# The importance of general practice in a primary-care-led National Health Service

BRITISH general practice is the envy of many other countries, yet recruitment is falling,[1,2] morale is low,[3,4] and there is considerable anxiety about possible additional workload as more patient care moves to primary care and general practice. The changes in the National Health Service (NHS) are creating opportunities to strengthen primary care, and the Secretary of State for Health has indicated that the Department of Health is actively listening to the views of general practitioners and their teams to gather their ideas on the possible future roles for primary care.[5] General practice now needs to take stock of what it can offer to a primary-care-led NHS and how it should develop in the future.

Perhaps the most important feature of primary care is the vital role played by the clinical generalist.[6] General practice is not the sum of a range of specialities undertaken in a more superficial way, it has knowledge and skills that are peculiar to it. General practitioners are skilled in using knowledge of disease together with an understanding of the patient and their social context, including their work and home environment, to help formulate a diagnosis. We rely on clinical skills, including consultation skills, rather than investigation and technological intervention. We are skilled in picking up small verbal or nonverbal clues which help to direct us to the likely cause of a patient's symptoms. We tolerate uncertainty and minimize risk. The changes in our Contract which were introduced in 1990 may have temporarily altered the focus of the strengths of general practice, and it may appear that we have been diverted from our prime function: delivering personal care to individuals and their families. Whether practices are fundholding or working as members of a purchasing consortium, providing care entirely through traditional surgeries or using the opportunities of the new contract to set up clinics for the care of patients with chronic disease and to deliver health promotion, there needs to be consistency of care. Every individual patient should be confident that they will receive high-quality primary medical care when they need it, and through that primary care, have access to appropriate secondary care.

To an outsider, it may seem that general practice is staffed by expensively trained medical clinicians, much of whose work seems trivial and could be undertaken by nurses. It is true that some of our work, particularly the management of patients with chronic disease, could be undertaken largely by nurses who have been suitably trained; Hasler[7] has described how a primary health care team can work together effectively to develop a wider range of services for patients. What is not yet clear is whether it is possible for a nurse working in primary care to diagnose and manage illness independently. Although it may be possible for a nurse to provide an initial contact point for patients presenting with minor illness, medical education, including a broad experience of clinical disease, equips a doctor to consider a range of alternative diagnoses. Nurses work to protocols extremely well, their success in improving care of patients with diabetes and hypertension is undoubted, and they work effectively in triage in a hospital setting, but research is needed to establish whether nursing training provides the clinical skills necessary to handle multiple problems in a single person. Nurses' knowledge of medicine is more limited than that of doctors and they are less likely to be able to exclude rare but life-threatening conditions, and unlikely to be sufficiently knowledgeable to be curious about an unusual presentation. Nurses, like doctors, are in short supply, so the NHS needs to use their skills wisely, neither asking them to substitute for a doctor nor asking them to be a doctor's handmaiden. There is urgent need for clarity about the role of practice nurses and nurse practitioners working in primary care.

Although many general practitioners work in a secondary care setting on a sessional basis, and increasingly provide services which have traditionally been the responsibility of secondary care, our strengths lie in our work in primary care. If we are asked to take on more work which has previously been the province of secondary care, there will be less time for our traditional role. If we are asked to become too specialized in one or two areas within medicine, such as gastroscopy or colposcopy, this may be to the detriment of our abilities as a generalist. How then should we influence and control the general trend to move more patient care to primary care, so that we enhance the strengths of primary care and create opportunities for more effective use of secondary and tertiary care?

The purchaser–provider split creates as many opportunities as threats to good primary care. General practitioners have largely focused on their role as purchasers, perhaps we now need to consider how we should respond as providers. What are the core competencies that a health authority might expect from good primary care, and how might they be measured? Are we ready to reconsider our personal contract and think about what clinical care, managerial standards, professional values, and commitment to education, training and research a health authority might expect from a general practice? As we approach a new millennium, it may be time to think about a practice contract which defines the primary medical care services, health promotion and disease prevention the population registered with the practice might expect. In setting up a new contract, we must be clear about our main function as generalists. Health authorities should not seek or expect additional services until they have assured themselves that the generalist services are well established and will not be compromised by taking on an extended role.

Once we are clear about the clinical standards we expect to provide for our patients, it should be possible to think through how those services might best be delivered to meet the health needs of the local population. This will identify the resources needed, such as medical, nursing and administrative personnel, their education and training needs, information support systems, and buildings. It will also clarify what we expect from secondary care, both in clinical standards and in accessibility, and which of those services might be provided by the practice, without disturbing our prime function as generalists.

The skills needed to develop such a system are high level. These include the ability to think strategically and to negotiate effectively; the general practitioner will need a high level of clinical competence, as well as the ability to monitor their own work and ensure that clinical standards are met consistently. The current training for general practice is only 3 years, the shortest of all the medical disciplines, yet in a primary care led health service, the general practitioner will take a key role. It is time to reconsider our training, and identify funding for all doctors preparing for a career in general practice, so that they can spend time gaining these additional skills. Health authorities are cur-

rently funding, through the medical education levy, training in research and managerial skills for specialist registrars. As we move towards a health service in which the focus is primary care, it seems unusual that this opportunity is not available for those pursuing a career in general practice. Higher professional education is a concept which as been promoted by the College[8] and included in the proposals to develop education and training in general practice.[9] One of the strengths of general practice is the diversity in its mode of delivery; it seems likely that higher professional education programmes will need to cover a range of learning opportunities, from the practical, practice-based skills to those of academic general practice. A modular approach to course provision may be one solution, allowing doctors to define their own programmes, perhaps with the help of a mentor. Many of the modules could build on existing programmes, encouraging multi-disciplinary learning. Not all doctors completing vocational training will want to become principals in general practice.[10] It seems that there is need to look imaginatively at the years beyond vocational training, creating new, time-limited posts which could meet a service need, such as development of inner city practices, together with an opportunity for the individual doctor to enhance their own skills. Some doctors may want to pursue an academic career—there are currently few opportunities to gain research skills in general practice—and two regions have already identified funding to develop research practices,[11] but these initiatives need to be supplemented by the creation of new posts which will prepare future leaders in general practice for an academic career and increase the evidence base of primary care.

If our health service is to be truly led by primary care, then all professions working in the health care system need to understand the strengths and limitations of primary care. We will need confident, competent general practitioners, who are able to lead their practice team and develop good working relationships with health authorities so that effective commissioning is established. We will also need to work with secondary care health professionals to strengthen relationships and use resources appropriately. What is essential is that general practice continues to be the main provider of primary care, and that the health service builds on the strengths of the clinical generalist, valuing breadth of knowledge as much as depth, and skills in listening and empathy as much as those of high-tech intervention.

JACKY HAYDEN

*Regional adviser in general medical practice, Department of Postgraduate Medicine and Dentistry, The University of Manchester*

## References

1. The Medical Practices Committee. *Medical practices recruitment survey.* London: The Medical Practices Committee, 1995.
2. General Medical Services Committee. *Medical workforce–task group report.* London: British Medical Association, 1996.
3. McBride M, Metcalfe D. *General Practitioners' low morale: reasons and solutions* [editorial]. *Br J Gen Pract* 1995; **45:** 227-229.
4. Leese B, Bosanquet N. Changes in general practice organization: survey of general practitioners' views on the 1990 contract and fundholding. *Br J Gen Pract* 1996; **46:** 95-99.
5. NHS Executive. *Primary care: the Future. The Debate.* London: Department of Health, 1996.
6. The Royal College of General Practitioners. *The nature of general medical practice. Report of a Working Party.* Exeter: Royal College of General Practitioners, 1996.
7. Hasler JC. *The primary health care team.* London: Royal Society of Medicine Press, 1994.
8. Royal College of General Practitioners. *Education and training for general practice policy statement number 3.* London: Royal College of General Practitioners, 1994.
9. NHS Executive. *Hospital doctors: training for the future. Supplementary reports by the working groups commissioned to consider the implications for general medical practice, overseas doctors and academic and research medicine.* London: NHS Executive, 1995.
10. Baker M, Williams J, Petchey R. GPs in principle but not in practice: a study of vocationally trained doctors not currently working as principals. *BMJ* 1995; **310:** 1301-1304.
11. Pereira Gray D. Research practices [editorial]. *Br J Gen Pract* 1995; **45:** 516-517.

**Address for correspondence**

Dr Jacky Hayden, Department of Postgraduate Medicine and Dentistry, The University of Manchester, Gateway House, Piccadilly South, Manchester M70 7LP.

# Experts and evidence

General practitioners have traditionally been the recipients of expert advice. With literally thousands of medical journals in existence, no general practitioner can satisfactorily follow all the original work in every field of medicine, or even one or two. Therefore, we have increasingly relied on the specialist, particularly through the medium of the clinical review article.

However, Antman *et al*[1] found that, when traditional review of literature by clinical experts was compared with meta-analysis[2] of trial results, the expert reviews did not identify important advances demonstrated by meta-analysis, and conversely, recommended other treatments for which evidence was equivocal. It is increasingly recognized that reviews of the conventional sort are likely to be seriously flawed.[3,4] There is a distinct tendency for traditional reviewers to exert subjective selectivity, whether consciously or unconsciously, in what is included in their review. Indeed, Sackett[5] only half-humorously suggested that '... the reason for this deficiency in reviews lies in the tradition of calling upon content-area experts to produce them. By the virtue of their expertise, these authors begin their task with a conclusion, backed up especially by their own work, and invested with not a little of their personal reputations....'

Unsystematic review is only part of the problem. Traditional reviews may not distinguish good from poor research, and much research is of poor quality. Altman[6] described how the twin pressures of poor research training and the need for clinicians in training to produce publications in order to secure promotion conspire to produce what he characterized as 'the scandal of poor medical research'. Publication in a peer-reviewed journal is no guarantee that the research is scientifically sound. Both the current and past editors of the *British Medical Journal* have expressed serious reservations about the system of peer review,[7,8,9] although there may be no better alternative. The unacceptable face of increasing pressure to publish for the purpose of promotion is increasing evidence of scientific dishonesty, exploitation[10] and outright deception,[9] all of which is difficult to detect.