QUALITY OF GENERAL PRACTICE

Epidemiological Studies, 1961-67

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INTRODUCTION

No perceptive general practitioner can fail to be aware of the clinical, academic and administrative difficulties which beset him. My own reactions are probably typical. After my first year of hospital residence, I spent six months in a rural solo practice where I soon became so concerned about the problem of maintaining high standards that I returned to hospital work for three more years. Subsequently, five years in an urban industrial group practice with ten partners, helped to impress upon me the advantages of team work and pooled resources. Yet I remained aware of many imperfections, both in my own performance and in the system as a whole. When I gave up general practice for epidemiology it was natural that I should apply epidemiological methods to the study of medical care in general practice.

The results of my studies, spread widely in time and place, are set out here. My methods have been to construct a model, to observe a sample of practices, to examine some sociological and academic characteristics and the distribution of doctors, and to ask general practitioners themselves to record a few facts about their daily work. Although this may not make a very coherent story, I believe it suffices to reach some conclusions.

Let me begin by repeating the definition of general practice

given in my essay[1] for the Tasmania Prize of the Australian College of General Practitioners: "Medical practice which offers direct access to care for previously unselected patients". Continuing care cannot be assumed by definition to be found only or always in general practice, but is an ingredient of quality requiring measurement. Neither is family practice synonymous with general practice. In the United States, the term "primary medical care" has been suggested to describe the treatment of previously unselected patients, and the doctor who delivers primary medical care has been called the "first-contact physician" (he may be a specialist or a general practitioner). These terms will occasionally be useful in the discussion.

It is advisable to say what this thesis is not about. I have not considered undergraduate or vocational medical education for general practice, except in passing; and I have tried to avoid involvement in the debate about role and function and optimum establishment. This debate has continued without pause at least since the publication in 1920 of the Dawson Report,[2] and my opinions, supported though they may be by evidence, will not help to resolve it. Here I am concerned only with assessment of some factors which can influence the quality of medical care. If the methods of measurement which I describe can be applied by others, this dissertation will have served its purpose.

Much of my work has been done in Britain, where the pattern

of general practice has been shaped by the National Health Service. However, I believe that most of my conclusions are relevant in Australia and other industrial countries with similar living standards and medical services.

Some of this work has already been published and has been paraphrased in the typescript. Elsewhere I have incorporated published papers as parts of chapters and added a commentary. Other publications in support of the thesis have been bound in sequence at the back, where questionnaires can also be found.

REFERENCES

1. Last, J. M. (1967) Objective Measurement of Quality in General Practice. Annals Gen. Pract., XII, Part 2, Suppl. pp. 5-26.

2. Dawson of Penn, Chairman (1920) Report on the Future Provision of Medical and Allied Services. London: H.M.S.O.

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