Making London better?

THE publication of Sir Bernard Tomlinson's *Report of the inquiry into London's health service, medical education and research* in October 1992 presented London's general practitioners with both opportunities and threats.[1] Much of the initial response centred on the threats and, in particular, the perceived threat to the provision of adequate secondary care in London.[2] In the particular circumstances of London general practice, this response is not surprising and must be understood and acknowledged before advantage can be taken of the opportunities. Policy issues in the National Health Service must always be open to criticism if the NHS is to remain a viable institution. The playwright Tony Kushner, writing about the acquired immune deficiency syndrome (AIDS) in the programme for his play *Angels in America*, reminds us that 'compassion has to do with passion, that health care is a political issue and a human right'.

As we know from our patients, when morale is low the imposition of change brings the threat of danger and not the promise of opportunity. For general practitioners, morale is lowered by the strain of trying to deliver health care against a background of government policy riven by contradiction. The government makes constant reference to the spectre of the bottomless pit of health expenditure while spending well below the per capita average for the developed world (Organization for Economic Cooperation and Development data, 1985); it exhorts general practitioners to achieve targets for smoking cessation among their patients, while refusing to ban tobacco advertising. General practitioners are required to marry up the consumerism of the patients charter,[3] the rhetoric of *The health of the nation*[4] and the health implications of the insidious socioeconomic degradation of the vulnerable groups in our society. It is not easy to work at the interface of these three aspects of government policy and not become sceptical about government agendas. This affects all general practitioners in all parts of the United Kingdom but the evidence of the socioeconomic polarization of society is perhaps most obvious in London,[5] where extremes of poverty and affluence coexist, often within the same geographical locality. We are exhorted to reinforce family values and yet we all know of young families with no prospect of employment or adequate housing. We have seen investment in schools and adult education seriously eroded and local authority spending reduced. The government has pursued a policy which results in socioeconomic polarization, and it must be aware of the implications this has for the health of the population.[6,7]

London general practitioners work against this background often from inadequate premises and with little support from the extended primary health care teams which are the norm in other parts of the UK. The Acheson report recognized this,[8] and yet none of the recommendations of the report, aimed specifically at London, has been implemented.[9] It was, therefore, not surprising that when reading the Tomlinson report London general practitioners saw a licence for hospital closure and little else. London general practitioners have always had difficulties gaining hospital admission for their patients in an emergency[10] and in the past we were told that this was because so many people were coming to London hospital beds from outside London. With the arrival of the 'internal market' (NHS and community care act, 1990), this is no longer true and now, instead of these beds being available for London patients, we are told that they are surplus to requirements and must be closed.[1] Our daily experience of a shortage of beds does not tally with the statistical assertion that London has too many hospital beds.[11]

The publication, in February 1993, of *Making London better*,[12] the Department of Health's response to the Tomlinson report, has done little to address the fears of London general practitioners or indeed the concerns expressed in the response of the Royal College of General Practitioners,[13] although it did state that 'The government recognizes the concern that hospital rationalization will be forced by the decisions of purchasing authorities before the necessary improvements in primary and community care are in place.' It is proposed that £170 million will be spent over six years on improvements to primary care premises and other capital projects[12] whereas the King's Fund Commission recommended a £250 million programme of investment.[14] The Tomlinson report acknowledged that 46% of general practitioner premises in London fail to meet minimum standards. Any extended role for primary care will have considerable space requirements and, in that context, many more premises become inadequate. Existing minimum standards make no provision for the space required for teamwork, undergraduate teaching, postgraduate training, research, minor surgery or consultant outreach sessions. A current estimate for building new premises to minimum standards for the six doctor practice in inner London in which I work is £1.2 million. The sums do not add up. The Department of Health estimates that 2000 to 2500 hospital beds will be lost in London over the next four to five years which presents an unrealistic timescale for the corresponding developments in primary and community care. Finally, the Department of Health has made no response to the widespread concern that improved primary care will facilitate access to screening and diagnostic services and thereby increase, rather than decrease, needs for acute secondary care.

In crucial respects, the Department of Health's response falls short even of the Tomlinson report's limited version, for example, in its failure to respond to the specific proposals on the provision of care for mental illness and mental handicap. The closure of long stay mental hospitals may have allowed some patients to lead more fulfilling lives in the community, but the erosion of provision is now such that it has become increasingly difficult to admit acutely ill and disturbed patients.[15] This places an insupportable burden on families and results in the increasing number of severely mentally ill patients living on the streets.[15]

However, our commitment to the care and welfare of our patients behoves us to explore the opportunities we are offered. It is clear that NHS managers are looking to general practitioners to move forward and are looking for ways to provide support. The opportunities, as is so often the case, are at the interfaces of existing provision.[16] We have the opportunity to shift the boundaries which exist between general practitioner and specialist, between hospital and home, and between service activity, research activity and teaching activity. We need to explore new models of practice across all these boundaries and the time is right to do so.

Hospital outpatient departments, the existing boundary between general practitioner and specialist, have long been in need of reform. A patient with a chronic disease attending hospital regularly every few months should not see a different junior doctor each time, nor should patients whose general practitioner has requested emergency admission have to queue in the accident and emergency department as if they had walked in from the street. We must explore and evolve new and cooperative methods of working across this boundary. Unfortunately, from personal experience it seems that the fragmentation of the provider side of the health service into trusts tends to undermine cooperative working. Nonetheless, we have the possibility of

developing methods of working with specialist colleagues to provide a service which is much more responsive to the individual patient and can be delivered locally. Consultants visiting surgeries to see patients can provide a much more focused opinion if they have already had the benefit of discussing the patient's history with the general practitioner and other members of the primary health care team. We can evolve structures in which students can learn across the boundaries between different disciplines to achieve a wider view of the patient, his or her illness and its impact.

Increasing general practitioner involvement in purchasing services is forcing general practitioners to look beyond their traditional preoccupation with the care of the individual and the family. They are beginning to consider and to try to define the health needs of their registered population as a whole but have little relevant expertise. We need to develop cooperative working with our public health colleagues whose central responsibility is defining public health needs.[17] Public health physicians are often isolated from their communities and a closer working relationship with general practitioners would allow them access to a mine of information about the local population. General practitioners must remain the advocates of the individual patient, public health physicians the advocates of the population, but there is much to be achieved at the boundary. At the very least, general practitioners and public health physicians can work together in the vital tasks of assessing needs, identifying gaps in provision, and amassing statistical rather than anecdotal evidence of unmet need.

The provision of low dependency beds, recommended in the Tomlinson report, gives community nurses an opportunity to extend the range of service that they provide. If low dependency beds are managed and staffed by community nursing teams with medical back up from general practitioners, the frail elderly patient being cared for at home by district nurses, for example, can be brought into a nursing bed for the treatment of an acute chest infection to be cared for by the same team. Hospital admission is avoided and discharge arrangements can be made between members of the same nursing team.

The inner city task force of the Royal College of General Practitioners is embarking on a survey of practices in deprived urban areas to identify innovative solutions to the delivery of health care in a difficult environment. The hope is that the dissemination of these solutions will empower us to seize the opportunities we have.

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Reaccreditation for general practice

RECENT changes in the National Health Service — and in general practice in particular — have been enormous. They have been so great that an issue which might have been expected to produce major headlines has come to prominence with surprisingly little controversy. The principle of reaccreditation for general practice, potential anathema to many in the profession, was implicitly accepted by nearly two thirds of those general practitioners responding to the General Medical Services Committee's 'Your choices for the future' survey early in 1992.[1] The political and managerial pressure towards reaccreditation may be great, but the United Kingdom has no strong tradition for reaccreditation of its professions, unlike other countries.[2,3] This is such a fundamental matter that, although we must recognize the external pressure, we should proceed cautiously if major difficulties are to be overcome. The establishment of reaccreditation for principals in general practice implies withdrawal of the licence to practise unsupervised for those who do not achieve the required standard. There are many organizational, ethical and legislative worms within such a can.

The case for reaccreditation is strong. Almost 40 years ago, seminal work by Peterson[4] showed that any link between levels of achievement at undergraduate and postgraduate stages of family medicine was lost after the age of 35 years, and that other factors became more important in determining the competence of the established doctor. This is easy to understand. Anyone who completed vocational training more than 10 years ago will be aware that they are practising in a wholly different world from that in which they were students. They have little or no knowledge of new technological procedures used in hospital; the pharmacopoeia has all but been replaced; and patients (and managers) have very different expectations about the provision of care. It could be argued that medicine has always been a rapidly changing field, and that the profession has invariably responded effectively to change in a voluntary way. However, such are the pressures of general practice today that reaccreditation should perhaps be seen as potential protection rather than a threat.

Furthermore, general practice has been prominent in steps towards reaccreditation of the medical profession in the UK, and we have a foundation on which to build. Selection and reselec-