

General Practice Towards The Year 2000

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My first duty is to convey to you and the College greetings and good wishes from the President and the RCGP. My second duty is to thank you most sincerely for the honour you have accorded me and, through me, British General Practice by your invitation to give the 1990 Sreenivasan Oration perpetuating the memory of the great man who was the first President of your College.

While I was flattered by your kind gesture, I have to confess that my initial reaction was to pause and reflect. This response was not prompted by modesty or innate Scottish reserve but by a very real awareness that General Practice, unlike most other disciplines in the vast and expanding field of medicine, must reflect something of the character, culture, and above all the health care needs of the people it seeks to serve. Its philosophy is only partly shaped by professional dictate. So, I ask you, what might a practitioner from the insularity of the UK, with its long tradition of family doctoring, the constraints and opportunities of the National Health Service (NHS), with a nominal Christian background and with, what, in political circles, is known as the "Scottish Dimension" (which is another way of expressing a rugged independence) - what could such a doctor possibly contribute that would have any meaning to you here at the cross-roads of the world, to you with a pluralistic multiracial society, systems of health care delivery in which market forces operate, to you in a setting with varying traditions of care where the range and nature of health problems are probably significantly different from these in the West?

I then recalled a decade of experience of debate with a group of colleagues from 12 different countries in Europe - the so-called "Leeuwenhorst group" (to which I shall refer again) during the 1970s when these and other issues were carefully considered. Rather to our surprise, when this Leeuwenhorst group of GPs had finished re-fighting the Franco-Prussian war, and the East and West Europe conflicts, we found we could agree on many fundamental issues. Furthermore, your invitation arrived not long after I had read "Skills and management in Family Medicine" (1988) by a trio of distinguished colleagues here. It was the philosophy underlying the writing of that book which convinced me, rightly or wrongly, that you and I are bound more closely by similarities than we are separated by differences.

I make no apology, therefore, that my contribution should be based on experiences of general practice in the UK during a particularly salient phase of development. I hope that this will be at least intelligible and will stimulate debate on future development of health policy here. Before looking to the future, we need to understand the present - and to understand the present we need to take stock of the past.

Some Past Events

My starting point is not the foundation of the Royal College of General Practitioners, but events preceding it, which culminated in 1948 in the institution of the NHS, and 2 issues to which it gave rise: namely clarification of roles of the general practitioner and the contribution such a doctor may make in an organised system of medical care delivery.

General Practice and Hospital Roles

The NHS, by administrative dictate at one stroke, settled a confused scene in which hospital and general practice had already been striving towards a clearer identity. Hospital-based care claimed for itself an identity ([Fig. 1](#)). In contrast, and mainly by default, at that stage, what was left became the stock in trade of the GP ([Fig. 2](#)).

Incidentally, during my early days as a teacher in general practice, I made the mistake of presenting to medical students this sphere of activity in such a way as to force, unintentionally, a false antithesis in their minds, because, educated entirely within a hospital context and by hospital doctors they knew nothing of what went on outside the hospital. I had to learn to share with them a common starting point. This was easily done by focussing on the needs of the patient and by inverting the diagram (Fig. 3) so that the complementarity of the roles of each could be seen and appreciated (Fig. 4).

The Gatekeeper Role

The second important issue arising from inception of the NHS was to make access to the specialist available mainly, if not solely, through general practice. This Venn diagram (Fig.5) which owes its origin to John and Elizabeth Horder may be used as a basis for a number of gradients in conceptualising the provision of health care. In moving from top right to bottom left of the diagram one may postulate, for example, a progression in life-threat posed by the health problem from predominantly minor through mixed to major. Again, in terms of autonomy (the "control" the individual has of decisions about his care) there is a gradient from full control to complete surrender. The issue I wish to emphasise, however, is the gradient of cost - self-care is cheap and super-specialist care is expensive.

So, emerging from the instituting of the NHS is the concept of at least 2 broad GP functions. First, the doctor of first contact deals with 90% of encounters without recourse to expensive hospital resource. Second, the gatekeeper ensures that only the right patient with the right problem obtains promptly the services of the appropriate expensive wizard. It is this function which has contributed to the fact that in the league of expenditure on health care delivery expressed as a percentage of the gross national product, Great Britain is among the lowest in the Western World.

Founding of the Royal College of General Practitioners

So, it was that, with a clearer image of its own identity, general practice had reached the point where the stage was set for the founding of the Royal College of General Practitioners. The story is recounted by Fry, Hunt and Pinsent (1983). The RCGP has proved to be a powerhouse of ideas, many of which were to transform the service and academic scene. Government thinking was greatly influenced by the Gillie Report (1964) and, together with the medico-political skills of our colleagues in the British Medical Association, the foundations were laid, in the New Charter of 1965, for the renaissance of general practice.

Ideas were discussed more widely in Europe, stimulated by the deliberations of the so-called "Leeawenhorst Group" to which I referred earlier, with its clear statements on such topics as the job description of the general practitioner. The EEC directives on training owed something to this group.

Academic Change

Meantime, medical education continued to struggle to break out of the 19th century mould in which it had been cast - such out-dated hospital-based disease-centred models continue to operate in most countries even today. The significant development in the UK was the publication of the Report of the Royal Commission on Medical Education in 1968, with its formal recognition that the main aim of undergraduate education had to move from being the production at graduation of a utility GP type doctor who might metamorphose into a specialist (given time and training) to an undifferentiated doctor who had to be trained further to take clinical responsibility in any speciality including general practice.

From there it was a relatively short step to setting up a system of Vocational Training and, in each UK medical school, a department of general practice or its equivalent. The stage has now been reached where the University system is being challenged to match, from its resources, the increasing financial commitment by the NHS to support academic general practice in ways set out in the Mackenzie Report (1986).

The Present Scene

The main features of the current scene are summarised in [Figure 6](#). Time does not permit me to elaborate on each, so I shall pick out only the last item - the 1990 New Contract - which is again altering the face, if not the heart, of UK general practice. An important element in this Government-initiated series of changes is the requirement that all general practitioners participate in medical audit activities.

Medical Audit

This activity, to which general practice is a relative newcomer, has the twin main aims of improving quality of care and furthering professional development of the general practitioner. The RCGP has long believed that this activity is central to the further development of our discipline. So I wish to say a little more about it. Steps in audit are outlined in [Figure 7](#) and by way of illustration I present the following which relates to alcohol abuse - a very common problem in Scotland.

In 1984, 62 problem drinkers were identified in the small practice which constitutes the clinical base of the Dundee Department of General Practice. Their outcomes were assessed in terms of compliance with medical advice to cut down their drinking. Lessons learned were then applied to a second cohort of problem drinkers whose diagnoses were made after 1984. Their outcomes were similarly assessed in 1989. Only about 1/6 of the original group met our criteria. Had we improved our performance with the second cohort? Alas! ([Fig. 7A](#)) our figures showed we had not - which is one reason why we are now negotiating with the local statutory alcohol services for the provision of a counselling service in our health centre in an effort to improve the care we provide.

A Changing Scene

The UK population is aging. These population pyramids ([Fig. 8](#)), drawn from the same Edinburgh NHS general practice of 19,000 people illustrate in a microcosm some of the changes that have occurred between 1969 and 1984. Some other related changes are summarised in [Fig. 9](#), but behind them all is the fundamental issue affecting Singapore as well as Scotland, namely the insoluble equation of health care delivery: demands always exceed needs and both can never be met by available resources. The added twist of differential in nation whereby health costs are escalating faster than national inflation rates now puts a premium on cost containment - which is why the UK Government is promoting medical audit together with the Gatekeeper role in general practice.

Some Questions for the Future

Against a background of increasing technological development is there a need for General Practice? On the grounds of value for money alone it seems to me that the UK is committed to promoting cheap efficient primary care almost at the expense of hospital care. But there are other considerations. Britain, along with some 40 other countries is a signatory to the Alma Ata Declaration, which seeks to promote health through a strong primary care system in each country regardless of its state of development.

Can general practice re-orientate its preoccupation with the diseased individual towards a greater provision for health of individuals, families and practice populations? This is at the heart of changes currently taking place in the UK and likely to go on to the year 2000 and beyond.

But for these challenges to be met there must be preparation of the young doctor by an undergraduate education much more closely related to the health needs of the patients in the communities served by the medical schools.

The tasks can no longer be tackled by the doctor in isolation from other health professionals. Increasingly teams of caring professionals and teamwork are required. These do not come about by chance - they need to be made to happen.

More Imponderables

The scene is complicated enough, but in the UK there are additional considerations. We are committed to the Unimarket in 1992. Will that bring about major shifts of the working population, with the challenges these pose to the provision of health care? Will unemployment, now beginning to be evident among doctors in the UK, become more marked? Will the UK continue to attract doctors from overseas, who in the past contributed significantly to solving staffing problems in the NHS hospital services?

And above all will general practice be suitably resourced, educated and trained to able to cope with the provision of health and health care for all by the year 2000?

For each of us Singapore and UK, the answers in an era of change and change at an unprecedented rate will to some extent depend on the working together with our hospital colleagues, our patients and our Governments who, increasingly will need the information and the ideas from our respective Colleges.

This brief attempt at fortune-telling has highlighted the increased rate of change so characteristic of our times. But, in conclusion, I should like to leave you with the thought that while some things change, others do not.

Geoffrey Rose (1990) puts it thus:

"If Dr Present (1990) were to meet Dr Past (1840) what would they make of one another? Clearly Dr Past was ignorant, his treatments useless and often hurtful: with hindsight leeches do not command respect. And in 150 years from now how will doctors regard us? Surely in much the same way, as ignorant purveyors of poisonous drugs: and the fiberoptic endoscope will look as horrible to them as does the rigid gastroscope to us. Yet if these 3 doctors - Past, Present, and Future - were each to record a conversation with a dying patient the play backs might not sound so very different. The science of medicine advances, its humanity does not; and nor does the nature of our patients' problems (pain, disability, fear and death)."

Cum scientia, caritas.

REFERENCES