The overlapping roles of primary care physicians, general specialists and subspecialists

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Summary

Family medicine has been central to the National Health Service since 1948, with its role and status being enhanced with each reform – from the GP Charter of 1965, the internal market of 1989, to the creation of primary care groups and trusts in the latest reforms (1998 to 2002). The clinical and social expectations of family medicine have increased greatly (and will continue to do so) and by and large have been met.

Despite the rhetoric of a "primary care led NHS" (with general practice, as family medicine is known in the UK, being a key component of primary care), recruitment is difficult, numbers are static, and the service has survived through the development of team working and flexible role definitions.

This paper looks are the background to and the current state of family medicine, and key issues that will influence the short term future of primary care in Britain.

Recent evolution in primary care in the UK

There is large inter-country variation in the numbers of family doctors, from one for less than a thousand to over two thousand. In the British Isles, for example, the average numbers of patients registered with each general practitioner varies from 1,859 in England to 1,695 in Wales and 1,441 in Scotland. Even within countries the density of general practitioners varies. In many countries family doctors are clustered in cities and more affluent areas, with deprived or remote areas less well served[1]. In Britain the distribution of family doctors was controlled by the Medical Practices Committee until 2000; now it is up to local primary care organisations to use incentives and mechanisms such as Personal Medical Services contracts to ensure recruitment. Many areas are experiencing, for the first time in 50 years, severe shortages of family doctors.

In some countries, such as Italy[2] or New Zealand, family medicine is overwhelmingly delivered by doctors working "single-handed". Although they may work in the same building as other general practitioners and may therefore share expenses[3], they usually see their own patients and keep their incomes separate. In other countries, such as Ireland, about half are single-handed.

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By contrast, in Britain only 10% of all general practitioners work now as single-handed, although in many deprived urban areas such as southeast London it is over 30%; and the trend is a gradual one away from single-handed practice to groups[4,5]. This is a result of a deliberate policy decision to encourage group practice. In the 1965 General Practice Charter a payment was introduced for those general practitioners entering into partnership agreements. Subsequently a complex debate has occurred. In summary, policy makers argue for the virtues of economies of scale, and the increased efficiency, management simplicity and accountability of group practices and the profession argues that group practice offers a wider range of services, more consistent care and better potential for teaching, research and audit.

On the other hand those working in small practices argue that single handed practices offered personal care and innovation and a better service[6]. They are satisfied with their sole status and do not yearn to join partnerships.[7] Patients agree that smaller practices offer better communication, personal care[8], availability, continuity of care and to be more accessible[9]. Smaller practices are, overall, preferred by patients[10] and they achieve higher levels of patient satisfaction[11].

Single-handed doctors tend to work in areas of the greatest deprivation and need. Deprivation is associated with lower prevention uptake, higher referral rates, emergency admissions and patient consultation rates – all then used as evidence to demonstrate the "problems" and limitations of small practices. Indeed some studies have suggested that single-handed family doctors were less likely to address patients' somatic problems, less likely to follow clinical guidelines[12], and were more likely to suffer from depression.[13] In contrast in a recent study that adjusted its analysis for deprivation, and the ethnicity and age of the practice population, the authors found no evidence that single handed general practitioners were clinically under-performing[14]. The dichotomy between patient choice and political imperative will continue to be a theme as the UK decides whether single-handed family medicine offers an appropriate model for the future.

In Britain patient registration has been in place since the 1912 National Health Insurance Scheme, and the "right of referral" (suspended in special circumstances such as genito-urinary medicine and emergencies) was enshrined in the setting up of the NHS in 1948. These two features are key to the roles, functioning and workload of general practice in Britain.

These two features also made possible the introduction of fundholding after the 1989 health service reforms since practices had a defined population and could control the elements of expenditure (prescribing, staffing, premises, out-patients and routine operations) included in the budget.

Registration and the right of referral also promote primary care involvement in public health. Practices can look at the health needs of their population (deprivation, housing, the environment, inequalities, high-risk life choices, occupation/ unemployment and diet) and measures service provision and uptake, for example primary and secondary prevention for coronary heart disease[15] and their use of statins[16]. Family doctors are increasingly becoming central in moves to understand and address social determinants of health.

Family doctors in Britain are independent contractors with the NHS. They are not paid directly by patients, and health care is largely free to patients with the exception of a charge per prescribed item. Most family doctors own their practices – are "partners" – although the numbers choosing to be salaried (either as salaried partners, locums or in a Personal Medical Services contract (see below)) is increasing. This trend is thought to be in reaction to the investment and long-term open-ended commitment required in general practices partnerships. However, for many doctors the autonomy of the independent contractor status remains a strong attraction. It is this autonomy, of course, that creates much of the concern felt by patients, health care providers and governments.

Traditionally general practices arranged their own out-of-hours care using a within practice rota. From the 1970s deputising services offered an alternative in urban areas although some have been criticised for the poor quality of some of their staff and their response times[17,18]. Since 1998 NHS funding has been provided for out-of-hours cooperatives[19] and these have become the preferred model. In the proposed new General Medical Services Contract, family physicians will be able to opt out of their 24-hour responsibility.

The work of family physicians and the primary care team in Britain

The vast majority of practices in the UK deliver care through an extensive primary health care team. As an illustration, Figure 1 shows the team in the author's practice of 6,200 patients.

- **6,200 patients**
- **3.5 Family Doctors + 1 registrar**
- **3 practice nurses**
- **5 community nurses**
- **1 pharmacist**
- **0.2 physiotherapist**
- **0.2 Counsellor**
- **Visiting dentist, optician, chiropodist, osteopath**

Figure 1: The Primary Care Team in the Collingham practice

As Figure 2 shows, the consultation rate is rising, but this is being met through increases in nurse consultations (Figure 3). It is interesting to note that the "average" patient has 5.4 consultations per year, with an average length of 12 minutes. The "average household" of four members has therefore four and third hours face to face with a family physician or practice nurse in a year.

While looking at consultation patterns in one practice, it may be of interest to note that the 6,200 patients who had 33,581 general practice consultations had 116 acute admissions to hospital and 960 referrals to hospital outpatients in 2001/2, emphasising the predominance of the modality of primary care in the NHS. Lastly, in a disease such as diabetes 84% of all people with diabetes are being cared for only in primary care – they are not being seen in hospital or other clinics (Figure 4).

1998/9	2001/2
28,581	33,581

Figure 2: changes in consultation numbers in the Collingham practice over 3 years

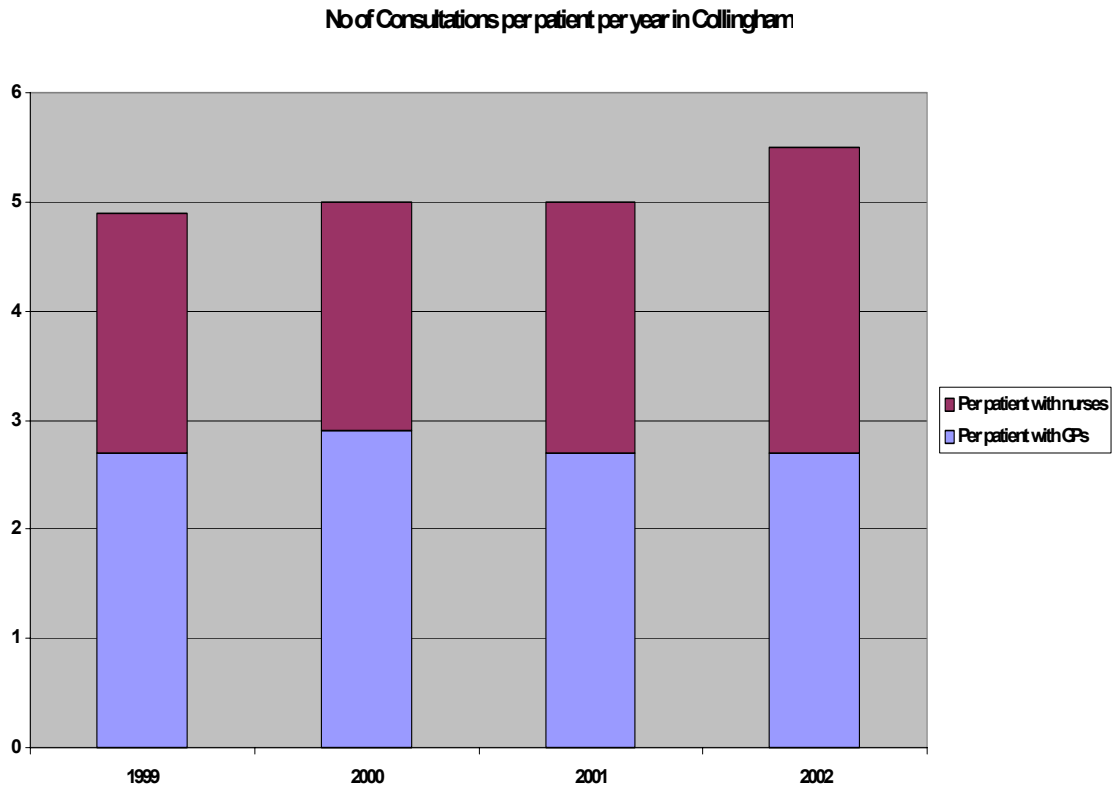

Figure 3: The consultations rate per patient overall and by doctors and nurses in the Collingham practice.

Total list size	**6,200**	
No with diabetes	**217**	**3.5%**
No of consultations	**2,477**	
No seen in diabetes OPD	**35**	**16%**

Figure 4: Care for diabetes in Collingham – prevalence of 3.5% of the practice population, with 84% of all those with diabetes being seen only in general practice

Family physicians still undertake the same core clinical tasks that they have been doing for the past century:

a) Delivery of complex medical care

A family physician is presented with the full range of symptoms, signs and histories in the physical, psychological and social domains. Dealing with these needs high level knowledge, the ability to tolerate uncertainty, the skill to create a safe, effective but not unnecessarily complex management plan, and high-level communication skills. The complexity of this role, at the interface between perceived illness and disease, must not be underestimated.

b) Flexibility

This is a hallmark of the personal care delivered by family physicians. They reformulate their care to meet the needs of individual patients as they evolve, developing roles to suit the needs of patients.

c) Developing the use of health care

This results from family physicians empowering patients to take responsibility for their own care when appropriate; from identifying the right routes through the primary and secondary care services; and from taking increasing responsibility for complex patient care in the community setting.

d) Delivering continuity of care.

People appreciate seeing a doctor who knows them and remembers key events in their life and that of their family, who will be there subsequently when required and who takes a longer term view of care and its outcomes. Continuity of care has been shown to reduce use of secondary care services and to improve patient satisfaction.

e) Population context and advocacy

In addition, a family physician must see care in the context of the individual, the family, the group, the community and the population. Without this variety of perspectives the family physician cannot be involved in health needs assessment, addressing health inequalities, prevention, and the commissioning of health services. This is linked to advocacy the family physician provides not only for individuals, but also for groups and entire communities.

f) Team working.

The general practitioner fulfils a key role within the primary health care team. Every user of primary care needs to know that someone – their general practitioner – is taking clinical responsibility for the care they receive and can be held to account for that care, regardless of which team member they consult.

g) Leadership

In this egalitarian age, this may seem perverse, but the family physician has a clear leadership role in primary care and, increasingly, in the entirety of health care systems.

Practice nurses have gradually moved from traditional nursing tasks, such as dressings into prevention and early detection[20] taking over day to day responsibility for smoking advice[21], diet and exercise advice, cervical cytology, immunisations, new patient registration checks, well person clinics, medicals for older people and foreign travel advice[22].

In the last two decades their role has extended into monitoring of care in chronic diseases, contraception, menopausal interventions and minor surgery[23]. They may be trained for these tasks "in house" and start with protocols to follow under supervision, but increasingly they are properly trained as nurse practitioners and increasingly take their own clinical responsibility for clinical decisions, but with the explicit support of the family physicians in the practice.

Increasingly nurses are caring for urgent problems, running open access clinics to assess and manage patients with self limiting and minor illness, filtering out those with more significant problems who require a general practitioner consultation[24]. As people become accustomed to nurse advice on telephone lines, and to nurse follow up for their chronic diseases, they will increasingly expect nurse assessment and advice for new and urgent problems.

Community nurses have important roles caring for people after discharge from hospital, especially after surgery, offering palliative care, continuing care for stomas and catheters, for wounds, infections and injuries, and for the frail or vulnerable person.

In addition to dispensing medicines, community pharmacists have traditionally fulfilled a key role in offering advice, filtering out those who need to consult a family physician, and supporting self-care. The UK is exploring the increased use of pharmacists as members of the primary care team with expertise in prescribing and it seems likely that their roles will become more central.

Britain has "public health nurses" called health visitors who have responsibility for the health of the young children and their families. In the last decades of the twentieth century access to counsellors or psychologists, including practice-based counsellors, has improved. Counsellors offer a range of psychological supports, including cognitive behaviour therapy, and see people with anxiety, depression, relationship problems and lifestyle issues. They do not usually manage major psychological or psychiatric illness, but they have an increasing role as team members in the management of eating disorders and chronic fatigue syndrome.

What about recruitment and retention in primary care?

In 2001 there were just over 24,000 consultants in the NHS, and nearly 29,000 family doctors[25]. The rate of growth of consultant numbers has been steep – from 18,200 in 1995, an over 30% increase in 6 years. By contrast the numbers of family doctors has risen very slowly, from 27,500 or by 5% in 6 years. This apparent rise has been negated by the increase in part-time working, meaning that the full time equivalent family physician workforce has contracted.

The poor rise in numbers of family physicians is partly due to structural issues. If the numbers of medical students are fixed, then a rise in consultant numbers must occur at the expense of general practice. In reality the numbers of medical students has been expanded by almost a third, but the increased places has not fed through into increased numbers of graduates yet, let alone fully trained family doctors or consultants.

Further explanations lie in the nature of the work of a family physician in Britain. Many young doctors perceive a family doctor's life to be demanding and risky, in the sense that clinical care in primary care settings is often more difficult and isolated. They also see a big managerial and financial commitment, but with lower lifetime earnings. The latter is probably not true except for consultants with distinction awards or private practice, but the perception is widespread.

However, there are signs of encouragement. Vocational training places for general practice are fuller than for many years, and the new general medical services contract (see below) will significantly increase the income for family physicians.

General Practitioners with a Special Interest

In the Department of Health's NHS Plan[26] published in the summer of 2000, there was a commitment to the creation of "specialist GPs":

"By 2004 there will be up to 1,000 specialist GPs taking referrals from fellow GPs for conditions in specialities such as ophthalmology, orthopaedics, dermatology and ENT. These GPs will also undertake procedures such as endoscopy."

The language was quickly changed to General Practitioners with a Special Interest, and it has become clear both that there are already a lot of family doctors fulfilling this role clinically[27] and that the paradigm should include teaching and academic as well as clinical activity. The programme to introduce clinical posts for GPs with a Special Interest continues, with the frameworks for each area being drafted by a project team within the Royal College of General Practitioners[28]. There will be three types. Some family doctors will offer a technical service such as endoscopy; these services are likely to be only short term since they are likely to be taken over by nurses or technicians. The second type will be an advisory or extended primary care service, for example around drug addiction, back pain, dermatology or asthma[29]. The third, more contentious, type will be involvement in service reconfiguration, for example around modernising diabetes care.

While the original intent may have been to ease pressure on hospital services, many family doctors see this innovation as an opportunity to develop their skills and roles, and to enhance the delivery of care in community settings. The "enhanced service" option in the new General Medical Services contract will help to cement this initiative.

The possible effect of a new General Medical Services Contract

In a report of an international conference on payment systems for family physicians[30], delegates from most countries identified the mixture of modalities that constitute GP income. In the UK all types of income, except for direct patient payment, have been features of the General Medical Services contract.

The first fundamental contractual change in recent years occurred with the introduction of a Personal Medical Services contract. This option, taken up by a third of family doctors, allows for a local contract in which a range of services and their specification are agreed for a fixed price. To the Department of Health this contract offered a break with national contract bargaining, local flexibility, promotion of salaried options if that suited and a fixed predictable financial commitment. For the practices and individual professionals it offered local autonomy and flexibility, a practice-based contract and increased investment.

For the past 18 months the British Medical Association, through its General Practitioners Committee, has been negotiating with the NHS Confederation (an employer's organisation representing the Department of Health) a new General Medical Services contract. If this contract is supported by the profession in a ballot then it is likely that the pressure back towards General Medical Services will be intense. If the ballot goes against it, then Personal Medical Services will become the likely preferred model.

The key features of the new General Medical Services contract are as follows:

- A 30% increase in investment in general practice (family medicine) – some for staff, premises and computers, but most for increased GP pay
- A practice-based contract
- A core contract with options, the latter including whether to provide out of hours care or not
- Substantial rewards for meeting quality indicators (performance management targets)
- Create more flexibility in service provision, including enhanced services

If accepted, it is possible that this contract will significantly change the balance of attractions between secondary and primary care as a career option for young doctors. In particular the contrast between the family friendly flexibility of this contract and the shift working in the (rejected) new consultant contract is stark.

Conclusions

Despite the clear evidence from Starfield of the importance of a strong primary care for cost-efficiency, outcomes and patient satisfaction[31,32,33,34] and the mantra of a "primary care led NHS", recent investment in people and structures has concentrated on the location of most concern – routine and emergency care in acute hospitals. Family medicine is a high quality, elastic service that has responded positively to almost every innovation save the enforced 1990 contract. Its productivity has risen as has its range of services. The increases in the quality of care in general practice in the past ten years have been remarkable.

The renewed recognition of the need for investment in family medicine offers real hope for improved recruitment and retention; for improved morale; and for primary care to continue to increase its contribution to the overall care of the NHS. In time we expect many services that conventionally have been delivered in hospital settings to move into the community. Diabetes care, dermatology, psychiatry, respiratory medicine and rheumatology require few of the support services of secondary care beyond those that should be available in intermediate care facilities in the community.

Once acute hospitals become high technology citadels for the seriously ill, the rest of health care can coalesce around intermediate, community, social and primary care to offer most health care close to the patients' homes in appropriately low- or medium-technology settings. Family medicine in the UK is well poised to become part of such an alliance.

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