

# Dismantling general practice

Twenty years ago general practice in the UK was frequently and justifiably described as the jewel in the crown of the NHS.<sup>1</sup> GPs led primary health care teams which provided comprehensive, continuous, coordinated, and personal care for registered patient populations, and exercised a benign gate-keeping role by regulating patients' access to more sophisticated and expensive facilities in specialist (secondary) hospital care. The work of Starfield and others indicated that an effective primary care system is an essential ingredient of a cost-effective health service;<sup>2</sup> for many years the NHS provided a good standard of medical care to the entire population for a relatively small proportion of gross domestic product.<sup>3,4</sup>

Despite the rhetoric of a 'primary care led NHS', a number of distinguishing features of general practice have now been progressively eroded or have disappeared altogether. Examples include withdrawal from 24-hour responsibility for patient care, cessation of weekend opening of surgeries, a decline in personal continuity of care and in levels of domiciliary care, and the introduction of contestability and alternative primary care providers. There have also been changes in the traditional gate-keeping role of GPs, through the introduction of alternative ways of accessing care, such as walk-in centres and NHS Direct.<sup>5</sup> The introduction of GPs with special interests, discussed in this issue of the *Journal* by Gervas and colleagues, represents a further change in the orientation of primary care, the impact of which is yet to be fully evaluated.<sup>6</sup>

Sir Ara Darzi has now published a report on health care in London which, among many other proposals, recommends building 'polyclinics' to re-provide some aspects of care currently provided in general practice.<sup>7</sup> Details of these polyclinics are sparse, but it appears that the intention is to concentrate some primary care services in large premises containing many GPs.

While it is clear that standards of primary care in London are uneven and that the costs and quality of premises create problems, some of the report's descriptions

of general practice are inaccurate. Concerns about poor access are largely a result of the Advanced Access system introduced by the Department of Health.<sup>8</sup> Of much greater concern is that Darzi's report on London may be a dress rehearsal for the wider review of the NHS which he has now been asked to undertake.

Cost containment in the NHS has largely been achieved through the gate-keeping role of GPs, working at the interface between primary and secondary care, by providing appropriate care for patients and avoiding unnecessary investigations and interventions. However, cost containment and the appropriate use of services are not accidents of the history of the NHS in which a sharp division between primary and secondary care was created at its inception. Rather, they are the result of the careful management of patients in primary care by a highly trained workforce, in which GPs and multi-disciplinary teams provide over 80% of all patient care.

The standards set for general practice by the Royal College of General Practitioners which were delivered through a national programme of vocational training have helped to produce GPs who are equipped to take on the entire range of clinical problems presented by patients; these GPs are also expert in managing psychological and social problems, and their own practices. Skills in doctor-patient communication, exercised against a background knowledge of individual patients and their families and alongside accurate diagnosis, are at the core of general practice. While GPs would never claim a monopoly on 'people skills', it is noteworthy that the lead on delivering the communication skills components of undergraduate medical curricula has often been taken by university departments of general practice.

It is essential that first contact care is provided by trained primary care physicians. Many years ago Thomas showed that as many as 40% of patients presenting in general practice do not have a condition to which a formal diagnostic label can be attached, describing them as 'temporarily

dependent patients'.<sup>9</sup> He also described the 'therapeutic illusion', in which, after a period of primary care management, symptoms resolve and patients stop consulting.<sup>10</sup>

Modern medical technology has not eliminated such patients who continue to exercise the clinical and research efforts of GPs.<sup>11,12</sup> There is little evidence that hospital doctors recognise the existence of patients for whom there is no physical diagnosis, and the last thing that these patients need is instant access to an ultrasound scan or a specialist. Over-investigation and over-referral have the potential to overwhelm the system. The skills required to manage such patients are transferable. Experienced GPs working in accident and emergency departments perform fewer investigations, write fewer prescriptions, and admit fewer patients.<sup>13</sup> However, putting an untrained doctor behind a desk in a polyclinic does not turn him or her into a GP.

Although the 'small business' model of general practice has its shortcomings, there is evidence that both small and larger practices are capable of delivering high quality primary care.<sup>14-16</sup> Once again, this is not a simple matter of putting people into a building or an organisation in which they have no professional, emotional, or financial investment. Practices are complex, often fragile, organisations in which doctors, nurses, and other healthcare professionals work closely with administrative and other non-clinical staff to provide a range of services.<sup>17,18</sup> Well-functioning primary healthcare teams cannot simply be taken off the shelf. Tenacity, commitment, and imagination are required to develop a top-class practice which provides a genuine service to its local community. Contact with this community is a further essential component of effective primary care.

The perception among policymakers that cost containment can be achieved in a health system with a strong primary care component seems to have led to a misapprehension that anything with a primary care label on it is cheaper. Hence we have primary care led NHS, primary care trusts, and the secondary-primary

care shift in which services would move 'closer to the patient' (that is, closer to the GP). This policy direction was further emphasised in *Our Health, Our Care, Our Say*<sup>19</sup> which contains some memorable images, including that of hospital gynaecologists, orthopaedic surgeons, and urologists decamping to community settings to deliver their services.<sup>20</sup> These community settings may be only a few hundred yards from a large teaching hospital, and the care provided there may be more expensive and no better than that provided in a hospital clinic.<sup>21</sup> Policy analysis in this document is sometimes at the Orwellian 'secondary care bad, primary care good' level of sophistication.

The future of the NHS is likely to depend, to a large extent, on the future of general practice.<sup>22</sup> At present, a disfigured general practice system is struggling to hold on to core skills, attitudes, values, and behaviours, in the face of a series of professional and governmental initiatives which have, successively, damaged its effectiveness. Further de-personalisation of general practice and increasing centralisation of services, particularly where general practices are already doing a good job, will accelerate this process and have the potential to impair the primary care sector's ability to moderate demand for specialists and expensive technology.

The health economic impacts of a weak primary care sector can readily be seen in the US,<sup>23</sup> while the effects on morale and patient care of the fragmentation of general practice are apparent in New Zealand's health system.<sup>24</sup> The government and its advisers not only need to appreciate the important role that general practice has in

demand management and cost containment, but also need to understand the complexities that lie behind general practice and the dangerous territory into which an over-simplified view of primary care in the NHS will inevitably lead.<sup>25</sup>

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## Talking to children

Children may have varied expectations of going to see a doctor, depending on age, what parents have said, and previous experience of health professionals. Many children might expect the doctor first to find out what is wrong, perhaps by asking questions, by prodding, by sticking a needle in, or by just knowing. I remember

once, as a paediatric registrar in Hackney, asking a Bangladeshi father whose wife spoke no English what was wrong with their child. He said that I was the doctor, so I should know. I would have done better to ask the child.

Children may often be dissatisfied with their interactions with health professionals,<sup>1</sup>

but may not say so unless asked, unlike their parents, who may insist on having their say. A simplified case example follows to illustrate the need to allow children to voice their concerns. A 10-year-old boy has recurrent abdominal pain that often begins on schoolday mornings, mostly gets better on Friday evenings, and