Flourishing or floundering in the 1990s

As the turbulence in general practice abates following the new contract,[1] the white paper[2] and the galvanizing impact of fundholding, it is perhaps time for progressive practices in the United Kingdom to take stock of their situation and plan for the future.

The pressures in general practice are enormous. Demands from patients are not diminishing, indeed in the prevailing consumerism they are being encouraged by often politically motivated words such as charter, choice and client-centred. Acute illness is being managed so rapidly in hospital that, following early discharge, patients need considerable amounts of continuing care from general practitioners and their professional colleagues. Chronic illness that does not need the technology of hospital departments is being devolved into the community. Preventive care is a major responsibility of general practice. Standard setting and performance related pay have been instituted.

All these changes are taking place at a time when the primary health care team is in turmoil. Health visitors are unsure where or with whom they are going to work; midwives are in limbo between hospital and community; there are too few community nurses and they are being supplemented by large numbers of practice nurses, not all of whom are trained for the responsibilities they undertake, and many of whom are unsure how far they are supposed to expand their roles. The practice nurse expansion is limited by the reluctance of family health services authorities to reimburse wages. Even the administrative and managerial staff who support the growing teams is being looked at parsimoniously by family health services authorities. Supposing that staffing levels could be improved, where is all this new style caring to take place? Expansion of surgery and health centre buildings has been restricted over the years and premises are no longer large enough. Can we flourish or will we flounder? Let me try and shine some light on this depressing scene.

All practices must increasingly employ managers and administrators with training and expertise proportionate to the tasks that confront them.[3] Their responsibilities will be reflected by high salaries and their status as shareholding partners in the practice. Enlarging practice premises, business planning, operational efficiency, modern office equipment, computerized records, and recruitment of staff will be the first areas for them to consider. They will also need to coordinate the clinical teams' functions, scheduling regular operational meetings when new and expanding roles can be considered and integration of activities can be organized.[4] Each team member's function must increase to a level that reflects present training and further increase as that training and experience increase. Audit of clinical work will be carried out by auditors employed by the practice and inferences from the results passed on to those actually doing the work.

In collaboration with the primary health care team's clinical tutor — not necessarily a doctor — practice administrators will spend time assessing the educational needs of the team, including holding regular inhouse postgraduate education allowance approved multidisciplinary educational meetings. Education outside the practice for team members such as receptionists and computer managers will need to be determined and time provided for this.

The numbers of nurses with all types and levels of training will need to rise. Nurses will be the clinical powerhouse of the future primary health care teams. Practice nurses will need formal post-registration training before starting a period of work in tandem with an experienced practice nurse. Once in post, they will have protected study time and continuing education. The care of patients with chronic illnesses will be undertaken by attached community nurses or practice nurses working to protocols at special clinics (for example, diabetic or vascular clinics). The problems they cannot manage will be referred to a general practitioner in the practice who has a special interest and knowledge of the condition. There will be special efforts to teach patients self care and how to monitor their own clinical conditions, for example asthma or non-insulin dependent diabetes. Acute minor illness may be largely managed by nurses with appropriate diagnostic training; the nurse practitioner will come into her own.[5] Patient run self help groups will be encouraged for all the commoner chronic illnesses. Well person checks, immunization, preventive care, paediatric development and routine antenatal and postnatal care, including the teaching of self care and the efficient use of services, will increasingly be undertaken by nurses, health visitors and midwives. Community psychiatric nurses and psychogeriatric nurses will provide continuing care in the community for appropriate patients.

Surrounded by all this expertise, and prepared to make full use of it, general practitioners themselves will need to redefine their role, abandoning many time honoured tasks, such as routine care of patients with chronic illness. Their major function will be as the person responsible for the coordinating of care for a particular individual. This personal involvement, fortified increasingly by personal lists, will remain paramount. Doctors themselves will not provide all the care; their role as diagnostician and accurate signpost to care will be of fundamental importance. This does not preclude direct access of patients to other team members as the patients become educated in the appropriate level of care for their illness. General practitioners' total number of consultations per patient may well fall, raising the probability of a greater list size and a resultant increased volume of major illness to manage.[6] To respond to this, their own clinical expertise for certain conditions, for example, hypertension, pregnancy or psoriasis, will need to increase to meet the clinical challenge that will evolve from often clinic oriented sub-specialization within practices. General practitioners' current clinical knowledge may be inadequate for such care and their deficiencies will require a more structured approach to future reading and postgraduate education than the present haphazard requirements. Preparation for periodic reaccreditation will also influence continuing programmes of education.

Liaison with medical schools regarding provision of undergraduate and postgraduate training within the setting of a large team practice may be negotiated by administrators. Some general practitioners will direct research assistants at practice based clinics, and provide a community slant to the teaching and research of clinical problems as varied as antenatal care, enuresis and parkinsons disease. This may well culminate in the rewriting of large sections of the textbooks of medicine.

Cross referral within practices from one doctor to another will be commonplace, particularly via the clinic system, and the referral rate to hospital outpatient departments will fall rapidly. Patients will be managed by their own general practitioner or the general practitioner's colleagues with whom it will be easier to strike up a continuing and cordial relationship. The occasional visit of a hospital doctor to the practice may well suffice to meet the residual need for out of practice expertise. Part time work for doctors overseeing nurses at special clinics will become more available and may be valuable for doctors wishing to job-share

or undertake temporarily a greater commitment to home care and parenthood.

But, as all general practitioners know, much of the work is not strictly clinical and the need to share care with paramedical and non-clinical colleagues is evident and realistic. Social workers, counsellors, elderly care visitors, physiotherapists, dietitians, as well as practitioners in the complementary therapies, will be vital to provide a truly holistic community based caring system.

But where are the resources and finances to come from to achieve this new world of community based health care? The Department of Health, if truly committed, will need to encourage a loosening of the restrictions on size of practice premises and the rentals paid for them. Reductions in hospital budgets as a result of contraction or closure of outpatient facilities and antenatal and postnatal clinics, and with many wards open only from Monday to Friday, should ultimately provide large sums for redistribution in the community. Family health services authorities will need to fight for more money in order to reimburse the justified increases in team staffing, as well as helping finance expansion of premises.

To provide expanded premises, large long term loans (for example, 30 years) may well become the lot of practice partnerships. Benefits accruing from improvement grants, tax relief, realistic rents and a higher income from larger lists and expanded performance related activities (such as minor surgery and undergraduate and postgraduate teaching) will have to be set against lesser expectations of increasing value of property, customarily a benefit for doctors in recent decades. Investment in premises may be to generate a large income from the activities within them rather than for any potential increase in value of the premises themselves. All this will need careful consideration by the review body when considering general practitioners' global finances and the levels of payment for expanded services, teaching and research activities. Variations in practice style and types of care, appropriate to the environment in which they work, will be much greater than at present and long overdue.

District health authorities will need to encourage the placement of health visitors, community nurses and other clinical workers into practices to provide community based care via primary health care teams. Above all they will need to resist the swing back to geographical patch working which was an unfortunate and unsuccessful feature of community care in the 1960s and earlier.

Not since the post-charter[7] years of the late 1960s and early 1970s has general practice had such an opportunity to change, to promote itself and to become the major clinical force in British medicine. If it takes up this challenge it will not only upgrade the health of the community but also fashion a fascinating and absorbing way of work for doctors and their professional colleagues.

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Interface between primary care and specialist mental health care

PRIMARY and secondary care for patients with mental disorders have traditionally been clearly separated, with communication between the two being mainly by doctor's letter.[1,2] Poor communication between the services, and the general practitioner's perception that those working in specialist psychiatric services are unaware of the familial and social context of patients' symptoms have been major and long standing problems.[3] Specialist services only see a small proportion of the people with psychological problems: between 5% and 20% of those known to the general practitioner are referred.[4] Younger patients, male patients and patients with psychotic illnesses are preferentially referred. The low referral rate is partly because of stigma, and partly because general practitioners consider that the psychiatric service offers treatments with little relevance to the problems of patients in primary care.[5]

The closure of mental hospitals and the development of community mental health policies has encouraged the expansion of specialist care into the community. This has taken place in three ways: an increasing number of psychiatrists have moved their outpatient services out of hospital bases and have established clinics in primary care; community mental health centres, staffed by multidisciplinary teams, have been established in some places; and elsewhere, community psychiatric nurses and psychologists are establishing their own independent links with local primary care services.

Although many psychiatrists now conduct outpatient clinics in primary care, the commonest pattern of work is the 'shifted outpatient' model, in which the psychiatrist conducts a normal outpatient clinic in general practice premises, often during a time when the general practitioners are not in the practice and contact with them may, therefore, be infrequent. The consultation–liaison attachment developed by Creed and Marks[6] is a model in which the psychiatrist attends a primary care meeting to discuss management of several difficult patients with primary care staff, after which the psychiatrist sees several patients, often with the general practitioner. The general practitioner continues to provide treatment for the patient, but is able to benefit from joint management plans, as well as to seek advice about patients whom he or she does not wish to refer. This allows specialist advice to be available in a flexible way according to the needs