

THE JOHN FRY FELLOWSHIP

1999

PATIENT-CENTREDNESS
AND THE POLITICS
OF CHANGE

A Day in the Life of
Academic General Practice

John Howie

Department of Community Health Sciences

General Practice

The University of Edinburgh

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Publications Committee

Professor John Ledingham DM, FRCP
Dame Fiona Caldicott DBE, FRCP, FRCPsych
John Wyn Owen CB

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Acknowledgements

This is the most important part of this monograph, and it could either be too concise or too busy. Many people have contributed hugely to the thinking and work described in its six chapters and some of them are named in the text.

My partners in Glasgow (Jim Wright and Fred Christie), my mentors when I was in Pathology (Robert Goudie, Sandy Sandison, John Beck), colleagues in the Department of General Practice in Aberdeen (Denis Durno, John Berkeley, Ross Taylor - and then John Bain) were all significant supporters in the early days in different ways.

In Edinburgh, Mike Porter became a hugely valued and influential friend and colleague and progressively our researches have involved others, including John Forbes and Jane Hopton, and most recently, and again significantly, David Heaney, Margaret Maxwell and Jeremy Walker. Our research team now includes George Freeman and Harbinder Rai from Imperial College, and Martin Roland and David Wilkin from NPCRDC in Manchester have listened and advised a lot - as have Nicki Mead and Steven Campbell too.

Achieving the political agenda depended hugely on others too - John Walker in particular, but at different times many others of whom David Morrell and David Metcalfe were most involved. Probably I shouldn't thank civil servants for their help in case it might embarrass them; I hope they know that I appreciated their counsel and support - even if not always at the time.

Many academic friendships over three decades have been key to broadening my thinking, values and competencies. It would be invidious to select names from a long - and still growing - list. Thank you all - the academic world of general practice has been a good one to be part of.

Not last and certainly not least, are my past and present colleagues in the Department of General Practice in Edinburgh. They have taken on the lion's share of our corporate clinical and teaching work over my time in Edinburgh and it is this that has made it possible for me to devote time to the more externally visible roles in research and politics this monograph describes. Thank you all for that. Pat Syme, of course, has done the same in

the administrative domain, and she and Liz Lamb have typed and re-typed this manuscript and its illustrations against short deadlines (what's new?); thank you for all of that too.

Lastly, this monograph represents a life story, and the most important part has been its evolution in terms of the beliefs and values it has come to embrace. For that - and for living with the trials of being married to someone (? anyone) in academic life in recent times - my wife Margot deserves more credit than anyone. All I can say to Margot is 'thanks' once more.

John Howie

John Howie qualified in medicine at the University of Glasgow in 1961. After his house jobs, he worked for four years as a registrar in laboratory medicine (pathology, haematology, bacteriology) completing an MD on the clinical pathology of appendicitis during that time. Halfway through that time he started working two evenings a week in a local general practice, and he became a full-time principal in the Partick area of Glasgow in October 1966. He quickly became involved in research and in 1970 moved to Aberdeen as a lecturer in the new Department of General Practice from where he moved to Edinburgh as professor in 1980.

Since 1980, his research interests have become increasingly multi-disciplinary and collaborative, working consecutively in the fields of stress amongst doctors, the use of time, and the definition and delivery of quality care at consultations. He has published extensively, his monograph 'Research in General Practice' having recently sold-out in its second edition after some twenty years. In the early 1980s he was Chairman of the Association of University Departments of General Practice, and then Chairman of its Head of Departments group from 1986 until 1994. Over the years, he has been a member of national committees in the fields of prescribing (the CRM), education (WGUMDER) and research policy (including a Culyer working party, and various Scottish CSO committees), and is now advisor to the National Primary Care R&D Centre in Manchester. He is Chairman of the Scientific Foundation Board of the Royal College of General Practitioners. He has travelled widely, particularly to Australia, Thailand and Scandinavia.

At home, he enjoys sporting activities (now golf and bowls, but previously cricket and refereeing rugby) gardening and cooking. His musical interests have included a brief try at playing the accordion, but are now shifting to learning to play the organ. He is married to Margot and they have three children and three grandchildren. There looks like being plenty to do when he retires in September 2000!

receive one of John's very personal notes of approval the day after a publication appeared - and wonderfully motivated by so simple but important an endorsement of the place of research in medical practice. John, of course, was a Trustee of the Nuffield Provincial Hospitals Trust for much of his professional life and this is why The Nuffield Trust has endowed this Fellowship in John's memory. I am hugely aware of the honour and responsibility placed on me to make a fitting contribution to the memory of a great man.

My connection with Nuffield and John Fry has one further link which will begin to explain how I have approached the development of this monograph. I arrived in Edinburgh in 1980 as successor to Richard Scott, the first professor of general practice anywhere in the world. Enthusiastic but (probably fortunately) naive, I knew I would have to meet two immediate challenges. The first was to explain why the University should continue to invest £134,000 a year on a Department dominated by a high clinical service demand and the teaching of a rather ill-defined form of clinical medicine; the second was to develop quickly a programme of fundable research projects.

The first task took on an urgent and frightening dimension when it became clear that the Faculty of Medicine in Edinburgh share of the 1981 first round of University Grant Committee 'volume cuts' was £160,000 - almost exactly the cost to the University of the activity I had come to lead. The Faculty was undecided whether to spread misery equally on a pro-rata basis, or to make a single sacrifice to protect the status quo for the majority. To the credit of my Dean (and I have to say that all six Deans I have worked with have been unswervingly protective and supportive of general practice as a core Faculty activity), the question of axing general practice, to the best of my knowledge, was never raised - but the threat had felt a real one to me. I needed to understand why general practice as an academic subject (despite in Edinburgh having NHS income from the care of over 5000 general practice patients) cost so much in comparison to, say, medicine and surgery where teaching loads were higher than ours, and research productivity was clearly on a quite different plane from that in general practice.

The second task of funding a research programme was, in a quite different way, equally difficult. Without doubt, the expectation

CHAPTER 1

Introduction

For the larger part of the last four decades of the 20th century, John Fry's name has been the international currency of British general practice. During his lifetime he was one of the few who described in figures what they did in their daily life, attached ideas and concepts to these figures and then advocated persuasively and with conviction from that base in both the spoken and the written word.

Although never an academic in the sense that he identified with any university, he was in every other way academic in the way he thought about his work. Strongly involved with the formative years of the College, he diversified to be the founder and driving force of the touring General Practice Research Club, and was the life force behind *Update*, for many years the most successful postgraduate journal of his discipline. That he was never President of his College saddened and surprised his many admirers, but in the end was no more than one of the anomalies that characterise the British way of life; however, offices and titles were not an important part of John's way of life.

At one level John Fry was best known for his huge output of written work, much based on observations on his own patients in his practice in Beckenham. For me, his 'Profiles of Disease', published in 1966, stands apart.¹ It was the first book I bought for myself when I started out as a general practitioner in Glasgow in 1966, and its description of 'catarrhal children' presents a snapshot of the bread and butter epidemiology of life in general practice that has still to be bettered four decades on. John Fry was indeed my first general practice hero, and I treasure John's autograph in my copy of this work which he signed for me when he visited my Department in Edinburgh in 1989. John Fry also wrote more broadly about the politics and structure of the discipline, and the series of 'Present state and future needs of general practice'² ending with his editorship of the 1974 'Trends in General Practice'³ showed the width of his vision and feel for issues of the day.

At another level John was a hugely warm and encouraging man. Many young writers, of whom I was one, would be astonished to

of many clinical colleagues in the Faculty of Medicine was that the new professor would provide research openings to allow hospital disciplines or specialisms to move out from their hospital base into general practice. Probably the Chief Scientist Office (CSO) in the Scottish Office (my 'natural' source of research funding support) expected this vision to prevail too, and indeed such a partnership involving a study of night cough in children was the first project we gained funding for. But the research I wanted to develop was about what influenced doctors to take clinical decisions the way they did, and why doctors seemed to practice well on some days whereas on other days they clearly did things less well, or at least quite differently. As early as 1981 we hypothesised that work stress was an important component of the equation that linked the content of consultations, the processes which took place, and the outcomes for both patients and doctors. Along with Mike Porter who, with his skills as a medical sociologist, quickly became an integral part of my future academic life, we applied to the CSO for support for a project linking stress and quality of care in general practice.

Whatever may have been the merits or demerits of our early research applications, we never found it easy to attract funding. Quality is a complex field to research in, and - at least in the early days of our work - 'stress' was a concept that was variously deflected as being either non-existent, unimportant, or unresearchable - or any combination of these. Whatever it was, it certainly seemed unfundable! In fairness again, we did eventually achieve a measure of support from the CSO to pilot our self-report measure of doctor stress, but little encouragement to follow that early development work in the direction we wanted. And here is my second connection with Nuffield and John Fry. The mediator was another good friend over many years - Michael Ashley-Miller, who was at that time moving from his influential role in the early formation of the Scottish CSO to succeed Gordon McLachlan as Secretary of the then Nuffield Provincial Hospitals Trust. At Michael's suggestion, we split our proposed quality programme into two components, one of which the CSO funded and the other of which Nuffield would in due course support. When our draft protocol reached John Fry in his role as a Nuffield Trustee, he immediately undertook major surgery on it - no doubt while sitting

at a College Council meeting where, of course, he often used debates which did not interest him to combine his other editing and political roles! Our fourteen page 'academic' protocol was reduced to less than half, twenty references to six, and clear directions given in pencilled notes in the margins to restrict text to the minimum and to state in simple lay terms (for the benefit of a highly prestigious group of medical eminences!) the key questions and point of the research. In the end, we received more '£/line' for that proposal than for any other I have been part of before or since.

THE JOHN FRY FELLOWSHIP

When John Wyn Owen invited me, on behalf of the Trustees, to undertake the 1999 John Fry Fellowship, he proposed as a title 'Empowerment and Quality' with an invitation to reflect on the importance of old-style values in the practice of medicine. Working in the close companionship of social scientists has taught me to look carefully at the meaning of words and about the grave dangers of taking on a field that one has only a superficial knowledge of. 'Empowerment' was, I felt sure, such a trap waiting to be sprung. Of course I would like to (and will) write about how a life time's interest in 'quality' in general practice has developed (focusing, however, on 'enablement' as a concept rather than 'empowerment') and will reflect on where our interest on 'quality' has reached as I enter my last year as a full-time member of the academic community in general practice.

As I approach retiral and the sense of history takes over, I cannot help reflecting also on the other theme I referred to earlier: the way in which at the start of the nineteen-eighties the ratio of costs to effectiveness of general practice departments gave a wholly unfair reflection of the commitment of their staff to the pursuit of excellence in academic clinical medicine. This, of course, leads in to the story of the quest for a share of SIFT (in England) or ACT (in Scotland) for the support of the academic activities of general practice. I will explain the meaning of these acronyms in Chapter 3; suffice it to say now that the story has never been properly documented and that this Fellowship offers

an opportunity to record one version of a negotiation that took twelve years to conclude.

So I want to use this Fellowship to complete some circles; or perhaps to show how circles are really better thought of as spirals. The story is of a journey through a medical career, or perhaps of one through an academic career. It is a story about trying to create the right structures in which to have freedom to develop, and using the opportunities they provide to create change for the better; and that is a story about today and tomorrow every bit as much as one about yesterday.

If my use of the Fellowship is necessarily autobiographical, it is not something I want to apologise for. In pursuing the causes we believe in it is impossible to dissociate the personal and particular from the wider and more general - and indeed always to separate the objective from the subjective.

I hope my use of this Fellowship will achieve three things. The first is to interest the reader in two strands of the development of the academic contribution to general practice which I have had a close personal involvement in. The first was the campaign which the University Departments sustained over rather more than a decade to achieve a 'level playing field' (or something nearer to it than previously) for funding the essential infrastructure for proper academic development. Chapter 3 traces this story. The second was to develop a significant research contribution to the debate about the nature of quality in general practice, and the 'distribution and determinants' of its delivery. This story is described between chapters 4 and 5.

Second, I want to use my Fellowship to point up the importance of developing and promoting a measure of the quality of interpersonal care to put alongside those now being canvassed in relation to technical care. We need to keep both these components of practice in partnership. More has still to be done to be sure about how to achieve this, but I believe we are now far enough advanced to campaign for contractual change to ensure that the rewards and incentives of the early years of the next millennium are appropriately balanced between the technical and the personal dimensions of clinical practice. This story develops throughout the monograph and is concluded (or perhaps the state of play is summarised) in Chapter 6.

The third purpose is to put on record the debt of many - of whom I am but one - to the contribution John Fry made to the lives of so many individuals and to his community.

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CHAPTER 2

Roots

EXPERIENCES

DAVID

It was the last Friday of February or maybe an early one in March. We almost never admitted patients outside our one-in-four receiving rotation but this day was an exception. My chief told me that a young doctor would be admitted during the afternoon for investigation of bruising and would be allocated the side-room. He needed a full blood examination at once, and might need treatment after that. He did not tell me that, like myself, the young doctor was a new houseman, had been in the same year as I had, had been at the next anatomy table, at the same clinics, and was one of my friends.

The awfulness of what was to happen unfolded with fearful suddenness. By mid-afternoon the diagnosis of acute leukaemia was confirmed and the course of what now seems a wholly misguided strategy embarked on. David would be told he had glandular fever; I would administer chemotherapy through a drip, explaining it was steroid therapy now believed to be a front-line approach in severe cases. Nobody told his parents anything.

For three months then, and for many years after David was my albatross. If he ever wanted to know what really was wrong - and he did ask why he was taking so long to get better - we never got near each other at any meaningful level. Eventually I did tell his parents the truth, and was told I shouldn't have - it wasn't my business. Although David never won a remission from this cruel disease, he picked up well enough (with the aid of four pints of packed cells) to be moved into the main ward and for the possibility of going home to be discussed. Then suddenly, and mercifully - but was it for him, or for me, or for the others who loved him - he had a cerebral haemorrhage and died peacefully on a sunny Sunday afternoon when the promise of summer was all around.

For three months then we lived a lie together. For three months then and for the two remaining months of my time as a house

physician, no one once asked me how I was, and if I was managing. The science of medicine let David down; the art of medicine let us all down. At least now I can talk about it.

I only decided to apply for Medicine after I had my appendix out at the start of my last year at school. While I was recovering in the side-room, the elderly man next to me - terminally ill with cancer - was sick; I helped clean him, gave him a drink of water and went to look for a nurse. Caring for others seemed a good thing to do; that was enough to get in to medicine then, but it probably wouldn't be now. I saw Luke Fildes' picture of the old doctor at the side of the fevered child and decided I would be a general practitioner in the tenements of Partick (Billy Connelly's country) further down Byres Road from where we lived.

When David died, I thought I would do haematology instead and signed up for a job in pathology to start with (haematology in my teaching hospital was then a laboratory-based discipline). In the end, I realised I didn't want to be an immunologist (which cancer research then seemed to equate with), but I had a wonderfully varied laboratory training in pathology, haematology and bacteriology during which I learned to observe, question, check and double check, and to appreciate the difference between association and causality. The story of my pursuit of the relationships between the pathology of the appendix, the syndrome of abdominal pain, and surgeons' decisions to operate is for another time and place, but it taught me that the naming of diseases by clinicians is at best an inexact science, and that truth was not always welcome in the wards.

Half-way through the four years of my researches on the story of the appendix and appendicitis, I met Jim Wright - later to be my first senior partner - looking for help with evening surgeries and a holiday locum after his partner's sudden death.

I sat in on two surgeries and he showed me where the sphygmo was, and where to find the bottle of ichthyol and glycerine for cleaning out ears. The next week I did two surgeries on my own - 'vocational training' complete! I was back in Partick, and almost without planning destined to become a principal in general practice, which I did on the first day of the Charter in October 1966

THE POLISH PATIENT

Soon after the Charter we joined Fred Christie, a senior Partick doctor whose premises were zoned for demolition and development, and created a group with an appointment system, a practice nurse and full-time receptionists (ahead of the pace then). Life settled down to a routine of a surgery a day (24 patients at five-minutes plus extras 'down the side', and a few at the beginning if necessary) and about 60 home visits a week.

One was to a Polish patient. It was earlier that week that a number of Partick general practitioners had been invited to have afternoon tea with the new professor of medicine in our local teaching hospital. He was new to Glasgow and wanted to meet his colleagues whose contribution to patient care in the community was what 'kept the Health Service going'. Our problems were his problems; he and his staff were our friends and support. My Polish patient was in his late sixties. It was the first call of the morning. He was lying in a bed recessed into the wall of his single room; he was two floors up with an outside toilet. It was difficult to see, even with the single ceiling bulb lit, and his English was difficult for me to follow. He was confused; his bladder was distended; his prostate rock hard; he was emaciated and his back ached. Perhaps unusually for the sixties, I did a blood urea and a haemoglobin, taking them to the lab. by hand. By mid-morning the story was complete. Anaemia (Hb 50 per cent, normochromic and normocytic) and uraemia; a patient probably nearing the end of his life and needing care and protection.

The professor's registrar was in a difficult position. My patient did not have thyroid disease and his problem was not really capable of being portrayed as 'interesting'. Had I thought of getting help from a district nurse? Or perhaps putting in a catheter and trying for an admission the next day when the next receiving unit would probably have more spare beds? Shouldn't I do some tests ... did I know what the MCHC was? The fact that not only was the answer 'yes', but that I also knew what it meant, tipped the balance of power significantly in my direction. I confirmed that the registrar was saying that he had no beds and couldn't or wouldn't help, drove the mile to his ward, found that it had space for at least half-a-dozen male patients, and arranged an ambulance for my patient. That day, I determined to confront that vision of 'academic

medicine' which had just denied care to my patient and had, by doing so, marginalised my discipline of general practice. I vowed to contest the values that underpinned it at every turn available to me. Most days, I think we have made slow but sure progress; but some days I still wonder. My patient died later that day.

RUCHILL

One Sunday morning each month we all went to Ruchill hospital for the winter lecture course. We had coffee and signed the attendance register, and received an hour of conventional lecturing from a hospital consultant - who in those days gave his services free while we were in truth paid for listening.

The first time I went was in December. The virologist who was lecturing had been a friend and colleague during my time in the laboratory, and had put a lot of thought into making his contribution relevant and interesting. It was that day I learned about the related periodicities of RSV and of influenza-like annual epidemics, and the bulges of pneumonia admissions that followed each.

The same morning, after coffee, the doctors filed into the lecture room, and the lights went out to allow fluorescent micrographs to be projected in complete darkness. When the lights came back on, all but 20 of my hundred colleagues had gone. 'So that's what general practice is about?' asked my friend. I was embarrassed for this equally unacceptable snapshot of a profession at work. I had to confess to myself that general practice in the late sixties embraced many other cavalier and untenable attitudes to the place of evidence and logic in the daily round of patient care, relying too much on the highly favourable odds in favour of poor practice not leading to obviously serious results. Something had to be done. I had made a second commitment.

* * * *

If general practice was to become more marketable as a scientific discipline, it had to be better taught, and before that could be done it had to be better researched. Nowhere was this more apparent than in the field of winter respiratory illness and antibiotic prescribing. My partners' policies were quite different - one prescribed a lot and one much less; but neither had any back-up

except 'experience' for their general approach. And 'experience' had clearly led them in opposite directions. So I didn't prescribe till someone got pneumonia; and then I did till several had developed thrush. Banks¹ reported a study suggesting early tetracycline aborted complications of flu-like illnesses in service personnel, and the idea for a study in general practice was born.

Our local pharmacist produced a drug representative who might be able to provide placebo tablets for his company's tetracycline, and that led to a meeting with his medical director. Lederle agreed to support a practice based double-blind randomised controlled trial of antibiotic against placebo, and our practice joined forces with our neighbouring practice from where Dr Angus Clark became my co-researcher. Apart from the tablets, the project cost only a few hundred pounds for printing and postage. My mother-in-law (Jean Donald) was our secretary, and - along with Angus Clark and myself - she came free. There were no institutional overheads in those days.

We struck lucky by coinciding with a major influenza outbreak (1969-70) and found that normally fit adult males under the age of 50 didn't benefit to any clinically useful extent by taking antibiotics in routine flu-like illnesses. We found that being a smoker was a bad prognostic feature, that morbidity had varied significantly during the different months of that winter, and that even those patients who had purulent sputum when they started treatment, had failed to benefit from active treatment. Three decades later this remains the largest study of its kind and its findings have been confirmed many times since. Sadly our study failed the Cochrane test of 'quality' because we randomised by patient and analysed by illness.² (Each patient was given in advance, two courses of treatment, to cover treatment of separate illnesses during the study. Patients received either two active or two placebo courses, to ensure that in the case of multiple illnesses there would be no confusion over whether active or placebo treatment had been used for the different illnesses.) If we had allocated randomly mixed treatments in advance, we would have qualified for a 'quality' study, although we would not have been able to say with confidence which patients had taken which treatments; but we were downgraded in print for the 'quality' of what we did because we happened to know who took what! Could Cochrane possibly have got this wrong?

INFLUENCES

It is, of course, conceptually untidy to try to draw a hard distinction between 'experiences' and 'influences', but it makes sense for the chronological development of this narrative to do so. By 1970, when I went to Aberdeen to my first post in 'academic' general practice, I had learned important skills in the fields of observing and categorising phenomena and in attaching weightings to evidence. I had also recognised that these were hard to apply to my new discipline of general practice where the events of the working day and the contexts in which they were set were not described in the same language I had grown up with in my undergraduate life or as a postgraduate in pathology. However, I had considerable belief that in the concepts I had acquired in pathology would lie the answers to the questions I wanted to answer as a clinician in general practice. I had still to recognise that the answers would not always be the ones I expected.

Several things have had more influence on my subsequent life than others, and a few of the more important of these are relevant to the evolving story of the academic contribution to general practice which this Fellowship is trying to trace. These are presented here in an order that again builds a story rather than reflects their actual happening, which, of course, is always much less tidy at the time than in retrospect.

IAN RICHARDSON.

I was fortunate to arrive in Aberdeen to start my formal academic career with two good and different data sets waiting to be analysed. The first was my own antibiotic randomised controlled trial (RCT). The other was the north-east Scotland 'workload study' - the result of a fruitful collaboration between the young department of general practice in Aberdeen and the local College Faculty, which had provided data on all consultations for one day in fifteen over a year by over half of the Grampian area's 350 doctors.³ I return to these opportunities shortly.

Ian Richardson's immediate background was in epidemiology and social medicine. He had a deep interest in the social and psychological determinants of ill-health and their effect on decisions to consult and on what happened at consultations; and an equal interest in students and their education. He was a critical

thinker par excellence, continually hypothesising and assembling and assessing evidence to test and develop theories. His unwillingness to make insecure connections between associations and causality often frustrated me, but provided an essential restraint on the natural pragmatism of the general practitioner at the interface between service and academic work. Ian's early work on mapping the distribution of doctors and their patients formed the basis of a health centre policy for Aberdeen,⁴ and his subsequent work directly observing consultations by general practitioners⁵ (and subsequently by district nurses and health visitors) paved the way for the work on the case for '10-minute consultations' which is developed later in this monograph.

However, the philosophical contribution that influenced me particularly was his setting out of the essential criteria of an academic discipline which formed the basis of his inaugural lecture in 1970 and was subsequently published at a time when many medical schools were still undecided about whether to support the creation of departments of general practice.⁶ The four criteria he identified for an independent discipline were the possession of an identifiable area of clinical activity, the application of a particular set of skills, the ability to support research and the possession of a distinctive philosophy.

The paradox of academicness in general practice has been linking research in the discipline to the development of its clinical activities; the priority is that it is only by so doing that its philosophy can be articulated and promoted.

MILLER AND OTHER TRIANGLES

Doctors, like architects, are believed to think diagrammatically while lawyers and students of the humanities think textually. I have certainly found diagrams helpful, particularly when exploring relationships that involve, say, three concepts at a time as against the one or two that research often concentrates on. Putting 'clinical care, teaching/learning, and research' in a triangular relationship is one obvious starter for a triangle, and Balint's 'doctor, patient and illness' follows close behind. Donabedian's 'structure, process and outcome' is another triangle of historic prominence - although it is not portrayed diagrammatically in its original description.⁷

My own early research career centred round putting 'symptoms/

signs, diagnosis, treatment' in a triangle and demonstrating that the expected logic that diagnosis preceded treatment often did not apply, and that - at least in the respiratory field in general practice - treatment decisions often preceded diagnostic labelling.⁸ (I later recognised that that phenomenon also explained the mismatches between the pathology of appendices and the management of abdominal pain by surgeons that had been my first major research interest in pathology).

Being a new lecturer, I was encouraged to read Miller's standard treatise on medical education, and there I learned of 'Miller's triangle', the progressive relationship between aims, methods and assessment (which, of course, has paradoxically done as much to harm as to help free medical teaching from the tyranny of examination-led curricula).⁹ More important, I was introduced to the hierarchy of adult learning, which places acquisition of knowledge at the first level, understanding next, and problem solving (with its twin components of analysis of problems and synthesis of solutions) as the principal goal. Again this fits to the challenge of the academic role in general practice - the need to develop problem solving models in a field where the appropriate knowledge has still to be articulated. 'Understanding' became the key piece in the jigsaw - and that, of course, is itself a richly complex mix in which beliefs, values and experience play parts that still resist adequate categorisation and quantification.

FEINSTEIN & KUHN.

Feinstein & Kuhn have been even more important. In the 1960s Feinstein, a clinical epidemiologist, wrote his classic work on 'Clinical Judgement' and highlighted the need to think laterally about how clinicians make decisions, and to escape from the assumption that explanations based on stereotyped clinical logic actually reflect the true basis on which behaviour originates.¹⁰ Feinstein's 1970 Lancet article, which I have quoted many times before, merits at least one further airing:

'Until the methods of science are made satisfactory for all the important distinctions of human phenomena, our best approach to many problems in therapy will be to rely on the judgements of thoughtful people who are familiar with the total realities of human ailments.

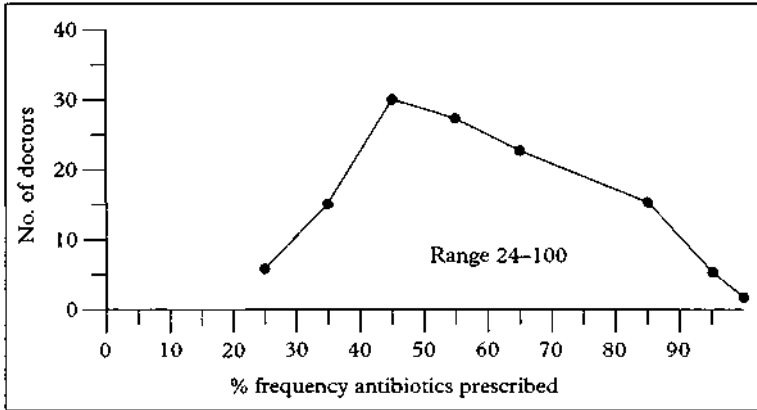


Figure 2.1. Range of frequency with which doctors prescribe antibiotics for new episodes of respiratory illness.

Source: ref 18. JRCGP 1971; 21: 657-663

It is the aim of the 'evidence-based medicine' movement to prove this view to be untenable, but I remain to be convinced that the 'methods of (its) science are (yet) made satisfactory ...'It is again the challenge to academicness in general practice to help achieve a balanced and progressing position on this truly important subject.

Kuhn, a scientific historian, is, of course, a much more recent influence. My first edition as Editor of *Family Practice* centred round a leader by Ian McWhinney¹² on Kuhn's 'Structure of Scientific Revolutions'¹³ (and included the first of three articles from his research team developing the issues of the importance of holism and patient-centredness which represent one important thrust of this monograph).¹⁴⁻¹⁶ Somewhat roughly paraphrased, Kuhn argues that a discipline develops when it discovers a new theory to explain the unanswered questions which unite its researchers. In time the theory outlives its usefulness and becomes progressively less able to take the discipline forward. It is then that a 'scientific revolution' takes place (often called a paradigm shift) and the process begins again. Although Kuhn excluded medicine from his theory (largely because he had not attempted to include it), McWhinney and others have argued that the power of bio-science to advance health in the broad sense is nearing its limit, and that holism and the patient-centred approach will increasingly assume centre-stage.

Like many others, I find this philosophy attractive. If it is portrayed as 'anti bio-science' it threatens to confirm general practice as anti-intellectual. If, on the other hand, it celebrates the integration of bio-science with the behavioural/social sciences, it can only represent a significant step forward in the movement to create balance in the thinking and research which will be increasingly needed to influence clinical practice in the twenty-first century.

ART AND SCIENCE

The two early Aberdeen data sets yielded valuable information. The clinical trial from Glasgow showed that a tetracycline taken early did not materially affect the natural history of undifferentiated respiratory illness in normally fit young adult males. It also showed that placebo takers had few attendances for the fail-safe ampicillin, that being a smoker prolonged illnesses by half as long again and that morbidity varied significantly over the six months of that winter at least.¹⁷

The workload study showed how widely 155 participating doctors varied in the frequency with which they used antibiotics for the respiratory illnesses they diagnosed. The range of from 25 per cent to 100 per cent around a mean of close to 50 per cent is shown in figure 2.1.¹⁸ Further analyses showed huge differences in the diagnostic labels used indicating, for example, that the terms tonsillitis and pharyngitis were often exchanged, that tracheitis was used in some practices but not in others, and that bronchiolitis was a term mainly used by former children's hospital registrars. A significant number of doctors treated children with tetracyclines, and tonsillitis with tetracyclines. Active campaigning with this data did apparently lead to both habits stopping ahead of consensus elsewhere. However, the general volume of antibiotic prescribing did not appear to be influenced by promotion of the results of the RCT.

When I related this to John Fry, his response was that publishing information in the *Lancet* couldn't be expected to change general practitioners, and that the *College Journal* only reached the converted too. He encouraged me to write my message for *Update* (John's 'house journal') and I did this in 1975 with the prophetic title 'Clinical Freedom - Right or

Responsibility'.¹⁹ I argued that failure to engage in audit and to respond to findings which suggested either isolation from consensus views or undefended rejection of good quality evidence, would result in the profession losing its defence of 'clinical freedom' as a right. (In 1999 we are now on a very last chance - and perhaps at last the evidence is that it is being taken!). I also argued that the evidence we needed had to be found within our own practice, and that depending on only using or adapting hospital-generated evidence could prove a disappointingly or dangerously limited strategy. My Gale memorial lecture in 1978 used the title 'The Art and the Epidemiologist' showing that I had committed myself to trying to identify the 'distribution and determinants' of whatever 'the art' could be found to be.²⁰

In this John Fry monograph, I was asked to reflect on quality of care, and on old-fashioned values. In broadening my brief to include aspects of the evolution of general practice as an academic discipline, I have given myself room to explore the conflict and confluence of the two sets of research observations described at the start of this sub-section. The breadth of the base of the distribution in figure 2.1 cannot be a healthy image for an emerging discipline to have in its shop-window. But it is the inevitable consequence of allowing old-fashioned values to run unchecked by constraints of quality. However, in empowering patients to influence decisions, the reality will always be that difference will be a consequence. The question is how much difference and which differences come within the accepted vision of what is quality.

Once the individual views and characteristics of patients and doctors, and the relationships between them are accepted as legitimate influences on how decisions are arrived at, the problem becomes conceptually manageable. Science becomes a mix of bioscience and social science (perhaps the paradigm shift of Kuhn) and the art becomes how the balance between these sciences is managed for individual patients and for communities. Before addressing the challenges I have taken on, there is one more detour to make.

ELIOT & BERGER.

I must confess to having read much less from the literature outside medicine than many colleagues do, and I always wish I did.

However, a number of colleagues have tried to right this wrong over the years, none more than Ian Stevenson and Mike Porter - important academic friends and colleagues over many years, and I am indebted to them for the references in this section. The first - a simple quotation in its own right - is from T.S Eliot's poem 'The Rock'²¹ and reads

where is the life we have lost in living?
 where is the wisdom we have lost in knowledge?
 where is the knowledge we have lost in information?

I used this as a theme for one eponymous lecture in 1984 (the Wedgewood Lecture)²² and the other reading provided my theme for another in 1986 (the James Mackenzie Lecture).²³ This was John Berger's classic 'A Fortunate Man', the story of a year in the life of an English country doctor.²⁴ In fact, Dr Sassall probably practised near Tintern Abbey in South Wales, and the story of his life was marked in the end as much by sadness as by fulfilment. The quotation which has struck so profound a note for me is on the inside front cover, faded over a rural and apparently tranquil evening scene:

'landscapes can be deceptive
 Sometimes a landscape seems to be less a setting for the life of
 its inhabitants than a curtain behind which
 their struggles, achievements and accidents take place'

There can be no single statement which better captures what general practice means for me and what this monograph is addressing. General practice is the discipline where things are not always what they seem to be, and where the way in which apparent clinical agendas and other life situations come together may be infinitely hard to determine - and not always fully understood either by patients or doctors. It is the discipline where the prize for getting it right is so great and the cost of failing of such long-term consequence. General practitioners are the professionals most often (but not always) closest to these challenges. By their training and skills and knowledge, and by their relationship with patients - whether in communities or at consultations, they are in possession of unparalleled opportunity to intervene to improve health in the widest sense. What are the determinants of success in this domain

of activity? Is it just through being a general practitioner, and if so why? Is it through having a set of beliefs or values particular to doctors who pursue a particular career path, and if so can these be selected for and/or trained for? To what extent is success or lack of success a feature of being a general practitioner as against being this person's own and personal general practitioner?

We cannot yet answer these questions, but we are getting closer to being in a position to refine them and sketch in a range of possible studies which in due course will help get nearer to important truths.

MODELS AND FRAMEWORKS

My text thus far has contained an abundance of possible key words: quality and old fashioned values; empowerment of patients; patient-centredness in doctors; the criteria of an academic discipline, and the issue of philosophy in an academic discipline; knowledge and understanding, information and the processes of problem-solving; art and science - and the sciences of bio-medicine and sociology, and the concept of balance between these; the essentially quantitative randomised control trial and evidence-based medicine, and the contrast with the more qualitative evidence of descriptive studies; clinical variation - how much is good and when is it too much; clinical freedom, clinical judgement and clinical responsibility.

These ideas summarise the themes I have touched on over time and tried to link in my own clinical academic career. Undeniably they reflect the dangerous spread of the generalist, but potentially also the challenge that appeals to the problem-solver that lurks close to the surface of every researcher or academic. How can these ideas be integrated, and what use can be made of such an attempt?

The challenge is to find a theory to work with - and this is, of course, one of the key lessons we have to learn from social scientists who are so much more aware of the importance of theory than are most medically qualified researchers. General practitioners tend to be frightened by the word 'theory'. Theory is most helpfully defined as 'an attempt to unite available knowledge and understanding by a formula of words or by a schematic representation or explanatory

model'. A satisfactory theory not only explains the present but will predict what is not yet known.

Research is at its most useful when it either reflects or tests an existing or proposed theory, or provides new information which can then or in the future, add to a theory.

ONE MODEL

My model of what happens at consultations has grown slowly. It has four components. At its left end is the content of the consultation, portrayed after the Stott & Davis model as a square with four cells.²⁵ These capture the essential holistic nature of general practice. Patients may have wants or needs in any number of squares; agreeing with patients what these are and how they should be prioritised is the first task of good consulting.

The second component of the model is the value-system which underpins the consultation. Balint wrote about the doctor, the patient and the illness and these components of the essential interaction can be configured as a triangle. Sometimes 'illness' (or disease) issues will dominate (has this child appendicitis or meningitis; is this urinary frequency due to a central disc herniation) but usually - and even sometimes when disease-management is the priority- involving the patient in the consultation and finding his or her health beliefs is a key to a good consultation. Add issues of education, language and culture - and the same for the doctor as well as for the patient and the importance of patient-centredness to good practice becomes a compelling vision.

Thirdly, the context of the consultation is important. When this is favourable, patient-centred values can be expressed and a broader and more perceptive agenda for the consultation negotiated. When the setting is wrong, the reverse happens. I have portrayed 'context' as a circle with an arrow in one direction implying constraints, and an arrow in the other direction indicating positive influences.

The usefulness of this model will depend on being able to link these three parts to predict the fourth component - outcomes.

The thinking behind the model has been developed elsewhere.²⁶ The interaction between values and context is of particular importance. In the schematic representation in figure 2.2, putting

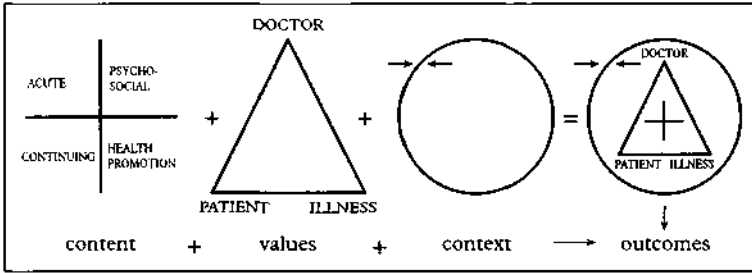


Figure 2.2. A schematic representation of the influences on the outcome of consultations.

Source: ref 26. BJGP 1996; 46: 479-481

the circle outside the triangle, and both outside the square implies that context drives values which determine the content of the consultation. It is, of course, arguable that it is the values of the doctor that determine the context rather than the reverse, and that the triangle should be outside the circle. As this story is developed, it will become apparent that context is in part determined outwith the doctor's control (contracts and incentives) and part within it (consultation length, continuity of care). Thus in future versions of the model, the allocation of issues between values and context may change as more and better information to inform the model is derived.

For me, the evolution of this model has helped place most of the concepts identified by the list of key-words offered above in some kind of order, out of which further progress should be easier than it would have been otherwise. It helps define the complex nature of other concepts as well. Skill, for example, includes the ability to identify a list of clinical problems; but prioritising the list one way as against another involves using a value-system as well, and the recognition of the consequences of using different value-systems in turn determines the range of knowledge that needs to be acquired.

At this stage, this model is relatively young and, in the absence of detail about how connections between its components relate should perhaps be described instead as a framework. In this way it can be put alongside others - such as those of Byrne & Long,²⁷ and of Pendleton²⁸ & Neighbour²⁹ - all of which in their own ways

are attempting to achieve the same goal of improving the way care at consultations is conceived and delivered.

TWO TRIADS.

I want to conclude this Chapter by referring briefly to the recently published history of the first 50 years of general practice under the National Health Service.³⁰ This interesting and informative anthology put together under the leadership of Irving Loudon, Charles Webster and John Horder, traces diverse aspects of the evolution of general practice and primary care in the UK between 1948 and 1998. In the chapter focusing on the growth of research, I have reflected on issues that have helped and hindered the evolution of investigative work in and about general practice during this time.

The difficulties can be traced to problems with the first of my triads - culture, infrastructure and training. All these are about 'structure' within the discipline. General practice has not been notable for its support of the culture of research or critical enquiry, or of those who engage in it. The infrastructure to support research, whether in practices or in university departments has been seriously deficient, perhaps an inevitable consequence of the different financial and contractual structures within the discipline. Research training has, until recently, been haphazard or absent. Chapter 3 describes one step in trying to address the problems of structure.

The successes from research have generally been attributable to the research being based on, or attempting to develop a theory, to the rigour of design and analysis, and to its cohesiveness with other work. Our work on quality of care at consultations has aimed to fulfil all the conditions of this second triad - theory, rigour and cohesiveness, and its development is portrayed in chapters 4 and 5.

Like all research, it has no end. Chapter 6 summarises where our thinking on the 'old-fashioned value' of patient-centredness has reached and points to four areas where further endeavour is now needed. One of these is changing the incentive structure to reward strengths in the area of inter-personal care as well as those in the area of technical care. That could involve as complex a set of political negotiations as did our earlier attempts to address the infrastructure needs for departments of general practice. If the lessons we learned between 1981 and 1992 can be put to use, perhaps restructuring general practice to reward the patient-

centred vision of quality will be an easier task than it might have been. Which would justify my title for this monograph:

'Patient-centredness and the politics of change'

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CHAPTER 3

A negotiation

On the 16th December of 1981, John Walker (then Chairman of the Heads of Departments of General Practice Group) wrote on behalf of his colleagues in England and Wales to Dr Henry Yellowlees, then Chief Medical Officer (CMO) at the Department of Health, asking for 'support for the activities of Departments of General Practice in England and Wales'. On the same day, on behalf of the four Scottish Professors of General Practice, I wrote similarly to Dr John Reid, the CMO at the Scottish Home & Health Department.

We enclosed a briefing paper 'Academic General Practice in the Universities of the United Kingdom : Some problems of establishment and development'. The paper ran to four pages and the key section is reproduced here:

5. NHS Obligations to Clinical Teaching

The first requirement is to establish that the NHS Act either allows or requires the Secretary of State to provide support for undergraduate teaching in General Practice.

The NHS Act 1977, Section 51 states:

"It is the Secretary of State's duty to make available, in premises provided by him, by virtue of this Act, such facilities as he considers are reasonably required by any University which has a medical or dental school, in connection with clinical teaching and with research connected with clinical medicine, or, as the case may be, clinical dentistry".

The NHS (Scotland) Act, Section 47 states:

"It shall be the duty of the Secretary of State to make available such facilities, in any premises provided by him under this Act, as appear to him to be reasonably required for undergraduate and postgraduate clinical teaching and research, and for the education and training of persons providing or intending to provide services under this Act".

It appears that the Secretary of State would indeed be

empowered to make payments to support the activities of a Department of General Practice provided that:

(a) the word 'facilities' in Section 47 of the 1978 NHS (Scotland Act is interpreted as in 4.6.1 of SHARE:

"Clinical facilities for undergraduate medical teaching:

The higher levels of medical and nurse staffing, of provision of more advanced equipment, and of clinical facilities in general in teaching hospitals should be reflected in the differences between the costs of the relevant functional classes of hospital." and,

(b) 'premises provided by him under the Act' is interpreted as including premises supported by Rent and Rates rebates consequent on provision of general medical services.

6. Levels of support

If the principle that the activities of an Academic Department of General Practice can attract NHS support can be established, it would remain at the discretion of the Secretaries of State to decide what level of support would be 'reasonable'. The present basis for identifying the notional level of hospital support (RAWP/SIFT in England; SHARE/ACT in Scotland) was based on working backwards from apparent existing teaching costs (approximately teaching hospital costs less general hospital costs divided by FTE students taught). No parallel applies in the circumstances of general practice. Methods of pricing a 'reasonable' level of support would require to be discussed.

Ten years and a few weeks later, on the 28th of January 1992, Mr M A Harris wrote from the National Health Service Executive (NHSE) to Regional Directors of Finance in England giving guidance on the use of their 'Tasked money' for the year 1992-3. (The 'Tasked money' was the small element of their overall annual Regional Allocations which carried a central directive for the year in question). The key paragraph in his letter was numbered 2.4, and this is shown in figure 3.1. £2m was identified as a new national fund to provide support to 'Academic General Practice'.

On the 14th of February 1992, Mr Michael Collier, Director of Finance at the Scottish Office wrote similarly to the General

Could I please ask you to let Steve Pashley in the Performance Management Directorate (room G21 at Richmond House) have the analysis by the end of March 1992.

2.3 Postgraduate and Continuing Medical Education (PGME) - £5m
M F Duncan [071 972 8299]. The priority is to continue implementation of more effective arrangements for PGME as required in "Working for Patients: Postgraduate and Continuing Medical and Dental Education" including:

- administrative support at region for the postgraduate dean as budget holder of the regional budget for PGME; and at units for clinical tutors;
- provision of lecture sessions to university departments of general practice;
- development of GP tutor arrangements under the regional adviser in general practice and strengthening course organiser arrangements.

An action plan to guide postgraduate deans will be discussed by HCD-HME division with COPMED.

2.4 Support for Academic General Practice - £2m - N Duncan (as above). There is increasing concern that service pressures on academic general practitioners is leading to an erosion of teaching and research time. Additional resources are required to assist with the service commitments and so release time for teaching and research. RHAs are asked to consult medical schools as to the academic general practices who should be aided in order to secure:

- one additional post in each practice paid at registrar grade to provide service support for existing academic staff and assist principals undertaking research and teaching;
- additional non medical posts, as required, to assist with patient care and assist GP principals with research. These may be research nurses, other health care professionals or administrative/clerical support.

This is an interim scheme pending further study of the issues.


2.5 Community Resource Management - £1.4m - D A Ash [071 972 3464). This is to enable delivery of the implementation plans for community resource management submitted by regions in response to EL(91)15, as agreed by the Director of Finance and Corporate Information.

Yours sincerely
M A Harris

M A HARRIS
FINANCE & CORPORATE
INFORMATION DIRECTORATE

Figure 3.1. Success! Fax of 'tasking letter' from NHSE to Regional Directors of Finance in England; note paragraph 2.4.

2 CC2/17/20 (9272)
 2 CC2/17/14672



THE SCOTTISH OFFICE

**National Health Service In Scotland
Management Executive**

St. Andrew's House
Edinburgh EH1 3DE

Telephone 031-244 3464
Fax 031-244 2683

Mr J Lusby
General Manager
Lothian Health Board
148 The Pheasant
EDINBURGH
EH8 9RR

14 February 1992

Dear Mr Lusby

ALLOCATIONS 1992/93

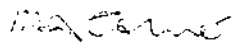
In my letter of 19 December 1991 notifying you of your Board's allocations for 1992/93 I advised you of the amount included within your allocation for The Additional Cost of Teaching. I also indicated that the Management Executive expected Boards to negotiate contracts with the appropriate providers for the distribution of these ACT monies.

I should explain that the Second Report of the Steering Group on Undergraduate Medical and Dental Education and Research (the France Committee) reflected the increasing concern that service pressure on academic general practitioners is leading to an erosion of teaching and research time. Additional resources are therefore required to assist with the service commitment and so release time for teaching and research.

What I omitted to make clear in my letter was that the resources made available to you for ACT included £94,500 for academic general practice. I would be grateful therefore if in your discussions with provider units and medical faculties you would ensure that arrangements are put in place for these resources to be made available to academic general practice where they should be used to secure a heightened level of teaching and research by the engagement of additional staff (medical and/or non-medical) or other means.

This support of academic general practice is an interim arrangement pending further study of the issues.

Yours sincerely



MICHAEL COLLIER
Director of Finance

MR100214.022

Figure 3.2. Even better! A clearer directive in Scotland.

Managers of the four Scottish Health Boards with medical schools, indicating that their allocations for 1992-3 should be regarded as including allocations to support academic general practice. The Scottish commitment was much more specific at £500 per fourth year medical student, a sum which was approximately doubled in 1993-4. Mr Collier's letter to John Lusby, General Manager in Lothian is shown as figure 3.2.

This chapter traces the story of the journey that lay between the letters of December 1981 asking for help and the eventual response at the beginning of 1992 indicating that we had won through.

THE FIRST LEG : DECEMBER 1981 -JANUARY 1984

The letters of 16th December 1981 need to be placed in context. In the mid-1970s, the Department of Health set up a Resource Allocation Working Party (RAWP) to derive a formula for redistribution of historic cash-limited budgets for hospital and community (but not general practitioner) services. As part of the process, the Working Party recognised the inherently different position of teaching and non-teaching hospitals and identified teaching, research and the provision of supra-area specialist services as contributing to the higher costs of teaching hospitals. The excess costs of teaching were estimated by subtracting district hospital costs from teaching hospital costs (excluding London), attributing 75 per cent to teaching, and dividing the sum by the number of clinical medical students in England. This 'excess cost' became the teaching hospital academic subsidy and worked out as £8372/clinical student/year in 1975/6, a figure which had grown to around £40,000 by 1990. This funding stream became known as the Service Increment for Teaching (SIFT).¹

In 1977, a closely similar document was produced in Scotland entitled Scottish Health Authorities Revenue Equalisation (SHARE). The Scottish report also recognised the extra expensiveness of teaching hospitals attributing 60 per cent of the difference between the costs of teaching and district general hospitals to teaching. The report saw no reason to cost student teaching differently from the figure identified by the RAWP process, and entitled the relevant element of funding the 'Additional Cost of Teaching' or ACT. The

Scottish document did go further than the English document in one important aspect; it identified these higher costs as reflecting the 'higher levels of medical and nurse staffing' needed to support undergraduate medical education, and indeed it went on to confirm that research activities 'tend to be concentrated in the teaching hospitals and should be reflected in their higher staffing levels and hence in their higher costs'.²

Perhaps David Morrell was the first senior academic to recognise the implications of the RAWP/SIFT issues for university departments of general practice. It was readily apparent that the relative apparent expensiveness of departments of general practice, compared to other clinical departments (chapter 1) was largely explicable by the absence of the inbuilt subsidy which SIFT and ACT provided to the hospital-based clinical disciplines. This subsidy was, in turn, reflected by the higher number of NHS staff in teaching hospitals (many or most of whom were in the junior training grades) who were often heavily research active themselves, and often carrying considerable teaching and clinical roles on behalf of senior University funded clinical staff.

David Morrell was head of London's only practice-based department of general practice and aware of the irreconcilable demands of patient care and academic activity on a small team depending substantially on clinical income to survive academically. His initial approach to the then CMO (Dr Henry Yellowlees) was sympathetically deflected with the observation that SIFT was a hospital funding stream and not appropriate for general practice. Not to be put off, in February 1981, along with John Walker he put a paper to the CMO's 'Academic Forum' (an informal group which advised the CMO on issues of the moment) which rehearsed the issues which were reflected in our subsequent December letters and supporting papers.

Our December 1981 letters were duly acknowledged and promises made about fuller replies once wider consultations had taken place. We owed our first suggestion of progress to wider discussions which followed publication of the Acheson Report into primary care in inner London.³ In April 1982, Robert Maxwell wrote to Henry Yellowlees (now Sir Henry) suggesting one way forward with the Acheson 'inner London' problem was



DEPARTMENT OF HEALTH & SOCIAL SECURITY
 Alexander Fleming House, Elephant & Castle, London SE1 6BY
 Telephone 01-407 5522 ext 7443
 From the Chief Medical Officer
 Sir Henry Yellowlees KCB FRCP FFCM

Professor J H Walker MD DPH FRCP FFCM
 The University of Newcastle Upon Tyne
 Department of Family and Community Medicine
 The Medical School
 Newcastle Upon Tyne
 NE1 7RU

14th January
 1983

Dear Professor Walker,

Thank you for your letter of 3 December 1982 about NHS support for academic general practice. I am sorry not to have replied sooner but I have been looking at some of the papers relating to activities since you last wrote.

The financial support which the NHS and DHSS can give in areas which are almost exclusively the province of the DES, the UGC and the Universities themselves, are strictly limited. However we are sympathetic and I would certainly like to explore, with all those concerned, what might be done.

I would certainly be delighted to see you and David Morrell but I wonder whether it would not be more useful to have a wider meeting along the lines suggested to me by Robert Maxwell last year. I have written to him suggesting that I would now like to take him up on his offer of sponsorship by the King's Fund but of a single higher level meeting in the first instance. I imagine that both you and David Morrell would attend such a meeting. Perhaps you would let me know if this would meet your wishes and if it takes too long to arrange or any other difficulties arise. I would certainly see the two of you alone.

Yours sincerely

H Yellowlees

HENRY YELLOWLEES KCB FRCP FFCM
 Chief Medical Officer

Figure 3.3. Henry Yellowlees (CMO) to John Walker.
 The start of the 'Health v Education' problem.

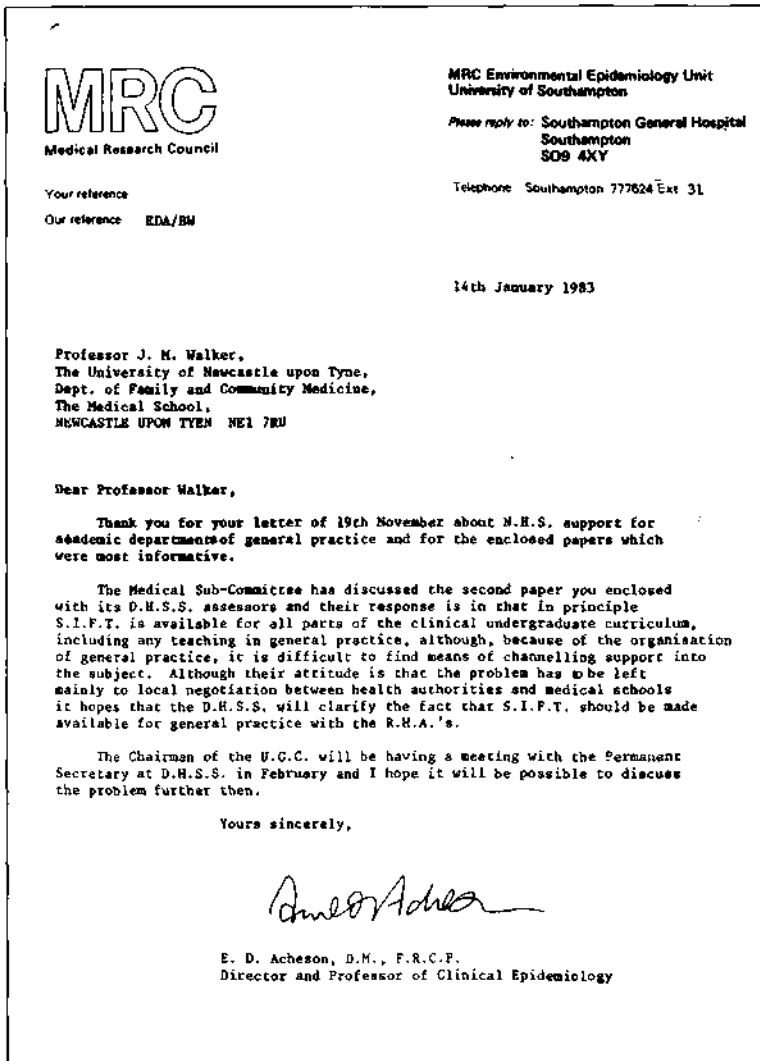


Figure 3.4. Donald Acheson (CVCP) to John Walker.
Same date; different angle; same story.

to 'strengthen academic units of general practice in London teaching hospitals with the firm intention that they should seek to understand and influence patterns of primary care in their surrounding districts'. The King's Fund offered to sponsor a 'high-level' meeting to explore how this might be taken forward (presumably then thinking mainly of London) and, in due course, this proved to be our first positive step on what would prove a long journey.

By the beginning of January 1983 we had letters in reply (to reminders from John Walker) from Henry Yellowlees and Donald Acheson (Chairman of the Medical sub-committee of the University Grants Committee) which I have reproduced as figures 3.3 and 3.4 because they reflect what was to be the greatest difficulty we were to face.

The Department of Health (DH) saw the responsibility for funding academic general practice as lying within the remit of the Department of Education & Science (DES) which funded the Universities through the University Grants Committee (UGC). The UGC in turn was unhappy about directing Universities as to how to spend their block grants, and in addition believed that academic general practice should not be excluded from support analogous to SIFT - although recognising the practical difficulties which would follow from even a minor re-distribution of SIFT from hospitals towards general practice.

From our point of view, although we generally felt we had received poor levels of support from most of our own medical schools, we did not see a 'UGC-solution' as having any chance of addressing the whole problem we had. Around this time, the UK budget from UGC to all medical schools together totalled around £150m per year (about £8,500 per clinical student per year); this compared with the SIFT component of now around £20,000 per clinical student per year. Clearly an NHS solution was essential whether or not a better UGC one could be achieved as well.

Of course we also faced another problem. The Medical sub-committee of the UGC was composed of one representative per medical school (normally the Dean) and these representatives were heavily bio-science orientated. Few believed academic general practice represented real science or was a discipline likely to be able to hold its own in terms of significant research. In truth,

many Deans probably also doubted the value of teaching in general practice, conceding only that it was probably a good idea for those students who would 'end up' as general practitioners (precisely those who had least need of the teaching the discipline had to offer).

Throughout our negotiations we have had to keep a few principles at the front of our minds. A negotiation involves three parts - making a case, finding a mechanism to implement it, and finding funding to prime the process. 'Making a case' has two sides to it, the intellectual and the emotional, or as it was later described to me 'winning hearts and minds'. Simply stated, but hugely difficult to achieve. Our final problem was that although we enjoyed excellent access to able and influential civil servants and medical politicians, many (but not all) showing genuine goodwill to us and our cause, we had no direct access to the Treasury, where all policies and strategies to implement them ultimately stand or fall.

In February 1983, I learned from the copy of a letter from John Reid to Michael Parry (Secretary of the Scottish Council for Postgraduate Medical Education - who had been helping rekindle the Scottish end of our initiative) that he and Henry Yellowlees were about to take up the King's Fund offer to sponsor the previously mentioned 'high-level' meeting, and this indeed took place in London on 1st July 1983. John Horder, recently retired as President of the RCGP, and then a Visiting Fellow at the King's Fund, and always the wisest and most resilient champion of our cause, was clearly the driving influence on this step forward. The meeting was chaired by Professor Brian Abel-Smith on behalf of the King's Fund, and the DH and Scottish Office, the UGC, the RCGP, London University and the Departments of General Practice were represented by senior (and often their most senior) officers.

It was difficult not to feel pessimistic at the out-turn of the meeting. There was a modest to good level of 'hearts and minds' support but no feeling of agreement on mechanisms, and far less on where money - let alone significant money - might come from. We were offered double 'basic practice allowances' for full-time academic practitioners (which would have equated to one member of staff in the largest practice-based departments,



DEPARTMENT OF HEALTH AND SOCIAL SECURITY
EILEEN HOUSE ROOM
80-84 NEWINGTON CAUSEWAY LONDON SE1 6FF
TELEGRAMS TELEPHONE 01-700 6380 Ext 3714

Your reference
Our reference

20 January 1984

Dr John Horder
98 Regent's Park Road
London
NW1

Copy for info (about RHP Session II)

Dear John

STRENGTHENING ACADEMIC DEPARTMENTS OF GENERAL PRACTICE

I am sorry I have not replied before to your letter of 5 October which asked for our comments on the draft minute of the meeting held on 26 September.

As I am sure you know we wish to be as helpful as possible but at the same time it is necessary to make sure that we do not step outside the legitimate fields of interest of the Department. It has been very difficult to second the note so that both these concerns are satisfied.

We are still actively looking at the problem and I am afraid it is going to be some time before we can respond fully.

Yours sincerely

D C Ower

John
Sad, but not without faint hope.
I shall ring David Ower in morning
John we'll see how things
for you soon
John Horder

Figure 3.5. David Ower to John Horder.
Confirmation of a long journey ahead.

and no help for departments without practices); or a trial of one two-year placement of an academic post in a medical school of our choice with the challenge to show at the end of that time how patient care in that locality had been improved. However, we did finish with an invitation to meet DH officials again to discuss financial issues (could we possibly have won the 'hearts and minds' battle so easily?) and an agreement (later to be withdrawn by the DH) that SIFT money was, in principle, available to general practice after negotiation at regional or district level - as long as it wasn't used to pay the salaries of teachers!

The second meeting with DH officials took place on 26th September. I don't recall that we made much progress, and I never saw a note of what took place. David Ower's letter of 20th January 1984 (figure 3.5) said it all. We had reached the end of round 1.

THE SECOND LEG:
NOVEMBER 1983 TO 15TH DECEMBER 1986

THE MACKENZIE REPORT

It would be difficult to say whether the over-riding emotion on leaving the September follow-up meeting at the King's Fund was of disappointment or of pessimism, but there was certainly a strong component of realism. On the plus side, our case was a good one both in terms of its logic and of natural justice, and a number of very busy and senior people had taken our initiative seriously. On the other hand we were clearly in no-man's land between two huge government departments and referral back and fore would obviously be one way - whether by design or not - to hold us at bay indefinitely. The new suggestion (hinted at in David Ower's letter) that the DH lawyers thought it might be illegal to provide a SIFT or SIFT-like support to general practice was ominous too. But we believed that the people we were dealing with could overcome almost any difficulties if they were really minded to. In short, we had gained the attention of hearts and minds, but had not actually won where it mattered on either count; we certainly weren't anywhere near getting a mechanism, and no one was queuing up to volunteer a share of their present slices of the proverbial cake.

We were at or near the end of one avenue, and something new had to be done to re-launch our cause. The thought of giving in never entered our minds.

I had become Chairman of the Association of University Teachers of General Practice (AUTGP) and its mission statement then was simply to promote the development of general practice as an academic discipline. Our prime function was academic, but where issues of structure seemed over-riding impediments to academic growth, we saw no problem in taking on a political role too. As James Mackenzie Professor of General Practice in Edinburgh, I also had effective control over a modest endowment from the Mackenzie estate designed 'to promote the development of general practice on a UK basis'. In November 1983, I decided to invest some of that endowment in an in-depth review of the present state and the achievements and potential of UK academic departments of general practice, and to use this to develop the case for support of our hibernating initiative to address our disabling infrastructure deficits for once and for all.

The thinking behind the 'Mackenzie Report' (as we called the project) was to visit each UK medical school and meet staff of the present departments of general practice or their nearest analogues. We wanted to canvass their views on their strengths and opportunities as well as about the problems they faced in achieving their potential, and we then planned to prepare a negotiated report for wide circulation. Ian Stevenson from the Edinburgh Department, and David Hannay (then in Glasgow and later Professor in Sheffield - and originally from a public health background) joined me in taking the work forward. We split the then 24 UK departments between us and spent much of late 1984 and early 1985 'on the road' pursuing the mission we had taken on.

By mid May of 1985 we had a draft report ready to circulate to our colleagues. We didn't seem to have got things right! The principal problem was balancing the needs and positions of departments embedded in working NHS practices staffed by full-time University employees (the model most easily translatable to a SIFT/ACT equivalent support mechanism), and of departments whose medical staff, some but not all of whom were full-time University employees, had their clinical commitments in NHS practices outside and independent of their Universities. There were

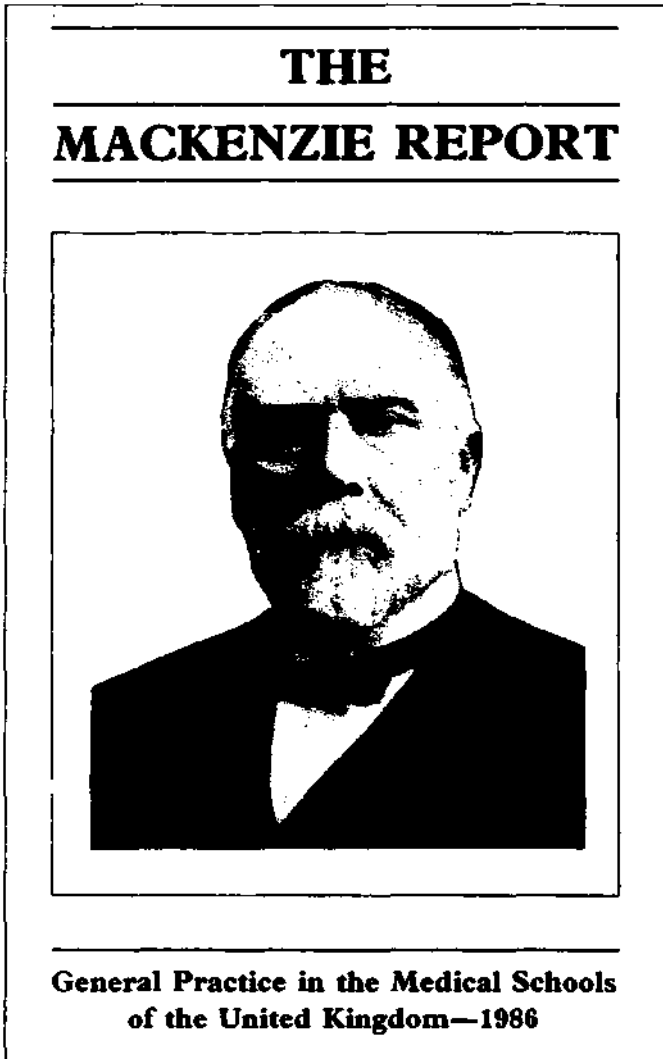


Figure 3.6. The Mackenzie Report. Repositioning our initiative.

also differences of view about how to balance advocacy for the funding needs for core activities of Departments with the need to identify payments to the many general practitioners teaching attached students in their practices. And there were debates about the relative priorities for career development between those with medical and with social science backgrounds, and those with full-time or part-time commitments to their various University roles.

After many hours of negotiating (often hard but always with good nature) we settled on agreement not to differentiate between practice-based and practice-linked departments, and to campaign for a level of funding for student attachments which would equate fairly closely to the postgraduate trainer's grant. We suggested that an 'average' department might cost £400,000/year to run and that perhaps a third should come from an NHS SIFT or ACT-like support payment. These two calculations together would have totalled around £5m/year, about £1m more than we eventually settled on as our substantive negotiating position which was almost exactly the figure we eventually ended with six years later.

The Mackenzie Report (figure 3.6) was published in May 1986.⁴ It was a fair reflection of significant achievements and a balanced request for genuinely needed new support. The document was marginally ingenuous in one place only, where (in paragraph 37) we said

'It is not the purpose of this document to be a negotiating forum for the economic problems faced by the discipline, except insofar as it seems helpful to explain them briefly, quantify them approximately, and sketch in the boundaries of possible solutions.'

We sent copies everywhere - some 5000 in all. We were advised to put a price tag on the inside cover (which we set at £3) as marketing wisdom indicates that pricing a product shows that it is of value. Needless to say, we did not try to recoup our outlays!

The effect of this venture was substantial and fully lived up to the expectations which had carried the idea through to fulfilment. The BMJ (Stephen Lock was a consistent supporter of the need for a stronger academic base for general practice) published a shortened version;⁵ the accompanying leader by the President of the Royal College of Physicians was symbolically rather than academically or politically helpful.⁶ The Health Departments, the GMC, the RCGP and the GMSC, the UGC and Principals and

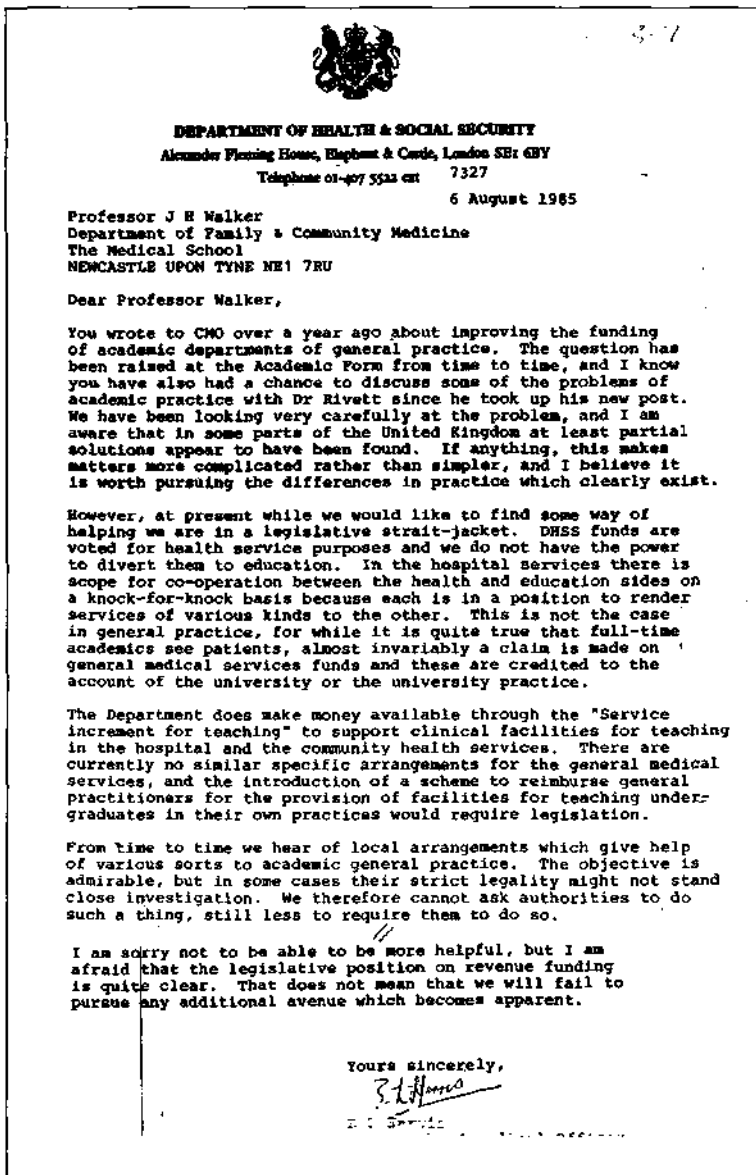


Figure 3.7. Extracts of letter from Dr Harris to John Walker. Even less encouraging - and now negotiating at deputy level.

Deans wrote warmly and seemed genuinely anxious to build on this further opportunity.

In the meanwhile, John Walker had received a formal reply from the deputy CMO (dated August 1985) which confirmed just how intractable was the problem we faced (figure 3.7). Apart from confirming the apparently insurmountable legislative difficulty, suggesting that hospital 'knock-for-knock' arrangements were balanced by academic general practitioners receiving fees for services given also confirmed the failure of the Department to acknowledge the hugely one-sided nature of 'knock-for-knock' in favour of hospital academic departments. However, this was the letter we had, and that was where we had to move from.

Every achievement needs its bit of luck. Ours came in the form of Alistair Riddell, then a Glasgow general practitioner and Chairman of the Scottish General Medical Services Committee (SGMSC) later Treasurer of the BMA. I had first met Alistair when he did a life-insurance medical on me shortly after I qualified in Medicine in 1961, and we had remained friendly over the quarter-of-a-century since that first meeting. Alistair was a recipient of an early copy of the Mackenzie Report, and phoned by return to offer help. He visited me at our Department in Edinburgh a few days later and explained that he felt we would need 'primary legislation' to achieve our aims, and that a once-in-a-decade opportunity to be included in a forthcoming Bill was imminent; notice of intent and the necessary ground work had to start within weeks rather than months.

John Walker and myself met for dinner on 18th June with Alistair Riddell, Michael Wilson (newly Chairman of GMSC) and Dorothy Ward (another persistently supportive Glasgow friend) at the Royal Society of Medicine. We re-worked our costings to £1.6m to support general practitioner teachers and £2.4m to subsidise core staffing - making a total SIFT/ACT-analogue request of £4m. Was the roast duck as good as I recall, or was it the feeling that we were now round the block to our progress that had seemed so problematic?

The meeting with the GMSC was symbolic as well as useful. The CMO's letter to me of 27th May (figure 3.8) had flagged up the issue of 'achieving consensus within the profession general sympathy with the problems of medical academics'. We had had



DEPARTMENT OF HEALTH AND SOCIAL SECURITY
 Alexander Fleming House, Elephant & Castle, London SE1 6BY
 Telephone 01-407 5522 ext. 7442
 From the CMO's Medical Officer

Professor J G R Howie
 Department of General Practice
 University of Edinburgh
 Levinson House
 20 West Richmond Street
 EDINBURGH
 EH8 9DX

27 May 1986

Dear Professor Howie,

Thank you very much for sending me copies of the report on general practice in the Medical Schools of the United Kingdom. Clearly much effort has gone into preparing the descriptive and analytic sections. I found it a pleasure to read, not merely because it was in accord with my past experience and convictions, but also because of its realistic approach to the problems of the discipline.

The report helpfully suggests two types of action. First is the need to achieve consensus within the profession that the future of the discipline depends in part upon general sympathy with the problems of medical academics. The second is the possibility of submitting evidence on academic general practice during the consultation on the discussion document. I hope that there are plans to do so.

You will, I am sure, be interested to know that we are looking at the question of financial support for undergraduate general practice teaching. I cannot, of course, promise anything!

Yours sincerely

E D ACHESON
 DM FRCP FRCM FRCM

* again!

Figure 3.8. Donald Acheson (CMO) to John Howie Looking much better!

backing from the College throughout (although I later learned that some views expressed in private had not been as supportive as those written in public), but having the GMSC 'onside' was regarded as the critical piece in the current jigsaw. This was confirmed by a further letter dated 30th June acknowledging receipt of the Mackenzie Report from Geoffrey Rivett (now Principal Medical Officer responsible for Primary Care at the Department of Health) referring positively to the fact that he had heard that our meeting with GMSC had gone well. We clearly had a new lease of life. We were encouraged by having Donald Acheson (now Sir Donald) as CMO. He had been Dean at Southampton where a new medical school with an active practice-based Department of General Practice had had a much more prominent role than was the case in many other medical schools. Sir Donald had also in the past been Chairman of the Medical Sub-Committee of the UGC (his previous letter on this subject in that role was reproduced earlier in this chapter as figure 3.4) and he had the best grasp of the issues of any senior officer we had yet worked with.

The next key meeting was scheduled for 15th December 1986 with the CMO 'to discuss the Mackenzie Report'. The meeting was at Alexander Fleming House at Elephant & Castle. It didn't go well. It was a cold grey day. The academic department representatives, the College representatives, the GMSC representatives (who were 'managing' the politics of the discussions) and the Department team were in place in good time, but the meeting started without Joe Pilling, the key Under-secretary. Under-secretaries are important people. As Joe Pilling explained to me a few weeks later, it is only Under-secretaries who can unlock the door to the Treasury; with their support anything is possible - without it nothing is possible. Joe Pilling was a high-flier from the Home Office (later to become a familiar TV presence on Prison matters) and he was on loan to DH. When he did arrive, he treated us to an ABC of SIFT - issues we were already well acquainted with - and diverted what had started as a promising sharing of views into yet another blind alley. We were far from pleased! After the meeting Joe Pilling found himself surrounded outside the toilets by half-a-dozen dark suited and heavy-overcoated highly unhappy medical politicians. He did concede he seemed to have got it wrong. He was to redeem himself fully before long.

That meeting on 15th December was one day short of 5 years from the time John Walker and myself had sent our original letters to the Health Departments. It would be another 5 years before we reached the conclusion we had set out to look for. We did, however, now know that we would see our mission through!

THE THIRD LEG : JANUARY 1987 - 27TH OCTOBER 1987

PRIMARY LEGISLATION

Michael Colvin, the senior Tory back-bench MP for Romsey visited John Bain's Aldermoor Health Centre in Southampton on 19th December-1986. He was impressed with what he saw and interested by the problem of the absence of SIFT support which he learned about during his visit. He offered to help raise the matter at Westminster.

Following the disastrous meeting at the DH in December, Joe Pilling and Geoffrey Rivett agreed to visit my Department in Edinburgh to see at first hand what academic general practice had to contribute to health service thinking and delivery in one University region. The date was fixed for the last week of January 1987. So we entered 1987 with two live lines of development.

The Pilling/Rivett visit went well. We visited three star teaching practices in Livingston New Town on the outskirts of Edinburgh and laid on a series of small group meetings about our own teaching and research work. With our own department based on a working NHS practice, the links between NHS and University were easily evident. On the second afternoon, I had a private and helpful session with Joe Pilling. He explained how the politics of change work; he told me about the significance of influencing Treasury thinking; he said that until now we had not persuaded him at either 'heart' or 'mind' level, but that now he was so persuaded. Then he told me he was about to leave the DH and I would have to start afresh with his successor! He did, however, promise to brief him (John Shaw) in our favour, and wished us good progress.

We had always been uncertain whether to involve politicians in our campaign. Several academic colleagues had potentially important contacts with MPs who either were patients or activists in local health care issues. But until now most of these contacts had been

with Opposition MPs and we were anxious that hostile tactics by them might rebound against us, even though our progress was slow and uncertain. During March, Geoffrey Rivett told me that it 'would not be unhelpful' now to enlist the assistance of a 'friendly' MP and I arranged to meet Mr Colvin at 'the House' early in April. The meeting was cancelled at short notice due to 'constituency pressures' (no doubt relating to the impending General Election) but we did meet early in the afternoon of 6th July in the seductive ambience of the Members rooms at Westminster, now with post-election glow much in evidence. Mr Colvin listened well and said he would put me in touch with a colleague with an interest in Health. I couldn't hide my disappointment that Mr Colvin would not help me himself after I had briefed him so fully. He agreed to take us on; within 24 hours he had asked a 'Supplementary question' in the House during Question time (figure 3.9) and two days later added a written PQ (parliamentary question). Within a week he had applied (this time unsuccessfully) for an Adjournment Debate before the summer recess (on 24th July) and I had written him a 10-minute speech for the occasion were he to need it.

Robert Jackson was the Parliamentary Under-Secretary of State at the Department of Education & Science, and his Office was on the phone early the morning after the flurry of questions had added a new dimension to the campaign. The purpose of 'friendly' questions includes embarrassing Ministers enough to be helpful, but not so far as to stimulate vengeance. Robert Jackson's reply took three weeks to formulate; it could not have been described as encouraging (parts shown in figure 3.10). The problem of 'legal and technical' difficulties was not all that new, but the comment that 'the case for additional support for general practice teaching (had not yet been) substantiated' confirmed how difficult it was to keep DH and DES 'singing from the same hymn sheet'. John Walker and myself had always felt the solution to our problems would lie in the DH, and this reply from the DES confirmed our view.

We continued to explore various mechanisms informally with Geoffrey Rivett as 1987 progressed. There were more ideas about 'academic' basic practice allowances or capitation fees, top-sliced research traineeships and the like, and we consistently tried to fit solutions to the £4m target we had settled for after the publication

175	Oral Answers	7 JULY 1987	Oral Answers	176
House of Commons				
<i>Tuesday 7 July 1987</i>				
<i>The House met at half-past Two o'clock</i>				
PRAYERS				
[MR. SPEAKER in the Chair]				
MESSAGE FROM THE QUEEN				
QUEEN'S SPEECH (ANSWER TO ADDRESS)				
THE VICE-CHAMBERLAIN OF THE HOUSEHOLD reported Her Majesty's Answer to the Address as follows:				
<i>I have received with great satisfaction the loyal and dutiful expression of your thanks for the Speech with which I opened the present Session of Parliament.</i>				
PRIVATE BUSINESS				
BRITISH RAILWAYS BILL				
<i>Read the Third time, and passed.</i>				
HARWICH PARKERTON QUAY BILL				
<i>To be considered upon Thursday.</i>				
NATIONAL PROVIDENT INSTITUTION BILL [Lords]				
<i>Read a Second time, and committed.</i>				
KEBLE COLLEGE OXFORD BILL [Lords]				
<i>To be read a Second time upon Thursday.</i>				
SELWYN COLLEGE CAMBRIDGE BILL [Lords]				
<i>To be read a Second time upon Thursday.</i>				
Oral Answers to Questions				
EDUCATION AND SCIENCE				
Academic Medical Staff				
1. Sir David Price asked the Secretary of State for Education and Science if he is satisfied that, in view of the increasing clinical demands of the National Health Service, academic medical staff have adequate time to pursue their research work as well as their teaching duties.				
The Parliamentary Under-Secretary of State for Education and Science (Mr. Robert Jackson): The Government are aware of the pressures on senior clinical staff in the universities, who have a threefold commitment to teaching, research and patient care. In our guidance to universities and to the National Health Service we have urged close co-operation in the planning of staffing and other resources.				
Sir David Price: I congratulate my hon. Friend on his first appearance at the Dispatch Box, where he so clearly belongs. May I draw his attention to recommendation No. 11 of the Select Committee on Social Services that looks into the problem of AIDS? In that recommendation, we				
invited my right hon. Friend the Secretary of State to take a much firmer line in ensuring that moneys allocated from his budget for clinical academic research are not abrogated for the purpose of providing clinical care by default.				
Mr. Jackson: This matter has been raised by the Select Committee on Social Services in its report on AIDS. The Government are considering their recommendation on that report and will reply as soon as possible.				
Mr. George Howarth: Does the Minister accept that it is high time that we stopped the pretence? Many of the academic appointments that are being made are hardly being used for academic work or research at all, but are being used to cut down waiting lists.				
Mr. Jackson: It is difficult to strike a balance to try to ensure that the tripod of responsibilities for teaching, research and patient care is maintained. The Government are concerned to ensure that each of the different legs of the tripod is sustained.				
Mr. Colvin: It is good to see my hon. Friend continuing the tradition of fellows of All Souls in the Department of Education and Science. Following the question of my hon. Friend the Member for Eastleigh (Sir D. Price), is my hon. Friend aware that the 4,000 students studying medical practice who are accorded to general practice as part of their studies are now facing under-funding? As there is no equivalent of the NHS support scheme known as SIFT—Special Incentive for Teaching—will he talk to his counterpart at the Department of Health and Social Security to ensure that, between them, the two Departments cover this responsibility?				
Mr. Jackson: I will certainly talk to my counterpart at the DHSS. I thank my hon. Friend for drawing my attention to the MacKenzie report. I shall have to write to him further about the matter.				
Student Grants				
2. Mr. Andrew F. Bennett asked the Secretary of State for Education and Science if he will make a statement about when he expects the review of student grants to be completed.				
Mr. Jackson: The Government hope to publish proposals for consideration early in 1988.				
Mr. Bennett: I wish the Minister well in his new appointment.				
Is he an enthusiast for loans or for partial loans? Is a bid being put into next year's public expenditure consideration so that the outcome of the review can be implemented a year next September?				
Mr. Jackson: The review is being conducted with an open mind. It will take account of all the arguments that are for and against loans and of the experience in other countries. Whether provision must be made next year will depend upon the review group's findings.				
Mr. Hunter: Will my hon. Friend take this opportunity to comment on the charge that the introduction of a students' loans scheme might deter potential students from higher education?				
Mr. Jackson: That is an important aspect of the inquiries that are being conducted by the review group.				

Figure 3.9. Quickly off the mark. Michael Colvin asks a Question

DEPARTMENT OF EDUCATION AND SCIENCE
ELIZABETH HOUSE YORK ROAD LONDON SE1 7PH
TELEPHONE 01-934 9000

FROM THE PARLIAMENTARY UNDER-SECRETARY OF STATE

Michael Colvin Esq MP
House of Commons
London SW1A 0AA

27 July 1987

Dear Michael

On 7 July you asked a Supplementary about the funding of undergraduate teaching in general practice, and I promised to write to you about this. I am sorry not to have let you have a reply more quickly. I have looked into the issues raised by your question and consulted colleagues at DSSS.

In your Supplementary, you picked up the point made in the Mackenzie Report that there is no equivalent for general practice, of the Service Increment for Teaching (SIFT) which is allocated to Regional Health Authorities by DSSS to compensate health authorities for the extra cost of service provision in (mainly teaching) hospitals, arising from the use of the clinical facilities in those hospitals for teaching undergraduates. Academic GPs have compared their situation with the funding of teaching hospitals and have argued for an allowance to be paid both to themselves (or their departments) and to GPs in non-university practices who take medical students on attachment.

In considering the implications of such arguments, a number of questions need to be resolved - for example, what the purpose of an allowance of the kind proposed would be. The point has been made that an allowance would provide compensation for the extra time taken by the GP in discussing cases with the student and explaining procedures during consultations with patients. We need to know more about these extra time pressures, and to take into account other aspects of academic general practice, for example, its role in improving local service provision, and in research.

If the case for additional support for general practice teaching were substantiated - and I should stress that this point has not been reached - options for appropriate payment arrangements would need to be investigated. There are legal and technical reasons why a SIFT type of approach cannot be adopted in the field of general practice. There are some complex issues here, with implications for both my own Department and the Health Departments. However, I can assure you that we are giving active consideration to these issues and I am most grateful to you for drawing these points to my attention.

Very truly yours
Robert Jackson

ROBERT JACKSON

← PARAGRAPH OMITTED

Figure 3.10. - and gets a reply. Still the same problems!

Volume 121 No. 31	Tuesday 27 October 1987
 CONTENTS Monday 26 October 1987 <i>[Continuation of Proceedings]</i>	
Sea Fisheries [Col. 129] <i>Motion to approve statutory instruments—[Mr. Gummer]—agreed to</i>	
Trewo and St. Austell [Col. 142] <i>Debate on motion for Adjournment</i>	
Tuesday 27 October 1987	
Oral Answers to Questions [Col. 151] <i>Secretary of State for Social Services</i> <i>Prime Minister</i>	
Financial Situation [Col. 169] <i>Answer to private notice question—[Mr. Lawson]</i>	
Social Security Benefits [Col. 179] <i>Statement—[Mr. Moore]</i>	
Defence [Col. 205] <i>Motion—[Mr. Younger]</i> <i>Amendment—[Mr. Dennis Davies]</i> <i>Debate adjourned</i>	
General Practice (Training) [Col. 274] <i>Debate on motion for Adjournment</i>	
Written Answers to Questions [Col. 41]	

Figure 3.11. An Adjournment Debate. The most significant advance so far.

of the Mackenzie Report. With 4000 students graduating annually in the UK, this gave us an easily memorisable target - £1000 per graduating student. Compared with the 1984 valuation of SIFT at around £20,000 per student in each of three clinical teaching years, our request was surely reassuringly modest!

Michael Colvin returned to the fray after the Summer recess, and won an Adjournment Debate slot for the 27th of October. I wrote his speech; Geoffrey Rivett wrote Edwina Currie's reply. The proceedings lasted from 10.03 until 10.28. There were, I recall, five Members present in the Chamber at the end of the Debate. Mrs Currie had managed to 'misunderstand' the Mackenzie Report by selecting only the part relating to payment to general practitioners who took students on attachments. She costed this at £1.6m, and referred to the need for 'Primary

legislation' to make such support legal. Mr Colvin pressed her on this. Mrs Currie strongly hinted that such legislation was imminent - given, of course, that it received the support of the House. It was my oldest son's 24th birthday. We sat in the Stranger's Gallery with our wives and watched this small moment in history; then we went for dinner - this time to celebrate. (The debate was chronicled in Hansard Volume 121, no. 31 between pages 274 and 280. The contents page is figure 3.11)

POSTSCRIPT

The 1988 Health & Medicines Bill included enabling legislation for payments to be made by the NHS to support general practice training (figure 3.12). Edwina Currie wrote to Michael Colvin (figure 3.13). Michael Colvin's Press Statement seemed to slightly over-simplify the process we had been through (figure 3.14)!

From now, two separate streams of activity were to develop. The first, related to securing payments for general practitioners taking students on attachment and is described as the 'fourth leg'. It was comparatively straightforward. The second, (which overlapped in time to some extent) attempted to secure core support for the University Departments themselves. It was far more problematic. It is my 'fifth leg'.

Health and Medicines

**A
BILL
INTITULED**

Act to make further provision in relation to the National Health Service, the testing of sight and instruction in matters relating to health and welfare and to amend the Medicines Act 1971.

Brought from the Commons 18th April 1988

Ordered to be Printed, 18th April 1988

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HL Bill 75 50/1

* *Clause 15 makes it clear that remuneration for those providing NHS family practitioner services may include remuneration in respect of instruction and so, for example, enables those providing general medical services to receive remuneration for clinical teaching and to be reimbursed expenses for training employed staff.*

* *Remuneration of practitioners*

15.—(1) At the end of subsection (1) of section 43A of the National Health Service Act 1977 (regulations as to remuneration of persons providing services) and section 28A of the National Health Service (Scotland) Act 1978 (which makes corresponding provision for Scotland) there shall be added the words "and may include provision for the remuneration of persons providing those services in respect of the instruction of any person in matters relating to those services".

25

30 (2) At the end of subsection (2)(d) of each of those sections there shall be added the words "or instruction".

35 (3) Any determination in relation to remuneration in respect of services under Part II of the National Health Service Act 1977 or Part II of the National Health Service (Scotland) Act 1978 which was made after the passing of this Act but at a time before the coming into force of a provision inserted by section 7 of the Health and Social Security Act 1984 shall be deemed to be validly made if regulations authorising such a determination could have been made had that provision been in force at that time.

Remuneration in respect of training for other persons.
1977 c. 49.
1978 c. 29.

1984 c. 48.

Figure 3.12. Confirmation of progress
The 1988 Health and Medicines Bill.

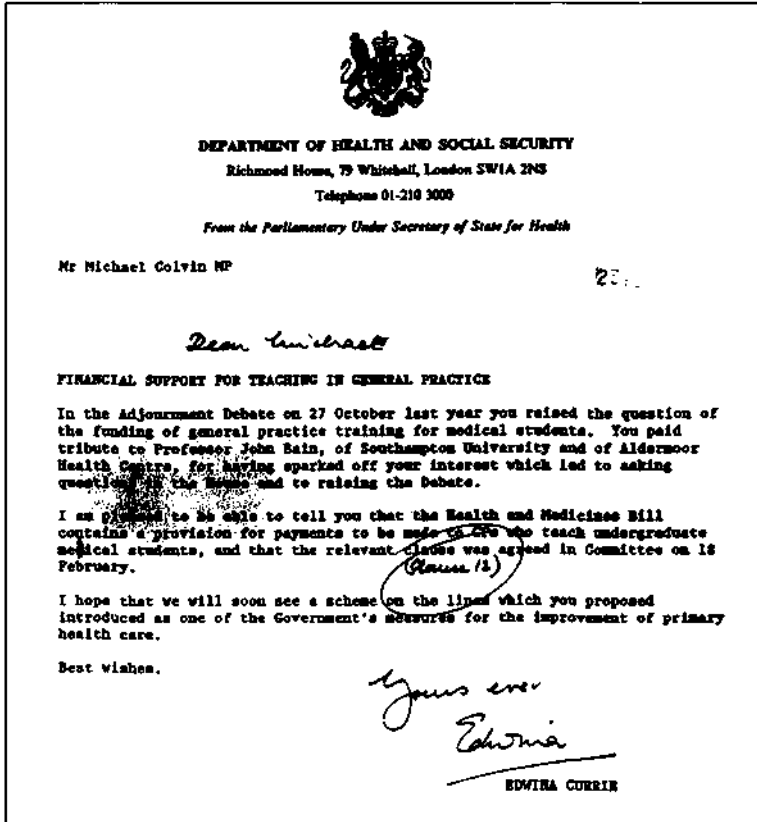


Figure 3.13. A letter from Edwina Currie to Michael Colvin

From: Michael Colvin, M.P.



HOUSE OF COMMONS
LONDON SW1A 0AA

PRESS STATEMENT

25 February 1988

VICTORY FOR MP AS GOVERNMENT AGREES TO FUND GP TRAINING

Romsey & Waterside MP Michael Colvin's campaign to obtain government funding for GPs who teach undergraduate medical students has been crowned with success.

"When I visited Aldermoor health centre last year at the invitation of Professor John Bain (of Southampton University), we discussed the question of funding for general practice training," said Michael Colvin. "Following on from that visit, I raised the matter in an adjournment debate in the House of Commons."

Mr Colvin told the Minister, Edwina Currie MP, that "GP training does not enjoy the drama of acute hospital services to catch the public eye or perhaps the public purse." But the 31 medical schools, including Southampton, which were carrying out this valuable work deserved the funds to make an important contribution to community care.

Now Michael Colvin's campaign has been successful. Clause 12 of the Government's Health & Medicines Bill, currently going through Parliament, secures the necessary finance for this essential work.

"I am delighted that the Government has fulfilled its promise, made by the Minister, to ensure that such training can continue," said Michael Colvin. "I consider it a vindication of all the splendid work being carried on at health centres such as Aldermoor."

Figure 3.14 . . . and Michael Colvin's 'Press Statement'.

THE FOURTH LEG : UP TO 1ST APRIL 1990

THE NEW CONTRACT - PARAGRAPH 40 PAYMENTS

All credit to the DHSS! By 12th December 1987, I had a copy of their 'action plan' to implement Edwina Currie's October statement of intent. Whatever else is said about the civil service system, there can be no doubting its efficiency when it commits itself to action. Extracts from the action plan are shown in figure 3.15.

Three 'options' were indeed identified by the end of December, and a 'small advisory group' (chaired by Professor Tim Clark, then Dean at UMDS) met on January 26th 1988. That group met only once, but its work enabled four options to be presented to the GMSC in a letter from Geoffrey Rivett to Ian Bogle dated 17th March. The four options were summarised in the 'note of the meeting' of 26th January as follows:

4. The first option, to pay the GPs on the basis of claims submitted, would be consistent with existing practice in the GMS, and would largely confine the administration of the scheme to FPCs. GPs doing similar amounts of teaching, in association with different medical schools, could be paid the same rate. Controls could be made effective, both on the claiming procedure and on the overall expenditure. The heads of departments felt that this option was quite inadequate, the number of student-days was a quite unsatisfactory measure of GPs' contribution or of the educational value of the attachment.
5. The second option would involve the medical school notifying the FPC of the value of different GPs' contribution to clinical teaching. It could involve the weighting of different kinds of time spent in support of teaching. This was considered to be unduly complex.
6. Of the three options the heads of departments and Professor Clark favour the third, the setting of a sum per medical student to be distributed to GPs. In this option, as in the previous options, a fee or allowance in respect of a GP who was a salaried employee of a university would be paid direct to the university.
7. It was proposed that medical schools should reach agreement locally with FPCs and, perhaps, associated local professional committees in advance of the distribution of students on

brief David Metcalfe
use DATE FIXED

(14/2/89)

①

FINANCIAL SUPPORT FOR TEACHING IN GENERAL PRACTICE

Objective: To provide some financial recompense to GMS practitioners involved in Undergraduate Medical Education (UME)

ACTION PLAN

To:

a. Review options for payment, obtain GMD's views	by end December 1987
b. Complete a survey of present methods of payment	by end January 1988
c. Establish a small advisory group to advise on method(s) of choice	by mid January 1988
d. Determine policy method and arrangements for evaluation	by mid February 1988
e. Provide Departmental negotiating brief for Joint Working Group on Training	by mid March 1988
f. Confirm procurement of finance	by October 1988
g. Implement proposals	by September 1989

ASSOCIATED KEY DATES

Conclusion of primary legislation	July 1988
Regulations made and laid	November 1988
Implementation at start of academic year	September 1989

NOTES ON ACTION PLAN:

- re (b) above: advise GMS before writing to GP providers of UME.
- re (c) above: small working group to comprise: representatives of MED; FFSID; FB; plus a Dean of a Medical School and a head of a Department of General Practice.
- As financial support for teaching in general practice is a part of the package of proposals set out in the White Paper, the timing of negotiations must be related to negotiations on the package as a whole. It is hoped that from the information gathering and from the consultations the Department will have a reasonably detailed proposal ready in time. Subject to progress being made on the package as a whole, it is hoped that the scheme would be introduced with effect from the academic year 1989/90.

Figure 3.15. Extracts from DHSS 'Action Plan' paper relating to implementation of commitment to support undergraduate teaching in general practice.

attachments and correspondingly of the distribution of the financial support. This element of joint planning was expected to be welcome to FPCs; it made this a distinct fourth option, which was favoured by the meeting.

In truth, although the fourth option may have been favoured by some at the meeting, it was not one which the Heads of Departments would have felt comfortable with, but it was not yet an issue to divide us. John Walker and myself met again with Michael Wilson and the GMSC negotiators on 12th May at the Royal Society of Medicine and we had a very supportive briefing document from them to work with. After that, a formal negotiation between DH and GMSC took place on 28th May and the Department's note of this meeting confirmed the generally positive direction of their negotiations on this issue:

5. Meeting held at BMA House. 28 May 1987
 - i) GMSC confirmed that the development of academic departments of general practice was vital to the long term future of general practice. It had a high priority in terms of funding and resources.
 - ii) UGC report recognised that there was no clear distinction between teaching and service, a knock-for-knock system operated. The report recommended better consultation between the DES and DHSS.
 - iii) The department did not think the knock-for-knock system worked to the same extent for academic GPs in university departments of general practice. It was difficult to identify the service costs of GPs with attached students. The GMSC said that service costs had to take into account the
 - a. extended consultations
 - b. Changed nature of consultations
 - c. Arrangement and organisation of the practice and premises
 - d. Time required by trainers to keep up to date
 - e. Extra pressure on partners
 - iv) Both sides agreed that section 63 might provide a legal avenue for additional funding and should be explored further. The Department agreed that the government does allocate an amount of money for each GP. Academic GPs on average only achieve half to two-thirds of the average

workload which attracts these payments. The GMSC felt this was an attempt to fund academic departments on a charitable basis with contributions from the income of other non-academic GPs. If section 63 funding was to be used, it must be made clear that new money was being introduced.

- v) The negotiators accepted the Department's proposal for a system of weighted capitation payments as a practical way of allocating funds. Such a system would need to take into account the GP devoting longer time to a number of students and should place equal importance on secure funding of academic departments and fees for GPs with student attachments. More discussions were needed on the capitation proposal.
- vi) The problem of attracting good young GPs into university careers was discussed. To improve the academic standing of GPs it would be necessary to recruit career academics who could be trained to fill senior posts in future. Research Fellowships would need to be provided.

John Walker and myself were invited to join the next formal DHSS/GMSC negotiating meeting on 10th August. The format was interesting; the Department team (at least a dozen strong) and the GMSC team (half that size) faced each other across a long table. Only Michael Wilson and John Shaw spoke (except for the item we were present for). An approximately equal number of debating points were made on each side, but there were few direct hits! It was easy to understand how easily confrontation could arise and goodwill break down - which, of course, was just what happened as the general negotiations around the implementation of the 1987 White Paper 'Promoting Better Health' dragged on through 1988 and 1989.

The Department proposed setting a per capita student allocation '... for the time and costs involved in support of clinical teaching...'. The issue between the sides was the not unimportant one of whether the money to meet this was to be a redistribution of existing general practitioner remuneration, or to be funded in whole or in part from resources to be made available to implement (or by implementing) the White Paper reforms.⁷ The Department also wanted to refer the issue to the DDRB (Doctors and Dentists Review Body) for pricing.

Progress was becalmed. Yet another political agenda was introduced by the January 1989 White Paper (Working for Patients)⁸ which introduced the controversial proposals for GP fund-holding, and relationships between Government and Profession became more strained than at any time since the 1966 Charter crisis.

By 11th July of 1989, nearly two years from our only face-to-face full negotiating meeting on the subject, John Shaw - in a generally positive letter to Michael Wilson reviewing the position on this single item of the whole White Paper negotiation package - concluded as follows:

'As to timing of the introduction of a 'student allowance'. I have had a look at the reference in the minutes of the 10 August 1988 meeting. The record says: "If good progress was made, implementation from October 1989 was feasible". Such were our high hopes in those days! Even if present difficulties are overcome, I think it is now unrealistic, with or without the involvement of the Review Body, to expect to work up a scheme and to have it in place and operational by 1 October 1989. I think we must accept that 'good progress' has not been made but that we are on course for 1.4.90 and that the 'students allowance' should remain within the package due for implementation from that date.'

The stand-off between Government and Profession had been an unwanted last hurdle, and our nervousness had been compounded by learning that the new teaching allowance was to be funded by money to be saved by scrapping free eye tests, another issue which the negotiating parties were at war about. No doubt this was no more than a tactical manoeuvre, but that 'new' money was eventually covered by further new legislation in April. As many readers will recall, negotiations later broke down altogether, and the Government's 1990 'New Contract' was 'imposed' on the Profession (from 1st April 1990)."

The 'New Contract' did, however, include a new fee for teaching undergraduate students! At £12.50 for a session up to three hours, it could not be described as a princely sum. But it multiplied up - given four weeks of attachments per student - exactly to Edwina Currie's 1987 £1.6m!

As it became apparent that this part of the Mackenzie Report package was going to be successfully addressed, it became equally

clear that this avenue was not addressing the other issue of core funding, which - for the academic departments themselves - was generally agreed as being the greater need.

By the time the 'eye test' money had been guaranteed, we were already pursuing the core-funding problem by another route.

POSTSCRIPT.

In Edinburgh, the new payments (embodied in paragraph 40 of the new statement of fees and allowances) allowed us to re-use for other purposes the £20k then being spent out of Endowment income to support our then token payments to our teaching practices for the essential support they so generously and willingly gave to our teaching programme. It was a step in the right direction, but not enough to solve the real problems of the insufficient critical mass we had to build a fully effective all-round academic clinical department on.

5TH LEG : SUMMER 1989 - 31ST MARCH 1992

'EVEREST THE HARD WAY'

The story of the last leg needs to be set in its proper organisational context. For that we return to Hansard and to a written answer to another Parliamentary Question only just three weeks after Michael Colvin's successful Adjournment Debate. Tony Newton, Secretary of State at Social Services announced the setting up of the Partridge Committee (Figure 3.16) to improve joint working between the Departments of Health and of Education and Science in the field of Medical Education. Michael Partridge was second Permanent Secretary at DHSS and had on his (eventually highly significant) Steering Group all the most influential players in the fields of importance to us.

In response to a general invitation to raise relevant issues, the College, through the late Bill Styles, sent a most impressive statement of our case to the Committee. Thus at the first possible opportunity our problem became an early and semi-permanent part of the agenda of the Steering Group and of its various off-shoots and successors, the most significant of which was the France (Sir Christopher France - Permanent Secretary at DH) Committee. The France Committee was soon renamed

as the Steering Group on Undergraduate Medical & Dental Education & Research (later known as 'SGUMDER')-

The Steering Group delegated work between its own meetings to two Task Groups. The Implementation Task Group had the following terms of reference:

'To develop the proposals outlined in 'Working for Patients' as they affect undergraduate medical & dental education & research; to consider other issues which may be identified by the Steering Group, and to make recommendations.'

and David Metcalfe was invited to join it.

In June 1989 the Steering Group produced its first major output headed simply 'Interim Report of the Steering Group'.

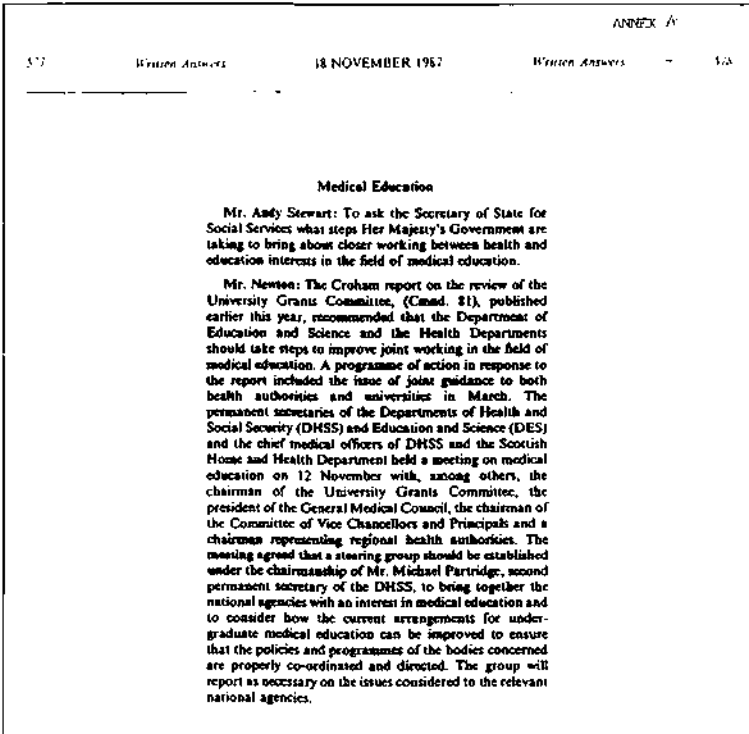


Figure 3.16. Setting up the Partridge Committee - a Written Answer to another Parliamentary Question.

The Report commented in several places on the desirability of shifting teaching to the community and to general practice and its last substantive paragraph read:

'63. Our report has identified the increase in primary & community care as one of the major changes in pattern for medical service. The implications of this for the costs and management of education should be considered and we recommend that we undertake further work in this area.'

THE STEERING GROUP; ITS 'FURTHER WORK'.

David Metcalfe and I wrote yet another position paper, revisiting much of the ground covered by earlier papers and the Mackenzie Report. This paper ran to four pages; the Task Force secretariat produced a three page response tracing accurately the history of the negotiations over the previous three years. Depressingly, the last four paragraphs - reprinted below - returned to advocating that solutions should be found within the University system.

'12. The paper above states that £2m is required for the core funding of academic departments, ie for such functions as the training of junior staff in teaching and research method and to free clinical time to discharge wider responsibilities. Although the paper above suggests that these costs are similar to those met by SIFT in teaching hospitals, they are in fact more closely related to academic purposes. The DH has no statutory responsibility for funding such development.

13. The responsibility for such funding is really a matter for the departments of general practice to negotiate with their medical schools and universities. Infrastructural costs are matters for universities to determine, and if academic departments of general practice cannot be properly funded within the block grant, it is for universities to shift resources from other priorities or to argue for increased resources. Such debate is outside the terms of reference of the Task Group (and Steering Group).

14. But the Task Group can legitimately suggest that, with regard to infrastructural costs, it should be recognised that changes in medical practice have led to increased emphasis on teaching in

E.R.

d. the £400,000 annual allocation to Departments of General Practice as announced by the Secretary of State on 10 July, which has been guaranteed for at least the next five years.

In my view this is quite an impressive package.

As regards the GP remuneration elements, the nut and bolts are now a matter of detailed consultation between the Health Departments and the GMSC. It has been agreed that these consultations should proceed on a confidential basis. I hope you will accept that I am bound by that agreement and that it would be wrong of me to enter into correspondence on the detail. Suffice it to say your views and those of your colleagues in academic general practice are well understood by the Health Departments' negotiating team.

The paper you co-authored with Professor Metcalfe along with your letter to Dr Isaacs and another paper submitted by Professor Metcalfe were studied by the Steering Group on 23 November. At the meeting I spoke about the importance of general practice for the training of all doctors, and acknowledged that there may be funding problems in some academic departments of general practice. All other members of the Steering Group who spoke echoed these feelings, without exception. The Steering Group endorsed the recommendation of its Implementation Task Group, which had studied your paper earlier, that any remaining funding problems should be given urgent attention within medical schools. Professor Sir Colin Dollery also promised to consider whether the medical committee of the Universities Funding Council should discuss the problems of funding infrastructure for general practice.

In my view the Steering Group's recommendation is correct. Any funding above that already committed by DH should come from university funds. I am sure that you have a strong case to put to University Courts and I am equally confident that, the UFC's Medical Committee will consider it carefully.

I hope this reply is helpful.

Yours sincerely
Donald Acheson

Figure 3.17. Part of a letter from Donald Acheson (CMO) to John Howie. Back to the 'Health v Education' roundabout yet again.

the general practice setting, a trend which seems likely to continue. The Task Group might go so far as to recommend that universities, in ordering their priorities, take into account developments in the health service, ie engage in joint planning in accordance with the ten principles.

15. The Task Group is invited to agree that the various measures being taken to protect academic general practice, such as the introduction of the teaching allowance and the £400k for academic departments, are sufficient to ensure that academic general practice is not being deprived as a result of the new contract, and that funding of infrastructural costs, though matters for universities to decide, should take account of the growing importance of academic general practice.'

(The reference to the £400k for academic departments in paragraph 15 referred to a sum provided to balance a 7 per cent uplift in SIFT which had been offered to Teaching Hospitals to support research in the post-1990 NHS reforms; SIFT then became SIFTR (R for research). The '£400k' was divided on a per student basis and worked out at about £100/student/year for 5 years. A further smaller short-term compensation for loss of income from basic practice allowances to practices with small list sizes in the 1990 Contract was later added as well.)

On 20th October 1989, the Task Group discussed the two submissions. The next day, David Metcalfe wrote to the secretariat in strong terms protesting yet again at the inequity of our continued exclusion from SIFT-like levels of NHS support. The Chairman of the Task Group, Tony Isaacs, promised to represent our position at the November meeting of the Steering Group. That meeting took place on 23rd November. The Steering Group (inevitably) took the same view as had the Task Group. A further letter from the CMO ended with just the news we did not want (figure 3.17). We were back once more on the DES route; once again we knew the University system would prove ambivalent when the need to move resources towards general practice was put to the test, and we also knew that in any case, the University system did not have the resource base to support medical education to the level which was built in through the NHS-SIFT system.

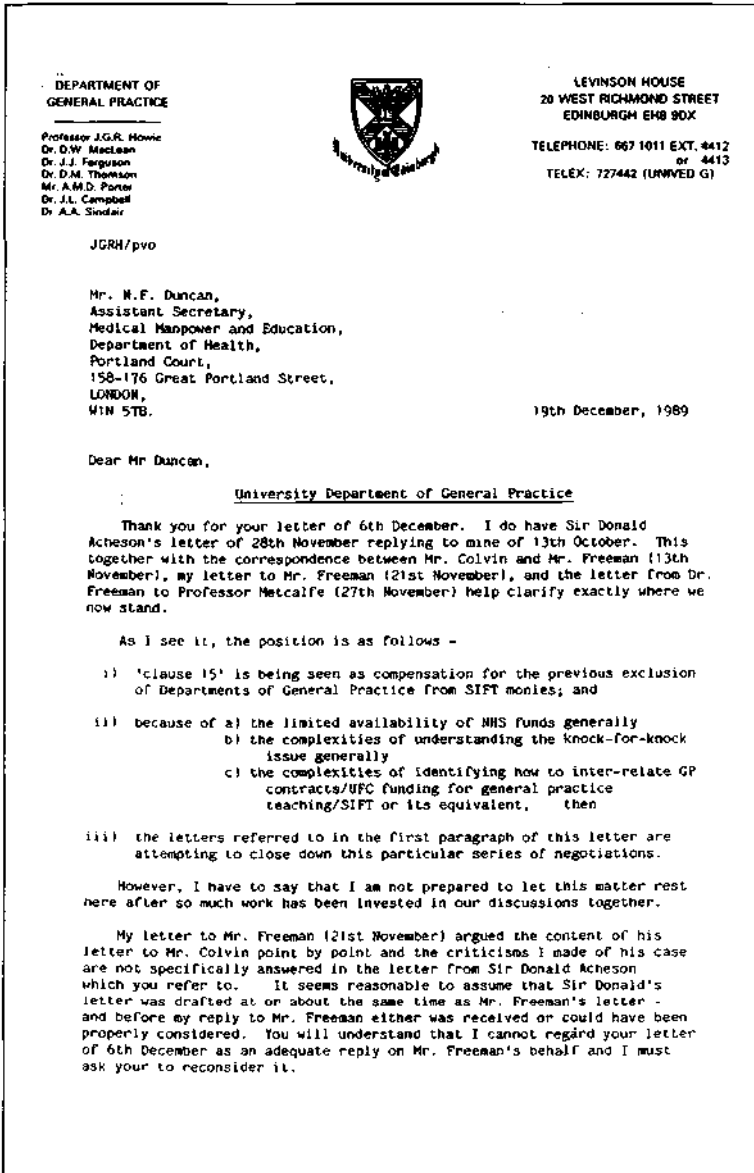


Figure 3.18. Exasperated! Part of a not-very-good natured letter to Norman Duncan reflecting a feeling of being trapped in an unsympathetic system

Dear Professor Howie

UNIVERSITY DEPARTMENTS OF GENERAL PRACTICE

Thank you for your letter of 19 December 1989.

I would like to clear up one misunderstanding. It was not Dr Isaac's decision that the matter be referred through the CACP to the UFC. The Steering Group on Undergraduate Medical and Dental Education discussed the funding of university departments of general practice on 23 November 1989 and decided 'that any further shortfalls in academic infrastructure should be addressed by medical schools and universities'.

At that meeting, the Steering Group accepted offers to have the issue discussed by both the Medical Committee of the UFC and the Medical Sub-Committee of the CACP.

I must abide by the decisions of the Steering Group, so I readily concede that I am indeed, as you say, trying to 'close down' this particular series of correspondence. But the issue is far from dead.

You have acknowledged the steps the Department of Health has taken to improve clinical support for undergraduate education in general practice. The Department is responsible for providing facilities to support undergraduate medical education in the NHS, teaching is the responsibility of universities. Direct comparison of the funding of 'facilities' in general practice with those in teaching hospitals is therefore deceptive, but I will comment briefly on this aspect of your letter. SIFT is distributed on a 'per-student' base (in the absence of better information), if it were possible 'per-student presence per consultation/treatment' might be better. As SIFT is a payment for excess NHS service costs, 'per UFC-paid clinician' has little meaning. 'Knock-for-Knock' is very complicated and it would be unwise of me to venture any statements before we have the results of the Steering Group's study in Southampton. However I cannot accept your assertion 'that the NHS contribution to hospital academic departments is much greater than the UFC funded staff contribution to direct patient care could possibly be priced at'. Of course more work is needed on Knock-for-Knock (and we will also review SIFT itself in 1992). Whatever the outcome, it will still be the case that NHS provision of 'facilities' in teaching hospitals will differ in nature from support in general practice, and 'per-academic post' comparisons will still have little or no value.

In the meantime, we wait to hear what steps may be taken by universities to improve the way they shoulder their responsibilities, which include funding for teaching, research, senior academic staff development and academic infrastructure (which have also been examined in your letters and papers).

Both Departments will be watching developments closely, and I will make sure that you are kept informed. In the meantime, I am sorry if you feel we are not making the progress you have hoped for, but as I have said already, I must follow the decisions taken by the Steering Group.

Yours sincerely,
Robert James

Figure 3.19 . . . and the kind of reply I was bound to receive

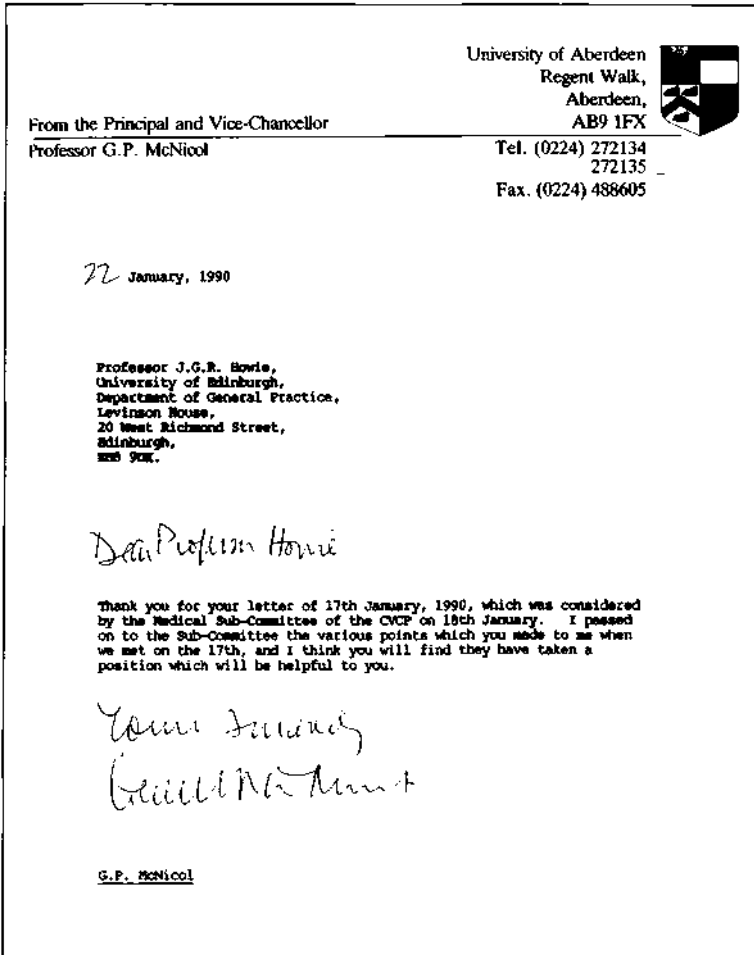


Figure 3.20. A letter from George McNicol (Chairman, Medical Committee of the CVCP). Enigmatic - could it mean what we hoped it did?

DEPARTMENT OF GENERAL PRACTICE		LEVINSON HOUSE 20 WEST RICHMOND STREET EDINBURGH EH9 9DX
Professor J.G.R. Howie		TELEPHONE: 667 1011 EXT. 4412 or 4413 TELEX: 727442 IUNIVED GI
JGRH/pvo		
Mr. Michael Colvin, MP, House of Commons, LONDON, SW1A 0AA		7th February, 1990
<i>Michael</i> Dear Mr. Colvin,		
<u>General Practice Departments in Medical Schools</u>		
This is a brief progress report! It is apparent that (not by any means for the first time) our funding negotiations are being coped with by a move from one major Department to another (on this occasion away from DoH back to DES). Undoubtedly the DoH believe they have honoured their obligation to you and us by the new student allowance which is now embodied in the New Contract for general practitioners, and by providing the '£400,000' to safeguard against specific losses to academic general practitioners as a result of New Contract changes. It would be wholly inappropriate to be other than very appreciative of what has been achieved.		
However, the original problem of funding the core activities of departments remains. As you will see if you revisit the correspondence enclosed, the matter is presently being taken up by the DES through the UFC and the CVCP. I have no doubt that this will lead nowhere, as it has never been the custom for central bodies to direct Universities on how to spend their money down to the level of detail that would be required to meet our needs. In any case, I believe that the DoH is still the body who has the responsibility to provide us with a genuine SIFT equivalent to allow us to carry out academic work properly without our being neutralised by an inappropriately excessive clinical demand.		
The papers I have enclosed for you are what I have circulated today to Heads of Departments. I understand the CVCP is conducting a quick survey type exercise with a view to making a conclusion about its role in our negotiations. I hope this will be concluded quickly. If as I expect, this then means that the DES declares itself unwilling to become further involved (as I expect it will and think it should) I will return to you and ask you to raise the matter politically again targeting the DoH once more (as I believe they are expecting me to do). I believe it would be inappropriate to make further moves at present as the DoH will have a completely watertight way of escaping from the pressure you or I might put on them.		
Please let me know if this general line of tactics seems appropriate.		
Kind regards,	Yours sincerely,	
Enc.	J.G.R. Howie	

Figure 3.21. A progress report to Michael Colvin

The CMO's letter was the last in a line of several almost simultaneous rebuffs. Norman Duncan was then Assistant Secretary at the Medical Manpower & Education section of DH, and had written one of these - and probably drafted several of the others too! He received a rather uncharitable letter from me, reflecting my exasperation at what was apparently an exercise in perpetual circularity (figure 3.18). His reply (figure 3.19) confirmed that I had read the position accurately!

THE CVCP

The medical sub-committee of the Committee of Vice-Chancellors and Principals (the CVCP) was chaired by the UK's only medically qualified Vice Chancellor, George McNicol from Aberdeen (where I had previously taught before moving to Edinburgh). I visited him on 17th January, the day before his Committee met to take forward the Steering Group's charge to address our problems 'within the University system'. His subsequent letter (figure 3.20) was suitably enigmatic. Clearly neither the CVCP nor the University Funding Council (UFC - the successor to the UGC) wanted to hold this particular baby any longer than absolutely necessary! My letter of 7th February to Michael Colvin (figure 3.21) was a more balanced statement of the position than my pre-Christmas outburst had been - but I didn't regret showing how I had felt then.

SECOND REPORT OF THE STEERING GROUP

The Second Report of the Steering Group, another landmark position statement, was published in June 1990. It devoted five paragraphs to Academic General Practice, the last two of which are reproduced here:

'3.31 It is the opinion of the Group that teaching in general practice is an integral and important part of the education of all medical students. The arrangements for funding academic general practice are more complex than for other academic disciplines. The Group recommends that in the first instance any shortfalls in the academic infrastructure of general practice should be addressed within the university system. Accordingly

it hopes that the universities will carry out a detailed examination of their present arrangements.

3.32 To this end, we have accepted offers from the Universities Funding Council and the Committee of Vice-Chancellors and Principals to examine the problems of funding for university departments of general practice. The funding of teaching in general practice may need attention again later, not least because of the changed relationship between Family Health Services Authorities (which will succeed Family Practitioner Committees) and RHAs. The Group therefore recommends that the funding of academic general practice should be monitored by any successor body to the Group.'

WGUMDER

A new Steering Group was created after the publication of the 'Second Report', and it met for the first time in October 1990. Instead of delegating work to Task Groups, it shared its work with its new Working Group on Medical & Dental Education & Research (WGUMDER). I was invited to join this Group and it met for the first time on 18th January 1991 at Portland Court in London. Item 5 was 'Academic General Practice'. I still had some 20 journeys to make to London or Leeds, but the waters seemed calmer again.

The first meeting of WGUMDER was what might best be described as a positioning meeting. I probably misjudged the occasion by taking what seemed a suitable opportunity to express regret at the Steering Group's final decision to retrace its steps (on academic general practice) to a CVCP/UFC solution. I did this briefly and, as always, with careful good taste, avoiding personalising past decisions in any way. At the tea-break Terry Hunt, Regional Manager of North East Thames RHA, who had spoken in support, had the proverbial 'quiet word in my ear'. He had been involved in previous Steering Group discussions and was as well briefed as any, even although he had previously heard/read our case only on paper. He said to remember that a lot of people were genuinely trying to help and not to shoot them for their trouble. He suggested I visited him when next in London and asked me to send him a review of progress over the period

Dear Member

ACADEMIC GENERAL PRACTICE SUB-GROUP

As you know, the meeting of the sub-group provisionally arranged for this afternoon has had to be postponed. I hope to reconvene it fairly soon.

In the meantime, however, I would like to be able to put some preliminary recommendations to the Steering Group chaired by Sir Christopher France. I have discussed different aspects of the issues with some of you individually. I think I can summarise our collective wishes so far. The Steering Group meets on 11 October, and if it endorses the sub-group's views, we can then make further progress.

I therefore propose to tell the Steering Group that, when the sub-group met on 25 June, we came to the conclusion that, while the Second Report of the Steering Group had said that the problems of academic general practice should be addressed by the university system in the first instance, the point had now been reached when solutions had to be sought elsewhere. The way forward appeared to be in the use of SIFTR.

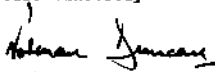
There are unquantifiable excess costs for the NBS in providing support for undergraduate medical education (and research) in the general practice setting, as there are in hospitals, simply because it takes longer for a GP to treat patients when students are also being taught. The same is true of research.

For hospitals, these additional costs are met by SIFTR. There is no comparable payment for academic general practice at present; the student allowance is too widely dispersed and inadequate for those core practices associated with academic departments. But there is no statutory objection to using SIFTR funds in general practice units. The legislation refers to premises and facilities, not to hospitals. And there is no theoretical reason to object; on the contrary, it is the Steering Group's stated intention that SIFTR should be directed explicitly towards sites where clinical teaching takes place, and those include general practice.

RHAs should therefore be advised to ensure that at least 1% of their SIFTR allocations should be distributed to academic general practice. The sum involved would amount to a total of a minimum of £3.7m in England in the current financial year. In making contracts for SIFTR, RHAs are already obliged to consult universities, and it would be a condition of SIFTR contracts for academic general practice not only that the university endorsed them, but also that it agreed to maintain or enhance its existing funding of the academic department.

What I have set out in the preceding four paragraphs reflects a distillation of the comments I have received. I intend to submit a statement on these lines to the Steering Group unless I hear from members of the sub-group to the contrary.

Yours sincerely



N F DUNCAN
Assistant Secretary
Medical Research and Education Division

Figure 3.23. Norman Duncan comes good! The conclusions of the meeting which never took place.

since we started negotiating in 1981. I met him in his office at Paddington on 4th March; he was another good listener and offered to help behind the scenes. On 27th March he wrote to say he thought 'things (would) get moving'.

On 8th May, WGUMDER (at SGUMDER's request) announced the setting up of a new 'sub-group on Academic General Practice'. I was allowed to suggest part of its membership. Norman Duncan became its Chairman and Terry Hunt one of its members. It met for the first time on 25th June. I wrote yet another briefing paper for the sub-group. It ran to six pages and 25 paragraphs.

The meeting was small enough to be personally easy, and most members of the group knew each other and the issues well. The remit from SGUMDER was:

'to consider the funding of academic general practice in the light of the Second Report of the Steering Group and subsequent developments, and to make recommendations.

At last there was no mention of identifying the case for support. We had only two issues left - finding a mechanism, and identifying funding.

The June meeting considered a carefully researched paper presented from the CVCP by Michael Powell, their Senior Administrative Officer. The CVCP had surveyed the levels of support provided from UFC monies in all medical schools and canvassed views on problem issues and their solutions. Their conclusions were succinct (figure 3.22) and both useful and unsurprising.

The second meeting of the Academic General Practice sub-group was due to take place on 20th September. Too many key players were unable to come and Norman Duncan and myself agreed it would be better not to meet with them missing. His subsequent letter to the members of the Group was as helpful as it was splendidly decisive (figure 3.23) and he duly briefed the Steering Group as he had indicated he would.

The sub-group met once more - on 28th November. There was only one paper to discuss. Optimistically it was titled 'options for funding'. There were six suggestions on the table - some non-starters had thankfully been discarded at a rather worrying

... from the view already expressed in the Second ... the need for universities to address this issue.

... was also considered necessary to determine the excess ... costs, if any, of academic general practice and the Sub- ... recommended that this work be undertaken with the review ... SIFTR. The long term solution would therefore lie with the ... universities and the review of SIFTR.

OTHER ISSUES

16. The Sub-group thought it possible that GPs in non-academic general practices who undertake university-approved research might need additional service support. It recognised that this was an issue that might be considered further.

CONCLUSION

17. RHAs' plans for 1992/93 are already well advanced. To ensure that funding proposals for academic general practice are included, the Sub-group's recommendations have already been submitted to the NHS Management Executive.

18. The Working Group are invited to comment on and endorse the Sub-group's proposals that:

- a. RHAs should be tasked with consulting medical schools to determine the funding position of their Departments of General Practice and then with providing the appropriate level of service support for the associated practices.
- b. the assistance described should be conditional on the university maintaining or increasing the level of funding to its Department of General Practice; and
- c. a study should be conducted with the Review of SIFTR to investigate whether SIFTR should be enhanced to cover excess general practice service costs of teaching and research.

Secretariat
January 1992

*X note in context of WANG (92) 4
'funding support for research
- NHS'*

*X Attached
SIFTR
remains responsible*

Figure 3.24. Journey's end. Then back to figures 3.1 and 3.2.

preliminary filtering stage. The idea of simply increasing the '£400k' (page 62) - perhaps by a factor of even 10 - was simple and potentially attractive; but apparently this could not be done before 1993/4. Earmarked regional funding was another real possibility, provided universities agreed to maintain or increase existing support. A SIFTR option was tabled but was still not favoured by the Department. Funding academic registrarships also had attractions. The other two options did not attract sufficient general interest to pursue.

The discussion centred on earmarking Regional funding and emphasising the likely usefulness of academic registrarships. The mechanism of 'Tasking' Regions to fulfil Departmental policy had already been used in previous years and was due to operate again for 1992/3. The 1992/3 Public Expenditure Settlement had been somewhat more favourable than anticipated. The Regional Treasurer on our Group assured us that Regions would be able to find the modest sums involved if they were 'tasked' to do so.

The Academic General Practice sub-group's Report became the basis of the WGUMDER's substantive paper WGME 92/3, which in turn was adopted by SGUMDER and then became the basis of Chapter 5 of the 'Third (Interim) Report of the Steering Group' in October 1992. Paragraphs 17 and 18 of the sub-group Report (figure 3.24) were what we had spent 10 years trying to achieve. By the time they came to SGUMDER for endorsement, the 'Tasking' decision had already been taken by the NHS Management Executive, ironically within one day of 10 years from the date John Walker and myself sent our letters to our respective CMOs!

POSTSCRIPT

Within days of the last (November) meeting of the Academic General Practice sub-group, I had a telephone call from someone at the NHSE asking if I had a reference which might help him cost the level of support the Tasking money might cover. My caller had not heard of the Mackenzie Report, but thought he might find a copy helpful!

The Scottish Office had reasons for preferring to top-slice ACT, and identified £500/student as 'GPACT' for 1992/3, a figure which

was doubled (as in England) for 1993/4. That, of course, was the simple solution and the one we had always asked for. If it could be done in Scotland, surely it couldn't be illegal! Why it couldn't have been done in England as well, still defeats me.

In the subsequent Reviews of SIFT/ACT, all 'paragraph 40' GMSC payments, the £400k support fund, and the 'Tasked monies'/GP ACT, were put into the SIFT/ACT pots and are now subject to annual local review and negotiation in the same way that hospital SIFT/ACT are. The target is to achieve around 5 per cent of the SIFT/ACT budget for general practice. For 1999/2000 we have reached 4.2 per cent in Edinburgh, a fairly representative and very helpful and encouraging position.

For much of the span of our negotiations the issues of teaching and research were treated together. The decision to disaggregate 'T' & 'R' shortly after we had concluded our work, reactivated a new round of discussions, Reports and negotiations. That story continues and has not been straightforward either; but it is not for just now.

Re-reading this chapter tells its own story. It starts with excitement and the spirit of the chase; by the middle there is a feeling of stodginess and a repetitiveness that itself becomes fatiguing. Then it picks up somewhat, but the sense of relief that comes across at the end feels somehow an anti-climax rather than the celebration it should have been. That reflects remarkably accurately how the whole process felt in real life. It shouldn't have been as difficult as it was; but I (we!) learned a lot about life and met and worked with a lot of genuine and able people. The problem was getting the myriad of their different agendas to overlap.

'Yes Minister' was surely a documentary programme rather than a comedy; it should be compulsory viewing for all medical politicians!

REFLECTION

The Christmas issue of the BMJ is always different, and contains something for everyone. The 1998 issue contained a splendid essay by Ken Caiman, recently retired from his distinguished tenure of the position of Chief Medical Officer.¹⁰ He gives excellent advice on how to conduct a negotiation with government. He emphasises the importance of being well prepared, tolerant of others who

have different priorities, having self-belief and being ambitious, and being patient and learning to accept set-backs. Above all he emphasises the need to be good-natured and courteous, and the importance of having a sense of humour. It was only the once in 1989 that I came close to breaking these guidelines. Did the interchange of letters that followed hinder; or did it maybe in the end help?

I would add one thing. It is essential to be prepared for the difficulty of getting to know the people you are dependent on for help. Junior and senior officers in the Civil Service change jobs about every three years, and sometimes more often. This avoids undue familiarity (I assume this is a Civil Service policy, and I can understand that). It has advantages and disadvantages, but it does promote the status quo. It is worth finding a friend who is going to last out your initiative. For me, I lasted long enough to see several of those I negotiated with more than once round the circuit - and sometimes in quite different roles. Poachers turned gamekeepers can be difficult to read!

In chapters 4, 5 and 6, I will work towards making a case for introducing a new incentive to general practice contracts to reward those doctors who spend more time with patients, and provide greater continuity of care. To get that into place could take another ten years - but perhaps the experiences of the past will help achieve quicker success in the future!

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CHAPTER 4

Quality of care I - 1982-1997

This chapter and the next describe and discuss the development of a series of researches attempting to identify the determinants of quality of care at general practice consultations, and how to achieve its delivery. To achieve these aims, we have developed survey instruments and methods suitable for multi-doctor and multi-practice researches. We have chosen a definition of 'quality', and tried to find a way to describe and classify doctors and how they work, and patients and their needs and expectations. We have had to become adept at handling large and complex data sets. Perhaps most critically, we have had to learn how to interpret descriptive data responsibly guarding against the temptation to attribute causality to associations even if it is the process by which hypotheses for subsequent studies are developed. And finally, we have had the opportunity to reflect on how the work derives from, confirms or helps to inform a theory of what drives effective and efficient consulting behaviour.

Over the period from 1982, we have been involved in four periods of data collection. The first was funded by a single grant, the second by two linked grants, the third by a single grant which was first extended, and then complemented by a separate grant to allow secondary analyses of an incompletely used data-set. The most recent (and still current) and most ambitious project has been made possible by funding from four different NHS sources. The completed projects have been the basis of 17 scientific articles in peer-reviewed journals, three chapters in books, one major non-refereed research report and an RCGP Occasional Paper. The current work is at the stage where further publications can be anticipated. How does this series of projects hang together? At what stage could or should the weight of descriptive and circumstantial evidence become the basis of health policy or contract changes?

For narrative purposes, this chapter covers the work we completed up to 1997, and the next chapter our current work from 1997 onwards. Inevitably, in trying to trace a complicated story over a period of nearly two decades, the story may once

again seem more tidy and more logical than was apparent at the time, but I will try to be as true to history as I can be.

BRIDGING

We left the two 1970 respiratory data sets in chapter 2 and it is time to revisit them. The graph of prescribing variation (fig. 2.1) was, of course, ripe for further exploration. Using the diagnostic labels the doctors had attached to their consultations helped in two ways. It confirmed that labelling is an unsafe way for making significant analytical progress (terms such as tonsillitis and pharyngitis are clearly interchangeable between doctors; some doctors label up to a quarter of URTIs as 'tracheitis', but others rarely use the term). It also showed that in general there is more consensus about some things than others. URTIs, for example, are more often not treated with antibiotics than treated; bronchitis is usually treated; and the treatment of sore throat then as now was effectively an antibiotic lottery. Two consensus positions had interesting 'tails'. A significant minority of doctors treated tonsillitis with tetracycline, and a similar group also treated URTIs in children with tetracycline. Even then both policies were contrary to 'best-evidence'.¹² Over the next two years I marketed consensus evidence from the North East workload study along with the RCT evidence from my Glasgow study (which clearly showed no advantage to antibiotic over placebo in routine URTI) on what would now be regarded as an 'academic detailing' tour of North-East Scotland. Two years later (admittedly based on small numbers) the consensus messages appeared to have been effective, but the RCT message had been as ineffective then as it remains a quarter of a century later. The other interesting features of examining figure 2.1 further were that the doctors who reported the highest prevalence of consultations for RTI were the highest antibiotic prescribers (despite relatively higher proportions of minor as against major illnesses), and second, that doctors' positions on the graph remained similar when a second similar exercise was carried out two years later.³

It was, in summary, apparent that doctors who were well respected by their peers and popular with their patients varied widely in how they prescribed antibiotics; that their prescribing patterns were influenced by the wish to reflect consensus; and that good

RCT evidence was surprisingly ineffective. Much more explanatory work was necessary first to understand variation better and second to identify which components of variation were attributable to inherent properties of the medicine of general practice. Then it might be possible to decide whether variation was in fact the problem it had originally seemed, and which components should be accepted and which targeted for reduction.

A further study confirmed the extent to which doctors' prescribing patterns for organic illness (extrapolating from the management of sore throat which was used as the exemplar) were influenced by the social circumstances of their patients and the contextual circumstances of their consultations.⁴ Another study tested the hypothesis that the children who receive most antibiotics for RTIs belong to mothers who receive most psychotropic drugs. Perhaps not surprisingly, this proved the case. In a single-practice study involving 50 families, children received most antibiotics between 4 and 6 years, and the mothers received most psychotropics when their children were younger and then again when they were older.⁵ Clearly decisions to prescribe - widely seen as a proxy for quality of care — are far too complex to reduce to simple equations.

Apparent differences between doctors in how they make clinical decisions could clearly reflect differences in the bio-psychosocial mix of their patients, or how the differences in beliefs and expectations of doctors and patients draw them together or keep them apart. But what about differences within individual doctors? Any general practitioner knows he has good and bad days, good and bad surgeries and good and bad consultations. If 'goodness' is hard to quantify absolutely, it is possibly easier to define relatively. Starting with a 'within-doctors' study might be easier than carrying out a 'between doctors' study. What might be the determinants of 'goodness', or perhaps more easily of 'non-goodness'? My own experience told me that when I was stressed, I practised 'first complaint' medicine, prescribed for everyone, and took quick control of the consultation agenda. What made me stressed? - running late, difficult patients, knowing a problem visit was pending, feeling ill, having unresolved personal conflicts to patch up, being tired, coming up to a night on call

In 1979, a year before leaving Aberdeen for Edinburgh, I

contemplated phoning doctors to ask them to answer questions about simulated consultations at a time of their choice, and then repeating the exercise (unannounced) a quarter-of-an-hour before they were due to start an evening surgery, and comparing the results. But wiser counsel prevailed, and I put the idea of a stress-study on the reserve list. Studying the relationship between respiratory illness consultations and antibiotic use had now moved on from being a primary cause in its own right, to becoming a substrate through which to study quality of care more generally. The doctor-patient-illness triangle in the conceptual framework (fig. 2.2) was in place. My theory was that, in the generality of general practice consultations, the balance between patient factors and illness factors in determining how clinical decisions are made is quantitatively so different between general practice and hospital practice, that a claim can be made for defining patient-centredness as a qualitative marker for the discipline of general practice — the 'philosophy' of Ian Richardson's definition of a clinical discipline.

GENERAL RESEARCH STRATEGY

The four main projects which are discussed in the next two chapters have developed the survey strategy used successfully in a variety of multi-doctor studies in this country and abroad over more than three decades. These studies, including four national UK morbidity studies and three major regional studies of workload and morbidity,^{6,2} have relied on volunteer groups of doctors collecting limited information on samples of their work selected to be of sufficient size to capture the essential diversity of general practice, but not demanding so much input that the nature of the job being described was distorted by the research, or the quality of the data being recorded was compromised by participant fatigue.

Most workload and morbidity studies have centred on a diagnostic statement by the doctor, with information like age and sex, surgery consultation or home visit, new or return visit as added descriptive data, and information on clinical decisions taken (prescribing, referral, to return or not) following. Analyses have concentrated on summarising workload and/or morbidity, but in general the weakness of the diagnostic data has made it difficult to link morbidity with clinical process in any strongly convincing

way. Additionally, in the absence of any outcome data, this method has had limited ability to contribute to the 'quality' debate, even although analyses of links between content (morbidity) and process (often dignified as 'outcome') have helped clarify issues needing to be explored further.

THE EARLIER RESEARCHES

When Mike Porter and myself submitted our first research proposal to the Scottish Office in June 1981, we planned to link workload and morbidity to process of care (as a measure of quality) adding linked data on feelings of stress and reasons for them as experienced by doctors. We had two hypotheses. The first was that the activity of doctors could only be evaluated in a study that linked actions with the context in which they were taken and that we had thus to add (for example) telephone consultations, interruptions, lateness in the running of surgeries, and commitments outside general medical services, to the more conventional load of surgery consultations and home visits. We hypothesised that stress and this wider vision of load were intimately linked. The second hypothesis was that stress was harmful to the quality of care provided and that this would be reflected in shorter consultations, more prescriptions, more referrals and lower recognition of patient problems of a non-physical type. The researches we have pursued since have stayed remarkably true to these original intentions.

The history of the early evolution of this planned work has been described elsewhere. Originally the Scottish Office didn't support our stress-research proposal variously saying that stress wasn't a good theme to research, that we didn't have the ability to do the work and that general practitioners were unlikely to take part in such a study - all views which have proved to be wrong. Eventually we were funded to explore whether stress could be quantified. Subsequently, having shown it could be, we were again not supported in our re-developed proposal to incorporate 'stress' into a modelling of quality, but as I described in Chapter 1, we did gain joint funding from CSO and NPHT to explore 'queuing and the use of time' in relation to quality of care. With the permission of the CSO we put the 'stress' element back into our study, but had to fund the operational on-costs of doing this from an endowment.

At the time this work was concluding, our Department was commissioned to evaluate the process of introducing fund-holding to a group of practices in North-East Scotland. This gave us valuable opportunity to develop our quality instruments one stage further and to see if they could detect change (assuming there was change to detect) in a series of cross-sectional studies over time.¹³¹⁸

It appeared that our methods did have the ability to measure change, and we next undertook a separately funded secondary analysis of our fund-holding data culminating in the publication of Occasional Paper 75 in the RCGP series of short monographs.¹⁹ This concluded with an agenda for a further project aiming to test the generalisability of our work - again including some further developments - beyond the Scottish context, and this is the work that is presently on-going and is described in Chapter 5.

The background references to these various projects are contained in the specific publications and reports on the various projects. In the remainder of this section describing our early work on quality, I have taken a series of snap-shots of some of the main features of our work on stress and the use of time at consultations ending with a short section summarising where we had reached when we started our fund-holding evaluation.

3 DAYS

Mike Porter reviewed the then available literature on occupational stress, drawing particularly on work on air-line pilots and cardiac surgeons, and constructed the diagram shown as figure 4.1 as a theoretical model for our project. (This model has since been upgraded by adding a feed-back loop from 'behaviour change' back to influences on the general practitioner).

A number of key words have appeared regularly in the general-practice stress literature since then (recently reviewed in the second edition of Payne & Firth-Cozens' book on Stress in the Health Professionals)²⁰²¹ and those include clinical and administrative workload, responsibility, emotional challenge, anxiety about making mistakes, and problems with relationships - both professional and personal. I have found three further terms particularly useful, namely role conflict (where the task being undertaken is not one the doctor

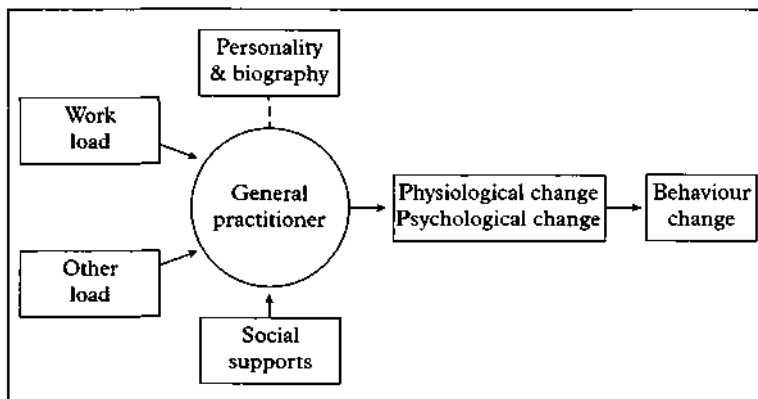


Figure 4.1. A simplified model for effects of stress on a general practitioner.

Source: ref 23. Family Practice 1985; 2: 136-146 (figure 1)

believes in or would have chosen to give priority to, or is being carried out sub-optimally due to other pressures) role ambiguity (where the doctor is not clear what his role is or should be) and job-decision latitude²² (where the doctor has or has not a high degree of self-determination in determining the scope of his job and the use of his time).

From our pilot study of stress and how to measure it (which involved 18 general practitioners in three practices recording information on 52 working days),²³ and the later definitive study in which 85 doctors recorded data on a total of 1646 working days, we collected a large volume of diary data on doctors' planned commitments and how these mapped to actual work done, on their perceptions of their own levels of stress as their days progressed, and on the clinical decisions they took.²⁴

A central part of developing our methods involved collecting half-hourly self-measurements of stress on a seven-point Likert scale, and we tested these against a gold-standard measure (Cox & Mackay's 'mood adjective check list')²⁵ before and after surgery sessions during our first pilot study. The diary card (which folded into sections) is shown in figure 4.2, and initially used descriptors of 'bored' to 'very-pressured' to describe the doctor's feelings. In due course we altered these adjectives to run from 'relaxed' to 'tense' and we found that, using these adjectives, scores of 5,6,7 correlated

Department of General Practice
University of Edinburgh
(031-667 3805)

DIARY CARD

Doctor: _____
Practice: _____
Date: _____

Were you personally on call last night?
YES/NO _____

No. of telephone calls received _____
How many of these were between
11.00 p.m. and 7.00 a.m.? _____

No. of times you were out _____
How many of these were between
11.00 p.m. and 7.00 a.m.? _____

Are you personally on call tonight?
YES/NO _____

Time _____

ANTICIPATED COMMITMENTS
(To receive 20 minutes)

NEW/CHANGED COMMITMENTS
(Reasons for change in pressure)

What are your feelings of
pressure just now?
(refused tense)

Figure 4.2. Daily diary card.

Source: Porter AMD, Howie JGR, Forbes JF. Stress in General Medical Practitioners of the United Kingdom. In Stress and Tension Control 3. Stress Management (eds McGuigan, Sime, Wallace). Plenum Press, London 1989 (figure 1 p107).

8.00 -	0-1-2-3-4-5-6	8.00 -	0-1-2-3-4-5-6	8.00 -	0-1-2-3-4-5-6
9.00 -	0-1-2-3-4-5-6	9.00 -	0-1-2-3-4-5-6	9.00 -	0-1-2-3-4-5-6
10.00 -	0-1-2-3-4-5-6	10.00 -	0-1-2-3-4-5-6	10.00 -	0-1-2-3-4-5-6
11.00 -	0-1-2-3-4-5-6	11.00 -	0-1-2-3-4-5-6	11.00 -	0-1-2-3-4-5-6
12.00 -	0-1-2-3-4-5-6	12.00 -	0-1-2-3-4-5-6	12.00 -	0-1-2-3-4-5-6
1.0pm -	0-1-2-3-4-5-6	1.0pm -	0-1-2-3-4-5-6	1.0pm -	0-1-2-3-4-5-6
2.00 -	0-1-2-3-4-5-6	2.00 -	0-1-2-3-4-5-6	2.00 -	0-1-2-3-4-5-6
3.00 -	0-1-2-3-4-5-6	3.00 -	0-1-2-3-4-5-6	3.00 -	0-1-2-3-4-5-6
4.00 -	0-1-2-3-4-5-6	4.00 -	0-1-2-3-4-5-6	4.00 -	0-1-2-3-4-5-6
5.00 -	0-1-2-3-4-5-6	5.00 -	0-1-2-3-4-5-6	5.00 -	0-1-2-3-4-5-6
6.00 -	0-1-2-3-4-5-6	6.00 -	0-1-2-3-4-5-6	6.00 -	0-1-2-3-4-5-6
7.00 -	0-1-2-3-4-5-6	7.00 -	0-1-2-3-4-5-6	7.00 -	0-1-2-3-4-5-6
8.00 -	0-1-2-3-4-5-6	8.00 -	0-1-2-3-4-5-6	8.00 -	0-1-2-3-4-5-6

Figure 4.3. Three days: recording of three doctors' stress diaries.
 Source: Howie J G R Quality of caring - landscapes & curtains. JRCGP
 1987; 37: 4-10 (figure 4).

with the 'stress' dimension on the mood adjective check list at a highly significant level ($r = 0.9$). These scores did not correlate with the check list's other dimension - 'arousal'.

Three examples of what we found when we looked at a 'doctor's day' are shown in figure 4.3. The one on the left represents an average working day with a rise of self reported stress in the afternoon compared with the morning and a peak in the middle of the evening surgery. The recording on the right shows a quiet morning with pleasant anticipation of a half-day thrown into disarray by a late-morning emergency call requiring arrangements to be made over lunch for admission to hospital. The fact that a hard (unchangeable) social commitment at two o'clock (could it have been a round of golf?) reduced flexibility may itself have caused stress, but the ability to cope with the problem may also have been reduced by the doctor having been 'on-call' the previous night. The middle scenario could generate many explanations. On one occasion a permanently stressed doctor admitted to taking his children to school for a 9.10 drop-off every day, thus arriving at work at 9.20 each morning to start his 5-minute-interval 9.00 surgery! Little

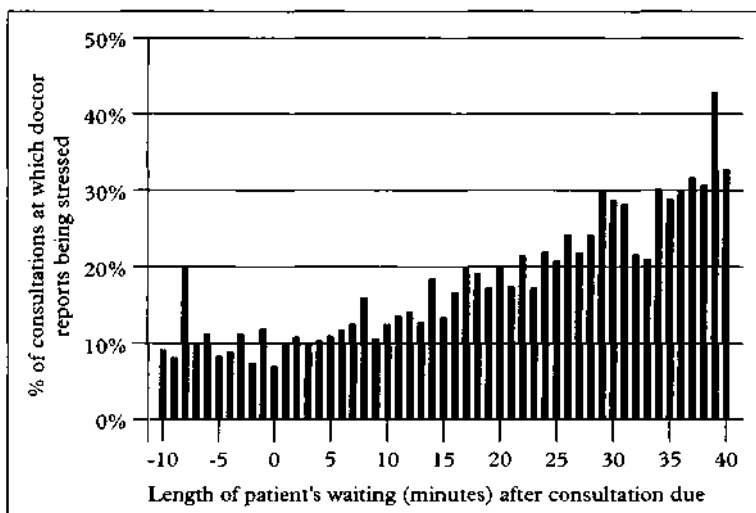


Figure 4.4. Rising stress levels of doctors as patients length of waiting for their consultations increases.

Source: ref 26. Occasional Paper 61 RCGP. Chapter 4; figure 6 - page 26.

wonder his days started badly, got worse and had led to his permanent dislike of his job and to significant psychological unwellness.

Summarising this body of work, we found that some 10 per cent of all recordings were at the level indicating 'stress' (equivalent either to an hour a day, or to a day a week), but these scores were unevenly distributed. Some doctors never recorded morning stress; others never recorded afternoon stress. Doctors with part-time commitments (and this included male as well as female doctors) were more stressed than those who worked full-time. Practice meetings were stressful, and for many doctors there were higher levels of stress the afternoon before being on call and also the morning after. Particularly significantly, stress levels rose progressively the later a surgery was running (figure 4.4).²⁶

How do these observations link with quality of care? This proved far from the straightforward association we had hoped to find and I will return to this shortly.

3 SURGERIES

We collected information on 1948 surgery sessions during our 1987-8 study of time, queuing and quality, and during our pilot studies we experimented with a number of different ways of

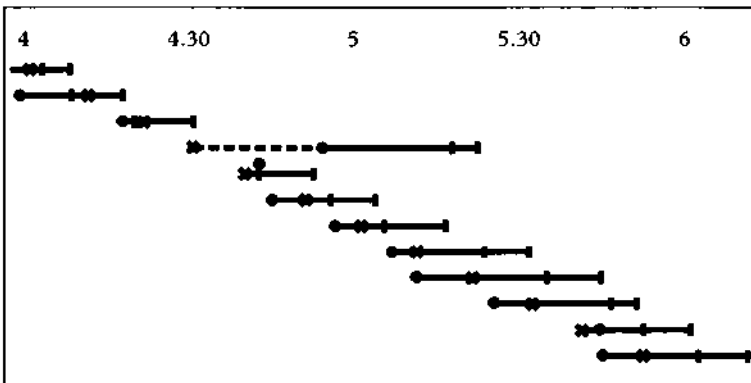


Figure 4.5. A well-organised evening surgery.

Source: Howie J G R Quality of caring - landscapes & curtains.
RCGP 1987; 37: 4-10 (figure 5)

portraying the flow of patients over single sessions. We marked waiting time and face-to-face consulting time on a grid with the due time of the appointment shown with a cross and the start and end of consultations marked with vertical lines. Figure 4.5 shows a thoroughly well-ordered afternoon surgery running from 4.00 until 6.00 with appointments booked at 10-minute intervals. The fourth patient is late and the doctor has 8 minutes unoccupied, and the fifth patient gets in to see the doctor promptly. The late-arriving fourth patient gets a five-minute consultation between patients seven and eight and all patients from eight onwards wait at least that amount later for their consultations than they would have otherwise. The surgery finished at 6.10.

Figure 4.6 shows a different doctor doing a morning surgery without appointments. It was planned to last from 9.00 until 10.00, and most patients had arrived by 9.30. Those arriving later in the queue had long waits, and the four patients who arrived as the surgery was due to finish fared just about as badly. In the end the doctor saw fourteen patients and finished about 10.45; a booked surgery would have lasted virtually the same time, and the cost to patients of waiting would have been much less. Patient satisfaction falls steadily after waiting more than 15 minutes beyond their due

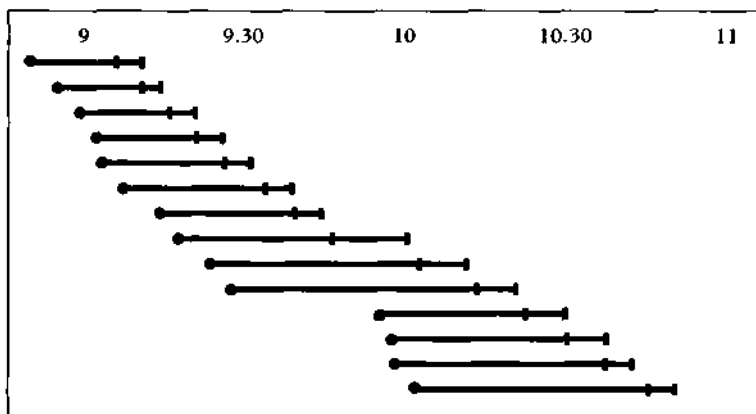


Figure 4.6. A morning surgery; open access.

Source: Howie J G R. Quality of caring - landscapes and curtains.

JRCGP 1987; 37: 4-10 (figure 5).

time in booked surgeries; we don't unfortunately have that information for open surgeries, but it is reasonable to hypothesise that the same applies.

The third of these surgeries was, however, the one that contributed most significantly to the evolution of this story. As figure 4.7 shows, the doctor starts a little late with a surgery booked for 13 patients and due to finish about 5.45. Patients are booked at two per quarter hour; the doctor has to be home for her children as soon after 6.00 as possible. The surgery starts late and the first three patients take an hour to see. By this time there are seven patients in the waiting room. The atmosphere is tense and patient ten waits as patients seven, eight and nine - who arrived after her - are seen before her, in addition to this being well after her own appointment was due. It is easy to postulate that her longish consultation between 5.40 and 6.00, might have included a large element of placatory listening. By 6.00 the doctor was in significant social and professional disarray. It is hard to see how her last three patients can have felt their consultations had been particularly worth waiting for.

Figure 4.7 must surely hold the key to the story about consultation length, stress and quality. The three are often self-evidently entwined, but how many other variables intervene, and how do they diminish the statistical impact of these associations when the differences are less extreme than in this case? Is the pursuit

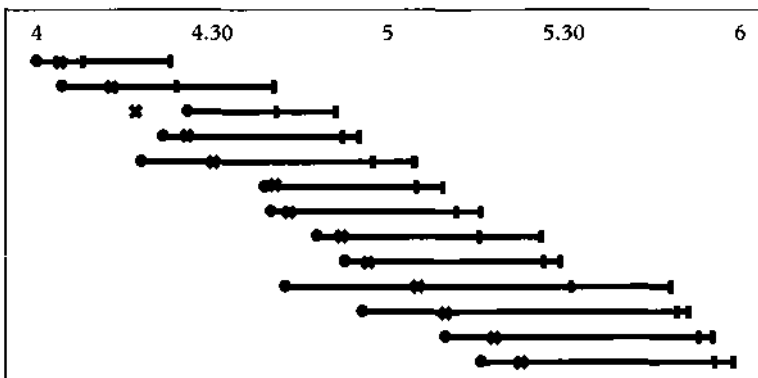


Figure 4.7. An evening surgery with problems.

of causal explanations suitable for the methods of quantitative research - or could the CSO have been correct in suggesting that the whole exercise was too complex?

Whatever the eventual result, this way of laying out the flow of a surgery is itself a useful tool when problems of either patient flow or stress (whether for doctors or receptionists) become persistent. In this case, starting late, fixed later commitments and, above all, a consulting style incompatible with booking patterns come together to create an outcome that was bad for virtually everyone involved over a period of at least the two hours portrayed by the diagram.

TIME; 2 STYLES OF DOCTORING

The major quality study which the previous two sections helped pilot, involved the survey-style approach described above and applied to all consultations carried out on one variable day per fortnight over 12 months of 1986-7 by 85 volunteer Lothian doctors. Information was collected on 21707 consultations. Consultations were timed for face-to-face contact time and note was made of due booking time and the time patients waited in the surgery. At the consultations doctors noted their diagnoses and indicated whether the patient they had just seen had had either a continuing health problem or a relevant psychosocial problem, and if so whether these had been dealt with 'in depth', 'a little' or 'not at all'. A parallel enquiry was made about any health education input to the consultation. Doctors also recorded whether a prescription was issued, and whether the patient was referred or investigated. After the consultation the patient completed a 33-item satisfaction questionnaire. During the latter part of the study, half the doctors asked their patients to complete the Nottingham Health Profile (NHP)²⁷ (a six-dimension health status measure) before their consultations to give an added measure of case-mix.

Figure 4.8 shows the distribution of the mean consultation lengths of the 85 doctors over the complete study. 24 doctors were classified as faster doctors (average face-to-face consultation time of 6.99 minutes or quicker), 21 doctors as slower doctors (average face-to-face consultation time of 9.00 minutes or more) and the remaining 40 doctors as intermediate.

The lengths of all 6858 consultations carried out by the faster doctors are set out in figure 4.9, and those of all 4460 consultations carried out by the slower doctors in figure 4.10. The consultations of the faster doctors were distributed narrowly around their mean with 54 per cent lasting 5 minutes or less and 25 per cent more than 10 minutes. For the slower doctors (who had a much longer tail of longer consultations), the respective figures were 20 and 45 per cent. As judged by the NHP and age and sex distribution of the patients, there were no apparent differences in case-mix to explain these differences.²⁸ In the next section, I will argue that quality of care in longer consultations is better than it is in shorter consultations. Faster and slower doctors differ in the number and proportion of longer and shorter consultations they have; it is hard not to conclude that this will represent a difference in the overall quality of care they provide.

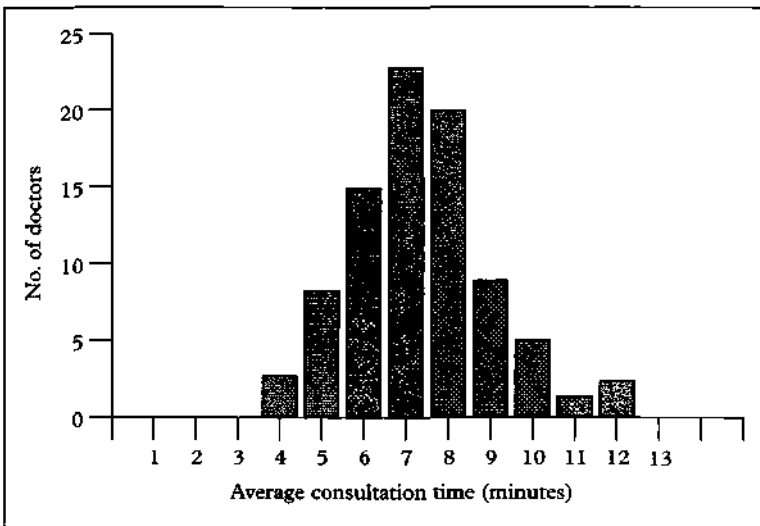


Figure 4.8. Mean consultation lengths of 85 doctors.

Source: Porter AMD, Howie J G R, Forbes JF. Stress in General Medical Practitioners of the United Kingdom. In *Stress and Tension Control 3. Stress Management* (eds McGuigan, Sime, Wallace). Plenum Press, London 1989 (figure 2 p109).

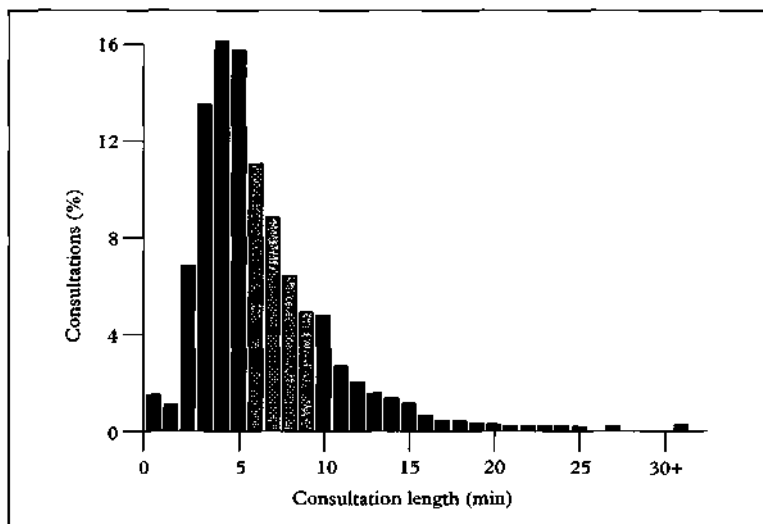


Figure 4.9. Distribution of consultation lengths of all patients seen by 24 doctors classified as 'faster'.

Source: ref 28. BJGP (1991); 41: 48-54 (figure 1a)

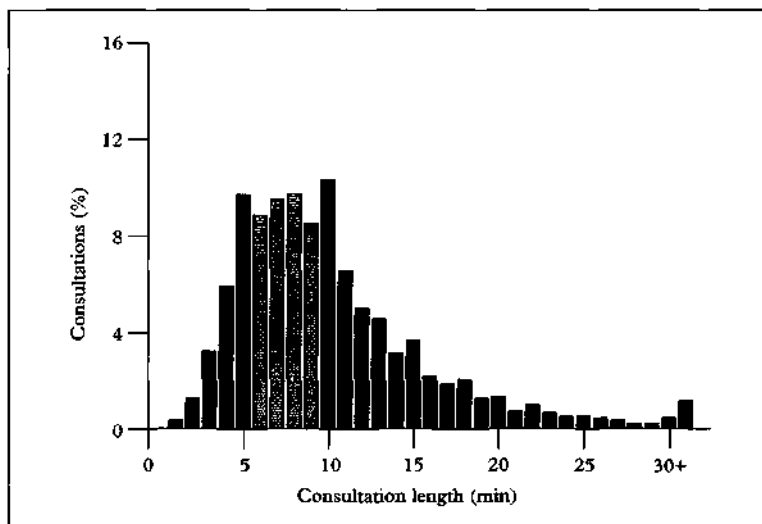


Figure 4.10. Distribution of consultation lengths of all patients seen by 21 doctors classified as 'slower'.

Source: ref 28. BJGP (1991); 41: 48-54 (figure 1b).

LONG OR SHORT CONSULTATIONS

Short consultations (5.99 minutes or less), medium consultations (6.00 - 9.99 minutes) and long consultations (10.00 minutes or more) were compared for faster, intermediate and slower consulting doctors on five quality measures: the proportion of relevant long-term health problems addressed out of all relevant long-term health problems recognised; the proportion of relevant psychosocial health problems addressed out of all relevant psychosocial problems recognised; the proportion of consultations where preventive care was carried out; the prescribing of antibiotics to patients with new consultations for respiratory illnesses and patient satisfaction with the consultation.

Figure 4.11 shows that, using the criteria of quality defined above, long consultations are better than short consultations (whether carried out by faster, intermediate or slower doctors) for the care of long term health problems. Figure 4.12 shows the same trend for psychosocial problems. There is a similar but less dramatic advantage for preventive care. Patients presenting with new respiratory illnesses were more likely to have relevant psychosocial problems dealt with 'in depth' by slower doctors than by faster doctors (20 per cent against 11 per cent; $p = 0.09$). When relevant psychosocial problems were recognised and were dealt with, an antibiotic was much less likely to be prescribed than when if they were not dealt with (45 v 54 per cent; $p < 0.01$).²⁹ In 17 of the 33 items in the satisfaction questionnaire, there was an advantage for longer as against shorter consultations.

ATTITUDES

We were aware that being a fast or a slow doctor was often a consequence of being in a partnership that had traditionally adopted such a style of working. Equally, we knew that some doctors were more discomforted by such a position than were others, and of these, the more determined had broken away and chosen to consult with a slower rate of booking. In the 1980s many practices had accommodated this growing trend by moving from booking 12 patients per hour to booking 8 patients per hour, essentially a compromise that it was hoped would keep both faster and slower consultants reasonably happy. We believed that

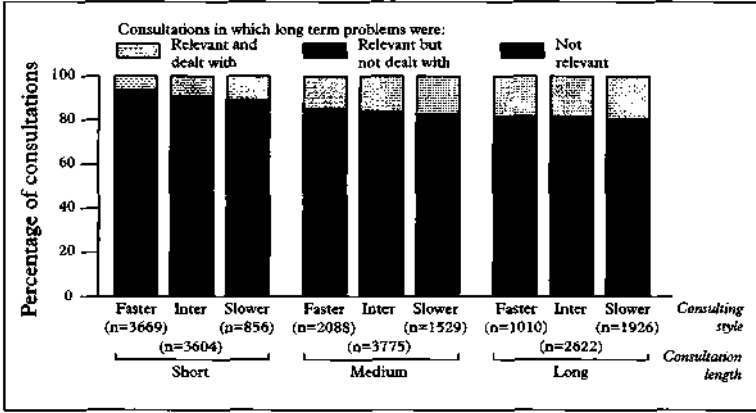


Figure 4.11. The proportions of long-term health problems recognised as relevant and dealt with or not dealt with at short, medium and long consultations carried out by faster, intermediate and slower doctors.

Source: ref 28. BJGP (1991); 41: 48-54 (figure 2).

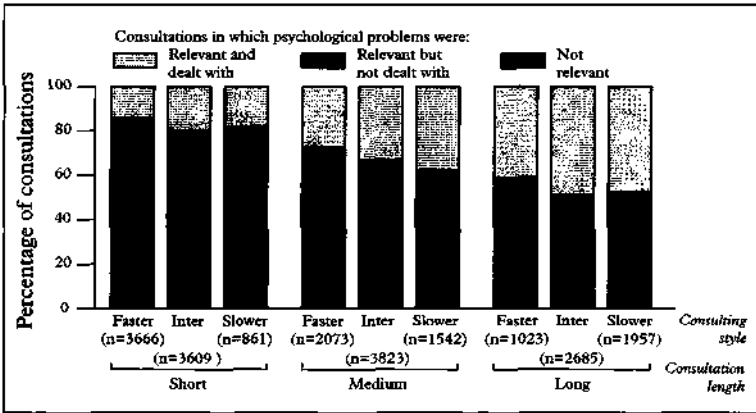


Figure 4.12. The proportions of psychosocial problems recognised as relevant and dealt with or not dealt with at short, medium and long consultations carried out by faster, intermediate and slower doctors.

Source: ref 28. BJGP (1991); 41: 48-54 (figure 3).

somewhere in the consultation booking times and in the consultation seeing times which doctors worked with, might lie an implicit statement about doctors' values and their attitudes to patient care.

We were attracted to Jill Cockburn's then new instrument for measuring doctors' attitudes to patient care and asked our volunteer doctors to complete it.³⁰ Scores on three of its six scales (a seventh scale was particular to Australian practice) correlated with aspects of quality we had identified from the principal analyses of our main study data. We then ranked our doctors on the basis of their scores for each of these three measures. Doctors scoring in the top quartile for two or more of these categories were categorised as 'higher' for what we then summarised as reflecting 'patient centredness'; doctors who scored in the top quartile on one measure were classed as 'intermediate', and those not scoring in the top quartile on any of the three measures as 'lower' for patient-centredness.

Higher - as against lower - patient centredness was weakly associated with being more likely to book fewer patients per surgery and to book at six patients per hour rather than at a faster rate. Mean consultation length was also slightly slower (8.4 minutes per patient) as against 7.5 minutes per patient). Of the more highly patient-centred doctors, 35 per cent were 'slower' doctors and 15 per cent were 'faster' doctors, as against 21 and 36 per cent respectively for the less patient-centred doctors. Because of the way patient-centredness had been defined, it was inevitable that in this study it was associated with 'better' care in terms of recognising the wider dimensions of consulting needs of patients. The association with longer consultations was, however, not related to the methods used to define patient-centredness and appeared likely to be real even if not particularly strong. The strongest correlation we found was, however, between patient-centredness and higher levels of reported stress at consultations, and this persisted whether consultations were labelled with the stress score which immediately preceded them (our preferred approach) or with the stress score which followed them. Higher patient centredness was associated with stress at 27 per cent of consultations as against the 11 per cent reported by lower patient-centred doctors.

When we attempted to tease out these figures further we found that the excess stress was almost entirely to be found in doctors with booking rates of eight or more patients per hour and that in a sub-set of three doctors who, in addition to booking at that rate, happened to be in the 'slower' consulting style group, that figure rose to 62 per cent of consultations. When these three highly stressed but highly patient-centred doctors were compared against the four un-stressed but also highly patient-centred doctors who were their most closely matched controls, they apparently differed only in terms of whether they booked their patients at a rate compatible with their ability to see them. In this small sample, the stressed doctors prescribed at 58 per cent of their consultations as against the 42 per cent figure reported by their 'un-stressed' controls.³¹

COMMENTARY

If the process measures of quality we have identified (more attention to recognised and relevant continuing health problems, more attention to recognised and relevant psychosocial problems, and greater input to health promotion) are accepted as valid, then it seems clear that

- longer consultations as a group are preferable to shorter consultations as a group; and
- that some doctors provide more longer consultations and fewer shorter consultations than others.

It seems reasonable to conclude that doctors who take more time to consult provide a better service overall than those who take less time.

However, having made these apparently safe general overall statements, there are some important caveats to be added.

- although case-mix did not seem an explanatory variable for variation in doctors' consulting styles, the NHP may have been an insufficiently sensitive instrument of this, and it was only used with a sub-set of doctors and for a part of the study
- our only 'outcome' (as against process) measure was satisfaction, itself a rather restricted concept. While satisfaction was better for longer as against shorter consultations, there

was no evidence that slower doctors generated higher levels of satisfaction overall than did faster doctors. This could, however, have been because slower doctors were more likely to run late - a significant cause of dissatisfaction in itself.

- we had no way of commenting on the relationship between effectiveness of consultations and the efficiency of doctors
- although 'time' and 'quality' appear related, we have not proposed an explanatory mechanism to link them, and other key variables may be being overlooked.

Our original hypothesis was that there was a link between stress and quality of care. What we had found was both interesting and credible, but far less straightforward than we had hoped. Being a fast doctor and arguably providing lower quality consultations was not particularly stressful. On the other hand, being a slower doctor and providing better quality consultations was often more stressful. However, it made sense when we found that stress was concentrated in surgeries where booking times and preferred consulting strategies were incompatible and doctors ran significantly behind time.

One further set of analyses which I have not yet referred to helps bring this set of observations to a clearer conclusion. David Heaney looked at the effect of the number of patients seen during a surgery session and of the patients' order of being seen in the surgery list (or queue) on consultation length and waiting times. The later the patient's place in the queue the longer they waited (itself a cause of dissatisfaction) and the shorter the consultation became. This effect was most marked for slower doctors³². Now a theoretically based explanation becomes available. Role conflict, already identified as a cause of work stress, comes into play when a doctor has to change style to catch up, and again the single surgery shown in figure 4.7 is the perfect example. Perhaps stress may as often be the result of knowingly giving poor care as it is the cause of it. The determinants of both alternatives have to be addressed.

Finally, our work on doctors' orientation or attitude to their work suggested that being more as against less patient-centred was most associated with stress when surgeries were inappropriately booked. In parallel to this there was the trend for higher patient centredness to be linked to slower rather faster

doctors and for it thus to be potentially associated with higher quality. However, our sample of doctors was a volunteer sample (initially recruited because of their interest in participating in our study of stress) and thus possibly atypical, and the way we had defined our categories of patient centredness was somewhat contrived. Attempts to link higher patient-centredness with higher quality on the basis of the work so far could thus only be, at best, tentative.

The work needed developed and tested on a different sample of doctors.

THE LATER RESEARCHES

Every research team needs its stroke of good fortune. Ours came in the unlikely form of the 1990 NHS Reforms. Michael Forsyth, who then held the Health portfolio in the Scottish Office, had persuaded six groups of North-east Scotland general practitioners to become the first fund-holders in the new world of the internal market. The price to him was agreeing to commission an independent external evaluation, and his problem had been finding an evaluator acceptable to both sides. I was invited to the Scottish Office in the week between Christmas and New Year of 1989 and asked to prepare a tender for a series of relevant researches against an undisclosed budget. The time scale for negotiating appropriate methods with six groups of doctors in a different part of Scotland from ourselves, two health boards, the Minister's representatives (and indeed the Minister himself), and the Chief Scientist (who was to have our proposals peer-reviewed and to manage - although probably not produce - the funding) was four weeks. That would be the end of January; we would then have eight weeks to develop and pilot our instruments; the fund-holding experiment was due to begin on April 1st. There was the added imponderable of the introduction of the 'New (1990) Contract' on the same starting date. And 'no', a description of the processes of introducing fund-holding was what the Minister favoured and there wasn't money available to contemplate recruiting control practices.

Both the opportunity and challenge were too good to miss. We designed a series of linked studies. One looked at changes in the volume and cost per unit of volume of drugs prescribed in the

first year of fund-holding. For this we developed the defined daily dosage (DDD) methodology then recently piloted by WHO (and still greatly under-developed in our NHS!), and for this component only we did negotiate access to a series of control practices.¹⁴ There was a study of hospital referral and related activities, which confirmed how difficult it is to get stable data on this sphere of activity at practice level, even on the basis of all relevant data being available for a year at a time.¹⁵ We designed a semi-qualitative diary card study to capture the perceived benefits and costs of being a pilot fund-holder, and supplemented this with interviews of key stake-holders over the three-year period the project ran. For a variety of reasons (some no doubt political, but others simply reflecting the absence of data at the time) we were unable to attach monetary costs to the administration of fund-holding or to comment on how unspent budget savings were used.^{13 18}

Because of our developing interest in measuring quality of care, we wanted to include a study of process and outcome at consultations for a representative series of marker conditions, and to use our consultation length proxy measure as at least one quality indicator. This element would, of course, involve the test practices in a series (three) of two-week periods of data collection, and raised the possibility that the conclusions reached might be critical of the way the doctors were working. For the first time we were looking forward to working with a whole population of doctors (even if not necessarily a nationally representative one), and their initial management allowances had been negotiated to include co-operation with any reasonable requests for data asked by us as part of our evaluation. Not surprisingly, not all the partners in the practices were as keen either on fund-holding or on taking part in research as were the lead doctors or ourselves, and questions were raised about whether our 'quality' ideas should be included in the evaluation. A meeting with the Minister allowed this issue to be explored further. The Minister, sharp and courteous, needed to be persuaded that equating more time at consultations with quality was not simply a recipe for inefficiency. Was the purpose of good practice not simply to diagnose and treat presenting symptoms with minimum distraction and to get the right patients to hospital as quickly as possible? Would we be suggesting fifteen-minute appointments next if it was conceded

now that ten-minute appointments were better than five-minute ones? But 'yes', he himself allocated ten-minutes per constituent at his own 'surgeries' because it was unrealistic to expect to achieve anything useful in less! He agreed that the quality component of our proposals was compatible with the evaluation!

We were anxious to add a tranche of pre-1st of April 1990 data collection to try to comment on the before-and-after effects of the New Contract which was due to start on that date, but our funders declined to support this. We did, however, at our own expense, collect two weeks of limited survey data during March to get a feel for working with practices at some distance (up to 200 miles) from our base, and from this we were able at least to confirm that the pattern of consultation lengths of our fund-holding sample of doctors was similar to that of our volunteer sample of Lothian doctors, and that more time again correlated with undertaking a more holistic range of activities at consultations. Almost certainly, our group of fund-holding doctors were already doing most of what was being introduced in the New Contract.

The reports on the various elements of the fund-holding researches are available elsewhere, and the main ones have been referenced earlier in this Chapter. Several general issues were or are relevant to the themes this monograph explores and these are taken up here.

A CASE-MIX MEASURE

Throughout our 'queuing and stress' studies, we had given doctors space to record up to four diagnoses for all patients consulting. As in all such studies, the vast majority of doctors had noted only one diagnosis per consultation, and often the labels attached were (no doubt appropriately) symptomatic to the level of being uninformative. The doctors' writing, in addition, was often hard to read and the process of coding and entering data represented a lot of work for the return gained. Towards the end of our early studies we had added the Nottingham Health Profile (NHP) as a pre-consultation 'health needs' measure, and this proved manageable for patients and much easier for us to use and interpret. When we started to plan the data collection for the quality-at-consultations element of the fund-holding study, we

decided to continue to use the NHP and to add two further pre-consultation components.

First we knew we wanted to focus later analyses on a series of marker conditions, chosen to reflect a mix of acute and continuing health problems, and symptomatic as well as more definitive diagnostic labels. We were anxious to have patients' rather than doctors' perspectives of what consultants' problems were, and were aware that we needed to try to recognise which problems patients wanted to discuss out of those they said they had. We added a list of appropriate questions about these marker conditions below those related to the NHP. In addition we wanted to be able to identify disadvantaged patients and added a list of social questions derived from previous similar survey work³³ to complete the questionnaire. We also asked patients to indicate if they wanted to discuss any of the social problems they said they had.

We now had access to patient-derived data on a selection of medical, psychological and social needs. Patients did require two to three minutes to complete our instrument, but generally had that time available before their consultations. We excluded children. Some groups did have difficulty completing our form - particularly the elderly (especially if handicapped visually) and the educationally or mentally less able, and mothers with a handful of small children. Overall around 70 per cent of eligible patients provided enough information to be useful.

In between the first and second of our three two-week consultation surveys, we noted that having a marker condition strongly predicted a positive response to one or other of the two 'medical' NHP dimensions (pain and mobility) and that having a social problem strongly predicted a positive response to one or more of the four social/psychological dimensions. We did not, however, have a single specific measure of mental well-being. At this stage we thus decided to drop our use of the NHP and to include the General Health Questionnaire (GHQ) instead. This instrument identifies 'potential psychiatric caseness' in the community and we chose to use the 12-item version taking a positive cut-off score at 5 or above as indicating a possible psychological health need. (A copy of this instrument is included in Occasional Paper 75 which is already referred to earlier in this Chapter.)¹⁹

DEVELOPING AN OUTCOME MEASURE

Seventeen of the 33 'satisfaction' questions we had derived from our earlier literature review, from interviews with patient representatives and groups of disabled people, and from work in a student project,³⁴ had shown significant differences between long and short consultations.²⁸ We were particularly interested in a group of six of these which were united by the theory that adjustment and coping are important modifiers of outcome and that 'what is important in predicting outcome is how the respondent actually feels and perceives life'.³⁵ We conceptualised that positive responses to these six questions (shown below in figure 4.13 in the form we are now using them after further modification as described in chapter 5) represented 'enablement'.

We added five complementary questions to this set (including two of the others which had previously been found to be scored

As a result of your visit to the doctor today, do you feel you are:	MUCH BETTER	BETTER	SAME OR LESS	NOT APPLICABLE
able to cope with life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
able to understand your illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
able to cope with your illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
able to keep yourself healthy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	MUCH MORE	MORE	SAME OR LESS	NOT APPLICABLE
confident about your health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
able to help yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Figure 4.13. The 'enablement' outcome questionnaire in its 1999 format.

Source: ref 12 of chapter 5. Family Practice (1998); 15: 165-161 (addendum)

more highly for longer than for shorter consultations, and one which had not been) and added a series of fund-holding-specific questions about satisfaction with the doctors' decisions about prescribing, investigating and referral. I will discuss later in this chapter and in chapter 5 why, at least for the time being, we have continued to use this particular group of questions as our main general outcome measure and to regard 'enablement' as related to satisfaction but as different from and extending that rather narrower concept.

THE FUND-HOLDING STUDY

The fund-holding study proved a most interesting academic experience. It was 'action research' in the true sense that we had constantly to adapt to the changing situation as fund-holding developed quickly in north-east Scotland. Our six pilot or 'shadow' practices all went 'live' early in our evaluation, as did the practices we had identified as 'controls' for our prescribing analyses. We faced delays in receiving much of the NHS prescribing and hospital activity data we had been promised and depended on, and some was - at least initially - less complete and easily handled than we had hoped. The practices and NHS managers worked comfortably with us, even if the managers proved reluctant to complete our diary cards on the costs and benefits they perceived.

The three periods of two-weeks of consultation data-collection ran remarkably smoothly. They centred round consulting patients being asked to complete pre- and post-consultation questionnaires and the doctors completing short purpose-built encounter records. The key information on them included the time the consultation began and finished; we progressively simplified the other information that we requested as the project proceeded. Patient data was linked by a series of 'running' numbers. Samples of the records of patients with our marker conditions were followed up and analysed by a team of practice-based nurses. This confirmed that information in records often correlates poorly with the problems patients say they want to discuss. Some of that gap no doubt relates to the reality that doctors record selectively from what often are diffuse interviews, but it would be difficult not to conclude that, within the setting of current UK general practice

consultation patterns, on many occasions patients' full lists of concerns are less than fully addressed in the time available to them.

We worked with six groups of fund-holders which included ten general practices. Together they looked after some 84,000 patients. Excluding trainees, 56 doctors contributed data to our surveys, 49 being involved in all three data collection periods. These captured information on 12650, 11227 and 11176 consultations in September 1990, September 1991 and March 1992 respectively.

The complete body of work we undertook was brought together in an overview which contained 19 separate conclusions, the majority of which are as applicable now to the reforms of 1999-2000 as they were then to those of 1989-90.¹⁸ However, only the data from the consultation surveys is immediately relevant to this particular part of our quality story.

THE CONSULTATION STUDIES

Categorising case mix was an important preliminary to our analyses. One early categorisation included a simple count of patients reporting social problems. This was central to the interpretation of our whole study, demonstrating a rise in their prevalence in our marker-condition patients from 26 per cent in 1990 to 34 per cent in 1992. This correlated with the economic recession of the period and the sharp increase in unemployment and its parallel problems. We had GHQ-12 data (indicating potential psychological illness) only for our second and third data sets. We had patient-generated marker-condition labels for 17 issues which we collapsed into 12 by amalgamating patients complaining of back, shoulder, hip and neck pain into one single 'pain' category, and those complaining of ulcer, hiatus hernia or indigestion into one single 'digestive' category. 35 per cent of patients wanted to discuss one of our marker conditions, and we looked at consultation lengths and enablement scores for those patients with and without social problems. For those with social problems we looked separately at patients who wished to discuss them.

Our first main study focused on the 15 per cent of our consultations where patients reported pain. Between 1990 and 1992, the percentage of pain patients with social problems rose from 25 to 37 per cent and a relatively constant fifth of those patients also wanted to discuss their social problems at their

consultations. The mean consultation lengths for all pain patients stayed almost constant at 7.6 minutes in 1990 and 7.7 minutes in 1992. At that time we were using the percentage of patients scoring 6 or more out of 12 possible points on our 'enablement' outcome score as the cut-off point for a 'good' outcome, and that figure fell for all 'pain' patients from 34 to 29 per cent, significant at the level of $p < 0.05$ level.

Patients with social problems were likely to have higher than average GHQ scores in the 1991 and 1992 data for which we had that information. Patients who wanted to discuss their social problems received longer than average consultations in both 1990 and 1992, and these consultations were notably longer in 1992 at 10.4 minutes as against 8.5 minutes in 1990. However, patients with social problems they did not say they wanted to discuss, received shorter than average consultations, which got shorter over the period of study at 7.4 minutes in 1990 down to 7.2 minutes in 1992. Longer consultations were again generally associated with higher enablement than were shorter consultations, particularly for patients with social problems.¹⁶

Our second consultation study looked at all 12 marker conditions together. The general trends were the same as for the patients with pain. Between 1990 and 1992 the prevalence of social problems increased in 11 of the 12 marker conditions, these figures being statistically significant in 7 of the 11. Mean consultation lengths stayed stable overall, rising in three and falling in nine marker condition groups, the only significant change being for people with hearing difficulties, who interestingly - and perhaps disappointingly - ended having the shortest average consultation length of any group at 6.6 minutes in 1992. Enablement fell for 8 categories of patients and rose for 4.

It was interesting that the condition where there was greatest benefit was for patients with diabetes where consultation lengths rose between 1990 and 1992 from 8.5 to 9.0 minutes, and enablement rose in parallel from 40 to 47 per cent of patients. The four conditions reporting increased enablement were all low prevalence and relatively 'organic' (diabetes, angina, chronic bronchitis - surprisingly infrequently acknowledged at present by patients - and difficulties with vision). The patient groups reporting the greater drops in enablement were the three with the highest

prevalence overall, and were in the six with the highest increase in prevalence of social problems. Thus although consultation length had apparently held steady, it had failed to respond to greater social need, and the quality of outcome in terms at least of enablement, had fallen in relative terms.

Again it was notable that patients with social problems they did not wish to discuss had the shortest consultations and the lowest enablement (both figures at their worst when patients had high GHQ scores), whereas those who wanted to discuss their social problems had the longest consultations and very respectable enablement scores.¹⁷ On the one hand this shows that doctors have ability to recognise patients' wishes and to respond effectively to them; at the same time, there are times when patients' needs may be different from their expressed wants, and perhaps this is an area that is not well dealt with when time is at a premium.

These results were credible. The case for advocating that more time was a good thing was holding up; and - if 'quality' was indeed to be equated with a holistic vision of the conduct of a consultation - time and quality were probably linked.

A DEFINITION OF QUALITY

When we started our researches into quality of care we committed ourselves to equating quality with holism, and to focusing on the factors which promoted or deflected doctors from delivering it at consultations. By the time we embarked on the fund-holding work we wondered if consultation length might provide a single proxy for quality of care generally, covering - as it seemed to have the potential to do - acute care, care of continuing health problems, care of psychological and social problems, and attention to health promotion and preventive medicine.

By the time we were completing the fund-holding project, a number of issues in the 'quality' field were becoming clear. The first was that our possible quality measure did seem to be holding up for the purposes we had used it for - examining what happened at consultations. There were, of course, other components of a quality service which needed to be researched and audited using different techniques. The quickening of the quality and clinical governance debates during 1998 and 1999

has confirmed that it is helpful and probably necessary to section off four areas, namely access, management and surveillance of continuing health problems, promotion of public health policy issues (particularly screening), and the care provided at consultations. The work described in this monograph is focused on the last of these, and the remaining parts of this chapter and those which follow, reflect that emphasis. (Perhaps out-of-hours care and the management of care at the interfaces between hospital and social care will prove to be separate issues as well.)

We now recognised the need to commit ourselves to a formal definition of what constituted quality at a consultation. We had enough information to sketch in the essential infrastructure of such a definition. There had to be a reference to needs and one to outcome. Each had to encapsulate both patients' and doctors' views, and the definition had to acknowledge the centrality of the process of negotiation and setting of priorities within possible consultation agendas. Outcomes needed to be couched in behavioural as well as in bio-medical terms. Consultations needed to be judged over time as well as in isolation. Both efficiency and effectiveness had to be recognised as important.

Thus we proposed this definition, which we still feel encompasses enough issues to be useful as a starting point for service, for educational and for research purposes.

Effective primary care entails listing the needs of a patient at a consultation, deciding on the priority for dealing with these needs, and giving care that meets the need or needs selected for attention. The care delivered should improve health or halt its deterioration; offer support where deterioration is inevitable; or identify an appropriate channel through which services can be provided. The needs to be addressed should be negotiated between doctor (or carer) and patient (or family); they may include physical and psychosocial problems or education or health behaviour or health promotion. Needs can be short term or longer term. Patients should normally feel satisfied by the consultation, although occasionally conflict may exist between meeting needs and patients' expectations, leading to dissatisfaction. The care delivered should improve patients' understanding and increase their ability to cope with the problem. Needs may be identified and met over a series of interactions (which may occur over a long time) rather than at

a single meeting. More efficient primary care involves carrying out the above processes at lower cost. Thus quality is a relative rather than an absolute concept.¹⁹

OCCASIONAL PAPER 75

The principal results of the complete fund-holding study were made available to the Scottish Office in February 1995, but relatively little had been done with the 'consultations' data set, particularly in relation to variation between doctors and practices. The Department of Health provided some funding to support a secondary analysis of that data and the completed work was published two years later as RCGP Occasional Paper no. 75.¹⁹ Some of the issues relating to the development of our quality measures and to the extended findings are summarised here.

INSTRUMENT DEVELOPMENT AND SCALES

The 'enablement' outcome measure included six items, each scoring from 0 to 2 giving a potential points range of 0-12. In each of the three recording periods 31 per cent of respondents scored zero. Six points and 1 point were the next commonest scores. For most of our fund-holding analyses we used patients' scoring 6 or above out of 12 as the cut-off point for a 'positive' enablement score - which accounted for almost exactly half of all patients scoring more than zero. However, we were also interested in a number of alternative ways of scoring enablement, particularly the overall mean score, which would allow us to count every response in an overall statistic, zero scores, and 0-2 and 10-12 scores, which represented outcomes at the ends of the distributions. We also experimented with the effect of giving different weightings to the various responses to the enablement questions, and found that this made no difference to any of the conclusions we had reached.

In our consultation length analyses, we had continued to look at the content and outcome of short (now re-defined as less than 5 minutes) and long (10 minutes or more) consultations, using mean consultation length as our summary statistic. We had kept off our previously proposed long:short consultation length ratio as it had attracted some criticism from statisticians because it was

a ratio rather than a rate, and did not include all the data we had available. However, we now wanted to compare our ratio (which was a conceptually attractive way of portraying visually the differences between contrasting styles of doctors) with the rather bland and often rather meaningless looking mean scores, and to look at another extreme value - the proportion of consultations lasting over 15 minutes. All these time variables proved to be highly correlated with each other, with $r = 0.96$ (for comparison of ranks of doctors) for mean length against long:short ratio being the most significant correlation. 'Mean length' against 'per cent of consultations lasting 15 minutes or more' produced another high correlation at $r = 0.82$.

Finally, we looked again at our handling of case-mix issues. In our main study we had focused on a selected range of acute and chronic health problems (which covered 36 per cent of all consultations). We had also noted which patients had current social problems (and whether they wished to discuss them and - for the later two data periods - had collected GHQ scores as an indicator of possible psychological problems. We invested some time in deciding first, how to categorise various combinations of physical, psychological and social problems, and second what kind of hierarchy of need it would be appropriate to use. This involved looking for patterns of consultation length and outcome in some relatively small categories of combinations of physical, social and psychological problems, and designing a series of best-fit classification solutions which made clinical sense. We were struck by the not-unexpected high level of correlation between patients with social problems and raised GHQ scores. We were also impressed by the finding that patients who wanted to discuss their social problems received much longer consultations than did patients who did not want to discuss their social problems, and that they were more enabled by these longer consultations. We thus added those patients with social problems they wished to discuss (2 per cent) and those with 'social problems and GHQ score of 5 or more' (9 per cent) to the other groups of patients with GHQ scores of 5 or more (11 per cent) to form a single 'psychological' group which then included 22 per cent of our responders. These were put in our highest needs-level category. There were 20 per cent of patients with 'social problems' left for

our intermediate category, and the remaining 58 per cent of patients were classed as 'physical' and regarded as the most straightforward. This group, of course, will have included patients attending only for administrative purposes and we thus carried out some analyses where we separated those patients we knew had marker physical conditions from those whose physical health we could not fully comment on. In general this did not affect any of the conclusions we drew.

We did have to field some questions on our decision to use '5' as our GHQ-12 cut-off score. Further analyses showed that we would have come to the same overall conclusions using a cut-off for 'caseness' at '3' or '4'. Our argument in favour of using '5' was that by so doing we identified patients with conspicuous psychological morbidity.

Thus, in summary, we had a needs hierarchy which placed patients in the ascending order of physical, social and psychological in the ratio 3:1:1; a process measure (mean time) which correlated with most other ways of conceptualising the use of time; and an outcome measure (enablement) for which the mean score was again the preferred summary statistic.

'ENABLEMENT'

We carried out checks on the internal correlations of the six enablement questions (all were higher than 0.5) and between the enablement set and other single items in the post-consultation satisfaction instrument we were now using. Enablement correlated positively with patients having felt their opinions had been valued, and with expressing the wish they could have had more time at their consultations. We carried out a reliability analysis using the Cronbach's alpha statistic. This showed that the original enablement questions were appropriately contained in a single instrument ($\alpha = 0.92$ on all three occasions we had used the instrument) and that omitting any of the questions so far included or adding any not included, reduced the strength of the statistic. (We have thus stayed with the 6-item version for our current work.)

POPULATION CORRELATIONS

Mean consultation lengths were highest in the psychological category (indicating appropriate identification of greater need by the doctors) and lowest in the social category (suggesting

Table 4.1. Associations between consultations of different lengths, different levels of clinical need, and enablement at the level of 6 or more points out of 12.

Source: ref 19. Occasional Paper 75, RCGP (1997). Table 3.5a, p10.

Consultation lengths

Needs	Short	Medium	Long	Very long	n	p
Physical	27	31	35	44	2122	.0051
Social	21	29	32	50	722	.0139
Psychological	19	24	29	37	801	.047

disadvantage to patients who had social difficulties but without conspicuous psychological distress). Table 4.1 shows that for patients who had any of our marker conditions, longer consultations correlated with greater enablement of patients (defined on this occasion as the percentage of patients scoring 6 or more out of 12 on the enablement scale). This suggests that as need increases, the benefit for similar allocations of time falls. At this stage a major analytical problem arises. 'Effectiveness' can be visualised as a doctor's ability to generate a high enablement score. 'Efficiency' could be argued as being the ability to do so for the minimum input of time. Thus, in the ideal world, all doctors would allot exactly the consultation length needed to achieve a single optimum enablement score, and all differences of the kind shown in table 4.1 would disappear. All that would remain would be a differential allocation of more longer consultations as need increased.

DOCTOR AND PRACTICE CORRELATIONS

We were able to work with only six practice groups and this was clearly too few practices to draw conclusions from. Suffice it to say that practices are variable mixes of their component doctors. Some of their doctors work faster than others, some enable more patients than others, and some see more social problems than others do. Analysing quality at practice level is thus likely to be a difficult challenge.

However, our work gave us access to a group of 49 doctors who recorded information throughout our study, and for this body

Table 4.2. Rank correlations for 49 doctors using five ways of scoring consultation length against five ways of scoring enablement.*Source:* ref 19. Occasional Paper 75, RCGP (1997). Table 3.4a, p10.

Enablement	Length				
	Mean	long:short	% short	% long	% very long
Mean	.53 (.000)	.53 (.000)	-.42 (.001)	.55 (.000)	.57 (.000)
Zero	.45 (.001)	.47 (.000)	-.36 (.005)	.48 (.000)	.47 (.000)
% (0-2)	.49 (.000)	.50 (.000)	-.39 (.003)	.51 (.000)	.49 (.000)
% (6-12)	.42 (.001)	.40 (.002)	-.32 (.013)	.41 (.002)	.48 (.000)
% (10-12)	.45 (.001)	.38 (.004)	-.25 (.041)	.49 (.000)	.61 (.000)

of work we used the 1991 and 1992 data-sets combined, these having used identical instruments to collect data. Table 4.2 is only for the data-connoisseur! We ranked all 49 doctors for their patterns of consultation length (using five approaches) and for their patients' enablement scores (also using five approaches). The correlations between these ranks is shown in the table.

Irrespective of what system is used, doctors who spend more time, enable patients more. (They also enable more patients - although that is not shown in this table.)

We attempted to add one further variable - namely the level of patient-centredness of the doctor. We used the same measure that we had used in our 'stress' study and categorised doctors by where they would have been placed in the distributions found in the stress study. The overall results were somewhat disappointing. For patients with marker conditions, 'low' patient-centredness in the doctor was associated with significantly shorter consultations (7.1 against 7.8 minutes; $p = 0.03$) but enablement, although less, was not significantly less ($p = 0.07$). However, when we looked at the best scenario available to us (chosen for the highest correlation in table 4.2) namely the correlation between percentage of consultations

Table 4.3. Enablement rank and attitude score for the quartile of doctors (out of 49) with most consultations lasting over 15 minutes (high time and low enablement ranks 'good')-

Source: ref 19. Occasional Paper 75, RCGP (1997). Table 5.2b, p15.

Time rank	Enablement rank	Attitude score
38	1*	2
39	33	0
40	5*	0
41	6*	1
42	23	0
43	20	0
44	9*	1
45	15	1
46	2*	2
47	4*	1
48	11*	2
49	12*	1
Mean rank	12	

lasting 15 minutes or more and enablement rank on the 10-12 scores, the highest achievers include more doctors who were more patient-centred (attitude score 1 or 2) and the lowest achievers included more who were less patient-centred (attitude score 0). These statistics are shown in tables 4.3 and 4.4

Table 4.4. Enablement rank and attitude score for the quartile of doctors (out of 49) with fewest consultations lasting over 15 minutes (low time and high enablement ranks 'bad').

Source: ref 19. Occasional Paper 75, RCGP (1997). Table 5.2a, p!5.

Time rank	Enablement rank	Attitude score
1	21	0
2	31	0
3	35	1
4	45*	0
5	39*	0
6	44*	2
7	46*	1
8	48*	0
9	37	0
10	22	1
11	19	0
12	49*	0
Mean rank	36	

SAMPLE SIZES

By this stage we were interested in how much our developing survey strategy could be adapted to become either a routine audit service for practices, or a method by which eligibility for a 'quality' time or enablement incentive could be judged. We had a total of four weeks work for each doctor available for analysis, giving an average of 450 consultations per doctor. Using the methods we had developed, we could expect around 50 per cent of consultations to be for adults over 16 and to have matched pre- and post-consultation questionnaires - that is about 200 consultations. This would give almost 50 each for our social and psychological 'needs' categories, and 100 for the physical needs category. However, the numbers for short and long consultations in each need category would remain too small for useful analysis.

Given that we have always felt that two weeks of continuous recording is as much as can realistically be asked of practices (probably more because of the load on receptionists as against doctors) we then looked at the implications of having only half our current levels of data available.

When we split our data set into two and tried to recreate table 4.2, the fit between mean time and mean enablement was still strong ($r = 0.44$ in each year as against 0.53 for both years combined), but the previous best fit (0.61 between high enablement and very long consultations) had become one of the lower correlations because of the small numbers of patients in that cell. We concluded that future studies needed to aim for 250 enablement scores per doctor if they were to replicate all our findings. Even at this level, study of doctors' performance for the smaller needs categories such as social and psychological problems could or would inevitably still be compromised by a 'small numbers' problem.

COMMENTARY

The work we had undertaken during our work for Occasional Paper 75 had combined an introspective look at our research strategy and instruments, with some pro-active work attempting to find the best-available fits between consultation length and enablement, controlling for case-mix. Given that we had re-analysed our data to seek positive results, what we had available was more appropriate for proposing hypotheses for further work than it was for drawing definite conclusions.

However, whatever the limitations of what we had done, it appeared clear that doctors who spend more time at consultations both enable more people and enable those they enable to a greater degree. What we were still unable to say was whether longer consultations are by themselves what enable more, or whether other attributes combine to make doctors who generally give more time into more enabling doctors generally. It would have been nice to be able to say confidently that being more patient-centred was the missing link. But again the uncertainty of the credibility of our measure made that a claim we could only suggest tentatively. And we needed to refine our measures of case-mix further to at

least try to identify consultations which were only for administrative purposes.

Before the Department of Health would consider our work as 'policy influencing', we needed to demonstrate that what we had done in Scotland was generalisable nationally. In addition we wanted to develop our instruments a little further, build in some other process and context variables to our model, and compare our potential quality measures with others available from routinely available NHS data. The work described in Chapter 5 was already being planned.

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CHAPTER 5

Quality of care II - 1997-2000

The logical extension to the analyses we reported in Occasional Paper 71¹ was to develop our instruments further, and then to test the repeatability of our work in different parts of the UK, including a wider mix of practices with more deprived and more ethnically varied patients. We also wanted to try to recruit a random sample of practices for this further work. Finally, we wanted to link our work to the growing interest in the creation of performance indicators for general practice more generally.² I had had the interesting experience of being a part of Clive Smee's DH 'Primary Care Effectiveness and Efficiency Indicators Working Group', and later of Peter Clappison's 'Prescribing Indicators Working Group', both of which had tried to create lists of indicators of quality which could be constructed from routinely available NHS data. Clive Smee's group was tasked to develop measures to compare large populations (at Family Health Services Authority (FHSA) level with around 0.5 million patients) but the probability that these measures would in due course be translated down to levels of locality (now Primary Care Groups in England) and from there to practice and even to doctor level, was not lost on members of the working group.

Many of the events available to the NHS for study using routine data were inappropriate or occurred too infrequently for use in primary care settings. Nevertheless, the issue of professional accountability and the concept of how to measure quality were being given a public airing. At the same time, Martin Roland at the National Primary Care Research & Development Centre (NPCRDC) was canvassing management and professional views on the validity and acceptability of some 300 indicators being independently used by NHS or professional groups around England and Wales. The result has been the tentative creation of a series of possible quality indicators in the domains of access to care, management of chronic illness, preventive medicine, the provision of services by practices, and prescribing.³ We were interested to compare our measures of 'quality of consultations' with some of these other emerging benchmarks. We also wanted

to canvass views amongst doctors as to whether they preferred the consultation quality measures we were developing to other NHS-data-based criteria which would be more under control of management. Other ways of valuing practices are also available and are presently being developed by the RCGP and others and include a series of quality awards at both Practice and Doctor level.^{4,6}

Our political agenda was still to promote a contract incentive either to encourage doctors to spend more time at consultations or to reward them for doing it effectively - provided, of course, our research continued to suggest this was a beneficial way to provide care.

George Freeman at Imperial College School of Medicine was wanting to research the possible link between enablement and various measures of continuity of care, and his local doctors - many single-handed and with large ethnic minority populations - complemented our own largely Scottish patients and the larger group-practice settings common in Lothian. Two medical advisers in England (Tom Jones in Oxfordshire and Morag Stern in Coventry) had previously expressed interest in a collaborative study of the kind we were wanting to develop, and their districts provided an admirable demographic support for the Edinburgh and West London populations respectively. These areas also covered a good spread of deprived and more affluent patients.

Funding was obtained from CSO at the Scottish Office to underpin the core element of our proposed four-centre study, and NHS R&D funds from North Thames, Anglia & Oxford, & West Midlands completed the funding package needed to support the regional collection of consultation data.

We started the project in February 1997.

INSTRUMENTS, PRACTICES AND SAMPLES

ENABLEMENT

Our first task was to develop the enablement instrument we had used in our Scottish fund-holding evaluation. Ideally we should have gone back to first principles and carried out a qualitative interview study to check and possibly extend the questions relevant to the domain we were interested in. However, time was not on

our side and we set out to compare enablement against two established measures of patients' satisfaction with their consultations, namely the Medical Interview Satisfaction Scale (MISS)⁷ and the Consultation Satisfaction Questionnaire (CSQ)⁸ ⁹ which a recent publication had found to correlate with each other at the level of $r = 0.82$.¹⁰ We created seven combinations of our instrument (which we now labelled the Patient Enablement Instrument or PEI) testing all possible combinations and orderings of PEI with either MISS or CSQ or both. 818 questionnaires were given to patients consulting in three contrasting urban practices. 613 (75 per cent) were returned completed sufficiently to analyse. The PEI correlated significantly and almost identically with each of the two satisfaction measures ($r = 0.48$ and 0.47) but notably less well than the two satisfaction measures correlated with each other (again $r = 0.82$ - exactly as previously reported). The PEI correlated less well with each of the four component sub-scores of each of MISS and CSQ.

When we added single items from MISS and CSQ to the PEI, none improved its internal consistency as judged by use of the Cronbach's alpha statistic." This supported our general feeling that enablement was related to, but different from, satisfaction. Particularly interesting was the low correlation between PEI and the satisfaction component entitled 'length of consultation'. This tied up with our previous finding that patients tended to express satisfaction with relatively short consultations even when they were not enabled by them. Perhaps satisfaction measures the meeting of expectations rather than of needs!

Finally, we ran a check on whether we should add a 'not-applicable' option to the three of much better, better, and same or less which we already used. 210 forms were distributed to patients, half each with and without a not applicable column. One third of 93 respondents who had a 'not applicable' option used it on an average of 1.1 times per 6-item questionnaire. 'Not applicable' responses seemed to be at the expense of 'same or less' responses, so we decided to include this column in our main study and to score answers in it as for the 'same or less' column¹² (figure 4.13).

NEEDS/REASONS FOR ENCOUNTERS

We wanted to be able to separate consultations for administrative purposes from those for biomedical, social and psychological purposes. We also wanted to separate consultations for acute and chronic biomedical problems, and to identify patients consulting purely for a prescription, or for screening or health promotion, or because they had been asked to return.

In the same way that we had previously separated patients with social problems into those who said they wanted to discuss them and those who left that option blank, so we wanted to divide all our other needs categories the same way, hoping to get some feel for the difference between 'needs' and 'wants'. We developed and piloted several versions of a suitable form and ended with a version which seemed to work well. We again added the GHQ-12 as a supporting indicator of possible psychological caseness (remembering to buy permission from the copyright holders) and we also re-used our previous set of social questions.

We added a question about languages spoken at home and at consultations, and as a proxy for the importance we attached to continuity of care as a concept,¹³¹⁵ we included a series of questions about the patient's choice of doctor and how well the patients knew the doctor they were due to see. Finally we developed a version for adults to complete when they were accompanying children under 12, and versions of both adult and child questionnaires in Urdu and in Gujarati. These were piloted too.

PACKAGING

In our previous studies we had used separate pre and post consultation questionnaires, plus a form for doctors to record consultation process data on. Apart from generating a huge volume of paper, the creation of matching running numbers for each patient's forms was an extra burden to receptionists, and co-ordinating the returns was a lot of work for the research staff. In our previous studies we had received data from over 70 per cent each of the 'before' and 'after' questionnaires but were able to link these responses at only 50 per cent of consultations. We now hoped we could raise that 50 per cent response rate by combining everything into a single instrument. We overcame the problems of blinding doctors to patient's statements, patients to our outcome measure before they had seen the doctor, and then to their earlier

responses after they had seen the doctor, by a series of gummed edges and seals whose creation (if slightly expensive) was a tribute to the ingenuity of our research team. (The eventual instrument is available on request from the Department of General Practice at Edinburgh University.)

RECRUITMENT OF DOCTORS

Our aim was to recruit about 12 practices and 50 doctors in each of our four study areas, and we hoped that about half the doctors we approached would agree to take part. We drew random samples from local lists of practices and sent an explanatory letter inviting interested doctors to attend local briefing meetings without commitment. Almost everyone who came to one of our meetings signed up to join the study. We achieved almost exactly the target we had set ourselves, ending with some 230 doctors from 56 practices agreeing to take part. (Our overall response rate was 38 per cent of practices approached, but this exceeded 50 per cent in both Lothian and Oxfordshire.) We managed our planned mix of small and large practices across the four regions rather than within each region. We asked participating doctors for access to the routine NHS data which their local medical advisers held about their practices and guaranteed that no identifiable data would be fed back to management. Doctors also provided us with demographic data about their practices, some personal data about themselves (which included the languages they spoke at home) and before the study started, almost all of them completed the Cockburn 'attitude' questionnaire we had used previously.¹⁶

SAMPLE SIZES

From our previous work we thought we needed data on about 250 consultations per doctor to be able to repeat our previous analyses. Having refined our data collection methods as described above, and as we were now including children, we decided to settle on a two-week recording period (this is as much as a practice can cope with at any one time). We asked practices to select any suitable two weeks for the study during March 1998. (In the end some practices recorded into April.) All but three of the practices who had said they would take part did so and in the end 221 doctors contributed data. (One practice misunderstood our request and provided 250 consultations for their partnership of four rather

than for each of the four partners and withdrew at that point.) We asked practices to record 'time-only' data if patients declined to complete questionnaires, or if reception staff were too busy or decided not to recruit a patient for any reason. Some practices used this option more than others, but the average consultation lengths for such patients were similar to those with completed questionnaires.

All data was coded and double-entered to computer files, this eliminating all impossible entries and allowing occasional clearly incorrect entries to be amended. In all, we received usable questionnaires from 25994 adults and 4588 children, and time-only data from a further 7336 consultations. This figure was slightly below our target, much of the shortfall being because of smaller numbers of consultations collected by doctors with part-time commitments in their practices. We examined the stability of mean values for enablement (PEI) and for consultation length at doctor level based on various different sample sizes, and eventually decided to accept all doctors with 50 adult enablement scores into the main analyses. (We found that any three samples of 50 enablement scores correlated with each other at the level of around $r = 0.90$, and any three samples of 50 consultation lengths correlated at $r = 0.95$.)

One of our first analyses showed that the 2195 adult patients who spoke languages other than English at home were much more enabled than were English-only speaking patients; they also had much shorter consultations (PEI 4.5 v 3.1; length 7.1 v 8.0 minutes). We thus decided to analyse these patients separately except where this was inappropriate, so our '50 qualifying consultations' became '50 English language consultations'. This lost us a few doctors whose figures then fell below the threshold, but we still ended with 171 out of 221.

(In all analyses reported in this chapter as significant, the confidence limits of the mean values which are quoted do not overlap)

CONSULTATIONS

The first analytical challenge was to create a hierarchy or categorisation of needs/reasons-for-encounter to use as a case-mix

control for further analyses of single or multiple variables. Scanning of returns showed an encouraging level of completion but with inevitable gaps and inconsistencies - such as patients indicating they 'wished to discuss' a problem (say an 'acute or urgent' problem) which they had not indicated that they actually had in the previous section entitled 'what problems do you have'. We created a number of house rules to cope with such eventualities and other difficulties created by incomplete answers. For example, with the GHQ-12, we scored patients as over or under our cut-off level of 5 provided any missing responses would not have affected that final classification even if none or all of any missing answers had been scored either positively or negatively.

Each consultation was allocated one or more of four general labels - administrative; biomedical; social; psychological. Where two or three labels were attached, the highest of the labels (administrative being lowest and psychological highest) was used. If both social and psychological categories were included, a new category of 'complex' was created and used. Table 5.1 shows this summary classification, with mean enablement (PEI) and consultation lengths. It also shows the distribution of short, medium, long and very long consultations, and the PEI scores achieved for each of these time allocations.

SINGLE VARIABLES

When mean consultation length increased this almost always reflected a shift in the distribution of consultation lengths from more to fewer shorter (5 minutes or less) consultations, and from fewer to more longer (10 minutes or more, or 15 minutes or more) consultations. Again in most comparisons, longer consultations were more enabling than shorter ones. Correlations between consultation lengths and enablement scores in any single cell were almost all significant, but normally at quite low levels (typically between $r = 0.05$ and 0.10). This suggests a high level of efficiency in general practitioners' ability to allocate time, although there is clearly important variation in their relative effectiveness (high or low enablement overall) as is discussed later in this chapter.

It can be seen that as the case complexity rises at consultations, enablement is maintained but consultation length rises. Table 5.1 shows that average consultation length overall is 8.0 minutes and

Table 5.1. Distribution of consultation lengths and enablement scores (PEI) for different levels of needs.

Source: adapted from BMJ (1999) 319:738-43 (Table 1).

needs level	n	mean length consultation values			distribution of length values			mean PEI for consultations of length:			
		mean length	% short	% med. long v. long	% short	% med.	% long	short	medium	long	v. long
Biomedical	9,413 (40%)	7.6 (7.5-7.7)	22.9	50.2	20.0	7.0	3.2 (3.1-3.3)	2.8 (2.7-3.0)	3.2 (3.1-3.3)	3.4 (3.2-3.6)	3.6 (3.3-4.0)
Social	5,080 (21%)	7.6 (7.5-7.7)	26.2	46.7	19.3	7.8	3.0 (2.9-3.1)	2.6 (2.5-2.8)	3.0 (2.8-3.1)	3.3 (3.1-3.5)	3.6 (3.2-4.0)
Psychological	2,287 (10%)	8.9 (8.7-9.1)	16.6	46.5	24.6	12.2	3.2 (3.1-3.4)	3.3 (2.9-3.7)	3.0 (2.8-3.2)	3.3 (3.0-3.6)	3.8 (3.4-4.2)
Complex	4,775 (20%)	9.2 (9.0-9.3)	16.9	44.5	23.9	14.8	3.1 (3.0-3.2)	2.7 (2.5-2.9)	3.0 (2.9-3.2)	3.4 (3.2-3.6)	3.6 (3.3-3.9)
Administrative	2,007 (8%)	7.4 (7.2-7.6)	29.4	44.2	18.7	7.7	2.5 (2.3-2.7)	2.3 (2.0-2.7)	2.6 (2.3-2.9)	2.5 (2.1-3.0)	2.5 (1.9-3.2)
SUB-TOTAL	23,799	8.0 (8.0-8.1)	22.4	47.4	20.9	9.3	3.1 (3.1-3.1)	2.8 (2.7-2.9)	3.1 (3.0-3.1)	3.3 (3.2-3.4)	3.6 (3.4-3.7)
'other language' patients	2,195	7.1 (6.9-7.3)	30.9	44.7	17.3	7.1	4.5 (4.3-4.7)	4.7 (4.3-5.0)	4.6 (4.3-4.9)	4.3 (3.9-4.7)	4.3 (3.6-4.9)
TOTAL	25,994	7.9 (7.9-8.0)	23.1	47.2	20.6	9.1	3.2 (3.2-3.3)	3.0 (2.9-3.1)	3.2 (3.1-3.3)	3.4 (3.3-3.5)	3.6 (3.4-3.8)

Consultation length values: 'short' - <5 minutes
'medium' - 5-9.99 minutes
'long' - 10-14.99 minutes
'very long' - 15+ minutes

Sub-total includes 237 unclassifiable consultations.

mean enablement 3.1. (These figures exclude 'other-language' speaking patients, who are shown separately, and children.) Less than 1 per cent of replies could not be categorised and were excluded from subsequent analyses. Fuller sub-divisions into 15 needs categories were also prepared, but numbers in several of these were too small to use meaningfully at doctor level, and often at practice level as well. Using the format in table 5.1, roughly 10 per cent of work is administrative, 40 per cent biomedical, and 50 per cent has an added or exclusively psychosocial content.

Being over 65 years of age was associated with higher enablement (PEI 3.8 v 3.0) and with longer consultations (mean time 8.3 v 8.0 minutes). Consultations with female patients were longer than those with male patients (mean time 8.2 v 7.6 minutes) but were equally enabling. 'Fit-in' consultations were shorter than booked or open-surgery consultations, and this was most marked for psychological problems (mean time 7.2 v 9.0 minutes); enablement was also lower for these (PEI 2.4. v 3.3). Patients who wanted but did not get a prescription reported lower enablement for equal consultation length, and this was particularly marked for bio-medical problems (PEI 3.4 v 2.8).

'Knowing the doctor very well' greatly increased enablement (PEI 3.6 v 2.8) but not seeing the doctor of choice made a difference only for psychological problems (mean time 8.4. v 9.1 minutes; PEI 2.7 v 3.4). Enablement was greatest in single-handed practices and lowest in practices of six or more doctors (PEI 3.4 v 3.0).

Interruptions lengthened consultations by an average of around 2 minutes, but only reduced enablement for bio-medical consultations (PEI 2.8 v 3.2). Having a student present should have increased consultation length, and it reduced enablement when that did not happen. The more problems a patient 'wanted to discuss', the longer the consultations (mean time for two or more problems against one problem 9.7 v 7.7 minutes), the greater the enablement (PEI 3.4 v 3.0), and the greater the correlation between consultation length and enablement at individual consultations.

We were only able to imply deprivation scores for consultations by noting the number of patients reporting social and psychological problems seen by different doctors. Doctors seeing more disadvantaged populations spent equal time per patient and

achieved equal enablement scores overall as did doctors seeing fewer such patients. This unexpected finding appears to reflect shorter consultations for patients with social problems being balanced by longer ones for patients with psychological problems.

Being vocationally trained or not did not appear to be an explanation for differences in enablement or consultation length. College members took longer over consultations than did non-members (mean time 8.4 v 7.7 minutes) but their enablement scores were similar. Similarly, doctors we categorised as higher as against lower for patient-centredness on the adaptation of the Cockburn scale we had used previously had longer average consultation lengths (mean time 8.7 v 7.8 minutes), but this did not convert into higher enablement. (The 'enablement' advantages of high patient-centredness in our previous study were found at consultations lasting over 15 minutes and were reflected in the number of enablement scores of 10-12. To demonstrate these advantages had required total consultation sets of around 400 and the benefit fell significantly in that previous study when we split that data-set into two halves. Thus the smaller average sample size of 130 in this study may explain the loss of significance of this particular finding between the two studies. Our higher patient-centredness doctors did have 12 per cent of their consultations lasting 15 minutes or more, compared with 8 per cent for the remaining doctors. Perhaps the measure we are using is simply not sensitive enough to demonstrate benefits with smaller samples).

As would be expected, the proportion of people who knew their doctor very well increased with the age and experience of the doctor. However, the least experienced doctors compensated by spending much longer at their consultations with unfamiliar patients (mean time 8.5 v 7.6 minutes for doctors with less than three year's experience in contrast to those with over 30 year' experience) and they thus enabled these patients equally as well as the more experienced doctors did.

DOCTORS AND PRACTICES

We were now ready to explore variation between doctors and practices in the processes and outcomes of the care they provided at the generality of consultations. We calculated mean enablement scores and mean consultation lengths for both doctors and

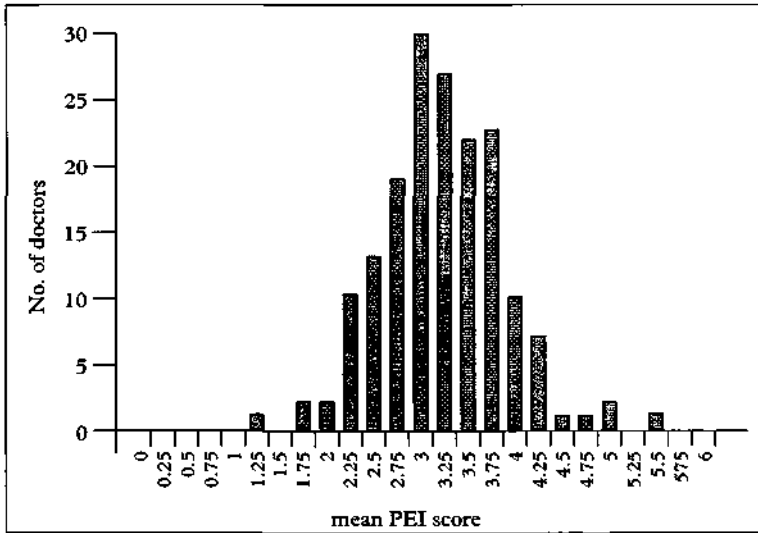


Figure 5.1. Distribution of mean enablement scores (PEI) for 171 doctors.
(unpublished)

practices. The distributions for doctors are shown as figures 5.1 and 5.2. Once again the figures are based on consultations with English speaking patients only, and included all doctors with 50 or more linked time and enablement records available.

Enablement scores for doctors ranged from 1.1 to 5.3 and their mean consultation lengths from 3.8 to 14.4 minutes. When we arranged all doctors with 50 or more enablement scores in ranks for how much they enabled and how long their average consultations lasted, the ranks correlated at $r = 0.38$ (statistically significant at $P < 0.01$). When we raised the qualifying number of consultations to 120, the number of doctors with enough consultations to be included fell to 59, but the correlation between their enablement and time ranks rose to $r = 0.66$. For the 7 doctors with over 170 qualifying consultations, the rank correlations reached $r = 0.93$.

Given the heterogeneity between doctors in partnerships, it was not surprising that the range in scores for enablement and time was lower for practices than it had been for individual doctors.

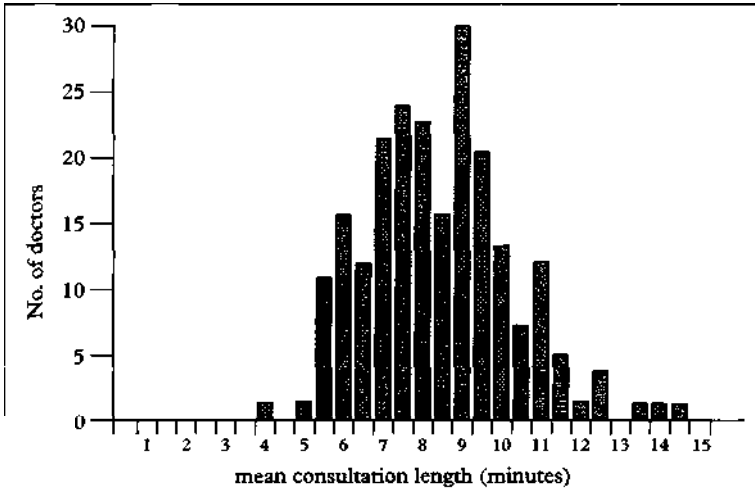


Figure 5.2. Distribution of mean consultation lengths for 171 doctors. (unpublished)

Practice enablement scores ranged from 2.3 to 4.4 and mean consultation lengths from 4.9 to 12.2 minutes. Correlations between rank orders for enablement and consultation length at practice level were low ($r = 0.11$) and were not statistically significant.

MULTIPLE REGRESSION

We attempted to 'model' these individual influences on enablement at consultations using multiple regression techniques, but with little success. The variables that we had found significant on their own, accounted for only 3.7 per cent of the total variation in enablement scores. Does this reflect the complexity of defining goodness¹⁷, the efficiency of doctors, the uniqueness of each consultation, or the existence of a variable (perhaps the consulting skill of the doctor, or the doctor-patient relationship, or whatever patient-centredness actually is) which we cannot define with our methods?

UNDERSTANDING VARIATIONS

GENDER

It has been shown that female doctors see a larger proportion of female patients at their surgeries than do male doctors. In this study the proportions were 75 per cent and 60 per cent respectively. We looked at enablement, mean consultation lengths and the proportion of patients who had reported that they 'knew the doctor very well', and split patients into their five principal case-mix groups. Patients seeing male doctors appear to know their doctors better than do those seeing female doctors (33 per cent v 24 per cent) possibly because more female doctors work part-time. Female doctors compensate by taking longer with their male patients than male doctors do (mean time 8.4 v 7.5 minutes) especially when they do not know them very well. They also take longer with their female patients than male doctors do (mean time 9.1 v 7.7 minutes). Nevertheless enablement scores achieved by male and female doctors when matched for case mix end up remarkably similar.

LANGUAGE

We carried out a similar set of analyses for patients who do or do not speak languages other than English at home, comparing finding for when they saw doctors who do or do not speak languages other than English at home.

'Other language' doctors (all of whom spoke south Asian languages) see more patients who know them very well than do 'English-only' speaking doctors and this applies whether or not their patients are English or other language speakers. (This is probably also a function of partnership size, an issue which is discussed below). Asian-language doctors generally appear to enable their patients slightly more for generally shorter consultations than English-only language doctors do, and this is most apparent when the patients are also non-English speakers (PEI 4.9 v 4.3; mean time 5.6 v 8.3 minutes). Against this general trend, English doctors enable English-speaking patients with complex problems more than Asian doctors do (their consultations are much longer at 9.8 v 8.3 minutes for the patients who know them very well, and 9.4 v 7.8 minutes for those who do not).

English doctors also enable non-English language patients with psychological problems better than Asian doctors do despite not knowing them as well, perhaps again reflecting much longer consultation lengths (mean time 10.7 v 5.9 minutes for patients who know the doctor very well, and 8.6 v 5.8 minutes for those who do not). This balance of both enablement and time is redressed for 'complex' consultations. The case-mix presented by English and non-English language patients is surprisingly similar.

PRACTICE SIZE

Although doctors and practices provided a lot of information about how they worked, it was difficult to calculate a meaningful statistic for list-size per doctor. Many doctors reported being 'part-time', but, of course, some part-time doctors work more hours with patients than do others who have full-time contracts! We did, however, have accurate information on the total list sizes of the practices.

Having noted earlier the relative disadvantage in terms of enablement of working in a practice of 6 or more doctors compared with a single-handed practice, and the relative advantage of 'knowing the doctor very well', we set out to try to link these issues. We examined mean enablement and consultation length scores for each of five list-size bands we had chosen, separating out the three practices making up the fifth band with the largest overall list sizes. Table 5.2 shows that, as expected, the percentage of patients who know their doctor well or very well falls as list size increases. The three practices with list sizes of 15,000 or more appeared to go against that trend and we analysed each separately to explore this further. This showed that two of the three did have very low figures for knowing the doctor well or very well; the third, however, had one of the highest figures in our study reflecting the fact that the doctors in it operated a personal-list system.

In most cases enablement was substantially greater when patients knew their doctors well or very well. However, in most cases mean consultation length was the same whether or not the patients know the doctor very well. Practice 1 was able to compensate for not knowing many patients very well by giving them generous time; but practice 3 had consultations which were

Figure 5.2. Mean enablement (PHI) and mean consultation length for patients who do not (N) and do (Y) know the doctor well or very well for practices of different list size.

Source: adapted from BMJ (1999) 319: 738-43 (Table 4)

practice list size	n (practices/ consultations)	mean PEI (N)	mean 1th (N)	mean PEI (Y)	mean 1th (Y)	% know Dr. well
<4,000	16/ 2,622	2.5 (2.3-2.7)	8.3 (8.0-8.6)	3.6 (3.4-3.9)	8.5 (8.5-8.7)	57.9 (55.9-60.0)
4,000-5,999	13/ 4,224	2.7 (2.5-2.8)	8.3 (8.1-8.5)	3.5 (3.4-3.7)	8.4 (8.2-8.7)	49.4 (47.8-51.0)
6,000-9,999	11/ 6,077	3.0 (2.8-3.1)	8.4 (8.2-8.6)	3.6 (3.5-3.8)	8.7 (8.5-8.9)	44.7 (43.4-46.1)
10,000-14,999	10/ 8,475	2.7 (2.6-2.8)	7.8 (7.6-7.9)	3.4 (3.2-3.5)	8.1 (7.9-8.2)	44.4 (43.3-45.6)
15,000+	3/ 2,401	2.6 (2.4-2.8)	7.2 (7.0-7.5)	2.9 (2.7-3.1)	7.5 (7.2-.7)	47.5 (45.4-49.6)

summary of practices with list size over 15,000+

practice ID	n (consultations)	mean PEI (N)	mean 1th (N)	mean PEI (Y)	mean 1th (Y)	% know Dr. well
1	603	3.0 (2.6-3.3)	8.8 (8.1-9.5)	3.5 (3.0-4.0)	10.8 (10.0-11.6)	37.9 (33.8-41.9)
2	636	2.7 (2.4-3.0)	7.5 (7.1-8.0)	2.7 (2.2-3.3)	8.8 (8.2-9.5)	29.4 (25.5-33.3)
3	1,162	2.3 (1.9-2.6)	5.6 (5.3-6.0)	2.8 (2.5-3.0)	6.1 (5.8-6.3)	61.5 (58.5-64.4)

too short to allow the benefit of their personal lists system to show through. A paper summarising this work has recently been published.¹⁸

CONSTRUCTING A QUALITY INDICATOR

By now our analyses were pointing towards how one or more quality indicators or measures might be constructed. There were three potential strands to such a measure. The first strand was enablement itself, an outcome measure reflecting patients' statements that consultations had helped them to understand their problems better and to feel more able to cope with their health and health problems. The second strand was the repeated finding that longer consultations enabled more, and that doctors who had more longer consultations enabled more of their patients and enabled them more as well. And thirdly, the benefit from 'knowing the doctor well or very well' came through strongly in terms of higher enablement, with higher enabling doctors generally scoring more highly on this measure too.

Although there might appear to be a problem of circularity in trying to combine three measures into one when one happens to be an outcome measure and the other two are process measures which predict it, all three measures were addressing features of care which were independently desirable in their own right, and the correlations between them, although reasonably strong, were not strikingly high. Some faster doctors (but not the fastest) are more enabling than some slower doctors. Similarly, although younger doctors may not yet see many patients who know them well, by investing more time with them (as has been referred to earlier in this chapter) they can still achieve good enablement scores. Thus even if there may be a 'double jeopardy' for those who miss out by having low scores on one or two of our 'quality' items, using all three together seems fairer on those who achieve better results on, say, our outcome measure although missing out on either or both of the process measures. We also found that doctors' positions on quality-score ranks for the PEI measure alone, for both process measures together, and for all three measures together, were highly correlated. We therefore decided to add the three measures together.

Before adding the three components of our prospective quality measure together, we wanted to run an internal check on the consistency of doctors' enablement scores when they saw different kinds of patients. There were two relevant dichotomies. The first was between consultations for patients with purely biomedical

problems as against those where social or psychological problems or both were present alone or in addition to biomedical problems. The second was between consultations for patients who knew the doctor well or very well and those who did not.

Just as we had found comparison between medical and social/psychological consultations difficult in our previous work because of small numbers of consultations available in these sub-groups, we had 'small-numbers' problems again now. However, the correlations for doctors' rankings on all these dichotomies were significant and rose as the n-values increased, reaching $r = 0.55$ for the biomedical/social-psychological split when there were at least 30 enablement scores in each arm, and $r = 0.60$ for the know well or very well or not split when there were at least 40 enablement scores in each arm. We thus decided to regard enablement as a single measure.

We now had two choices. We could either place all 171 qualifying doctors in a single continuous rank for each of our three components, or divide the 171 doctors into sixths (sextiles) thereby creating six categories (from 'best' to 'least good') for each component. In previous exploratory work we found that the six-categories approach produced remarkably stable allocations when repeated sub-samples were drawn from doctors' total bank of consultations, and we chose to use this approach again as it allowed us to set provisional boundaries between categories that could be varied in future if other commentators feel that different cut-off points would be more appropriate. (Again we were able to confirm an almost perfect fit between the continuous and categorical approaches with r values of 0.98 or better for the three components.)

Table 5.3 shows the provisional cut-off points we have arrived at for each component. We now awarded 6 points for a top sextile score down to 1 point for a sixth sextile score, and thus produced a score out of 18 for each doctor. 3 of 171 doctors scored 18 points; no one scored the minimum of 3! The table shows that the scores are roughly normally distributed. Table 5.3 also links our quality measure to the 'implication' referred to at the start of this section; namely that higher quality scores are associated with doctors who work in smaller practices and lower quality scores with doctors who work in larger practices. Even if there is again a

Table 5.3. Cut-off points for different sextiles/scores for three components of 'quality score', and distribution between various aggregates of these components.

Source: submitted for publication.

sextile / score	PEI	time	know the doctor 'well' or 'very well'	total quality score range	n (doctors)	average list
6 ('best')	above 3.69	above 9.90	above 67.0%	16-18 ('best')	17	6,757
5	3.36-3.69	8.95-9.90	58.9%-67.0%	13-15	37	8,606
4	3.12-3.35	8.20-8.94	49.1%-58.8%	11-12	26	8,170
3	2.89-3.11	7.24-8.19	36.2%-49.0%	9-10	28	9,206
2	2.52-2.88	6.46-7.23	21.4%-36.1%	6-8	50	9,858
1 ('least good')	below 2.52	below 6.46	below 21.4%	3-5 ('least good')	13	10,487

possible 'circularity' issue in that one or two doctor practices would be expected to have more patients who know the doctor very well, a third of the doctors in these practices were not in the top two sextiles for this attribute, and several doctors in larger practices did achieve these figures.

PRACTICE LEVEL

We looked at the mix of doctors' scores in different practices. Not surprisingly there were some important variations. In one two-doctor practice, both partners (a husband and wife) scored 17 points. In another two-doctor practice, a senior female doctor scored 17 and a new part-time male partner scored 7. In one three-doctor practice, the partners scored 8, 7 and 4. In two four-doctor practices the scores were 17, 15, 12, 10 and 15, 13, 12, 4. In one group of six doctors, all partners scored below 8, while in another large group of nine doctors, 8 doctors scored in single figures and the ninth scored 16. On the other hand in two groups of six and seven doctors, all partners except one scored 10 or more.

FURTHER WORK

The project which this chapter has described is not yet complete. We are collecting practice-based data on a further set of 18 performance indicators based on routinely available NHS data, with the full knowledge of the participating doctors. Some are prescribing indicators, others about achievement of screening and immunisation targets and the remainder about the range of services practices offer and the amount they invest in staff training.

We plan to rank practices for these attributes and to compare these ranks with the quality index we have described for doctors individually. At this stage we don't have a single clear hypothesis, but it would be fair to say we will be somewhat surprised if most of the routine-data indicators correlate strongly with ours. There is, of course, work to be done adapting our 'patient-centred' doctor measure for use at practice level, and how we should compensate for the effect of locums and part-time doctors is not yet clear. From an early look at the routine-data indicator information from the practices we approached as part of our initial random sample but who declined to take part in the main study, it appears they have very similar patterns to the practices who joined our study.

When we have completed these comparisons, we plan to go back to the doctors and practices who have worked with us and ask for their views about our project as a whole and about the conclusions we have drawn. We will ask if the doctors think that the measures we have developed might be used more widely, and whether or not they would favour the promotion of an incentive to reward or to drive change in remuneration packages in the direction our work has pointed to as being better - for patients and for doctors.

Almost certainly those who have come out higher on our distribution will be more in favour than those who have fared less well, and our further discussions will be likely to throw up ways in which safeguards and checks and balances need to and can be put in place. We will need to develop our peer-referenced scoring system into a criterion-referenced system, even if the divisions end up looking similar. Our discussions are likely to point up the burden on practices of taking part in such surveys and the need to try to simplify the information we collect. Now that we have a

better feel for what matters and what does not seem to, this should be possible. From our point of view we also need to develop our methods to a point where data handling and analyses can be mechanised.

Like all research, what we have done has generated new questions as well as providing some answers, and these will prompt new avenues of enquiry. Some of these are discussed in the final chapter of this monograph.

CONCLUSIONS

DEVELOPING INSTRUMENTS

This part of our research programme had three specific aims. The first was to check the extent to which our post-consultation 'enablement' outcome instrument reflected or extended the concept of satisfaction (it seems to do both) and whether it could be improved by incorporating conventional satisfaction questions. In the end we improved it only by adding a 'not relevant' option to the responses available. The next was to develop our pre-consultation needs/reason-for-encounter instrument. This has been considerably changed to incorporate significant new components about the content of consultations, about the languages patients speak at home (a first attempt to develop a proxy for ethnicity) and about the choice of doctor and the extent to which the patient knows the doctor they are seeing.

Thirdly, we found a way of amalgamating our pre- and post-consultation instruments into a single form which also incorporated the doctor's record of when consultations began and finished (now almost the only information the doctor is asked to record). This has improved the capture rate of complete data at consultations from around 50 per cent of patients to almost 80 per cent. At the same time we have reduced the load on both receptionists and doctors. However, we know that taking part is still a considerable commitment for practices and we need to simplify what we are doing still further if our methods are to have the general usefulness and acceptability we would like to think they could have.

WIDENING THE SAMPLE

Our second task was to try to repeat our previous Scottish survey findings in a more diverse set of environments and with a random sample of doctors and practices. The availability of support in West London, Coventry and Oxfordshire was serendipitous rather than by design, and we had to use a Lothian arm to secure funding from the Scottish Office. We did select practices on a random basis and achieved the necessary number of participants by asking about twice the number we needed. We achieved the mix of ethnicity, and of large and small practices we had hoped for, but across the whole study rather than in each component area. The doctors who agreed to take part delivered what we asked with remarkable commitment; and the support of their reception staff provided the essential underpinning we depended on to ensure the success of the project.

THE RESEARCH FINDINGS

The research findings are useful in their own right, and reassuring to the extent that virtually every analysis in our previous work (reported in Occasional Paper 75) was found true again. Mean values for enablement and consultation length were remarkably close to previous values and the strengths of associations between consultation lengths and enablement scores after controlling for case mix held steady. The new findings using languages spoken at home as a proxy for ethnicity open avenues of great interest and importance for the future understanding of how to configure care for important groups within our increasingly multi-cultured society. The work on the influence of gender also shows how much can be drawn from well-designed survey work where careful attention has been given to planning the key variables which have to be controlled for.

This chapter has again picked out the relationship between consultation length and enablement at doctor level as of particular importance. The new variable of 'how well do you (the patient) know the doctor (you are seeing at today's consultation)' has proved equally valuable. For the purposes of this summary these are the single most important associations, but it remains impossible to say that either of these links is causal. Whatever the missing parts of the equation, more time at consultations still seems

to be associated with more good things than is less time. It is surely no longer conceivable that the '5-minute' model of consulting can be defended; and, given that there is an average of 2-minutes dead-time between consultations, it is pretty hard to defend the 'eight patients an hour' model either! The final chapter of this monograph takes this subject a little further forward.

*FROM RESEARCH FINDINGS TO A USABLE MEASURE
OF PERFORMANCE*

The last section of this chapter hinted at how we are thinking of moving from research findings to a practical proposal for incorporating a measure of performance into general practice contracts. The further work we have still to complete will help show the extent to which what we have done at doctor level can be extended to practice level, and how far our 'consultation quality' indicator will match with measures of the other activities which together make up the jobs of the general practitioner and the general practice.

POSTSCRIPT

I started in Chapter 2 wondering why antibiotics are used so widely when everyone seems to accept there is no biomedical justification for prescribing them to more than, say, one third of patients who consult with respiratory illnesses. Apart from knowing that consultations when a doctor is stressed are ones where prescribing is more likely, we don't seem all that much further forward now, although my consultation model (figure 2.2) helps put the issues in a credible framework. It was interesting that we found in this most recent study that adult patients with an acute illness who wanted but didn't get a prescription were less enabled than those who did. This, of course, is why doctors say they continue to prescribe. However, when we looked at consultations for children with acute illnesses, and at the accompanying adult's enablement score for these, not prescribing when a prescription is wanted or expected does not cause the mothers' enablement scores to fall. So perhaps we could at least stop prescribing so many antibiotics for children for a start.

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CHAPTER 6

COMPLETING CIRCLES

This last chapter provides the opportunity to see whether the several circles that have been being traced in this monograph can be completed, and to explore the extent to which they overlap and build on each other.

OLD-STYLE VALUES

The principal task I was given was to reflect on quality of care, with particular emphasis on empowerment of patients and old-fashioned values. Two-thirds of the main body of this work has indeed addressed this remit, centring for better or worse on the series of researches I have undertaken with others over a number of years. Had I had more time, I would have liked to have put our most recent work into the context of a proper review of the literature on either patient-centredness or on the role of incentives in moulding practice, but there have been too many competing pressures to do either properly. Sadly the vision of academics sitting around with nothing to do but read and reflect doesn't match with reality!

The definition of quality which our research team has been working to, values identifying patients' views of what their problems are and negotiating with them about what should be the agenda at consultations and how it should be prioritised.¹ Our definition stresses the importance of helping patients to increase their understanding of their problems and their ability to cope on their own. 'Enablement' is a concept which captures the thrust of that definition; but is it the same concept as empowerment? By this stage in my academic life I know better than to start making simplistic observations about significant sociological concepts I am not informed about and this monograph has not been the occasion to make an exception. Almost certainly empowerment lies uneasily with the paternalism that many or even most doctors who regard themselves as patient-centred doctors are unwilling to forego completely, and although 'enablement' (not a word that is to be found in the Oxford English Dictionary) may well have much in common with empowerment, there are probably important differences between the two concepts.

Spending more time at consultations is now widely accepted as being better than spending less time - at least within the limits of the traditional UK model of general practice.² Consultations of less than five minutes can be long enough to cope with a straightforward single complaint, but become inadequate when overlapping biomedical and psychosocial problems need disentangled and managed together. At the same time, simply spending longer at consultations without improving outcome is inefficient, and some fast doctors simply manage to do everything faster than average, and they can achieve as good results as do slower colleagues. However, in the research we have been doing recently, none of our fastest doctors were among our highest enablers, and none of our doctors who spent most time at consultations were amongst the lowest enablers.

This brings us to the other main strand of our quality theme - how well our patients know us. Our decision to measure this concept from the patients' as against the doctors' angle was perhaps a chance consequence of the way we had designed the main part of our survey to centre round patients' rather than doctors' judgements. But it has proved a fortunate choice managing as it does to represent a proxy measure for continuity of care from a patient-centred perspective. Knowing the doctor 'well' or 'very well' is associated with much greater enablement and for no extra input of time. Where doctors (for example young doctors or new partners) do not yet have many patients who know them well, good levels of enablement can still be achieved with unfamiliar patients given the investment of sufficient time.

Table 6.1 shows the best we can do to lay out the relationships between enablement, time and 'continuity' alongside each other. Our most enabling and least enabling quartiles of doctors seem different in several ways. The time they give their patients is materially different. Both groups of doctors appear to allocate time efficiently for the patients who know them well (or perhaps it is the patients who allocate time efficiently!) achieving equal enablement whatever their consultation lengths. Where patients do not know the doctor well, the high enablers do progressively better as their consultations lengthen, but it seems they would need still more time to achieve what seems their maximum potential. The lowest enablers seem simply to be less effective all

Table 6.1. Some comparisons between the work of the top and bottom quartiles of doctors ranked for their ability to enable.
Source: adapted from BMJ (1999) 319: 738-43 (Table 3).

consultations where the patient does not know the doctor well												
doctor type	mean length	n (doctors/ cons.)	% short	% medium	% long	% very long	mean PEI (all cons.)	mean PEI (short)	mean PEI (medium)	mean PEI (long)	mean PEI (v. long)	
HIGH enabler	9.1 (8.9-9.4)	42, 1,692	15.9	43.8	24.5	14.1	3.5 (3.3-3.6)	2.8 (2.4-3.3)	3.4 (3.1-3.6)	3.6 (3.3-4.0)	4.1 (3.6-4.6)	
LOW enabler	7.3 (7.1-7.4)	43, 2,892	27.9	46.7	18.2	5.9	2.1 (2.0-2.2)	1.9 (1.7-2.1)	2.1 (2.0-2.3)	2.3 (2.0-2.6)	2.1 (1.7-2.5)	

consultations where the patient knows the doctor well												
doctor type	mean length	n (doctors/ cons.)	% short	% medium	% long	% very long	mean PEI (all cons.)	mean PEI (short)	mean PEI (medium)	mean PEI (long)	mean PEI (v. long)	
HIGH enabler	9.3 (9.1-9.5)	42, 2,597	11.8	47.1	26.8	12.4	4.1 (4.0-4.3)	3.8 (3.3-4.3)	4.1 (3.9-4.3)	4.1 (3.8-4.4)	4.4 (3.9-4.8)	
LOW enabler	7.2 (7.0-7.4)	43, 1,988	26.5	48.6	16.5	6.2	2.7 (2.5-2.8)	2.6 (2.3-3.0)	2.7 (2.4-2.9)	2.8 (2.3-3.2)	2.9 (2.2-3.6)	

HIGH enablers: mean practice list size = 8,105 % know doctor well = 52.9%
 LOW enabler: mean practice list size = 10,357 % know doctor well = 34.5%

round; they don't give as much time to their patients, and the evidence that more time would help is at best unconvincing. Almost certainly they are practising single-complaint rather than holistic medicine, a conclusion compatible with the generally shorter consultations they offer.

Is the finding that the more enabling doctors both see more patients who 'know the doctor well' and work in generally smaller practices an example of the same circularity we reflected on in relation to the development of our quality measure (table 5.3) in the previous chapter? If it is, does it reflect two aspects or manifestations of a common theme? In the theoretical model of the consultation I offered in fig. 2.2, the holistic left hand 'content' square was separated from 'outcome' at the right hand end, by a 'values' triangle and a 'context' circle. Originally I put consultation length in the context circle and patient-centredness in the values triangle.³ It certainly now seems as logical to put the two processes of giving longer consultations and making oneself more available to ones 'own' patients together as a pair, and to position them in the values triangle to represent or to be a proxy for whatever 'patient-centredness' actually signifies. 'Context' would then be left as the way in which the health care system helps or hinders the expression of patient-centredness and other values; and perhaps the most interesting and pressing question would be whether the present package of contract incentives are helping or hindering the delivery of the more patient-centred care which this monograph has argued is so important to patients.

Moira Stewart and her colleagues have helped more than most to describe what patient-centredness is and means for patients, and to suggest how the concept can be measured.^{4,8} Their visions accord closely to those advocated by Colleges of General Practitioners and by educators world-wide, and researchers and examiners have tried to capture 'goodness' by viewing and listening to tapes of consultations and analysing their content. Such work is heavily labour intensive and it has proved hard to link patient-centred consulting behaviours like listening and responding to cues to measurable outcomes in a way than can be generalised to consultations or to doctors on a large scale.

Can we, from the body of work described in chapters 4 and 5, suggest that valuing continuity of care, valuing the spending of

more time, and valuing consulting behaviours which enable patients, combine to reflect the old-style values that this Fellowship was asked to explore? If, as I believe is the case, this is at least a reasonable position to take, it raises one further issue - the possible dis-benefit of large practice size. Where the cut-off lies, the extent to which dis-benefits can be lessened (for example by personal lists), or indeed might be compensated by other advantages, needs further discussion, but the findings of our work confirm the findings of others which suggest that five doctors or 10,000 patients may be critical figures.^{9 11}

One caution! This monograph has produced one kind of 'evidence-base' for defending and promoting old-style values. It is romantic to think that the use of listening/enabling skills, spending more time, knowing patients well and working in a smaller/more homely setting were always the rule in times past. These features were not a uniform feature of the practice of bygone days¹², and in asking questions about the future and present we must take care not to over-sentimentalise what it is replacing.

FOUR MILLENNIUM TASKS

Outside the laboratory settings of pure bioscience, it is rare for research to answer a question with certainty. Most research, even with RCT design, raises as many questions as it provides answers, and this has been true of our work on quality of care.

In the first part of this chapter I have assumed that although we now understand much more than before about quality of care at consultations - and in particular much more about the importance of time at consultations - there is still a lot we need to study further. Here are four tasks to make a start with.

TASK 1 -

WHAT IS PATIENT-CENTREDNESS;

WHAT IS ENABLEMENT; AND HOW DO THEY RELATE?

Because this chapter represents the interface between ending one project and starting another, I have indulged in moving concepts around to see how they might fit and interact. Patient-centredness is a value we all pay homage to but find difficult to get hold of. It could, as I have tried to make it, reflect what happens when empowering or enabling behaviours, enough time, and an effective

relationship between a doctor and patient come together. If this is what happens, then we have a concept which we can measure, and we have at least the basis for creating a usable performance indicator.

However, our own work has been largely survey based and our measurements (although not necessarily our thinking) have been dependent on mainly quantitative work. We need to revisit consultations using a more qualitative approach and try to see if 'enablement' is a concept which could be measured better and differently if we used different questions. And we need to explore whether 'empowerment' and 'enablement' are more like each other than different from each other and how much they are linked or overlap.

If 'patient-centredness' is to endure as a useful and usable concept, we have to try to find a way of 'operationalising' it better. In research terms that means continuing to explore practical (and reliable and valid) ways of measuring it, and then finding which outcomes it links to and how to measure them.

The first millennium task is to revisit the consultation using qualitative methods to try to understand better the nature of enablement and patient-centredness, and the relation between them.

TASK 2 -

WHAT IS THE RELATIONSHIP BETWEEN GOOD PERFORMANCE ON A 'PATIENT-CENTREDNESS' MEASURE, AND GOOD PERFORMANCE ON 'BIOMEDICAL' MEASURES?

Earlier in this monograph, I listed the various components of quality that different researchers are now addressing separately. These include the care of continuing health problems, the meeting of public health policy targets, and access to care. Other work is looking at care of emergencies, and the quality of referral to both secondary care and social care. In addition, work continues on defining the proper management of single acute illnesses (such as sore throat and otitis media) although - perhaps strangely - this aspect of work is only now beginning to figure prominently in the packages being talked about for clinical governance quality audits.¹³

Of great importance is the possibility that good performance in one domain or for one topic, is at the expense of good performance in others - and work of the kind we (and others) are

now engaged in will show how real this problem is. From our own research, the possible patient-centredness benefits of smaller lists could, for example, be a trade-off against better organised chronic illness surveillance and systems for screening and health promotion in larger practices.

In possibly the most important paper of 1998, Ann-Louise Kinmonth and her colleagues suggested that there was some evidence that training in interpersonal skills improved feelings of well-being of patients with diabetes, but that that gain might be at the expense of the control of some of their diabetic biochemistry.¹⁴ Close reading of their paper suggested that the disadvantages were probably marginal (and other work has, in fact, suggested better personal care and better 'medical' care do go hand-in-hand),^{8,15} but the issue is of great importance.

The second task is to produce more evidence on the relationship between personal care and biomedical care at doctor and at practice level.

TASK 3 -
WHAT ARE THE POSSIBLE ROLES OF PERSONALITY AND
EDUCATION/TRAINING IN IMPROVING THE QUALITY OF
CARE AT CONSULTATIONS?

Our work has shown that some doctors enable well and others don't. Given that 'enablement' is a valuable outcome, and that the other process measures we have linked it to do, in fact, correlate with it, what other influences might be associated with the link between doctors and enablement - or might be causally related to it?

One is personality, or some aggregate of personal attributes. Another is education and/or training - which hopefully does have some effect given the very considerable investment in time and money which is put into vocational training. (Let us assume for the present that although our recent study showed no measurable benefit in terms of enablement between those vocationally trained or not, this was probably because our sample size was too small or that other variables such as age and equivalent experience confounded the comparison!).

Various attempts have been made to categorise doctors into personality groups. In 1968, Henry Walton split a class of graduating Edinburgh students into four groups, two being labelled 'physical' and two 'affective'. More belonged to the physical

category and these were divided into the 'adequate graduate' and the 'limited graduate' depending on whether their lack of interest in the emotional problems of patients did or did not trouble them personally. Of the two affective groups, one was interested in emotional or psychiatric illness from an intellectual position, whereas the other was motivated more by a desire to be helpful to patients and those in it were described as the 'patient-centred' graduates. Walton went on to conclude that doctors' clinical styles depended on their age and the degree to which they tolerate uncertainty, and found older doctors to be less interested in providing continuous care for patients than were younger doctors.¹⁶

Not long after, David Mechanic proposed another four-way categorisation of doctors, with two main axes described as scientific orientation and social role. Doctors could be 'withdrawers' (low for scientific and social) technicians (high scientific; low social) counsellors (low scientific; high social) or moderns (high for scientific and social).¹⁷ Similarly, June Huntingdon has used three dimensions (orientation - physical or psychosocial), relationships with patients, and relationships with doctors for another typology.¹⁸ We have tried using Jill Cockburn's seven dimension approach, which also tried to identify doctors who value social and psychological problems, and sharing decision-making with patients¹⁹. Regrettably, based on the numbers of observations for each doctor in our current study, the Cockburn questionnaire has proved unable to discriminate between doctors in any truly useful way in relation to our three main quality measures.

Psychologists seem to disagree over whether personality is a fixed or a changeable attribute. However, there seems agreement that personal attributes can change and, by implication, education and training should be able to create change in a desired direction. There is an urgent need to improve our understanding of the nature of the personal attributes that define different styles of doctoring. Although it would be wrong to imply that any particular style was incompatible with being a general practitioner, some are clearly less suited to the task of general practice (and indeed of clinical medicine) than are others.

The third task is to increase our understanding of the contribution of different personal attributes, and of education and training to providing

high quality general practice, and to find usable ways of measuring these attributes and of measuring the ability of education and training to influence them.

TASK 4 -

IF WE ACCEPT THAT THE VISION OF 'PATIENT-CENTREDNESS' DEVELOPED IN THIS CHAPTER DESERVES TO BE PROMOTED, AND AGREE THAT A CONTRACT-BASED REWARD OR INCENTIVE WOULD HELP, HOW CAN THIS BE ACHIEVED?

There is a literature on the effectiveness of incentives in driving change and there is no doubt they are effective.²⁰ Anyone who has worked in general practice during the 1990s knows how changes to contracts and to incentives can dominate the activities of a practice and the feelings of purpose and well-being of those who work in it.²¹ No matter how important continuing education, personal and professional development, and idealism are in improving quality of care, their impact is slow and most beneficial for those who are least in need of them. How long can we afford to wait for something effective to be put in place to promote patient-centred practice? Given the sudden quickening in the forces pushing for better processes and outcomes in health and medical care generally, my feeling is 'not much longer'.

The experiences I gained from trying to be a manager of change over SIFT/ACT payments (as described in Chapter 3) have made me realistic about the difficulty of the task ahead if we want to introduce a reward for patient-centred practice. The Minister of the day could, of course, help us to achieve all we want simply by saying so. However, before taking a position, he would likely ask his medical advisor for an opinion. The advisor would point out that the Minister already had a strategy for improving quality of care, and that perhaps NICE (the National Institute for Clinical Excellence) and CHI (the Commission on Health Improvement) should be left free to develop their own initiatives in the first place.²² In any case the new proposal might lie awkwardly with the emphasis on the use of clinical guidelines which the Minister saw as an important safeguard against future embarrassment in the quality arena. The advisor might commission a couple of statisticians to look for flaws in the case for the new proposal and would certainly want to take the views of the GPC and the BMA, and of the RCGP.

The advisor would probably not draw the Minister's attention to the fact that the evidence-base for the new proposal - even if not constructed on the new gold standard RCT approach - was based on better evidence than are some consensus-based guidelines, and was probably at least as evidence-based as either the Minister's current health service policy or his strategy for implementing it.

GPC would welcome the idea in principle. Something that directed the debate on quality away from guidelines and revalidation based on the technical competence of doctors would be a relief to many; but all doctors would need to receive the incentive payment, and new money would have to be found rather than existing money re-distributed. Collecting data about quality to be able to claim the incentive would, of course, mean a new payment to practices and policing the system to avoid fraudulent claims would be an issue which had to be referred to the annual conference of LMCs.

The College would favour the idea in principle and discuss it at Council. It would then refer it to Faculties for discussion and no doubt create a working party to deal with the new issue.

It is people rather than organisations who make things happen, but most of the people who are effective are answerable to organisations which appear to be constructed to resist change. Presidents and Chairmen have too little time in office to learn the routes to change, and understandably have their own agendas as well as those of the bodies they lead or sometimes only represent. Secretaries last longer, but most safeguard their future positions in their hierarchies by treading a safe corridor between the often disparate groups within their organisations.

Getting research findings into practice will not be any easier in the future than it has been in the past!²³

The fourth task will be to implement the incentives necessary to put our research findings on quality at consultations into practise.

BEING AN 'ACADEMIC IN GENERAL PRACTICE

It was about 2 o'clock on a Sunday morning in May 1959 when, as a fourth year medical student on his first locum, I pulled a

white coat over my pyjamas and with my heart racing, descended three floors in a service lift to give aminophylline to a 50-year old man soon to die from rheumatic valvular disease and LVF. This Fellowship has allowed me the real indulgence of reflecting on issues and events, and changes in practice and in thinking over four decades. In Chapter 1, I explained that in this monograph I would trace parts of my personal journey through a career in academic general practice. Collins Concise English Dictionary does not put a particularly flattering spin on the word academic; 'Of purely theoretical or speculative interest', 'excessively concerned with intellectual matters'. But the definition does include 'belonging or relating to a place of learning' and that I am proud to have been. The OED definition includes the words 'scholarly' and 'unpractical'. I certainly accept that an academic career has allowed me far greater opportunities to contribute to research, teaching and politics than are open to full-time clinicians, but - sadly - the vision of days spent reading and contemplating tallies poorly with reality!

In fig. 6.1, I have tried to lay out a collage of the collections of words and ideas that I have used as this monograph has developed. It covers a wide panorama, and most professionals will have been aware of most of the issues at some time. Many of these issues are in fact alive now and are greatly affecting how those who work in universities and in the health service are feeling about their work and their well-being. I want to pick out three words or groups of words from these lists to justify my title and to begin to draw this story to its conclusion.

The first word is from Ian Richardson's criteria of a discipline and is his inclusion of the concept of having a 'philosophy'. Here my dictionary is much more helpful: 'pursuit of wisdom or knowledge, especially that which deals with ultimate reality or with the most general causes and principles of things'. The famous WHO Alma Ata declaration of 1968 defined health as 'complete mental, physical and social well-being, and not merely the absence of illness' and the medicine of the community has a special commitment to the holism that this vision implies. Prolonging life is one essential of medicine, and it applies to the medicine of general practice as much as to the medicine of hospitals; but it represents a smaller part of the whole task than it does in hospital

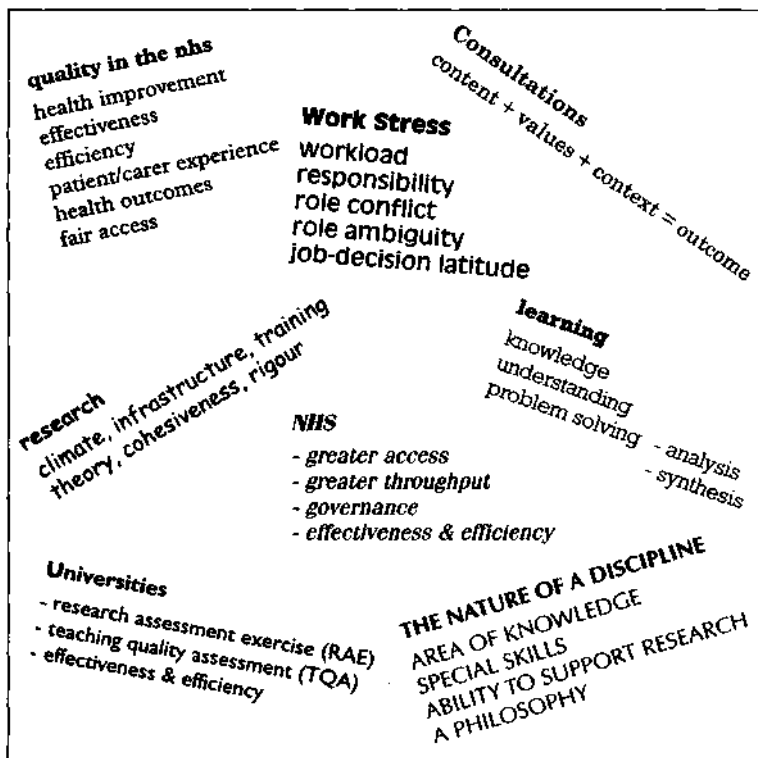


Figure 6.1. A collage of interests and ideas.
(unpublished)

practice. Making the life we have better than it would otherwise be is the challenge and contribution which general practice is best able to take up and provide. To do this well depends on forming real partnerships with patients, and I thus want to put 'patient centredness' as a concept and as a value closely together as forming the essential 'philosophy' of the discipline of general practice. Without a philosophy, general practice risks losing its identity; if 'patient-centredness' is its philosophy, general practices and the teams of professionals who staff them will surely endure.

The second cluster of words is 'theory, cohesiveness, rigour' which I used in my review of 'research' in the recently published

history of general practice in the UK in the first 50 years of the NHS.²⁴ Research is the process of careful and systematic endeavour to discover facts by scientific study of a subject' or a 'course of critical investigation'. The tendency of researchers and service workers to undervalue each other's contributions in favour of their own, has threatened the ability of general practice to explain and defend itself as a discipline, and of general practitioners to retain influence over the setting of their own standards of education and practice. The 'art' or 'science' debate is a real one, but - as I have said earlier in this monograph - I believe it is different from the way most seem to visualise it. Science in medicine has two strands, biomedical science and behavioural or social science. The 'art' is knowing when to give primacy to which. Researches in general practice which neglect the inter-relation between its component sciences endanger knowledge and thus practice by drawing conclusions which are either simplistic or simply wrong. Good research is the platform for progress. It has to be done professionally, and that is rarely quickly and usually requires the development of a coherent series of studies which build on each other in a continuous and additive way.

In my last word, or pair of words, I want to join 'infrastructure' (from my experiences of trying to achieve a proper base for university departments of general practice) with 'context' (from my model of the components of consultations). If 'infrastructure' is wrong, the quality of activities in the domain concerned risks being compromised. I see this happening still in our consulting rooms. In this monograph I have argued a case for developing an incentive to reward or encourage what our research has led me to believe is probably true - namely that the philosophy of patient-centredness is of value, and that its delivery has been compromised by, and is still in danger of being compromised by, health services reforms targeted too much at efficiency and at only the biomedical vision of effectiveness. It is not too late to redress the balance. Failure to do so will be against the best interests of health care as it affects most patients for most of their lives.

I have used one more illustration (figure 6.2) on many occasions in recent years. It portrays one last triangle, with patient-care, teaching and learning, and research at its apices. This is the world we all live in but contribute to differently. To teaching and learning,

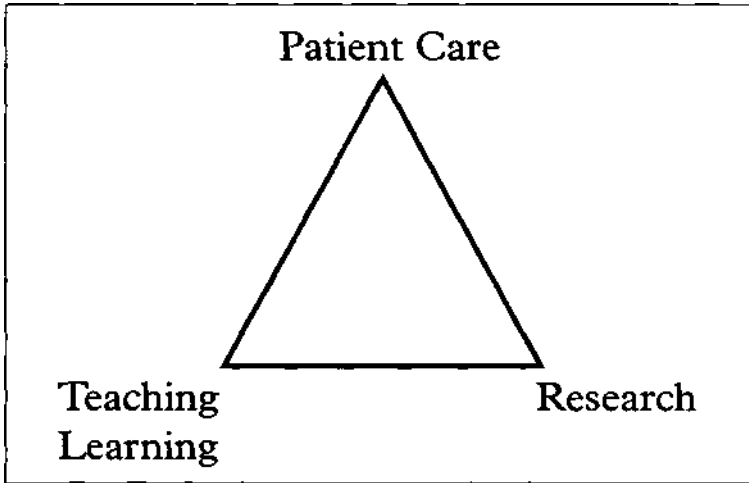


Figure 6.2. One last triangle.
(unpublished)

add philosophy and patient-centredness; to research, add theory, cohesiveness and rigour; and to patient care add infrastructure and context.

In the centre of the triangle, I sometimes put 'politics', but perhaps it should be 'being academic'; Perhaps one or the other should be in the centre, and the other be represented by a circle outside. It wouldn't matter which way round. However, the truth is that neither politics nor being academic are useful without the other. I believe that the greatest difference between the general practice before the 1966 Charter and in the year 2000 will be the degree to which those within the disciplines which make up and relate to general practice accept this as true.

Being 'academic' in general practice is now a priority; it is no longer a paradox.

EPILOGUE

At home as a child, I learned to ask questions and to try to find answers for myself. In pathology I learned to observe, and learned about the disciplines of scientific method. When I became a general

practitioner I learned how little I really knew about medicine or about life, but I did start to try to measure what seemed to be important and to be accessible to study. Moving to an academic job, I was progressively brought face-to-face with the deeper reality that most of the things in general practice that were easy to count were not tremendously important, and that the things that mattered most were hard to tease out using traditional quantitative methods. In Edinburgh, working increasingly with others with different disciplinary backgrounds and methodological skills, I have been able to edge towards a better research-based understanding of what I want to teach and how I want to practise and to promote practice. Research is always a means to an end; almost never is it an end in itself.

When I was a full-time general practitioner in Glasgow, for a season I was a real doctor for 2000 patients, sharing their joys and sadnesses, curing occasionally and hopefully comforting more often. When I became an academic, I lost most of that forever, and although I still have that role for a few and from time to time, I know that I have taken a different route. In the end we are all travelling to the same place, but - off the main road - my path on the mountain has sometimes been hard to trace and the view obscured by clouds and inclement weather. But when the sun shines, the views can be spectacular and the journey seems worthwhile.

At present the Medical Research Council along with the NHS have launched a two-year initiative to support primary care R&D. I have read fifteen of around 100 proposals which were sent in, half in fields that I feel I have contributed to in the work traced in chapters 4 and 5 of this monograph. Several of the proposals have been for sums of money substantially greater than all the grant money I have been able to put together to support my own work over thirty years. Not one of the papers I have written or contributed to were quoted in the literature reviews in the proposals I read - although, in fairness, some had been absorbed into reviews and meta-analyses. The 'little has been done on ...' and 'there is a dearth of ...' type of statements, so common in modern papers and grant applications, have made me philosophical about my own contribution to my discipline. The new research and researchers are in some ways much better trained than my generation was, and they have more sophisticated methods. As

the philosopher wrote '... times change, and we change with them too'.²⁵

But perhaps not altogether. Another philosopher wrote 'the more things change, the more they are the same'.²⁶ We must not lose sight of where general practice and the primary care available to patients was in the early years of the NHS. It was from the focus given to its serious deficiencies by Collings in his famous 1950 Report that the impetus which led to creation of our Royal College of General Practitioners was born, and the development of general practice as a discipline within University Medical Schools has grown in parallel.¹² We all, whether professionals or patients, owe a debt to those whose leadership and visions were then based on feelings rather than on figures, and whose values have since been translated by research, teaching and politics into the assumptions we take for granted now.²⁷

John Fry was an important member of that early select band of pioneers and it is right to salute his contribution both in its own right and for the wider vision he and his work encompassed.

For me it has been an honour to have had this chance to celebrate a friend and a mentor. If those of us who share the values I have used this monograph to develop and promote have something that unites us, it is probably to make sure that what happened to my 'Polish patient' now over thirty years ago (page 9), will never again happen in the future. I would be being optimistic if I finished by saying we were there now; we are, however, nearer than we were. But if we ever lose sight of the fundamentals of patient-centredness (however we eventually manage to define and measure it) in our thinking, our teaching and our practice, we could all too quickly lose the precious ground we have gained. To recapture it would surely be more difficult another time round.

I hope and believe John Fry would have echoed these sentiments. In truth, they apply to medicine generally as much as they do to general practice in particular.

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