

London Landscape

That was then, this is now...

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I sit in the sun, perched on a five-barred gate, chewing on a straw – and I look back at it all...far back to a time long before I had even thought of medicine as a career, a time when my father was struggling desperately to run a small-list practice in a deprived area of London, a time soon after the NHS had been established.

It seems unbelievable that the annual per capita fee then earned by a GP for an NHS patient was as little as 17 shillings and sixpence – irrespective of how many visits you made; how many letters you wrote; how many phone calls you made for your patients. There was no system of reimbursement of expenses for premises, for staff, or anything else. Irrespective of the effort – or lack of it – you might put into caring for your patients, that small per capita sum was all you could earn. For the practices with large lists, this was acceptable; those with small lists struggled – and even when attempts were made to improve the situation, it was the big practices which did well...a case of ‘to him that hath, to him shall be given’. It took a long time and much hard negotiation for things to improve. But improve they did so that, when I entered general practice in 1972, it was – quite simply – the best of times. With a father, two uncles, and a brother all GP’s, I had been brought up in the world of general practice and never really wanted to do anything else. I was lucky enough to join a superb practice which aimed at, and achieved, the highest standard of medicine. The system of reimbursement of rent and rates together with a far more realistic per capita fee structure and item of service payments made it possible to run a good service while earning a reasonable living.

But the system worked, largely because we accepted all the stresses and strains built into the GP’s life. We worked hard, and the work was exciting, exacting, exhausting and, occasionally, frightening. The hours were overlong; the life–work balance was at times non-existent, so that too many of us were absentee fathers and husbands but – selfishly, perhaps – we were imbued with the excitement of doing our best as doctors. Continuity of care was built into the system. We knew our patients well; they were on our lists as opposed to being on a practice list. We knew the local consultants well; we knew their strengths and special interests so that we knew to whom cases should be referred – and

we could, if necessary, refer to any London hospital of our choice in order to seek the best specialist attention for our patients.

The Contract in 1991 incorporated the idiocies of the Internal Market and Fundholding; healthcare was dragged into the market place, and co-operation was replaced by competition as the government attempted to construct a lean and mean health service ruled by commercial considerations. Managerese became the language and our freedom of referral meant that patients could be referred only to those hospitals with whom the Family Health Services Authority had a block contract. Any extra-contractual referrals meant long and tedious arguments with administrators rather than doctors. In the secondary care sector, bed numbers were slashed; nurses’ accommodation was sold off; cleaning and catering alike were put out to tender – with the cheapest favoured over the best, and the result that hospital hygiene and nutrition both deteriorated drastically. We struggled, often, to find beds for our patients; admission stays were shortened, and the re-admission rate went up due to infection and haemorrhage and wound breakdown. None of this changed much when New Labour came in; the bed state was unchanged; nurses still had nowhere to live and the government remained obsessed with the private sector.

The next New Contract removed responsibility for out-of-hours care, and imposed a Quality and Outcomes Framework on us which quantified and costed all those things we were already doing. Inevitably, this introduced a profit motive into the consultation and standardising the consultation to iron out that individuality of approach which was the fruit of long experience. Target succeeded target; initiative succeeded initiative; choose-and-book offered the pretence of private practice privilege to patients with little or no knowledge on which to base such choices.

What next? Further privatisation is on the march – this will inevitably increase competition and reduce collaboration. We dare not progress down the American path that has the most expensive and unfair system in the world. How can thoughtful general practitioners respond?

As general practitioners we must retain our place as the central co-ordinating figures in patient care, and speak loud and clear about our work, telling it like it is. Journals such as *LJPC* must enable this voice. It must speak about the essence of general practice – its excitement; its blood and guts at the rockface of medicine; its connections with all aspects of health and society. The *LJPC* is doing a good job. But I know from my own editorial involvement with *London Calling* (and, more recently, with *The Writer* – the journal of the Society of Medical Writers) just how difficult it can be to persuade people to contribute.

London's GPs must flood these pages with case reports, ideas and memories. Without such input, the true value of general practice will be forgotten.

Above all – we must remember that general practice is privileged to be the last bastion of the true general physician. That privilege must be preserved.

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