unsatisfactory'. More recent initiatives such as the 'What sort of doctor?'[3] and 'Quality initiative'[4] proposals of the Royal College of General Practitioners seem to have foundered and in the recent white paper[5] the government is trying to force change on a profession that is slow to implement it for itself.

There is no reason to suppose that doctors are motivated in different ways from other people, particularly middle and top grade managers in industry and the civil service with whom they may be compared. General management in the NHS has adopted many of the features of industry that allow growth and development and satisfaction within the job[6] and it is now only the doctors who are left with a career system that is decades old. Ironically it may be the very success of the model created by the 1911 Health Insurance Act that is responsible for some of these difficulties. There is always resistance to changing a familiar system that has worked well.[7] There is evidence that morale in the profession is a major problem. O'Donnell[8] described doctors as 'resentful prisoners' chained to their job by fetters of security. Recent work by Branthwaite and colleagues[9] showed that a substantial minority of general practitioners have major problems in their self image and satisfaction with their work, feeling lonely and isolated and uncertain in their role. One reason for this may be their low mental energy caused by the lack of stimulus, monotony, absence of growth and challenge, and constant mental debility from the 24-hour commitment. There is evidence that these factors are responsible for much stress related morbidity among general practitioners.[10-12] In a recent seminar, developments in general practice were described as 'tuning a finely engineered car which has four flat tyres'.

If doctors cannot find continuing satisfaction in their career they have several choices. They can leave general practice and small numbers do so; they can opt out intellectually so that their stimulation comes from outside their profession; they can continue in a desultory way until retirement or alcoholism[13] intervenes; or they can try to provide the intellectual stimulus and justification for what they have been doing. Is vocational training just the opium of the profession?

Much contemporary medical activity is about the raising of standards. Perhaps we should first look at our own needs and those of our colleagues. Unless we start to improve the quality of our own life and our careers we may be wasting our time talking about improving quality for patients.

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The future of community and residential care

THE expansion of the private sector of residential care in the last few years has been both a relief and an anxiety for general practitioners. A relief, because the number of places in local authority homes has often not kept pace with need. An anxiety, because in popular retirement areas, concentration of disabled elderly people in homes has become an excessive burden on general practitioners and other community services.[1] In addition, concerns have been expressed about the standards of care in some of these homes.[2]

One reason for the growth in private care is the increased awareness of the social security allowances which are available to cover the cost of fees in private and voluntary residential care. No assessment of the need for residential care is made before people are admitted to private homes. The result is that people who could manage perfectly well at home if they were provided with appropriate support are pushed towards expensive residential care, while local authorities are starved of the resources to offer alternatives because of financial restraints by central government.

Three recent reports have considered these developments and while there are some interesting differences in emphasis they present broadly similar approaches to dealing with the difficulties.

The first report to be published was from a working party sponsored by the DHSS and the local authority associations, chaired by Mrs Joan Firth.[3] The report, perhaps reflecting the local authority influence in its membership, recommended by one vote that all potential residents of residential care homes should be assessed by local authorities. This was despite evidence from DHSS commissioned research[4] that patients placed in private homes are in general in need of the services, according to the criteria of experienced local authority staff. The Firth report also recommended that local authorities should continue to set quality standards in private and voluntary homes by registration and inspection, but be responsible for financing care within them.

The Wagner report on residential care — coming from a semi-official committee financed by the DHSS and managed by the National Institute for Social Work[5] — made similar recommendations, but covered a wider field of interest, going beyond financial concerns to look at the quality and style of provision. One of the priorities of the report was the need to improve the status of residential care work for social workers. Although in the field more than 80% of social workers are qualified, the proportion of qualified staff in residential homes ranges from 1.5% (for junior staff) to 26% (for managers in children's homes).[6] The report recommended that all senior staff should be qualified,

and that more training should be available to basic care staff and that artificial divisions in management and training between junior and senior staff in homes should be removed.

The central recommendations in the report were based on the importance of preserving choice for individuals: nobody should feel forced to go into a home; there should always be realistic alternatives and if an elderly person does enter a home, the quality of life should be better than could be found elsewhere. The report also wanted these concepts to apply as far as possible to children in care and to groups such as the mentally ill and the handicapped.

Once in a home, residents should have a clear contract for the services they receive, and access to complaints procedures and reviews of their case to enforce it. Ordinary community health and leisure services should be available, so that public authorities cannot refuse to provide them if, for instance, they disapprove of private homes. Each resident should have certain rights to privacy and if these are taken away, the decision to do so should be recorded and subject to outside checks.

In order to ensure that there are realistic alternatives to residential care, the report proposed that there should be a range of supported accommodation in the community, such as sheltered housing, and that additional domiciliary care, such as home helps and meals, should be delivered to people's own homes. Local authorities should have a duty to designate 'nominated social workers' to take responsibility for creating a package of community services according to the patient's preference.

A number of welcome improvements might result from an implementation of the Wagner committee's recommendations. First, patients would benefit and decision making would be easier if divisions between private and public sector care were discouraged. Secondly, the quality of care in homes would be monitored better. Thirdly, there would be considerable incentives to promote community care opportunities, where these are desired in place of residential care. Overall, these developments would ease the burden on carers and their supporters in the health and social services.

One of the more distant gains is that the nominated social worker system would allocate clear responsibility for particular clients within the social work departments thus emphasizing individual accountability and improving communication with other agencies. It could also add to the status of working with those, particularly the elderly, who at present do not get a high priority within the social services.

The problem with many professional reports is the gap between recommendation and implementation. Residential care is currently an important political issue, because of its relevance to the controversial topic of community care. Sir Roy Griffiths' report on the finance for community care[7] was born of a controversy stirred first by a Social Services Select Committee on the topic,[8] and then by an Audit Commission report.[9] A government embarrassed by criticisms of the perversities and frustration of finance and policy in this field invited a managerial examination of community care by a person who has already made a major contribution to National Health Service management with his proposals for general management which were implemented in the early 1980s.

The report was much delayed, and was released by the government in a way which many have interpreted as reflecting lack of enthusiasm. Comment in the press has centred on the recommendations, put forward also by the Firth and Wagner committees, that local authorities should take the leading role in planning. Sir Roy also agreed with the Firth committee that local authorities should manage the financing of care services, but, more in line with the views of the Wagner committee, he saw a more important role for the private and voluntary sectors. The report shared the Wagner committee's enthusiasm for packages of care to be created in the community by the 'nominated social worker' as a case manager and for experiments with community care allowances or vouchers.[10] It explicitly attached greater importance than either of the other two reports (which are social services biased) to the potential contribution of general practitioners. However, none of the reports examine how primary health care teams can develop the appropriate expertise and be provided with the appropriate resources to care for increasing numbers of elderly disabled people in residential homes. Griffiths differed from the Wagner committee in his preference for decision-making for patients being managed by local authority social workers, rather than by the patients themselves. He is also markedly less enthusiastic about training for staff, and in particular social work training.

All three reports have identified the role of the private sector in providing residential care as a crucial issue. Residential care in the private sector has, on the whole, been a success and may become a blueprint for further expansion in other types of care. If public finance to purchase care becomes more widely available there is now evidence that people will come forward to offer it. It is quite likely that community care finance will lead to the growth of private day and domiciliary care services to complement the extensive private residential care and sheltered housing which already exists.

It is hard to gauge the effect of these developments on family practitioner services. Extensive private provision of care might lead to a much more fragmented and unplanned service and, while the range of options for care may be increased, this may not necessarily create improvements in the actual care provided for an individual. There is a serious risk that developments will spring up with no attention being paid to the capacity of health and social services to cope with the increased demand. Residential homes may become even more concentrated in a few areas and so put an unreasonable burden on services in that locality. This outcome can be avoided if we heed the recommendation of all three reports that local authorities should take a lead in the planning of residential care.

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