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General Practice – why bother?

Abstract:

This paper will outline the nature of a general practice population, its social history, and why it matters.

Transcript:

I would like to begin with two examples of my experience with general practice.

In the early 1980s I moved to the United Kingdom to start a research carer in academic general practice. I did a locum in a town called Ware, where I was to work as a GP.

It was quite exciting because I wanted to see how different general practice was in the UK compared with New Zealand. The difference couldn't have been more marked.

The practice had one 70-year-old GP. He worked in a small office that had a table, two chairs, a very small bed and a hand basin. There was no medical equipment. In particular I had to provide my own blood pressure cuff and my own plastic gloves to examine patients. There was no telephone and no records. Patients would arrive and quietly sit in a very small waiting room and be seen on a first in, first served basis.

Each morning I would invite the first patient to come into the consulting room where I would place their name at the top of a blank sheet of paper and in one line write all my clinical notes. Each patient would get a line or two on that sheet of paper.

If patients wanted repeat prescriptions for their medications, they had to bring their own lists for me to work out what they had been prescribed previously. At the end of the day the sheet of paper was placed on a pile of paper that was about a metre high from the floor.

There was no receptionist and no practice nurse. Marian, my wife, had to sit at home to answer the telephone. If somebody wanted a house call, Marian would telephone the taxi service situated next to the consulting room and someone would bang on my wall to inform me that I had to attend a house call.

Marian's other job was to file all the consultants' letters at home, so if I wanted to read what had happened to a patient I had to go home from the practice to do this. It was a solo general practice *par excellence*. I remembered it because it was unique. The GP

had worked there for over 20 years with his long-suffering wife who was reported to have died at the end of the telephone after getting him to go to a house call. The GP was proud that all his patients' clinical information was stored in his head and that he had a wealth of experience with patients. The GP retired shortly after my working there, and the practice disappeared.

The second example is the practice I joined here in Canberra. It took four months to get the required medical council number, provider number, prescriber number, a couple of insurance numbers and the RACGP number before I could practice.

When I did start it was easy because the range of patients is very similar to the practice I left in Wellington. Also, the structure of the practice was similar. Now I am working with part-time GPs, practice nurses, receptionists and a manager. I am using purpose-built consulting rooms and a completely computerised information system. The main difficulties have been to learn about the referral systems and to navigate through the complex health administration that occurs in Australia compared with New Zealand.

I found working in the UK practice extremely stressful compared with working as a locum in general practices either in New Zealand, the UK or Australia. I found it also much less stressful to create two brand-new general practices in New Zealand.

My experiences aren't unique. I've met locums who tell me that their experiences also vary between different general practices. For example, one locum will go to two general practices within the same suburb and experience vastly different work at the two places. Furthermore, the locum can experience differences between the groups of patients that see individual GPs within the same general practice.

My experience has been that when I work part time in a practice that has largely female GPs, my work has an even split between male and female patients, whereas the female GPs encounter a greater proportion of female patients.

So locums have two kinds of practice experiences with practices - those experiences when consulting the range of people seen by an individual GP, and those experiences between different general practice populations.

My stressful experience is easy to explain. The old GP and his general practice were one and the same. He *was* the general practice. When he left for a holiday or retired, his general practice disappeared. The stress arose from my having to work as a GP in a setting that didn't constitute a general practice as I understood it.

In contrast, the Yarralumla practice does constitute a tangible workplace, which has an existence that is not dependent on the existence of any one GP.

These experiences matter because not only are general practices real work environments that can cause a discernible effect on a locum, but also general practices differ from each other in important ways.

There are three qualitative studies that help us understand these differences.

Firstly, there is the life cycle of a general practice. In the early nineties I was involved with a small research network of the Royal New Zealand College of General Practice where we sampled randomly 46 GPs from around New Zealand. Two researchers did

ethnographic work to describe the nature of the general practices they encountered. They spent time with the practices observing how people worked and what they had to say about their practice. The researchers found that the social and cultural milieu of the practices was best understood by describing a practice as having a life cycle with four stages.

The beginning practice was one where, for example, a young GP would open new rooms in a new suburb and have few patients to see in the first year. The changing practice was one where either a GP bought the practice from another GP or the practice had changed location. The cutting back practice was one where there was an active policy of slowing down to reduce the workload either because the GP might be retiring or might be suffering poor health.

The bulk of practices were in the fourth stage of the life cycle, the mature group. These practices could only develop their personality to the extent that external factors would allow.

The character of the practice was affected by the pool of people from which its patients could be drawn. The patient profiles of mature practices differed from their local community when patients had greater freedom to choose the GP they visited, or where the GP could influence the type of patients seen. Some of the categories identified by the researchers at the time of the study are now very familiar, such as the categories of inner city, suburban and rural practices, though they weren't thought about like that in the eighties.

Other categories are not so familiar. The female practice was one where the GPs, the receptionists, the practice nurses and the bulk of the patients were largely female. Such practices would have a lone male lurking somewhere in the practice (I was such a GP in my last practice).

The special interest practices were those where the GPs had a special interest, such as obstetric care or occupational health. These practices had a skewed patient profile in terms of age and gender. Interestingly, over the last five years, obstetrics has virtually died in general practice in New Zealand.

Now, the GPs in this study agreed with the categorisations identified by the researchers. They also agreed with the various descriptions of the ambience of the practices. The 'very smooth' practices ran very efficiently and smoothly. The 'conservative' ones were similar to the smooth practices but the GPs and their practice buildings were much older.

The 'rough and ready' practices had significantly poorer practice building conditions than all the other practices combined. The 'tense' practices were not efficient because of conflict or tension between various GPs within the practice, or with the receptionist, or the practice nurse.

Finally, the 'busy' practices had a very high turnover of patients. It's interesting that the busy, tense and rough practices were more demanding from an ambience point of view and they saw more patients per day than all the other practices. However, it turned out that the quieter, smooth and conservative practices were more profitable, in that they made more income per patient encounter. We knew this because at the time we were able to get hold of all the GPs' financial accounts.

The second qualitative study I'll describe is a historical study of general practice in Wellington between 1895 and 1995. Wellington is about the same size as Canberra.

We had 1063 addresses and used the phone book from 1935, which has the most consistent record of GPs, and the Stone's directory, which up until the 1930s had a list of all practitioners in the Wellington area. It meant we could count the average number of practices or addresses that had GPs in them at the time.

Wellington City had a huge rise in the number of GPs, which plateaued and then went down, while the suburbs had a gradual rise in practices.

If we focus on Wellington City itself, the business district had a decline and the local suburbs a gradual increase around the central business district over time. The really interesting observation I thought concerned the central Willis Street itself. In the 1930s it was the Harley Street of New Zealand. I believe they had 18 general practices in it. Now it's down to three. It just shows how the pattern and the number of practices do change with the demography of the area.

The other thing is that in 1970 there was one practice called a medical centre. In each of the following decades an increasing number of practices called themselves medical centres. The first after hours medical centre was I think 1995 or 1996.

The third study was done by Tom Love and others from the Wellington Independent Practitioners Association. They mapped the practice population against a measure of socio-economic deprivation of populations called the Nzdep. This measure provides a value that reflects eight dimensions of deprivation and was created for small areas with at least 100 households, called a meshblock.

A value of 10 indicates the meshblock is in the most deprived 10 per cent of small areas in New Zealand. There were four practice types. The Type I practices were located in city areas and the less deprived suburbs. These practices tended to recruit patients who lived in the less deprived areas.

Type II practices were located in residential suburbs with a more even distribution of deprivation and tended to recruit patients in the middle deprived deciles.

Type III practices were also located in residential suburbs with a reasonably even distribution of deprivation, but tended to recruit patients living in somewhat deprived areas.

Type IV practices were situated in the most socio-economically deprived areas of Wellington and recruited patients representative of those areas. This study shows practice populations largely mirrored the deprivation profile of a community even though practices recruited patients for registration under a mixed fee for service and capitation system and patients were free to use as many practices as they wished.

The three studies I've described illustrate that a general practice is a place that has a particular demographic; it has an ambience and it has a history. The locums react to the varying workloads and practice profiles. These features give credence to the notion that general practices are real places that provide continuity of care at the community level.

One of the core definitions of general practice by institutions that promote general practice in countries like Australia and New Zealand, the UK and Canada, is that general practice is defined by continuity of care.

Now, Saltz had done an excellent review of how continuity is defined around the world. It has a hierarchical definition with informational continuity being at the top. This is an organisational collection of medical and social information about each patient available to any health care professional caring for the patient.

Then there is longitudinal continuity where each patient has a 'medical home' where they receive most health care, which allows the care to occur in accessible and familiar surroundings from an organised team of providers. Finally there is interpersonal continuity where an ongoing relationship exists between each patient and a personal physician. The patient is known by name, knows the physician by name and comes to trust the physician on a personal level.

These definitions get jumbled up when we talk about continuity in general practice. In my last general practice in Wellington, and also in my present practice in Yarralumla, the only feature of the general practices that are continuous 24 hours a day, seven days a week, is the computer system and the building. The GPs, nurses, reception staff and patients come and go at various time intervals. Some of us are more continuous than others.

In our study of the history of general practice, only about 13 per cent of GPs had provided a lifetime of service within the greater Wellington region - that's more than 30 years in a practice. Most GPs were there for less than five years. And, as I showed earlier, the number of general practice addresses in Willis Street varied from three to 18 over time.

Educational general practice has existed around the world since the mid-1960s, and all the training schemes emphasise the virtues of interpersonal continuity of care. It's what any GP will eventually emphasise when talking about how their work operates and what is important in their clinical care.

The reality is more complex. Studies have shown that what patients and GPs think constitutes continuity doesn't gel. Patients want a personal GP but also want to be able to choose different practices when they feel like it. For example, in New Zealand I found about 10 per cent of patients registered to me as what we called 'a capitated patient' also saw other GPs around the Wellington region as casual patients.

I didn't really mind from the economic point of view because I was charging the fee for other GPs' capitated patients when they came to see me as casual cases. However the informational continuity was a problem, particularly for prescribing.

I argue that continuity of care is a myth if we accept the story that longitudinal continuity is all that matters for general practice. In one of my general practices we found that in some years 20 per cent of the total practice population would move in and 20 per cent would move out. Our historical study found that a third of GPs were gone for ever from Wellington after five years of work. Considering GPs and their patients move around the country, we had better clarify what we value about the three levels of continuity I've mentioned.

From what I've said so far, we might ask the question: General Practice – Why Bother? We might ask this because we have a strong feeling that in some ways general practice is invisible.

Previous medical students in this town may have been encouraged to look away from general practice by hospital specialists because it is seen to be trivial and that those who work in general practice do so because they failed in other specialties. Furthermore, the student would make a better income as a specialist.

This kind of rhetoric is not new. It has been around since the inception of academic general practice in the early 1960s. It stems from a lack of understanding of the virtues of general practice. The rhetoric, however, does encourage the exclusion of general practice from the field of view.

I suspect that the rhetoric used by GPs also contributes to the invisibility of general practice. For example, I developed a national database of GPs who are members of the College of GPs in New Zealand. It covered about 2000 GPs. When asked about the characteristics of the practices, many GPs would say that they worked in a solo practice, even though the practice name, telephone number, address and number of allied staff were exactly the same as what other GPs said was in their group practice.

Such GPs identified themselves as working in a solo independent practice, even though it looked to all intents and purposes that they worked with other GPs in the same locality called a group general practice.

Our history study also hinted at this invisibility when we found that the words 'general practitioner' didn't appear once over a hundred years in the phone books. I was stunned by that. Not one doctor called themselves a GP. And the word 'general practice', up until 1995, wasn't a title for medical centres. I want to repeat the study here in Canberra to see if it's similar.

I will make one final comment about the invisibility of general practice. If you look at the relationship between general practices and schools here in Canberra, the practices are scattered throughout Canberra, just as the schools are. This makes me believe Canberra is well served by general practices because it looks to me as though there are no large gaps of practices scattered around Canberra.

However, I'm told I'm wrong by all the GPs I have visited in this town. There are too few individual GPs to serve the population in the same proportion that serve other metropolitan areas in Australia. None, however, have said that the distribution of general practices is wrong.

The disjunction between the meaning intended for the words 'general practice' and the words 'general practitioner' is confusing and contributes to the invisibility of both the GP and their practice. Researchers contribute to this disjunction when they say their studies involve general practice, when often what are being considered are the activities of individual GPs.

I want to end by talking about how we might define a general practice population, what are some uses of a general practice population and a comment about the future.

So, how to define a practice population? In the UK capitation system, the patient is defined by the locality that they are living in. You can define it like you do in Australia where patients pay a fee and it's just a record of that transaction. Or you can do it as a mixture, like they do in New Zealand, where a patient pays a fee and is formally enrolled in a practice.

But in our practice in New Zealand a lot of patients didn't formally sign a bit of paper if they'd been seen a GP. The IT system automatically made them registered and if they hadn't been seen they became casual.

You can also define the practice population according to the prevalence of disease and elements and suffering in a locality. Can you do quality assurance programs using the practice population as a denominator for quality? There are economic and social uses; the history of a general practice population adds to the history of the local community. There are labour historians who assess general practice records from various parts of the UK to give you a flavour of those tasks by using general practices. Also, a practice is a product that can be bought and sold.

Then there are theoretical uses of a general practice population. It might be ownership of a population. Looking over a population, a provider gives a level of support needed for public health issues.

There is a difference between 'seen' and 'unseen' patients. You can separate, using a general practice population, the difference between the patients you see as a GP and those you don't. For example, I've looked at those members of a population with asthma to see who were and who weren't diagnosed and what happened to them. We did a case control, an observational study, and we found that 4 per cent of them who weren't diagnosed had actually been to hospital and diagnosed, but we didn't know about it.

There are a lot of studies done on seen patients. There was also a nice little scientific study correlating medical conditions. It used PMS - premenstrual syndrome - as a control study and found that there is a correlation, a positive correlation, between the diagnosis of it and hay fever and eczema.

We also studied a bunch of women in New Zealand who'd missed out on rubella immunisation when they were about 11 or so. We thought it would be quite a good service for us to identify the women who were aged 24 and then cohort. We tried to get hold of them and ask them: 'Have you thought of getting yourself checked for immunisation for rubella?' The interesting thing about that was we worked out the cost of actually doing the checks was $10 a woman just to get about 65 per cent of them.

And then you can look at the unseen patients, for example looking at delayed immunisation. We looked at the households in our practice that were up to date with immunisation and compared them with households that weren't. Sure enough, the lower socio-economic households were different from the better off ones where they were up to date.

And there was another study of men in their 40s. About 5% of men like to be registered but never want to see a doctor. They don't want contact but they also don't want to be taken off the books.

What of the future? Most developed nations have a series of drivers for change in general practice and the organisation of primary care is changing in most places I've been to.

These drivers are: that the organisation of primary care is changing, that the demographics of the medical workforce are changing, that medical technology is always changing, populations are aging and chronic disease is mounting.

So is it unrealistic to expect future generations of GPs to commit to a lifetime in one community when so few did so in the past? There is this unwritten assumption that when you are going to be a GP you'll be there forever.

I believe in the future there'll be two kinds of continuity. You'll have longitudinal continuity, and then you'll have personal continuity, which will be a feature for the members of the primary health care team, where GPs will develop information mastery, good medical knowledge and good interpersonal skills. These things are what patients value in a general practice.

Thank you.