

Evidence-based management?

The series of articles in the *British Journal of General Practice* have provoked some thought, for me, concerning the imminent introduction of Advanced Access to our practice.¹⁻⁴ We were among the practices recruited to the National Primary Care Collaborative (NPCC) first wave. During the last 3 years we have been developing other aspects of our practice. In particular, the infrastructure, which includes both the building in which we work, and the use of the IT resources to become 'paper-light'. We have also become a personal medical services practice, in which, theoretically, patients are no longer allocated to an individual GP.

Patients are, however, traditionalists, and cling to the idea of being registered with an individual practitioner. As has been noted for emergency care, 'inverting pyramids takes time'.⁵ The writer of this letter to the *BMJ*, a consultant in accident and emergency, made the erroneous observation that 'in primary care most patients are already seen by senior doctors'. Although this is relatively correct, GPs, like hospital doctors, vary in their ability to be strictly objective with patients. In fact, the relationship between GPs and patients is one of the aspects of primary care most often cited as being important in British general practice. The emotional attachment of a patient to an individual practitioner may not be entirely 'rational', and may not correlate with clinical outcome.

The idea, which appears to be gaining favour in the United States (yes, another idea from the US), coming from managed health care in health management organisations, of report cards of outcomes for individual practitioners, determined by adherence to the principles of evidence-based practice, may eventually result in greater uniformity of patient management.^{6,7}

Each of the articles in the *BJGP* raises concerns over the introduction of Advanced Access as the government's favoured method for decreasing 'waiting lists' in general practice. In an article from *JAMA* on innovations in primary care last year, two alternative models, 'the traditional' and the 'carve out' models, are described.⁸ Certainly I

recognise both of these, having experienced them at first hand. However, the application of industrial models in a demand-led system, for which there is little evidence of effectiveness other than qualitative evidence, concerns me. Furthermore, these models are based on Japanese, not American, ideas of re-engineering, dating from the 1980s.⁹ Human beings are not commodities. One of the strongest messages that comes out of the series in *JAMA* is that 'no scheduling system, including Advanced Access, can work if a physician has too many patients ... Advanced Access can work well even if demand exceeds capacity on a given day, but if demand permanently exceeds capacity, no system will work'.⁸

Although list size in general practice is thought to be reasonable, at approximately 1800 to 2200 patients per GP, we have no real evidence either of the correctness of this estimate, or of the local variation that may occur concerning individual patient needs and whether it matches capacity.

A further issue that may, in future, change the way in which we manage patients, will be the unified electronic medical record. Theoretically, communication, and therefore continuity of care, could improve using a single electronic medical record.¹⁰ Of course, one of the problems with this may well be 'information overload' at each consultation. We will be expected to have accessed all of the relevant items in a medical record, to which social services, the police, accident and emergency doctors, other GPs, and so on will have added further information, some of which will be relevant, and some not.

As health care becomes more sophisticated we will have to have improved methods of information management. This may, possibly, result in being able to manage fewer patients, and thereby increase the number of primary care providers that will be required to serve any population.

Chris Salisbury raises several relevant points in his editorial.⁴ If one is to continue the managerial approach, I seem to recall a dictum that endorses what Dr Salisbury mentions with respect to the expansion of demand being led by the provision of services.

Public health doctors will recognise this as 'provider moral hazard'. If a service is offered demand will expand accordingly. Secondly, the transplantation of an American model into the NHS, where there is no financial disincentive for patients to consult, seems to be folly. Thirdly, the lack of assessment and research, despite the current contributions, of this particular model seems to run contrary to the tenets of 'evidence-based management' if such an animal exists. Personally, I would hope that the animal involved in the experiment is not me.¹¹

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References

- Pickin M, O'Cathain A, Sampson FC, Dixon S. Evaluation of Advanced Access in the National Primary Care Collaborative. *Br J Gen Pract* 2004; **54**: 334-340.
- Chapman JL, Zechel A, Carter YH, Abbott S. Systematic review of recent innovations in service provision to improve access to primary care. *Br J Gen Pract* 2004; **54**: 374-381.
- Windridge K, Tarrant C, Freeman GK, et al. Problems with a 'target' approach to access in primary care: a qualitative study. *Br J Gen Pract* 2004; **54**: 364-366.
- Salisbury C. Does Advanced Access work for patients and practices? [Editorial] *Br J Gen Pract* 2004; **54**: 330-331.
- Fogarty A. Inversion of emergency pyramid. Inverting pyramids takes time [Letter]. *BMJ* 2003; **326**: 553.
- Kazel R. Corporate group turns to doctor rating system: Companies band together to monitor physicians' performance as a way to control insurance costs. *American Medical News*, 2004; 26 Apr. <http://www.ama-assn.org/amednews/2004/04/26/bisb0426.htm> (accessed 17 May 2004).
- Prager LO. Report cards in the works for primary care physicians. *American Medical News* 2000; 31 Jul. <http://www.ama-assn.org/amednews/2000/07/31/prsb0731.htm> (accessed 17 May 2004).
- Murray M, Berwick DM. Advanced access: reducing waiting and delays in primary care. *JAMA* 2003; **289**(8): 1035-1040.
- Berwick DM. Sounding Board: Continuous Improvement as an Ideal in Health Care. *N Engl J Med* 1989; **320**(1): 53-56.
- Majeed A. Ten ways to improve information technology in the NHS [with commentaries by S de Lusignan and S Teasdale]. *BMJ* 2003; **326**(7382): 202-206.
- Morrison I, Smith R. Hamster health care. *BMJ* 2000; **321**(7276): 1541-1542.