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Squaring the circle?

THE Leeuwenhorst declaration defines a general practitioner as a doctor who provides 'personal, primary and continuing care to individuals, families, and a practice population, irrespective of age, sex and illness'.[1] In its emphasis on the generalist role it mirrors the central identifying characteristic of general practice in the United Kingdom. Maintaining the link with the traditional family doctor of pre-National Health Service days can be seen as one of the great strengths of our discipline. It is widely believed that patients value the continuing existence of family doctoring, and in Cartwright and Anderson's study 75% of doctors thought that family care was important or very important.[2] In two articles published some years ago Honigsbaum saw the preservation of a corps of general practitioners as one of the successes of the NHS, and one largely responsible for its low costs.[3,4]

However, Honigsbaum also saw the desire of general practitioners to maintain their separation from hospital medicine as a hindrance to the development of the discipline. He cited the evidence of hospital outreach programmes for conditions such as asthma and diabetes, the frequent use of hospital accident and emergency facilities by patients who could be treated by their general practitioners, and the unwillingness or inability of many general practitioners to perform simple surgical procedures. He felt that general practice was struggling to sustain a generalist approach and simultaneously searching for a new role. He saw the promotion of prevention in general practice by the Royal College of General Practitioners as symptomatic of this search.[3,4] In a study measuring general practitioners' approach to continuity of care, Freeman pointed out the potential conflict between continuity of care and the development of special clinical interests.[5] An article in this issue of the *Journal* identifies another weakness of uniform generalism. Bisson and colleagues have shown deficiencies of doctors' management of preeclampsia compared with accepted modern practice. Because 'accepted practice' has only been defined by papers in specialist journals, Bisson's paper highlights the need for generalists to keep themselves abreast of developments in specialist fields.[6]

Such arguments are inherent in the nature of our discipline, and have been discussed for many years, for example by McKeown.[7] However, if the theoretical arguments for specialist approaches in general practice are persuasive, the reality of these approaches has been less successful. The experiment into age specific care in Southampton, where general practitioners specialized in care of children, adults or the elderly, collapsed under the burden of its administrative complexity and inflexibility, and was subsequently abandoned in favour of traditional generalism.[8] The Court report, which suggested improving the care of children by creating a new job of primary care paediatrician was consigned to the dustbin of history by the hostility of general practitioners who saw it as a threat to family doctoring.[9] In Livingston new town all doctors appointed as general practitioners were also required to hold contracts as hospital assistants in specialist departments. The scheme was devised in 1964 in order to combat the problems of poor recruitment and morale that were then widespread in general practice.[10] In the 10 year review of the scheme the conjoint appointments were judged to have been successful, providing greater therapeutic and diagnostic back up in the health centres to the advantage of patients, and maintaining the clinical interests of the practitioners and the nursing teams.[11] Despite this, the continuing divide between the hospital and general practice has lately meant that new general practitioners are not offered conjoint appointments. In the face of these unsuccessful experiments, it is worth remembering one widely

practised model of specialist care in general practice: the selective use of women general practitioners by women consulting for gynaecological and contraceptive problems.[12,13] This is largely patient led and hence lacks the kudos of other professional special interests.

This debate has been thrown into sharper relief by the increased demands on general practice imposed by government reforms. For instance, general practitioners are to be specifically rewarded for running certain special clinics. Stott has pointed out that special clinics risk being disease- rather than patient-centred.[14] These may be organized around a particular general practitioner acting as a specialist resource, and so tend to 'deskill' the other doctors working in the partnership. In addition, the long term training requirements needed to qualify for providing paediatric surveillance may make it uneconomic for all partners in a medium or large practice to provide this surveillance and conflict with the aim to integrate preventive with curative and family care. Finally, the requirements for audit, to demonstrate high standards of care, encourages the examination of activity identified by specific diseases, rather than by wider concepts of health.

The desire of general practitioners to continue providing the generalist care that is apparently valued by their patients can be reconciled with the need for effectiveness within their practices and credibility with specialist colleagues. The key lies in being explicit about the work done by general practitioners other than face-to-face contact with patients. In one workload study approximately 3.5 hours a week were spent on education and practice administration.[15] Unfortunately, there has been a tendency among the profession and its observers to devalue such activity, so that only face-to-face contact counts as 'real' work. Instead it is important to value educational and management work, and to recognize that this portion of the workload may be more effectively achieved by individuals within a practice taking responsibility for a particular area of activity. By taking time to plan with colleagues the response to common predictable diseases and problems, the members of the practice can specialize and inform their colleagues from their own standpoint. Advice can be written into management plans and intra-practice referral can be encouraged. General practitioners often feel put on the spot by patients' demands; it is perfectly acceptable to ask for time to think and consult colleagues (both within and outside the practice), so that formal referral could become less frequent.

Thus, in a medium or large practice each partner should be a traditional generalist family doctor in his or her clinical work, while taking responsibility for keeping the rest of the practice in contact with modern developments, and for planning and audit of the overall service in a particular area of practice. Such an approach also offers doctors the opportunity of changing their interests over a working lifetime, thereby helping to create a career structure for established principals.[16] The need to consider education under the three headings of disease management, prevention and service management may distract rather than assist in planning a rational response to problems met in practice. Nevertheless, it may offer a way to combine the two highly laudable desires to be simultaneously as technically polished as our specialist colleagues, and as much a family friend as our professional ancestors.

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Mental handicap — care in the community

LITTLE is known of the extent to which mentally handicapped people benefit from primary health care services. The few studies that have been reported have been disturbing and suggest that many families are not receiving the help that they need. There are a number of reasons for this. General practitioners are fully stretched and have to decide priorities among many competing claims and vulnerable groups. Additionally, undergraduate training in mental handicap has been restricted and the facilities for postgraduate training are sparse. The opportunity to learn by experience is constrained by the relatively small number of people with severe mental handicap, about six on the average doctor's list of 2000. Yet, while the numbers are