

# Problems of inner city general practice in north-east London

CHRISTOPHER SMITH, BA, M.SC

Institute for Social Studies in Medical Care, London

JAMES STIFF, FRCGP

General Practitioner, London

**SUMMARY.** This paper looks at differences in primary health care between the inner city and suburban areas of the North-East London Faculty of the Royal College of General Practitioners. Most of the differences observed were in the expected direction. However, the inner city area did not appear worse off in terms of the proportion of doctors specifically trained for general practice, the availability of doctors outside normal surgery hours, the links between general practitioners and hospitals and the attitudes of doctors to change. The data were derived from a postal survey of general practitioner principals whose main surgery was in the faculty area.

## Introduction

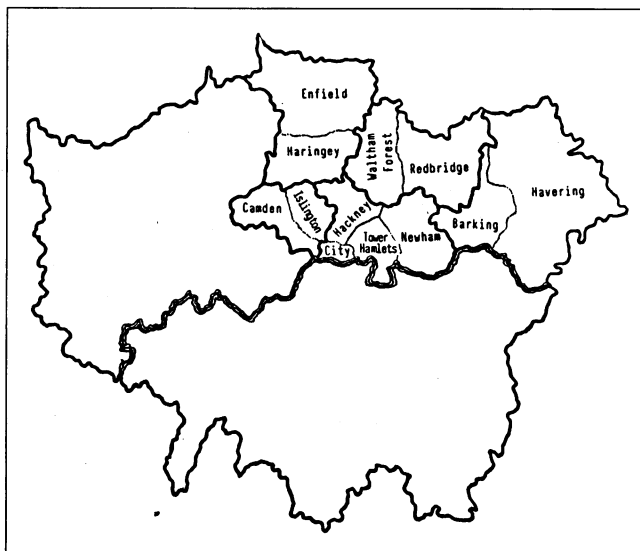
**I**N January 1978 the Faculty Board of the North-East London Faculty of the Royal College of General Practitioners (RCGP) decided to initiate a study of the problems of inner city general practice. The aim of the study, as defined by the Research Committee of the Faculty Board, was to investigate the hypothesis that within the faculty area there are significant differences between inner city and other practices.

## Method

The study was carried out in the five family practitioner committee (FPC) areas covered by the North-East London Faculty of the RCGP, that is Barking and Havering, Camden and Islington, City and East London, Enfield and Haringey, and Redbridge and Waltham Forest (Figure 1). In August 1980 every general practitioner principal on the five FPC lists whose main surgery was within

the study area was sent a questionnaire with an explanatory letter. The response rate after two reminders was 69 per cent.

Information about the age, country of qualification and type of practice of the doctors who did not complete the questionnaire was obtained in confidence from the FPCs. When the response rate was calculated in terms of these characteristics, it fell from 81 per cent for doctors under the age of 35 years to 62 per cent for doctors aged 65 years and over and, related to this, from 82 per cent for doctors who worked with four or more partners to 68 per cent for doctors who worked on their own. In addition, the response rate was higher for doctors who qualified in Great Britain than for those who qualified in India,



**Figure 1.** Map of North-East Greater London showing the five FPC areas and the local authorities within them.

Pakistan, Bangladesh, Sri Lanka (Asia) or Ireland; the response rates were 75 per cent, 66 per cent, and 61 per cent respectively. (Attention has only been drawn to differences which statistical tests suggest are unlikely to occur by chance more than five times in 100.)

Definitions of Inner London vary.<sup>1</sup> In this study, Camden and Islington, and City and East London FPC areas have been designated 'inner city areas' and Barking and Havering, Enfield and Haringey, and Redbridge and Waltham Forest FPC areas have been designated 'suburban areas'. The response rates for the two types of areas were 65 per cent and 72 per cent respectively.

## Results

*The doctors.* A higher proportion of doctors in the inner city areas than in the suburban areas was aged 65 years or over. This can be seen from Table 1, which also shows that in the inner city areas a higher proportion of doctors were single and a lower proportion were currently married than in the suburban areas. One characteristic which did not vary significantly between the two types of area was the proportion of women doctors. Another finding was the higher level of membership of the RCGP in the inner city areas than in the suburban ones. Apart from this difference, there was little variation in qualification and training between doctors who practised in the two types of area. As far as the country of qualification of the doctors who completed the questionnaire was concerned, in the

inner city areas a relatively high proportion had qualified in the United Kingdom or in continental Europe and a relatively low proportion in Asia. (See Table 1 for the figures.)

*The practice team and premises.* The proportion of doctors in receipt of a group practice allowance was lower in the inner city areas than in the suburban ones. The figures are in Table 2, which also indicates that doctors in the inner city areas were more likely to be single-handed and less likely to work with four or more partners and with ancillary staff than doctors elsewhere in the faculty area. Turning to practice premises, a higher proportion of doctors in the inner city areas than in the suburban areas lived at least 15 minutes commuting time from their main surgery. This can be seen in Table 2, which also

**Table 1.** The doctors.

	Inner city areas	Suburban areas	Total faculty area
Doctors aged 65 years and over (%)	17	10	13
Doctors' marital status (%)			
Single	11	4	7
Currently married	81	89	85
Ever married	8	7 <sup>a</sup>	8
Membership of the RCGP (%)	25	16	20
Country of qualification of doctors (%) <sup>b</sup>			
United Kingdom	68	59	63
Ireland	8	9 <sup>a</sup>	8
Continental Europe	5	2	4
Asia	18	29	24
Elsewhere	4	3 <sup>a</sup>	4
Number of doctors (= 100%) <sup>c</sup>	385	437	826

<sup>a</sup> Difference did not reach the required level of statistical significance.

<sup>b</sup> Percentages add up to more than 100 as some doctors gave more than one response.

<sup>c</sup> Instances where inadequate information was obtained have been omitted from this and later tables. Where the base number relates to more than one set of proportions, the minimum has been quoted.

**Table 2.** The practice team and premises.

	Inner city areas	Suburban areas	Total faculty area
Doctors in receipt of a group practice allowance (%)	51	59	56
Size of partnership (%)			
Single-handed	33	26	29
Partnership of two or three doctors	48	48 <sup>a</sup>	48
Partnership of four or more doctors	19	26	23
Ancillary staff in practice team (%) <sup>b</sup>			
Receptionist	91	96	93
Nurse	55	70	63
Secretary who can type	60	61 <sup>a</sup>	61
Health Visitor	40	53	47
Social Worker	18	29	24
Geriatric Visitor	18	15 <sup>a</sup>	16
None of these	3	1	2
Doctors who lived at least 15 min commuting time from their main surgery (%)	47	31	39
Types of premises (%) <sup>b</sup>			
A house conversion	41	51	46
A privately-owned purpose-built surgery	13	25	20
A health authority-owned health centre	15	13 <sup>a</sup>	14
Own residence	10	9 <sup>a</sup>	9
A shop conversion	13	5	9
A council-owned surgery	13	3	8
Other types of premises	3	2 <sup>a</sup>	3
Doctors who regarded their main surgery as unsatisfactory (%)	20	13	16
Numbers of doctors	365	415	783

<sup>a</sup> Difference did not reach the required level of statistical significance.

<sup>b</sup> Percentages add up to more than 100 as some doctors gave more than one response.

demonstrates the different types of surgery accommodation within the faculty area. Although the changes that doctors in the faculty area wanted to make to their surgery were similar in the two types of area, the proportion of doctors who regarded their main surgery as unsatisfactory was higher in the inner city areas than in the suburban ones. (Again, see Table 2.)

*Workload and enjoyment.* Inner city doctors in comparison with their suburban colleagues were more likely to have a list size of under 2,000 patients and less likely to have one of 3,000 or more patients. Furthermore, a relatively high proportion of doctors in the inner city areas felt that under present practice arrangements the ideal list size was less than 2,000 patients. The figures are in Table 3, which also shows that doctors in the inner city areas were less likely to operate an appointment system for their surgery consultations and more likely to be on call for five or more nights a week than doctors in the suburban areas. There was little difference between the two types

**Table 3.** Workload and enjoyment.

	Inner city areas	Suburban areas	Total faculty area
List size (%)			
Under 2,000 patients	31	22	26
2,000 to 2,999 patients	48	48 <sup>a</sup>	48
3,000 or more patients	21	30	26
Doctors who felt that under present practice arrangements the ideal list size was less than 2,000 patients (%)	63	52	57
Doctors with an appointment system for surgery consultations (%)	64	74	70
Doctors on call five or more nights a week (%)	20	13	16
Average proportion of surgery consultations felt to be for trivial, inappropriate or unnecessary reasons (%)	34	39	37
Number of doctors (=100%)	395	431	831

<sup>a</sup> Difference did not reach the required level of statistical significance.

of area in the proportion of doctors who used a deputizing service. Although doctors in the inner city areas perceived a relatively low proportion of their surgery consultations as being for trivial, inappropriate or unnecessary reasons (see Table 3), there was little difference between the two types of area in the proportion of doctors who thought they were too busy as far as their practice work was concerned and in the proportion of doctors who said they enjoyed general practice very much.

**Table 4.** Social factors.

	Inner city areas	Suburban areas	Total faculty area
Doctors with mainly working-class patients (%)	63	49	56
Doctors with at least 10% of their patients aged 65 years and over (%)	86	78	82
Doctors who thought the main problem for general practice in their area was the population structure: an unbalanced population, including elderly, single people, young unmarried mothers, minority groups etc; population mobility; social deprivation; poor housing and general socio-economic medical problems	32	19	25
Prevalent patient groups and problems (%) <sup>b</sup>			
Social or family problems: single/one-parent families; broken families; inadequate families; young unmarried mothers; young families; disadvantaged families/groups; homeless families; domestic problems; patients with no relatives near etc.	37	19	28
Psychiatric or emotional problems: psychiatric patients; psychiatric/psychosexual problems; schizophrenics; depressed patients; chronic anxiety neuroses; study and emotional stress problems etc.	22	15	18
Other patient groups and problems	35	38 <sup>a</sup>	36
None	17	31	24
Doctors whose practice premises had been vandalized or broken into during the 12 months before the survey (%)	43	32	37
Doctors who had had a professional member of their practice staff physically attacked while at work during the 12 months before the survey (%)	13	6	9
Number of doctors (=100%)	338	375	718

<sup>a</sup> Difference did not reach the required level of statistical significance.

<sup>b</sup> Percentages add up to more than 100 as some doctors gave more than one response.

**Social factors.** Doctors in the inner city areas were more likely than those in the suburban areas to have mainly working class patients and at least 10 per cent of their patients aged 65 years and over. The former were also more likely to mention the population structure as the main problem for general practice in their area and, when asked 'Are there any particular groups of patients or patient problems that are particularly prevalent in your area which contribute disproportionately to your workload?', to mention social or family problems and psychiatric or emotional problems. The figures are in Table 4. This table also shows that doctors in the inner city areas were more likely than those in the suburban areas to have had, during the 12 months before the survey, their practice premises vandalized or broken into and a professional member of their practice staff physically attacked while at work. There was little difference between the two types of area in the proportion of doctors who had had their car vandalized during the 12-month reference period.

**Access to facilities.** Analysis showed that doctors in the two types of area had similar items of equipment and facilities available at their practices. There was also little difference between the two types of area in the proportion of doctors who had direct access to urine microscopy and culture, skeletal radiographs, barium meals and thyroid function tests. Doctors in the inner city areas were, however, more likely than those in the suburban areas to have direct access to electrocardiography, physiotherapy and ultrasonic diagnosis. Overall, a higher proportion of doctors in the inner city areas than in the suburban areas felt that they had access to enough diagnostic facilities. The figures are in Table 5. Other data in Table 5 show

**Table 5.** Direct access to facilities.

	Inner city areas	Suburban areas	Total faculty area
Facilities to which doctors had direct access (%) <sup>a</sup>			
Electrocardiography	72	52	62
Physiotherapy	49	32	40
Ultrasonic diagnosis	33	21	26
Doctors who felt they had access to enough diagnostic facilities (%)			
	82	70	76
NHS hospital beds to which doctors had direct access (%) <sup>a</sup>			
Obstetric	20	44	32
Medical	11	17	14
Other specialities	3	6	5
None	71	48	59
Doctors who wanted access or further access to geriatric beds (%)			
	3	7	4
Number of doctors (=100%)			
	342	377	721

<sup>a</sup> Percentages add up to more than 100 as some doctors gave more than one response.

the relatively low proportion of doctors in the inner city areas who had direct access to National Health Service (NHS) hospital beds where they retained full responsibility for the treatment of their patients and who wanted access or further access to geriatric beds. There was little difference between the two types of area in the proportion who wanted access or further access to beds in other hospital departments.

**Contact with other doctors and social services.** Doctors in the inner city areas were less likely than those in the suburban areas to meet their neighbouring colleagues socially or at clinical meetings. The former were also less likely to know socially at least one of the consultants to whom they most frequently referred patients and to feel there was adequate consultation between general practitioners and hospital medical staff about the admission of patients to hospital. The figures are in Table 6. The

**Table 6.** Contacts with other doctors and social services.

	Inner city areas	Suburban areas	Total faculty area
Doctors who meet their neighbouring colleagues:			
Socially (%)	58	71	65
At clinical meetings (%)	86	92	89
Doctors who knew socially at least one of the consultants to whom they most frequently referred patients (%)			
	55	63	59
Doctors who felt that there was adequate consultation between general practitioners and hospital medical staff about the admission of patients to hospital (%)			
	68	75	72
Doctors who described the social services for their patients as 'good' (%)			
	32	26	29
Number of doctors (=100%)			
	396	435	837

proportion of doctors who felt there was adequate consultation between general practitioners and hospital medical staff about the discharge of patients from hospital was similar in the two types of area, as was the proportion who regarded communications between themselves and the social services as 'good'. Inner city doctors were, however, more likely than their suburban colleagues to describe the social services for their patients as 'good' (see Table 6).

**Other activities and attitudes to change.** In general, doctors in the inner city areas spent more time on private and other non-NHS medical work than doctors in the suburban areas. This can be seen in Table 7, which also shows the relatively high proportion of doctors in the inner

city areas who taught and who mentioned teaching or research as something they would like to spend more time on. Inner city doctors were, however, less likely than their suburban counterparts to mention minor surgery or surgical procedures as something they would like to spend more time on and to want a paid or honorary appointment on the staff of an NHS hospital (see Table 7). The proportion of doctors who held such an appointment was similar in the two types of area. As far as attitudes to

**Table 7.** Other activities and attitudes to change.

	Inner city areas	Suburban areas	Total faculty area
Average proportion of doctors' time spent with private patients (%)	4	2	3
Average proportion of doctors' time spent on non-NHS medical work other than private patients (%)	5	3	4
Doctors who taught (%) <sup>b</sup> :			
Undergraduates	32	20	26
Others	24	24 <sup>a</sup>	24
No teaching	60	68	64
Doctors who would like to spend more time on (%) <sup>b</sup> :			
Teaching or research	12	7	9
Minor surgery or surgical procedures	2	6	4
Something else	87	87 <sup>a</sup>	87
Doctors who wanted a paid or honorary appointment at an NHS hospital (%)	26	33	30
Doctors who did not want to be a salaried general practitioner because of the effect this would have on their income (%)	5	10	8
Number of doctors (=100%)	241	290	532

<sup>a</sup> Difference did not reach the required level of statistical significance.

<sup>b</sup> Percentages add up to more than 100 as some doctors gave more than one response.

change were concerned, there was little difference between the two types of area in the proportion of doctors who wanted to be a salaried general practitioner with premises, equipment and staff provided for them, in the proportion of doctors who wanted to work from a health authority-owned health centre and in the proportion of doctors who wanted to see more emphasis on the team approach in general practice. Apart from the relatively low proportion of doctors in the inner city areas who did not want to be a salaried general practitioner because of the effect this would have on their income (again see Table 7), the reasons given for not wanting to be a salaried general practitioner and for not wanting to work from a health authority-owned health centre were similar in the two types of area.

## Discussion

It should be recognized that although some information about doctors such as age, list size, number of partners or country of origin can be more accurately obtained from Department of Health and Social Security (DHSS) statistics,<sup>1</sup> many of the questions in our survey related to information which could not be obtained in other ways.

Although the response rate of 69 per cent was in the expected range, it was evident that in common with other surveys based on a postal questionnaire the response rate of doctors who qualified in Asia was significantly lower than that of doctors who qualified in the United Kingdom.<sup>2</sup> Lower response rates from older doctors, single-handed doctors and doctors who had qualified in Ireland have been noted by other studies<sup>2</sup> but reached the required level of statistical significance in this one.

Definitions of Inner London vary. City and East London, and Camden and Islington are usually regarded as inner city areas. Haringey is sometimes regarded as being an inner city area but more recently it has been defined as part of a non-white immigrant zone.<sup>1</sup> Since it is only part of the Enfield and Haringey FPC area, which extends into Outer London, we have defined it as being a suburban area. Conversely, Newham is sometimes regarded as being suburban but as it is part of the City and East London FPC area, we have included it in the inner city group. In both respects our decisions and the reasons for them are the same as in the Acheson report.<sup>3</sup>

Many of the differences found between primary care in the inner city and suburban areas of north-east Greater London were in the expected direction.<sup>1,3-6</sup> The inner city areas when compared with the suburban areas had more doctors aged 65 years and over, and fewer doctors in partnerships. However, partnerships may just reflect a financial relationship, sometimes even one of exploitation, whereas doctors who do not have legal ties can still work closely together, often in the same premises.<sup>7</sup> It is therefore more interesting to note the relatively low proportion of doctors in the inner city areas who reported that they were in receipt of a group practice allowance. A doctor does not necessarily have to be in a partnership to receive this but usually does have to work with at least two other doctors for a significant period of time in shared premises which satisfy certain minimum standards.

The inner city areas also had more doctors who regarded their main surgery as unsatisfactory, fewer doctors with ancillary staff and fewer doctors who operated an appointment system for their surgery consultations. The desirability of appointment systems for all surgery consultations has been questioned<sup>8</sup> — especially for Inner London, where fewer patients have telephones and public telephone boxes are frequently vandalized.<sup>9</sup> Further expected findings were that the Inner London areas had more doctors with small lists, more doctors who spent a relatively large part of their time on private and other non-NHS medical work, more doctors who were isolated from their neighbouring colleagues, fewer doctors

who lived in the community they served and a higher incidence of sociomedical problems, violence to practice staff and vandalism to practice premises.

One unexpected finding was that fewer doctors in the inner city areas than in the suburban areas reported that they had qualified overseas. This, however, might be due to the poorer response to the survey in the inner city areas than in the suburban ones by doctors who had qualified in Asia.

It has been said that in the inner city there is a lack of doctors specifically trained for general practice but in this study and another one in Manchester<sup>10</sup> similar proportions of inner city and suburban doctors were found to have had some sort of specific training in general practice.

Another area of concern has been the availability of general practitioner services to inner city populations outside normal surgery hours. However, in this study the inner city doctors were more likely than the suburban ones to report that they were on call for five or more nights a week and there was little difference between doctors in the two types of area in the proportion who made some use of a deputizing service. We did not ask the doctors for details of their use of deputizing services, but a study in Manchester<sup>11</sup> showed that inner city doctors were relatively likely to say they usually screened or filtered calls before passing them on to a deputizing service.

It has also been suggested that the links between general practitioners and hospitals are poorer in inner city areas than elsewhere. Our data were inconclusive about this. While inner city doctors were less likely than their suburban colleagues to have direct access to NHS hospital beds and to feel that there was adequate consultation about the admission of patients, they were more likely to report direct access to electrocardiography, ultrasonic diagnosis and physiotherapy. This relative deficiency of direct access to electrocardiography and physiotherapy in suburban areas has also been reported in Manchester.<sup>11</sup> It is important that such facilities for the patients of suburban doctors should not be overlooked. It is possible to establish direct referrals for all general practitioners to physiotherapy departments without demanding extra manpower resources and without diminishing the availability of physiotherapy for other categories of patients.<sup>12,13</sup>

A further criticism of inner city general practice is that its structure (for example, a high proportion of elderly and single-handed doctors and a lack of ancillary staff) militates against change. However, among the doctors who completed the questionnaire there was no difference between those in the inner city and those elsewhere in the proportion who wanted to see more emphasis on the team approach in general practice and in the proportion who wanted to work from a health authority-owned health centre. Silverstone and colleagues<sup>9</sup> found that the reluctance of doctors to join health centres was based on a realistic appraisal of the drawbacks, which included inappropriate design, poor interpersonal relationships and certain bureaucratic controls. They suggested a number of organizational changes which might make health centres more acceptable to doctors; in view of the difficulty doctors in inner city areas have in obtaining satisfactory premises, such suggestions need to be seriously considered. There was also no difference between the two

types of area in the proportion of doctors who wanted to be salaried general practitioners with staff, equipment and premises provided by the health authority. It would seem that, like their suburban colleagues, the majority of inner city doctors do not wish to lose their independent contractor status. Any attempts to change primary medical care services in inner city areas will need to take this into account.

## Conclusion

The data obtained from the postal survey largely support the popular image of inner city primary care. However, contrary to this image, the inner city areas of the North-East London Faculty of the RCGP did not appear worse off than the suburban areas in a number of ways considered to be important. Jarman<sup>1</sup> found that the differences between general practitioner services in Inner London and those elsewhere were less marked for the East End than the West End; our data may reflect this finding.

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## Address for correspondence

Dr James Stiff, 380 Upminster Road North, Rainham, Essex RM13 9RZ.