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Medicine for Managers

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All Change for Primary Care

Primary Care is the first point of contact of care for people in the community setting. About 90% of it is provided by general medical practitioner services, but some is also provided by dentists, opticians and pharmacists. The provision of care is directed more towards caring for people as a whole, rather than treating them for one specific disease. Doctors in primary are are generalists managing physical, psychological and social problems.

General Practice is stretched. Increasing numbers of people are attending their GPs with what many believe are more minor problems. In amongst this deluge of consultations will be some which are more serious and important to identify in a timely manner. This raises the questions of whether diagnoses are being missed, how serious a problem is it and what consequences it is having.

So, what has changed over the last (say) fifty or sixty years in general practice and has it contributed to what appears to be a considerably increased demand with the attendant risk of a larger number of misdiagnoses.

The typical practice of the 1970s was quite different in many respects from that of 2024. Many practices of the time displayed features which have now disappeared.

- Many general practices were singlehanded
- The great majority of GPs were men
- A large proportion of practices were located in the front rooms of the doctors' personal dwellings
- Most GPs were full-time in their practices and had 24-hour a day, 365 days a year responsibility for their patients
- Most practices did not have appointment systems and patients were seen if they attended the practice and waited, irrespective of the number who came

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- Practices with several GPs often only shared a premises and did not interact in any other way
- Referral rates were much lower
- The availability of support services was much less and most GPs only had an attached District Nurse, an attached Midwife and a Health Visitor, shared between several practices.
- The doctor of the time would have house calls to make between the morning and afternoon surgeries, often numbering perhaps six to ten. Most were for viral illnesses but some were for routine follow-up
- Most GPs did some or all of their own out-of-hours on-call

The image of the seventies doctor was of an avuncular, well dressed man with a suit and tie, sitting behind a large desk which had little on it apart from a sphygmomanometer and a cup and saucer with tea in it. In front of him was the A5 Lloyd George folder from which he would pull a card on which to write often illegible notes. Importantly he would commonly know your name, the other members of your family, the dog and bits of information about employment and even hobbies. He did not usually seem rushed. His receptionist and nurse was often his wife, a trained nurse who he had met at medical school!

From the patients' perspective, they were:

- More likely to see the same GP each time and there was a much closer professional relationship
- Often just turned up at the practice at surgery time and waited their turn to see the doctor of their choice
- Seemed to have been more likely to have tried simple remedies for viral illnesses before coming to the doctor
- Generally put up with symptoms for longer before seeking advice
- Seemed more grateful and less complaining about delays

In comparison, the modern general practice is really quite different:

- It is more likely to operate from a complex health centre, with multiple consulting rooms and a range of visiting ancillary staff.
- It is likely that the patient will see a different doctor each time, because the concept of 'their own doctor' has largely disappeared
- The surgeries are therefore more impersonal and the GP may know little or nothing of the family or social history
- The prospect of seeing a doctor on the day when needing to do so has diminished, with some people saying they have to wait days or even weeks to get an appointment
- It appears that a proportion of patients are attending with fewer and more minor symptoms.
- Some patients now see GPs as a minor ailment service and go to A&E if they think the problem is serious
- Complaints about all aspects of the service provided in primary care have burgeoned, particularly over the last 10-15 years

In my personal view, one of the most important changes and, I believe, a key loss, was the phasing out of the GP/Consultant meetings

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which occurred on the same day at lunchtimes once a week or once a fortnight at the local postgraduate centre. Primary and secondary care clinicians would meet, discuss cases, give advice and consume what was usually a plate of undistinguished stew or curry, and there was usually a presentation by a consultant or a GP about some aspect of medical care of importance to both groups. GPs would often turn up with ECGs or blood results in their pockets to discuss with the appropriate consultant and much advice was given. The relationships which developed between GPs and Consultants was very important in the shared care of their patients. Nowadays, advice and guidance can be obtained electronically and it works some of the time, but the personal relationship is no longer there.

Perhaps the most important question is whether the ***quality*** of the medical care has declined or whether the quality of diagnosis and the management of disease and disability have improved over the last fifty years.

I think it is probably impossible to know for a variety of reasons:

- The body of knowledge of disease and illness was very much less in the 1970s than it is now
- Access to information was solely from books whereas now there are a plethora of electronic and other sources of information and online tools may aid safer prescribing, diagnosis and management. There is also a far wider range of services available at hospitals
- The medication of fifty years ago was far more basic than now. It is hard now to believe that "Cab Driver's Linctus" was a popular remedy for coughs in the '70s.
- The professional relationship of patient and doctor has changed fundamentally in many cases and the doctor is now someone they may meet only once
- The consultation may not always be with a doctor now, with referrals to assistants, nurses and to the pharmacist amongst others

Possibly one of the greatest influences on practice operation is that now the flood of patients attending the practices means that GPs are often rushed and treating patients in haste results in less comprehensive histories, less thorough examinations and possibly more errors in diagnosis and treatment.

A recent American paper reviewed diagnosis and common errors in practice. One of the great difficulties is that common complaints such as fever, rash, breathlessness or abdominal pain may be serious and necessitate immediate referral to secondary care, or benign and require only symptomatic (or no) treatment beyond over-the-counter remedies.

As in the UK, the report noted the additional pressure of increased demand, although average consultation times have increased and there are increasingly vague descriptions of symptoms by many patients (which may be influenced by pre-consultation Googling) and raised anxiety levels in the population as a whole.

In the United States, in an article of about eight years ago, it was estimated that five in every hundred attendances resulted in a diagnostic error. The most frequently missed diagnoses included, urinary tract infections, kidney infections, kidney failure, early signs of heart

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failure, pneumonia and bronchitis and cancer, but virtually any diagnosis was capable of being missed.

Of course, missing a cancer diagnosis is one of the most serious errors, but failing to follow-up abnormal tests and investigations these days is a cause of negligence claims.

It is estimated that up to 30% of GP records contain errors. They may be anything from simple spelling mistakes to missing information or incorrect information.

Of course education requirements for revalidation have been helpful in maintaining standards but, for the average GP, the rate at which new information is published is a tsunami which it is not possible to assimilate.

Apart from failing to identify diseases or disorders, the response has often been to refer to specialists more patients with unexplained symptoms as a form of protection and to order huge numbers of tests to try to exclude as much as possible as the cause of symptoms.

The consequence of increased time pressures and demands, huge increases in potential diagnoses and tests and a more militant population ready to complain or litigate rather than forgive any errors, is that one of the basic yet extremely valuable skills of doctors has been in some cases sidelined.

Going back to the 1970s GP, the profession did not have so much in the way of knowledge of many diseases, nor tests or guidelines and GPs had to rely on basic skills; what they heard, what they saw and what they found during the examination. The examination would include questions about past medical history, a detailed examination physically, both of any local issues such as a lump or a rash, and a more general examination of the body as a whole, and then the use of a stethoscope for any abnormal sounds.

Such examinations occur less commonly these days and it is likely that positive findings may not be identified. Doctors today may argue that the diagnosis of many medical problems has been superseded by tests, such as, for example, BNP for excluding heart failure and the FIT test to rule out bowel cancer. The risk is, of course, over investigation but that may be unavoidable because of society's expectations, disrupted by reassurance on its own not being enough and the continuity of care of the family doctor having been almost entirely lost.

The role of ancillary team members has expanded and patients may now see their GP on fewer occasions and may more commonly be treated by a nurse or a pharmacist or other support staff.

This must raise the question of whether the training of staff other than a doctor who make diagnoses is adequate. The danger is not with straightforward diagnoses of eczema, or verrucas or viral infections. But what about more complex cardiac, respiratory and other pathologies, which may not trigger appropriate referrals.

As part of medical training, doctors learn conscious incompetence (where there is a gap in knowledge or skills, and where there is readiness to learn) as a core competency. The awareness of when to seek help comes only with considerable training and cannot be compressed into a shortened training program of clinicians providing para-medical skills.

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Similarly the broad scope of medical training with five years at medical school and up to another seven in postgraduate training roles is invaluable for the GP in dealing with undifferentiated early illness and vague presentations.

Most GPs and specialist clinicians argue that this ability cannot be developed using shortened and condensed training programs.

Primary Care is a wonderful service, providing enormous amounts of care to huge numbers of people every day. The health service and the patients rely on it.

But, the Government must ensure that they understand that proper diagnosis demands proper history, examination, treatment planning and investigation.

To do so maximises diagnosis and minimises error.

They should perhaps consider what should be delegated and to whom and GPs should have the time and freedom to provide the traditional care which has come under pressure over recent decades.

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