



Medicine for Managers

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The Rise (and fall?) of the GP

The first doctor one sees at times of medical need usually provides Primary Care. This may occur in a Hospital or Community Assessment Unit or A&E but the considerable majority occur in the GP's surgery. Opinions vary as to who was the first primary care physician (GP) but in my view it was probably Galen of Pergum and things changed very little for

Galen had advanced medicine but used the tenets of Hippocrates of Cos (born around 460BC) in treating his patients. Doctors were skilled at recognising certain conditions. Hippocrates himself had recognised the four principles of infection; calor (heat), dolor (pain), rubor (redness) and tumor (swelling), to which Galen added laesa functio (loss of function). So they could recognise inflammation and they also realised that collections of pus were serious and that the patient would feel better if the pus was drained. Hence the term *laudable pus*, to be praised when eliminated from the body. And it helped; symptoms were relieved and the patient felt better. The principle of draining pus holds equally good today.

They recognised other things too; emetics were important to eliminate toxins and dehydration was to be avoided. The concept of blood letting was generally not such a good idea and often made a weak and ill patient weaker and more ill. They had a variety of other gimmicks most of which were at best ineffective.

For eighteen centuries, those who provided care drained pus and treated fevers and

provided comfort. They were a mixture of travellers, nuns, monks and a variety of

generally unqualified and often untrained vagabonds and quacks. However there were those skilled in medicines derived from a variety of plants and herbs. All too often, however the method of practice, as described by William Douglass in 1755, was very uniform; bleeding, vomiting, blistering, purging and anodyne [relieving pain].

And so it went on with those people intent on trying to help those people who were ill whilst others used scams and quack remedies to extract money from the vulnerable. There were University Departments of medicine in many educational establishments. Gradually things started to change. By the sixteenth century, there was the beginning of a separation between the physicians, using physical remedies, and the surgeons, who recognised the importance of excising diseased tissue to stop infection spreading and cauterising the resulting wound to seal it and to stop the bleeding. It was barbaric and was confined to swift interventions, normally involving limbs. It is said that the

fastest limb removal was done in seven seconds, allegedly with the loss of two of the assistant's fingers at the same time! (probably apochryful) They were held in relatively low esteem compared to the physicians because surgery was seen as a manual trade. Such surgeons as there were, were organised in trade guilds. They were habitually dealing with diseased flesh and were seen as blundering and bloody operators, a million miles from the bewigged and perfumed physicians. Surgeons used knives, saws and cauterising irons. They were seen as little more than butchers. Their bad press was accentuated by the absence of anaesthetics. And of course, most patients died of their surgery.

It should not be thought that surgery was innovative at that time. There is archaeological evidence that the Egyptians were carrying out rudimentary amputations and cranial trepanning to drain bleeds in the brain 10,000 years ago.

Surgeons and surgery reached an important milestone in 1540 when the Guild of Surgeons joined with the Company of Barbers to form the Company of Barber-Surgeons. Henry VIII was supportive of surgery but his general approach to the welfare of his subjects was less so. His reformation closed many monasteries, convents and hospitals which gave aid and shelter to the sick.

Surgeons developed gradually and, after about 1800, they began to carry out more varied and intrusive surgery as anaesthetics became more available.

By this date, the Royal College of Physicians already had nearly 300 years of history having been founded in 1518. Wealthy and powerful, the College steadily improved its standards to eliminate the quacks and charlotans and the beginnings of valid research and study were starting in the 1800s.

The sort of medically knowledgeable general practitioner probably became established as we know him (and it was invariably him) around the beginning of the nineteenth century. There had already been itinerant healers of various types who would provide impromptu surgeries in public houses and other locations and who would visit people who were ill in their homes, but the whole process was informal and of very variable quality. However by the nineteenth century, doctors had learned about the pulse, the heart, the lungs and more about the significance of symptoms. In 1815 Laennec invented the stethoscope in France (although it took forty years to be universally used).

In my view the first recognisable GP as we would know him was the Victorian Home Doctor who would provide surgeries and visits on a more formal basis. In many ways the role and approach of general practice changed little in over 100 years and, by the early 1970s, GPs still did surgeries and visits in the same way as their Victorian predecessors. The most fundamental reason why things had not changed hugely was that developments were very slow to occur until the explosion of new technology and medication in the 1980s and beyond. It is worth remembering that a GP in 1970 had no ultrasound, no scans and radiography that was still relatively basic. ECGs were new and not universal and there was no foetal monitoring. There were few antibiotics and anti-hypertensives and virtually no heart medications other than digoxin. The British National Formulary was an A5 hard-covered book with only about one fortieth of the drugs available today. Medication in general was rudimentary.

The Victorian GP would often struggle to earn a living. In the less affluent areas, people would call a doctor only as a last resort because of the costs involved. Indeed patients would die with treatable conditions simply because they did not have the necessary finance. This was the

pre-scientific phase of medicine. Sweating and emesis were seen as necessary parts of treating any patient with a fever. Many of the medicines were flavoured gelatinous preparations which, at least, did no harm. Patients in the Victorian era did understand the fever-orientated approach of the doctor and called him accordingly.

In more affluent areas the doctor would be called for a wider variety of medical problems, infectious, cardiac, pulmonary and obstetric and gradually management skills improved. There was an increasing element of counselling in consultations, if only to prepare families for the death of their loved one.

By 1870, in some of the most affluent areas, GPs found themselves delivering medication to elderly wealthy clients for whom attending the doctor was wholly unacceptable. The expectation was that the doctor would come to them.

By the early 1900s, doctors were providing surgeries but they were often relatively quiet and they would undertake, often using a horse and trap, upwards of thirty visits a day.

And so it went on for the first half of the twentieth century, through two world wars, with little in terms of treatment actually changing. However, there were changes afoot, from the turn of the twentieth century. From a provision and management perspective the development of National Contracting of GP services first became a reality in 1911 with the **National Insurance Act** which introduced a capitation system called 'the pool' with which to pay the GPs. The system was administered by Local Insurance Committees covering areas such as counties or large cities and each held a list of doctors, known as the **panel**, who were prepared to work under the scheme. Lloyd George, who was the British Prime Minister from 1916 to 1922, was an advocate of the scheme and supported increases in

payment to doctors having recognised that they were treating many poor patients for no payment.

In 1924 the British Medical Association and the Ministry of Health reached agreement by which the doctors payment was increase to 50% of total income although it was expected that the work would only occupy two-sevenths of his time. The remainder of his income would be generated privately.

In 1942, a report by the Liberal thinker, William Beveridge, which had been commissioned by the Government the year previously, was published. Its purpose was to advise the Government on how to manage want, disease, ignorance, squalor and idleness after the war. In 1946, the Labour Government of Clement Attlee announced that it would introduce **the welfare state** as described in Beveridge's report. On July 5th 1948, a universal free medical system was introduced to provide **social security** so that the population was protected **from cradle to grave**. The system was partly built on Lloyd George's National Insurance Scheme. People in work had to contribute each week as did employers but the benefits provided were much greater. The contract for each doctor was a personal one and so it remained until 2004. Patients were registered with a named doctor.

It is interesting to note that, in 1953, doctors were seeing somewhere between 25 and 50 patients a day in surgery and were making anything up to thirty visits a day still. The Royal College of General Practitioners was founded in 1952.

Dissatisfaction developed in general practice in the 1960s and mass resignation was threatened. A bone of contention was that a GP earned little more than half what a hospital consultant earned. The 1948 Act had envisaged the GP as the lynch-pin of medical care but the hospitals had become pre-eminent with general practice relegated to a disparate 'cottage industry'.

The 1966 GP Contract addressed a number of the major concerns of the doctors and improved the finances for staff recruitment, a basic practice allowance and fees for particular items of service although the capitation arrangement for payment survived. Staffing levels in practices increased and there were a flurry of new premises as GPs were allowed to claim back 70% of staff costs and 100% of premises costs.

During the 1970s and the 1980s general practice flourished. Services expanded and the quality of clinicians increased. There was a steady change from home based care to surgery based care with a steady reduction in the number of visits provided. As a GP myself I was able to take advantage of a **cost rent scheme** to build a new surgery where the total costs of the land and the building works were totalled and rentalised at a percentage linked to inflation and agreed by the General Practice Finance Corporation.

In 1989 a new type of contract was proposed and was introduced in 1991. It was certainly the most radical change since the introduction of the NHS and it created two new types of medical delivery:

1. The **NHS Trust**. An autonomous hospital with income derived from the contracts for work provision that were negotiated with Health Authority purchasers and with:
2. **GP Fundholders**. These were doctors in practices of more than 9,000 patients who were given budgets on the basis of historical work to purchase all pathology services, outpatient services, elective surgery and other elements of medical care. The scheme started with a small number of GP practices (about 128) in 1991 but in subsequent years the number of practices in each wave increased dramatically.

The result of GP fundholding was a rush of innovative concepts with GPs arranging for visiting consultants in Outpatients in their surgeries, new arrangements for operating, near patient pathology testing, reorganisation of laboratory services and so on.

The result was that, for the first time, GP Fundholders (and Health Authorities acting for non-fundholding GPs), became Commissioners of care and hospitals became Trusts or remained as Directly-Managed Units (DMUs) until such time as all could become trusts.

The arrival of the Labour Government of 1997 resulted in the abandonment of the Conservative market arrangements. Fundholding was abolished and most of the advances in primary care were lost as services set up by fundholders were closed down.

In 2001 **Primary Care Trusts** were introduced as part of the health system in England. They provided the replacement system for commissioning primary, community and secondary care services from providers and they were largely administrative bodies.

The next seismic change was the 2004 GP contract which made a new set of changes:

1. The red book, on which all payments had been based for over thirty years was abandoned
2. The practice received a Global sum based on list size adjusted for age and sex.
3. The Minimum Practice Income Guarantee (MPIG) was introduced for small and rural practices that would have lost out because of the Global sum. The MPIG was transitional and was withdrawn over time.
4. A Quality and Outcomes Framework (QOF) was introduced which was designed to incentivise GPs to do more work by introducing about 150

parameters. The more requirements that were met, the greater the increase in income. The term “**QOF points**” entered the medical lexicon.

The changes spelled the end of 24-hour responsibility and almost all GPs opted out of night and weekend work.

Over successive years there were regular amendments to the system which attempted to tighten the criteria for earning QOF points to control the costs of general practice. The downward pressure on practice costs has continued since that time.

Perhaps one of the most universally catastrophic NHS reorganisations occurred following the election of the Coalition (Conservative/Liberal) Government of 2010. The appointed Health secretary, Andrew Lansley, produced what are now widely regarded as reforms which ‘damaged and distracted’ the NHS at a time of increasing demand and post-banking collapse financial pressure. Many feel that Andrew Lansley contributed to the NHS crisis which has followed. His Health and Social Care Act (2012) led to what the King’s Fund called the ‘biggest and most far-reaching legislation in the history of the NHS’. It resulted in a complete overhaul of management producing what many have called a bureaucratic NHS structure whilst placing greater emphasis on competition and the operation of the medical market economy. Reputedly costing three billion pounds to implement it is regarded by many as the most disastrous NHS change ever produced. The current Government, struggling with burgeoning demand, budgets heralded as being increased but which are in fact lost in billions of so-called savings, has meant that large parts of the NHS are teetering on the edge of crisis.

I called this article “the rise and fall of the GP” because it is hard to see how the

traditional GP will be able to survive. A number of factors seem to be playing against the possibility of a continuing family doctor which, until twenty years ago was little changed from the Victorian Home Doctor of the 1850s.

1. General practice as currently established is a cottage industry, endearing and appealing and locally based but substantially in buildings that cannot be expanded to take on more work from secondary care, many of which are obsolete and many of which are too small to allow the mergers and rearrangements necessary to deliver more modern medicine
2. The nature of GPs has changed. In the period since recognisable general practice began, through to the 1980s, medicine was done by men, working full-time in the same practice for thirty or forty years. Continuity was the key element which made the practice a family concern. Everyone knew their GP, who was a central part of the community. Now medicine is fragmented with many part-time male and female doctors, increasingly salaried with little or no commitment to any particular surgery (because they have not bought into it), continuity has been lost and quality is patchy.
3. Recruitment is increasingly difficult. There is a national shortage of GPs.
4. Litigation has gone mad and doctors now act in fear of being sued if they miss anything.
5. GMC complaints are up thirteen fold since the 1990s. Despite the protestations of the GMC hierarchy, they make doctors’ lives a misery, are felt by many to treat all referred doctors as guilty until proven innocent, and research showed that, in a ten year period in the early part of the century there were over one hundred excess

- deaths, including suicides, of doctors under a GMC investigation.
6. GPs have increasingly taken on much more complex medicine - no longer giving antibiotics and sick notes. There is specialisation and the GP of today is hugely more knowledgeable than the GP of 1970 or 1980. They are, in effect, general physicians of the type who were formerly Consultants in every hospital. Yet they are located in relatively basic premises.

Those, and other factors are encouraging doctors to retire earlier and to do work other than full-time general practice. I was a GP from 1976 until recently and I loved it, but I feel that my generation has presided over the destruction of the caring, vocational medicine.

I fear that we shall see doctors moved to polyclinics where the patient sees whoever is available. Much care, formerly provided by doctors, will be provided by nurses and other staff. Maybe that is good but it feels impersonal. I am sure that I shall be dead in twenty years' time but, if through some miracle, I survive, I suspect that I will not be able to recognise the system of personal and sympathetic care which remained so solidly through to the late 1980s. I hope I am wrong but, you never know, do you? Perhaps it will all turn out to be very much better.

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