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GENERAL PRACTICE—ANY PORT IN A STORM?[1]

When considering what I would say to you tonight I was struck by an Editorial in the Ulster Medical Journal of April of this year. Professor David Hadden, the Editor, began "All Change—1948, 1972, 1994; will these dates be remembered by future social historians as important points of change in the progress of health care organisations in the United Kingdom?" He concluded that he could, in general, find few phrases which show how we really feel about the present or past changes. Professor Hadden did note that in a 1972 issue of the Journal Dr J A McVicker, a distinguished family doctor in Belfast, could reminisce that general practice had always been an exacting way of life and looked back with concern at the reduction in the general practitioners' role which took place after 1948. Dr McVicker did however think that this was gradually being reduced, notably by the founding of the College of General Practitioners, soon to be the Royal College of General Practitioners.

And, believe it or not, in 1972 a group of general practitioners met at a management conference at Ballygally Castle and looked forward with remarkable foresight to the community care team and an expanding health centre concept.

In this address I shall also look back but only to explore themes which I believe are very important in the evolution of general practice. It will doubtless be quite apparent how I, and many others, feel about the times in which we practice. My task is to delineate the place of general practice in health care, how it came to occupy that place and finally to infer how it might develop in the future.

ORIGINS OF MODERN MEDICAL PROFESSIONALISM

Modern British medical professionalisation developed during the first half of the 19th century culminating in the Medical Act of 1858. With difficulty, the Act brought together three hitherto almost entirely separate occupations: a few hundred physicians in London and Edinburgh, with gentlemanly status, a knowledge of latin and greek, but virtually no practical training; a few teaching-hospital surgeons; and several thousand provincial surgeons, apothecaries, and surgeon-apothecaries already calling themselves general practitioners without gentlemanly status, but with practical training in survival procedures and the dispensing of medicines.

An uncertain majority in all three groups eventually found a common interest in legislation for a single profession of medicine. This view was contested in the parliamentary committee which prepared the Act. It was suggested that a less qualified grade for everyday care of the poor, more or less equivalent to the feldsher grade in Russia, might be a cheaper and more realistic alternative. The British Medical Association (BMA) successfully resisted this proposal, using an important argument:

> "Every attempt to create an inferior grade of medical men of limited education and with aptitude only for the ordinary exigencies of practice should be resisted. Disease affected people wherever they were, and so the same degree of medical skill should be available for everyone."

The British medical profession therefore owed its birth to an egalitarian social argument. This theme has recurred time and again since, despite the obvious fact that it denies the validity of a medical market, with some consuming more and others less medical care than they need. Both ideas, medical care as a human right and medical care as a marketed commodity, have persisted ever since, in uneasy alliance or open conflict, and neither has ever had complete ascendancy.

EDUCATIONAL/TRAINING MODEL

The currently accepted model of what a good doctor is became fully developed around the start of the 20th century, when medicine began to make serious claims to association with science. It is most easily dated from 1910, when implementation in the United States of the Flexner Report on medical education, drawing on British, German and French experience, elaborated an international professional model which essentially persists today.

Flexner added enormous power to this upward movement in social rank. He defined the doctor as a

[1] *Ulster Medical Journal*, 1995, v64(1), p3.

science-based, autonomous professional, relating to society through intimate, individual contacts, whose principal task was the relief of sickness as it came to his door. His unpaid care of the poor gave him access to fees for care of the rich. Either way, doctors derived their authority from associations with science and with gentlemen.

Sir William Osler was the most influential of, and advocate for, this professional model. He was a giant figure, of unquestionable greatness, who posed many of the fundamental questions which still face us today.

His aim was to educate doctors to clinical inquisitiveness, a passionate belief in the application of science to the solution of diagnostic puzzles. Osler's concept of clinical medicine, bringing bedside practice into association with laboratory science, was a huge and necessary advance, but it was obtained at very heavy cost. It was essentially a pursuit of personal excellence, based on the assumption that excellence was not, and never could be, a universal objective.

This model, illustrated here in the form of a patient/doctor/illness triangle, tends to isolate the patient from the real world of his or her family, occupation and work circumstances. This model is episodic, reactive and problem based with the patient occupying an essentially passive role. Further, it is based on a reductionist view—analysing complexity by breaking things down into simple constituents. Osler's model, or paradigm,[1] was widely accepted at the time and still dominates traditional medical thinking and teaching.

In the first half of the twentieth century application of the scientific approach of the Osler model to the harsh realities of general practice proved difficult, if not impossible. Sir James MacKenzie the famous general practitioner and cardiologist recognised this in the early 1920s: 'I left college under the impression that every patient's condition could be diagnosed... For some years I thought that this inability to diagnose my patient's complaints was due to personal defects...but gradually I came to recognise that the kind of information that I wanted did not exist....

[1] A paradigm is a general comprehensive theory dominating the assumptions of science over a substantial period of time. A paradigm tends to influence the questions scientists ask and the answers they find credible. When a paradigm fails to explain the reality of scientific experience it disintegrates to be replaced by another. An example is Newtonian physics which disintegrated earlier in this century in the face of discoveries about particle physics. The word paradigm has been extended to include any generally shared set of assumptions governing teaching and research in any (scientific) subject, and has been a favourite term among medical educationalists.

SOCIO/ECONOMIC, POLITICAL AND PROFESSIONAL CONSEQUENCES FOR GENERAL PRACTICE

General practitioners were very unlikely to keep up with any technical innovation. The circumstances of their practice and the means of their patients, especially in working class areas, made such initiative almost impossible. Where a working man's club formed the bulk of the practice, the work was superficial. We have the famous criticism—"perfunctory work by perfunctory men".

The Lloyd George era

The terms of service obtainable by general practitioners for looking after such "Medical Aid and Provident Societies" (the so-called clubs) were frequently appalling. Nevertheless when Lloyd George sought to nationalise these societies in the 1912 Insurance Act many general practitioners were convinced that they would lose their only apparent means of escape to financial security and clinical self-respect through fee-earning practice, clinging all the while to the Osler paradigm of practice. But for the poor doctors of poor people—that was the substantial majority of doctors and people, there was never any question of counting corpuscles, performing bacteriological examinations, estimating the chemical value of secretions or of acquiring skill in the use of microscopes. Hospitals were where medicine was concentrated. The BMA was split. Though many local branch secretaries may have had scores of protests, yet some 15,000 general practitioners signed contracts with Insurance Committees, capitulating to the legislation which the BMA opposed. The principal functions of general practitioners under the 1912 Act, and the only reason they were included in it, was to adjudicate fitness for work and, if need be, prescribe access to cash benefits.

Notwithstanding this defeat the BMA remained representative of the medical profession, especially general practice. In the 1930s, the BMA made difficulties for socially brutal government policies by drawing public attention to the effects on child health of mass unemployment and malnutrition. They proposed an extension of the primary care services to the dependents of manual workers and encouraged discussions on post-war health services in their wartime Medical Planning Commission.

The Advent of the NHS

In 1944 the BMA sought the views of its members concerning the wartime coalition government's White Paper on post-war health services. This White Paper proposed group practice from health centres, a mixture of salaried and private general practice and

measures to ensure a more equal distribution of general practitioners across the country. Despite the difficulties of balloting doctors in the armed services, which favoured higher returns from established older (and possibly more conservative) doctors, there were majorities of over two thirds for almost all the above proposals. For any post-war government intending to create a National Health Service on radically new lines, there was a clear mandate from the profession. But only four years later all that changed. What in fact occurred was an almost exact repetition of the events of 1912. The BMA leaders retreated from the 1944 position and mobilized the membership against the alleged threat to clinical standards of a "socialist" service.

But there was an important difference from 1912; the true opposition was led by the general practitioners, not by the consultants. Aneurin Bevan, the Labour Minister of Health, made investment in nationalised hospitals the central feature of the plans for the NHS. He conceded a great deal of power to the consultants, confessing to Brian Abel-Smith that he "choked their mouths with gold". But above all that Bevan offered them means to expand and improve their clinical work, and this was a vital and necessary innovation. However, as is well known, the presidents of the Royal Colleges (representing medicine, surgery, obstetrics and gynaecology) concluded a deal with Bevan. The BMA maintained its stand against any negotiations with the Minister with furious denunciations of the treachery of the Royal Colleges. In the event, the new NHS began on time with 90% of general practitioners "coming into line" and enrolling under the Act, and 93% of the population registered with those general practitioners. Frankly, many doctors had done all that was possible to obstruct a major advance in the social organisation of medical care and had isolated themselves from public opinion.

THE NATIONAL HEALTH SERVICE

General practice was quantitatively extended to cover the whole population but qualitatively unchanged because it received no significant public investment, even in the new post 1948 era. The costs of general practice consisted almost entirely of payments to general practitioners and the then small cost of prescribed medications. Everything else, receptionists, nurses, cleaners, office and medical equipment, furniture and buildings came from the general practitioners' pocket—a public service privately administered.

Somerville Hastings, a Labour MP in the 1945-parliament who was also a consultant at the Middlesex Hospital made a telling comment: "During the negotiations that preceded the NHS Act the GPs came together to oppose us. They were also concerned, quite rightly, with their remuneration under the scheme, but gave little thought to their rightful place in it or opportunities for doing good work under it. They only asked to be left alone and they have got what they asked for".

Between 1949 and 1971 the number of hospital medical, nursing, administrative and clerical staff each more than doubled. Over the same period the number of general practitioners increased by only 16%, though they were gradually redistributed to reduce over-doctoring in wealthy areas, and increase the numbers of general practitioners in poor areas. There was material evidence of professional demoralization expressed in the way general practitioners thought of their patients, their work, and themselves, more than at any time before or since. General practitioners were defined, not by what they were but what they were not—consultants. Trained by specialists in hospital for specialism, significantly handicapped by the Osler paradigm, future general practitioners were ironically not scientific enough to see what stared them in the face: a huge largely unmapped field for effective medical care requiring skills largely unknown to hospital specialism but badly needed by their future patients.

A NEW APPROACH: EDUCATION AND QUALITY

Marginalised general practice resolved to form a College as a means of rehabilitation, especially around issues of education and quality of practice. During the first 13 years of its existence, from 1953 to 1966, the ends preached by the College were virtually unsupported by means other than what general practitioners spent of their own money. The self-critical reforming approach enjoined by the College on its members was not only unrewarded but incurred costs because its implementation required more time for the patient and more money for supporting staff. It was voluntary, and most general practitioners were not volunteering.

Earning depended almost entirely on capitation (pay per registered patient) so that the most successful doctors were those with the biggest lists (the legal maximum at that time was 4000), and almost inevitably the least time available for their patients. Though general practitioners still insisted on independent contract or status, they wanted the government to pay for improvements in the service. The general practice share of the NHS budget fell from 12% in 1950 to 8% in the early 1960s.

The obvious and effective way to help general practice was the way the NHS had already helped hospital-based specialism: public investment in appropriate education, better buildings and equipment and more office and nursing staff. The agreement which emerged in 1966 is known as the GP Charter. It was a major turning point for general practice and had seven main features:

(1) Increased basic salary, with a reduced proportion due to capitation.
(2) Reimbursable rent on suitable premises, and cheap loans to encourage purpose built premises.
(3) 70% reimbursement of wages of employed office staff and nursing staff, up to a maximum of 2 whole time equivalents.
(4) Seniority payments and vocational training payments contingent on certain conditions.
(5) Development of a cadre of trainers, introduction of vocational training schemes, and payments to district course organisers to run day release courses.
(6) Local Health Authorities were encouraged to redeploy community nurses, health visitors and midwives to care for practice populations.
(7) Limited fee for 'item of service', to encourage general practitioners to take responsibility for an extended range of clinical activities such as contraceptive services and cervical smears.

The GP Charter underwrote the College and general practice by giving its independent ideology of general practice a material base. Most of the disincentives to investment in staff, premises and equipment were removed and the College acquired a practical task supported by public funding for the development of vocational training. General practice became a more attractive career. By 1980 it was the first career choice of 37% of pre-registration doctors, twice the proportion favouring the runner-up, hospital internal medicine. For the first time, many of the most successful students opted for general practice. There was a rapid expansion of vocational training schemes led by the College, which provided a structure for postgraduate training superior to any other speciality. In 1969 The Royal College of General Practitioners proposed that:

> "a general practitioner is a doctor who provides personal, primary and continuing medical care to individuals and families…his diagnoses will be composed in physical, psychological and social terms … he will work in a team … he will intervene educationally, preventively and therapeutically to promote his patient's health".

THE NEW GENERAL PRACTICE PARADIGM

This model, shown in the form of a diamond, incorporates the additional dimension of maintaining health, recognises the supportive role of the patient's family, and includes the concept of the primary care team. This paradigm notes that there is no dichotomy between health and illness and at its best, encourages patient autonomy.

Until this period few if any medical schools gave any significant teaching in or about general practice or by general practitioners, little postgraduate education was available and virtually all of that was by specialists. A Royal Commission on Medical Education was appointed in 1965, and published its conclusions in 1968. This was the Todd Report, and proposed:

(1) a sustained increase in medical manpower to double output by 1990.
(2) recognition that no newly qualified doctor can ever be competent in all fields and that the aim of undergraduate training should be to produce educated health workers able to continue specialist education throughout their working lives.
(3) that general practice was itself an important speciality requiring substantial time in the undergraduate curriculum and a planned programme of postgraduate vocational training, partly in hospital and partly in the community.

The Todd report was a landmark in thought about medical education, and gathered important data about the social composition, attitudes and experience of medical students. One might reasonably argue that with the general practitioner paradigm and the proposals of the Todd Report general practice had at last reached the right port after a long stormy passage.

DEVELOPED FEATURES OF PRIMARY CARE

However UK general practice, including the RCGP, should have looked elsewhere throughout the world to augment its model and looked critically not just at what primary care was but at what it might become. Primary care has the following characteristics:

Unique features	
First contact care	Accessibility of facility Access to care Use of facility as place of first contact

Longitudinality	Knowledge of the patient and the patient's social milieu
	Use of the regular source of care
	Length of relationship with patients regardless of type of need for care
Comprehensiveness	Spectrum of problem dealt with
	Primary and secondary preventive activities
	Recognition and management of psychosocial situations
Co-ordination of care	Mechanisms for continuity
	Recognition of information from prior visits
	Referral/consultation visits (occurrence and results)
Essential but not unique features	
Medical records	Problem list in place
	Completeness of the medical record
Continuity of care	Seeing same practitioner on follow-up
Practitioner-patient communication	Content/quality of interaction
Derivative features	
Family centred	Knowledge of family members
	Knowledge of health problems of family members
Community orientated	Knowledge of community health needs
	Participation in community activities
	Community involvement in practice

While it is important to acknowledge that educational and training issues as well as political issues influence any developments and interact with each other, it is also important to note and even to expect that in the years since 1968 the general practitioner paradigm has slowly shown a need for further refinement.

THE GENERAL PRACTICE PARADIGM UNDER PRESSURE

Even though excellent initiatives were visible, on the ground there were large variations in a service which was largely focused on patient-led demand and symptomatic treatment. There was not nearly enough emphasis on prevention and health promotion, particularly in the face of the pattern of morbidity, namely slowly evolving chronic illness with multi-dimensional aetiology.

Yet there is an enormous structural strength in UK general practice—that of the registered patient list. At any given time all but 2.5% of the population are registered with a general practitioner. Many people are registered with the same general practitioner for decades. This advantage has to be pressed home in the prolonged opportunity it gives to form productive professional relationships with patients. It is surely still greatly valued by the vast majority of people and must form a major reason why many doctors become general practitioners.

But there is a "community" dimension to general practice which implies that the general practitioner has a responsibility beyond the care of individuals, and that they should monitor and systematically improve the health of all of their registered patients. Each practice list has a unique profile of "ill-health" conditioned by many factors including age, sex, social circumstances and environmental factors, which generate a distinct pattern of health care demands. In such situations the world is immediately more complicated, and the general practitioner is cast in the role of a doctor in public health for his or her patients, with a responsibility for planning, implementing and reviewing all patient care and not just the care of the individual. This can also be regarded as "proactive" or anticipatory care, which is complementary to but does not supplant traditional "reactive" care. Responding to and alleviating the suffering, the pain and the distress of our patients will and must continue to be the cornerstone of general practice. Health care demands are not the same as patient needs, and therefore appropriate care implies adequate local needs assessment by general practitioners and primary care teams, with active patient involvement. This role, with its responsibility for the locality, is a contentious area for many general practitioners. It seems to get in the way of what they regard as their primary purpose, which is to see patients.

ANTICIPATORY CARE

The RCGP set up a working party in 1980 to look at the general practitioner's role in preventive medicine. The group decided to look at four very different fields of work in some detail, to make sure that its conclusions were so far as possible concrete, practical and usable by primary care teams in their ordinary conditions of work. These fields were family planning, child rearing and child health, psychiatry, and arterial disease. Alcohol problems were added later, but han-

dled in the same way. The reports of this working party and its subgroups were an important feature in the development of UK general practice.

In order to look systematically at what general practitioners were already doing about prevention, it was essential to match achievement against registered populations at risk, (with illness of various sorts as the numerator and the practice population as the denominator). General practitioners soon realised that this was necessary not only to study prevention, but also to look objectively at other aspects of their work, including what had always been their central function—the management of disease. The practical tasks of prevention fused with systematic management of disease in the registered population become the single task of anticipatory care. Combined with rapid advances in information technology, it began to seem possible that primary care teams serving registered populations might be able to measure and even respond to the health needs of the people, with optimal effectiveness and economy.

TENSION BETWEEN GENERAL PRACTICE AND PUBLIC HEALTH

The 1990 general practice contract took account of many of these ideas and actually incorporated several public health elements: monitoring through child health surveillance, three yearly health checks for adults, the offer of annual assessment for people over 75 years of age, assessment of health needs through recording referrals to hospital and health promotion clinics. The quality and uptake of clinics was very uneven and not related to the needs of the population.

So now doctors and nurses in general practice face the frustration of being bribed or bullied by government to achieve targets that many people are not ready to accept for personal and social reasons. Achieving apparent targets may well be a short term gain, and is likely to tax the doctor-patient relationship as well as the integrity and self-respect of the former. The latter needs individual care when frightened and/or ill but willingness to change cultural and social habits comes in small steps in response to both external opportunity as well as an inner readiness to change.

This approach to the population through primary care is not going to produce large reductions in the risk of cardiovascular disease as several well constructed studies have shown. Yet general practice teams have some evidence for the effectiveness of clinical efforts in secondary prevention of vascular disease, and growing evidence that professional support for people who are not ready to change their lifestyles will not improve outcomes. These are large tasks in themselves and there seems to be no justification for the ritualistic collection of risk factors when the public health benefits are marginal. Less motivated patients are upset by the process, while primary care professionals are demoralised by bureaucratic payments linked to targets and population coverage. The ethics of screening are clearly being ignored in the contract imposed on general practitioners, and the scientific evidence that existed before 1990, namely that screening has little effect, has been strengthened.

For those of us who support the public health role in primary care in the new arrangements for health promotion it is heartening to see that in respect of new chronic disease management arrangements one message has at last been correctly grasped—the practical tasks of prevention and health promotion fuse with systematic management of disease in what is known as anticipatory care.

CONSEQUENCES OF A PROACTIVE APPROACH IN ANTICIPATORY CARE

But what is the scale of this proactive task? Using indicative prevalences, one could construct a profile of a hypothetical practice in a given locality with a list of 10,000 patients. Below the waterline are hidden risk markers for coronary heart disease and stroke; above the waterline are overt clinical events.

Indicative prevalences fit well with innovative models of primary health care. For instance, a model of preventive medicine through anticipatory care in general practice has been developed over several decades, based on opportunistic screening and interventions informed by epidemiological studies. Focused and personal intervention can be more effective and cheaper than population based interventions or multiphasic screening and advice. However, it is not possible to cover patients comprehensively and reliably without a team based practice organisation, efficient patient information systems, and an inbuilt audit cycle. The resources needed to address this task should not be underestimated.

General practice has many advantages for pursuing health promotion, since about 85% of patients will consult a member of the primary health care team each year. In the past general practitioners have mainly reacted to patients' problems rather than acting to prevent problems. The role of the general practitioner as personal physician and the gatekeeper to secondary care is vital and must be sustained. But anticipatory care is possible and effective if practices have high motivation, sufficient resources, trained

staff, appropriate organisation, and a targeted approach based on research. The expansion of the primary health care team to include practice nurses, health visitors, and other clinical professionals has brought anticipatory care closer.

I have noted above that the so-called general practitioner paradigm is under strain and that this naturally occurs as our learning and thinking evolves. We should also remember that in the Hippocratic tradition each person has primacy and doctors who swear allegiance to this tradition or the Geneva convention have earned the respect of their patients for centuries despite occasional errors of clinical judgement or personal behaviour. Indeed, doctors who fall foul of their patients are much more likely to have shown contempt for the value of an individual as a person than to have been technically negligent. The centre piece of family medicine is what happens in the one-to-one consultation; population health is always a secondary dimension.

Recent government policy documents provide a definite emphasis, indeed a preference for the population as against the individual. The Health of the Nation placed great emphasis on "health gain" and "resource effectiveness": both are utilitarian concepts which are measured primarily in population terms. This strategy also includes the "people centred" concept which represents consumerism in the health service rather than any deeper value system. The population approach cannot be allowed to dominate clinical practice without loss of professional credibility with the public and indeed with ourselves. The first 25 years of academic development in general practice contributed much to our understanding of the use and abuse of the doctor-patient relationship and the therapeutic value of feeling valued and understood.

RETURN OF THE PATIENT

We have begun to balance appropriate technology with the advantages that can accrue from a good doctor patient relationship. The generalist role has always been to make inquisitive clinical observations, to tolerate uncertainty to understand local probabilities, and to be health advocates for the patient in these contexts. The constant need is for personal, primary, continuing and accessible care. At its best this provides a wide range of clinical competence which minimizes a fragmented approach to the patient. At its worst it can be screening or "symptom swatting" with expensive tools applied in an idiosyncratic way with scanty regard for individuals, their health, their real problems, or even regional and national priorities.

Each consultation can have exceptional potential in primary care. The Stott and Davis model has strong face validity in general practice settings throughout the world. External factors impact on every consultation and recently national government has attempted to force general practitioners to focus on the needs of the population at the expense of the individual. The 1990 contract set out specific objectives regarding availability, preventive medicine, and information for patients. These are reasonable objectives but need to be balanced by an appreciation of the true potential of the generalist when that role is performed well. The patient too is shortchanged. It is superficially attractive to be installed in the role of consumer, with all that that concept can confer in a market, especially if one is in full employment with an above average income. The reality is that in the context of today's prevalent morbidity patients had also better be "producers of health". Given the behavioural and economic as well as the pathophysiological features that combine to establish an illness, the professional relationship with a good generalist is of potentially great value and empowerment. Some lay observers are noting this already.

It is of course essential to acknowledge the place of public accountability, information technology, management and audit. But general practitioners must not let go their responsibility for and accountability to individual patients, otherwise they will become utilitarian public health doctors. Equally, if general practitioners retreat from the individual to focus on the cellular and molecular they lose the generalist role and become biological scientists. I wish no disrespect to public health nor to biological science in these comments, indeed I would regard it as absolutely fundamental that general practitioners are not only able to make accurate observations in both of these areas but are able to apply them competently in the context of their patient care.

THE RETURN OF THE GENERAL PRACTITIONER

General practice has come a long way not only since the middle of the last century when the British Medical Association was formed but also since the middle of this century when the NHS was founded. As a group they have faced social and political crisis, in the Lloyd George and Bevan eras. In my opinion they did not distinguish themselves during those times of change and indeed tended to head for what was perceived as the safest port during those particular storms. Where general practice has distinguished itself is in rehabilitating itself from what, until almost the present day, is a potentially disabling educational

experience. Disabling because the overarching Oslerian paradigm is inapplicable and largely inappropriate. What general practitioners have done, through the training phase of their careers, has been to hang on to clinical problem solving (buttressed by basic science—the really valuable part of Osler's legacy). They have also been the prime movers in how to communicate with patients. Essentially they have put these two skills together in the context of the communities in which they practice.

Notwithstanding the variation in performance which any branch of the medical profession can and does show, general practitioners now have a paradigm within which they can work effectively. Like any paradigm it can and should experience strain—how can accessibility, continuity of care, or patient empowerment be demonstrated? Like any paradigm it can face direct challenge, in this case from no less than national government. Whatever one's views about that, and I think that I have at least made my views clear, such a challenge is actually a sign of being in possession of something that is useful and valuable, even effective. During this period general practitioners should have the courage of their convictions and be very careful about needing to reach any port during this particular storm.