The non-principal phenomenon: a threat to continuity of care and patient enablement?

GENERAL practice, and its place within the primary care landscape, is changing. Its workers, too, appear to be changing. The old pattern of lifelong continuous service provided by one person to one population is breaking up, and what will emerge instead is uncertain.

The old model of lifelong partnership has been likened to a marriage, and like a marriage may be good or bad, depending more on internal practice dynamics than the national context. As in marriage the commitment required to maintain a long-term relationship, and to resolve problems such as unequal partnerships, may be lacking. General practitioners (GPs) are becoming quicker to separate from practices when there are problems.

This degree of freedom of movement (or instability) would have been unusual previously. Now that it is possible, and indeed that change may be viewed positively, GP turnover is increasing. This implies that there can be a change in how GPs relate to the time frames of their role. In particular, although we may express belief in the value of continuity of care we may not be willing, or feel supported, to deliver it now.[1-3] The short-term focus of much National Health Service (NHS) management is clearly mismatched with the traditional long-term focus of general practice.

Just as in the wider society the default relationship is no longer a stable marriage, so in general practice we are seeing an emerging range of relationships between GPs and their work. The spectrum is now from lifelong partnership (GP principals) to serial monogamy (commonly, salaried doctors) to short-term affairs (for example, a 6-month maternity locum) and one night stands (for example, a short-term locum). This may be a reasonable development but there is a risk in the shorter relationships that we could see 'casualisation' of the GP workforce, so that, like staff at McDonald's®, a GP can be taken out of one place and slotted into another and no one notices any difference. Tallis describes this phenomenon as affecting medicine in general and worries about creating 'sessional functionaries robotically following guidelines'.[4]

An increasing range of roles is now open to GPs so that many GPs are now active well beyond routine clinical practice in areas such as undergraduate and postgraduate education, primary care trusts, special interests, drug rehabilitation work, occupational health, and so on. Within practices the number of GPs providing solely clinical services to patients is dropping.

For a practice manager, keeping track of this range of activity while simultaneously implementing the new contract, administering the practice, and adhering to access targets is a wide ranging task. In this issue of the Journal, Checkland begins to map out how practice managers may tackle this challenge.[5]

To some extent these new roles are welcome and provide new opportunities for variety, learning and development for GPs. However, they all take us away from direct patient contact and into other areas. In terms of the new landscape of primary care this diversification may be seen as creating new niches where GPs can flourish, or as spreading us too thinly to cope with the core workload.

The next key dynamic affecting medicine is the increasing number of women entering the profession. The ninth report of the British Medical Association cohort study of graduates followed since 1995 shows that the majority of female doctors, and an increasing number of male doctors, are likely to choose to work part-time rather than full-time.[6] This trend to part-time working was more marked in GPs than hospital doctors. This study documents the growing demand for improvements in work–life balance, and part-time working is one means to achieving this.

The RCGP workforce survey estimated in 2000 that with these trends working together it takes at least 1.5 graduates from the vocational training schemes to provide as much clinical work as one old-style full-time GP principal.[7] This estimate is probably too low now.

Getting accurate numerical and contextual information about these trends is difficult, and so the papers in this issue of the Journal are welcome. No GP can stand back and take a totally objective view of this area, as we are at once both a part of, and a player in, the phenomenon being observed. We are experiencing history being made, as we make it.

Wordsworth *et al*[8] look at the preferences for career choice between principals and non-principal roles. They note that all the doctors in this experiment wanted to have longer consultations, to enable higher quality of care. They comment, however, that there are significant differences in what doctors in older age groups value compared with the younger and between male and female preferences about the desirable and less desirable elements of GP jobs. All groups placed a low value on out-of-hours work and preferred a job with less of this. Wordsworth *et al* comment:

> '*At the centre of recruitment and retention concerns is the relative attractiveness of different jobs and careers available to both current and future GPs.*'[8]

We can learn a lot about this from how others see us. Ballard *et al*[9] describe the views of French doctors who have moved to practices in south London. Their reasons for coming started from an initial dissatisfaction with conditions in France, and for these doctors the main problems were long hours, on-call commitment, meeting patient demand, and dealing with the business side of practice. The process that brought them to south London continued with activating factors, such as the perceived attractiveness of the salaried way of working itself, accompanied by the opportunities for development and options for part-time working. They were grateful for facilitating factors, such as practical help with General Medical Council and other paperwork. These doctors would not have come to the UK to take on GP principal posts.

Writing from Bradford, Stinson *et al*[10] describe very similar wishes that need to be met to retain the British salaried doctors there. They summarise these as 'support, security, stimulation.'

The non-principal phenomenon is currently emerging from within general practice. There is a shifting balance between full-time principals and an increasing number of salaried, sessional, portfolio, and part-time doctors. This phenomenon is going to be a major theme for the next few years in general practice employment patterns, and the ideal balance of these types of working is not yet known, either collectively or for individuals.

Patients may have a view on these developments but they have little collective voice[11] and while some, especially those with chronic diseases, may regret the passing of the traditional GP providing continuity of care, many (often the young and healthy) will be indifferent.[1] They may have to develop a range of relationships to their doctors (not doctor) mirroring that of the doctors to their jobs.

The non-principal phenomenon, while delivering reasonable episodic care, is unlikely to deliver the best medical results to patients. Those who value continuity of care[1,12] and the role of an ongoing therapeutic relationship as a means to promote enablement[3] of patients need to argue more strongly, and make the long-term GP role (whether as a self-employed principal or otherwise[13]) more sustainable and attractive, both to doctors and healthcare purchasers. Otherwise, these internationally admired elements of British general practice could be lost.[12]

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References

1. Pereira Gray D, Evans P, Sweeney K, et al. Towards a theory of continuity of care. *J R Soc Med* 2003; **96:**160-166.
2. Hjortdahl P. Continuity of care. In: *Oxford textbook of primary medical care*. Oxford: Oxford University Press, 2004: 249-251.
3. Howie J, Heaney D, Maxwell M, et al. Quality at general practice consultations: cross sectional survey. *BMJ* 1999; **319:** 738-743.
4. Tallis R. The NHS examined: a feeling of quiet despair. *Times 2* (Supplement). 2 August 2004.
5. Checkland K. Management in general practice: the challenge of the new GMS contract. *Br J Gen Pract* 2004; **54:** 734-739.
6. British Medical Association. BMA cohort study of 1995 medical graduates: ninth report 2004. www.bma.org.uk/ap.nsf/Content/cohort2004/$file/CohortStudy04.pdf (accessed 1 Sep 2004).
7. Royal College of General Practitioners. The primary care workforce – an update for the new millennium. London: Royal College of General Practitioners, 2000. http://www.rcgp.org.uk/corporate/ position/careupdate/index.asp (accessed 1 Sep 2004).
8. Wordsworth S, Skatun D, Scott A, French F. Preferences for general practice jobs: a survey of principals and sessional GPs. *Br J Gen Pract* 2004; **54:** 740-746.
9. Ballard KD, Robinson SI, Laurence PB. Why do general practitioners from France choose to work in London practices? A qualitative study. *Br J Gen Pract* 2004; **54:** 747-752.
10. Stinson L, Dickson P, Pearson D. Support, security, stimulation: the secret of recruitment and retention in primary care trusts. *Education for Primary Care* 2004; **15(3):** 291-297(7)
11. Davies P, Glasspool J. Patients and the new contracts. *BMJ* 2003; **326:** 1099.
12. De Maeseneer J, Hjortdahl P, Starfield B. Fix what's wrong, not what's right, with general practice in Britain. *BMJ* 2000; **320:** 1616-1617.
13. Tudor-Hart JT. *A new kind of doctor*. London: Merlin Press, 1988.

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Occupational asthma case finding: a role for primary care

THE Revitalising Health and Safety strategy[1] was launched jointly by the British government and Health and Safety Commission in June 2000 across England, Scotland and Wales, with Northern Ireland working in close partnership. This 10-year strategy seeks significant improvements in workplace health and safety, setting a target to reduce the incidence of cases of work-related ill-health by 20% by 2010. The predominant work-related disorders are musculoskeletal, mental, dermatological and respiratory diseases.[2] Occupational asthma is the most frequently reported occupational respiratory disease in Great Britain, accounting for almost 1000 cases reported to the SWORD (Surveillance of Work-related and Occupational Respiratory Disease) scheme for occupational and work-related respiratory disease every year.[3] Reporting schemes are likely to underestimate true incidences because not all cases come to light,[4] with some workers not seeking medical advice.[5]

The scale of the problem

Most patients with occupational respiratory disease are not seen by a consultant physician and thus their cases are not officially reported. The Health and Safety Executive (HSE) estimate that 1500–3000 people develop occupational asthma each year, that is, adult asthma caused by workplace exposure and not by factors outside the workplace.[6] This figure rises to 7000 cases a year if work-aggravated asthma is included, that is, pre-existing or coincidental new onset adult asthma, which is made worse by non-specific factors in the workplace.[6] The symptoms and functional impairment of occupational asthma caused by various agents may persist for many years after avoidance of further exposure to the causative agent, leaving people disabled or unable to continue in the job that caused their asthma. About a third of work-