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General practice

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ABSTRACT – There have been considerable changes in the NHS, medical science and practice in the last 25 years. This article describes the developments in general practice over this period. The increase in the primary healthcare team members and the improved premises from which they now practise has revolutionised primary care. Issues of considerable influence have been the movement of care once provided in hospitals into primary care, the use of computers, new technologies, enhanced training, changes in the demographics of the workforce, the hours general practitioners work and commissioning.

KEY WORDS: commissioning, NHS, partnerships, primary care, teamwork

Premises

It is often quoted how general practitioners (GPs) practised from their own homes or worked from a semi-detached/terraced house. Now many purpose-built medical centres have been created which may be described as 'fit for purpose'. When I started as a GP partner in a busy suburban group practice in 1987 I was to work in the old surgery which consisted of a semi-detached house, once the surgery of a two-doctor practice which now had five partners. Within a few months we had moved to a huge new purpose-built medical centre with its own car park where we each had our own consulting room with our names on the door and a modern system to call patients from the waiting area. So much has changed since then including disposable instruments, paper sheets for the examination couch and disposal of the old wool rug as part of infection control.

Receptionists and the waiting room

Before 1987, the reception office could not be referred to as a grand or even a modern day conservatory. There was a small fan heater for those cold winter days and wooden structures housed the famous Lloyd George patient folders where handwritten notes and hospital letters were pushed into until the folders tore apart.

Now many GP surgeries are paperless. To see the doctor in the 'old surgery' there were no appointments. One started to queue outside the main door before opening time and everyone then made their way to the glass hatch where patient names were put in a notebook under the names of the doctors who were consulting that day. There was no choice of doctor offered, the lists were filled up in order and equally, and the length of time you waited depended on your space in the queue and the speed, or otherwise, of the named doctor. You then sat quietly on one of the uncomfortable wooden seats, if one was available, waiting for your name to be called and to be told which room you were to go to.

Appointment system

This seemed to happen with the move to the new building in 1987. Appointments were initially allocated 7.5 minutes, but with increasing complexity of the consultation and the GP's role in chronic disease management, many GPs moved to 10 minutes. For the last two years in my own practice, where we teach undergraduates and supervise postgraduates, we frequently allocate 20 minutes to an appointment as GPs with a dual role in educational supervision, many consultations last 15 minutes. Now appointments are made on the GP computer system rather than a handwritten register and can be made by the receptionist or by the GP in the consulting room at the end of a consultation when a review or follow-up consultation is required.

Practice nurse

In the new surgery a large room had been designated as the 'treatment room' and initially a part-time practice nurse was appointed. She undertook tasks such as dressings and phlebotomy and vaccinations. Within a short time we had three part-time practice nurses whose roles expanded as they each took on designated areas of chronic disease management working carefully to evidence-based protocols for diabetes, asthma as well as cervical cytology. With training they could undertake other tasks such as ear syringing, assisting with minor surgery, undertaking cryotherapy and, more recently, roles as smoking cessation advisors. Inevitably, the new purpose-built medical centre required an extension within five years to provide space for the extra staff and increasing role of primary care within the NHS and healthcare.

There remained a strict divide between these employed staff and district nurses, midwives and health visitors who were attached ancillary staff employed by the family practitioner committee (FPC) who tended to see patients in their own homes, but who were offered a room in the new surgery where they could consult if they wished. Thus, general practice was changing from a service primarily run by a doctor through a receptionist to a multidisciplinary team activity and utilising skills in the community and time more appropriately. GPs remain independent contractors with a small business culture subcontracting their NHS services to the FPC, later to be called the family health services

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authority (FHSA), health authority and now primary care organisations (PCOs) called primary care trusts – PCTs in England and health boards in the rest of the UK. GPs were joined by many other professionals including physiotherapists, chiropractors, community psychiatric nurses and many more.

Information technology

In our new surgery we were soon approached by commercial firms to use their 'free computer systems' in return for sharing data. Many GPs were unhappy about the ethics of this and now there is a national system and data spine. However, the biggest hurdle was e-phobia.

Now most GP surgeries do all their consulting using a computer for the written record and prescribing. Many surgeries have scanned patient records and scan each letter as it arrives at the practice carefully summarising, read coding its contents and designating a problem as significant or not, active or past, enabling a useful template for note summaries. There is then a legible accurate summary of significant conditions and associated medication and, when a referral letter is generated, all this data is automatically downloaded into the letter.

Similarly, we receive laboratory results and reports online which we can download into the patient record and we can refer using the often controversial system of Choose and Book where letters are attached electronically. It has been a slow but certain revolution and ensures good clinical care in so many ways, such as monitoring prescribing, recall and review of patients on disease registers and clinical audit utilising read codes. A disadvantage is that the computer becomes a 'third person' in the consultation particularly as systems now highlight 'target data' required to be collected as part of the Quality and Outcomes Framework (QOF) and may not necessarily be relevant to that particular consultation.

Phlebotomy

GPs employ phlebotomists to take blood samples and there is a collection in the middle of the day to take these to an agreed hospital laboratory. No longer is there a need to wait for the result forms to be printed and posted. Rather they can be received online and filed into the patient record as the GP provides an appropriate message for patients when they ring for results and has a system to act on urgent abnormal findings.

Home visits

GPs still perform home visits, but considerably less so than 25 years ago. With the advent of out-of-hours services and GP cooperatives to take urgent calls, and the presence of large practices, triage by experienced clinicians has led to patients receiving increasing amounts of advice, rather than face-to-face contact. Where a clinical assessment is required a convenient time is provided for an assessment in a modern clinic where diagnostic facilities are more readily available. There is a particular argument that the unwell, feverish child will benefit from a clinic rather than a domiciliary assessment where a well-lit room will increase the likelihood of seeing a meningococcal rash should it be present or developing.

All GPs will, and should, visit the housebound and terminally ill patients when it is clinically indicated. Interestingly an assessment is never complete until the home environment is experienced. Home circumstances should never be assumed, as the true situation can be quite a shock not to mention the inhabitants and even varying types of livestock that one occasionally encounters!

Practice-based commissioning

In the late 1990s the concept of a purchaser–provider divide was no longer emphasised in an attempt to remove the idea of a competitive internal market. As a result, 'commissioners' replaced 'purchasers' and PCOs became the legal commissioning bodies.

Practice-based commissioning (PBC) is not a new concept and is not about new money. This initiative, first described in a 1997 White Paper, sees PCOs extending indicative budgets to GP practices for services. The precedent for PBC came about in the early 1990s with NHS reforms, the creation of the purchaser–provider split and GP fundholding. Practice-based commissioning is different from GP fundholding as it involves the whole budget of a PCO and the services commissioned with that budget. Fundholding covered a proportion, approximately 25%, of secondary care services, did not involve all GP practices and patients. There were different levels of fundholding and therefore inequities. Perhaps the greatest inequity was where the PCOs (then called health authorities or health boards) commissioned services for GP practices that did not wish to fundhold or were too small to do so.

PBC is a much debated politically driven NHS innovation at a time of ongoing change. Unlike GP fundholding the aim is to involve all GP practices. A possible outcome is that some current secondary care services may be commissioned in primary care in the form of local enhanced services or intermediate clinics run by GPs with special interests. Examples where this has occurred are diabetes and anticoagulation. Similarly, private providers may be commissioned. Inevitably there will be an impact on hospital services through a possible reduction in funding and consultants being subcontracted to provide services in primary care. Issues such as clinical governance and cost-effectiveness, however, require evaluation to determine the potential effect on the working relationships and so the interface between generalists and specialists. Perhaps one area of hospital practice that has also disappeared as a result is that of the 'domiciliary visit' where a specialist came out into the community and conducted a home visit at the request of the GP to make an assessment.[1]

Salaried posts/partnerships

With the 2004 General Medical Services (GMS) contract and the introduction of the QOF, contractors argued that GPs had

achieved increased earnings. However, many have been cautious about sharing their higher incomes with incoming doctors. At many practices, new joiners are not business partners, but salaried GPs, many of whom are female sessional doctors. As employees they cannot easily influence the practice's development and may deeply resent the differential between their pay and that of the partners. Offering partnership has become the exception and salaried posts the norm when recruiting.

General practice thrives only because GP principals (GP partners are the equivalent of GP principals and salaried doctors as referred to as GP non-principals) still have a degree of autonomy. They can influence not just their own practices but primary care service delivery through, for example, PBC. If most GPs become salaried rather than maintaining their self-employed status they will lose this autonomy. There will be a resultant loss of energy to develop and improve patient services as successive governments try to steer GPs in these new directions.

Politicians want to control GPs and a salaried profession is the easy way to achieve this. General practice should be about teamwork and enabling new colleagues the freedom to make their mark. GPs should consider going back to appointing partners subject to a successful mutual assessment period and then a defined period to parity.[2]

Teaching/training

Until 1952 it was possible to work as a GP in the UK without any further training and then it became mandatory to complete a pre-registration year in hospital practice before entering general practice and so gaining full registration. In 1972 it was recognised that this was not sufficient experience to become a GP and that 'learning on the job' should be as a supervised GP trainee as part of a vocational training scheme (VTS) for general practice with two years spent rotating in hospital specialties and one year with a GP trainer. This became mandatory in 1981.[3] Subject to satisfactory performance through a signature from their GP trainer, GP trainees would then be eligible for a Joint Committee on Postgraduate Training for General Practice (JCPTGP) certificate allowing them to work as GPs. A more formal assessment was then introduced in 1996 referred to as 'summative assessment' and ensured that newly qualified GPs had reached a minimal level of competence with an approximate 2.5% failure rate. This included satisfactory performance in each of four areas; a multiple choice questionnaire, an audit, video of consultations and a trainers report. Gaining the gold standard of the Royal College of General Practitioners (formed in 1952), the MRCGP diploma by examination, was not compulsory.[4]

In 2007 this changed following the definition of the new GP curriculum and so vocational training now has a mandatory exit examination (nMRCGP) which includes a clinical skills assessment (CSA). Other components include: workplace-based assessment and the applied knowledge test. The new diploma assesses both competence and performance to ensure that GPs are fit for independent practice and have achieved a higher standard than a 'minimal level of competence' and so a failure rate which is running between 10–20%. Negotiations are underway to extend this training to five years in line with other specialties and recognising the increasing complexity of the role of a primary care physician and the preparation required, where for the last two years the registrar may be referred to as a senior registrar. Many GPs are involved in teaching medical undergraduates and supervising the training of foundation year 2 doctors and GP registrars and attend appropriate training courses themselves to be proficient at this activity. In this 'extended role' their work may be quality assured.

Technology

Some of the biggest changes that this paper refers regularly to are the increasing role and reliance on computer-based technology and the fact that most practices are 'paperless'. Glucometers are in wide use by GPs and their staff, as well as by patients. Electrocardiogram (ECG) monitors, 24-hour ECG and blood pressure (BP) machines are common place. The mercury sphygmomanometer has nearly been phased out and the mercury thermometer by equivalent calibrated electronic devices. The pulse oximeter has made in-house management of acute respiratory problems much easier and hopefully reduced the number of referrals to hospital medical assessment units, together with the use of nebulisers. Spirometers can now be used in the community to aid in the diagnosis of chronic obstructive pulmonary disease (COPD) and international normalised ratio machines have transformed anticoagulation and follow-up of patients on warfarin. Practice and district nurses are making more informed decisions about venous and arterial leg ulcers using dopplers and sonic aids have replaced what is now perhaps a museum piece of the Pinard foetal stethoscope. Skills and training are required in the use of computers, these many diagnostic and emergency treatment aids as well as semi-automatic defibrillators. There is now an annual cardiopulmonary resuscitation certification requirement. Some equipment still requires special training, such as the use of dermatoscopes.

Minor surgery

Some GPs have undertaken extra training or have a specialist interest in minor surgery. In some cases they have been able to get funding for new treatment rooms with the latest specifications of, for example, laminar air flow, electric couches and operating lights. Some GPs will therefore undertake, particularly dermatology-related surgery (more than just cryotherapy), by performing skin biopsies and removal of suspicious skin lesions. Similarly some GPs will perform vasectomies and may be commissioned by the local PCO to undertake such activity. Many GPs still insert contraceptive implants and intra-uterine devices.

Practice managers

With increasing practice sizes and audit trail activities ('paper work') and an increasing number of staff and the development

and maintenance of complex premises, greater administrative input and direction is required. In the late 1980s came the advent of practice managers and a new member of the primary health care team. The need for providing reports, keeping patient data and targets on spreadsheets was now beyond the remit of the jobbing GP with a rapidly increasing workload and an ongoing movement of activity from secondary care into primary care. PCOs were requiring yet more reports and accountability.

There has been an explosion in protocols, for example, such as the increasingly complex patient complaints procedure or patient group directives for vaccination schedules and becoming compliant with new acts, such as the Disability Discrimination Act 1995. There is also the need for someone to oversee staff disputes, maintaining the GP computer system. In addition to practice meetings, there are regular meetings to attend at the PCO to discuss agenda, for example, patient access, latest protocols, commissioning, practice leaflets and issues, such as the email consultations, appointments via the internet or ePrescriptions. The manager has a huge task and some large practices may also require a finance manager.

Prescribing

The role of pharmacists has changed and is continuing to change with the development of consulting rooms for BP checks and blood glucose. There has been a complete move to prescribing generics rather than trade names. As a result, seeing a pharmaceutical representative is a rarity and prescribing targets under the QOF means that GPs will prescribe the cheapest drugs available, for example, currently simvastatin for a statin rather than one advocated by a pharma representative. There are prescribing incentive targets through the QOF and also prescribing is IT-based and soon primary care will move to ePrescribing and ePrescriptions. Many practices have their own formularies as well as PCOs. Most also employ a pharmacist for at least one session a week to help with prescribing audits and rationalising and reviewing prescribing so that evidence-based practice is as closely adhered to as possible and expensive medications are used for the time intervals and clinical reasons indicated, such as for clopidogrel. There is the advent of nurse prescribers and the input of nurse specialists in prescribing such as the Macmillan nurse and diabetes specialist nurse.

'Time on the golf course'

There has always been a golf course myth as to what GPs do between their morning and evening surgeries. In the late 1980s my time was spent on house calls which, as described earlier, are now much fewer in number. With the increasing size of the primary healthcare team and GP practices there was a need for practice meetings (team meetings) and in-house clinical meetings.

Similarly, increased activity in health promotion and chronic disease management has meant the running of a huge variety of clinics during the middle of the day, such as childhood vaccination clinics and diabetes clinics. Although these are primarily nurse-led running closely to evidence-based protocols based on latest guidelines, a GP needs to be present for often complex diagnoses and decision making. The way continuing professional development (CPD) has changed means that GPs do not turn up to hospital meetings to collect their CPD 'points' but tend to adhere to a personal development plan and so complete electronic modules, record patient unmet needs and doctor educational needs, and attend protected learning time events once a month. This feeds in to GP appraisal which has now been running for five years. Perhaps then, with all this new found activity and administration, there is little time in the middle of the day for golf!

Open all hours

When I started as a GP in the 1980s our GP contract was such that we were responsible for providing care to registered patients and some temporary residents 24 hours a day, 365 days a year. This meant that a GP practice would share an on-call rota between the doctors and perhaps, if they were a small practice, organise a larger cross cover rota with a neighbouring practice. In the 1980s it was possible to pay a commercial 'deputising agency' to do evening and night work and some weekend work if your practice was in a large city with such an organisation. The quality of such organisations was variable and as a result GPs joined together to form out-of-hours (OOH) GP cooperatives to organise and run OOH rotas run by local GPs who were not locums and deputies. GPs continued to provide a service on Saturday mornings.

In 2004 came the new GP contract when GPs were given the opportunity to opt out of OOH cover, including Saturday mornings, which most GPs did. Many will say that it was great for their work–life balance, but perhaps not ideal for patients. This was particularly the case when local PCOs changed OOH providers from the more expensive GP-led, but GP-run, cooperatives. The return to using locums and deputies in a more organised way came back and has recently been the source of considerable media and political debate. Some GPs now provide what is called an 'extended hour's surgery', by appointment only, where patients for convenience can consult one evening a week or on a Saturday morning. To compliment this the government has now funded 'Darzi centres' or GP-led health centres, at great cost and debatable benefit, and NHS walk-in centres. The result of all the changes has been a loss of continuity of care by a personal doctor, the fragmenting of primary care and perhaps soon de-skilling of GPs in caring for 'emergencies'.

Change in role

GPs have very much become general physicians with hospitals providing increasingly specialised activities and shorter inpatient stays as more complex care is managed in the community. Great advances have taken place in hospital day surgery and rapid access clinics for getting patients seen with suspected cancer and use of new technologies, such as endoscopy and colonoscopy, not to mention the revolution in imaging

techniques that are available through radiologists. Similarly the day-to-day care provided in cardiovascular disease by GPs since the advent of risk calculators and statins and greater adherence to evidence-based medicine and guidelines.

All doctors, whether in primary or secondary care, are undertaking increasingly complex care as a result of greater diagnostic potential and treatment options. General practice is not necessarily the 'job for life' as it once was as GPs move practices and there are greater career opportunities, for example GPs gaining specialist skills and becoming GPs with a specialist interest and perhaps being commissioned to provide more specialist care in the community by local PCOs. One area that has not changed is that of GPs as 'independent contractors' subcontracting their services to the NHS through PCOs. This means that practices are cost conscious and income generation is important as GP practices are ultimately still small businesses. There is increasing target work, but despite the extra workloads that this creates GPs have maintained an element of autonomy which allows them to continue to develop and innovate their services for the benefits of patients. Doubtless GPs will continue to avoid becoming a salaried service under PCOs and continue an important role in commissioning which is led by clinicians, not managers, and interfacing and working ever more closely with colleagues in secondary care.

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