General Practice Observed

Anglo-Canadian Exchange in General Practice

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For the patient, the strength of the personal relationship between him and his general practitioner lies in its permanence—continuing care provided by one personal physician whom he gets to know and to whom he can bring all his medical problems. Paradoxically, for the general practitioner it is this very permanence which becomes one of his greatest problems—to spend his life in the same building, in the same town, and with the same colleagues for many years does present problems of mental constriction and narrow horizons which he attempts to overcome in many of several ways. Local hospital activities, participation in college or medical association functions, attendance at refresher courses, and even holidays—all refresh him to some extent. Nevertheless, their comparatively short duration and the speedy return to the old environment of the same colleagues and patients can still produce an ennui which is difficult to shrug off.

To some extent the reason for this experiment of exchanging general practices for a five-month period and moving from one country to another arises from just such feelings. No doubt it is for similar reasons in different settings that teachers exchange class-rooms, parsons churches, and executives desks.

This paper gives an account of the success of a five-month exchange between two members of group practices—the one in Burlington, Ontario; the other in Stockton-on-Tees, England.

Apart from the need for mental stimulation, there were other reasons for the exchange. Both the participants have made some study of general practice in their own country. Both are members of practices embarking on varied experiments in the delivery of primary medical care. Both felt that knowledge of the attempted solutions to the problems of primary medical care in an English-speaking country other than their own would be inordinately valuable. Each was aware of major deficiencies and insoluble problems in his own practice; the thought arose that these might have been solved in the other country. Each had heard differing accounts of the medical situation in the other's land—the British doctor mostly glowing accounts of a stimulating life with a better job and financial satisfaction, the Canadian doctor mostly gloomy ones of "socialized medicine." The exchange would put these accounts into a more accurate perspective.

By visiting other practices and talking with as many doctors as was possible in the time available, a picture of general practice in an area of Canada and of England could be built up. Clinical aspects of the work, too, would be of interest. Patterns of disease, diagnostic criteria, disease management,

and therapeutic systems would differ greatly. Studies of these differences would be fascinating, and cool appraisals of time-honoured customs could be undertaken.

There would, of course, be fringe benefits applicable not only to the doctors but also to their families; travel opportunities, different educational systems for the children, and the opportunity to experience a new way of life without the permanent break of emigration.

Mechanics of the Exchange

Establishing contact with a general practitioner interested in exchanging practices was not difficult. Advertisements in a journal and a drug firm's news letter elicited seven replies from Canada to the English doctor. Selection turned on similarity of practice. From the onset the success of the exchange depended on enthusiasm and mutual trust. Everything was exchanged. The English family flew to Canada within 12 hours of the Canadian family arriving at the English home. Each doctor arranged for the other to take four weeks' holiday while he was in his practice.

The attitude of the partners in each group was of inestimable help, and each participant received every encouragement and assistance—initially in the planning stages, and subsequently in the warm reception accorded to each stranger in his new group. This hospitality and friendliness in the social as well as the medical aspects of the exchange ensured its success.

Medico-legal problems proved easy to overcome. The Canadian doctor registered in a province whose medical registration is recognized by the G.M.C., and he was accepted by the executive council as a bona fide replacement. The English doctor was granted five months' sabbatical leave of absence by the executive council, and his payments were continued to the practice as though he were still working. He was granted registration on the Special Register of the College of Physicians and Surgeons of Ontario, and local hospital privileges identical with the Canadian doctor's were granted.

The financial aspects of the exchange could have dwarfed all others if trust had not been established and if financial details had been gone into. In the event the doctors established certain principles and then handed over the management of their financial affairs to their own accountants. In essence, the Canadian doctor received the British doctor's income for five months while living in Britain, and the British doctor received an estimate of the Canadian doctor's income for that period of time. The cost-of-living differential would to some extent equalize the difference in actual cash received, but any blatantly apparent financial discrepancies could be equalized at the end of the exchange.

A period of five months was thought long enough for each doctor to have four weeks' holiday and yet still be working for a period sufficiently long for him to take on the full responsibility of the practice and the continuing care of

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chronically-ill patients. The patients too, when aware of the time that the new doctor would be present, were obliged to look upon him as their "own" doctor, albeit a fairly short-term one.

The attitude of the patients in both practices was both enthusiastic and helpful. Many of them appreciated the mental refreshment that it would bring to their own doctor. Nevertheless, there was no perceptible lessening of medical demand in deference to the new doctor. Suffice it to say that both doctors found that they had to work extremely hard indeed, but the stimulus of novelty proved an excellent support.

Before the exchange took place each doctor wrote a series of "instruction sheets" on such topics as "prescribing," the "referral system," "certification," "the local hospital consultants," "the team concept of delivering medical care," etc., so that careful memorizing of these sheets made the early working days easier. Both doctors spent much time in writing up notes of problem patients and getting their practice "just so" before departure.

Enthusiasm carried the exchange along. The first contact—a transatlantic telephone call—took place on 19 January 1970. The exchange was made on 13 April.

Canadian View of British General Practice

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Summary

Before embarking on this exchange venture in British general practice I had many preconceived impressions of what it might be like to be an English family physician. Early in my five months of group practice it became apparent that many of my attitudes had no real basis and in fact I had to admit many aspects of the British health system were indeed superior. It has been my impression that a group general practice in Great Britain can certainly afford the practising family doctor a stimulating and rewarding professional and social life.

Introduction

I started out on this exchange venture to England with a sceptical attitude. English general practitioners who had emigrated to Canada had told me about British general practice in England, but it was soon obvious that this information was based on the National Health Service in its formative years. I returned to Canada feeling quite humbled and took back with me ideas and concepts that should effectively help our group to reorganize its efforts to deliver better community first-contact health care.

The Practice

The group of five doctors with which I was associated in Britain cared for about 15,000 patients in a highly industrialized area. I did not have the opportunity of visiting any but group practices, since all except 11 family doctors in the area were group-orientated. In addition to the five doctors there were 12 paramedical personnel—one health visitor, three local authority nurses, one practice nurse, one midwife, one mental welfare officer, one secretary, and four receptionists. It was this group of co-ordinated personnel which impressed me most favourably when I entered general practice in England.

It was encouraging to see the way the British Government supports the concept of group practice by giving money for constructing local authority health centres and group practice centres. Rents and rates paid by the Government, together with improvement grants, all encourage a high standard of

facilities. In the practice I worked in recent renovations and enlargements financed by the doctors provided nine consulting rooms, a battery of examination cubicles, a doctors' board room, a staff common room, a health education area, a nurses' treatment room, and adequate room for secretarial and reception staff. Such premises specifically designed to accommodate the expanded health team are much superior to the average general practitioner's surgery in Canada. This standard was representative of various centres that I visited.

I found the patients' "life-long" record envelope too small and most of the doctors' writing as illegible as it is in Canada. In several of the practices larger folders were being experimented with.

Doctor's Day

I spent 17 hours a week consulting 155 patients—an average consultation rate of six minutes. Consultation periods never lasted more than two hours. I did no health examinations ("check-ups"), and well-baby care was done by the health visitor. To my amazement there did not seem to be any appreciable latent unidentified disease entities in any age group. I question the productivity and yield of annual health examinations (currently in vogue in Canada) and hope that English general practitioners will not enter this field until medicine has identified the real value of screening at-risk groups.

Of the 50 house visits made each week about half were for chronic conditions. About half of my weekly working hours were spent making these calls, many of which appeared unnecessary. In this area English patients' demands and expectations, rather than needs, were met. Certainly the age distribution and the relatively large number of incapacitating chronic illnesses increase the need for home visiting, but the time afforded for actual patient contact was relatively short. Tradition and the absence of cars and telephones all lead to this situation. With better screening of requests for house calls and a more organized approach to the management of the invalided chronic cases, I feel that the present frequency of these calls could be reduced.

Hospital Affiliations and Referral System

With several regional exceptions the family doctor does not have admitting and treating privileges in general hospitals. It was this aspect of patient care that I greatly missed while in England—as I am committed to the concept that family

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