How to undermine general practice
Margaret McCartney, p 41

Doctors must not forget how to use their hands

High tech investigations are fallible and are no replacement for hands-on medical practice, writes **Ben Richardson**

During a recent cardiology ward round, the consultant listened to a patient's heart and described a harsh mid-systolic ejection murmur with a very quiet S2, on top of a higher pitched pan-systolic murmur heard best over the apex, with P2 being more audible than normal. To me this was uninterpretable. He postulated that the patient had severe aortic stenosis with moderate mitral regurgitation. Subsequent review of the echocardiography report confirmed that he was spot on. To me this was intellect and perspicacity at its most beautiful. Those with a more sceptical outlook may suppose that he had furtively inspected the echocardiography report beforehand.

Occasionally in the preceding weeks, I had found myself assessing patients and wondering whether it was worth listening to the heart and lungs if at first glance I knew that I was going to order an echocardiogram and chest x ray examination. During a hectic and time pressured on-call shift physical examination of patients can seem difficult to justify. It wasn't until I reflected on Kinesh Patel's view in *The BMJ* arguing against clinical examination that I thought, yes: it is absolutely necessary.[1]

Of course, I appreciate the necessity of investigations, but we rely on them too much. Some are not as good as we think. A single 12 lead echocardiogram fails to diagnose about 45% of acute myocardial infarctions.[2] And other investigations detect clinically unimportant disease for which patients are then overtreated, such as computed tomography for pulmonary emboli.[3]

As the Stanford physician Abraham Verghese put forward in his talk at a 2011 TED conference, clinical examination is much more than inspect, palpate, percuss, and auscultate.[4] Clinical examination is essential to forming a good doctor-patient relationship, and its roots interweave the history of pioneering medical greats.

As medical students, seeing and learning how to examine patients not only inspires but allows us to aspire, and it encourages academic discipline. It helps us to understand many aspects of human science: it develops the medical mind and encourages us to apply

ZERO CREATIVES/CULTURA/SPL

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logic and to actually think. I can recall many times when examination has been the key to diagnosis. I fear for students if the only reason they can aspire to be consultants is to be able to order investigations without running it by someone else.

Some might argue that in the developed world clinical examination is a way of holding on to history and rituals, with a Western air of "we do know best," but surely globally there are even better reasons for doctors to have good examination skills.

In many parts of the world medicine is gritty, inaccessible, and impoverished. Resources are scarce, and patients present with advanced disease. An adept understanding of the use of clinical examination is essential in these settings since other investigations may simply not be possible. What UK general practitioners have at their fingertips when assessing patients is not too dissimilar to what's readily available in resource poor environments. When rapid access to blood tests and imaging is not available we may find that we are lost without honed clinical acumen and confidence in our senses.

And in the current financial climate in the UK, cuts in NHS budgets mean that we struggle with staffing, our emergency departments are bursting at the seams, and we have to invoke major incident response procedures because our medical wards are too full. Sadly, fingers of blame are often pointed in the direction of general practitioners. You often hear a bit of GP bashing for "inappropriate referrals" while on acute medical and surgical takes, but few secondary care doctors would have the confidence to discharge a patient without the back-up of extra investigations.

I am forever filling in forms for Wells scores and deep vein thrombosis algorithms, ticking boxes to indicate that clinical signs are present, racking up points so that the scan gets the go ahead. These algorithms were introduced to reduce overinvestigation, but they can be manipulated to reach thresholds, so what does it matter if we don't know how to look for the signs? Sadly, our practice is becoming governed by fear of litigation so we overinvestigate and overdiagnose—and become dismayed that we are losing our autonomy. Perhaps if doctors had more confidence in examination techniques and the interpretation of signs we would have fewer referrals from primary care, have quicker discharge from secondary care, save some money, and free some beds.

Maybe clinical examination is outdated in some specialties. Perhaps this ancient dogma will go down with the NHS. Perhaps we should don the shackles of private practice and become overpaid technicians. But, and I'm sure I speak for many doctors when I say this, for those of us who want to be real physicians, clinical examination is still very much alive.

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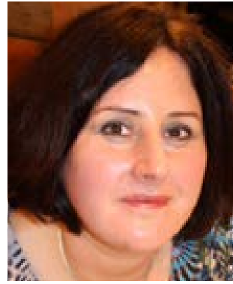
NO HOLDS BARRED **Margaret McCartney**

How to undermine general practice

The destabilisation of general practice is underway. Most general practices in England are not paid a regular amount but make their money through the contract negotiated in 2004. Core funding includes the "global sum," which makes up about half of a practice's income[1] and now amounts to £66.25 for each patient every year[2]—cheaper than the cost of health insurance for a pet dog.[3]

The rest of a practice's income is earned in bits, bobs, and from ticking the boxes of the quality and outcomes framework. It was anticipated that the 2004 contract would leave some practices vastly worse off, and so the "minimum practice income guarantee" (MPIG) ensures that practices cannot end up with a net loss.

This guarantee is now being withdrawn, and some general practices—often those in areas of high deprivation in London[4] and rural England[5]—may have to close because of the resultant drop in funding. Other practices have stopped paying partners an income in order to balance the books.[6]



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Other primary care income comes from providing "locally enhanced services"—for minor surgery or chronic disease management, for example—but many local authorities and clinical commissioning groups are putting these services out to tender, meaning vast amounts of paperwork to complete and lost income if Boots or Bupa win the contracts.[7]

The endgame is surely not just to rock the GP boat—but to tip it over. Being a partner will be too risky for those with mortgages, dependants, student debts, or indeed staff to pay and a building to maintain. Waiting in the wings are the private companies—or conglomerates of general practices—with bank balances capable of surviving transitions, and who are prepared to be more rigid with what they offer and who supplies it.

This will not translate into better value for patients: part of the current deal is that the clinical, housekeeping, and staff buck stops with the partners. A salaried doctor will have better ability to negotiate a limit on patients seen—and the time he or she leaves the building.

If I trusted our political masters I'd want to be in a salaried service which could be made free of financial incentives for clinical care. But I don't trust our politicians, who scarcely understand our work and yet seek to manage the minutiae of our day. Our NHS is fragmenting and dissolving under our watch: what are we going to do about it?

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BMJ BLOG OF THE WEEK **Billy Boland**

The power of "systems" in healthcare

I looked down at my name badge. Although it said "chief executive officer," I felt like an impostor. Across the table sat a suitably intimidating panel. The members of the Health Overview and Scrutiny Committee (HOSC), who wanted me to justify why we were keeping open a crumbling hospital with poor outcomes, while the community was crying out for more resources. Expectant faces were staring at me, waiting for my presentation. A presentation? No one told me about that. I looked down at my notepad searching for something to say. It was blank.

This scenario was all part of a simulation, and one of the many training experiences I've undertaken at the NHS Leadership Academy. The truth was, two days earlier, I'd never heard of HOSCs. These committees are a function of local authorities in England and Wales, and have a role in independently reviewing and holding health services to account.

In this particular exercise, our trust board had come up with an options appraisal to tackle its ailing services and financial problems. Now it had to convince all and sundry, including this committee, that this was the right thing to do. Such experiences are gravely familiar at the NHS Leadership Academy.

It's now mundane to say that the NHS is subject to political influence. Gripes about interference are so common, you'd be forgiven for thinking it's not worth getting involved. But the learning at my last Academy residential helped me understand the power of systems in our communities. Local government, the local authority, education, and other such "systems" are key to shaping how our local NHS evolves. Healthcare leaders ignore these forces at their peril.

In this case, we were lucky to have people who had worked as councillors and MPs to help us get to grips with how their systems work. Their insight into their motivations, what bothers them, and what they want to achieve reminded me that services don't develop just because it's the right thing to do. While stakeholders want the best for patients, there can be many other simultaneous agendas that an NHS organisation can get dragged into. There are reputations to enhance, political points to make, and egos to be served. It's not all about you.

When the systems aren't working well together and are under stress, your organisation can become a football, used by other stakeholders to score goals. Stay on guard and have clarity of communication to get your messages home. But at their best, system movers and shakers can be critical friends, and champion what you have to do if they understand and believe in where you're going. Just be prepared—take your presentation—and be clear about what's needed.

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