

PRACTICE OBSERVED

Law and the General Practitioner

Assisting the police

STUART CARNE

When the police require medical assistance, either to obtain evidence or because a person in custody is ill or injured, they seek the services of a police surgeon. The more specialised work of these doctors will not be considered here, but occasionally their help may not be available and another doctor will be asked to assist the police. Furthermore, general practitioners may come in contact with the police in connection with a patient or, more likely, a dead body they have seen.

Unexpected death

Until this century death was no stranger in most households; families coped with death as they did with birth. Today when a patient dies at home the family may panic and call the police, even though the death may have been anticipated. The police will always attempt to contact the deceased's own general practitioner but, regrettably, this may not always be possible, especially in the inner urban areas, and another doctor, usually a police surgeon, will be called to pronounce the person dead. Only a registered medical practitioner may certify death, however obvious the death may be; even where death has occurred days or weeks before and decomposition has begun, a doctor will have to make the formal pronouncement that life is extinct.

If it is his own patient, and one whose death had been anticipated, the general practitioner will have no problems in issuing a death certificate. Should there be any doubt about the cause of death, however, or in cases where the doctor had not seen the patient within 14 days of death the Coroner must be notified, usually through the Coroner's Officer.

The criteria on which death is confirmed (before the appearance of lividity and rigor mortis) are:

- absent heart sounds—more reliable than an absent pulse;
- absent respiration—ideally observed for five minutes;
- fixed dilated pupils and ophthalmoscopic changes of tracking. ECG and EEG changes are not normally needed to determine death except when patients have been on a life-support machine in hospital or when the patient is suffering from severe hypothermia.

SUSPICION OF FOUL PLAY

If there is any suspicion, however remote, that there may have been foul play the police should be notified as well as the Coroner. It is essential that as little as possible is touched or moved at the scene of the possible crime. However, if there is any chance that the person may still be alive, then every resuscitative measure needed must be carried out, including transferring the patient to hospital even though this may necessitate moving objects in the room.

Should the doctor be called by the police to certify that life is extinct in circumstances that indicate possible foul play, he may well find CID officers already on the scene. Sometimes in these cases it is beyond doubt that life is extinct: lividity and even more advanced stages of death will be present. In these circumstances there is no need to touch the body, even moving the bedsheet or turning the body over can interfere with the collection of evidence that might be vital. Police photographers will have been called. Only when the preliminary photographs have been taken, and only after the permission of the police officer in charge of the investigation has been given, should the doctor move the body. At this stage he might be asked to record rectal temperature and determine what injuries are present in the previously unexposed parts. It is essential that the doctor records all his observations, including the time of arrival, the names of those to whom the information was given, the state of the body, and any other peculiar circumstances in the room or house.

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times their medical condition will tip the scales in favour of being granted bail. If sent to hospital they must be accompanied by a police officer—or two if possible—lest they attempt to run away: this can be an expensive use of relatively scarce police manpower.

MENTAL ILLNESS AND DRUGS

Prisoners with a severe mental illness can be "deemed" by a police officer under Section 136 of the Mental Health Act and sent to a mental hospital. A number of arrested persons are on drugs, often tranquillisers (in quite enormous quantities in some cases) or hard drugs. Those on tranquillisers will usually be given further doses by the police surgeon while in police custody: it would not be appropriate to stop such treatment suddenly. Those on hard drugs could, if necessary, be given methadone. Though many prisoners like to have intravenous methadone there is rarely an indication for this while they are in custody, and tablets give a longer, though albeit "less lifting," action. Alternatively a tranquilliser—for example, diazepam or chlorpromazine—will often ease many of the pangs of the withdrawal symptoms. Barbiturate habitues and alcoholics may have fits as they withdraw from their drug. Many "epileptics" in custody admit that they only get convulsions when they are unable to get alcohol or "barbs." If necessary, I give them phenobarbitone 60 mg every 12 hours to reduce the risk of their convulsing.

CASES THAT ARE NOT CLEAR-CUT

In the majority of cases of physical illness the doctor has no difficulty in deciding whether the prisoner is fit or unfit to remain in custody, but some problems may arise:

- (1) The prisoner who has an injury. Is there any possibility of a fracture? In ordinary practice when a patient has, say, a nose injury one may wait a day or so to allow any swelling to decrease before having an x-ray examination. If a prisoner has such an injury it is desirable to establish the full extent of the injury while he is still in police custody, as this may later become a matter for inquiry.

- (2) A drunken prisoner who is semiconscious. A police cell is not a safe place to leave a semiconscious patient: he might have a head injury; he might choke on his vomit. Even if a drunk or drugged prisoner is rousable, the doctor must decide whether or not it is safe to leave him alone in a cell: if not, he must be sent to hospital.

- (3) A pregnant woman who is bleeding, however early in the pregnancy. A police cell is not an appropriate place in which to have a miscarriage.

- (4) A prisoner with a feverish respiratory infection may need only antibiotic treatment, but it would not be reasonable to leave a pyrexial patient in a police cell.

The local hospital has no option but to accept these patients for examination in the casualty department. Many require no more than an x-ray examination or repair of wounds too large to have been dealt with at the police station, or both. The prisoner is then returned (after an hour or two) to police custody. A few prisoners have to be admitted to hospital for observation, treatment, or both.

Fitness to stand trial

An accused person may ask his doctor to provide a certificate saying he is unfit to stand trial. Before issuing a certificate the doctor must be sure that he can, if so required, back his opinion on oath in the witness box. The words on the certificate must state that the accused is "unfit to stand trial." "Unfit for work"

is unacceptable wording, and the certificate is likely to be rejected. The accused must be told by his doctor to ensure that his solicitor is aware of the existence of the certificate, and someone must present it to the court at or before the time set for the hearing. The court has the right—which it not infrequently exercises—to send their own doctor (accompanied by police officers) to examine the accused at home or in hospital. The police surgeon will then report his findings in court (on oath) to the judge. Regrettably, in my experience as a police surgeon I have seen many cases in which the accused, far from being unwell, merely postured to postpone the evil day. I have seen allegedly bed-bound patients with so many outdoor clothes under their pyjamas that I can only assume that they jumped into bed when I rang the doorbell.

No definite criteria have been laid down for the determination of such fitness. The doctor who is asked to issue a certificate must remember that it is rarely possible to have a case postponed indefinitely on medical grounds: sooner or later the day of judgment will have to be faced. A few examples will perhaps clarify the picture:

- (1) Someone in hospital recovering from a surgical operation could ask for—and expect to receive—an adjournment of a month or so to allow for recovery.
- (2) An acute myocardial infarction might warrant an adjournment for, say, six weeks, at the end of which time the risks of a trial bringing on a further attack will have to be assessed.

- (3) A person with a feverish cold is probably unfit to stand trial and it would be reasonable to ask for, say, a week's adjournment.
- (4) Peptic ulceration would normally not be satisfactory grounds for requesting an adjournment.

- (5) Backache, with or without symptoms of sciatica, would be likely to succeed on medical grounds only if it were essential for the accused to stay in bed. A request that the accused be allowed to sit throughout the trial would almost certainly be granted.

- (6) Anxiety or depression are commonly offered as medical reasons for seeking a postponement, but such applications are unlikely to succeed. Should the accused be so mentally ill that he could not be expected to follow what was happening at the trial, the court would expect a psychiatric report to be submitted and would, in addition, seek the opinion of a psychiatrist if nominated.

- (7) Illness in another member of the family is not a medical reason for seeking an adjournment.

Fitness to give evidence

The same criteria that apply to fitness to stand trial apply to fitness to give evidence. If necessary, however, the court may visit a sick person at home or in hospital to obtain his evidence.

Fitness for jury service

A number of people find jury service inconvenient—either for domestic or business reasons, or because they fear they are not capable emotionally of giving such an important decision affecting the life of another citizen. Deafness, poor eyesight (after correction with glasses), mental ill health, pregnancy, and unstable diabetes are examples of illnesses which would be reasonable grounds on which the doctor could support a patient's request to be exempt from jury service.

Reference

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TIME OF DEATH

Assuming a full examination is permitted, some idea of the time of death may be gauged from the presence and degree of rigor mortis and the body temperature, but only a very approximate timing can be given; the number of variables is endless. Lividity due to hypostasis is first detectable about 30 minutes after death and is maximal six to 10 hours later. It usually becomes fixed about 24 hours after death. Look for its position. Unless the body has been moved after death the colour changes will be maximal over the most dependent parts. Carbon monoxide poisoning is not commonly seen these days, but look for the cherry red colour; other colour differences in the lividity are the pink of cyanide and the bronze of sodium chlorate poisoning. Rigor mortis sets in about six hours after death and is no longer detectable after 48 hours. But both these times are variable—for example, the ingestion of large quantities of barbiturates (suicide or death in an addict) will accelerate the onset and spread of rigor.

Contrary to the mythology of the detective novel, accurate determination of the time of death by measuring the rectal temperature is not possible even by directly recording the internal body temperature through a stab wound into the liver (a technique used by many forensic pathologists, but not one recommended for the novice). Nevertheless some guidance can be given. The formula usually used is: (99 F rectal temp F)/1.5—hours since death. A low-reading thermometer should be used; be sure to shake it right down before inserting it. Note the time at which the temperature was recorded and also the room temperature and the presence of heaters or a draught. Ideally a second reading should be taken 30 minutes later.

INJURIES

All injuries should be noted. Avoid making dogmatic remarks about their cause unless you are absolutely sure about your facts. You can be challenged in court, and many a doctor has been made to look foolish by a barrister in cross-examination. It does no harm to say to the police: "I'm not sure. You'd better ask one of your experts."

Often, especially in a possible suicide, the police will require assistance in the identification of tablets: could they be associated with the death? An open, empty or half-full bottle of tranquilliser—perhaps with a few scattered around the floor—suggests suicide, especially if there is a bottle or glass of alcohol nearby. Bottles (open or closed) of trinitrin or beta-blockers, or both, suggest coronary artery disease—and then the probability (but no more than a probability) of natural causes.

Suspected rape

In cases of rape, buggery, or any other sexual offence the police, whenever possible, like to have the victim and any suspect examined by an expert, for so much in these cases depends on the clinical findings and their interpretation. The general practitioner may, however, be involved if he or she is consulted by a patient who alleges she has been raped or by a mother alleging her child has been sexually assaulted. It is helpful in such cases if the doctor can get the patient's permission to notify the police so that arrangements can be made for a doctor experienced in such examinations to make the necessary tests. What the general practitioner must always do—and this of course applies equally to the police surgeon examining a victim on behalf of the police—is firstly to ensure that facilities for rape counselling are offered, and secondly that advice is given about possible medical complications (pregnancy and sexually transmitted diseases). Both these services require earnest talk and understanding: rape victims have sometimes complained that the subsequent inquiries are an even greater outrage than the assault itself.

EXAMINATION OF THE VICTIM

Should an ordinary doctor be called upon to carry out such an examination because no one else is available, he will be expected to look for injury to the sex organs, including the anal area, breasts, and mouth; all signs of injury anywhere else on the body. The presence or absence of an intact hymen is of only limited forensic value, except when it can be seen that the hymen has recently been ruptured. The presence of recent vaginal or anal tears and bruising is important and must be carefully looked for with the help of an adequate light and proper instruments. Glaister Keene rods are often used by those who frequently examine victims of rape, but few other doctors have this equipment.

Specimens for examination in a forensic laboratory will also be needed. Training in the collection of some of these specimens is very desirable if the evidence is to be used in court. Most police stations have "rape kits" which have the specimen containers for collecting

- blood for grouping and (if appropriate) blood for alcohol content;
- urine for drug and alcohol content;
- sputum for grouping;
- saliva, vaginal, penile (preferably coronal sulcus), anal, and rectal swabs;
- containers for fingernail scrapings, which should be taken if there has been a struggle (cuticle sticks or orange sticks to collect the specimens are not usually available and experienced police surgeons carry their own supply);
- head and pubic hair.

Items of clothing, especially underwear, that might be contaminated with semen, blood, hair, or other particles—for example, paint—should also be sent to the laboratory, but these specimens are usually collected by a police officer. In the rape kit is a large sheet of brown paper to place on the floor while the person being examined undresses; this paper is also sent to the laboratory to be examined for "droppings."

Fitness to be detained in police custody

An arrested person must be kept in police custody or granted bail until he appears before a court. Once charged he will normally go to court the following morning (or on Monday if arrested on a Saturday): thus a normal period of detention is less than 48 hours, but it is possible for a person to stay at a police station for a longer period "assisting the police" while they make their inquiries.

There are no facilities in police stations for nursing or observation of sick prisoners, except at a very superficial level. Once they have appeared before the court they will, if not granted bail, be taken to a prison where hospital facilities are available. If they are taken ill while still in police custody, however serious or minor the illness a doctor will be called. (In a major emergency an ambulance might be called to transfer the prisoner immediately to hospital and expedite the matter.) The main task of the doctor called to the police station—usually a police surgeon—will be to determine whether or not the person is fit to remain in custody. In the majority of cases the medical problem is relatively minor, and there are no medical reasons why the prisoner should not remain in custody. If necessary, medication must be given. Strict instructions must be left by the doctor giving the times at which further doses should be given. Prisoners are not allowed any medicines with them in their cells—certainly not if any harm could follow from misuse of the drug or, in particular, misuse of the container. An exception might be made in the case of, say, a dyspeptic prisoner, who could be given three or four antacid tablets to keep with him in the cell; not liquid, for he might break the container and either swallow it or use it as a weapon.

Those who are unfit to remain in custody have to be taken to hospital. They cannot be sent home unless granted bail. Some-

Emergencies in the Home

Role of ambulance services

R A SLEET

Prehospital management of the critically ill or injured patient has recently changed considerably. Emphasis has been placed on the value of competent first aid by lay members of the public supported by trained medical or paramedical teams who are skilled in resuscitation.<sup>1</sup> Such systems of immediate care are not universally available in Britain. The general public's standards of first-aid knowledge are poor and basic ambulance training is often inadequate to provide all the necessary care for the ill or injured patient.

Despite this, doctors do not uncommonly drive past an accident without stopping and later justify their action with the comment that there appeared to be sufficient people at the scene of the accident or that the ambulance had arrived. Similarly, despite the known risk of life-threatening arrhythmias during the early hours of a myocardial infarction some family doctors still leave the patient who has suffered a serious heart attack before the ambulance has arrived to take the patient to hospital. These actions are inexcusable. They may reflect the doctor's lack of confidence to cope with the emergency and this may be a consequence of inadequate undergraduate or postgraduate training in basic first aid, resuscitation procedures, and the principles of dealing with accidents.

Medical care

During 1979 the accident and emergency department of Southampton General Hospital received a total of 6272 patients who had been injured or taken ill suddenly. In 701 (11%) of these cases the family doctor had been called. The prehospital care of the remaining 5571 patients was undertaken by the ambulance service with little or no first-aid support and no medical help at all. Under 10% of the ambulancemen dealing with these patients had received any form of advanced training; this raises the question of whether we should be leaving the immediate care of the severely injured or critically ill patient to the ambulance service or whether the doctor should be encouraged to give prehospital treatment.

The doctor has been providing immediate care in Britain for over a decade in areas recognised to have a high risk of accidents. Dr

Kenneth Easton pioneered immediate medical care for the victims of road accidents in the A1 in the early 1960s with considerable success.<sup>2</sup> Similar schemes have been established to help people who are injured on the road, in the mountains, in caves, and off our shores.<sup>3</sup> Over the years these groups of doctors, usually general practitioners, have developed skills in caring for the patient during transportation over difficult terrain and on the long distances to the nearest accident department.

For the family practitioner concerned with such immediate care, a flexible practice organisation is necessary to make doctors available over the 24 hours. Reliable radio communications are essential, and co-operation with the police, fire, and ambulance services must be good.<sup>4</sup> Specialised protective clothing and equipment is essential and medical skills must be of a high order. These skills include management of the obstructed airway, caring for the traumatic pneumothorax, and correcting hypovolaemia, and the doctor must be able to use them in poor light, inclement weather, and cramped conditions. Since 1977 doctors providing such care have been united in the British Association of Immediate Care Schemes (BASICS) and about 1100 members now provide care over one-third of the land mass of the United Kingdom.<sup>5</sup>

Needs of urban areas

These schemes have arisen from a recognisable need in areas where the accident risk is high and the distances from hospitals great. The needs of urban areas in Britain are different. Distances to the local accident and emergency department are relatively short and ambulance response times good. As the Southampton figures have shown, however, the family doctor is available for only about 11% of emergency calls. This may reflect the nature of the family practice in large towns. The average list size is over 2900 patients, and the doctors are expected to provide all necessary care for those patients. This includes health education, preventive medicine, and supervising the continuing care of the elderly patient or those with long-term illness. Modern treatments have meant that more can be done for many patients but these treatments often carry the risk of iatrogenic disease, requiring the progress of patients to be monitored frequently and carefully. The growing population of elderly people adds to the family doctor's commitments, particularly as many elderly patients are unable to travel to the surgery for assessment or treatment.

Practice organisation

Many family doctors traditionally supplement their income with part-time employment—for example, as clinical assistants, industrial medical officers, or advisers to insurance companies. To cope with

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Details of injuries and prehospital treatment of 6272 patients attending an accident and emergency department

Family doctor contacted before ambulance service	Road traffic accident	Home	Nature of injury					Place of injury not recorded
			Work	Not inflicted and not reported	Sport	Other		
Emergency services contacted immediately	5	808	216	40	5	120	204	
	1311	368	15	481	145	1076	1474	

these many commitments practice organisation is paramount. Appointment systems, set routine visiting lists for the elderly, and special clinics with regular hours restrict the flexibility of many doctors to cope with emergency calls.

In some practices emergency rota schemes, radio communication, and teleprinter systems are part of the solution. It would seem, however, that in many urban areas the contribution that the practitioner can make to immediate care is limited and the prehospital care of the individual or the responsibility for the care of the members of the general public, supported by the ambulance services.

Necessary medical knowledge

Public education in first aid is sporadic, and opportunities have been missed to improve this by not including first aid as part of the secondary school curriculum and as a mandatory requirement for the vehicle driving test.

Effective management of the accident victim requires knowledge about: (a) protecting the accident site to prevent injury to other road users, the victims of the accident, and those helping them; (b) sending accurate messages via the "999" system to obtain early assistance from the police, fire, and ambulance services; (c) applying basic life-saving procedures for patients in the accident. These will include care of the unconscious patient, management of the airway, protection of the spine, and control of external haemorrhage.

Basic ambulance training usually consists of six weeks' education in anatomy, physiology, first aid, and patient handling. This training is followed by a fortnight's refresher course every six months to three years, depending on the supervising authority. These refresher courses usually consist of one week's education at the ambulance training school and one week attached to the local hospital, usually in the accident and emergency department.

Many ambulance services recognise that such training is inadequate to meet demands placed on crews dealing with the ill patient, and advanced training schemes have therefore been developed in certain areas over the past 10 years. Avon, Gloucester, and Hampshire have an advanced training course that emphasises accident handling and infection and isolation techniques. The East Sussex Ambulance Service in Brighton has provided advanced training for some ambulance crew in the care of the patient who has suffered a myocardial infarction. Training to a high standard in interpreting the electrocardiograph, recognising arrhythmias, and using the DC defibrillator has been developed with good practical results.

Since 1977, in association with BASICS, ambulance crew have formed the Association of Emergency Medical Technicians to promote high standards of immediate care within their own service, and they are already educating the public in first aid and resuscitation techniques. These developments in advanced training in the ambulance services follow the development of paramedical services in other countries, but as yet there is no Department of Health and Social Security policy for a national training programme for the ambulance services as a whole, or for the development of paramedical care in this country which will depend on (a) better education of the public in accident handling and first-aid techniques, supported by an ambulance service with higher standards of immediate care and resuscitation; (b) in high-risk areas, participation by medical immediate care teams, usually based on local general practitioner services, but occasionally on the accident and emergency department.

Nevertheless, such developments do not exclude the rest of the medical profession, and the standards of undergraduate and postgraduate education in immediate care need to be improved so that any doctor can provide competent prehospital care for the critically ill or injured patient and help where necessary in his transportation to hospital.

British Association of Immediate Care Practices: inquiries should be directed to the Secretary, BASICS, 14 Chancery Gate, London SW7 1RF.

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People ought to be extremely cautious lest they take other eruptions for the itch; as the flogage of these may be attended with fatal consequences. Many of the eruptive disorders that children are liable to, have a near resemblance to this distile; and I have often known infants killed by being rubbed with greasy ointments that made their eruptions fester suddenly, in which Nature had thrown out to preserve the patient's life, or prevent some other malady.

Mucus mixed is likewise done by the use of mercury in this distile. Some persons are so fool-hardy as to wash the parts affected with a strong solution of the corrosive floburine. Others use the mercurial ointment, without taking the least care either to avoid cold, keep the skin open, or observe the directions of the physician. These practices would be easily guessed. I have known even the mercurial girdles produce tragical effects, and would advise every person, as he values his health, to beware how he uses them. Mercury ought never to be used as a charm, or in the greatest care. Ignorant people look upon these girdles as a kind of charm, without considering that the mercury enters the body.

Aborbents are the proper medicines. In this case an ounce of powdered chalk, half an ounce of fine figar, and a quarter of an ounce of gum Arabic, may be mixed in an English quart of water, and a tea-spoonful of it taken as often as is necessary. Such as do not chide chalk may take a tea-spoonful of prepared oylly-hells, or of the powder called cab-eyes, in a glass of cinnamon or pepper-water. But the safest and best absorbent is magnesia alba. This not only acts as an absorbent, but likewise as a purgative; whereas chalk, and other absorbents of that kind, are apt to lie in the intestines, and occasion obstructions. This powder is not disagreeable, and may be taken in a cup of tea, or a glass of mint-water. A large tea-spoonful is the usual dose; but it may be taken in a greater quantity, if necessary. These things are now generally used into lozenges for the convenience of being carried in the pocket, and taken at pleasure. (Buchan's Domestic Medicine, 1766.)

Correction

Referring patients to a gynaecologist or psychiatrist and to a marriage guidance counsellor.

We regret that an error occurred in the last sentence of the fourth paragraph under "London Marriage Guidance Council" (16 May 1981, p. 1590): the word "experimental" should read "experiential".

her this way. Having got so far she then asked if I would refer him to a psychiatrist. Obviously I had to be Billy, but she insisted that Billy would refuse. We connected a little scheme to put pressure on the doctor to have Billy brought to hospital and have him arrested for criminal behaviour. I guessed he would be naive enough to fall for this. Whether he did or not, he arrived in the surgery. The interview was most unsuccessful. He was hostile and aggressive. After all the adult world treat him badly. Why should he not reciprocate? I tried reason, persuasion, remonstrance, and threats of legal action and the use of non-existent compulsory powers. He simply sat and laughed. He had no intention of changing his life-style. He is not likely to seek help until it is too late and he becomes a fully fledged alcoholic.

Of course, unemployment does not cause drug abuse or alcoholism but prolonged idleness gives these youngsters an opportunity they would not have otherwise for this type of activity. If Billy had a job he would not lie in bed in the mornings. He could not afford to have a hangover every day, and the discipline might do something to correct his personality defects. But without this corrective force he is on the slippery slope at an early age. He is not alone in this. For example, Bob's mother actually brought him to the surgery. He too, at 19, is a borderline alcoholic—again, no work. The problem is that a job gives one self respect. To work means to contribute and play one's

part as a full adult. It should be the first step a youngster takes towards the development of his adult psyche. Without this (and it usually is in my practice) will look for other avenues in which to assert his adulthood. In my part of the world alcohol intake is equated with malice, and these youngsters compensate for the other deficiencies in their developing life-style by demonstrating their prowess with the bottle. It is an easy step to drugs from here. I understand that there is quite a market, presumably serviced by them.

So where does this leave us? A few case histories are not scientific proof, but they make suggestions for formal investigation. Perhaps women are affected less by the effects of unemployment. My examples have all been men. It is possible that women can find fulfilment in other ways. Male chauvinism is not an advantage to the male. One is left with the impression that unemployment has not caused a dramatic change in the general practitioner's work, but there is a nagging feeling that too many middle-aged men are being thrown on the industrial junkheap and that too many youngsters are falling victim to the dangers that beset Billy and Bob. The result for the GP is an increase in patients with the problems of Mr M, Billy, and Bob. Maybe Mr H points the way out. Perhaps what we need is greater flexibility in work schedules and shorter hours in general, but that takes us into the economics of production, and as a GP I have no remit to speak on that.

Profiles of Practices

Views of general practice

RICHARD HOBBS

During a student attachment in my final year I first encountered general practice in the flesh and thought that this could be the life for me. I had been among the big majority of the medical students in my year who felt that the medicine I wanted to practice could only be accommodated in big district general hospitals. I had considered that the remuneration for a family doctor was quite satisfactory and being on call from home most desirable, but I think my general attitude was one of indifference. As luck would have it, however, this callous youth spent most enjoyable weeks in 1976 being entertained by two congenial, astute clinicians who provided, from comfortable and functional premises, an excellent medical service. Since qualifying I have visited a score of other practices, some of which have helped to convince me that my vocation lies in general practice, and I write about some of them in this article.

Towns and country

A fine group practice exists in Bath. Located in an attractive Georgian suburb on the eastern edge of the city, it is a part-time set-up for the four partners, two of whom are female. Having about 85% urban patients and 15% rural patients on a list seemed a happy balance to a confirmed city dweller who nevertheless enjoys frequent forays into the countryside. It looked good on paper, but when the 85% were living in a city as special as Bath and the rest in farms and villages in the county vales to the south or the Cotswolds the prospect was very inviting. The surgery, though pleasant in aspect, perhaps was not ideal in layout, and the partners had well-advanced plans to move to an authority-owned health centre. The partners' consulting rooms were of an elegant size with plenty of useful equipment, but the practice trainee was not so lucky. Padded for space, he was allocated the only spare room, which had been a cupboard between the first and second flight of stairs. This was not so grand; he almost had to leave the room so that the patient could lie down to be examined. Luckily he had long arms. The list was kept small at around 8000 patients. This must have been bad for incomes, but was good for patients, who received an excellent and comprehensive service. There was a high proportion of elderly patients on the list and, overall, social class was not so top heavy as I had expected despite the rows of Regency terraces that vied for your attention on even

Unemployment in My Practice

Dundee

ALBERT JACOB

Dundee was the city of jute, jam, and journalism, but jute and jam have gone. Naturally there have been attempts to replace them but these have met with only limited success. The trouble was anticipated many years ago and immediate postwar development plans attracted new light industries to the city. Now some of them are faltering, too.

Dundee has another employment problem. Jute and jam were industries that were specially suitable for women workers, so that the city had a tradition of female labour since the last century. This means that men were disadvantaged in their search for work compared with their brothers in other parts of the country where industry is based on heavier skills. It is hardly surprising that Dundee has one of the worst employment problems in the country. It worsens daily.

How does this affect the general practitioner? It would make a good topic for a thesis, but I missed the boat and must, perhaps, be anecdotal. After all, with a predominantly working-class practice, one would expect to have some experience of the effects of unemployment.

I have the impression that the isolated incidents that impress a general practitioner reflect an underlying general pattern, but this is a dangerous assumption. Take my own case. In my quarter century of practice I have twice changed premises, moving from a converted shop to a health centre that opened in 1977, with a converted bungalow as the staging post. I have introduced an appointments system and changed from a father-and-son partnership to a friend-and-friend partnership. So changes in work pattern are to be expected and there are problems in deciding cause and effect. The practice attendance rates illustrate this. In 1966 I made 6-5 contacts per patient a year, but that was before introducing an appointments system. By 1969 the rate had fallen to 4.4, but in 1973 and 1974 it was about 5. In 1976 and 1977 the rate was again under 4.5, but in 1980 it rose to 4.75. This rise could be the result of unemployment. It could equally well be the result of opening the health centre, which improved doctor availability. The figures, however, suggest that in this practice, at least, there are no grounds for claiming that unemployment has reduced the work load beyond those with an uncertain job future are prevented from seeking attention for fear of work absence.

Might the slight increase observed have a component that results from unemployment? Mr M's case would suggest so. Mr M was a bus driver until one day he drove his bus into a ditch. It was not a serious accident, and he escaped with bruises and a bad attack of low back pain. All the indications were that he had returned to his bus in the days that followed, but weeks the pain in his back did not settle. The investigations showed that he had osteoarthritis of the spine but nothing more serious. At last "I signed him off," and he tried again. Within days he was back in the surgery. The bouncing white driving made his

back too painful, and he could not control the pedals properly. It might have been a gesture, but the expression on his face indicated that it was genuine. With full employment he would have had no difficulty in finding another job, but with unemployment at its present level this idea is a non-starter for a man in his mid-fifties with no skills other than his ability to drive a bus. In any case no employer is likely to look favourably on a recruit with a physical disability if he can get a fit man to do the job; and with unemployment there are plenty of fit men looking for work. So Mr M found himself back on social security.

It was only a matter of time before he came to the attention of the regional medical officer. His assessment was accurate: "fit for some form of work." It was accompanied by a suggestion that Mr M should be trained for some other occupation. Mr M is pleasant, but his abilities are limited; and in any case, even after retraining employment is such that it is unlikely that he would be re-employed in a new occupation. He would be in competition with others who were following their life's career. So because of his back he remained on the insurance—that is, until I had a visit from the RMO. Our RMOs are gentle and caring people. I explained the problem to him and he accepted it, but pointed out that employment was not within our remit and that willy-nilly Mr M should get a final line. I have not seen the last of Mr M. He still has his backache. He will not get a job, and his morale is dropping. He will need a great deal of support, and yet 10 years ago he would have been in one of our factories with words of the original candidate, happily contributing to the welfare of the community.

Middle-age and youth

Mr M was unlucky in his choice of age. The mid-fifties are vulnerable years. Once the patient returns near age, say 63 or 64, the medical officer at a small, old factory in a nearby town. The buildings could scarcely have altered over the past 150 years. The general practitioner was able to suggest changes to bring the working conditions in line with the proposed new and strict legal controls on industry. Involvement with a small and close working community with special health risks certainly seemed to be an attractive addition to this doctor's responsibilities.

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the shortest journey. The practice could also count on excellent hospital services with good and rapid access to x-ray examinations and laboratory tests: what a difference that can make, benefiting both doctors and patients.

Suburbia and the Black Country

In absolute contrast was a three-partner practice in a West Country city. The surgery was a dark and dingy Victorian manservant built near the corner of two extremely busy roads. The building was set back off the road, causing it to melt into the dimmed background. I remember driving past two or three times on my first visit before I worked out where the path started and then had to park the car about 300 yards away down a back street full of rubble and boarded-up terraces. Inside the surgery the sombre ambience persisted. The surgeries I sat through were depressingly similar, composed of brief exchanges with little verbal communication between roomful of deprived unfortunate people and a tired, elderly general practitioner near retirement. The content of the consultations and the presentations were often unusual or unhappy. Arguments and scuffles with a junkie and attempts to organise the shattered lives of unmarried schoolgirl mothers, sometimes disowned by their families, are vivid in my mind. It is difficult to imagine how the aspect of the practice might have changed in the bright fluorescent lights of the health centre that was being mooted as a possible merger or move in the future.

I visited an industrial practice in a large local authority health centre serving three separate practices in the Black Country. I joined a general practitioner who had remained single handed despite joining the health centre. The premises were capacious, with generous waiting areas and every ancillary worker one could think of could be found in a labyrinth of rooms. Despite the obvious expense of the construction, the consulting rooms were very small, the only saving grace being separate examination rooms. A persistent impression during my travels was that local authority health centres provided more inferior accommodation for the doctor than health centres that were privately built, despite the fact that they were costing around four times as much to build.

The surgeries were very busy with a good dose of visits at the end of the session to finish you off. The general area seemed quite depressed and this was represented by a disproportionate number of unemployed patients seeking medical advice. It had become disturbingly apparent over the past few months what a strain the ever-increasing unemployment or threat of closure was placing upon the people in virtually every area I visited.

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Two rural practices

I recently visited a very pleasant two-man rural dispensing practice in Shropshire. The senior partner had brought a lovely, large, late Georgian farmhouse with a few acres on the edge of a village. He had subsequently knocked down the orchard and built a small modern surgery that just managed to squeeze in a fair balance of rooms, equipment, and drugs. The pharmacy was an attractive proposition for someone who, like me, has a fondness for anything that needs organising and stacking. As well as

dispensing being a very important source of income to many rural practices, it may also encourage a useful self-consciousness in prescribing habits by acting as an efficient and continuous audit. I suppose this feature illustrated the view of general practice of business most vividly, as here was stock control and supply operating as in any commercial concern.

One of the possible disadvantages of rural practice was illustrated by a group practice in south Shropshire. It was a purpose-built privately owned centre serving about 6000 patients over an area of about 90 square miles. Good facilities and ancillary staff were available for a high degree of primary care, but Health Service cuts had meant that hospital back-up was over-stretched, sometimes. This was particularly true of maternity services, where, since the closure of the local maternity unit nine miles away, pregnant patients were being sent to a general district hospital, 40 miles away for some patients. This could inevitably lead to unattended deliveries, possibly in transit to the hospital. It was obviously putting pressure on the doctors to provide a home delivery service, although without the help of district midwives. However experienced or committed to home delivery a general practitioner is, it seems an undesirable trend if he or she is forced by circumstances to provide such a service, particularly if the back-up domiciliary services are not expanded. This situation would affect the rural general practitioner first, but with the closure of many maternity beds over the past 10 years and now a surge in the birth rate the same circumstances might well affect the city general practitioner shortly. Deterioration in the standards of services is not likely to improve our present unsatisfactory perinatal mortality and morbidity rates.

In deepest Somerset

I only hope that cuts do not interfere with the standard of care provided from a very active practice in deepest Somerset. A large modern surgery provided centralised general practice to a large area, in association with a cottage hospital that was fully used. The five general practitioners rotated to provide night cover and also a casualty service from the cottage hospital, including doing their own x-ray examinations and managing simple fractures, dislocations, or surgical procedures. Visiting consultants provided further local surgery with anaesthetics given by the GPs. A local maternity unit was also provided. I suppose that this practice offered the most complete medical services of all the practices I visited. I had left Bath to visit on a bitterly cold winter's evening. The 30-mile drive was through winding country roads that had only just had a lane cleared of snow to serve both directions. The snowdrifts towered over the car in places as I drove through the pitch blackness and the whole impression of the ease with which some rural communities like this could be cut off by the weather reinforced my sense of the importance of these excellent services in an area as effectively remote from district hospitals as this.

Joining the queue

I have enjoyed most of my visits and would like to take this opportunity to thank all those who tolerated me during them. I suppose I have formed a rather select group on the whole. It would be too much to expect that this was the average standard of general practice in this country, although not too much to hope for, perhaps.

The one feature that was consistently demonstrated to me was that there is no such thing as a representative general practice. They were all so unique and idiosyncratic as the doctors who ran them. I am grateful to have had the good fortune to see them at work. Had I not had this opportunity, I am sure I would not be joining the queue to swell their numbers.

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