It was suggested that this was the result of rebound stimulation of the renin-angiotensin-aldosterone system.^{11,12} We also found that withdrawal of diuretic drugs leads to an initial increase in oedema. The process seems to be reversible in patients in good health. Six weeks after diuretic therapy was stopped the oedema, although still decreasing, had almost reached the starting level.

We chose to study the effects of withdrawal by comparing a group in which withdrawal was open with a group in which treatment was continued. We therefore cannot separate the pharmacological effect and the placebo effect. However, it is not likely that a psychological effect would have had an important influence on our outcome measure. Moreover, for general practitioners it is more relevant to know the total effect of stopping drugs openly.

We found no significant differences in effects between various types of diuretics. The power of the trial may not have been sufficient to detect such an effect and more extensive investigations with a longer follow up and larger study population would be useful. We conclude that if cardiac insufficiency is unlikely and careful monitoring is provided, withdrawal of diuretics is feasible in elderly patients who have been prescribed diuretics for ankle oedema. After with-

drawal patients may develop moderate oedema, which in most cases seems to be temporary.

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Enriching Careers in General Practice

New roles for general practitioners

Stuart Handysides

This is the last in a series of articles examining ways to increase fulfilment from a career in general practice.

General practice is likely to change greatly over the next few years. Increases in care in the community and day surgery will lead to more work, and the demand for better data on practice activity will mean the development of audit and epidemiological work. To make time general practitioners will have to learn to delegate work that does not require a doctor. Fundholding has already stimulated some practices to bring services to patients rather than send patients to hospital, and this trend seems set to continue. It is important to pool resources, not only within practices but among other practices in the area—joint action will increase the ability to improve the services for patients. If general practitioners take the opportunity to gain control of the changes the morale of the profession should improve.

The work of general practitioners has not changed greatly over the years. Fewer home visits are made now than previously, but the pattern of morning surgery followed by visits, paperwork, and evening surgery has endured for many years. Such familiarity has benefits but also threatens to stifle innovation. The financial security and tenure of general practitioners offers no incentive for progress¹ but despite this innovations have been and continue to be made. This article looks at evolving aspects of practice and their implications. The new roles I shall consider are the general physician in the community, the epidemiologist, the entrepreneur, the networker, and the defensive general practitioner.

The general physician in the community

The general physician in hospital practice is a thing of the past.² Higher training as a senior registrar produces an expert in a narrow field, and general

experience is not likely to increase by shortening specialist training as outlined in the Calman report.³ General practitioners who offer fewer services make more complaints about the number of consultations for trivia than those who offer more services,⁴ and in the 1980s it was claimed that they had restricted their repertoire with few doing "very much with their hands as far as treatment is concerned."⁵ If general practitioners develop the skills and enthusiasm to be general physicians in the community they might solve the problems of consultant overspecialisation and general practitioner boredom.^{2,6,7} General practitioners' time could be freed to take on this role by developing the skills of other members of the primary health care team⁸ and, in particular, using nurse practitioners to treat minor illness.⁶

Geoffrey Marsh, a general practitioner in Teesside, was one of the pioneers who employed a practice nurse before the 1966 charter made it economic to do so.⁹ The nurse's role in his and many other teams has since been refined.¹⁰ He believes that "Society has to develop a conventional wisdom of using a health professional who doesn't earn as much as a doctor. In the United States nurse practitioners became cheap alternatives to doctors, decided they wanted to be paid as much as doctors, and have now been virtually abandoned."

The minor illness nurse in Marsh's surgery, already an experienced practice nurse, sat in with one of the doctors for a year before taking on the role. The nurse decides what treatment is necessary but has to approach a doctor for a prescription, so a check takes place. "Doctors aggrandise medicine and their own role," Marsh told me. "Our patients love the nurse, availability is more important than the highest expertise. If the patient is seriously ill the nurse can get the doctor to see him or her straight away. The doctor is freed to deal with serious illness." Marsh has clearly taken great

General practitioners may take on the role of hospital general physicians

pains to educate his team, and to be educated by the team, but there is a risk of dumping unwanted tasks on to staff untrained to perform them.⁹ As well as training practice nurses, general practitioners have had to develop their skills as employers and learn to coordinate the work of nurses attached to surgeries but employed by health authorities.¹¹

A controversial idea of Marsh's is that rather than smaller lists (a target of 1700 is often quoted¹²) a general practitioner should be able, with a well developed team, to look after 4000 patients.¹³ The rationale is that with minor illness taken care of, general practitioners have freed two thirds of their time.⁶ "Whatever work a general practitioner does it should require a medical qualification."⁶ The importance of paramedical members of primary health care teams is likely to increase given the shift of responsibilities into the community and the lack of growth in the number of general practitioners.¹⁴

Developing the expertise

Are general practitioners good enough clinically to be general practice physicians? Donald Irvine suggested that the conditions for such a shift in role are "a shift of patients from secondary to primary care, a higher level of skill and diagnosis in general practitioners, and the assumption of greater clinical responsibility than before. When these conditions are met general practice will become the foundation service of the NHS rather than simply its gateway. The future of general practice depends on raising its clinical base to justify increasing resources." Future general practitioners will need sound ethical principles, a deep understanding of people, confidence and mature judgment, greater clinical and interpersonal skills, epidemiological skills, well managed practices, and to provide quality assurance.¹⁵

This idea implies a need for higher training. Vocational training could equip you for a salaried post, but further training (perhaps through a day release scheme) might be needed for partnership in the future. Higher degrees are one route, but higher professional education should be flexible enough to offer a wide variety of opportunities, accessible to all general practitioners.¹⁶ Such an opportunity is being developed in the Northern region. George Taylor, an associate regional advisor there, told me, "We hope the project will be relevant to a larger cohort of general practitioners than programmes of higher training that are currently available. It is aimed at doctors in the first five to 10 years after vocational training and is based on the development of

skills relevant to work in the practice. It will consist mainly of distance learning, with some residential courses [and will cover] practice management, quality assurance, epidemiology, communication skills, research method, and clinical skills." The pilot scheme, for 10 people, has generated considerable interest. It will lead to an advanced diploma from the University of Newcastle. Dr Taylor stressed that it was intended to enrich the participant's practice as well as the participant.

The epidemiologist

Epidemiology is a largely untapped resource of general practice. The opportunities for epidemiological studies in general practice have been exploited by enthusiasts such as William Pickles¹⁷ and Julian Tudor Hart,¹⁸ but the registered list and life long patient record mean that a mass of data on morbidity lies hidden around the country.¹⁹ The scheme run by Value Added Medical Products (VAMP) offered general practitioners free computers and instruction in exchange for good quality data on prescribing, and the data have been validated.²⁰ The incentive worked for about 2000 general practitioners, about a fifth of VAMP users (Ian Cockburn, personal communication).

Denis Pereira Gray's practice in Exeter had a VAMP computer installed in 1987, and they have had good data from it since 1990. The partners were all willing to enter data, and the computer has stimulated change and argument. I was shown how a group at high risk of coronary heart disease could be quickly identified and targeted for surveillance by intersecting fields of smokers and patients with other risk factors. The computer generated bar charts that showed which doctors had measured the largest proportion of their patients' blood pressure. Threatening? No, it seemed more like a football league—better next season, no relegation. The practice can assess outcomes as well as process—for example, by monitoring changes in the serum concentration of fructosamine in patients with diabetes.

The value of data depends on how acquisitively the computer is used, but the reward of feedback on your own performance is a stimulus. It is one thing to audit your own work, but the results from one practice, or one hospital, may not be generalisable.²¹ Incompatible software and standards of data collection make it difficult to link practices' databases but these should not be unassailable. Putting your own house in order is the first step, by developing a disease register, keeping it up to date, and referring to it.

General practitioners and public health doctors have had little contact for many years, working in parallel—perhaps even in competition—as advocates for individuals and populations respectively, but both are responsible for preventing disease and promoting health.²² As both professions have a role in purchasing, closer relations are desirable²² and may be eased by the merger of district health authorities and family health services authorities. Collaboration enabled a comprehensive death register to be set up for the benefit of general practitioners in Newcastle.²³ It may be, however, that to keep primary care and public health distinct maintains a creative tension that is good for both disciplines, and good for patients.²⁴ As general practitioners make more purchasing decisions they run the risk of alienating individuals for the benefit of the herd.

The entrepreneur

General practice has always been run as a small business and many still seem surprised that the

alternative, a salaried service, should be entertained. The job retains a measure of status and money: second homes and private education for doctors' children seem fairly common, although not among young general practitioners.²⁵ Some general practitioners relish business, others see it as a necessary evil, and others forget to fill in claim forms.

Eric Caines, professor at the Centre of Health Services Management, Nottingham University, sees great potential in the entrepreneurial spirit of general practitioners. He believes that the NHS could run more simply if general practitioners did more in their surgeries: patients would prefer to be treated there than to go to hospital. As day case surgery increases hospital beds are used less. Surgical procedures could be performed in well equipped primary care centres. "Money needs to shift from secondary to primary care. We would end up with a few tertiary referral centres and a series of locally based and locally delivered health services, run by general practitioners with input from local specialists. They would be like cottage hospitals or polyclinics. General practitioners would need more staff and more business acumen, but they should be able to treat many more patients for the money that is currently spent." Up to now the financial incentive to perform minor surgery in general practice has not reduced the number of referrals to hospital clinics, although procedures in surgeries rose by over 40%.²⁶

Opportunities of fundholding

Fundholding has brought some of the power for change into the hands of general practitioners. As providers they can compete with local district general hospitals and trusts. A fundholding group practice in Epsom acquired Epsom Cottage Hospital in 1990 and has great plans for it. Tim Richardson, the lead partner, told me about them, "I hear doctors bemoaning the state of secondary care, but we have the opportunity of taking much of it over. I perceive a shift in the attitude of many consultants: they are willing to provide advice rather than take over, especially the ones who come out to general practitioners' surgeries. We have six visiting consultants. Rather than junior hospital staff coming as well each general practitioner acts as a back up to one of the clinics and gets paid as a clinical assistant. We employ separate staff for the secondary care service. It still works out cheaper than the patients being seen in hospital, and if we do the follow up sessions it reduces

the workload in primary care." They also plan to rent out part of the building to a private medical firm as a day surgery unit. Their negotiations should enable them to arrange day surgery for NHS patients at trust agreed prices on their own premises.

Tim Richardson thinks the days of district general hospitals may be numbered. "They are too small to be centres of excellence and too big to be a community facility. They can't all attract the highest quality junior staff because as on call rotas have become less onerous and there are fewer inpatients, many jobs are no longer accredited for training. We should build up centres of excellence, do away with district general hospitals, and build up community based care." An independent review is needed, he says, to develop a strategic plan. Fundholding itself is still under scrutiny, however, because of its economic and political costs. The purchasing power of fundholders may not be as great as they have thought, and they may undermine broader health policies in their communities.²⁷

Fundholders seem to have been able to negotiate deals for themselves and their patients which, at face value, appear desirable. The fundholding practice may be a step towards a polyclinic or health maintenance organisation. Such comprehensive community practices raise questions about accessibility, continuity, patient choice, and the ethos of the health service.²⁸ Their introduction might mean the end of personal lists, believed by many to be a fundamental strength of British general practice.²⁹

The networker

Whatever the topic of a meeting it is often the times between sessions when participants meet that are the most important. The sharing and acknowledgement of common experiences bonds people together. The experience of someone who has had to think through the problem you are facing can be valuable. This is the beginning of networking: general practitioners in one area could, formally or informally, generate a resource group which uses the special skills and experience of its members. It might offer a way out of isolation, recognition, a market for your skills, and the opportunity to learn new skills from others.

Rosalind Eve has worked as a coordinator and facilitator in Sheffield since 1989 on a project called "Towards coordinated practice."³⁰ This arose from informal contacts between eight practices in the city. The aim of the project is to explore ways in which practices can collaborate with each other and with other agencies to improve the health care of patients. The initiative has five strands (box).

One of them, monitoring quality in service agreements, is a general practice led response to the NHS reforms. The quality of communications after discharge from hospital, access to acute beds, and the likelihood of seeing a consultant or senior registrar in outpatient clinics have been monitored so that necessary changes can be identified. Rosalind Eve told me, "Both fundholders and non-fundholders take part, and provider units have been anxious to respond. About half of Sheffield's general practitioners take part. The work takes about an hour every month, filling in a questionnaire about one in 1000 patients on a practice list. Providing information is rarely enough to effect change in clinical behaviour and spread good practice. You can't expect hospitals to change suddenly in the light of the evidence you present. You have to consider their constraints."

Communicating with hospitals

Links with local hospitals have become increasingly important as outpatient clinic waiting lists have grown.

Five elements of project "Towards coordinated practice"

- 1 Confidential advice about practice organisation and management and anonymised learning from other practices through the facilitator
- 2 Promotion of skill sharing and networking. The facilitator helps to put people with common concerns in touch and arranges visits to other practices and shadowing
- 3 Data sharing to inform practice decision making and complement resource management decisions currently being made by the health authority. The project has identified a set of core data—service utilisation rates, and morbidity (hypertension, asthma, diabetes)—which it is currently standardising to enable comparison
- 4 Collaboration on training—for example, workshops on methadone prescribing, skills in group work for practice nurses and health visitors, and bereavement work for receptionists
- 5 Develop the interface between practices and other agencies—for example, monitoring quality in service agreements

Consultants and general practitioners have worked together to develop local protocols for sharing the management of particular diseases—for example, diabetes.³¹ General practitioners in Hertfordshire met local hospital consultants to plan audits of, and guidelines for, various aspects of care including managing depression, antenatal care, asthma, and microbiology. James Ferguson, one of the participating general practitioners, told me, “The process of getting together was in itself useful: it arose at a time when consultants were motivated to communicate. We made a lot of new connections.” The impression of fundholders, particularly, is that consultants have become more accommodating. As well as getting patients seen quickly increased contact helps improve understanding of each other’s roles in the health service. All general practitioners have worked in the hospital service, but not all hospital doctors have worked in general practice. A scheme enabling hospital doctors to spend some of their training in general practice now operates in the west country, and an early participant wrote of the value of learning to consult effectively, contrasting the educational experience in general practice with that in hospital specialties.³²

The defensive general practitioner

This series has suggested that change should be managed actively and that further changes are needed to improve morale. The contractual changes of 1990 were imposed without agreement³³ and the wish to consolidate is understandable. Night visits increased in the 1980s, and rose more steeply after the 1990 contract.³⁴ Complaints against general practitioners have escalated³⁵ and violence by patients affects at least a quarter of general practitioners in the west midlands.³⁶ Defensive responses to these threats will reduce the accessibility of general practitioners: many would like to give up the 24 hour commitment.^{37 38} The General Medical Service Committee’s working party has proposed greater professional control over the complaints procedure,³⁹ and some general practitioners wish to remove violent patients from their lists with immediate effect. This seems a long way from the ideas of total quality management, in which the customer is king and “every defect is a treasure.”⁴⁰

Defensive thinking may make general practitioners afraid to look up from the desk and take stock. If you stop work and think for five minutes the number of patients in the waiting room may have doubled. So time for reflection is put on hold. We have to learn to accept that time spent thinking about the job is not time wasted, but time invested. Investing time in thinking enables us to plan our practice, to become proactive, and to take control. The alternative is to be passive and, in the end, resentful. Lack of control is the source of unhappiness.

Taking control, paradoxically, means being prepared to delegate. Enabling and encouraging all members of the team to work to their greatest ability can free time to think about the direction of the practice, to develop and maintain a vision.⁴¹ A practice that can set out its standards and aims can negotiate with health service managers. Mac Armstrong, the secretary of the BMA, says that we need to be realists, and think in terms of modern management, “Change is continuous and unpredictable. There is no point in trying to prepare for A or B, you have to go for maximum flexibility. The most successful are those with strong internal values who understand their own values, have a clear detached view of how society works, and keep their private space clear. You need a strong sense of what you can and cannot do, otherwise you get run ragged.”

Conclusion

The developments outlined here are rooted in the practice but linked by political expediency. General practitioners need to be physicians in the community to contain the costs of the health service. We need to think like epidemiologists to see if we are achieving our goals and set new goals. We need to maintain our entrepreneurial skills because health care has been reorganised to use market forces. We need to collaborate with our colleagues to speak with a united voice on health policy on behalf of our patients. We have to learn to respond to a changing society without retreating behind barbed wire or acceding to unreasonable demands. Those who have trained may have to relearn. Those planning medical education should enable tomorrow’s doctors to learn cooperatively from the start, to value themselves, the colleagues they work with, and their patients.

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