Patient care and the general practitioner

Joint Working Party of the Welsh Council of the Royal College of General Practitioners and the Welsh General Medical Services Committee

The following paper is an abridged version of a discussion document drawn up to generate debate about the clinical generalist of the future. In particular it aims to clarify the position of clinical generalists by defining their role, outlining their strengths, demonstrating the central position of the patient, and considering future work patterns and relationships

The role of general practitioners is being redefined in the light of the emphasis on more care in the community, economic factors, and patients' expectations. The strength of general practice lies in the doctor-patient relationship; this strength must not be lost sight of. Specific tasks of the general practitioner include the responsibility for the care of individuals; the role of gatekeeper; broad knowledge of curative, preventive, and rehabilitative medicine; teamwork; management; and development of population based strategies. Future work patterns include the general practitioner first and foremost as a clinician and an integrator of health services, but they also involve audit, education and training, research, management, and relations with organisations in the public, private, and voluntary sectors. It is important to make changes only when they benefit patients and to maintain the principle of equity of access to care.

General practitioners have occupied a central position in the provision of primary health care for many years and their role has evolved in response to professional, political, and social pressures. At the introduction of the NHS the average general practitioner was single handed, worked from home, often had no ancillary staff, but provided exceptional personal continuity of care. Now he or she works in a team with other general practitioners, receptionists, practice nurses, community nurses, health visitors, midwives, counsellors, and practice managers. Throughout all these changes the general practitioner has shown an ability to adapt and continues to provide a primary health care service admired throughout the world.

There are now new pressures for change in the provision of health care, and an attempt is being made to plan the sort of service that will be required in the new millennium. In particular there is a shift in emphasis from secondary care towards more care in the community. Much of this care will be provided by general care services. Yet there is no clear concept of what general care services will be, and the role of the new general practitioner has yet to be defined.

The Welsh Council of the Royal College of General Practitioners and the Welsh General Medical Services Committee have attempted in this paper to define the role of the general practitioner and the structure, composition, and relations of future primary health care.

Members of the working party are listed at the end of the article.

Correspondence and requests for full version of documenft to:
Dr D H O Lloyd, Cadwgan Surgery, Old Colwyn, Clwyd LL29 9NP.

BMJ 1994;309:1144-7

Pressures for change

Some pressures for change can be seen as positive forces, such as the advances in medical knowledge and technology that have led to shorter stays in hospital and an ability to provide an even greater proportion of health care in a community setting. On the other hand, economic factors are frequently regarded as negative forces, limiting the scope of the profession to adapt as it would wish. Patients' expectations may at times work with the profession's own views of the future but at other times will pull in the opposite direction. For example, the traditional doctor-patient relationship provided a stable influence on the use of services that is becoming displaced by consumerist views.

The various pressures for change need to be acknowledged. But it is also important that change is made only when there is evidence that it produces benefit to patients and that the principle of equity of access to all aspects of care can be maintained.

The need to contain costs drives many of the changes occurring within the NHS. This has also contributed towards the shift from secondary care to primary care since general practice is recognised as being good value for money. The same economic pressures, however, favour an increase in the number of activities carried out by nurses rather than doctors. Nurse clinics and "specialised" clinics lead potentially to the fragmentation of care and loss of some of the advantages of the generalist clinical approach.

We have evidence that patients are generally satisfied with their general practitioners and the care they offer, but patients' expectations (and needs) are rising. General practitioners need to acknowledge the supremacy of the views of those that the profession serves, in preference to the views of professional colleagues in other branches of medicine. As Ian McWhinney puts it, "If the profession is failing to meet a public need, society will find some way of meeting the need, if necessary by turning to a group outside the profession. Professions evolve in response to social pressures, sometimes in ways that conflict with the expressed intentions of their members."[1]

A general practitioner's natural curiosity will encourage him or her to look at investigations or treatments that could be done in the surgery. There are also entrepreneurial changes encouraging individuals to approach the provision of health care in a variety of new ways. There is no evidence, however, that such entrepreneurial innovation leads to equity. Innovation is more appropriately driven by social and humanitarian concern. In responding to these changes it is vital not to lose sight of the strengths of general practice that have so far contributed to its success.

Current strengths

General practice is cost effective, low-tech, and flexible. Its unique strength, however, lies in the particular relationship that evolves between the general practitioner and the patient; this relationship is seen most clearly within the consultation. During the consultation trust and understanding are developed and allow effective care to be offered. There are, of course, other ways in which the general practitioner relates to patients, such as through other members of the primary health care team. In addition a patient may be viewed not just as an individual but also as part of a family and sometimes as a member of a wider group such as the people within the practice with asthma or diabetes. General practitioners are also rightly being encouraged to see their patients as part of a population so that the doctor can take part in planning

Qualities of a general practitioner

- Person and family centred
- Core professional skill
- Confidentiality
- Accessibility
- Advocacy
- Trustworthiness
- Toleration of uncertainties
- Respect for the determinants of health

for or the health gain of the whole population.

None of these relationships is exclusive to the general practitioner and all are important in the care that the generalist provides. However, the personal nature of the continuing holistic care provided to an individual within primary care is the mainstay of the general practitioner's care for patients. The general practitioner brings particular qualities (see box) to the specific tasks required to provide the holistic care of an individual. Four of these qualities deserve comment.

Advocacy—The general practitioner continues to act as the patient's advocate within a complex health service. Generally the patient has confidence that the general practitioner has the patients's best interests at heart, although conflicts of interest are beginning to creep in when, for example, the fundholding doctor may have other considerations that patients may feel compete with advocacy.

Accessibility—Being accessible at all times is clearly impracticable, but a good relationship between a general practitioner and a patient includes a knowledge of when and where the patient can consult the doctor. Barriers of lack of time or the inappropriate interposition of other health care professionals degrade the relationship.

Toleration of uncertainties—The general practitioner must continue to be able to tolerate clinical uncertainty to protect patients from unnecessary investigation and intervention. Medicolegal and consumerist pressures must continue to be balanced by the need to make professional judgments so as not to subject patients to overenthusiastic investigation or treatment. This quality is essential to the role of gatekeeper.

Respect for the determinants of health—The complex determinants of health, illness, and disease include genetic factors, nutrition, environmental variables, and lifestyle choices. The maintenance of well being and the restoration of health always depend in large measure on the body's own health processes, sometimes assisted by interventions of a physical, psychological, social, or spiritual nature. The well trained general practitioner respects the balance between these many factors and recognises that "healing" can be qualitatively different from "cure."

SPECIFIC TASKS

Responsibility—The overall responsibility for the care of an individual rests most easily with the general practitioner and allows for coordination and horizontal integration of care. This does not detract from the individual professional responsibilities of others or of patients themselves.

The role of gatekeeper to secondary services is vital not only to the individual but also to the effective and economic functioning of the health service. The gatekeeper role should recognise the need for vigilance not only over entry to secondary care services but also over exit from these services.

Curative, preventive, and rehabilitative medicine—Since general practitioners act in all these types of medicine, they need a broad knowledge and specific training and education.

Teamwork—The general practitioner works as part of a team and is responsible for that team, yet the science and effectiveness of primary care teamwork is in its infancy and requires further research and discussion.

Management—General practitioners are responsible for organisational management, finances, personnel, and information to a greater extent than previously and their skills in these tasks are improving with increased experience, better training, and appropriate delegation.

Population based strategies—The new general practitioner will need to develop strategies to relate to broader groups of patients because of involvement in health promotion, disease orientated management, fundholding, and the production of plans and strategies. However, the cornerstone of general practice will continue to be the provision of integrated personal care sustained by the individual doctor-patient relationship.

Definition of general medical practitioners

By the year 2000 every general medical practitioner should have acquired a respectful understanding of the complex determinants of health, illness, and disease with insight into the boundaries of professional knowledge. The maintenance of wellbeing and the restoration of health, by whatever means, depend in large measure on natural healing processes. Health is influenced by genetic structure, nutrition, environmental factors, and lifestyle. Sometimes recovery is assisted by intervention of a physical, psychological, social, or spiritual nature.

The general practitioner recognises the autonomy of all people and is qualified and accredited to be responsible for personal, primary, continuing, and preventive medical care delivered in ways appropriate to individuals, families, and small communities. The general practitioner will normally attend patients near their homes in purpose made, well equipped premises (the centre) or sometimes in a locality hospital. Home visits will be a component of the general practitioner's work but reserved mainly for the housebound.

Close collaboration with core primary care team members (those who meet in a common workplace daily and who have contracts to work with the general practitioner) will provide a staff structure to enable the general practitioner to accept overall responsibility for the functions of the core team and sharing of clinical responsibility. Agreed protocols for the delegation of duties will be an important component of this core team's accountability arrangements.

Consultation with specialists (medical or social or professions allied to medicine) will be at the general practitioner's discretion irrespective of whether specialists consult in the centre, the local hospital, or other location.

Diagnosis and management plans will be framed to embrace physical, psychological, and contextual factors. A background understanding of the risks and benefits associated with medical diagnostic, therapeutic, or preventive interventions will be essential. The general practitioner will also be skilled in helping people make appropriate personal choices about clinical interventions and in decision making processes in local context. All general practitioners will need protected time and support for continuing education, clinical audit, or research.

The general practitioner and the associated core primary care team will be expected to intervene educationally, preventively, and therapeutically to promote the patient's health.

A proportion of general practitioners will opt for further professional training in clinical subjects or in management so that they can become clinical directors of fundholding practices or take other health management roles. Those who adopt management roles must show a continuing involvement with the primary clinical services they purport to manage. Some general practitioners from both groups will undergo a formal research and teaching training that will prepare them for university appointments and academic leadership.

Future work patterns

Reduced list sizes to allow increased responsibilities are preferable to increased delegation that will allow larger lists to be the norm. If there is to be an investment in primary care and a movement of

resources as the balance of the provision of care shifts away from the secondary sector, additional resource must be directed towards general practitioners. In calculating manpower requirements for general practice, non-clinical commitments should be acknowledged. A realistic appraisal of current manpower is required before any estimate of future needs is attempted.

In future the responsibilities of general practitioners will probably increasingly be defined in terms of obligatory "core" services and additional voluntary services. To a large extent this is already the case, but there is a danger that new developments will always be seen as additional voluntary services. Unless general practitioners are prepared to accept that their core responsibilities will inevitably change, other providers may be seen by the public as a more appropriate source of certain services.

CLINICAL WORK

First and foremost the new general practitioner will be a clinician. The core content of general practice will have to be modified and defined to reflect the changing patterns of care in the health service as a whole. It is questionable now, for example, whether maternity services, contraceptive services, and child health surveillance can really be considered optional extras. Changes to the agreed core content must, however, always be negotiated. The changes will also have to be reflected in appropriate alterations to the content of education and training and should be justified and validated by research.

Most clinical work will continue to take place within the consultation with the patient in the surgery. Home visits will be reserved mainly for the house bound. Use of community beds will continue to be an important part of many general practitioners' work.

As medicine becomes more specialised and complex the general practitioner's role as the integrator of the health services for patients becomes increasingly important but difficult. General practitioners have to facilitate the patient's access to the whole health care system and interpret the system to the patient, explaining the nature of the illness, the implications of the treatment, and their effect on the patient's way of life. They must help the patient to make decisions.

It is essential that all pertinent health information is easily and quickly available, regardless of which institution, agency, or individual renders the service. In this way a general practitioner will help to remove barriers to care, whether they be economic, emotional, social, or occupational.

OTHER ACTIVITIES

Audit—Both medical and clinical audit will continue to be important in maintaining high standards of clinical care. The implementation of agreed clinical guidelines which have been shown to improve outcome and the introduction of changes as a result of audit will require regular structured discussion by all those concerned. Achieving effective audit will continue to require education and training, and the results of audit often have implications in terms of educational needs.

Education and training—Education should be a continuum from medical school onwards. The nature of primary health care makes multidisciplinary education and training an absolute necessity to ensure good understanding and communication between the various professions. Similarly, the education of general practitioners and specialists should be integrated to facilitate closer working. Protected time is essential not only for education but also for audit, research, and management.

Research—The scope and opportunity for research in general practice is enormous. All general practitioners should be trained in critical appraisal of literature, and those who wish to conduct research should be encouraged and trained. An increase in the level of research carried out in general practice will help to ensure that new diagnostic and therapeutic interventions are justified and old interventions reappraised. Good clinical practice and effective care are based on the results of sound research; the most effective use of teamwork, commissioning, and planning in primary care should also have this basis.

Management—Although general practitioners are increasingly delegating the day to day management of their practices to practice managers, there is a growing need for some general practitioners to have management skills. Moreover, general practitioners cannot totally abdicate their responsibilities for managing their practices.

Information—Careful planning, wise investment, and thorough ongoing training are required to unlock the full potential benefits of information technology for primary healthcare. The debate needs to continue on the best way forward, and much research needs to be done.

Future relationships

In many respects the relationship between the general practitioner and the patient will remain much as it is now and, in particular, should retain all the current strengths recognised within that existing relationship. In addition, it should remain free at the point of contact and there should be no artificial barriers limiting the patient's access to the doctor. Already in primary health care patients may elect to see the practice nurse or may attend a casualty department as their first point of contact. In most instances, however, the general practitioner will remain the most appropriate point of first contact and maintain responsibility for the patient's medical care.

The question of what is appropriate access, however, needs to be clarified. General practitioners have long recognised their role in negotiating access to services. Unfortunately, patients' expectations of ease of access to their doctor, especially out of hours, have been raised unreasonably. Indeed, patients' expectations of the health service in general have been raised too high; the proclamation of patients' rights needs to be counterbalanced by the recognition that patients also have responsibilities associated with their use of the health service.

General practitioners can help to encourage the responsible use of the health service mainly through discussion with individual patients and by working more closely with organisations representing patients' interests such as patient participation groups within their practice and local community health councils.

THE PRIMARY HEALTH CARE TEAM

General practitioners already work as members of a multidisciplinary team. The core team will tend to consist of those who work from the same building as the general practitioners and who have contracts to work with them. General practitioners will not always be the key workers or the team leaders. However, they will always take on overall responsibility for the functioning of the core team and be responsible for ensuring that members are appropriately trained. They have a responsibility to support the professional development of their peer group and other health professionals.

INTERFACE OF PRIMARY CARE AND SECONDARY CARE

The role of the general practitioner as the gatekeeper to all secondary care services, and its evident advantages, is currently under threat from various directions.

the relationship between general practitioners and specialists. Secondly, and more importantly, the shift from secondary care to care in the community has led to the establishment of many specialist community posts, particularly in paediatrics and psychiatry.

Community specialists are increasingly making use of specialist outreach clinics, which are often more convenient for the patient and can lead to closer contact between the specialist and the general practitioner. These advantages would be negated if the clinics led to open access for the patient, as this would lead to a fragmentation of care. The referral process to an outreach clinic should be the same as that to a hospital outpatient clinic.

Much chronic care in future will be in the form of shared care, and already there are well established examples of this. The key factors that underpin good shared care are good communications, patient held records, clear lines of responsibility, locally agreed protocols, shared medical and clinical audit, and closer integration of training. Well organised shared care provides not only advantages in high standards of patient care but can also produce the opportunity for learning for all the professionals concerned.

Easy access to diagnostic tools, including newer ones, should be available to the general practitioner. The general practitioner must be prepared to discuss the use of newer procedures with specialist colleagues, conduct research on how to use them appropriately, be aware of the cost implications, and agree to audit the use of such equipment.

OTHER BODIES

General practitioners will continue to relate to many different organisations in the public, private, and voluntary sector.

Social services—Many difficulties remain, such as lack of coterminosity, worries over confidentiality, different priorities, and understanding of degree of urgency. Examples of good practice where close cooperation is the norm should be highlighted so that others can benefit. At a minimum, each practice should have a named social worker and care manager.

FHSAs, health authorities, NHS trusts—Not many years ago few general practitioners felt that health authorities had anything more to do with their everyday lives than to provide administrative support. Now all general practitioners are aware of the potential influence of their family health services authority on their practice. In the future, closer cooperation, especially in deciding on local priorities for health gain, will benefit the population, but it must not compromise personal care. General practitioners are becoming increasingly involved in the commissioning; the greater voice that general practitioners (and through them their patients) are having in commissioning of health care services is something that needs to be fostered.

The voluntary sector—General practitioners will need to be aware of the increasing part that the voluntary sector plays in counselling, providing support for carers, self help groups, and so forth. Information technology could play a vital role in keeping general practitioners in touch with all the various groups in the area.

Members of the joint working party were: Welsh General Medical Services Committee: Dr A R Dearden, Dr G I Graham, Dr R B John, Dr J S Jones; Welsh Council of the Royal College of General Practitioners: Dr M H Herbert, Dr H P Joshi, Dr D H O Lloyd (chairman), Dr S A Smail, Professor N C H Stott; secretariat: Miss R Roberts, Miss K F Pope.

1 McWhinney IR. *A textbook of family medicine.* New York: Oxford University Press, 1989.

For Debate

Public health 2020

Stephen J Watkins

The aim of public health is to improve the health of people in communities and in populations (protection from environmental hazards and provision for health needs). The challenge for public health doctors is to re-establish public health leadership of communities, address social and environmental causes of ill health, and link with primary care (*a*) to improve the health of neighbourhoods and (*b*) to combine perspectives in commissioning services. Current threats derive from organisational philosophies. For example, focusing on market development does not allow for population based functions and so neglects the main influences on health. The way forward is a network model of organisation in which small teams collaborate with each other to the common good. For example, successful commissioning authorities would have the public health leadership of the director of public health and the support of the chief executive, treasurer, and representatives of primary care, including a medical adviser from the family health services authority.

District Offices, Stockport Health Authority, Stockport SK7 5AB
Stephen J Watkins, *director of public health*

BMJ 1994;309:1147-9

Remit

Public health exists to improve the health of the people, firstly, by advising on the action communities can take to improve their health; secondly, by protecting populations from environmental and biological hazards; and, thirdly, by assessing populations' needs for health services.

I use the terms "communities" and "populations" distinctly. It is possible to assess the needs and protect the environment of, say, the population living in a square of the National Grid. But a community shares an identity, has a culture shaped by common media, and operates through common institutions and organisations. Public health doctors work on that identity and culture and those media, organisations, and institutions. They cannot do this for arbitrarily defined populations.

Improving health is more complex than other aspects of commissioning health care because it entails persuading other organisations to commit their resources or change how they carry out their business. Time is needed to cultivate those who have local power and influence.

Environmental issues are of increasing importance. Protection from obvious environmental hazards is no longer enough—public health needs to have a positive influence on decisions about how land is used to address issues such as transport policy, industrial pollution, and open spaces in towns.