

Polyclinics – or old-fashioned GP surgeries?

Over 1m people have signed a petition to keep out polyclinics and 'save our local GP surgeries'. Trisha Greenhalgh asks why

Imagine you have an elderly mother with a bad hip. Just around the corner is a polyclinic. You take your mother to the polyclinic, and she is immediately seen by a GP and quickly transferred to the next room where an orthopaedic surgeon examines her and orders some X-rays. Your mother has her X-ray at the polyclinic the same day. The following week, the surgeon's secretary phones with a date for your mother's hip replacement operation.

This is the dream of Professor Sir Ara Darzi, erstwhile professor of surgery at Imperial College London, government health minister and self-styled expert on the design of healthcare systems. As far as he is concerned, it's a no-brainer to have GPs and specialists working in the local community under the same roof. Care will be faster, more convenient, and more 'seamless'.

If this is the case, why are GPs so opposed to the idea? The British Medical Association's General Practitioners Committee was uncompromising in its rejection of Darzi's proposals. Dr Iona Heath, a GP in Kentish Town and columnist for the *British Medical Journal*, wrote: 'It must be asked who thought it could possibly be a good idea to ask a tertiary care specialist to redesign the provision of primary care.'

'Tertiary' care means ultra-specialist hospital care – the place where you get referred when your local hospital ('secondary' care) can't deal with your problem. A tertiary care specialist typically focuses on a part of one organ (for example, the retina or the mitral valve). 'Primary' care is care outside hospital (including GPs, dentists and community physiotherapists). The leading textbook on the subject (written by a US professor called Barbara Starfield) defines good primary health care as generalist (addresses all diseases and complaints), accessible (open to all), integrated (includes preventive care, treatment, rehabilitation and palliative care), continuous (the same from one year to the next), based on teamwork (involves doctors, nurses and allied professions), holistic (addresses the whole person in a family context), personal (focused on the person rather than the disease), family and community oriented, coordinated, confidential, and playing an advocacy role (protects and gives voice to the vulnerable).

Heath's main grievance about Darzi's vision of the polyclinic is that its very design erodes the features that define primary health care: polyclinics are specialist-

rather than generalist-focused; disease- rather than person-oriented; one-shot rather than continuous; and they ignore (or, at least, fail to engage with) the family and community context. They are designed to deal with the kind of squeaky-clean, one-dimensional stories that only happen in medical soap operas (and which I caricatured in the opening paragraph to this piece).

GPs more personal?

When did you ever know an elderly lady whose only problem was her bad hip? My own mother (82) proudly boasts five other illnesses, and she rightly considers herself one of the fitter members of her generation (she is, for example, neither bonkers nor incontinent, and still goes to the gym). But in the run-up to her hip operation, she benefited from a GP who could keep an eye on her heart, her lungs, her thyroid, and so on, thereby ensuring that she went into the operating theatre with the best chance of coming out alive.

When my late father was admitted to a care home with dementia, a specialist psychiatrist visited once every two years. But it was the GP who held the overview of all his problems – diabetes (with insulin injections given by care assistants), recurrent urine infections, constipation (which needed regular attention from the district nurse), and wandering at night (successfully managed without medication because the GP was ethically opposed to chemical straitjackets). Far from being more efficient, 'polyclinic' management would have required Dad to be seen by multiple specialists, each of whom would have treated a different organ (or part of an organ) but none of whom would have taken responsibility for his overall care.

Of course, those of us who are still in our prime and go to the doctor once in a blue moon for a one-off problem might well benefit from the convenience of a drop-in polyclinic. But one person's convenience is another person's compromise – and the British Medical Association's concern is that 'polyclinic' care will benefit the younger, fitter and more articulate members of society at the expense of continuity of care for the frail, the sick, the elderly, the mentally ill and the socially excluded. If you're interested in following the BMA's fight, log on to www.saveoursurgeries.co.uk.

One person's
convenience is
another person's
compromise