Personal care or the polyclinic?

Duncan Keeley

This is the second in a series of articles commissioned in response to the General Medical Services Committee's strategy paper "Building Your Own Future"

One set of responses to three key subjects discussed in *Building Your Own Future* would produce a change from traditional British general practice, based on personal care, towards a system of general practices as polyclinics. At present general practitioners contract to provide services as individuals, their numbers are still intended to expand to achieve average list sizes of 1700, and their role is only gradually expanding into health promotion and into prevention. The strategy document speculates that family health services authorities may in future contract with practices instead of individuals (and that many general practitioners may therefore be salaried); that the role of the general practitioner in prevention, management of chronic disease, and care of patients discharged early from hospital may continue to grow; and that the number of principals may fall, with the possible emergence of a hierarchy among general practitioners.

Let us suppose that the profession chooses to endorse policies that encourage further extension of general medical services and the role of the general practitioner, further growth in the size of practices and practice teams, but a reduction in the overall number of principals and an increase in average list sizes. Although the strategy document makes little mention of the contentious issue of fundholding, such larger practices would clearly be likely to hold funds if this option survives. We may imagine what such a practice might be like and then consider what would be gained and what lost should such practices dominate the provision of primary health care services. Firstly, however, it is worth considering in more detail the debate about list sizes.

List size debate

In recent decades the trend has been towards larger group practices and an expansion in the scope and numbers of the primary health care team. There has also been a gradual increase in the number of general practitioner principals and a reduction in average list size. In general each of these trends—bigger partnerships, bigger teams, and smaller lists—has been regarded both by policymakers and by general practitioners (academics and representatives alike) as conducive both to better patient care and to better working conditions for doctors. A minority have argued that larger primary health care teams made reductions in list size unnecessary and that with efficient organisation and delegation large lists need not sacrifice quality in general practitioners' care of their patients.[1]

This last view has found new favour in the context of political decisions to limit expenditure on general medical services and to encourage competition for patients by increasing capitation payments as a proportion of general practitioner remuneration. Thus the green paper *Primary Health Care: an Agenda for Discussion* stated that "there is at present little evidence of a direct link between list size and the quality of care, and consequently there is little to indicate what might be the optimum list size."[2] This view is not widely shared by academic general practitioners[3]—nor was it held by the General Medical Services Committee, who in 1983 stated that "general practitioners need more time to give patients the personal confidential care and advice that is the heart of good medical practice." The committee recommended reducing the average list size from 2200 to 1700, which with the appropriate supporting staff would "allow doctors to spend sufficient time with each patient to deliver the standard of service at which we aim."[4]

Policy advisers are apt to suspect an element of self interest in general practitioners' case for smaller lists. Professor John Butler from the Health Services Research Unit, University of Kent, Canterbury, has studied extensively the relation between list size and quality of care.[5] Although he doubts that reducing list sizes is sufficient to improve standards by itself, he concedes that "the argument that a continuing reduction in list sizes is a necessary precondition for an extension of a general practitioner's responsibilities is difficult to dispute."[6]

Such an extension of responsibilities is undoubtedly taking place. With increasing evidence from research for the benefits of increasing the length of consultation[7] and with short consultation time as "the major criticism of general practitioners expressed by patient organisations,"[8] the wisdom of halting or reversing the trend to smaller lists must be doubted. Taylor has shown that the 20% fall in average list size since 1970 has been accompanied by a reduction in the proportion of NHS expenditure devoted to general medical services[9]: a successful combination of extending family practitioner services while containing costs.

Delegating a substantial part of general practitioners' workload to other team members as an alternative to reducing list size may be problematic. In its evidence to the Community Nursing Review Team the Royal College of Nursing stated that "as a matter of professional principle, nurses should not be subject to control and direction by doctors over their professional work."[10] The ideal of efficient cooperation between a team of mutually respectful autonomous professionals is not always easy to achieve and requires a substantial investment of time. The Cumberledge report recommended phasing out the reimbursement of practice nurse salaries[10]; this has not been implemented, but family health services authorities will be free to decide their policy on reimbursement as they form, in conjunction with district health authorities, their response to the options for nursing in the community outlined in a recent report.[11]

Ministerial statements have tended to imply, perhaps disingenuously, that the government envisages no change in the trend to smaller lists. The logic of the new contract incentives, however, is that larger, better organised practices should increase their list sizes, putting increasing pressure on the income and ultimately the financial viability of smaller and less successful practices. One response to the questions posed in the strategy document would be to encourage this process in order, among other aims, to give general practitioner principals a more powerful role in the organisation of health care services and a stronger position in negotiating remuneration. Under these circumstances the question of the relation between list size and quality of care becomes crucially important as

Caversham Group Practice, London NW5 2AJ
Duncan Keeley, MRCGP, *general practitioner*

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this would determine whether the pursuit of our objectives as a profession was in the interests of our patients.

The polyclinic

Let us consider the practice of the future as a large spacious and well designed building, still owned by its 10 (probably male) partners—eight general practitioners and two managers. It holds a fund from the regional health authority for primary care and certain hospital and personal social services for its 24 000 patients. It owns and runs an adjacent nursing home. The work of organising, supervising, and auditing the practice's services and negotiating contracts with hospitals, together with certain outside commitments, means that the medical partners can offer only a limited number of clinical sessions. However, the practice employs four (probably female) salaried general practitioner assistants on three year renewable performance related contracts, which, together with efficient delegation of tasks to the practice team of nurses and other paramedical and social workers, ensures that clients receive an excellent and comprehensive service. The service offered is kept up to scratch by friendly rivalry with the one other (broadly similar) practice in the town.

A primary health care system organised along these lines might have much to commend it, particularly if it became as available in the inner cities as in the county towns. The range of services available to patients in such practices would undoubtedly be greater than what many practices can offer now. Giving general practitioners greater responsibility in deciding how to spend NHS funds might result in better value for money being obtained and greater responsiveness of the service to patients' needs. Such responsibility would, however, take more of the general practitioners' time, and preparation for it would need to be included in their training.

Difficulties presented by polyclinics

The losses in moving towards such a system are perhaps less evident, but they are important. Potential problems can be identified in four areas—the professional autonomy of general practitioners, the role of women general practitioners, the preservation of freedom of choice for patients, and maintaining personal and continuing care, which has been held to be the cornerstone of good general practice.

The professional autonomy of general practitioners would seem to be enhanced by these changes. Many practices that have chosen to hold funds have been influenced by the perception that only by taking on the risks and responsibilities of fundholding could they preserve their autonomy in relation to the family health services authority and district health authority in such matters as the employment of staff and freedom of referral. Nevertheless, overexpansion may make it difficult for general practitioners to retain ownership of their increasingly costly premises and equipment. Already some practices that own large premises in areas where property is expensive are finding that few applicants for partnerships can afford the cost of buying in. Should practices find themselves looking for a buyer health authorities would be unlikely to step in—at least in the present climate—but private health care companies might well be interested. Few doctors would regard this as a positive development.

Reducing the number of principals and the re-emergence of the salaried assistant would have adverse implications for women doctors given the largely predictable gender division between partners and assistants. A fall in the influence of women as policy making partners in practices might in turn diminish the responsiveness of practices to the needs of women as patients.

The changes might also reduce patient choice in primary care. Large practices with large lists and efficient delegation tend to provide less continuity of care, less home visiting by doctors, and less consultation time per patient, all of which may be important to patients.[12] Patients will inevitably have to travel further to attend the surgery, which could be difficult for some patients, especially the more disadvantaged. The different services offered by large practices may outweigh all these considerations, but if there are no small practices left the patient will have no choice.

The greatest difficulty would be to preserve the personal and continuing relationship of doctors with patients, which is a major source of both the quality and the cost effectiveness of British general practice. Already many larger group practices provide less continuity of care than might be desirable[13]; larger lists, greater administrative burdens on partners, the employment of assistants, increased delegation of a widening range of tasks to other team members are all likely to reduce continuity further.

Does it matter? To quote McWhinney: "Human variability is such that for a seriously ill person the physician cannot be a replaceable part. If we insist on treating ourselves as such, we should not be surprised if society treats us as labourers rather than as professionals. We should also not be surprised if it does something to us as people. As we withdraw from our patients, we will be the poorer for it. Our professional lives will be less satisfying, and we will lose much of the depth of experience that medicine can give us."[14]

New role for doctors?

We are seeing the possibility of a major redefinition of the role of the general practitioner principal. The emphasis would be less on "personal primary and continuing care of individuals and families"[15] and more on organising the work of a team of (hierarchically inferior) health workers, deciding how the money for the health care of our patients should be spent, and keeping that expenditure within limits. This responsibility for resource allocation is not, as far as I am aware, to be found in any account of the family doctor's function dating from before the publication of *Working for Patients*.

The incentives to take on this new role are firmly enshrined in the new contract and certain innovations

in the white papers. We must decide whether it is in the interests of our patients, and of our professional satisfaction as doctors, to accept it.

My own view is that certain strengths of British general practice are threatened by recent changes. We cannot accept the role of controller and allocator of health care resources without it affecting our relationship with our patients and putting at risk their trust that we make our decisions solely in their own interests. Decisions about "distributive justice" must be made but not in the consulting room and not by the general practitioner. We should not yield to the perverse incentives in a contract that is "widening the gap between high and low investment practices, inversely reflecting the social and clinical burdens with which they contend."[16] Instead we should seek changes that will promote quality in practices regardless of their size and complexity, so as to preserve and enhance the wide range of choice in high quality primary care services that the government says is the key objective of its reforms.

Many general practitioners are concerned that the cart of *Quality in General Practice*[17] has been hitched up to a horse going in the wrong direction—to a set of reforms which contain an unsatisfactory approach to the problem of cost containment and insufficient commitment to a single equitable national health service. Should we now try—gently—to turn the horse round, or should we concentrate only on staying in the driving seat?

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A PAPER THAT CHANGED MY PRACTICE

Wheezy children

The commonest single cause of admission of a preschool child to a general paediatric ward is an episode of cough and wheezing. In my early days in paediatrics we labelled this condition "wheezy bronchitis" or sometimes "asthmatic bronchitis." We studiously avoided the term "asthma," which was thought to have alarming prognostic implications. I did not feel able to give sensible advice from a knowledge of the natural history of this common disorder.

Williams and McNichol's paper in 1969 clarified both the nature and the natural history of the disorder, and made me far happier in dealing with and discussing it. They examined the prevalence of a history of wheezing in 7 year old Melbourne children, and compared the clinical features, and the outcome at 10 years, of those who had never wheezed with those labelled as "wheezy bronchitis" or "asthma." The latter two groups seemed indistinguishable in family history and clinical features. Eleven per cent of all children had had wheezy episodes; two thirds had stopped having such attacks by the age of 10, while the remaining third continued to have them and would conventionally be diagnosed as asthmatic.

After I had read this paper I stopped equivocating and recognised (and said) that all these children had asthma. I was able to add the reassuring message about the natural history and the high probability of the child "growing out of it." Many other studies dating from about that time illuminated the pathophysiology of wheezing in childhood, such as those by R S Jones and Simon Godfrey showing the importance of exercise induced bronchospasm. Williams and McNichol's study would have been strengthened by measurements of respiratory function, and they may have underestimated the role of viruses in provoking wheezing in young children. But for me their paper was the first and major step towards understanding wheezy children better and allowed me to talk more comfortably and confidently to their parents about the diagnosis and natural history of asthma. When I did so—usually several times a week on the wards—I always had this paper somewhere at the back of my mind, and the picture of Melbourne children who had wheezed and got over it.—ROGER ROBINSON, *formerly professor of paediatrics, London; now associate editor, BMJ*

Williams H, McNichol KN. Prevalence, natural history, and relationship of wheezy bronchitis and asthma in children. An epidemiological study. *BMJ* 1969;ii:321-8.

Ventilation in the newborn

Twenty years ago a paper written by Professor Osmond Reynolds in the *Archives of Disease in Childhood* had an immediate effect on the clinical care of babies with the respiratory distress syndrome in many countries throughout the world. It certainly had a bigger impact on my own clinical management than any other paper before or since. The main message was that with the ventilators currently available high respiratory rates had little beneficial effect on carbon dioxide clearance, while oxygenation was improved and right to left shunting reduced when slow rates and long respiratory times were adopted. This paper led to the concept that a reversal of the normal inspiratory:expiratory ratio was beneficial, a concept that remained largely unchallenged, certainly in the United Kingdom, for the next 10 to 12 years. It still has an important influence.

Rereading the paper 20 years on was illuminating. Although the message came over with equal clarity, I had forgotten that only six babies had been studied; all but one were over 30 weeks' gestation and 1500 g in weight. Three subsequently died. Over the past eight years there have been several studies using ventilators specifically designed for neonates and including babies down to 23 weeks' gestation, 500 g in weight. The trend now is to go back to the high rates which were in vogue when Professor Reynolds's paper was published and to shorten inspiratory times in an attempt to reduce morbidity and mortality further. Indeed, as a result of improvements in obstetric care and neonatal resuscitation techniques, respiratory distress syndrome is relatively rare in babies over 32 weeks' gestation. When it does occur, however, it is an unwise clinician who does not at least consider the message that was published by Professor Reynolds so long ago.—A D MILNER, *professor of neonatal paediatrics, United Medical and Dental Schools of Guy's and St Thomas's Hospitals, London*

Reynolds O. Effect of alterations in mechanical ventilator settings on pulmonary gas exchange in hyaline membrane disease. *Arch Dis Child* 1971;**46**:152-9.