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:

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—absent heart sounds—more reliable than an absent pulse;
—absent respiration—ideally observed for five minutes;
—fixed dilated pupils and ophthalmoscopic changes of trucking.
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 potentially dangerous or liable 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 habitués 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 his 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 unfit, merely hoped 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 it 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.

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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 communications, and bleeper systems have in part overcome this problem. 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 suddenly ill or injured patient must lie initially with 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 service; (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 employing authority. These refresher sessions 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 infusion and intubation techniques. The East Sussex Ambulance Service in Brighton has provided advanced training for some ambulancemen 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.[8]

Since 1977, in association with BASICS, ambulancemen 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 service follow the development of paramedical services in other countries,[9] but as yet there is no Department of Health and Social Security policy for a national training programme for the ambulance service as a whole. It seems that the development of immediate care in this country 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 Schemes: inquiries should be directed to the Secretary, BASICS, 14 Princes Gate, London SW7 1PU.

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

MUCH miſchief is likewiſe done by the uſe of mercury in this diſeaſe. Some perſons are ſo fool-hardy as to waſh the parts affected with a ſtrong ſolution of the corroſive ſublimate. Others uſe the mercurial ointment, without taking the leaſt care either to avoid cold, keep the body open, or obſerve a proper regimen. The conſequences of ſuch conduct may 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 medicine without the greateſt care. Ignorant people look upon theſe girdles as a kind of charm, without conſidering that the mercury enters the body.

WHEN bilious humours occaſion the heart-burn, a tea-ſpoonful of the ſweet ſpirit of nitre in a glaſs of water, or a cup of tea, will generally give eaſe. If it proceeds from the uſe of greaſy aliments, a dram of brandy or rum may be taken.

IF acidity or ſourneſs of the ſtomach occaſions the heart-burn, abſorbents are the proper medicines. In this caſe an ounce of powdered chalk, half an ounce of fine ſugar, and a quarter of an ounce of gum-arabic, may be mixed in an Engliſh quart of water, and a tea-cupful of it taken as often as is neceſſary. Such as do not chuſe chalk may take a tea-ſpoonful of prepared oyſter-ſhells, or of the powder called crabs-eyes, in a glaſs of cinnamon or peppermint-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 much greater quantity when there is occaſion. Theſe things are now generally made up into lozenges for the conveniency of being carried in the pocket, and taken at pleaſure.

(Buchan's *Domestic Medicine*, 1786.)

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 third paragraph under "London Marriage Guidance Council" (16 May 1981, p 1590): the word "experimental" should read "experiential."

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 has 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, perforce, 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 because 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 would return to his bus. But as the days turned into weeks the pain in his back did not settle. The investigations showed that he had osteoarthrosis 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 while driving made his back too painful, and he could not control the pedals properly. It might have been a story, 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 difficulty 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 within weeks of the original accident, 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 nears retiral age, say 63 or 64, the outcome is happier. Mr H had a similar problem but he was too near to retiral to make it worth while signing him off. He became a pensioner and several weeks later appeared in the surgery with a beam on his face. The complaint was minor. "Oh! By the way, doc, I've got a little part-time job now." It seems that there are still opportunities for this kind of work. Long may this last.

Billy is a different kind of problem. He is one of the many school-leavers who has failed to find a job. He is now 18. Satan finds mischief for idle hands. Typically, it was Billy's tearful mother who appeared in the surgery. She was anxious and depressed—could she have some tablets? In response to my inquiries she burst into tears, and after she settled the whole story came out. She had had a blazing row with Billy—the problem, his behaviour. The previous night he came home obviously under the influence of drugs. It was not an isolated incident, and he takes them with with alcohol. The situation had become intolerable and hence the row. He lies in bed in the mornings after his binges and does nothing to help her. That day he had thrown a mass of obscenities at her and threatened to walk out. Any mother would be distressed when her baby treats

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her this way. Having got so far she then asked if I would refer him to a psychiatrist. Obviously I had to see Billy, but she insisted that Billy would refuse. We concocted a little scheme to put pressure on the boy. She would threaten to bring the police 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 treats him badly. Why should he not reciprocate? I tried reason, persuasion, remonstration, 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 he (and it is usually he 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 manliness, 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 theft.

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 all 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 this 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 callow youth spent two 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.

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Town and country

A fine group practice exists in Bath. Located in an attractive Georgian terrace on the eastern edge of the city, it was an enviable set-up for the four partners, two of whom were part-time. 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 gentle 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. Pushed 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 as top heavy as I had expected despite the rows of Regency terraces that vied for your attention on even

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 monstrosity built near the corner of two extremely busy roads. The building was set back off the road, causing it to melt into the dismal 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 roomsful of deprived unfortunate people and a tired, elderly general practitioner near retirement. The content of the consultations and the presentations were often ususual 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.

In common with many other general practitioners the doctor at this surgery had medical interests outside the practice. He was 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 this 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.

Two rural practices

I recently visited a very pleasant two-man rural dispensing practice in Shropshire. The senior partner had bought 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 as a 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 standard 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 view it 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 these practices 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 as 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.

Br Med J (Clin Res Ed): first published as 10.1136/bmj.282.6279.1842 on 6 June 1981. Downloaded from http://www.bmj.com/ on 19 April 2024 by guest. Protected by copyright.