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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 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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## 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.

In the aftermath of the Shipman affair, some GPs may decide not to carry opioids. This small study suggests that the overall frequency of use is relatively small (approximately 10 times per year) but may be desirable; for example, when analgesic problems occur in cancer patients who are dying at home.

From laudanum (tincture of opium) to the 21st century, will future GPs continue to carry controlled drugs?

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## The Shipman Inquiry

The proposals of the independent public inquiry into the issues arising from the case of Harold Shipman, as currently listed on The Shipman Inquiry website, include the recommendation that coroner's investigators should be trained to 'think dirty'.<sup>1</sup>

Doctors will soon learn that medical coroners are keen to discover medical error and that such a search should occur after every death. Donald Berwick predicted the response that such a search will produce, 'Any good foreman knows how clever a frightened workforce can be. Practically no system of measurement is robust enough to survive the fear of those who are measured'.<sup>2</sup>

The government is committed to implementing the Shipman Inquiry's proposals. General practitioners will then have a regular (typically every 2-3 weeks) interrogation by coroner's investigators 'thinking dirty'. It is likely that investigators will receive only superficial help in a climate of fear.

We estimate that 10% of all deaths have potentially contributory factors that may have been prevented in primary or secondary care, but only rarely have these caused the death.<sup>3</sup> A distinction now needs to be made between 'medical errors' that have caused the death and those that may have contributed to the death.

Everyone hopes that the Inquiry will indeed serve to protect the living.<sup>4</sup> To do this, it is vital that GPs and other doctors who have treated the deceased

are informed of the medical coroner's conclusions and the reasons for them.

Fearful doctors could easily, and probably justifiably, over-investigate, over-refer and over-hospitalise the main group of people who die, the frail, chronically-sick elderly. The Shipman tragedy may still cast an even longer shadow.

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## Fat intake and diabetes

It was with great interest that I read the article on 'Fat intake in patients newly diagnosed with type 2 diabetes' in the March edition of the *BJGP*.<sup>1</sup>

In 1970, I was a house surgeon at Freedom Fields Hospital in Plymouth, working under the late Mr Peter Childs. Mr Childs firmly believed that diet was the major factor for most of his patients with biliary disease, and also for the patients with diabetes. He firmly believed that the cause of type 2 diabetes was an excessive fat intake in the diet, and the vast majority of his patients were advised to have a strict fat-free diet. It is of interest to note that the main sources of saturated fats in The Netherlands are meat, spreads, and dairy products. In the opinion of Mr Childs, practicing in the West Country, the main sources of dietary fat were clotted cream and Cornish pasties!

Plus ça change!

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## Changes in perception of workload

Dr Mulka has written an excellent and stimulating article.<sup>1</sup> He certainly demonstrates a difference in workload between the years. I believe it demonstrates primarily a change in perception, not increased workload.

Numbers of patients seen are less. Time spent seeing those patients is similar, if one factors in time for visits. If one assumes 20 minutes per visit, he spent 34 hours in 1982 and 13 in 2002, or if 30 minutes, then 51 and 20 hours respectively. Added to the hours in surgery, this equals 92 or 109 hours in 1982, and 97 or 104 hours in 2002.

He sees a different type of patient. As he says, he has grown older with his patients, so they have more complex problems, but does a new doctor have a different workload to an established doctor? The type of patient he saw in 1982 was the sort a GP registrar could expect — more single problem patients, more who needed a sick note — patients who did not feel that continuity of care made a significant difference to their current problem. I certainly felt that the complexity of work increased after a few years in practice. Would the type of patient Dr Mulka saw a few years after starting general practice be much different from the patients he saw in 2002?

Waller and Hodgkin in *General practice: demanding work* mirrored Dr Mulka's finding — that of no objective measurement of increased workload other than an increased number of repeat prescriptions and results.<sup>2</sup>

If one looks at out-of-hours workload, the situation is not clear cut. Salisbury found 'evidence that levels of provision of out-of-hours care have risen considerably, but the wide variation between areas, and differences between studies ... make it difficult to confirm this finding'.<sup>3</sup> Data from my practice show variation but no increase in night visiting in the period 1995-2002 (Table 1).

Subjectively, the workload was lighter. Early in my career a night on call without visits would have been inconceivable, 15 years later and it was not rare. In terms of time commitment, the majority of GPs have worked fewer hours on call, as Hallam noted, '25 years of