, and Academic Associations of General Practitioners/Family Physicians (WONCA) and its development has been actively supported by the Royal College of General Practitioners. The aim of the new journal is to provide a forum for the exchange of information about clinical practice, the organization of services, and education and training. Its appearance marks a new stage in the development of general practice and an opportunity for family physicians in all parts of the world to learn from their colleagues. This should help to establish principles, concepts and objectives of primary care which will have universal relevance and appeal.

There is an example of a lesson from abroad in Paul Starr's book *The social transformation of American medicine.*[1] While it may seem only of peripheral interest to doctors in Britain because the structure of our profession is so different and because nine tenths of medical work is done within the National Health Service (NHS), a chilling final section of the book describes the rise of proprietary hospital chains in America and suggests that they can become less a service to the public and more a profit-making enterprise for investors. 'Health centres can become profit centres' and the indigent sick turned away.

Realistic assessment of the best use of medical time and skills in the public interest within the NHS is required. The private sector is a marginal irrelevance unless it is developed in a way which distorts the orderly evolution of the NHS. The aim must be to provide the best service possible within the constraints imposed by the availability of resources. As Hampton argued in 'The end of clinical freedom',[2] there must be consensus on clinical policies. The fee-per-service system can act as a spur to medical effort, and can be useful in some ways even if potentially harmful in others. Does the NHS have other equally compelling incentives? In theory, the professional drive to do one's best for patients should be enough. Anyone who is broadly familiar with the NHS will know that there are many doctors in general and in specialist practice who review the pattern and outcome of their work carefully, with the object of improvement. Nonetheless he may also know that systematic clinical review is not yet normal British practice and that in this respect we lag far behind Australia, New Zealand, Canada and much of the USA.

Whichever political party is in power in Britain, the intrinsic problem will not go away; since it will never be possible to provide every beneficial service, choices must be made. The system of district management within a regional organization in England and a national organization in the other countries in the UK provides the most economical administration in any developed health service. If the Griffiths report[3] is followed, there need be no threat to professional responsibility so long as erratic intervention from the centre is reduced. It is essential that individual specialties should accept that an extra allotment for their own work can only be obtained at the cost of a reduced allotment for some other sector. Changes can and will occur, but they should be made for good reasons and not to satisfy a political whim or a demand for some new technology not yet of proven value. This means that we need a better system for reaching consensus at district level and at the centre, and that the consensus must embrace other professions and the users of the service.

We expect the continuing debate about the future role of general practice in the UK to be better informed by reference to the experience of practitioners in other countries. To this end, we welcome *Family Practice.*

References

1. Starr P. *The social transformation of American medicine.* New York: Basic Books, 1982.
2. Hampton JR. The end of clinical freedom. *Br Med J* 1983; **287:** 1237.
3. Department of Health and Social Security. *NHS management inquiry.* (Griffith ER, Chairman.) HMSO: London, 1983.

Note

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