
WHAT'S NEW IN . . .

General Practice

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Introduction

Primary health care occupies an increasingly pivotal role in the National Health Service (NHS). Historically, General Practitioners (GPs) were characterised as failed specialists, unable to work in hospital medicine, and marginalized with respect to the planning, management and delivery of health care (1). In the 1970s the Royal College of General Practitioners took steps to address this perception, endeavouring to raise the profile of General Practice by establishing mandatory vocational training, setting professional academic standards and lobbying politically for greater involvement of GPs in all aspects of NHS management (2). These initiatives enabled GPs to establish a "new specialism", but the unprecedented growth in medical technology and therapeutics, and the constant political pressure of healthcare reform has resulted in almost perpetual change for doctors working in primary care. GPs have been required to adapt and evolve their working practices to a degree experienced by no other branch of the medical profession.

Writing an article entitled "What's new in General Practice?" presents the author with a dilemma: on the one hand the daily activities of consultation, investigation, diagnosis, prescribing and referral continue as before, although with greater frequency and a much broader range of choices for both the patient and the doctor. In this purely practical sense, little has changed in general practice in the last forty years. On the other hand, new medications, treatments, philosophies and structures are conceived and applied to healthcare every year, and to attempt an even brief account of all that is truly new in primary care risks a glib over-generalisation of the current position and offers only a personal view. Given the multidisciplinary nature of the likely readership of this article, it is perhaps of greater interest and value to outline briefly a few hot topics in general practice today within the contexts of general practice as medicine, as a business, as a profession and as a vocation.

General Practice As A Medical Speciality

At the outset of NHS primary care, GPs provided an acute medical treatment

service, responding to patient attendances by dealing almost exclusively with the problem in hand. In the 1970s sociologists identified the developing potential of the general practice consultation for more than just reactive medicine and a more holistic approach involving behaviour modification, management of ongoing problems, and opportunistic health promotion became popularised (3). At the same time, better public education concerning health and wider media representation of health issues resulted in increasing rates of self-referral to primary care staff, and a more health conscious population. The inevitable result has been a relentless increase in workload for GPs in the past 30 years, due in part to our ageing population and their increasingly complex medical needs.

Modern acute and long-term medical care ensures that patients survive major health problems such as acute myocardial infarction, stroke and cancer in greater numbers than previously. These patients live on to develop more than one health problem, or multiple morbidity, presenting complex management problems which require more regular contact with their general practitioner and primary health care teams. Consultations for the elderly are now the most common, with the over 75s tending to consult their GP twice as often as other patient groups (4). Multiple morbidity and the ageing population pose a significant, but generally overlooked, challenge to the delivery of effective health care (5). Concurrently, the focus of long-term health care has shifted from the hospital setting to general practice. Ninety percent of all consultations in the NHS now occur in primary care, totalling around 300 million consultations per year (6). Having traditionally occupied a 'gate-keeping' role for secondary care services, GPs are taking on more long-term management of chronic disease themselves.

Changes of national policy have added to increasing GP workload, the most recent being the publication of the NHS Plan 2000 that sets specific goals for many areas of health care development. An example of this has been the introduction of the National Service Framework (NSF) for Coronary Heart Disease published the same year, which has strongly influenced GP prescribing habits for secondary

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prevention in coronary heart disease. A fourfold increase in spending is expected for cholesterol lowering statins for the year 2003/4 as a result of increased prescribing following the guidance in this NSF (7). As more service frameworks are published GP activity is likely to shift further away from acute treatments towards long-term disease management.

Chronic disease management is no longer confined to the elderly population, with many younger patients requiring regular monitoring of their drug treatment as newer and more potent medical regimes become widely adopted. Unlike colleagues working in specialised and super-specialised fields, GPs have a broader awareness of new drug therapies and indications, and wherever possible it behoves them to maintain an appreciation of clinical context, drug interactions, and cost to ensure safe prescribing and good medicines management. There is increasing pressure to adopt shared-care prescribing arrangements for drugs such as methotrexate, lithium and methylphenidate, with inherent risks for both patient and doctor should regular monitoring arrangements go wrong (8). The inclusion of near-patient testing in the enhanced service framework of the New Contract for general practice indicates the government's desire to move some of this costly and labour intensive activity out of secondary care into primary care.

The net result of an ageing population, multiple morbidity, more numerous drugs and drug interactions, and a trend for GPs to be actively involved in the management of chronic disease, is that the primary care consultation *per se* is becoming more intellectually challenging. GPs are taking longer in consultation to elicit the necessary information and make the correct and safe choices unique to each case. In spite of a reduction in the number of consulting sessions per GP per week, the length of session and the time spent per consultation has increased (Table 1).

Table 1. Comparison of Surgery and Consultation Lengths, UK 1990-2003 (9).

	1990	1997	2003
Activity			
Average number of surgery sessions per week	8.47	8.38	N/A
Average length of surgery sessions	2h 22 mins	2h 44 mins	N/A
Average length of consultations in surgery	8.33mins	9.36mins	13.3mins*

*Transforming Primary Care: the Role of PCTs in Shaping and Supporting General Practice. London: Audit Commission, 2004.

The modern patient-centred consultation style and emphasis on advice and health promotion have added to the pressure to spend longer in consultation. There are

numerous positive outcomes, including fewer prescriptions and better handling of psychosocial problems (10). There is also evidence that patients feel more positive and better able to cope with their illness or condition following longer consultations with their doctor (11).

GPs not only have more to do, but can genuinely do more than in previous decades. Many new treatments are highly beneficial and have acceptable safety profiles for use in primary care; two examples below demonstrate clinical conditions for which newer drugs are rapidly being adopted by GP prescribers.

'Biological' treatments for eczema and dermatitis

Consultations for skin conditions comprise around 11% of all primary care attendances (12) of which many are for eczema and related skin conditions. The mainstay of treatment for atopic eczema is the daily application of emollients with the intermittent use of topical steroid preparations to control acute flare-ups. Whilst this approach is effective, interest in any treatment that may be more effective or produce more rapid benefits for patients who are severely affected is likely to be high, given the inconvenience and embarrassment this condition causes for sufferers. Pimecrolimus and tacrolimus are immunosuppressant drugs with useful effectiveness against eczema that cannot be controlled with emollients and topical corticosteroids alone (13,14). Comparative data is not yet available to indicate whether tacrolimus and pimecrolimus are superior to topical steroids, but their action has been proven to be better than placebo and tacrolimus is considered to be at least equivalent to treatment with a high potency topical steroid (15). Whilst the safety of these preparations for long-term topical use is yet to be established, there is cautious optimism that their use by GPs, particularly those with special interest in dermatology, may become more accepted.

Tiotropium for Chronic Obstructive Pulmonary Disease

Chronic Obstructive Pulmonary Disease (COPD), in which gradually deteriorating lung function results in persistent breathlessness and progressive disability, can be a demoralising disease for both patient and doctor. In the past, many patients only received attention during an acute exacerbation, but new contractual requirements for GPs to register all sufferers and perform annual reviews will encourage structured contact with COPD patients and better care.

Effective drugs to treat COPD are scarce, partly because these patients differ from

those with asthma in the pathogenesis of their disease and the pharmacological opportunities to reverse the airways obstruction. In COPD, drugs inhibiting smooth muscle tone in the airways may be the only effective means of reducing dyspnoea. A new inhaled anti-cholinergic drug, tiotropium bromide, has been shown to achieve better and longer bronchodilation than older drugs such as ipratropium bromide and salmeterol (16). The half-life of this drug is sufficient to require only once daily dosing, making compliance with treatment more likely than with the four times daily drugs such as ipratropium. A Cochrane Library review of the role of tiotropium in the treatment of COPD has confirmed its benefits in reducing acute exacerbations and hospitalisations in COPD sufferers, and there is evidence to suggest that with regular use tiotropium may slow the progressive deterioration of FEV1 and FVC that is typical of advancing obstructive airways disease (17). If this effect is sustained, tiotropium will represent the first inhaled medication that is able to halt the progress of the disease. In addition, patients referred for pulmonary rehabilitation have been found to achieve better pulmonary fitness and improved health status if they are concurrently treated with tiotropium (18).

Guidelines for the management of COPD published by the National Institute for Clinical Excellence (NICE) include early regular treatment with long-acting inhaled bronchodilators (19) and are being widely adopted. There is, however, some concern that tiotropium may not be the most cost effective treatment available, a review in the *Drug and Therapeutics Bulletin* in 2003 concluding that further trials were needed before this drug could be considered the treatment of choice for all patients (20).

General Practice as a Business

NHS general practitioners hold a uniquely autonomous position as self-employed businessmen, and have jealously guarded this privilege despite the extra workload of managing practice finances, staffing and encouraging business development. The Quality and Outcomes Framework (QOF) of the New Contract for general practice and the re-emergence of Practice Based Commissioning (PBC) are two recent contractual initiatives that are likely to have a dramatic influence on the way GPs manage their business in future.

The contract under which the NHS engages GPs has a major impact upon both the clinical services they provide and the business activities, structure and ultimately the morale of the primary care teams. Levels of job satisfaction among GPs have been falling dramatically over the last 15 years due to the expanding workload (see above), declining interest in primary care as a career

choice (21), increasing bureaucracy, and the progressively more onerous responsibility for out-of-hours care.

Major reform of GP contracts has occurred with nearly each decade since the inception of the NHS, starting with the 1965 Charter for Family Practice. Each reform has imposed new terms and conditions, and occasionally changes in the way funds are obtained and managed. Very little was achieved during the 1990s by the introduction and then abolition of GP Fundholding by successive governments of different ideologies, and yet more confusion was brought about in 1997 by the development of Personal Medical Services (PMS), a funding structure for GPs which was intended to free them from the bureaucratic fees-based system of remuneration inherent in the old General Medical Services (GMS) contract framework. By September 2003 around 35% of unrestricted principal GPs in England provided services through PMS arrangements (22).

The Quality and Outcomes Framework

The NHS Plan 2000 identifies a lack of national standards and a lack of clear incentives to improved performance as two systematic problems in need of reform in the health service of the 21st century. A significant development has followed, with the introduction of the Quality and Outcomes Framework of the New GMS Contract. The QOF is essentially a performance management tool that rewards practices with extra funding if they can demonstrate high achievement against a set of predetermined quality indicators. There is a difference of opinion concerning what exactly the QOF represents, with some commentators labelling it as a voluntary system of financial incentives and others as a national system of allocating primary care improvement monies.

The QOF divides clinical and administrative activity into domains, each containing a range of key indicators relating to clinical and organisational standards, extra (additional) services and patient experience. Evidence-based criteria have been used to define the key indicators for each of the clinical (and non-clinical) domains, with each criterion being assessed by percentage achievement against a minimum of 25% and a variable maximum. Table 2 shows an example from a clinical domain, the fifth quality indicator for hypertension. To score 56 points for BP 5, a practice must have recorded a BP of less than 150/90 for more than 70% of its hypertensive patients. Computerisation has helped significantly with data recording of this type, allowing disease registers and clinical measurements to be kept accurately and updated frequently. Some account of local changes in disease

prevalence is made, and patients can be excluded from the disease register for valid reasons such as a terminal diagnosis. The QOF is, however, the first national system of health care recording which quantifies a specific practice's achievement against a set of pre-determined parameters and rewards achievement with income.

Table 2. Extract from the *Quality and Outcomes Framework, New GMS Contract 2003* (23).

Indicator	Points	Maximum threshold
Hypertension BP 5. The percentage of patients with hypertension in whom the last blood pressure (measured in last 9 months) is 150/90 or less.	56	70%

Diseases of high prevalence and significance, such as cardiovascular disease, diabetes and hypertension, have been weighted with a high proportion of the available points. A total of 1049 points are available across the range of 146 domains, with remuneration being based on an average list size and patient demographic. The monetary value attached to each point will rise over each of the first three years of the new contract. This intention is to offer a strong incentive and the financial means to achieve high quality improvements across the range of primary care services, particularly for practices that have historically underperformed.

A new data collection system, the Quality and Outcomes Management and Analysis System (QMAS) was installed in 2004 to enable practices to monitor their achievement of points and likely payment. Data is collected monthly by local PCTs and Strategic Health Authorities, and an individual practice's achievement in the QOF is now available on the DH website (24). This transparency raises the spectre of league tables and rating scales for GP surgeries, but more positively QMAS data will allow accurate comparison between regions, health authorities, PCTs and practices, and will enable the establishment of accurate disease prevalence databases.

The QOF is likely to raise standards and improve care for many patients, but the framework is not exhaustive. The NSF for Coronary Heart Disease includes patients suffering with peripheral vascular disease and atrial fibrillation, but patients with these common problems are not covered by the QOF. Similarly the indicator for cholesterol in secondary prevention of coronary heart disease is a considerable oversimplification of the true NSF target.

Practice Based Commissioning

Following the QOF, a second and equally important change in the business of general

practice has been the re-emergence of Practice Based Commissioning (or primary care commissioning) as a credible alternative to the current arrangements for commissioning health services. Primary Care Organisations (PCOs) have failed to optimise their commissioning role, distancing GPs and interested members of the public from the development and management of local services. PCOs have also failed to use the power of commissioning as leverage to achieve improvements in service delivery, a key area of reform in the new NHS Plan. The concept of practice based commissioning is not new, and is the focus of DH attempts to encourage GPs to re-engage with and support the PCOs. Forerunners of our current models of primary care commissioning include the GP Fundholding and Total Purchasing schemes of the 1990s, which were abandoned by the incoming Labour government in 1997. Benefits of these schemes included shorter waiting times for secondary care, reduced rates of elective hospital admission and lower rates of rise in prescribing costs. The down side was that the staff, equipment and computing costs for fundholding practices were high, and there was evidence of an inequitable two tier system being established. Available resources were preferentially directed towards fundholding practices (25) and homeless people with multiple morbidity were less likely than others to be registered with a fundholding practice (5).

From April 2005 practices have been able to obtain indicative budgets from the PCOs for the whole range of health care services they use, including scheduled care, unscheduled care and diagnostics. Although practices may use this information to develop local services, the PCTs will continue to hold the budgets proper and will be responsible for negotiating and maintaining any contracts with secondary care providers. The expectation is that practices, or consortia of a few or many practices, will eventually hold notional budgets covering almost the entire scope of health care provision. The perceived benefits of primary care commissioning will be the ability of GPs to shape the delivery of services to suit the local requirements of their immediate population, whilst at the same time achieving national targets for care in line with country-wide and local delivery plans.

In the current climate of our health economy this may seem too good to be true, but protection for the Trusts exists in the proviso that practices that overspend on three consecutive years are suspended from the scheme. Any such practice would have its commissioning role assumed by a more effective group, transferring the respons-

ibility to others who are more able to make the system work. It remains to be seen whether such sweeping change is achievable, with resistance to such restructuring likely to come from both the primary and secondary sectors. GPs are exhausted and demoralised by decades of contractual miasma, and many feel that the resource implications of the new system will severely stretch what is an already attenuated thread of good will.

The pre-requisites of both the QOF and practice based commissioning are accurate and up to date information, with the facility for a large number of stakeholders to quickly store and retrieve data as required. Through the National programme for Information Technology and the establishment of the NHS Integrated Care Record Service, the unified Electronic Patient Record, and initiatives such as electronic prescribing, there may be the facility to reduce the volume of paperwork and administration undertaken by GPs whilst at the same time providing the necessary level of information required to make primary care commissioning a reality.

General Practice as a Profession – Revalidation

The pressure upon doctors to demonstrate their fitness to practice has intensified following high profile medical scandals concerning professional skills, ethics, and in the case of Harold Shipman, basic human nature. Trust in professionalism has been superseded by a culture of management, resulting in greater demand from government and the laity for a mechanism by which doctors may be licensed to practice. Changes to professional regulation for doctors in the United Kingdom have been painfully slow and there is confusion concerning the most appropriate timing, mechanisms and outcomes of such a process. The public needs reassurance that doctors continue to be fit to perform their role throughout their career, not simply upon graduation. A 2003 Gallop poll in the USA revealed that 80% of adults believed doctors should have their qualifications periodically re-evaluated, including among other things an assessment of their individual success in treating the common conditions of their specialty, and a written test of factual knowledge (26).

In 1998 Sir Donald Irvine, then President

of the GMC, began a review of the meaning of registration, and proposals for a system of accreditation. As the model developed, a two-tier system of registration based upon annual peer review (appraisal) and revalidation at five-yearly intervals during a doctor's career evolved, the end point being seen as a license to practice. Various obstacles have appeared to delay the establishment of a meaningful system, including criticism of self-regulation of the medical profession in the UK, failure to understand the differing nature of appraisal, revalidation and clinical governance, and most recently a wholehearted attack on the current regulatory frameworks and the GMC from the Chairman of the Shipman Inquiry Dame Janet Smith (27).

Self-regulation is a fundamental requirement for the medical profession, since we rely for advice upon those with specialist knowledge and experience who, by necessity, are drawn from our own ranks. Other nations successfully use self-regulation of doctors by putting greater emphasis on the validity of the processes of assessment used in each setting (28). In health care systems in the US, Canada and Australia the responsibility for licensing, education and fitness to practice are delegated to individual states or provinces. Local mechanisms are relied upon to ensure fitness to practice, and such systems offer valid models for local regulation of doctors that could be applied within our national framework. Added reassurance is achieved by specialty-specific certification being awarded by the relevant academic body and for a limited period. Greater involvement of the Royal Colleges in this process in the UK would enable them to confirm the skills and educational currency of their membership on a regular basis.

Defining what each of the various assessment methods is, and how they should be used, has been an important step in developing a useable framework (Table 3). The three principle methods of assessment overlap, but are not interchangeable. Appraisal is a formative process, not intended to weed out the "bad apples" but designed to guide career development and personal growth. Revalidation is a summative process, based upon compliance with a set of defined competencies resulting in a pass or fail decision in respect of continuing fitness to practice (29).

Table 3. The three principle methods of assessment.

<p>Appraisal – a formative and developmental process, about identifying development needs not performance management.</p> <p>Revalidation – an episodic process demonstrating fitness to practise to the professional regulator (the GMC).</p> <p>Clinical governance – a framework through which NHS organizations are accountable for improving the quality of services and safeguarding high standards of care.</p>

The model proposed by Irvine failed to recognize that the process of appraisal was unlikely to be an adequate defence against doctors performing significantly badly or those who were intentionally setting out to mislead their assessors. Identifying and dealing with these doctors should be the task of local health care organisations and Strategic Health Authorities, who should have sufficient knowledge of individuals to be able to perform such a role. The solution to a failure of this process at local level is to strengthen the local system rather than transferring responsibility to a national organisation (the GMC) that has a unique but different contribution to make (30).

There is confusion, mistrust and apathy with regard to revalidation, and reform is desperately needed. Walshe and Benson have offered a strategy which includes harmonization of the 9 regulatory bodies for health care professionals in the UK, an explicit definition of the scope of professional practice for each group, better systems to ensure professional competence is maintained, and a restructuring of the GMC to ensure that boards and councils are primarily elected, and represent a greater proportion of the laity than is currently the case (31). Lay involvement in setting standards for clinical governance and appraisal is currently non-existent and some opinion suggests that lay people should be intimately involved in the approval of every doctor (32).

Annual appraisal for GPs has been a reality for some years, although financial investment in the system has been poor and the process remains time consuming and labour intensive. Development of a process of revalidation applicable across the range of doctors working in the profession has been halted, while further consultation and discussion takes place. General practice is a natural testing ground for new processes and frameworks, and many GPs do feel encouraged and reassured by their experience of annual appraisal. Despite the recent scandals and preferential reporting of medical error in the media, public trust in doctors remains higher than in any other professional group (33). The requirement to demonstrate fitness to practise repeatedly over the course of a career will put yet more stress and demands upon doctors,

but is an inevitable development that will benefit the medical profession by strengthening public trust in doctors and their work.

General Practice as a Vocation

The career model for general practice has undergone dramatic changes of emphasis in recent years, reflecting disenchantment among young GPs with the traditional vocational model of the role of the family doctor. To remain in the same practice in partnership for all of one's working life is now seen as only one of a number of options available to a newly qualified GP. The traditional work ethic that encouraged family doctors to be available to their patients at all hours, providing continuity of care from cradle to grave, has all but disappeared. Increased day and night time workloads, greater consumerism in the attitude of patients to their health care, and the desire for greater flexibility in careers to allow a more equitable work-life balance have had an impact on the manner in which GPs view their work. The rapidly increasing number of female doctors in general practice workforce has made part time and flexible working structures much more common (22). The developing role of the GP with Special Interest (GPwSI) and the almost universal decision to opt out of providing out of hours care are important developments which may weaken the vocational nature of general practice but will in the longer term improve recruitment and prevent career burn-out.

GPs with Special Interest

Historically some GPs have been able to develop an area of interest through sessional work in secondary care as clinical assistants, associates, or staff-grade doctors. The increased demands of modern care upon all sectors of the health service has led to innovative posts in many clinical roles, but until recently there were few national standards and little recognition of the greater clinical knowledge and skill of GPs working in this way. Although there is no established pathway to developing a special interest, the Department of Health (DH) and the Royal College of General Practitioners (RCGP) have published framework documents setting standards and encouraging the national development of GPwSI posts across a number of clinical specialties (Table 4).

The guidelines differ for each clinical specialty, but a GPwSI will generally be required to demonstrate a set of basic competencies, usually obtained by success in a diploma-level qualification for the relevant specialty. In addition, ongoing clinical supervision by a consultant mentor, and in most cases a basic attendance of at least 100 clinics in a specialist service, are

Table 4. Clinical specialties for which GPwSI guidance has been published (34).

Care for older people	ENT
Child protection	Epilepsy
Coronary Heart Disease	Headaches
Dermatology	Mental Health
Diabetes	Musculoskeletal conditions
Drug Misuse	Palliative Care
Echocardiography	Respiratory Medicine
Emergency Care	Sexual Health

seen as the standard to obtain accreditation. Considerable personal investment is required prior to an appropriate level of training being achieved that, whilst correctly ensuring that only competent doctors are able to work in this way, may result in a disappointingly small percentage of GPs taking up the opportunity to become GPwSIs. According to the DH there were 1,400 GpWSIs working in the UK in 2004, corresponding to around 3.5% of the general practice work force.

There are clear benefits for the health service as a whole from the development of this intermediate grade of health care, bridging a gap between traditional primary and secondary care. Unofficial reports suggest that GpWSIs seeing referrals from non-specialist GPs are able to discharge 85% of cases without onward referral to secondary care (35). This could relieve much of the pressure on secondary care services as well as improve satisfaction by offering patients the opportunity to be seen closer to home and in familiar surroundings.

Many contractual and governance issues still need standardisation, since the majority of GpWSIs work to locally agreed contracts. There is a high degree of variability in the standard and content of these contracts, but it is hoped that the new Association of GPs with Special Interest (36) will enable further development of national standards and accepted best practice. Whether a GP would continue full time generalist work having embarked upon the necessary study and training to become a GpWSI remains to be seen, a matter of some importance at a time when the number of full time unrestricted GP principals working in the NHS has been in steady decline for some years (37).

Out-of-hours Care

The backdrop of increasing dissatisfaction with heavy workload, a perception of changed roles and responsibilities within the health service as a whole, and the need to alter the working lives of GPs substantially to prevent a fatal decline in the workforce, led to the option to hand over responsibility for out-of-hours care to PCOs under the New GMS contract in April 2004. Night call data indicated wide variations in the rates of night visiting between GPs in different geographical and demographic areas, and a consistent rise in the rate of night visits over a 10-year period (38). The decision to offer an alternative was informed by a 1992 ballot of GPs, which indicated that 4 out of 5 felt they should be able to opt out of 24-hour responsibility for their patients (39). The result has been that the vast majority of GPs no longer provide out-of-hours care for their patients, despite warnings in a government report at the time that the cost of

transferring out-of-hours care to the PCOs could be significantly higher than the existing arrangements.

Patients can now obtain advice and treatment from a range of sources out-of-hours, including NHS Direct, local primary care centres run by the PCOs, walk-in centres, and accident and emergency departments. This has been an unpopular development, since patients prefer out-of-hours care to be provided by their own family doctors (40). The care these patients receive is, however, as good as that which can be provided by their own GP, and in certain specific situations such as acute asthma and post-coital contraception the quality of diagnosis and advice may even be better (41).

Conclusion

General practice remains one of the most rewarding but also most challenging roles for doctors working in the NHS. The traditional vocational career model is being superseded by more flexible career structures, and the development of a new grade of GP with special interest in one or more clinical field. Past uncertainties due to contractual upheaval, political manoeuvring and ever-increasing workload are likely to continue, whilst the complexities of medical therapy and the range of services provided in primary care are set to increase year on year. A work force crisis in general practice has been averted by the New Contract, but it remains to be seen whether current initiatives to reform primary care and restructure service delivery are sustainable for anything but the short term.

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