General practice in the 1990s: a personal view on future developments

DONALD IRVINE

Introduction

FOR many general practitioners the recent period of unprecedented change has resulted in more work, more pressure and more uncertainty about the future. Recently, a survey reported that four out of five doctors thought deficiencies in their training and continuing medical education had contributed to their difficulties by not preparing them adequately for their changing role.[1] Yet continual change has become part of modern health care. A key question, therefore, is how we can anticipate and influence change rather than react reluctantly to it.

This paper has three objectives: to raise awareness about changes in general practice expected within the next decade; to consider their impact on our responsibilities as doctors; and to examine the consequences for our education. These are all issues which individual practices and medical teachers will want to consider in their strategic planning. Doctors who are sure of their subject are more likely to handle change well and indeed lead it; conversely, doctors who have been inappropriately trained for their responsibilities will become stressed and may lose heart.

The opportunity and challenge

Besides the threats, general practice in the National Health Service is being presented with a huge opportunity and a testing challenge.

The opportunity stems from pressures to shift the balance of care somewhat from hospitals to the community.[2] In the United Kingdom general practice is the obvious foundation for community care because it already provides patients with ready access to 24-hour medical and nursing services of good quality, at home if necessary. Building on this, patients in future are likely to be offered total care, provided where possible by the practice, and when appropriate purchased or commissioned from secondary care.

The challenge is to exploit this opportunity with imagination and speed. Future success will depend on our ability to ensure that every practice provides a quality service which patients need and want, and which gives the taxpayer value for money. We must decide, therefore, what exactly we think our job is, what extended range of care our patients can expect, and how we intend to assure consistency and quality, and so reduce the damaging effect of wide variations in the standards of care. Then, because patients value good general practice, we will be well positioned to promote the benefits of our service widely and attract the resources necessary for its development.

International trends

Several international trends in health care are shaping general practice from outside. These trends, reflected in the NHS reforms (NHS and community care act 1990)[3] are moving us towards a health service which is more responsive to patients, more accountable in terms of explicit health priorities and quality of service, and cost effective. These trends are:

- The accelerating expansion in the science and technology of medicine, placing general practitioners under greater pressure than ever to keep up to date and to demonstrate effective clinical performance.
- The consumer revolution, in which more people want more say about their health and health services,[4] the best care for themselves and their families[5] and choice in that care.[6] For the NHS the result has been a profound shift in emphasis from service providers to patients, the full effects of which have yet to be realized.
- Managed health care, in which the principles of general management are being introduced at all levels in the NHS.[7] In this context the *Health of the nation* gives a much needed sense of direction.[8]
- The trend towards being explicit wherever possible. Thus, managed health care means explicit aims, objectives and targets. Contracts are being framed in more specific terms, as the new contract for general practitioners demonstrates, and health professionals are beginning to use explicit guidelines to describe good clinical practice.
- The need for harmonious multidisciplinary teamwork, which often sits uneasily with our perception of ourselves as individualists. In the main we, like specialists, still have to learn how to work effectively within modern networks of care.[9]
- The pursuit of quality in its own right, and the theme of value for money. The drive is on, worldwide, to develop health care of the highest possible quality at the lowest possible cost.[10]

Developments within general practice

Given these trends, several major developments are imminent; most have educational consequences.

Clinical services

As part of the move from hospital to community, general practice will be expected to deliver more care of high technical quality. As Moore argues, generalists must be able to demonstrate that they provide better personal medical care than specialists do for common medical problems, especially problems of moderate severity.[11] General practitioners will also be extending their practice by developing special clinical interests. Minor surgery and dermatology are obvious examples, but a practice may establish expertise in depth in, for instance, child health, mental illness and care of elderly people. The many possibilities should, in sum, lead to more clinical care in the practice setting — and in community hospitals — and fewer patients being referred to or retained in district hospital outpatient clinics unnecessarily.

Public health function

Two unique features of NHS general practice are the registered list and the ongoing patient record. Both have had limited use as epidemiological tools partly because of the difficulty of abstracting data, and partly because of limitations on the data themselves stemming from small population sizes.[12] However, today's practice computer systems can categorize registration

D H Irvine, CBE, MD, FRCGP, general practitioner, Ashington, Northumberland.
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data and clinical summaries. Soon more powerful information systems and databases will become available, so the scene is set to develop the public health role of general practice, to complement individual patient care.

The public health function is the capacity of a practice to improve the health of its registered population through a wide range of interventions using its ability to describe, analyse and assess the health status of people on a regular basis. If developed successfully, general practice will become the leading specialty in implementing the *Health of the nation* strategy[8] and a major contributor in its own right to epidemiological research. To achieve this each practice will need epidemiological skills; these are not routinely taught in vocational training today.

New opportunities for teamwork

The new arrangements for practices to contract for community nursing and health visiting services should establish a sound foundation for developing teamwork by removing frustrating constraints.[13] Innovative practices may experiment radically with differing blends of medical and nursing personnel, and introduce new disciplines to the practice team. In particular, the newly acquired right of nurses to prescribe, and the evolution of the nurse practitioner, will lead nurses into areas of care which have until now been strictly medical.

Multidisciplinary learning will come into its own. In particular, in-house training for doctors and nurses, linked to practice based quality improving activities, could become the practice team-builder *par excellence*. Moreover, there will be new opportunities for doctors and nurses in primary and secondary care to learn together, starting with the needs of patients they share.

Improving and assuring quality

Primary health care professionals are exploring quality assuring and quality improving methodologies within the framework of modern practice management.[14-16] Soon the focus will shift from a preoccupation with process to scientifically rigorous, patient centred outcomes. Generating good outcome measures for primary care will be one of our major tasks.

Practice accreditation will become established as a general quality measure. The regional postgraduate organizations are already accrediting teaching practices, and the Royal College of General Practitioners through its fellowship by assessment,[17] the King's Fund (King's Fund Organizational Audit Project in Primary Health Care, personal communication) and the British Standards Institute (BS5750) are also offering some form of practice accreditation.

Purchasers of health care are starting to think about quality when writing contracts,[18,19] as are fundholders. For example, the new arrangements for practice health promotion plans will result in health authorities specifying quality standards. Purchasers are also likely to use accreditation as an indicator of quality, as indeed are the defence societies when assessing risk.

Lastly, there is the general movement within British society to improve the quality of public services. The patient's charter, which embraces general practice, exemplifies this.[20]

Contracts

The 1990s should see experiments with different forms of contract. There are three basic options; each could be operated simultaneously in the same health district so that practices and purchasers could choose.

Personal contracts. Today, each general practitioner is in contract with a health authority. Personal contracts are likely to continue where doctors value a high degree of independence within a partnership.

Practice contracts. Today's fundholding practices are the prototype of tomorrow's freestanding group practices in which any practice, regardless of size, could contract with a health authority to provide a specified range and quality of service for a defined population, at an agreed cost. The role of the fundholding practice as a provider would become pre-eminent, with additional elements added to the budget for hospital care where desired. Fundholding practices would become in effect small NHS trusts operating their own 'mini health service.' The current centrally negotiated contract would become one of a series of contracts which, together, would provide the practice with an income weighted to reflect the health needs of its population, from which all staff and services would be paid. The practice would enjoy considerable autonomy as to how it organized patient care and would be judged by its results.

Salaried general practice. A growing number of practitioners would like salaried employment.[21,22] There will be more opportunities for this in the future, both in freestanding practices and with larger providers such as hospital trusts extending their care into the community, or with community trusts providing primary health care services. The 'wider provider' model is most likely to emerge in any reorganization of primary health care in the inner cities, especially London.[23]

Developments in partnerships

Fundholding is fuelling discussion on partnerships, in particular on the delegation of responsibilities and on establishing effective accountability. Partnerships based on personal NHS contracts have one fundamental weakness: as size increases there is often difficulty in securing and implementing working agreements when several doctors, each with their own agendas, expectations and notions of commitment, are reluctant to give up much of their independence. Partnerships therefore make decisions which reflect the lowest common denominator of agreement. In tomorrow's world this may turn out to be too slow and too limiting for survival, hence the growing interest in shifting the contractual responsibility from the individual to the practice.

Partnerships based on a practice contract open up all sorts of possibilities. For example, Charles Handy describes a 'cloverleaf' organization comprising a small, central core of highly paid partners who are expert, hard working and totally committed to ensuring the success of their organization.[24] The partners contract with or employ others in support. Applied to general practice, a small partnership of doctors, and possibly other health professionals, would form the core. High levels of agreement on direction and policy would be achieved by choosing new partners carefully on the basis of their training, commitment, previous performance, and leadership qualities. Full partnerships would thus come a little later in a doctor's career than is usual now. The partners would employ or contract with other health professionals, including doctors (associate principals and specialists), nurses, counsellors, dietitians and others to help run the practice.

Management

The modern general practice, a complex organization, will need to employ the principles and methods of general management regardless of the contract type and style of partnership chosen.[25] Indeed, given the pace of change, practices which do not possess the attitudes, knowledge and skills required to manage effectively will find it increasingly difficult to furnish the quality of care expected of them. This is why more and more practices are making the development of practice management

their highest priority, buying in new skills and upgrading their own through further training.

Teaching and research

There are exciting new opportunities for developing teaching practices provided that we address them boldly, with careful attention to clinical standards. Multidisciplinary teaching practices which excel in the delivery of patient care, in their clinical method and in their professionalism as educators, will become the foundation for training doctors, nurses and other professions in the practice team. For general practitioners, teaching practices should contribute to higher training and continuing medical education as well as vocational training. More widely, the General Medical Council is encouraging medical schools to use general practitioners for teaching medical students the basic clinical skills, as well as for demonstrating care in the community.[26] Similarly, general practice now has the chance if it chooses of engaging in general clinical training[27] and in the early training of hospital specialists.[28]

Similar opportunities are opening up for research. Here, unlike education, our track record is poor. Yet many younger doctors would respond enthusiastically to academic leadership backed by properly funded and organized training in research method. As one indication of interest, in 1992 the north of England faculty of the RCGP ran an excellent scientific meeting, with all 20 papers based on research in ordinary practices in the region; there is now a thriving MD club with 24 active members in the faculty.

Changing responsibilities

In their totality these trends and developments represent a sea change for general practice and its patients. The aims of general practice in future may thus be described as: providing specified services of good quality to individual people and families; securing hospital care, specialized community health care, and social services of good quality for patients when required; improving the health of the practice population overall; and promoting learning by teaching and research.

To achieve these aims, all general practitioners will have core responsibilities. These will be: to provide basic clinical care; to encourage individual patients to live more healthy lives; and to contribute to the day to day quality improving activities of the practice.

There are also additional areas of responsibility, which are essential for the modern practice to function effectively. These include: additional clinical services and clinical care in greater depth; the public health function; the supervision of quality improvement/quality assurance systems; management; and teaching and research.

Some general practitioners will want to carry both the core and additional responsibilities. However, certainly in larger practices, it is inevitable, and desirable, that some rationalization will take place, with the core responsibilities undertaken by all doctors and the additional responsibilities by some.

This more formal delineation, based on the level of knowledge and skill possessed and the responsibilities taken, will hasten the emergence of a career structure. Many general practitioners would welcome this development. It would satisfy those, both full time and job sharing, who enjoy taking substantial clinical, managerial and academic responsibilities. It would also satisfy those who would prefer a job with more limited responsibilities, so leaving more time for other interests and families. These preferences would naturally be reflected in status and income.

Consequences for education

There are important consequences for education, which today does not prepare us adequately for an extended clinical role, for teamwork, as managers of people and resources, and as assurers of quality. To close the gap, training and continuing medical education should in future be considered under two heads:

- The essential competencies, and therefore the basic knowledge, skills and attitudes required by all general practitioners for the core responsibilities of general practice.
- The further competencies, knowledge, and skills required by doctors who choose to take on additional responsibilities.

To meet both these requirements, the following changes will be necessary.

The competencies

The attributes of the future general practitioner, described in a publication by the Joint Committee on Postgraduate Training for General Practice,[29] need to be complemented by a description of the essential competencies of general practice. These should provide the framework for curricula and assessment. Ideally, the RCGP's *The future general practitioner: learning and teaching* needs to be updated.[30] Can the RCGP once more rise to the occasion?

Vocational training

Preparation for the core responsibilities needs improving in several respects. First, the experience in general practice should be at least 18 months, but preferably two years, and the hospital component shortened accordingly. One year is too short for all the things that have to be done.[31] Secondly, hospital posts should be selected more critically to improve their value to trainees. This is timely, as the specialties themselves decide to prepare consultants better for their teaching role,[32] and as postgraduate deans acquire greater control over senior house officer posts. Thirdly, there should be formal training in the elements of public health medicine needed for basic general practice. Fourthly, every trainee should learn the ethical principles of medicine and know how to apply them. Lastly, half-day release should complement and enhance experiential learning, rather than compensate for its deficiencies.

Higher training

The case for higher training has been advanced sporadically since the 1970s.[33-35] Recently there have been experimental schemes in several centres and some general practitioners are taking MSc courses to achieve similar educational aims. The approach has been primarily educational, the appeal limited in terms of the total workforce, and the overall impact on general practice minimal.

The case for higher training becomes compelling only when linked to service development. The argument is that NHS general practice will not achieve its new objectives unless every practice has at least one doctor who has been trained to take on the additional responsibilities. The areas for training include clinical practice, communication, epidemiology, management, quality assurance, teaching and research. Participation should be by choice. A modular national programme of higher training could be designed and implemented at reasonable cost to the NHS by the year 2000 if we set our minds to it.

Continuing medical education

Traditionally, continuing medical education has been *ad hoc* and open-ended, a matter for the interests and conscience of the individual. The ethical duty we have to maintain our knowledge and skills has been implied rather than explicit. Not surprisingly, therefore, our efforts have varied widely from the highly con-

scientious to the frankly neglectful. Successive governments have made several attempts to close the gap by contract, by requiring participation in educational activities; the latest is the postgraduate education allowance.

We have good educational methods. So the key question, as ever, is how to sustain the desire to learn. There are four complementary approaches. First, we can harness the powerful personal motivators. These include, for example, our understanding of professional commitment, natural curiosity, our sense of self respect and need for the respect of others, our competitive instincts and our desire for career progression. Secondly, we can adopt the concept of continuous retraining in order to ensure that the technical knowledge and skills required specifically for general practice are systematically updated, and that deficiencies revealed by audit are corrected. Thirdly, we can link education with quality assuring activities in the practice to strengthen the connection with performance at work. And fourthly, we can foster our broader professional development through a more catholic education.

These approaches will be most successful where there is a culture within each general practice which values and nurtures the pursuit of excellence by every individual in the practice team as the best guarantee of high quality patient care.

Accreditation and reaccreditation

In medicine, accreditation applied to a person is normally used to describe the satisfactory completion of a period of education. Accreditation of training is in a muddle. On the face of it there is an argument about assessment methods; underneath is the lack of consensus about the job, uncertainty about what should happen to doctors who fail, anxiety about testing a doctor's factual knowledge in case significant deficiences are revealed, and opposition to the linkage of the MRCGP examination with membership of the RCGP.

The obvious solution is for the profession and health authorities to make more imaginative use of the distinction between minimum, optimal and ideal standards, and between restrictive and indicative accreditation. Minimum standards define a level of competence or performance anything less than which is deemed unacceptable. Optimal standards reflect the best that can be achieved at any particular time, taking account of all the circumstances. Ideal standards are the best that can be achieved in the absence of any constraints. Accreditation which is mandatory for a field of practice is said to be restrictive; it therefore normally reflects a minimum standard. Indicative accreditation is permissive; it thus reflects an optimal standard.

These principles can be applied to vocational training today. Thus, the Joint Committee on Postgraduate Training for General Practice will always work to a minimum standard because its certificate of accreditation is restrictive; by law a doctor cannot practice as a principal in the NHS without it. The MRCGP examination, on the other hand, represents an optimal standard and is indicative — that is, it shows what should be achieved by doctors committed to a good standard of practice, but it is not essential for employment. Doctors take the MRCGP qualification for a variety of reasons including the satisfaction of achieving a national standard of good practice after training, as a qualification for career advancement, or to join the RCGP. Universities and a growing number of practices use it as a valued indicator of likely performance when making academic appointments and selecting practice partners.

Quality conscious health authorities are almost certain to follow the profession's lead, and to make simultaneous use of both the Joint Committee on Postgraduate Training for General Practice and RCGP standards of accreditation in future because together they provide a graduated mechanism for securing progressive improvement in the competence of new contractors. For example, one health authority may decide to settle for the minimum Joint Committee on Postgraduate Training for General Practice standard. Another may decide, and publicize the fact, that the patients it is contracting for should be in practices which normally choose their partners from applicants holding the optimal MRCGP qualification. There can be more than one optimal standard. If, for example, the General Medical Services Committee were to produce another optimal standard, higher in perceived value than the MRCGP, then yet another health authority might choose this as its guide since it would come nearer to the ideal. It is this natural tension between minimum and highest optimal standards that can be used positively and constructively to raise the baseline overall, particularly in the formative years which precede the evolution of a single national standard, as minimum and optimal standards converge.

Personal reaccreditation is even more sensitive and complex.[36] At the very least it may be used to indicate a doctor's attendance at recognized educational activities. However, attendance does not necessarily lead to learning and improved performance.

Theoretically, therefore, reaccreditation should be based upon the periodic reassessment of the doctor's knowledge, skills and performance in practice. This approach is used in family practice in the United States of America where the reassessment for board certification is based on a records review and a national examination.

The advantage of personal reaccreditation is that, provided it uses valid and reliable assessment methods, it should help doctors maintain a minimum standard of competence. The disadvantage, apart from the obvious difficulty of achieving agreement on assessment, is that some doctors will do the minimum necessary to achieve reaccreditation. Thus the pursuit of high standards through a broader, more extensive and more liberal education may be more difficult to encourage.

In the context of modern medicine the principle of personal reaccreditation is virtually unarguable. What is needed now is much more discussion on the best ways of implementing it, and how it should relate to practice accreditation.

Conclusion

Trends in health care at long last offer the real possibility of making general practice the true foundation of the NHS. General practitioners urgently need to put their own stamp on new developments and so vigorously lead change in ways which will benefit both patients and health professionals.

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Address for correspondence

Dr D H Irvine, Mole End, Fairmoor, Morpeth, Northumberland NE61 3JL.