

practised model of specialist care in general practice: the selective use of women general practitioners by women consulting for gynaecological and contraceptive problems.^{12,13} This is largely patient led and hence lacks the kudos of other professional special interests.

This debate has been thrown into sharper relief by the increased demands on general practice imposed by government reforms. For instance, general practitioners are to be specifically rewarded for running certain special clinics. Stott has pointed out that special clinics risk being disease- rather than patient-centred.¹⁴ These may be organized around a particular general practitioner acting as a specialist resource, and so tend to 'deskill' the other doctors working in the partnership. In addition, the long term training requirements needed to qualify for providing paediatric surveillance may make it uneconomic for all partners in a medium or large practice to provide this surveillance and conflict with the aim to integrate preventive with curative and family care. Finally, the requirements for audit, to demonstrate high standards of care, encourages the examination of activity identified by specific diseases, rather than by wider concepts of health.

The desire of general practitioners to continue providing the generalist care that is apparently valued by their patients can be reconciled with the need for effectiveness within their practices and credibility with specialist colleagues. The key lies in being explicit about the work done by general practitioners other than face-to-face contact with patients. In one workload study approximately 3.5 hours a week were spent on education and practice administration.¹⁵ Unfortunately, there has been a tendency among the profession and its observers to devalue such activity, so that only face-to-face contact counts as 'real' work. Instead it is important to value educational and management work, and to recognize that this portion of the workload may be more effectively achieved by individuals within a practice taking responsibility for a particular area of activity. By taking time to plan with colleagues the response to common predictable diseases and problems, the members of the practice can specialize and inform their colleagues from their own standpoint. Advice can be written into management plans and intra-practice referral can be encouraged. General practitioners often feel put on the spot by patients' demands; it is perfectly acceptable to ask for time to think and consult colleagues (both within and outside the practice), so that formal referral could become less frequent.

Thus, in a medium or large practice each partner should be a traditional generalist family doctor in his or her clinical work, while taking responsibility for keeping the rest of the practice in contact with modern developments, and for planning and audit of the overall service in a particular area of practice. Such an approach also offers doctors the opportunity of changing their interests over a working lifetime, thereby helping to create

a career structure for established principals.¹⁶ The need to consider education under the three headings of disease management, prevention and service management may distract rather than assist in planning a rational response to problems met in practice. Nevertheless, it may offer a way to combine the two highly laudable desires to be simultaneously as technically polished as our specialist colleagues, and as much a family friend as our professional ancestors.

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Mental handicap — care in the community

LITTLE is known of the extent to which mentally handicapped people benefit from primary health care services. The few studies that have been reported have been disturbing and suggest that many families are not receiving the help that they need. There are a number of reasons for this. General practitioners are fully stretched and have to decide priorities among

many competing claims and vulnerable groups. Additionally, undergraduate training in mental handicap has been restricted and the facilities for postgraduate training are sparse. The opportunity to learn by experience is constrained by the relatively small number of people with severe mental handicap, about six on the average doctor's list of 2000. Yet, while the numbers are

small, the support needed by the affected individual and the family is life-long and the expectations of the carers are rising, with demands for better services from the general practitioner.

It is against this background that the Royal College of General Practitioners set up a working party in 1987 under the chairmanship of Dr Martin Barker to explore the role of the primary care team in the early diagnosis of mental handicap, in caring for the patient with mental handicap in the community and in supporting the carers and liaising with other services.¹ At that time the working party had no knowledge of the changes in services for mentally handicapped people which were to be proposed by government² in response to the Griffiths report.³

The central role of general practice was recognized in the Griffiths report; it recommended that a general practitioner's duties should be sharply defined and that there should be a contractual obligation to inform the social services authority of the community care needs of any patient on his or her list. In turn the social services authority would have to indicate the action it proposed to take. Most general practitioners would see this as no more than a formalizing of the existing arrangements. Whatever the service requirements are in the future, it is to the general practitioner that mentally handicapped people most consistently turn. Not surprisingly then, there is apprehension about the difficulty in devising community care plans not only for the 30 000 people with mental handicap still in hospital, but the health care needs of the larger, unknown number already living in the community.^{4,5}

Pressing issues of management and community care must not deflect the attention of doctors from the medical needs of people with mental handicap. No two people with mental handicap are alike and generalizations about their medical needs are dangerous. As a group they show a high incidence of psychiatric illness, behavioural disorders, epilepsy and multiple physical handicaps. As individuals they have a greater number and variety of health care needs than those of the same age and sex in the general population; yet it can be difficult to identify these needs because of the way in which the symptoms of illness are modified by the patient's low level of intellectual ability and the inadequacy of his or her communications. Only a minority are capable of negotiating medical, dental or personal social services and so the decision to seek advice is not autonomous but devolved to the care givers. They in turn may see common treatable complaints as being relatively trivial when compared with the major untreatable handicap and do not seek medical advice. It is therefore not surprising that screening people with mental handicap in the community discloses significant untreated morbidity.^{6,7}

Many people have suggested that mentally handicapped people require no special services and can be assigned without difficulty to the ordinary system of general practice. This is a dangerous misunderstanding of the principles of 'normalization'. Normalization has little to do with making people normal: it is concerned with the creation of opportunities for handicapped people to have real choices, valued experiences and personal dignity. The general practitioner can best help to achieve these aims by supporting the family and making sure that the medical problems of the handicapped member are not overlooked. The working party considered that one of the most effective ways of doing this was to carry out health checks on the lines of those recommended for the over 75 year olds. Of course the doctor must have permission to do this and the issue of consent in the management of people with mental handicap in the community is complex.⁸ Often the patient with mental handicap will be legally competent to give valid consent; otherwise the examination should only be carried out with the agreement of the usual carers.

It is unreasonable to expect a general practitioner to be an expert on every syndrome, but he or she must know where to get help and should see himself as part of a local network of services. Most health districts employ one or more community mental handicap teams, usually consisting of a community mental handicap nurse and a specialist social worker with part-time input from a variety of specialists. The community mental handicap team is essentially a domiciliary service and therefore must work closely with the primary care team.

Mentally handicapped people and their carers value most highly those doctors who take time to listen and who emerge as working with the family and not against them. But 'community care' means more than merely supporting the patient outside hospital. It refers to the acceptance of a precise, tightly defined set of values and provisions which include high standards of medical care for people who are mentally handicapped.⁹ Good community care will not be possible if general practitioners are overstretched or undermotivated. Because people with mental handicaps comprise a vulnerable group with high morbidity, it has been suggested that their care should attract extra financial rewards similar to the under five year olds and the over 75 year olds. With this in mind the working party has devised a protocol of care.

The commonest identifiable cause of mental handicap is Down's syndrome and this condition can be used to illustrate the wide-ranging challenges of community care which are associated with mental handicap. The first issue is the fear of parents that their baby may be handicapped at birth. We judge such a handicap by reference to our own lives, but in doing so we do not wish to hurt people who have Down's syndrome or those close to them by the suggestion that it would have been better had they not been born. We know that some people with Down's syndrome have lives which are more satisfying than the lives of many normal people. Despite this, it remains true that someone with Down's syndrome is less likely than a normal person in the same situation to live a worthwhile life. Not surprisingly therefore, antenatal screening of mothers has been widely advocated and most parents would welcome the opportunity to terminate a Down's pregnancy. It is important to stress that the decision to have an amniocentesis has to be made by the couple, the duty of the general practitioner being to provide them with up-to-date information free from any personal prejudice. After the decision has been made parents who elect to continue with the pregnancy require the full support of the doctor and for those who make the equally courageous decision to have a pregnancy terminated the need for support is no less great.

The second problem is the increasing number and increasing age of mentally handicapped people in the community. Whereas 30 or 40 years ago only 50% of Down's babies survived infancy, improved medical care has resulted in an increased life expectancy. Because people with Down's syndrome now survive into their 50s and 60s the prevalence of the condition has greatly increased during the past 10 years,¹⁰ such that almost all general practitioners are now faced by the particular problems of the condition.¹¹ Foremost among these are sensory impairments, congenital heart disease, hypothyroidism, neoplastic disorders and the early development of an Alzheimer-like disease. This also highlights the third issue which is the necessity for general medical screening of people with Down's syndrome and indeed for all patients with a mental handicap.

The trend for the 1990s will be for increasing numbers of mentally handicapped people to live in ordinary housing in the community. The hope is that, with support from the statutory agencies, voluntary organizations and neighbours, their lives will be more fulfilled. Primary care teams must see that the medical needs of mentally handicapped people are not disregarded and

to do this they must be aware of the special difficulties. As more dependent patients are moved into the community the demands on family doctors will increase. It may become desirable to introduce special postgraduate training or other provisions to ensure that satisfactory standards of health care are achieved for this group of people living in the community.

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Working at the coalface: miner or geologist?

A LETTER to the *Journal* this month¹ reports an analysis of the source of papers published in the *Journal* over the last 10 years. The writer goes on to deplore the fact that the proportion of all papers coming from authors who are 'ordinary' (sic) general practitioner principals and trainees has fallen from one half in 1980 to one third in 1989 and that there has been a corresponding increase in the proportion of papers written by academic general practitioners and those from other disciplines. This shift in the balance of papers by non-academic general practitioners and by academics/others raises three questions. First, why has it occurred? Secondly, can or should anything be done about it? Thirdly, does it actually matter?

Let us look first at why the shift has occurred. It could be due to bias in the editor's choice of papers in favour of those coming from academic departments. I think this is unlikely. All submitted papers are refereed by at least two referees — and we use as many referees who are 'ordinary' general practitioners engaged in or knowledgeable about research as we do academics — so that any bias by the editor is reduced. Furthermore, the referees are blind to the authorship and source of the papers — a policy which can never be wholly successful but which is an attempt to reduce the kind of bias which would favour academics over non-academics or famous name researchers over unknowns. Finally, we apply the same criteria to the selection of material for publication — originality, good research methodology, importance of the results and interest to the readers — whether a paper comes from a university department or a service practice, from a trainee or a professor. I believe (although I have not yet examined the figures) that the trend in the data has more to do with an increase in the number of papers being submitted for consideration by academic departments. This may be because there are more academic general practitioners, because academics are becoming more prolific writers of papers (because of the greater pressure on them to publish), because there is more research into general practice being done in academic departments of many different complexions (and this is a reflection of the importance and interest

that general practice has created for itself) and because more academics are submitting their papers to the *Journal* in the first instance (perhaps a reflection of the rising prestige, readership and influence of the *Journal*).

Could or should anything be done about it? I do not think anyone would want us to apply different criteria to the acceptance of papers from different sources. General practice research has now advanced from the first simple stages of an academic discipline — description and counting — to the next more complicated stage — understanding and evaluation. Inevitably, then, good research in general practice is becoming more difficult to do, now that researchers must submit to the greater rigour involved. It would be both patronizing to the many excellent authors in ordinary service practices and demeaning to the standards of the discipline to 'make allowances' for what the 'ordinary' general practitioner can achieve. We occasionally receive suggestions for more papers to be published which just air views or report on simple studies and audits, the implication being that this would provide more opportunities for non-academics to have papers published. Such suggestions are always given serious consideration. However, there is a danger that in doing this we would create a two-tier *Journal* with one section of high quality papers by academics and one section of poorer quality papers by non-academics. Readers must ask themselves whether this outcome is really a desirable one for general practice as a whole. Surely more service general practitioners should be aspiring to the research standards now being set by academics (and this is after all one of the reasons for the existence of academics) and be fighting for the time and resources to do good quality research themselves rather than being satisfied with exile to a specially created niche of poor quality? In fact there is a place in the *Journal*, not for failed or bad research, but for ideas and views and for the results of studies which do not meet all the criteria (pilot studies, case reports and small number studies). This section — 'Letters to the editor' — ensures that the status of the quality research papers is not eroded.

The third question is: does it really matter? The data in Dr