Guest Editoral

Millennium 2000 - questions for all

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The WONCA theme was "innovation in teaching, clinical practice and the delivery of care". As we move into the new millennium, the key issues affecting general practice or primary care seem to be the same everywhere. When we are ill, can we see a doctor? Will the doctor be expert, or at least competent and safe? Will the care be effective? In turn, these questions raise three issues – are we talking about general practice or primary care? How do we deliver our care? What are the roles of governments, colleges and universities?

What is our discipline?

Both medicine and general practice are applied sciences and tend to be reactive rather than proactive. The absence of a clear theoretical base has not helped us to engage in "best possible" discussions over important issues like the definition and management of need and rationing. The defining characteristics of a discipline include having particular territory and skills, the ability to support specific research and training, and – most significantly – an identifiable philosophy. In most countries where "general practice" is the vehicle for delivery of "primary care", we include holism, continuity of care and empowerment of patients. Together these approximate to what we call "patient-centredness": so easy to believe in, but so difficult to define, measure and evaluate. Are countries where primary care is provided differently disadvantaging patients?

How do we deliver it?

I have experience of primary care in three economically and organisationally contrasting countries. Thailand has one-fifth the number of graduates from medical schools in the UK, but the same population. Australia’s output of doctors is more like the UK. Primary care in Thailand is delivered either by new graduates working with outpatients in state hospitals, or privately by specialists working out-of-hours as generalists but not specifically trained. In the UK patients register with a doctor or practice, whereas in Australia they are free to move between practices, as in Thailand.

Primary care in Thailand is still very much a cinderella subject, although some visionaries are strongly committed to raising its status. The financial rewards for working in primary care in the state system are,

however, a major disincentive to either recruitment or retention of potential generalists of ability. Both Australia and the UK have postgraduate training (and undergraduate teaching) in general practice with strong and effective traditions, and the status of the discipline is good. However, the Australian free-market system encouraging overmanning in cities is threatening the viability of general practice as a career, unlike the UK, where levels are controlled by health authorities.

What do consultations look like?

In our work on quality of consultations in the UK, we have found benefits in outcome for patients (both in terms of empowering or enabling patients and in greater holism) from longer consultations and continuity of care. Our "best" doctors have average consultations of 10 minutes (face-to-face) and 70 per cent of their patients know them well. Possibly Australian patients may not know their doctors as well if they shop around and use walk-in clinics. Thai doctors often see over 100 patients a day, necessarily very quickly and continuity of care is at a premium in the state system.

However, before assuming that the Thai pattern is less effective, our UK research has shown high enablement scores from very short consultations between Asian speaking doctors and patients in their own language. Although we have researched general practice intensively in recent years, we have done little to try to understand the effect of cultural diversity on defining "goodness" of care. What is good for the UK may not be good for Thailand.

Governments, colleges & universities

If holism, continuity and adequate time, and attention to the opinions and wishes of patients are the building blocks of good general practice and primary care worldwide (and – despite the caveats from our research presented above – I believe they are) what is the role of institutions? Governments must ensure appropriate rewards and incentives, and in turn are entitled to ask for professional accountability and value-for-money. Colleges are responsible for ensuring proper standards and availability of training and retraining. Universities lead research and, I believe, have particular responsibility for vision and innovation, and independently questioning the appropriateness of the status quo.

Millennium 2000

In the new millennium, primary care is set to grow and we need to lead innovation by example. To do so we need to define our corner, and train doctors (or nurses) to work in it and act as advocates for investment. We need to research our identity and our role still further, and with greater attention to the cultures of health and illness of our various societies. Above all, we must be more proactive. And we must

base more of our effort on theory and principle than in the millennium just ended.