

The new general practitioner?

THE Royal College of General Practitioners was founded in 1952 at a time when intense controversy surrounded British general practice. The Collings report in 1950 had been very critical¹ whereas just three years later Taylor produced many examples of good British general practice.² The controversy surrounding these events stirred the Department of Health and Social Security into fairer financial provisions for family doctors and their practices. By 1965 the improving terms and conditions of service for doctors and the associated charter for general practice led to the creation of a service that was jealously regarded from other countries where clinical generalists had perished and with them the gatekeeper to all specialist services and one of the most effective barriers to the excesses of specialist medicine.

Clinical standards have always been the legitimate business of the Royal College of General Practitioners and the most basic means of standard setting is to define the tasks of a doctor in terms that can be audited and re-fashioned in the light of progress and new discovery. An influential job definition for the general practitioner was published by an RCGP working party in 1972:

'The general practitioner is a doctor who provides personal, primary and continuing medical care to individuals and families. He may attend his patients in their homes, in his consulting-room or sometimes in hospital. He accepts the responsibility for making an initial decision on every problem his patient may present to him, consulting with specialists when he thinks it appropriate to do so. He will usually work in a group with other general practitioners, from premises that are built or modified for the purpose, with the help of paramedical colleagues, adequate secretarial staff and all the equipment which is necessary. Even if he is in single-handed practice, he will work in a team and delegate when necessary. His diagnoses will be composed in physical, psychological and social terms. He will intervene educationally, preventively and therapeutically to promote his patient's health.'³

This definition has been criticized in the nineties for its sexist, paternalistic, undisciplined and all embracing tones. Nevertheless, most doctors would probably agree that the 1972 job definition stood the test of time, particularly as it was written for general practice rather than for the primary care team. By 1987, the RCGP had expanded its vision of teamwork⁴ and the Leeuwenhorst European definition had also emphasized a wider professional responsibility to the community.⁵

In the networking nineties the new contract for general practitioners was imposed with governmental determination to contain the cost of the National Health Service by deregulating monopolies, blurring the boundaries between all professional groups, shifting institutional care into the community and encouraging competition with consumer voice and choice. General practitioners of the 1980s whose training in clinical breadth had provided the gate to specialist clinical depth found that they were being instructed by politicians to learn to become cost-conscious purchasers of services in addition to the panoply of provider responsibilities. The aspirations of the many professions allied to medicine were also being encouraged to compete for tasks and the primary care team was growing at an extraordinary rate. Home grown general practices of the 1970s were being spun into the big primary care networks of the 1990s with huge new communication needs because every additional team member takes more formal and informal time for interaction. Complex contexts

absorb more time than simple working arrangements.⁶

The general practitioner in the nineties has a more task-sensitive contract, yet has continuing 24-hour responsibility to a patient list, and a burgeoning network of paramedical, social and lay experts with whom he/she is expected to communicate to provide a network of primary provision: curing, caring, rehabilitating, preventing and health promoting. The past emphasis on the continuing doctor-patient relationship is being displaced by an emphasis on teamwork, team building, consumerism, networking, computer aided communications, sophisticated purchasing skills and commercial incentives.

What manpower provision has the government made for these new demands on general practitioners? What is the relationship between quality and quantity in relation to clinical skills and managerial skills? Is the breadth of skills demanded of the new general practitioner so wide that a crash is inevitable as market forces (that always favour specialist incomes) are unleashed? Has teamwork been shown to compensate effectively for the loss of personal medical care? Do health gain targets arise from specialist or generalist principles? What does task orientation do for generalist clinical standards, morale and public support?

The first of these six questions has been answered in the reports on medical manpower.^{7,8} The number of specialists increased at over 2% per year between 1986 and 1991 and the medical manpower projections for the United Kingdom reveal a steep increase in the number of specialists (not all consultant) into the next century, notionally to compensate for the planned reduction in the number of junior hospital posts and expansion in most specialties. In contrast, the rise per year in the number of general practitioners in England and Wales between 1986 and 1991 was less than 1%. Only 94 new unrestricted principals were appointed in the two years 1989 to 1991, an increase of 0.35% over two years or 0.17% per annum.⁸ Neither of the recent reports on manpower is clear about whether 13 hour, 19 hour and 26 hour contract practitioners are counted as equal in the manpower calculations.^{7,8} The Medical Manpower Standing Advisory Committee anticipated increased spending on primary care but mainly directed at 'a wide range of improvements, not just increased numbers of general practitioners'.⁷ The committee accepted the impact of the 1990 general practitioners' contract and patient's charter on the already increasing demands on general practitioners but decided that they were 'unable to quantify any measure of that increase at the present time'.⁷ The message is clear: a more specialist-based hospital and community service is planned with a near-static general practitioner workforce, yet an expansion of general practitioner responsibilities is occurring which can only be met by delegation to paramedical workers. A relative decline in the ratio of doctors entering general practice as a career (0.65 to 0.61 over the five years to 1991) and the number of vocational trainees in 1991 being 4% less than the 1985 peak⁸ are additional pointers to what the new general practitioners will be facing at the turn of the century.

The unravelling of the paradox of a shift of health care into the community without an increase of generalist medical manpower must surely help us to understand the government's intentions for the next decade.

The other five questions are being considered by a new working party chaired by the chairman of the education network of the RCGP, Bill Reith, and a joint Welsh Council/Welsh General Medical Services Committee working group is also revisiting the future general practitioner. Both groups should report in 1994. Their deliberations are informed by the views of all faculties who

responded to the RCGP honorary secretary's call for informed comment last summer. Anyone who feels that they have an important contribution to make to the 'task of the new general practitioner' should send evidence soon to the chairman of the education network at Princes Gate, London, or to the chairman of the joint Welsh Council/Welsh GMSC working group, at the address below. The jury is still out on what is professionally realistic for the new general practitioner in the networking nineties and beyond: the time has come to reconcile the political agenda with professional realism and responsibility.

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Does lipid-lowering therapy promote regression of coronary atheroma?

LIPID-LOWERING therapy in patients with high cholesterol levels has been shown to reduce their risk of death from coronary heart disease.¹ Lowering elevated cholesterol levels might therefore be expected to slow down the rate of atheroma progression, but should it also be expected to promote regression? Direct pathological evidence of atheroma regression has been observed in the coronary arteries of animals,² but these results cannot necessarily be extrapolated to the human situation, particularly in view of the strictly controlled conditions used in animal experiments. How good is the evidence that lipid-lowering therapy in humans can produce atheroma regression, or is a slowing of disease progression the best that can be achieved? We have conducted a meta-analysis of all randomized controlled trials of lipid-lowering therapy on coronary atherosclerosis to evaluate the evidence for regression in humans with particular reference to the magnitude of any changes in disease and potential problems such as methodological bias, measurement variability and other pathological processes which might lead to an appearance of arterial widening.

Since 1985, the effect of lipid-lowering therapy on underlying coronary atherosclerosis has been reported in six randomized controlled trials.³⁻⁸ Five of these were carried out in the United States of America: the National Heart Lung and Blood Institute (NHLBI) type II coronary intervention study,³ the cholesterol lowering atherosclerosis study (CLAS),⁴ the program on the surgical control of the hyperlipidaemias (POSCH),⁵ the familial atherosclerosis treatment study (FATS),⁶ and the University of California San Francisco intervention study (UCSF).⁷ Only one randomized controlled trial has been performed in the United Kingdom: the St Thomas' atherosclerosis regression study (STARS).⁸

The study methods have varied considerably between the trials. Each study included subjects with hyperlipidaemia and angiographic evidence of disease, but otherwise the clinical groups were quite different. For example, CLAS was restricted

to subjects with previous coronary artery bypass grafting,⁴ the POSCH study to those who had suffered a myocardial infarction,⁵ and STARS to those with angina;⁸ women were not included in three of the studies.^{4,6,8} The treatments comprised mainly lipid-lowering drugs (either cholestyramine,^{3,8} or colestipol combined with niacin^{4,6,7} or lovastatin,^{6,7} an HMG-CoA reductase inhibitor), but also included partial ileal bypass in the POSCH study,⁵ and a dietary regimen in STARS.⁸ The duration of follow up ranged from two^{6,7} to 10 years.⁵ Each study used angiography to estimate the degree of coronary artery disease before and after treatment, combined, in the more recent trials, with a computerized technique to define the amount of atheroma.⁶⁻⁸ As in most intervention trials there were several methodological problems, particularly selection bias in those studies which recruited only individuals who demonstrated a suitable response to drug therapy,^{4,8} together with the incomplete collection of data from around one quarter of subjects entered into each trial. In addition, not all trials were double blind,^{4,7,8} and some participants also consumed other drugs,^{4,6,7} particularly aspirin which may reduce the progression of plaque by inhibiting platelet function.⁹

Despite the use of different criteria for patient selection, and the varying treatment regimens, the trials consistently showed a significant slowing of disease progression in treated subjects compared with controls. Regression of atheroma was also demonstrated in a minority of patients, between 6%⁵ and 39%⁶ of those receiving treatment. Analysis of the results in terms of severity of the initial stenoses showed more regression occurring in advanced plaque (greater than 50% reduction in luminal diameter), than in less severe disease.^{3,7,8} This might have been expected, as advanced plaque generally has a substantial cholesterol content which could be mobilized by lipid-lowering treatment. In the POSCH study, which examined the relationship between angiographic change and subsequent clinical events, a significant association was found between definite progression of