Medical Controversies

Medical care in the inner cities

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Dr Michael Downham was asked by the *BMJ* to make a critical assessment of the primary medical care provided in inner cities by the NHS. His article, printed below, was then sent to two general practitioners and an AHA principal medical officer; all four met to discuss the topic with one of the *BMJ* medical editors, Dr Tony Smith, acting as chairman.

Working paper

Health services do not in the long term hold the key to the health and happiness of those living with the problems of our urban society. To a large extent these problems are an inevitable result of our political and economic philosophy. This does not mean, however, that the doctor and the nurse can with a free conscience cede their responsibilities to the politician and the economist and the philosopher; because there are real contributions, in terms of both alleviation and prevention, that health services can make, but are not making, to the special problems of inner cities.

Can general practice, the institutional core of our primary health care service, the envy of health services in other countries, provide the answers? I no longer believe that it can in its present form.

Why is general practice not working? First, because of its "geographic disintegration." The principle that patients must be free to choose their doctor, and doctors to choose their patients, has led to widely scattered practice lists. The city GP, unlike his rural or small-town counterpart, cannot identify with a community, live in it and learn its ways, see it as his responsibility. He has to deal with too many health visitors, social workers, schools, housing departments, and voluntary agencies to be able to make constructive working relationships. Similarly his patients do not see him as their undisputable source of help, and are often deflected by a crisis to casualty departments or community services.

Secondly, the health problems in inner cities, to an even greater extent than in other communities, very often involve a mixture of social, medical, and educational factors, which demand close working relations between professionals from different services at an individual level. In addition, preventive action holds more hope of success than crisis intervention. Neither of these approaches—close co-operation with other professionals, and giving priority to prevention—have been strengths of general practice in the past, and progress in these directions is occurring only in a minority of practices.

Thirdly, young vocationally trained doctors are not taking up posts in the inner cities where they are most needed; and who can blame them? It is common knowledge that the existing system of financial incentives, based on designation of under-doctored areas, is ineffective. The young doctor contemplating an inner city vacancy foresees heavy patient demands, many of them requiring an across-the-services approach for which there is no structure; having to work from inadequate premises; and having to live in an area where housing, schools, and community may be unattractive to his family. He will also have recent undergraduate recollections of the impersonal and inadequate relationships between urban practices and teaching hospitals.

Finally, for the few young doctors attracted by the inner city challenge, there is the inflexibility of the current system of remuneration, which makes it extremely difficult for them to join or form a group with progressive attitudes.

What is needed to make it work? I have six suggestions—a geographical patch, for which a group of doctors is clearly responsible, in terms of prevention as well as the provision of a 24-hour emergency service, readily available and not solely dependent on telephone contact; a truly integrated primary care team, with medical, social, educational, housing, religious, and voluntary agencies, working as equal partners from a single building; incentives—for doctors to work in inner cities, direct finance, help with housing within the practice community, and flexibility of educational choice for their children; local epidemiological information about current health needs and provision of services for localities within cities such as wards and enumeration districts—this data is essential for deciding where positive discrimination in primary care services should be focused, and for monitoring the effect over time of geographical teams (professional satisfaction from preventive work depends on readily available epidemiological evidence of change); specific links between hospitals and primary care teams, consultants in the most relevant specialties (geriatrics, paediatrics, psychiatry) undertaking a responsibility to certain primary care teams, which should include regular joint consultation at the teams' premises; more relevant undergraduate and postgraduate training to prepare some doctors for the special skills required for inner city work, particularly in preventive medicine and in working jointly with other services.

How can all this be achieved? There seem to be three options. We can continue in the hope that general practice, which has changed a great deal over the last 20 years, will evolve towards its own solutions within its existing framework. I cannot accept this option because change is occurring too slowly, and there seems little movement within general practice itself to face the special needs of the inner city family. The Court Committee reminded us that for children the substandard and disintegrated services of inner cities are particularly disastrous; they pointed

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towards solutions centred on the existing structure of general practice. General practice representatives have rejected these solutions without putting forward constructive alternatives.

A second option is to build a special service for inner city communities, based on the hospital and AHA community services. As a paediatrician I reject this solution, believing that there can be no satisfactory substitute for a community-based family doctor, who provides continuity of care across all ages and for the family as a whole. This has been clearly demonstrated in the best rural and small town practices.

I therefore believe that the only long-term solution is to make radical changes to the structure of general practice and to its relationship with AHA services, in the ways I have outlined above. These changes can be achieved only by making general practice, at least in inner cities for a start, a salaried service, fully integrated with AHA services. Hospital and AHA community doctors have had difficulties with the NHS structure, but they are learning, and there would be great mutual benefits to all doctors as well as to patients if GPs were to become full members of the service. Independence is not justifiable if it does not work for the patients most in need.

Discussion

DR GEORGE PRESTON: There is a degree of pessimism in this document which I don't share. I don't see inner London as a deprived area, I think it's really quite an exciting place to live.

CHAIRMAN: But do you see inner London at the moment as having adequate primary care?

DR PRESTON: I'm a little bit concerned about what is actually meant by inner cities. In London, certainly, the problems vary enormously from one borough to the next. In the part where I practise I see a mixture of everything from peers of the realm down to the homeless vagrants. I'm sure that is also true of parts of north of the river, where a lot of middle-class people have moved in and the area is really very patchy in terms of social structure.

CHAIRMAN: Are there problems even in middle-class areas in the inner cities?

DR ROBERT MACGIBBON: Yes, there are. Certainly in the area I work, in Camden and Islington, the general medical services are neither coping with the specific problems of city areas nor are they providing general medical services satisfactorily. People don't complain to their GP, but if you ask the paediatricians, or the community physicians, they know the primary health care system isn't working.

DR MICHAEL DOWNHAM: We know in Newcastle that there are a relatively small number of areas where nearly all the children die and where nearly all the main child health problems are. Morbidity and mortality show vast variations between small local populations and there is quite a bit of evidence to suggest that in the worst areas people are not using the services as much. That's the strongest argument to me that the system isn't working.

DR SHELAGH TYRRELL: I think the people who are not getting primary care actually don't know they're not getting it because they don't know they need it. A few are the homeless families; others won't go to doctors anyway because they've always been to their mother-in-law or the chemist.

DR MACGIBBON: The three community health councils in Camden and Islington are certainly not satisfied; and there are community groups setting up specific inquiries to find out how they can try to improve the services because there have been so many complaints from people who live there.

CHAIRMAN: What do they see is wrong?

Finding a GP

DR MACGIBBON: The primary problem is they can't find GPs. Very fundamental, and a common complaint.

DR PRESTON: I've never come across that problem—and in fact I have the impression that we're slightly over-doctored—I suppose because we've got three teaching hospitals within a radius of a mile and a half.

DR TYRRELL: Difficulty in finding GPs is certainly a problem in North Kensington. It's not only the social problems of urban deprivations that cause us concern; it's also the structure of general practice. The average age of our GPs was 55 at the last count and over half are in single-handed practice. Our health visitors reckon that about 5% of their families are not on any general practitioner's list.

Some families (possibly because of their particular problems) are very aggressive, and the GPs aren't very keen to have them. One or two of these families have been turned down four and five times by a general practitioner.

This shortage of GPs is very evident in casualty departments with the high proportion of self referrals. Mothers will come up and be told by the casualty officers (who may be on the GP rotation) that they will be seen only with a doctor's letter—next time. Often they have no GP.

DR DOWNHAM: The pattern in the north-east is very different. We're a much smaller conurbation. We don't have the same mobility problems, with people coming in and out of the area. The striking thing about Newcastle is that we don't have many middle-class families—we certainly don't have any peers of the realm and the ones we do have are gathered together in relatively segregated groups in relatively localised areas of the city. I would suspect from the one or two areas where there is overlap that there is a problem, and not only for the deprived and the disadvantaged families. Furthermore, I agree with Dr Preston that we're coming to recognise that the problems which have been labelled "inner city" are not always right in the centre of cities. They sometimes occur in new towns close to cities which have had a heavy burden of rehoused problem families.

Clinic doctors

CHAIRMAN: Is there any truth in the belief that clinical medical officers in the community health service could or should take on any part of the primary care in inner cities?

DR TYRRELL: Only if they were part of general practice or provided a special service. In my view the total developmental care of the child is more appropriately in the hands of the general practitioner with particular paediatric skills than it is in the hands of the clinical medical officer.

DR PRESTON: We always try to get all our own babies into our own developmental clinic rather than having them go to the local baby clinics. Mothers very often say "it's just across

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"It makes the practice much more worth while if the doctor lives close enough to shop in the same areas, to go to his patients' shops and see them in the street."—Dr George Preston.

"People don't complain to their GP, but if you ask the paediatricians or the community physicians they know the primary care system isn't working." —Dr Robert MacGibbon.

"The people who are not getting primary care don't know they're not getting it because they don't know they need it."—Dr Shelagh Tyrrell.

the road, it's five minutes shorter"; but once they've been and found that the physician running the developmental clinic cannot prescribe the eye ointment or the nose drops or whatever they change their minds very quickly.

Educational medicine

DR TYRRELL: Educational medicine is a different matter, however. In an idealised society with primary care in the hands of the general practitioner and secondary care in the hands of the hospital, educational medicine should be a specialty within primary care. If it's done properly it is a specialty, but few general practitioners are interested in it.

DR PRESTON: What do you mean by educational medicine?

DR TYRRELL: What the school health service is trying to do is to monitor the health needs of all children and to assess and treat learning difficulties and behaviour difficulties—using a multidisciplinary team in the school.

DR PRESTON: You are talking about children with special problems.

DR TYRRELL: In our inner cities, perhaps 15-20% of the children do have special problems. If we can find out about these children while they are only three or three and a half or even younger, there is some chance of prevention being effective. So "educational medicine" starts very early.

DR DOWNHAM: What you say emphasises that educational medicine is very much part of what we're talking about. This morning, for instance, I went through a class in a comprehensive school; and found that three-quarters of the 30 children were not living with both natural parents. That is one kind of measure of the extent of family breakdown in some of these areas. Next, when we began to think about how we should link up with these children's GPs—to talk to them about co-ordinating activity—we found we were going to have to deal with 15 different doctors. Very often the teacher is in a strong position with these families to identify problems and yet hasn't got the link because the school has to deal with so many different general practitioners.

DR TYRRELL: Another thing that school medical officers have not done in the past but might well do in the future is research. Up till now the research in growth and development has mostly been done in private schools, while in the state schools, with their vast numbers, we have not even been measuring or weighing children accurately in many instances.

CHAIRMAN: Aren't you begging the question as to really who should be doing it? I went recently to Milton Keynes where the general practitioners who were brought in afterwards to look after the influx of patients in the new towns were appointed school medical officers as they came in. Because it is a new town set-up it has been possible for the teams of doctors working in the health centres to have a defined geographical unit to look after. All of the children in that geographical unit go to the community school, and the obvious person to be the school doctor there is the general practitioner—thus providing proper continuity of care.

DR TYRRELL: This seems a good idea, but I think it is important that the doctor doing the work—whether it be a general practitioner or a clinical medical officer—should have been adequately trained. For that reason I am in favour of the Court Committee's concept of general-practitioner-paediatricians.

Vocation training

DR DOWNHAM: Certainly the education and vocational training of GPs should be relevant to the problems found in schools. Families don't differentiate between a medical and a social and educational problem; they need one source of help and a preventive approach. Neither of these are traditional strengths of general practice and neither of them necessarily strengths at the moment of vocational training. I just wonder whether vocational training is moving enough in these directions?

DR MACGIBBON: Yes, it is moving. I've been qualified for 10 years plus, and a lot has happened in those 10 years. I can't answer the question more specifically than that because all the vocational training schemes are so different, but vocational training in paediatrics and other disciplines does look at these medicosocial aspects.

DR DOWNHAM: It is vital to get vocational trainees working in the difficult areas. One of the big problems in the north-east is that we have very few training practices actually in the deprived areas—there are very few training practices in the urban areas of Newcastle at all. The regional advisers are concerned about this and are trying to work out ways of doing something about it. The city GPs are greatly concerned because they say if we don't have trainees we won't get good people to come into our practices, but at present the training is going on largely in areas where these problems don't exist.

Attracting GPs

CHAIRMAN: This is, I think, one of the central points of your paper: the difficulty of attracting general practitioners into areas which are on the way down. In London, with the population of the inner areas still falling, local medical committees are reluctant to appoint successors to doctors who die or retire, which leads to the situation that you describe with a very high average age and many single-handed general practitioners.

DR MACGIBBON: I think the only answer—as Dr Downham suggests in his paper—is for the local authorities to provide health centres and for GPs to work there with a full primary health care team on a salaried basis.

DR DOWNHAM: Delineation of the areas would be very difficult.

DR PRESTON: For example, how would you take North Kensington and Paddington and divide that into areas?

DR MACGIBBON: It's already divided up by the community health service and by the social services. The only people not working within these areas are the GPs.

DR TYRRELL: One thing which would worry me about an urban city salaried service (though basically I'm not sure that this wouldn't be a good idea for the whole nation) would be how to unscramble it. In London certainly there are places that within 10 years come up in the social scale and become much improved and there are other places that go down. Now would your salaried service gradually encroach over the whole city, or would you say we no longer declare this an area of urban deprivation and so it can go back to independent contractor general practice?

CHAIRMAN: We need to encourage general practitioners to come into inner city areas, and particularly younger and well vocationally trained ones. How else is it going to be done?

DR TYRRELL: If GPs are in a health centre, working in partnership of say, four or five, why does it matter if they commute? Surely only one need be on call any one night and he could actually spend that night at the health centre.

DR MACGIBBON: It's not that young doctors don't want to work in these areas. There are lots of people like me who were born and bred in London, who actually like to work here.

DR DOWNHAM: There's a lot of ethos about living in poor London now but there's much less about living in poor Liverpool. What are you going to do about Wallsend and Tower Hamlets and central areas of Merseyside?

CHAIRMAN: One solution is that we should take more medical students from such areas—because there is good evidence that people are willing to go back to their homes as doctors. At the moment medicine is a predominantly middle-class profession, and indeed it is. We're not taking enough medical students from places like Tower Hamlets: if we did then we might be able to solve these problems in an entirely different way.

DR MACGIBBON: The problem in my area is *not* that GPs don't want to come in; the trouble is that there aren't the group practices for them to come and work in. Vacancies are not coming up very often and the lists of retiring GPs are being dispersed because of the low average list size in Islington. The trouble is that there are no practices worth taking—who wants to move into a single-handed practice nowadays?

DR PRESTON: I think there is a move back towards single-handed practices. We've had one or two doctors who have worked as trainees in the area who have specifically chosen to go back into a single-handed or possibly two-partner practice—working from small premises without an appointment system and without the trappings which the group practice acquires. They feel that some of these trappings in fact deter patients from coming to see them and they prefer an open access system.

DR DOWNHAM: Can I ask you how important you think it is for your understanding of your patients and their needs to live in the community in which you work? We have to accept that there are areas which are going to be unacceptable for largely middle-class trained doctors to live in with their families. Should we be seeking a solution as Shelagh was suggesting of a flat in the health centre where one doctor is on duty overnight, or should we really be trying to train and encourage some trainees to see the challenge of living in deprived areas?

DR PRESTON: It is important that a practitioner should live within striking distance of his practice so that he can do his emergency calls; but I also think that it makes the practice much more worthwhile if the doctor lives close enough to shop in the same areas, to go to his patients' shops and to see them in the street.

CHAIRMAN: Do we think that if we change the organisation of primary care—to take one specific problem—we would have more success in getting women to attend antenatal care early.

DR PRESTON: I would have thought not. I see a steady small stream of women who present very late in pregnancy and they do it every time. I tell them what to do, I explain how important it is, and the next pregnancy I don't see them again until they are 36 weeks. When they've had their baby they've discharged themselves on the second day and they are off home, and the next time the same thing happens.

DR TYRRELL: The French have got the answer, haven't they? We've got to make it worthwhile to the mother. I think many are so clobbered with problems that they can't think straight. It's very often poverty and problems that keep people from making use of services.

DR DOWNHAM: I agree, we underrate poverty.

Choice

DR TYRRELL: Can I be a consumer for a moment? I think it's important that patients should have a choice. People want to be free to choose their own general practitioners as they do now. Allow them to choose their general practitioner but don't let the general practitioner be hurt if for specific things the patient wants to go elsewhere—for example, to a walk-in paediatric clinic or a walk-in adolescent psychiatric or advice clinic. Some people need a great deal of help and I don't see why the district general hospital couldn't expand to provide these as alternative services. Doctors at present working in the community—those doing child health, for example, could be attached to the district general hospital team and then provide primary care.

DR DOWNHAM: I think this business of choice has been overstated. I think it's a matter of accessibility and I think if we're talking about a group practice where there are two, three, or four doctors, it must be unusual for patients not to be able to find somebody in that group that they can get on with.

DR PRESTON: Yes, I think that's true, I think that's the way most groups work. In London before reorganisation we were all part of the Inner London Executive Council and it didn't matter where our patients were within that area. Since it's changed, we find ourselves with eight separate executive councils. They keep writing to us and saying, look, you've got 30 patients in our area, or you've only got 10 patients in our area, do you really want to stay on our list as being someone who is providing services? And in many cases they more or less imply we should give these patients up. I think this is interfering with the choice of the patient.

DR MACGIBBON: Choice is overrated. Community health councils are finding that people don't realise that they even have a choice to start with. They don't know they can change their GP. Theoretically they can but what happens is that if they don't like their GP they start using the casualty department and other sources of medical care instead.

CHAIRMAN: Are we being perhaps a little bit sentimental to say we need to retain the old traditional and paternalistic general practitioner in parts of ancient cities that can't provide him with the environment that's attractive to young men?

DR DOWNHAM: No doubt a hospital could provide good primary care service for the immediate vicinity; but so many of the vicinities we're talking about don't have a hospital right on their doorstep.

DR TYRRELL: And another thing. In London, there are many single people; maybe the general practitioner is the one person to whom they can actually relate.

CHAIRMAN: The concept of the general practitioner being someone on whom the patient can rely is no longer true in places such as Kensington where 30% of the list turns over every 12 months. The general practitioner is no more familiar a figure than the casualty officer at the local hospital.

DR PRESTON: Yes, but that's a function of patients rather than doctors. If you have an area where patients turn over quickly—as we have a lot of European students who come to learn languages—we provide what service we can for them. We may have to relate to doctors in Hamburg or doctors in Milan and we do what we can.

DR DOWNHAM: I'm very glad to hear you say that. I don't think I'm leaning over too far backwards to suggest that the old concept of paternalistic general practice is important. Even if it's a shifting population and it's only for a relatively short period of time, the concept that there is somebody who can follow you through and who is prepared to look at any problem you take to them—that is the real strength of our general practice. What concerns me is it's not working in some inner city areas—and that's why we need to look at alternatives.

WORDS What is an INFARCT? The term denotes ischaemic necrosis. There is an implication that only part of the affected organ is necrotic, for when the whole organ or limb has undergone ischaemic necrosis gangrene is the usual term. By derivation infarct means stuffed (L *infarcire*, to stuff; past participle, *infarctus*). This is true anatomically only for lung infarcts where, because of the double blood supply, the alveoli are full of blood and the lung parenchyma is consolidated. Actually, the past participle of L *farcire* is *fartus*. I imagine that this was too near the wind for its adoption by even the most morbid of anatomists. It seems that the Romans had difficulty in pronouncing -ct- and dropped the "c" as their Italian descendants have done—for example, with arctic, in Italian *artico*.

In a myocardial infarct the myocardium is, on the contrary, ischaemic. In culinary French *farci* means stuffed, whence the English force, as in force meat, which is stuffing made from chopped seasoned meat. Etymologically the only true cardiac infarcts are stuffed hearts for eating, the *coeurs farcis* of the chef, not the *infarctus du myocarde* of the French physician. Farcy or glanders is an infectious disease primarily of horses, occasionally communicated to man. In this condition subcutaneous nodules appear along the lymphatics, which, because of their stuffed appearance, are known to the laity as farcy buds. And what is a farce but a play, originally short, whose object is to excite laughter. This derives from the interludes of impromptu buffoonery that actors in religious dramas were accustomed to interpolate or, as it were, stuff into the text.

Enough of this stuff for today.