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A car with flat tyres?

MANY people are surprised to learn that the foundations of British general practice are much older than the National Health Service, being based on the earlier Health Insurance Act of 1911. This originated not just the familiar medical record envelope but also the general practitioner's list and the capitation system for payment, the self employed status of the general practitioner, and the system of referral to specialists. There have certainly been changes since then, the most radical being the inclusion of everyone onto a general practitioner's list in 1948. Other important developments have occurred such as the doctor's charter of 1966 and the implementation of vocational training in 1977. But these changes have been in the nature of fine tuning — the basic structure of an independent contractor working in the same community has remained unchanged since the turn of the century.

General practice today is a difficult and demanding job. Many would point out that general practitioners are well paid and enjoy a high degree of job security. Practices operate as small businesses and doctors can benefit from the entrepreneurial advantages of small work units. The list system provides a unique opportunity for personal care and preventive medicine. Depending on your point of view, general practice provides either a cost effective, or a cheap, primary health care service.

Unfortunately, this rosy picture is flawed because it is a snapshot of general practice at any one moment and does not show what happens over a period of time. General practitioners accept a great deal of responsibility which can sometimes be very satisfying — but often they have no support and no mechanism for varying demand according to their ability to cope. General practitioners achieve a good income early in life and then remain at the same level — there is no opportunity for enterprise and reward. The increasing mobility of the population means that the notion of a family doctor's career developing in parallel with patients' lives often has little relevance. Doctors are penalized severely if they get things wrong, for example by complaints or litigation, but rarely rewarded when they get things right, as rewards are not part of the normal system of work. Practices are set up as small businesses but are not usually run as such because doctors lack management training and traditionally see no need for it.

Since being a general practitioner soon becomes a static role, there can be no career growth and no professional development. In other human endeavours, seniority is accompanied by increasing challenge, responsibility and reward, and a reduction in routine tasks. No such progression is expected for the general practitioner. The same job description applies from the day of appointment until the day of retirement. Recent work from the British Institute of Management[1] shows that executives in their prime are not principally motivated by money and status, but look for other factors such as the quest for challenge, recognition, learning opportunities and creativity. That so many practices are as good as they are demonstrates the strength of this need in doctors, as the reward for a well organized practice with a low list size enabling the doctor to provide good quality care is a reduction in income.

There have been many initiatives for introducing change and for improving the quality of general practice — none embraced with enthusiasm by the profession itself. Even the doctors' charter of 1966 has not yet been totally implemented, with many practices still employing less staff than they are allowed and keeping poor records. A recent National Audit Office report[2] concluded that 'more than 40% of all inner-city doctors' premises are substandard and one in seven surgeries in England is

unsatisfactory'. More recent initiatives such as the 'What sort of doctor?'[3] and 'Quality initiative'[4] proposals of the Royal College of General Practitioners seem to have foundered and in the recent white paper[5] the government is trying to force change on a profession that is slow to implement it for itself.

There is no reason to suppose that doctors are motivated in different ways from other people, particularly middle and top grade managers in industry and the civil service with whom they may be compared. General management in the NHS has adopted many of the features of industry that allow growth and development and satisfaction within the job[6] and it is now only the doctors who are left with a career system that is decades old. Ironically it may be the very success of the model created by the 1911 Health Insurance Act that is responsible for some of these difficulties. There is always resistance to changing a familiar system that has worked well.[7] There is evidence that morale in the profession is a major problem. O'Donnell[8] described doctors as 'resentful prisoners' chained to their job by fetters of security. Recent work by Branthwaite and colleagues[9] showed that a substantial minority of general practitioners have major problems in their self image and satisfaction with their work, feeling lonely and isolated and uncertain in their role. One reason for this may be their low mental energy caused by the lack of stimulus, monotony, absence of growth and challenge, and constant mental debility from the 24-hour commitment. There is evidence that these factors are responsible for much stress related morbidity among general practitioners.[10-12] In a recent seminar, developments in general practice were described as 'tuning a finely engineered car which has four flat tyres'.

If doctors cannot find continuing satisfaction in their career they have several choices. They can leave general practice and small numbers do so; they can opt out intellectually so that their stimulation comes from outside their profession; they can continue in a desultory way until retirement or alcoholism[13] intervenes; or they can try to provide the intellectual stimulus and justification for what they have been doing. Is vocational training just the opium of the profession?

Much contemporary medical activity is about the raising of standards. Perhaps we should first look at our own needs and those of our colleagues. Unless we start to improve the quality of our own life and our careers we may be wasting our time talking about improving quality for patients.

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The future of community and residential care

THE expansion of the private sector of residential care in the last few years has been both a relief and an anxiety for general practitioners. A relief, because the number of places in local authority homes has often not kept pace with need. An anxiety, because in popular retirement areas, concentration of disabled elderly people in homes has become an excessive burden on general practitioners and other community services.[1] In addition, concerns have been expressed about the standards of care in some of these homes.[2]

One reason for the growth in private care is the increased awareness of the social security allowances which are available to cover the cost of fees in private and voluntary residential care. No assessment of the need for residential care is made before people are admitted to private homes. The result is that people who could manage perfectly well at home if they were provided with appropriate support are pushed towards expensive residential care, while local authorities are starved of the resources to offer alternatives because of financial restraints by central government.

Three recent reports have considered these developments and while there are some interesting differences in emphasis they present broadly similar approaches to dealing with the difficulties.

The first report to be published was from a working party sponsored by the DHSS and the local authority associations, chaired by Mrs Joan Firth.[3] The report, perhaps reflecting the local authority influence in its membership, recommended by one vote that all potential residents of residential care homes should be assessed by local authorities. This was despite evidence from DHSS commissioned research[4] that patients placed in private homes are in general in need of the services, according to the criteria of experienced local authority staff. The Firth report also recommended that local authorities should continue to set quality standards in private and voluntary homes by registration and inspection, but be responsible for financing care within them.

The Wagner report on residential care — coming from a semi-official committee financed by the DHSS and managed by the National Institute for Social Work[5] — made similar recommendations, but covered a wider field of interest, going beyond financial concerns to look at the quality and style of provision. One of the priorities of the report was the need to improve the status of residential care work for social workers. Although in the field more than 80% of social workers are qualified, the proportion of qualified staff in residential homes ranges from 1.5% (for junior staff) to 26% (for managers in children's homes).[6] The report recommended that all senior staff should be qualified,