An Australian's impression of general practice in the United Kingdom

MAX KAMIEN, MD, FRACP, FRACGP
Professor of General Practice, University of Western Australia

Introduction

WHEN the UK Foreign Sectretary, Sir Geoffrey Howe, was asked by a reporter in South Africa what new ideas he could possibly contribute, he replied that a visitor from afar sometimes sees issues more clearly than those closer to the scene. Even though there is some truth in that statement it still takes a brave or foolish man to accept an offer from the *Journal of the Royal College of General Practitioners* to attempt, on limited experience, to comment on general practice in the UK. I can only take comfort in the knowledge that 36 years ago a fellow Australian, Joseph Collings, set the precedent and that he is now more respected than reviled.[1]

More than any other branch of medicine, general practice can be performed at many levels. At its best it incorporates a high level of analytic thought with a synthesis of knowledge over a broad cognitive base from the biological and the social sciences. At its worst it is an unimaginative process of rapid pattern recognition applied only to the problem which the patient brings to the doctor. To perform well, a general practitioner requires a clear, conceptual framework for his task, a structural support system and the will to provide the type of care that he would like if he were the patient.

In the summer of this year I was invited to speak at the 11th World Conference of WONCA in London and took the opportunity of long service leave to visit old friends and learn of recent developments in general practice teaching and practice in the UK.

How then did I perceive general practice in the UK from the narrow cross-section provided by the 34 doctors with whom I sat during their consultations? There is no doubt that the doctors I saw were members of a caring profession. This was obvious from the attitudes of concern which they displayed when talking about their patients and was amply demonstrated through the maintenance of regular home visiting, especially for patients who were house-bound with chronic or terminal illness. But caring is more than a humanistic interest in a fellow human being. It also involves a clear philosphy tied to a set of clear objectives, which will enable a doctor to provide the most appropriate care to fulfil the needs of the individual patient as well as the needs of the community of patients registered with him.

Conceptual thinking

There is no dearth of this essential conceptual thinking coming from British general practice: McWhinney has presented the theory for the scientific basis of general practice;[2] Metcalfe has clarified the similarities and the differences between general practice and hospital practice;[3] and Stott and Davis have made a major contribution to the practice of medicine through their map of the exceptional potential of the consultation.[4] These authors are but part of the considerable intellectual activity in British general practice which is evident from this *Journal* and the spate of publications emanating from the Royal College of General Practitioners.

The paradox is that these concepts do not appear to have greatly influenced the practice of general practitioners in the UK. Most of the office practice I observed was similar to that in Australia and based almost solely on dealing with the patient's presenting problems. There were also the common problems of the doctor's self-image of busyness and the lack of a clear philosophy of practice. Two other problems which I thought particular to British practice were the weight of tradition and the low expectations of the majority of the consumers of health care.

Rarely was the exceptional potential of the primary care consultation realized through opportunistic health promotion and health education. There also appeared to be little emphasis on this in what I observed of the vocational trainee programme and the MRCGP examination. When the general practitioner was asked 'What is your consultation objective for that patient?' there was often a long pause as he struggled to make conscious that which was implicit in his actions.

Workload

Although there was a general admission that they were not really overworked, all the doctors felt busy and projected an aura of harassment. Nearly all took the view that it would be hard to get through the patients or through the day by organizing it in any other way. Nearly all patients were booked in for five-minute intervals even though most consultations lasted a few minutes more than that. There is evidence that this rapid consulting rate is not particularly desirable.[5,6] I would assert that no matter how experienced he is, a doctor can do little more than superficial medicine in a five-minute time-slot. There can be few practices in the UK so busy that the five-minute appointment remains a necessity.[7,8] I think it is a relic of tradition bolstered by the doctor's need for a self-image of being one of the busy people of this world. It is further reinforced by books which show that even some psychotherapy can be done in a similar time period.[9] In earlier years it was important to recognize how much could be done in just six minutes with a patient, but when something better is attainable there is a risk of being stuck with what was once praiseworthy but is now barely excusable.

Patient expectations

The maintenance of the present patterns of care are also perpetuated by the attitudes of British patients. Compared with the more 'Americanized' Australian patient they are not particularly demanding consumers of better health care. All the working-class patients (and acquaintances) I questioned maintained that they were perfectly happy with the treatment they received, even when they were spoken of in the third person as 'this chap' in place of their name. The middle-class patients were not nearly so happy and a number had voted with their pocket and joined a private health fund. Perhaps this is another reason for the persistence of social class inequalities in health status.[10]

Patient management

A leading philosopher of American family medicine — Gayle Stevens — maintains that the quintessential skill of the family practitioner is the skill of patient management.[11] A good test

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of whether this skill is average or better is to see what happens to the 'somatic' patient. This is the patient with a thick file whose problems usually lie towards the psychosocial end of the bio-psychosocial spectrum. These patients tax the problem-solving abilities of doctors in most countries of the world and have usually had repeated biomedical checkups by different specialists. In my view they should be accepted as a general practice problem requiring the highest use of our analytical powers and treatment skills. These patients need to be protected from doctors and doctors from them. The specialist from afar is unlikely to be able to help them even if he has the will to try. To do so would require an appointment of at least one hour. The management of somatic patients requires a holistic view of their problems. The general practitioner needs to take their notes home and to study their case like a novel being prepared for discussion at a book club. It often requires getting a 'new eye' on the problem from a colleague in the same practice. Using these criteria as one measure of the quality of excellence and wisdom in general practice, the UK still has a long way to go.

Referral to consultants

Again, tradition prevents progress. Although no longer looked up to with the awe of early years, consultants are still generally regarded with deference by general practitioners and their advice accepted without too much attempt to relate it to the patient's home and work circumstances. Some of the letters I read from hospital consultants were arrogant and imperious and should not have been tolerated from colleagues. The degree of deference is such that the idea of helping consultants learn by providing feedback was regarded as disrespectful, especially if the consultant happened to be wide of the diagnostic mark. It was also seen as potentially dangerous as the consultant might refuse to admit that general practitioner's patients into his unit.

Referral patterns depend upon the style, skills, experience and confidence of the doctor. In Victoria, only 6% of consultations are made for the purpose of diagnosis.[12] From what I saw, similar circumstances would apply in the UK. However, there seemed to me to be a high referral rate of what I would regard as bread and butter medicine, such as mild heart failure, stable type II diabetes and arthritis of various kinds. This was not due to laziness and nearly all the general practitioners were aware that the patient would in all probability be seen by a registrar of lesser experience than themselves. The stated reason was that they did not wish to appear before a family practitioner committee complaints hearing. The actual chance of a general practitioner having a complaint against him go as far as a hearing is about one per 350 000 consultations or about once in a medical lifetime.[13] When it is taken into account that over 60% of all complaints are about the organization of the practice or the manners and remarks of the practitioner or receptionist then the fear of litigation must be regarded as irrational and needs to be expunged in the interests of good medicine and the well-being of the National Health Service.[14]

Teamwork

The lack of financial competition makes for good relationships between doctors. Together with the high proportion of health centres and subsidized ancillary personnel and the attachment of health visitors and district nurses to general practice, team care in the UK is better than any I have yet experienced. The registered patient list with the possibility of age–sex registers is the envy of all would-be general practice epidemiologists and, together with team care, should ensure that the structure of British general practice is better than that of other countries. Again, its main drawback is the lack of a conceptual framework about the role of the general practitioner in looking after that human aggregate that makes up his registered list.

Anticipatory care

This lack of vision about what a general practitioner can or should be doing probably reflects the training in disease-centred acute medicine that doctors receive as medical students. It is difficult for a vocational training programme, however good, to change attitudes about what is a doctor's job. Does this reflect the Royal College of General Practitioner's comparative neglect to promote undergraduate general practice education with the same financial resources and political skills as it does for postgraduate training?

At the very least the doctor should detect which of his patients are at risk for certain disorders and provide them with the information with which they can decide whether or not to take appropriate action. For over 20 years Dr Julian Tudor Hart has described the conceptual framework around which to construct a coherent system of anticipatory community care.[15] All the doctors I met were aware of his writings, even if they were often unsure of the methods that he has used to accomplish his aims. Unfortunately, the general perception was that he had special skills and qualities not given to the ordinary mortal general practitioner. However, some doctors were beginning to practise this form of community medicine and others were thinking actively about it.

Again, high-risk patients cannot be adequately detected or comprehensive patient care accomplished without an adequate medical record. Although most of the practices I visited had converted from the all-encompassing Lloyd George envelope to the A4 folder, none of their records would have escaped the wrath of Dr Lawrence Weed for lacking a properly indexed problem-oriented health summary which is an instant guide to patient management.[16] However, most of the records were half-way there and many doctors were either talking about or experimenting with methods of practising a form of population medicine.

The future

Despite some evidence to the contrary, I think general practice in the UK has come a long way since I worked in the National Health Service 20 years ago.[17] In 1966 few general practitioners were keen on my observing their consultations. In 1986 no single doctor demurred at my request. This reflects the current confidence of British general practitioners. By world standards British general practice is very good. Even by Australian standards, which have been largely defined by those understandably disgruntled refugees from the National Health Service in the late 1940s and 1950s, it is still good. Dr Joseph Colling would have to change his statement of 1950 that 'The overall state of general practice is bad and still deteriorating' by substituting the words good for bad and improving for deteriorating.[1]

However, I was asked to offer criticisms of general practice in the UK and I have done so with some humility but from the viewpoint that excellence is a state to be strived for, even if, like the pot of gold at the end of the rainbow, it is impossible to reach. The UK is a conservative country and British medicine is steeped in a long tradition. On first principles it should take longer for new concepts to be translated into actual change than in a country whose traditions are still developing. In effect, general practice in the UK seems to be changing fast and for the better. The academic and political leadership of the College is of a very high standard and the intellectual calibre of the new generation of general practitioners is refreshingly high. At present there is not all that much difference between general practice in the UK and that in Australia. But in terms of concepts, structure and will, the potential for excellence is greater in the UK. It is an intriguing possibility that general practice in the UK will progress towards very high standards while Australian general practice will be dominated by 24-hour 'emergency' centres with mink-lined couches providing a quick fix for all that

the patient wants but hardly anything of what the patient needs. On the other hand, British general practice may go flirting with a fee-for-item-of-service system just at the time when North America and Australia will be coming more and more to realize the benefits of a pre-paid service.

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Address for correspondence

Professor M. Kamien, Department of Community Practice, University of Western Australia, 328 Stirling Highway, Claremont, WA 6010, Australia.

Predicting complications in coronary care

The use of the initial electrocardiogram as a predictor of complications was evaluated in 469 patients with suspected acute myocardial infarction. An electrocardiogram was classified as positive if it showed one or more of the following: evidence of infarction, ischaemia, or strain; left ventricular hypertrophy; left bundle-branch block; or paced rhythm. Life-threatening complications were 23 times more likely if the initial electrocardiogram was positive ($P<0.001$). Other complications were 3 to 10 times more likely ($P<0.01$), interventions were 4 to 10 times more likely ($P<0.05$), and death was 17 times more likely ($P<0.001$) in patients with a positive electrocardiogram.

The authors conclude that patients with a negative initial electrocardiogram have a low likelihood of complications and could be admitted to an intermediate care unit instead of a coronary care unit. This would reduce admissions to the coronary care unit by 36% and thereby save considerable hospital costs without compromising patient care.

Source: Brush JE, Brand DA, Acampora D, *et al.* Use of the initial electrocardiogram to predict in-hospital complications of acute myocardial infarction. *N Engl J Med* 1985; **312:** 1137-1141.