PRACTICE OBSERVED

Conference Report

Prevention with all deliberate speed

SUE BURKHART

Prevention was the theme of the Royal College of General Practitioners's spring meeting, organised by the Thames Valley Faculty, at the John Radcliffe Hospital, Oxford, on 8-10 April. The academic programme consisted of papers given in three simultaneous sessions. The 600 delegates, mostly general practitioners, many of whom were young and women, undoubtedly came away from the meeting exhilarated by some of the papers and ideas explored but perhaps also overwhelmed, trying to think how they could possibly fulfil all the tasks that they were asked to do in their daily work.

They were told to talk to their members of Parliament to influence health policies, set up weekly clinics for children and for adolescents, screen all women of childbearing age for rubella immunity, talk to rather than prescribe for their tense, unhappy patients, and screen all women aged 35-65 and all those under 35 who are sexually active for cervical cancer. Some good, not so new, and important advice was put across strongly. And there were startling reminders that Britain falls behind other countries in, for example, failing to eradicate handicaps from rubella and reduce appreciably the number of deaths in older women from cancer of the cervix. The thrust of the advice throughout the meeting was how to practise prevention without greatly reorganising the practice routine.

Rubella, cancer, and children

In Dr John Hasler's practice since 1978 they have had a policy of checking on rubella immunity in every girl and woman of childbearing age from 13½ years, double checking school immunisation records as well. They have increased the rates by discussing immunisation when the girl or woman consults for something else. A few have slipped the net, so that it is essential for everyone in the practice team to remember to check on the immune state with each patient seen. Citing the rise in the incidence of neonatal rubella in 1982,[1] Dr Hasler said that it was a national scandal that every woman in Britain was not identified and offered immunisation. Every general practitioner could check most if not all women during routine consultations, without sending out postal invitations.

Older women are the ones most at risk of dying from cancer of the cervix. According to Dr Ann McPherson, although screening has been going on in Britain for 20 years, the mortality rate in the whole country has fallen only a little, whereas in North America, Finland, and parts of Scotland it has fallen appreciably. And this is despite general practitioners being able to claim an item of service payment for a cervical smear in women aged 35 or over and for those who have had three pregnancies. Cervical carcinoma is five times as common in women in social class V as in women in social class I. Screening has been recommended by the Department of Health and Social Security five yearly from age 35 to 65, but Dr McPherson also reported a "worrying" twofold increase in the number of deaths in women under 35, so she screens every sexually active woman under 35 in her practice as well. She has sent letters (two or three if necessary) to all women in her practice inviting them to attend for a smear, and they take away a card that records their examination and results. She has screened 90% of women aged 35 to 64. There is no national recall system, but a family practitioner committee working party has recommended that family practitioner committees set up such a system for cervical cytology. Unfortunately, only half of them have plans to do this.

On just as serious a note Dr Chris Donovan implored general practitioners to recognise their responsibility to children—from conception to adulthood—by supporting families as much as possible. One in four marriages is now likely to end in divorce, and many children live with one parent only. General practitioners need to (*a*) improve the early diagnosis of treatable conditions in children, such as hypothyroidism and undescended testes; (*b*) support the relationship between parent and child; and (*c*) improve immunisation rates: 100 000 children have

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SUE BURKHART, staff editor

measles every year in Britain and 20 die, while in the United States they are talking of eradicating measles.[1] How could this be done? For a start, because many children are never registered with a general practitioner (up to 20% of children in some blocks of flats in his area were not), everyone concerned with mothers should encourage them to register their new babies. Secondly, it would be easy to set up a weekly clinic for children with the health visitor, and perhaps an afternoon session for adolescents, who rarely step inside the surgery. Very little has been done in the 10 years since the Court committee looked into services for children. Are general practitioners going to make children wait longer still? The college should take a role to help decide priorities and where to place the resources. Not surprisingly, a general practitioner in the audience reacted incredulously to this, listing five special clinics that he had been told that day to run for his patients.

Consulting the patient

Perhaps the time to do preventive activities will be gained from reducing the number of repeat consultations if general practitioners learn to help patients to understand their illnesses better. This is what three general practitioners and a psychologist, Dr David Pendleton, the college's Stuart Fellow, suggested may come out of using their consultation techniques. Noting both recent criticism of communication between doctor and patient and low job satisfaction reported by some general practitioners, Dr Peter Havelock, Dr Peter Tate, and Dr Theo Schofield thought that the two might be linked since general practitioners rarely have defined aims for their consultations and little or no feedback. Moreover, from their reading they concluded that there was a strong relation between a patient's understanding of his illness from the consultation and compliance.

After four years of studying consultation techniques using video recordings they have come up with a package of tasks for the general practitioner aimed at getting the patient to understand his illness by listening to and discussing his ideas and concerns about the illness. Recording consultations on video—two were shown at the meeting—allows the general practitioner to "map" on a "consultation map," which lists "patient's ideas," "at risk factors," etc, the areas touched on, but more importantly, shows him areas he missed, and allows others in the "learning" group to evaluate the consultation on a comprehensive rating scale. They have tried to measure a notoriously important and difficult aspect of care. Will other general practitioners be willing to try their techniques?

Politics of prevention

Despite the speakers' emphasising how easily some preventive activities may be incorporated into general practice, undoubtedly such work will attack only the tip of the iceberg. The underlying social inequalities perpetuate inequalities in health in Britain.

"Don't underestimate the influence that you as a general practitioner have with your member of Parliament," roared Dr Muir Gray, community physician in Oxford, in the session on the politics, philosophy, ethics, and economics of prevention. Members of Parliament and local councillors welcome advice from general practitioners, and it is the general practitioner's job to give advice based on epidemiological data. Politics is about individuals, and politicians unlike civil servants (and community physicians) are accountable. They take note when they hear from several constituents on the same subject.

Speakers who were not general practitioners may have thought it politic to tread lightly. One was Dr Peter West, senior lecturer in health economics at St Thomas's. Preventive activities, he said, must be based on the benefit to patients and the small amount of time available. Moreover, in the patient's view the health gains were very distant, so the immediate and positive benefits have to be emphasised. The "reassurance" benefit to a patient in whom screening has excluded disease is enormous, however, and should be calculated in the cost-benefit analysis.

Another who trod lightly to start with was Dr Charles Webster, director of the Wellcome Unit for the History of Medicine. Having related the history of the first institute (and chair) of social medicine, which was endowed by Lord Nuffield in 1943 at Oxford, he warmed to his subject only in the discussion afterwards. The paradox, he said, was that, though Nuffield was a generous benefactor to medicine at Oxford, he had no interest in the institute of social medicine and neglected the health and welfare of his car workers at the Morris plants, cutting their wages to finance his philanthropy.

Not being twins, or even triplets, I could listen to only one out of three papers. Thus may I paraphrase Spooner (as related in a hilarious talk by Jan Morris), who said "In the sermon I just preached when I said Aristotle I meant St Paul." So for rubella read smoking and hypertension; for politics read ethics and philosophy and health education; and for children read the elderly and mentally ill.

Reference

1 Brook CGD. Immunisation policies [Editorial]. *Br Med J* 1983;**286**: 1082-3.

"There was no greater pest to medical men that had his custom than old Cooke, the Miser, who died some short time ago at the age of 86, leaving behind him the enormous sum of *one hundred and twenty seven thousand pounds* in 3%, consols, with which he never assisted any one individual nor ever did any good in the course of that long life! ! ! This old man would without ceremony go to the houses of Apothecaries, and have them called up at four or five in the morning, to administer some medicine for a complaint in the bowels which he would want for *twopence*; if this was refused, he would go as far as fourpence, but if it was to cost sixpence he would go to another shop, and call the house for a pennyworth of Jalap: for, he said, he would sooner bear the pain in his guts all day than pay such a great deal of money as sixpence for physic. . . . Many are the anecdotes of the tricks this avaricious old man used to play, to cheat Medical Men of their time and save his money; such as putting on ragged cloaths and going as a pauper to Mr Saunders and other gentlemen, to have gratuitous advice for his eyes—getting a letter for a Dispensary and attending there as a decayed tradesman, for several weeks until detected. . . . When on his death bed, he sent for several Medical men: some would not attend—amongst those who went to him, Mr Aldridge of Pentonville was one. [Cooke] earnestly entreated Mr Aldridge to tell him candidly, how long he thought he might live. The answer was, that probably he might last six days. Cooke, collecting as much of his almost exhausted strength as he could, started up in bed: "are you not" said he "a dishonest man, a rogue, a robber to serve me thus?" "as how, sir?" asked Mr Aldridge with surprize "Why sir, you are no better than a pickpocket to go to rob me of my gold by sending in two draughts a day to a man that all your physic will not keep alive above six days—Get out of my house, and never come near me again." (WILLIAM CHAMBERLAINE. *Tirocinium Medicum or a dissertation on the duties of youth apprenticed to the Medical Profession*. London 1812. p 49-51 footnote.)

Overlapping with General Practice

Doctors one, priests one

KEVIN BYRNE

A very devout person rings for the priest before the doctor. Many ring only for the doctor, but some pious neighbour may send for the priest. On these occasions there may be competition for the body, as priest and GP pass in the night, hurrying back to catch up on their sleep. Sometimes the two meet. I have given oxygen while the doctor jumped up and down on the person's chest, trying in vain to resuscitate him. That was a perfect partnership because the doctor joined in the prayers, too.

The wise GP who knows a particular patient's needs will sometimes ask the priest to visit one who is troubled because the patient will not get better while he is anxious and distressed. Perhaps his illness is caused or made worse by a guilty conscience. His problems may be more moral than physical. The priest, for his part, may save the doctor a call from a person who imagines that she is sick. She really wants someone who will listen to her and assure her of her value and importance as a person, despite her misfortunes and her loneliness.

Recently I visited an old lady who refused to go to the doctor because he might send her to hospital. She wanted to receive Holy Communion before she went in; but she had not been to confession for 30 years. This was soon remedied, and she toddled off happily to her appointment.

There may be serious misunderstanding between doctor and priest. I went to visit a Catholic patient in a New York hospital. The young doctor explicitly asked me not to see him because he was very ill and rather nervy. One wrong word from me would send him over the edge. I suggested amicably that she should stick to her medicine and I would stick to our religion. I saw the patient and anointed him with holy oil in the sacrament of the sick. Any experienced doctor or nurse knows that this raises a person up spiritually and often physically. Next day the doctor was all smiles. "I don't know what you have done to this guy, but he's very happy and rapidly getting better. I was wrong."

Priests may also be wrong in their treatment of those who are sick and distressed. It is a tragedy when the priest is harsh and unbending and the doctor is understanding and compassionate. Everybody loves the GP who has time to listen to his patients. Sometimes patients say "He won't listen to me. He won't talk to me. He never tells you anything." It is more usual to hear poor people and the old people say "He's a lovely man. You can talk to him. He doesn't just push you out and say 'next please.' "

Treading a narrow line

Mind and body are so closely connected that GPs need to respect people's consciences and their natural feelings. It is at the least folly to counsel abortion to a patient who has a respect for life. I have met many women who remain inconsolable because "they took my baby away," and tormented because they had said "yes." In the worst behaved and least disciplined family I know the mother was talked into being sterilised. She regards herself as useless—and behaves that way. Her husband regards her as merely useful.

Some operations are minor, but they have major effects and are open to serious moral question. Vasectomy is an easy operation to perform, they tell me. So is slitting a throat; but the morality of both is open to debate. In the same way the possibility of successful genetic engineering does not ensure that it is in every case right or prudent; and the patient should feel free to consult his priest before submitting to some brave new experiment. Trouble is also caused by counselling about contraceptive practices to those who consider them to be immoral or unnatural or both. It seems much healthier to recommend natural family planning; but some GPs seem to think that this is still achieved, or rather not achieved, by the sole use of a calendar.

Many churches have healing services. These are not intended to be cheap and magic medicine, and only the idiot priest would suggest that the sick should not see the doctor. God generally uses the skills of a doctor to heal people; but He sometimes acts independently, perhaps to show the doctor that he is not God. If a person is healed of hatred, jealousy, and lust (to name but a few) the doctor's remedies are far more likely to be successful.

Many people are far from their religious and cultural roots, and the GP often helps them to return by his own faith. It was reported of my own brother, Pat Byrne, God rest him, that a patient had asked him man to man what his chance would be if he went in for an operation. "Fifty, fifty," Paddy replied. "Is there anything I can do?" the patient asked helplessly. "You can go home and pray." The man's wife said "And he has been praying like hell ever since." He also recovered.

The priest feels an affinity to the GP because they both belong to caring professions. If they are both dedicated they live similar lives, their time is fully occupied, they know that what they do is valuable, and they are respected and loved by those they serve, if they occasionally receive a kick from those who have been disappointed in them. Compared with the priest the GP is a specialist because he deals largely with the sick. The priest is concerned with sick and healthy alike. But both GP and priest work under pressure. They carry a great deal of responsibility, and they can both crack up just as easily, or take to the bottle. What they both need is an extra splash of humanity. Good doctors and priests are made not only by their deep knowledge of medicine or theology but also by their deep knowledge and love of the human soul and by their ability to communicate with another person.

The doctor may know that his patient has more than physical suffering to contend with. The priest may know that his parishioner's problems are not so much spiritual as physical. Each should have the sense to refer the person to the other. Why should it be prayers only or pills only? We could all do with a little of both. One GP friend of mine said that he sometimes gives Our Lord's advice, "Go, show yourself to the priests." He finds it difficult to help those who have suffered the loss of

St Laurence's Presbytery, Birkenhead, Merseyside L41 3JD
KEVIN BYRNE, dean, canon, and parish priest (brother of the late Dr Patrick Byrne)

someone they loved when they ask "Why should this happen to me? Why couldn't she live?" He feels that sleeping tablets are not the best answer. If the patient is a believer the priest can help him to come to terms with his grief.

Although I was asked to write this in a light, chatty style, my GP friend introduced a sombre note. All his patients want to know when they will be better and how soon they will get back to work. He wants the priest to remind them that one time they will not get better and that we shall all die—even doctors. "Somebody should speak to them of eternity." Our time on earth is limited; we cannot hope to protract it for ever. God will call us to heaven. I don't know why but he reminded me of my own mother. She had a miscarriage after her fourth child. The doctor told her not to have any more children; it would kill her. She had four more and died at 80, long outliving her GP. To be fair, he was in every way a good shepherd to his ailing flock. Moreover, my mother would not have lived so long if my brother Paddy and his wife Kathleen, both doctors, had not taken her into their home and looked after her in her declining years.

After St Luke probably the most famous doctors were the two Arabs Cosmas and Damian, "Who practised their profession with great application and wonderful success; but never took any gratification or fee." This is more than may be said by most priests. And for the comfort of both doctors and priests I conclude with the remarks of Alban Butler, writing in 1745 about Cosmas and Damian, who were beheaded because of their Christian faith in 303.

"These saints regarded it as a great happiness that their profession offered them perpetual opportunities of affording comfort and relief to the most distressed part of their fellow creatures. Men engaged in professions instituted for the service of their neighbour may sanctify their labour or industry, if actuated by the motive of charity towards others, even whilst they also have in view the justice which they owe to themselves and their family of procuring an honest and necessary subsistence, which is itself often a strict obligation and no less noble a virtue, if it be founded in motives equally pure and perfect."

General Practice in the Year 2000

Which way general practice? View from outside

BARBARA STOCKING

There is a prevailing attitude that general practice has undergone a revolution in the past 20 years and that having had quite a close shave in the early 1960s it has now regained its position in the medical profession and in society. In many ways this view is justified: most general practitioners are now in group practices or health centres; the concept of the primary health care team is well accepted if not always well practised; postgraduate centres and vocational training have been started; and remuneration is on a much sounder basis.

Of course, not all doctors have yet been incorporated into the new thinking and even those who have may not always have the best possible practice organisation or patient care. Nevertheless, general practice seems to be in a consolidation phase, having undergone its major upheavals in the 1960s. But where is it going from here, and who is deciding the direction? Will general practice look pretty much the same 20 or 30 years from now with the odd computer and geriatric surveillance clinic added in or will it be quite different?

These questions are unanswerable, but current trends and the changes that are going on quietly in the background now will determine what is possible in the future. Some trends have implications for the future role of the general practitioner and may cause conflicts, in part because general practitioners seem to be facing in two directions at once. Some examples of the confusion may make this clearer.

General practitioner as person of first contact

In the job definition accepted by the Royal College of General Practitioners[1] it is said that the general practitioner "will make an initial decision about every problem which is presented to him as a doctor." There have been, however, several studies in the use of nurses as person of first contact,[2,3] and the results of two recent studies by Cartwright and Anderson[4] and by Bowling[5] indicate that this practice is in fact quite widespread. Cartwright and Anderson found that 33% of doctors with either attached or employed nurses or both said that as a matter of policy the nurse sometimes made first contact for an episode of illness in the surgery and 12% in the patient's home. In a differently selected sample of general practitioners Bowling found that 23% of general practitioners occasionally delegated initial home visits but none delegated initial screening in the surgery. This last finding is fascinating, not least because the nurses when questioned preferred the possibility of screening for disease in the surgery because of the presence of the doctor to whom they could refer—the opposite of what was taking place. Thus in practice, and also in some other questions on attitudes in Bowling's survey, general practitioners seemed to feel less threatened by other professionals taking over home visits than screening patients in the surgery. As Bowling said, ". . . perhaps because they [home visits] are not regarded as such a central part of the doctor's role and are merely seen as time consuming."

Without judging whether nurses are or are not capable of assessing patients at home or in the surgery it seems that some consensus needs to be reached on whether the central role of the general practitioner is the assessment and diagnosis of all patients or not. If it is then presumably he should always make first home visits. If it is not then we ought to be training more nurses in roles akin to the nurse practitioners or physician's assistants in the United States, since they would be much cheaper to train and would allow the general practitioner to use his time

Department of Community Health, London School of Hygiene and Tropical Medicine, London WC1E 7HT
BARBARA STOCKING, BA, MS(USA), research fellow