Will the future GP remain a personal doctor?

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SUMMARY

During the past three decades, general practice has evolved into a form of primary health care that provides a wide range of reactive, anticipatory, and preventive services, and now also purchases secondary care. As a result, practices now have more staff and more complex patterns of organization. However, most patients prefer smaller practices and personal list systems. There is a danger that a core feature of general practice — personal care — is gradually being eroded. If this trend is to be halted, the organization of general practices and the support available to them must be revised so that they can continue to provide personal care, yet also offer a wide range of effective services in the community.

Keywords: general practitioners; continuity of patient care.

Introduction

FOR many years, personal care has been recognized as a core characteristic of general practice. It was a principal component of the influential definition of the general practitioner's (GP's) job published in 1969,[1] and within the past year the central importance of personal care has been restated by the Royal College of General Practitioners,[2] the General Medical Services Committee,[3] and the Department of Health.[4] Despite this degree of concordance, concern has been expressed that personal care is under threat.[5,6] In this paper I will argue that personal care is indeed in decline, but that this is not simply a consequence of the recent health service reforms but is explained by problems that are more fundamental. These include the lack of a common definition of personal care and long-standing and almost irresistible pressure to transform general practice into comprehensive primary health care.

'Personal' is defined in the Oxford English Dictionary as 'one's own', 'individual', 'private'; thus, personal care can be viewed as being care of individual patients in contrast to groups of patients. However, it is not merely quantitatively different from the care of populations, it is also qualitatively different. It is tailored to the requirements of the individual, some of which may be so sensitive, complex, and difficult to articulate that they must be protected by privacy. While consultations with individual patients will, to a considerable extent, determine whether care is personal, the operation of other elements of care, in ways that meet the requirements of individuals, also has an influence. Continuity of care may determine the degree to which a personal relationship between doctor and patient is allowed to develop,[7] and the size and organization of the service as a whole may influence whether patients perceive care as designed to meet their individual requirements. Therefore, to understand the decline in personal care, it is necessary also to consider continuity and the organization of care.

From general practice to primary health care

There have been substantial changes in the structure and organization of general practices in association with the development of an extended role for the GP. Figure 1 shows that the percentage of GPs in England and Wales in single-handed practices fell from 21.7% in 1969 to 10.4% in 1994, and the percentage in practices of four or more principals increased from 26.3% to 58.9% (additional data provided by Department of Health).[8,9] The mean number of whole-time equivalent ancillary staff, such as receptionists, practice nurses, and practice managers, increased from 0.9 per principal in 1976, from when data are available, to 2.0 in 1994, causing a rise in the mean number of ancillary staff per practice from 2.0 to 5.9 (Figure 2).[8,9]

Group practice, provided from modern, well-equipped premises and staffed by a large multidisciplinary team, has become the norm. For example, in a study of changes in 124 practices between 1982 and 1990, substantial proportions of those practices gained a practice manager, a practice nurse, an age-sex register, and a computer, and set up blood pressure and child development screening schemes.[10] While the growth in size and complexity of primary health care has been accelerated by the recent health service reforms,[11,12,13] the process has been underway for much longer, as Figures 1 and 2 show. Concern about quality of care and practice management in some general practices,[14,15] the introduction of preventive and anticipatory care,[16] and the extension of primary care to relieve the burden on secondary care have combined to produce a powerful force dictating the future of general practice. In these circumstances, abandonment of fundholding might have little effect, as it would inevitably be replaced by an alternative arrangement in response to the underlying forces at work, and general practice would continue on its relentless progress towards larger, more complex primary care units.

Impact on personal care

What impact have these developments had on the provision of 'personal, primary, and continuing medical care'?[1] While GPs are now providing an extended type of primary health care that includes health promotion and the management of patients with chronic illness, there has been only limited investigation of the consequences for personal care. However, information is available about how continuity and elements of practice organization influence patients' perceptions.

Continuity of care has been argued to be an important prerequisite to the development of a personal relationship between doctor and patient, although continuity alone cannot guarantee the development of such a relationship.[7] The quality of communication may also influence the degree to which care is personal, since a succession of consultations characterized by poor communication may generate less personal care than a few consultations with good communication.[17] A proportion of patients may feel that availability or choice are more important than continuity.[18] Nevertheless, there is substantial evidence about the importance of continuity in influencing patient satisfaction and other aspects of outcome. Higher levels of continuity are consistently associated with higher levels of satisfaction amongst groups of patients.[19,20,21] Furthermore, being able to see the same doctor has been rated by patients as among the more important features of general practice.[22]

Continuity influences other aspects of care in addition to satisfaction. In one study, patients who felt they knew their doctor well were more likely to comply with treatment.[23] In a Norwegian study, if the GP had accumulated greater knowledge

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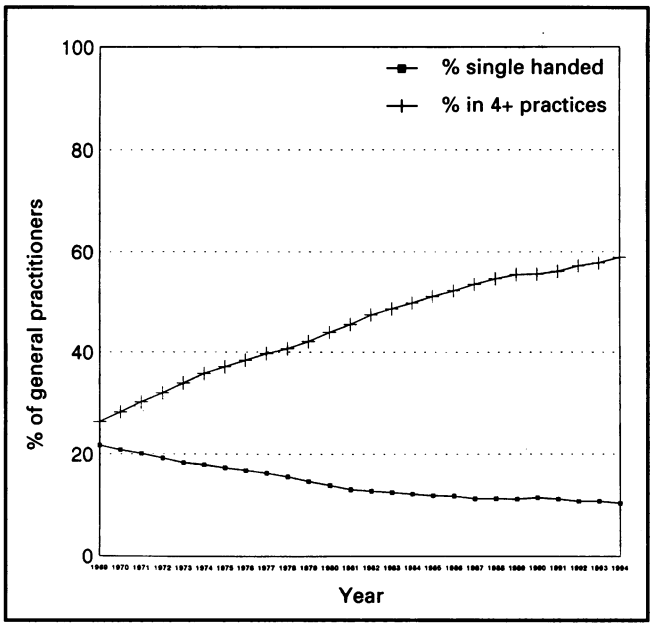

Figure 1. Percentages of general practitioners in practices with one, or four or more principals. England and Wales, 1969-1994.

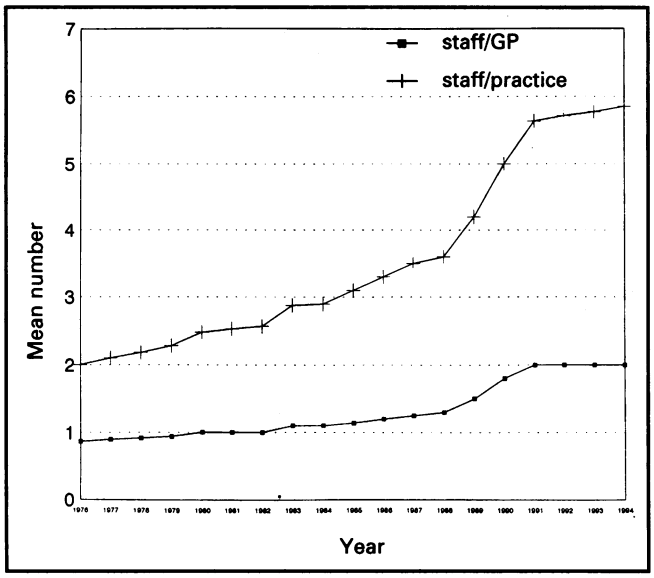

Figure 2. Mean numbers of whole time equivalent ancillary staff per principal and per practice. England and Wales, 1976-1994.

of the patient through previous consultations, it was likely that fewer tests would be used and slightly fewer prescriptions issued, but expectant management, use of sickness certificates, and referral would be more likely.[24]

Practice organization may also influence whether patients perceive care as personal. For example, the level of continuity of care can be higher in practices that have personal list systems,[17,18] and also in smaller practices.[25] Several studies have consistently shown that smaller practices are preferred to larger ones,[25,26,27] with larger practices being perceived by patients as offering reduced availability[28,29] and having more complex organizational structures, such as complicated appointment systems.[25] Satisfaction with consultations, including patients' opinions on the depth of relationship with the GP, is also associated with organizational features such as personal list systems and practice size.[30] The association between increasing size of primary care organizations and declining patient satisfaction is also found in the USA.[31]

The trend in general practice for almost three decades has been towards the development of larger practices that provide a wider range of services. However, patients are more satisfied if practices are smaller and provide a more personal service. Although the quality and efficiency of care must be improve, and opportunities to shift services from secondary to primary health care must be explored, there is a danger that patients will become increasingly disenchanted with the less personal style of practice. Research evidence about the impact of reforms on the provision of personal care is limited, and there is even less evidence about how services should be structured and operated to ensure efficient, modern primary care that is also personal. Research in general practice has a short history and is less well-developed than in other medical disciplines. In consequence there is little direct information about the impact of the reforms on personal care.

Furthermore, despite considerable rhetoric about the importance of patients' views they do not have an equal voice in planning services. Patient satisfaction is still sometimes referred to as a 'soft' outcome; a point of view that is reinforced when the methods often used to measure it are inappropriate and poorly discriminating, thereby creating the misleading impression that patients are invariably satisfied.

Is personal primary health care possible?

It would be wrong to view the case for personal care as an argument for resurrecting the isolated and inefficient small practices of the past. Modern practices must offer a wide variety of services. They must operate efficiently and relieve the costly burden on secondary care to the benefit of the service as a whole. They must provide care that is guided by current best evidence, and be open to audit and comparison with peers. They must enable the practitioners who work within them to avoid burnout and remain up-to-date and satisfied with their work. But it would also be wrong to demand that patients choose between personal care and comprehensive, efficient care. Those patients who want care that is both personal and efficient (the majority) are not making an unreasonable demand, and we should seek methods of providing care that has both these attributes in full.

One potential method for redressing the balance towards personal care is to improve GPs' communication skills to make individual consultations more personal.[32,33] However, although communication skills should be improved, the extent to which they could compensate for less personal organization of services is not clear. Indeed, more personal organization might improve consultations. Therefore, organizational changes are also required, which will ensure the provision of care from a personal doctor while at the same time providing a full range of effective and coordinated services. Several models for the organization of general practice are now emerging that may offer solutions.

The new approaches have in common the creation of coordinating agencies, with several local practices relating to the agency. The consequent advantage is that the GP, if he or she wishes, can be relieved of several coordinating and management activities. While a full range of services would be available in the community through the coordinating agency, the practice itself would be smaller and less complex in organization, and therefore the likelihood of personal care would be increased. The functions of the agency might include the operation of services shifted from secondary care, activities to support practice management, purchasing on behalf of affiliated practices, and audit and monitoring activities. For example, services operated by the agency might included physiotherapy, outreach clinics, and organization

of out-of-hours services. Practice management support might include help with business planning, team building, employment and training of staff, and handling of complaints.

The emergence of arrangements of this type can be seen in the creation of agencies such as multifunds, primary care trusts, or agencies[34] and resource centres.[35] The Independent Practitioner Associations (IPAs) in New Zealand provide a more developed example of how such local coordinating agencies can be contracted by practices to providing support and promote innovation while, at the same time, preserving personal care.[36] The contractual nature of the arrangement is important because it ensures that practices do not lose control although they do delegate activities to the IPA.

Implications

There will be implications for GPs and policy makers if they decide with their patients to redesign general practice in order to preserve personal care. Policy makers should no longer be obliged to make decisions based on limited evidence. Research is required into the relationship between type of service and level of personal care, and on the impact of extending the GP's role on patients' experiences of care. For example, the decline in personal care might be one factor explaining an increase in patient complaints. It may also be undermining the ability of GPs to act as gatekeepers, leading to a rise in referrals to secondary care. More evidence is also needed about the effectiveness of different methods for enhancing personal care. Policy makers may also need to review the financial incentives that undermine practitioners' aspirations to provide personal care.

General practitioners will have to make difficult decisions about practice structure and organization. Those in larger practices need to consider the introduction of personal list systems or the creation of personal teams consisting of a GP grouped with one nurse and one secretary.[37] Practices that are particularly large may need to consider reducing their size by dividing into smaller units. The creation of local coordinating agencies would require the development of effective relationships with practices to ensure the confidence of practitioners. Some GPs may have particular skills or preferences for management and may take on a leadership role within their local agency or undertake sessional work under its auspices.

In 1969, the GP was defined by GPs as being a doctor who provided personal, primary, and continuing care. Evidence from studies undertaken since then indicates that the majority of patients agree that the provision of personal care is a key feature of the GP's role. However, strategies used to achieve the necessary modernization of general practice have eroded the ability of GPs to provide personal care. Whether current experiments in the organization of general practice will lead to the creation of coordinating agencies is uncertain, but without a re-evaluation of the long-established trend towards larger and more complicated practices staffed by growing numbers and types of professionals, there is a danger that patients will become increasingly disenchanted with primary health care services. It is now time to decide whether the future GP will still be a personal doctor, or whether he or she will be a relatively impersonal coordinator of care provided by others.

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