

# Out of Hours

## General practice: a better way forward?

This article is a contribution to the current debate about the future of general practice. Present rhetoric emphasising under-resourcing is disappointingly one-dimensional and is hindering exploration of alternative solutions.

### THE ISSUES FOR DOCTORS

Workload is a major problem. Demand and expectations have risen substantially and an ageing population has brought increasing comorbidity. Early discharge and the devolution of more follow-up care to the community have also added to the responsibilities carried by primary care teams.

GPs are reporting high levels of stress; morale and job satisfaction are lower than they should be. Retention of doctors is sub-optimal and recruitment worryingly low. The administrative burden associated with the Quality and Outcomes Framework (QOF) is burdensome and often to no good purpose.

### THE ISSUES FOR PATIENTS

Many patients report outstanding care from individual GPs and from practices generally. However, not all care is good, and there is noticeable public disenchantment on a number of fronts.

Patients report real difficulty accessing GPs in general, and 'preferred doctors' in particular, which is worse in large practices. Continuity of care is poor, especially where there are large numbers of part-time doctors and again, worse in large practices.

There is a feeling that consultations are over-influenced by doctors' agendas (often computer-driven) rather than centred on patients' agendas.

Patients feel abandoned at times of crisis by present patterns of out-of-hours care, let down by doctors opting out of their traditional role for round-the-clock responsibility, while accepting that care will reasonably be provided on a shared basis. Problems are particularly bad over holiday weekends.

### TOWARDS A SOLUTION

There are no easy answers, and a one-size-fits-all solution is unlikely to be found. I believe the best way forward lies in a knock-for-knock agreement between GPs and NHS management. On the one side, GPs agree to take back 24-hour responsibility for patient care, providing care by small area cooperatives out of hours and at weekends. In return, NHS management agrees to discontinue the QOF while leaving the current resource in place to benefit general practice and primary care. This would reduce administrative burden significantly, and recognise that although processes of care for incentivised conditions have improved, it is hard to find evidence of change in actual health outcomes.

These moves would address virtually all the problems mentioned. Freeing doctors from the administrative burdens of QOF and from chasing targets they believe to be largely meaningless, would reduce job stress and increase work satisfaction.<sup>1</sup> Patients' agendas would once again be prioritised. Improved morale would increase recruitment and retention and congestion at A&E departments would be lessened. The quality of patient care would improve, particularly for situations not previously covered by QOF: most importantly in the area of psychosocial morbidity.<sup>2</sup> The standing of general practice as a profession would return to that which was the norm in the past.

Something will still need to be done to improve continuity of care. 'Continuity' is a concept which reflects values that doctors and patients share. The ability to provide it is strongly influenced by contextual factors. Removing the burdens of QOF would be a major 'context' step forward. Splitting large practices into smaller units for the provision of routine care while retaining the advantages of scale for the purposes of administration and the provision of special services such as physiotherapy, would also be a move in the right direction.

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Quite reasonably, the NHS will want some measures of accountability to compensate for the loss of the QOF, and to track the effectiveness of public health strategies. Any data to be requested should observe the maxim that 'what is easy to measure is often not of importance and what is of importance is often hard to measure'.

### FINAL OBSERVATIONS

The debate about the future of general practice should be apolitical, recognising that all political parties are committed to a strong NHS. The issue of private provision has become a distraction; some element of private provision does not run counter to a commitment to an NHS free at the point of care. Private provision has contributed materially to waiting list initiatives, and to improving care of groups of patients, including those requiring cataract surgery, coronary artery by-pass surgery, and joint replacements, and may have an increasing role in shortening queues for essential investigation such as scans and colonoscopies.

Although adequate resourcing of the NHS and of general practice are real concerns, the issues of restoring and improving the public image of general practice, of assuring job satisfaction for GPs, and of confirming the commitment of GPs to be responsive to the traditional needs of patients are at least as important.

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DOI: 10.3399/bjgp15X685345

### REFERENCES

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