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Family practice in the National Health Service: a mid-life crisis?

THIS is the fortieth year of the NHS and the Government's white paper[1] promises changes in the milieu of general practice within it. The pattern of general practice in 1988 is vastly different from that of 40 years ago, but just as in 1948 general practice took the main brunt of the increased burdens, in 1988 it remains the component of the NHS mainly responsible for continuity of care and the perceived humanity of a service which is the least costly in the developed world. This seems a good moment to reflect on some of the changes that have occurred, and their bearing on the opportunity before the general practitioner now.

Medicine changes continuously as biomedical science advances, but the initial impact of these advances tends to be on hospital and specialist services. Some new treatments or prophylactics, such as poliomyelitis vaccines and dopamine derivatives, abruptly affect primary care, but other changes, such as the use of corticosteroids, filter in gradually after specialist experience with the small initial supplies defines a pattern of use. High technology methods continue to be used only in hospitals, whether for therapy or diagnosis, and there has always been something of a struggle to make diagnostic facilities available to general practitioners as early as they should be. But British medicine is based upon a clearly understood division of function between generalist and specialist, neither subservient to the other, and the provision of a comprehensive service to the public depends on an effective partnership between the two. One of the principal areas covered by the white paper concerns the maintenance of that partnership.

The medical science available to general practice in 1948 was very different from what is available now and at that time practice was almost unstructured. The white paper emphasizes the further structural changes needed now, after nearly 40 years of development. Change has been continuous, by a series of short steps rather than great leaps, but not always universal. It has not been related to changes in the administrative structure of the kind politicians can bring about, but the initiatives of a few have become generalized more easily when administrative action which favours them has been agreed. It is useful to note how natural evolution has been facilitated in the past, as we seem to be on the brink of fresh changes. Primary care is provided by a large number of people, some medical, many not, varying in age, trained at different times in different disciplines and serving people who have even more widely differing lifestyles and health objectives. There is not — nor should there be — a standard pattern of health care to be packaged and marketed at minimum item cost. There can be broadly agreed objectives and policies which offer the best outcome; these we should plan now.

Forty years ago general medical practice was simply regarded as a one-to-one relationship between a patient and a doctor, invoked mainly by or for a sick person; the wide scope of prevention was then unknown. About half the doctors were single handed, partnerships were small and there were very few organized groups and they were essentially medical. In 1948 general practitioners were unfairly treated over their remuneration and there was little incentive to improve. Many people talked of health centres with no real understanding of their possibilities and the finanical terms offered

were unfavourable. Collings,[2] Hadfield,[3] and Taylor[4] were sharply critical of the quality of the worst practices and unflattering about a lot of others. Morale was at its lowest.

Practice as it was under the National Health Insurance would not do for the future but creative planning in 1948 was concentrated on the hospital service. However, two events in the early 1950s gave an opportunity for change. First, the Danckwerts adjudication, accepted by Government, made a fair settlement of the general practitioners' pay claim, including four years retrospection. A new system of distribution was negotiated without rancour, favouring group practice and new entrants, and providing for training. Those with medium sized lists gained some advantages as a means of promoting quality rather than sheer numbers — a point that must not be lost when the white paper proposals are considered. However, the anomalies of indirect and partial payment for expenses, especially rent and staff costs, were not addressed and, until a Royal Commission and the later general practice charter, doctors who provided better facilities for patients did so at their own expense. The one contribution toward better premises was made by the doctors themselves through their interest-free group practice loans scheme — a piece of altruism too often forgotten.

The second hopeful event of the 1950s was the foundation of the College of General Practitioners with the aim of fostering quality in practice by improved training for entrants, continuing education in practice, better practice organization and research. It has been fascinating to watch the way in which the early initiative of an oddly assorted but enthusiastic group has passed on to a second, third and soon a fourth generation of leaders with a progressively broadening concept of the function of the College. The change from monolithic medical practice to multidisciplinary primary care came gradually — a few practices in the mid 1950s and then a general realization of the benefits of working, first with community nurses and later with others. Geoffrey Marsh's Mackenzie lecture[5] describes the evolutionary process. The charter negotiated by Kenneth Robinson with a medical group led by Jim Cameron made generalization possible; it did not initiate the change.

Good medicine will not be generated by financial promotion, on which the white paper places too much emphasis, but financial disincentives can obstruct it. Health care cannot be standardized, uniformly packaged and delivered at the cheapest rate without sacrificing the elements of continuity and humanity. The NHS, like all organized health services, will never have the resources it could use effectively and it must be cost conscious. We do not want larger lists with less satisfactory care for each patient; nor do we want needlessly costly payment for lists too small to provide a full medical job. In recent years the funding of the NHS has been damagingly restricted, more so in the hospital and other community services than in general practice. Too much has been made of head counts of things done and not enough of the rising toll of services left unperformed.

The white paper is still concerned with some of the problems that were not solved when the charter was negotiated, such as the setting of an age limit for doctors and a firmer commitment to continuing education, but it also allows us to reach a new agreement, bypassing some of the obstacles that have seemed immovable for so long. If the opportunity to plan for quality is not obscured by a preoccupation with cost control the College's long campaign for review of outcome in practice could take a long step forward. Hopefully the same obligation will be accepted by all the specialties, for reasons well expressed by Hoffenberg.[6] The generalist and the specialist must come together if the true interests of the people and the profession are to be served.

The white paper makes much of prevention and, although wider preventive programmes require the sort of action which successive governments have failed to take to prevent commercial promotion of health destructive behaviours such as smoking, it will be through primary health care that the message will be pressed home. For this to succeed there must be organized exchange between the practice group and the practice population of the kind the National Association for Patient Participation has been seeking for 15 years.

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References

1. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Promoting better health. The Government's programme for improving primary health care (Cm 249).* London: HMSO, 1987.
2. Collings JS. General practice in England today. *Lancet* 1951; **1:** 555-585.
3. Hadfield SJ. Field survey of general practice 1951/52. *Br Med J* 1953; **2:** 683-706.
4. Taylor S. *Good general practice.* Oxford University Press, 1954.
5. Marsh GN. Clinical medicine and the health divide. *J R Coll Gen Pract* 1988; **38:** 5-9.
6. Hoffenberg R. *Clinical freedom.* London: Nuffield PHT, 1987.

Benzodiazepines: time to withdraw

IT has been estimated that between 15 and 44%[1,2] of long term users of benzodiazepines may be expected to show withdrawal symptoms when the drug is stopped. These symptoms emerge in the first week after stopping the drug but may also develop if the dosage is reduced. The withdrawal syndrome may last for up to three months or even longer with some patients.

The withdrawal symptoms are often similar to the anxiety symptoms for which the benzodiazepine was being taken but may be distinguished from a recurrence of anxiety by an increased sensory perception, with hypersensitivity to noise, light, pain and touch. Other symptoms which are frequently reported include headaches, dizziness, disturbed sleep and a disturbed gastrointestinal tract.

The best way of avoiding dependence is to avoid unnecessary prescribing. Many patients presenting with anxiety may be suffering from depressive or other neurotic disorders that could be better treated with antidepressants, which are not associated with dependence.[3,4] Some patients are more likely to become dependent than others, especially those with a previous history of drug and alcohol dependence, dependent and obsessional personalities, and others with long-standing neurotic symptoms. The evidence for the usefulness of benzodiazepines in minor anxiety states is weak. They should properly only be used for short courses at the lowest possible dose. The use of an intermittent dosage regimen with instructions to take a drug holiday, say every two or three days, is likely to reduce both overall intake and dependence. Brief counselling may often help to avoid a prescription for a benzodiazepine. Benzodiazepines should not be used for minor sleep disturbances and a shift away from their easy availability as hypnotics would be welcome.

The major problem facing the general practitioner now is how to manage the withdrawal of patients who may be dependent on benzodiazepines. Although some people seem to be able to