health care team and by increases in the number of support staff.[1] Yet there is evidence that many general practitioners lack information on local services for priority groups, and that, in some cases they may assume that all medical care falls within the remit of the specialist.[6] Studies have demonstrated that the primary medical care needs of people with learning disabilities and the physically disabled are not always met.[7,8] Continuity of care means more than care by a single practitioner, although it is often defined in this way.[9] It may involve setting up monitoring systems (such as dependency registers) and ensuring coordinated care. For example, the Griffiths report advocates 'a more systematic approach by all GPs to identifying the potential community care needs of their patients'.[4] Moreover, it gives general practitioners responsibility for informing social services of the community care needs of their patients. While it is not essential for a general practitioner to act as a case manager, it is important that care provided by general practitioners and by district health authority and local authority services is properly coordinated.

Many have argued,[10,11] particularly in relation to prevention, that general practitioners should combine a public health and population-based approach with traditional clinical skills. Reports on the health of a practice could include social and environmental influences on health. Already, some family practitioner committees are working with community physicians to use information on the population of the family practitioner committee for planning purposes.

Planning for practice populations forms only part of the picture. Increasingly, general practitioners will be charged with improving their accountability to consumers and demonstrating value for money in the way services are delivered. As independent authorities directly accountable to the Secretary of State for Health, family practitioner committees are developing their planning role. Referral and prescribing patterns will come under scrutiny, surveys of consumer opinion are being carried out and more rigorous monitoring of practice premises is being undertaken. Targets for certain preventive services are likely to be set in conjunction with district health authorities. In particular, the Health and Medicines Bill makes provision for family practitioner committees to become budget holders for the ancillary staff reimbursement scheme and this represents a major extension of their planning responsibilities. General practitioners can either become active participants in the planning process or can retreat into a defensive position in the face of these developments.

The broad goals for primary health care set by the World Health Organization[12] emphasize that primary health care is more than the sum of the activities of professionals involved in delivering it. For the WHO, primary health care is the key to achieving health for all by the year 2000. Their definition of primary health care includes proper nutrition, sanitation, immunization and basic treatment for health problems, and requires joint working by all the agencies providing services. Despite criticisms of 'sloganeering'[13] and an over-simplistic approach to solving major health problems,[14] 'health for all' has reaffirmed the main determinants of a population's health status, firmly relegated primary medical care to one element in a much broader framework and encouraged action to make this broad definition of primary health care a reality. An indication of a country's success or failure to provide primary health care may be gauged by the extent to which inequalities in health are reduced — the number one target for the European region of the WHO.[15]

While general practice forms only part of this picture, changes in the organization and management of primary health care already demand that general practitioners become more population-based in their approach and more accountable to consumers and the public purse for the services they provide, and that they collect more information on social and environmental aspects of health. If general practice meets this challenge we can look forward to improvements in the health of the whole population based on a strong primary care system.

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Training for hospice care

THE hospice movement has become well established within the UK to the extent that there are now recognized training courses for nurses and palliative medicine is beginning to be seen as a specialty in its own right. Initially, many hospice doctors were recruited from general practice, which they either maintained on a half-time basis or left to take up full-time medical appointments at their local hospice unit. Often these general practitioners have been instrumental in setting up and establishing the unit in which they have subsequently worked.

There has been much negotiation over proposed training for palliative medicine and the Royal College of Physicians has recognized that palliative medicine is emerging as a specialty.

A programme for training at senior registrar level has been approved by the Joint Committee on Higher Medical Training of the United Kingdom and Ireland. The objectives and requirements stipulated are comprehensive and laudable, adequately covering the broad areas of expertise that any hospice consultant should acquire. However, for a person to be eligible for accreditation in palliative medicine an obligatory period of two years full-time as a senior registrar in a specialized unit will be combined with a non-obligatory one to two years in general medicine or other relevant specialty, including oncology, infectious diseases, radiotherapy, haematology, geriatric medicine and general practice.

The recommended general professional training stipulates broadly placed experience 'in medical specialties leading to MRCP or other appropriate qualifications' and it would appear that for the time being, probably five years, the training body who is responsible accepts that 'the most suitable candidates will not necessarily possess MRCP'. Thus the MRCGP is recognized as a suitable postgraduate qualification for palliative medicine — but will it remain so? Is this recognition a temporary measure to tide over the period while doctors who have come from general practice or other backgrounds are currently pursuing a career in palliative medicine?

The hospice provides a bridge between community and hospital, and hospice care is complementary to community care with the general practitioner and the hospice team sharing their expertise to help maintain a patient's independence. Hospices have been successful in spanning the rigid boundaries between primary and secondary care. Only general practice training, however, can provide experience of the many subtle pressures on a sick patient and relatives caring at home. The primary care team are reliant on these untrained carers who carry the 24 hour responsibility for the patient. Thus the goals and expectations required to achieve a high standard of patient oriented home care differ substantially from those perceived by a hospital trained team, who have never cared for a patient throughout 24 hours without trained nursing staff on site.

Currently in the UK the average general practitioner will have two terminally ill patients per annum, so that experience in palliative medicine is slowly accrued. It seems reasonable that any person wishing to enter palliative medicine must obtain a wider base of experience by having a period in a specialized hospice unit. Unfortunately, the emerging training requirements do not make experience in general practice mandatory. This is a serious omission.

A rigid system of training may prevent doctors being able to cross boundaries from one medical discipline to another. Job security from a permanent post will be difficult to abandon for the insecurity of a short term senior registrar contract with no definite promise of a long-term post in palliative medicine, while those failing to progress in other specialties may view palliative medicine as an easy option. There is a career bulge of young doctors who have become stuck at registrar grade and possess the MRCP who may see palliative medicine as particularly attractive. But are these the people who we should be attracting into a field where possibly one of the most valuable attributes is human experience and compassion gained over many years practice in the community? Currently, hospice doctors in the UK are noted for their devotion to the job and to their patients. If the mature doctor is unable to make a vocational career switch to enter hospice medicine, perhaps one of the most valuable assets of British hospice care will be in jeopardy.

We may have missed a unique opportunity. There are many who would argue that every hospital consultant should spend a year in general practice before taking up an appointment. If this were applied to palliative medicine it would ensure that those entering palliative care must continue with a commitment to community care of patients and a firm understanding of the role of the general practitioner. The MRCGP combines a broad knowledge of general medicine with applied communication skills, understanding of the difficulties for families undergoing major life changes and some grounding in staff management. Surely that must be a more appropriate qualification for a future hospice medical director than the MRCP?

There will be a need for some form of assessment of those who express an interest in palliative medicine so that the advent of a diploma in palliative medicine seems inevitable. The Royal College of General Practitioners could act in conjunction with the hospice movement to establish a diploma examination and curriculum. We must recognize that members of the College have special interests and often hold diplomas in subjects such as obstetrics and paediatrics. The alignment of academic standards of palliation with general practice would ensure that the role of the general practitioner in the care of his terminally ill patient, who usually spends about 90% of that illness at home, remains firmly recognized. The College should set the standards in this field of medicine.

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Activity, audit and accountability

THE assessment of quality in health care is a topical and controversial subject. Both government and consumer organizations are seeking to put general practice under scrutiny, albeit from different perspectives. The government is concerned to receive value for public money devoted to the National Health Service while consumer organizations are more concerned about the performance of individual doctors in terms of their accessibility, courtesy and effectiveness. It is clear that general practitioners need to be able to provide information about the range of services they provide and about their workload. However, without their active participation in the collection and interpretation of data, there is a danger that routine data on aspects of practice such as prescribing and referrals to hospital may be analysed inappropriately and judgements formed out of context. Fortunately Drs Pinsent and Crombie identified the need for general practitioners to analyse their own activities and through their initiative the records and statistical unit of the College was established, later reconstituted as the Birmingham research unit in 1961. The unit pioneered practice activity analysis and for the past two decades many general practitioners have collected information about their own performance in a systematic and structured fashion. In addition to this self-assessment, the unit has organized large scale studies which have documented consultation patterns in general practice in the United Kingdom, the most notable example being the third national morbidity study.

Occasional paper 41, published this month, describes the range of studies conducted by the Birmingham research unit over the past 20 years but it is much more than an historical record of the achievements of the unit. It is a careful, thorough considera-