The Future of General Practice

General practice as a career

Clive Richards

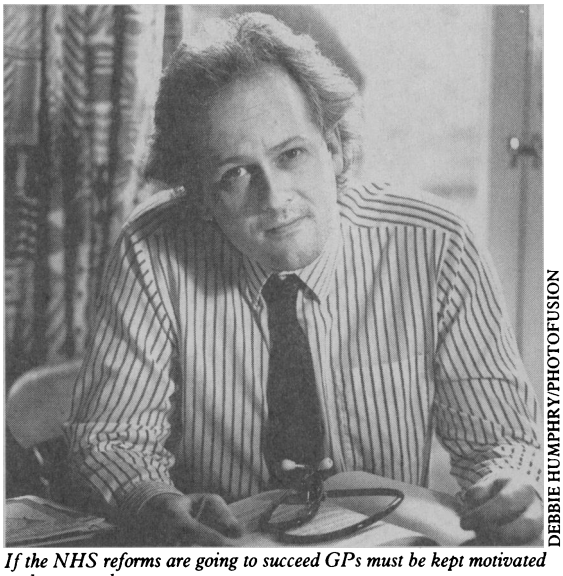
This is the tenth in a series of articles commissioned in response to the General Medical Services Committee's strategy paper "Building Your Own Future"

The past few decades have seen considerable political, economic, and organisational changes in society which have been mirrored in the organisation of health care. Expectations have risen. There is more sharing of power with patients and concern for informed choice. The information revolution has affected every aspect of life. Enormous additional changes are implicit in introducing market place concepts in health care, and developments in general practice to parallel these changes have already occurred. Fuelled by the Doctors' Charter of 1966 general practices have become larger as doctors formed groups and rotas, appointment systems and clinics have been developed, ancillary staff have been employed, and work has been shared with primary health care teams. Above all, general practitioners have taken charge of their own education and, having identified a core body of knowledge, skills, and attitudes unique to their discipline, have introduced general practice into the undergraduate curriculum and required vocational training for all entrants into the specialty.

Together with these developments there have been concerns. A paper about general practitioners' educational needs showed that a substantial minority of general practitioners had problems in their self image and in satisfaction with their work, feeling lonely and isolated and uncertain in their role.[1] A survey of general practitioners showed a growing discrepancy between practices, with doctors working in areas of poor socioeconomic status using less resources and having a lower income than their colleagues in other parts of the country.[2] In 1988, a National Audit Office report concluded that "more than 40% of all inner city doctors' premises are sub-standard and one in seven surgeries in England is unsatisfactory."[3] Although general practice has been successful, it has been clear that some doctors continue to employ too few staff, keep poor records, and generate concern about the quality of their work. Doctors' health has also been of concern. The four d's (drink, drugs, divorce, depression) to which doctors are vulnerable are well known; many of these problems are caused by stress associated with conditions under which doctors work.[4] Allen showed unprecedented levels of depression, disenchantment, and gloom in doctors who had qualified in 1981,[4] a trend that seems to have been slowly growing.[5]

Lack of career structure

Central to the role of the family doctor is a stable figure working within a community with a responsibility for individual patients and a duty to care for them throughout their lives. The absence of an organised career is striking. By organised I mean an occupational structure that allows growth and opportunities for creativity and learning at different phases of life and not the traditional hierarchy progression (stages at ages) which may characterise the advancement of hospital doctors. When doctors become principals in practice the basic conditions of work will remain similar from the day they enter practice to the day they retire. Changes may occur at the margins—a doctor may work up to senior partner and become a trainer or course organiser; have new premises to move to or a new computer to install; and have different patients to see at different phases of their lives—but there is little progression and little change in the pattern of work. In no other walk of life do keen, highly trained executives expect to leave the same job in their 60s as they entered in their 30s. The paradox for general practitioners is that having rejected the oppressive aspects of a hierarchical career in hospital they have to face the consequences of no career at all. Poor morale is common and not surprisingly many general practitioners are burnt out or bored stiff by the age of 40. Michael O'Donnell, the television personality and journalist, once described doctors as "resentful prisoners" chained to their jobs by fetters of security.[6]



DEBBIE HUMPHRY/PHOTOFUSION

If the NHS reforms are going to succeed GPs must be kept motivated and supported

The traditional organisation of general practice is founded in the small business ethic of the self employed contractor. This structure facilitates innovation among general practitioners, who enjoy a high degree of professional autonomy. It does, however, place restrictions on mobility of labour and on personal freedom by constant availability to patients. The freedom of family doctors to become truly entrepreneurial within the intensely regulated environment of the NHS is restricted. Some of the frustrations were

Health Care Evaluation Unit, Department of Epidemiology and Public Health Medicine, University of Bristol, Bristol BS8 2PR
Clive Richards, FRCGP, *regional adviser in general practice audit*

BMJ 1991;303:827-8

expressed by a senior doctor: "It is almost a degrading experience to be an independent contractor in your own building and yet have to go to the FHSA asking for staff."[7] There are difficulties in negotiating equitable terms and conditions of service that allow all small businesses to compete on equal terms while giving individuals opportunities for career development. The target net income system gives general practitioners little financial incentive for extra work, but it was the profession that rejected a "merit award" type scheme for general practitioners.

Effect of reforms

The new contract for general practice was intended to rectify some of these problems. Whether the net effect will be beneficial remains to be seen. The much publicised fact that 90% of general practitioners have reached their immunisation and cervical smear targets has obscured the reality that in at least one inner city family health services authority half the general practitioners have stopped putting in claims for the work, presumably because they have no hope of reaching their targets.[8] Central to all the reforms is a requirement that general practitioners should retain their traditional position as personal doctors of first contact. This is the role in which general practitioners have been most successful and one which is popular with the public. The new contract even specifies minimum hours that should be spent in contact with patients. Although this may seem unexceptionable, the perverse outcome of this is that it makes many of the other requirements of the reforms difficult to achieve. Tension is apparent between the traditional role of the doctor and the new proactive corporate image requiring a different model where the doctor is also manager, leader, influencer of service provision, and competitor for budget allocations. The problems of adding this to the 24 hour responsibility for patients and the requirements to work at night have been described.[9] The effects can be seen in increasing pressure on time. A recent paper provides an insight into this pressure: "The essence of audit . . . is standing back from our everyday slavery and looking at what we are doing."[10]

Prospects for continuing education have also changed under the new contract. This may be one of its most important features. The postgraduate education allowance was introduced to enable general practitioners to continue their professional education. It is important that this reflects their daily life of "multiple possibilities, conflicting motives and emotions, competing priorities and difficulties in communication."[11] Unfortunately, gains in professional self esteem have been undermined by the simultaneous imposition of mandatory procedures such as regular health checks for which there is no evidence of benefit.[12] A major problem over the organisation and financing of essential research in general practice has been described.[13] A difficult balance exists between a practitioner's main contractual requirement to be available to patients and the need to spend time away from patients in order to think and reflect and undertake serious academic work.

One of the most innovative of the health service reforms is to allow general practice fundholding. This may prove to have its greatest benefit by providing job enhancement in allowing general practitioners to determine their own professional future. Yet it is disappointing that such wide ranging reforms did not address other pressing problems. Women doctors, particularly those unable to work full time, have always found parity with their colleagues difficult to achieve and the new contract makes this worse. The new deprivation supplement to the basic practice allowance is cosmetic and capricious in its workings and does little to address the real problems of providing care to inner city and deprived areas.[14] Lack of job mobility traps many doctors. It is disappointing that the new contract does nothing to facilitate movement of doctors between practices, possibly by allowing general practitioners a "portable" basic practice allowance. Doctors unable to settle permanently in difficult areas could work in them without detriment during the course of a medical career.

Maintaining job satisfaction

All the effects of the new contract and of changes in general practice will take time to develop. But there are considerable risks in continuing to enforce changes without considering the effects of those changes on the doctors themselves. There has already been a considerable fall in the numbers of doctors applying for training in general practice and a substantial increase in the numbers of doctors considering options outside medicine. At a recent trainers' conference, it was reported that a quarter of the general practitioners in one group had already looked for work outside medicine.[15] A questionnaire in the south west showed that many mature doctors were considering early retirement specifically to escape the new contract (R Maxwell, personal communication). Any effect on general practitioners' health will be a long term outcome. Other changes (morale, participation, recruitment, migration) will be apparent long before effects are seen in the morbidity profiles of general practitioners.

A challenge to those who seek to change the NHS for the better will be to ensure that the needs of general practitioners as well as those of their patients are met. If the fundamental intentions of the NHS reforms are to be achieved it will be important to provide patients with doctors who are motivated, sustained, and supported at every stage of their professional careers.

1 Branthwaite A, Ross A, Henshaw A, Davie C. *Continuing education for general practitioners*. London: Royal College of General Practitioners, 1988. (Occasional paper No 38.)
2 Leese B, Bosanquet N. High and low incomes in general practice. *BMJ* 1989;**298**:932-4.
3 Comptroller and Auditor General. *Management of family practitioner services. National Audit Office report*. London: HMSO, 1988.
4 Richards C. *The health of doctors*. London: King Edward's Hospital Fund, 1989. (Project paper No 78.)
5 Allen I. *Any room at the top. A study of doctors and their careers*. London: Policy Studies Institute, 1988.
6 O'Donnell M. *The resentful prisoner game*. In: *Doctor! Doctor*. London: Gollancz, 1986.
7 Taylor A. Let every GP hold a budget. *General Practitioner* 1991 September 6:1.
8 Glasman D. Doubts over GP success story. *Health Service Journal* 1991 August 15:3.
9 Iliffe S, Haug U. Out of hours work in general practice. *BMJ* 1991;**302**: 1584-6.
10 Leonard P. Audit can be easy. *Audit Newsletter of the Royal College of General Practitioners* 1991;**2**:1.
11 Savage R. Continuing education for general practice: a life long journey. *Br J Gen Pract* 1991;**41**:309-14.
12 Morrell DC. Role of research in development of organisation and structure of general practice. *BMJ* 1991;**302**:1313-6.
13 Gray DJP. Research in general practice: law of inverse opportunity. *BMJ* 1991;**302**:1380-2.
14 Carr-Hill R, Sheldon T. Designing a deprivation payment for general practitioners: the UPA(8) wonderland. *BMJ* 1991;**302**:393-6.
15 Bain J. General practices and the new contract. In: Reactions and impact. *BMJ* 1991;**302**:1183-6.