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Advertising unleashed

FOLLOWING a government review of restrictive trade practices,[1] the Monopolies and Mergers Commission was asked to consider the advertising restrictions on medical practitioners, especially the guidance issued by the General Medical Council. While this report was in preparation, the Department of Health pinned its colours to the mast: 'The government believes that the advertising of services offered by practices should become the norm, subject only to safeguards necessary to protect the quality of professional services available'.[2]

It is hardly surprising therefore that the Commission's report[3] has come out in favour of relaxing the rules on advertising by doctors, against the advice of the General Medical Council,[4] the British Medical Association[5] and the Royal College of General Practitioners.[6] For some doctors this will represent a considerable philosophical setback for general practice,[7] but before accepting such a cataclysmic view the proposals need careful consideration.

The report recommends that the doctors involved in secondary care should not normally be able to advertise direct to patients. This should be warmly welcomed since any relaxation in this area would have represented a substantial threat to the referral process, and thus to the role of primary care itself.[8] Specialists will, however, be allowed to advertise their services to professional colleagues.

The Commission recommends that advertising by general practitioners should be subject to two broad caveats: it should not bring the profession into disrepute; and it should not abuse the trust of patients or exploit their lack of knowledge. In order to comply with these two principles, it is proposed 'that the content of advertisements should be limited to factual information, should be legal, decent, honest and truthful, and should not disparage other doctors or make claims of superiority'. It is also intended that the guidelines should forbid claims to specific cures, 'cold calling' and such frequent advertising as to assert undue pressure.

The profession's main concerns have centred around the distinction between information and promotion, and the vulnerability of patients when ill. The Monopolies and Mergers Commission recognizes that the public is becoming skilled at making sophisticated choices and that wide dissemination of information is implicit in a more consumer-sensitive profession. It also makes the point that the majority of patients choose their doctor at a time when they are not acutely ill, for example when moving house, and are therefore quite capable of rational choice.

So what effects might we expect if these changes are implemented? It is important first to get the scale of change into perspective, and for this we should look at the experience of others. Both solicitors and dentists have undergone a similar relaxation of regulations but the airwaves are not filled with their advertisements. The local press has been used, but usually in a dignified and responsible manner. It is likely that general practitioners will behave in a similar way.

The most significant change is that practices will be free to advertise to their own patients. They will be able to use the local media (parish magazines and notice-boards, and the local newspapers) to inform their patients of the times of well-person clinics, the existence of health initiatives and even changes in partnerships. While such notices would be aimed at existing patients they will, no doubt, be seen by the patients of other practices.

If a practice wishes to increase its patient numbers then local residents can be directly addressed either through local press advertisments or through 'mail shots'.

Such promotions might draw the potential patient's attention to the personnel, the facilities and the levels of care, for example the immunization rate, of the practice. Any practice indulging in such competitive advertising would have to be careful to keep the content factual and avoid disparaging its neighbours. It is more likely that practices will follow the example of solicitors and advertise to raise the public's awareness of their existence, reserving the details for their practice leaflet. Specific groups, for example patients moving into the area, may well be targeted with a letter of introduction enclosing an informative practice leaflet.

The final type of advertisement that we are likely to encounter is one that has been allowable up to now but which has been largely ignored. If the political or societal climate requires it, general practitioners may wish to advertise through the Royal College of General Practitioners or the British Medical Association to promote the corporate image or view of the profession. If the current disputes with government are a guide, this form of advertising is likely to become a necessity.

Allowing general practitioners to advertise their services to their own and prospective patients will lead to better quality information being available to patients when making a choice of practice. Fears about the extensive use of the mass media beyond local newspapers will probably be unfounded. In the final analysis, it is likely that these proposals will offer benefits for patient choice which outweigh any theoretical detriment to the doctor–patient relationship.

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Community hospitals — time to come off the fence

THERE are approximately 403 000 staffed available hospital beds in the United Kingdom. Though it is impossible to be exact, current estimates indicate that just over 11 000 of these are under general practitioner control.[1-3] Unfortunately, many general practitioners see these beds as an embarrassment and an anachronistic remnant of a type of health care which is no longer relevant to current needs. Can they be persuaded that general practitioner beds are a vital resource within modern general practice which allow some doctors to provide a standard of care which would be impossible in their absence? Indeed could community hospitals be the basis for an extended form of general practice which might become a model for the 1990s and beyond?

For many years general practice has suffered from a failure to confront and acknowledge the implications of its diversity. We have assumed that as long as we all call ourselves general practitioners we somehow create a common job, with similar work and objectives. This may have some validity for the core of our work, the consultation, but it is far from being correct when one considers the wide variations in the types of practice in which we work.

A general practitioner in a large city is manifestly practising in a way which is different from that of a rural practitioner, with half the list size, who serves a 30-bed community hospital, an accident and emergency department and an obstetric unit. This is not to say that one type of practice is any better than the other — differences in the structure of practices should not be equated with differences in the quality of practice. However, the skills and attitudes required in one type of practice may be totally different from those required in another.

Viewed from overseas, general practice in the UK has become synonymous with primary care practised outside hospitals. General practitioners are seen as being involved in prevention, the initial diagnosis of acute illnesses and providing continuity of care for people with chronic disease. Our role as gatekeepers for specialist care is well established and the separation of primary and secondary care is entrenched in the National Health Service. This rigid separation of primary and secondary care is not a feature of health services in most other countries. Community hospitals provide an intermediate level of care and thus offer the prospect of bridging the widening gap between community based primary care and the increasingly specialized secondary care in large district general hospitals.

The current white paper, *Working for patients,*[4] suggests that large hospitals will tend to develop 'core functions', specialized areas of expertise which they can profitably promote at the expense of the less popular. Such developments can only further increase the need for low technology community hospitals where care, convalescence and respite can be provided for a wide variety of conditions.

The technical demands of medical specialization are such that it is questionable whether any general physicians will remain in hospital practice by the year 2000. This does not mean that we will not still require generalists in hospitals. The general practitioner of the future should not be afraid to re-establish his role as a generalist in hospital as well as in the community. Vocational training is now producing young doctors in general practice, willing and able to take on this role. Their ability to do so would be greatly augmented by the provision of an intermediate level of care in the form of community hospital beds under their control. Many medical problems do not require high technology or specialists for their effective treatment. Many can be appropriately dealt with in community hospitals with good nursing care, and access to haematology, biochemistry and radiology services. This type of care can be provided appropriately and completely by the interested family doctor. It should be