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## Predictions — past and present

In April 1984, a year sacred to a generation of futurologists, we proposed in a letter to the *JRCGP*, as it was then called, that GPs should be rewarded by a payment based on practice performance.

Exactly 20 years later, we have the new GMS contract. We were wrong about consultant colleagues being involved in the quality and outcome framework, but our suggestion that the seniority pay was not compatible with a compulsory retirement age has been born out, albeit not in the anticipated direction.

We feel justified, therefore, in looking forward another 20 years.

What will life be like in April 2024? Will illness be simply be the lack of wellness in an increasingly complex society, will variant CJD have proved to be the new AIDs, or will our day be spent dealing with the consequences of violence and social disintegration.

Some predictions are easy. The epithet 'new' will have been dropped from GMS sometime previously. In fact the whole contract will have disappeared. Following the GP retirement bulge around 2010, the majority of patient contact will be with others. Doctors will deal only with investigation, care planning, and obtaining informed written consent to treatment.

By 2024, following several more reorganisations of the NHS, remaining GPs will be employees of a single body managing the whole of the patient's pathway through primary and secondary care. They will split their time between hospital medicine and primary care.

With a salaried, predominantly female, shift-based workforce, the average practice size will be much larger, with a consequent move from doctor-owned premises into combined health

and social service primary care centres. In order to survive, the RCGP will become the Royal College of Primary Care Practitioners, or perhaps, reflecting wider social change, the CPCP.

The GMC will be long gone, professional standard setting being the remit of a NICE/CHAI derived quango. Reaccreditation, not even under discussion in 1984, will be a human resources function.

And a fully integrated electronic patient record will be just months away.

Doctors, as we know, are respected by their patients for the ability to predict the course of their condition.

Ironically, although the future of general practice itself is entirely transparent, our crystal ball becomes very cloudy when we try to see who will be around in 2024 to check the accuracy of our predictions.

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## References

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## Administering controlled drugs in general practice

As a general practitioner in his 25th year of practice, including on call (mainly in a local two-practice rota but sometimes for a deputising service), I decided to audit my controlled drugs register (CDR). The study period was from September 1979 to January 2003, a total of 244 months. Recorded diagnoses reflect a practical approach to patients seen and managed as emergencies in a primary care setting.

Table 1. Number of patients requiring controlled drugs, by diagnostic category.

Diagnostic categories requiring controlled drugs	(n)
Cardiovascular	142
Other chest emergencies	7
Abdominal emergencies	114
Cancer/carcinomatosis (not specified)	28
Gynaecological emergencies	6
Orthopaedic	17
Miscellaneous	
Migraine	10
Leg ulcer	1
Total	325

The total number of patients requiring a controlled drug was 325, and approximately 38 different conditions within seven categories were recorded (Table 1). Drugs used were diamorphine injection ( $n = 177$ ), pethidine injection (140), and morphine sulphate tablets (8).

A CDR does not record outcome or further management strategies (for example, hospital admission). Good communication and follow-up are clearly essential for any patient requiring this level of analgesia. A visiting doctor carrying a bag containing drugs also raises the issue of personal safety. In 25 years I have been cautious and probably lucky.

While home visits have become less popular, more patients are discharged early from hospital and there is a greater emphasis on 'packages' of care, enabling patients to remain at home for longer. The new GP contract may finally free many GPs from an on call commitment, however, the range of medical problems, their severity, and diurnal pattern of presentation will not simply go away. This creates another dilemma in adequately training our future registrars.

There is a paucity of published information on the emergency administration of controlled drugs in primary care.