Proposal to Rebuild General Practice in the United Kingdom

Only the restoration of individual care and responsibility will lead to high quality long term ongoing care.

Putting money into General Practice is going to result simply in more of the same, unless we address the matter as a complete rebuild from the ground up.

Traditionally, Medical practice used to be undertaken by the local Doctor, who had his personal list of patients and undertook care for them day and night on every day of the year. In the 1960s there was a move to promote group practice, and significant financial incentives were given by the government to encourage singlehanded practitioners to join together and operate in groups.

The smaller practices still operated substantially as individual personal physicians who simply worked in the same building and shared expenses and covered each other for time off, but they retained the total responsibility to look after an individual from the cradle to the grave. The larger practices began to lose ongoing responsibility for the individual. In those cases patients could chop and change the doctor that they saw, at any time within the practice. The result of this large group work is that doctors arrange to see and follow up their favourite patients time after time, and by booking them ahead, largely fill up all of their appointments such that another doctor is then appointed to deal with emergency cases. No one can get an appointment booked unless they are being followed up in the manner described, or they claim to be an emergency

It was thought that by putting doctors into a larger group, that they would consult on difficult cases between each other and that the patients would benefit from having second opinions when necessary. This however simply does not happen. Doctors are constantly in fear of being criticised, of making a mistake, of being sued. They largely have a code of silence and secrecy and they very rarely consult another or seek assistance. They simply see a patient, deal with an immediate problem, and have no interest in the long-term care or well-being of the patient. This has now progressed to the stage where patients are simply something to deal with in the next five or ten minutes so that the session is complete and we all go home at five o'clock.

1. **Psychological Assessment**
   Shockingly, prospective GP's (indeed all doctors) are not assessed as to psychological aptitude. The only assessments are a report from the school and an interview at the University. All candidates for medicine should have a thorough psychological assessment and aptitude /attitudinal assessment. This being of paramount importance when someone is to be trained at great expense over many years for a career of public service, that will last much of a lifetime.

2. **Specific General Practice Training**
   What is needed is a separate route into GP, separate from, and completely additional to the standard training that exists at the moment. At present we have students applying for medical training without any idea of what career they will eventually undertake, or even

whether they will continue in medicine at all. The first step in this determination must surely be that they are psychologically assessed, second that they are enrolled in a new and specific programme that trains them and certifies them for general practice specifically and solely for general practice, commencing day one in university. The qualifications should be specifically that of a General practitioner whose certification would be specific to that job alone. He or she would not be able to simply move into another branch of medicine. To prevent such loss, heavy financial penalties must apply. If the person specifically trained for general practice were to take his talent elsewhere after this programme, then he or she must be obliged to repay part or all of the cost of their training. Twenty years service, for example, might be set as the period to repay the training cost.

3. **Number in training**

The number of doctors required for general practice must be calculated and a significant excess be incorporated say 20% to allow for illness and wastage. The matter of how many female doctors to employ must also be carefully reconsidered. 40 years ago the number of the percentage of females in training in Medicine was 10%. This was because it was known that women will have families to care for, and their lives are often not well aligned to the arduous nature of full-time general practice. Most women entering Medicine go into part time jobs, or in time withdraw from practice to look after their family. Very few stay permanently in full time general practice. Like it or not, this must be allowed for in the numbers taken into training. The ratio of male to females for this new training in general practice must be something in the order of 80% male to 20% female. In the unlikely event that we ever had too many GPs then the rules could always be changed, but it seems inconceivable that we would ever have too many GPs, and **a much improved GP service will substantially reduce the burden of care now placed on hospitals**. With regard to a greater number of females in GP that would be highly desirable, but facts must be faced. An alternative entry for a large proportion of women remains available that they train like any other doctor enrolled in the general program and enter into GP whenever they want at a later stage.

4. **Retention of Experienced Doctors**

There has been a huge loss of GPs at or even before the age of 60, whereas doctors in the past were in it for life in many cases, certainly did not retire before the age of 65, and a significant percentage continued to 70 or even older.

There are five basic reasons:

1. Over-regulation and imposition of targets. Traditionally , the medical profession set its own standards and controlled training and supervision. The ongoing lifelong training and supervision needs to be reviewed and rethought. It should be a seamless mix of training with assessment built in such that the stress and anxiety of revalidation is removed.
2. Undue pressure from demand, excessive paperwork and targets. Computerisation of records ought to allow certain information to be easily extracted at the push of a button by a secretary. The Gp should not be having to spend their weekends filling in forms for third parties. Targets should be completely removed. Doctors know what is best for the individual patient, and merely taking an action to complete an administrative target is undermining the ethos of looking at the whole patient and addressing their needs, even those unperceived. Most patient do not wish to be pursued just to complete the numbers, and those that overuse the system do not need another excuse.

3. A change of emphasis from prevention to cure. It remains more important to have adequate resources available to deal with illness as it occurs, than to attempt to prevent every ill that cannot ever be predicted. Billions are spent and mostly wasted, on treatments that only statistically reduce illness, but which possibly delays some, and which for the individual has rarely any benefit. See section 9.
4. Unreasonable expectations and fear of litigation. The press is substantially to blame in terms of many years of causing patients to phone all day and all night for the most trivial of reasons. There should be a new code of practice for the press that should steer journalists away from scaremongering and towards building a new respect for general practice. Respect for the GP has however been substantially lost, simply because no-one has a personal physician. When a patient has a personal relationship with one GP there develops both trust and respect. This works both ways. The patient does not wish to disrespect or lose their relationship. When the practitioner is simply anonymous, that relationship ceases to exist, there is distrust, and abuse follows.
5. Alteration of pension regulations. It seems that regulations were changed to prevent doctors investing heavily in pensions such that they could retire early in style, but the adverse effect has been that senior doctors work less because tax rates are too high on their pension investments. It would be better to revert to allowing as much pension to accrue as desired, but to legislate that pensions can only be drawn at or after age 65 unless due to serious illness

5. A new culture of personal care

This was previously the entire ethos and raison d'etre of General Practice. However, it was lost when large practices were introduced, when doctors rarely saw the same person twice, and when the responsibility of ongoing personal care was removed. The best care is given when a GP has sole responsibility for a patient throughout their entire lifetime and career. Of course, patients may move and change doctors, but in times past, lists were jealously guarded, and care is best given when the whole family is under the care of the same doctor long-term. There has been a campaign to prevent and destroy single-handed practice. This has not necessarily benefitted the patients, who ought to have been able to make that choice. If it were felt that standards in those practices were not always high enough, they should have been addressed by training and supervision, not by wholesale destruction and closure of practices.

6. Total care within the practice

In recent years GPs have referred more and more cases to hospital Often this is of cases that could and should be treated completely in general practice. Outpatient clinics have swelled enormously. Domiciliary visits were introduced when the consultant was supposed to jointly attend the case and train the GP for future cases, but this never functioned as a training exercise and was largely used as a means of getting a hospital admission. Initial training needs to incorporate additional specialities as mandatory. There must be 3 months ENT, 3 months dermatology, 3 months ophthalmology, 3 months psychiatry, as well as the 6 months of Paediatrics and 6 months obstetrics and gynaecology. Some of this could be spread into the first few years of GP, and there should be repeat exposure and training built-in over a 20 or 30 year period.

Some GPs have had very high referral rates. These can be substantially cut and should be monitored. Much of the treatment that is currently pushed into outpatient clinics, should be taken back into general practice.

7. **Monitoring standards; Complaints and Hearings.** Forty years ago, complaints were rare. It is the loss of relationship with a personal physician that more than anything has led to the increase. Mutual respect is lost when the patient never sees the same doctor twice. Equally, the physician cannot hope to assess many problems without detailed holistic knowledge of the patient and the entire family. Following a culture of litigation fostered by the press and advertising by lawyers, expectations are often unrealistic. Advertising by lawyers seeking to pursue every ill should be prohibited. The press should be recruited to assist in the process of nurturing a new way of working. Worst of all is the culture of blame within the health service itself, with secrecy and total lack of open-ness. Mistakes and misjudgements must become entirely a learning exercise. Instead of GPs having to fund ever increasing indemnity premiums, the government and profession need to accept that this is a public service and the organisation must own up to mistakes. These must become a shared learning exercise and any compensation must be from the public purse. Doctors and nurses in the community and hospital can then properly share experience and learn and the public will benefit from better care, doctors will jointly learn. I have personal examples of how the present system is detrimental to all, should these be helpful. Cover up and blame helps neither the patient nor the doctor.

   Large numbers of doctors have been put on gardening leave after complaints or mistakes. This action nearly always leads to the eventual retirement loss of the employee. This policy must cease entirely. Assessment in service is required. Loss of experienced practitioners both in GP and Hospital must be avoided at all costs. Monitoring of standards of care would be best maintained by the analysis of video of consultations. Consultations are often videoed by GP trainers. Both their own consultations and those of trainees are submitted to peer review. This process is well known to all GPs in training practices, and there is every reason why this should continue as part of regular and routine assessment of all GPs throughout their career, and indeed it would seem that for the patients safety and well-being and in the name of best practice, all consultations both in hospital and general practice, should be recorded and archived long term in the same way as telephone calls generally are.

8. **New small practices should be started from scratch** having 3 or 4 practitioners, and set up with a fresh approach incorporating these ideas:
   a. no paperwork; the computer is there to fill forms
   b. personal lists as absolute with no exceptions, the whole family under the care of a single GP. Sometime personalities may not entirely match, but only by making the rule hard and fast, does it work in practice. There would be other medical practices to sign up with if this does not suit, but the new GP under this scheme would have this provision as immutable.
   c. Indemnity covered by the health service with a new culture of open-ness -**Learning Not Blame** (no-one makes mistakes on purpose). A culture of mutual respect fostered by controlled and limited list sizes. Treatment fully in the community without immediately

referring to hospital. A substantial reduction in complaints but with sharing of information and a willingness to treat fostered by state funded indemnity.

d. Lifelong training with seamless assessment, with short refreshment periods in hospitals built-in to the life-long scheme.

9. **A total review and assessment of preventive medicine** is needed. Billions have been spent on wholesale prescription of statins for instance. The cost has been immense, and yet the benefit to any individual is little or none. Statisticians will give numbers of those who are "saved" but those people die soon enough anyway, and for the individual, if say 3% are saved from death at that time or within a five year period, then 97% have no benefit at all and may in some cases have very serious adverse effects. Others have minor but still troublesome ill effects, all at incredible high cost and it seems certain that if they had to pay for their own preventive treatment, there are almost none that would do so.

10. **Reconsideration of controls on prescribing are needed**. When the government imposed a blacklist of cheap medicines that GPs could no longer prescribe, the opposite effect to that desired occurred. Whereas the GP could previously write something cheap and innocuous such as an antacid, now they prescribed expensive anti-ulcer treatments that cost the country billions. Perhaps half of those prescriptions were previously avoided. Likewise cough mixtures were previously prescribed for children and antibiotics withheld longer. GPs do not waste money, they save it wherever possible and should be trusted again to prescribe as they know best. We could save billions by reassessing the need of statins and reinstituting the prescription of antacids alone. Budgets should not be saved by having to spend every penny as at present throughout the health service. Money should be capable of being saved and transferred within departments, hospitals and practices. The current management of budgets is especially wasteful.

Author

Mark Rumble, M,A., M.B., Ch.B.

(Retired GP, GP trainer, Cambridge Univ. tutor.)

19.11.2019