Editorial

Balancing GP responsibility between practice and patient

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For as long as general practice has been a discipline, GPs have seen their fundamental medical responsibility as being toindividual patients. Indeed, this is enshrined in the College constitution in the definition of a GP as "a doctor with particular knowledge and skills to provide personal, family, whanau and community orientated medical care".

However, for some time now GPs have debated where the line falls between accountability to the individual person in our consulting rooms and to that of the overall health outcomes of our practice population and, ultimately, to national health goals. Many examples come to mind, such as the inability of some patients to cope both with side effects from the funded ACE inhibitors and with paying for a non subsidised one. Or going out on a poorly supported limb to help a particularly deserving or particularly persistent patient jump more readily through waiting list hoops.

It has all got rather murky due to related issues such as difficulty in measuring health outcomes and, more importantly, the realities of health rationing. This has meant political support for IPAs in New Zealand and unified budgets and locality purchasing in the UK. IPA activity has bought accountability for our practice populations to the fore as dollars are involved. More or less can be added by a decimal point to shrinking GP incomes.

However, for me, the difficulties and realities of defining the line between personal and practice responsibility has never been more apparent in the major swing in recent years to using warfarin for the active management of atrial fibrillation. We have all seen examples of progressive dementia occurring in otherwise healthy elderly people as a result of multiple TIAs and background atrial fibrillation. The overall benefits of warfarin in stroke prevention cannot be denied.

These positive facts have to be balanced by a practical and financial downside, such as the cost of regular blood tests, careful monitoring and practice staff chasing up poor responders. So, for my practice, I systematically talked through the pros and cons of warfarin treatment with each person with existing atrial fibrillation, with a positive sell message.

It has been an interesting exercise. Many have relations who suffered an incapacitating stroke and had no hesitation, responding positively with "you know best Tessa/Dr Tess". Just a couple struggled gamely with perceived side effects before giving up and for equally few I considered the drug to be too risky.

The downside of warfarin, however, was suddenly brought home to me. An elderly and very independent patient whose warfarin control was exemplary was knocked over by a backing car. This was a case I had really pondered over. Five weeks of hospital care, two operations and persisting incontinence are the outcome of what

should have been an uncomplicated fractured pelvis. Warfarin, the cardiologist's dream, is the orthopaedic and vascular surgeon's nightmare.

Despite this personally heart chilling experience, I will still positively sell the benefits of warfarin. I understand balancing financial and health responsibilities is never going to be easy. However, I believe GPs are capable of working towards striking the balance between accountability to individual patients and financial responsibility in both practice and national settings.