TALKING POINT

An expanding remit for general practice

JOHN S NOBLE

Northumberland Local Medical Committee's challenging proposals on an expanding role for general practice have been sent to all local medical committees.¹ They provide general practitioners with an opportunity to participate in the debate on a new charter for general practice. This is also being studied by a special working group of the General Medical Services Committee.² The LMC has proposed that the GP should provide a wider range of personal services for fewer patients, with good equipment, facilities, help, and proper remuneration for continuing responsibility. They envisage his carrying out personal preventive and curative medicine for all age groups and performing much of the routine work now done in hospitals and specialist clinics. The cheaper cost of primary care should make the proposition attractive to the Government.

Good general practice means unhurried, sympathetic, competent, and comprehensive care for patients. This ideal is inhibited by too few GPs and the structure of the NHS. Moreover, under his terms of service the GP contracts to provide necessary and appropriate medical services without precise definition, and he carries the burden of the Secretary of State's responsibility to provide 24-hour cover for every citizen. To provide this open-ended, on-demand service the time available for patient consultation is often reduced unacceptably, the doctor's efficiency is diminished, and the development of general practice is impeded. Far too many patients are referred to hospital and are then held on to in follow-up clinics when they could be looked after by the GP. Doctors are frustrated by this pattern of care and by the failure of the Government to pay them adequately for continuing night and day responsibility while other sections of the community enjoy a shorter working week and substantial overtime payments. At the same time, a more discerning public is becoming disenchanted at the failure of the Health Service to provide the care which they demand. This is evidenced by complaints about appointments systems and lengthy waiting lists for hospital outpatients and admission.

Challenge

It is in the interests of good quality personal medical care for GPs to expand their function in community-based services. Medical treatment and the efficiency and vocational satisfaction of doctors would be revolutionised, especially in conurbations, where general practice is at a low ebb. General practitioners would revive their pride in work well done and provide a secure matrix for health care.

An EEC working party has defined general practice as follows.³ "The general practitioner is a licensed medical graduate, who gives personal, primary, and continuing care to individuals, families, and a practice population irrespective of age, sex, and illness. It is the synthesis of these

functions which is unique. He will attend his patients in his consulting room and in their homes and sometimes in a clinic or a hospital. His aim is to make early diagnoses. He will include and integrate physical, psychological, and social factors about health and illness. This will be expressed in the care of his patients. He will make an initial decision about every problem which is presented to him as a doctor. He will undertake the continuing management of his patients with chronic, recurrent, or terminal illness. Prolonged contact means that he can use repeated opportunities to gather information at a pace appropriate to each patient and build up a relationship of trust which he can use professionally. He will practise in co-operation with other colleagues, medical and non-medical. He will know how and when to intervene through treatment, prevention, and education to promote the health of his patients and their families. He will recognise that he also has a professional responsibility to the community."

This definition implies that the GP will be clinically responsible for the continuing medical care of his patients. This care should be provided so that with adequate facilities, time, and help he could diagnose and treat all conditions which do not require highly specialised consultant opinion or institutional investigation and treatment. This could be achieved with more personnel and extra diagnostic facilities. So the GP must have adequate premises. Area health authorities must recognise that care in the community is cost effective, and that more nurses and health visitors and other supportive professional staff are needed. Economies in this area are self-defeating. The attachment and direct reimbursement schemes should be widened to include physiotherapy, occupational therapy, social work, and technical staff. There is a case for "sharing" these colleagues among practices. Though most GPs now work from adequate premises, the cost rent and improvement grant schemes should be widened to give doctors in their own premises the same opportunities accorded to those in health centres. There should be provision to acquire all necessary items of equipment either by leasing or by direct funding.

As the responsible clinician the general practitioner must be the leader of the primary care team. But he will need training to deal with his relationships with the other members of the team and to understand their aspirations. Equipped in this way, with a list smaller than the present "average list" to allow for his wider remit, the GP would have a duty to provide full diagnostic and therapeutic care, as well as personal preventive medicine and health education. This would include paediatric development screening and more time for geriatric assessment and care.

Some of the procedures which could be performed in the surgery include minor operations and manipulations, intra-articular therapy, and electrocardiography. It makes sound professional and economic sense to recognise the potential of general practice and its use. The emphasis of care would move to the patients' point of contact, releasing

hospitals to concentrate on special functions, and achieving a more comprehensive service.

Improved practice organisation

If general practice is to achieve this extended remit, record keeping must be efficient. Though the A4 system has been temporarily abandoned, we should aim for full computerisation of records with adequate safeguards for preserving confidentiality. Practice management is vital to the smooth running of the unit. There are many competent lay managers, and doctors must be trained to relate policy to management and be paid for doing so. To maintain the momentum of the new general practice continuing education would be imperative.

In return for a better deal the profession could offer a better service. Like any group, there are good and bad doctors. But many of the latter are the result of environmental handicaps, such as dense conurbations, new towns, and gross social deprivation. There is still too much professional isolation and we should find ways to overcome this. Audit by peer review would lead to rising standards and better medical care. If the profession does not take a lead here then others—the Ombudsman, for example—will do it for us.

This new concept of general practice should be negotiated and priced. The first GP charter succeeded because it offered a better service. Many new items of service should be included and the doctors' terms of service would need to be redefined. Only the independent contractor status can provide the right personal relationship between patient and doctor and ensure the latter's continuing responsibility for the patient. GPs believe this and turn to other methods only in frustration. Remuneration must recognise a reasonable working week, with adequate reward for out-of-hours service. This should encourage individuals and groups of doctors to undertake their out-of-hours service. They should receive a financial loading for doing so. The ideal would be for the patient's own doctor or a known colleague to attend in an emergency and this practice should be fostered.

Northumberland's proposals offer the prospect of a better service for patients, hope for the profession, and a future for highly trained vocational trainees.

References

- ¹ Northumberland Local Medical Committee, *A New General Practitioner Service*, March 1978.
- ² *British Medical Journal*, 1978, 1, 58.
- ³ Working party appointed by the Second European Conference on the Teaching of General Practice, *The General Practitioner in Europe*. Leewenhorst, The Netherlands, 1974.

Ashington, Northumberland

JOHN S NOBLE, MB, FRCGP, general practitioner and secretary of Northumberland Local Medical Committee