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18.IV.88.

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Dear Paul,

I have delayed writing until now because I wanted to up-date myself on the changes that ~~are~~ have taken place in General Practice during the twelve years since I was principal, although I am still a member of that college.

When I was a trainee and then a principal in General Practice, '74 to '76, it was very evident to me then that ~~at the time~~ there was an enormous drive by the Government to encourage General Practitioners to take up family planning, and as a result very many of us ensured that we had done a Family Planning Course, so that we could qualify for the IUCD fee, which at that time was £10. I am surprised to see that it has actually risen more than three times to £33.15.

By comparison, the consultation and minor operations fee is £14.75. (This fee did not exist in 1976). This fee ~~would be~~ is appropriate for any non-emergency minor surgery, such as excision of a sebaceous cyst, treatment of an ingrowing toenail, removal of superficial lumps and bumps on the skin - (providing that there was no clinical indication that there was malignancy, and providing that all tissue excised was sent for histology). If the General Practitioner was available, there is no reason why he could not do the more simple emergencies, such as suture of simple lacerations and removal of a superficial foreign body in the eye.

Since these procedures would probably involve more than a comparable procedure of fitting an IUCD, (although the latter does involve also general family planning advice), I believe that at the very least this consultation and minor operations fee should be doubled or possibly trebled. for 1 year? 2 of £14=75.

2/-

There are, of course, certain other problems which dampen incentives for General Practitioners to undertake work which they could do more cost-effectively than hospital emergency services:-

(1) Lack of provision of CSSD services - (Central Sterile Supply Department).

(2) Lack of appropriate premises for many inner city single-handed General Practitioners - (by comparison to Health Centres).

(3) Lack of nursing support - (even though there is a 70% re-imbursement of the nurse's salary by the FPC).

These problems would not be insurmountable providing there were sufficient incentives.

We in Accident and Emergency would be only too delighted to run courses on minor surgery for General Practitioners, and if those General Practitioners saw that there was appropriate remuneration, I believe the financial incentive would be sufficient to overcome difficulties. It could well be that once these difficulties were overcome, i.e. once a General Practitioner had his premises, a nurse and appropriate skills, over a period of years the fees for minor surgery could proportionately be reduced from the initial pump priming that would probably be necessary.

~ +CSSD equipment supply

It must be remembered that General Practitioners are answerable to Family Practitioner Committees who are answerable to the DHSS, whereas Community Services are (including District Nurses), are answerable to the District Health Authorities, whilst personalized social services, e.g. Meals-on-Wheels, Home-Helps, come from local authorities. If these three were under one Community Health Service, I believe it would be easier to provide the necessary support to the General Practitioners to make use of their minimum of nine years' training. (Five years as a Medical Student, one year as a Houseman, three years as a Vocational Trainee). In addition, remembering that there is a block in certain grades in certain

specialities, e.g. Registrars in General Surgery, there would be an incentive for General Practices to appoint partners who had a specific surgical expertise, and could train other members in the practice. Again, the financial incentive would need to be sufficiently high initially to enable this to come about.

The local Accident and Emergency Departments would be supportive of their local General Practitioner colleagues, such that if a wound dehisced - (broke open), bled or a procedure they were carrying out went wrong, then that local Accident and Emergency Department would be there to provide a 24-hour emergency service back-up. By giving the patients this service, they would give the General Practitioners the support that they needed in order to have the courage to proceed.

I believe that these problems will become more acute as the population ages and the post-war baby boom becomes a retirement bulge. Then it will be of enormous importance to keep patients out of hospital and in the community.

A large number of vocational trainees in General Practice spend six months of their three years in Accident and Emergency, and in Accident and Emergency they learn basic surgical procedures. Although we do not deal primarily with cold minor surgery, I do not in point of fact turn such patients away, as they are very useful teaching material for our junior Senior House Officers who can carry out minor operations under supervision.

We all know now how the pendulum has swung, such that there is enormous competition for good practices. Vocational trainees who have a practical surgical training, would ~~have~~ increase their financial worth to a practice, and therefore ~~those~~ trainees would have a great incentive to develop a surgical expertise. Thereby minor surgery-type patients would be removed from waiting lists.

I should also say that simple superficial abscesses could also be incised by General Practitioners, as they are far too often treated with antibiotics without surgical intervention at the cost to the patient

because antibiotics do not dissolve pus, only create a sterile abscess.

Finally, developing what I have said above for a Group Practice, there is everything to be said for one member of that practice to have a surgical expertise just as perhaps another one might have an anaesthetic expertise, and so on through the practice. Small hospitals could provide a community a cottage hospital service, but the large district general hospitals serving populations of 300,000 +, with Accident and Emergency Departments seeing 50,000 or more patients a year, would be the trauma centres of the future, perhaps being on-call for trauma in rotation with other large district general hospitals, so that surgical teams were readily available for major trauma. (This is another topic I know, but one which is increasingly going to be discussed as a result of what is happening at the College of Surgeons of England).

because there would be sufficient trauma to make it worth their while to be available for that trauma, as opposed to doing old elective surgery.

Again, developing the theme of my earlier letters, money would follow ~~the~~ patients, and the General Practitioners who provided these services for patients would be paid on an item of service basis. In a hospital setting, again, money would follow the patient, such that those departments which provided low cost services would receive more patients and thereby more money. This would provide the competition that would be necessary to keep costs down. However, money would not follow the patient in district general hospitals for those services which the DHSS deemed would be more appropriately carried out in General Practice. The only rider here is that Teaching Hospitals would perhaps receive a small fee so that they could train their junior staff in treating minor surgical problems, remembering that in a strictly surgical sense there is no minor surgery; only minor surgeons.

General Practitioners, being self-employed, have always been an entrepreneurial breed, and also somewhat more individualistic than their hospital colleagues, who are more institutionalized. Therefore, an extrapolation of the item of service payments system would find fertile ground in General Practice.

P. Gray, Esq. 18.IV.88.

I hope what I said is both pertinent and relevant, and thereby helpful.

Yours sincerely,

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CONSULTANT IN ACCIDENT & EMERGENCY
