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 practice emergency rota schemes, radio communications, and bleeper systems are 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 patient must be initiated by the ambulance service 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 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 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 this 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 resuscitation techniques. The East Sussex Ambulance Service in Brighton has provided advanced training for some ambulance staff 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.²

People ought to be extremely cautious left they take other eruptions for the itch; as the flogage of these they are attended with fatal consequences. Many of the eruptive disorders (to which children are liable, have a new resemblance to this disease, and I have often known infants killed by being rubbed with greasy ointments that made these 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 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 purgative 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 leaves of fennel 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 flatulency of the stomach occasions the heart-burn,

Since 1977, in association with BASICS, ambulance services 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 prehospital services in other countries,³ 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, nor is there any development of junior staff 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 Schemes: inquiries should be directed to the Secretary, BASICS, 14 Princes Gate, London SW7 1PU.

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abortifacents 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-spoonful of it taken as often as is necessary. Such as do not chafe chalk may take a tea-spoonful of prepared oyster-hells, or of the powder called cab-eys, in a glass of cinnamon or peppermint-water. But the safest and best abortifacient is *magnesia alba*. This not only acts as an abortifacient, but likewise as a purgative; whereas chalks, and other abortifacients 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 convenience 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. 1390): 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 these are faltering, too.

Dundee has another employment problem. Jute and jam were industries that were especially 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, therefore, 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 patterns 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 accident 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 job in the day time, but five 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 he 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 wily-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 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 reaches retirement age, say 63 or 64, the outcome is happier. Mr H had a similar problem but he was too near to retirement to make it worth signing him off. He became a pensioner and several weeks later appeared in the surgery with a beard 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 help? In fact, Billy had inquiries she burst into tears, and after she settled the whole story came out. She had a blazing row with Billy—the problem, his behaviour. The previous night he came home obviously drunk, and the influence of the row 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 tears

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, 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 the (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 their 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 given 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 furnished premises, an excellent medical service. Since qualifying I have visited a score of other practices, many 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 house on the eastern edge of the city, it is 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 trainees was not so lucky. Puffed 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

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.

Suburban 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 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 about 300 yards away down a back street full of rubble and boarded-up premises. Inside the surgery the sombre ambience persisted. The surgeries I sat through were depressingly similar, composed of brief exchanges with little verbal communication between thoughtful or deprived patients 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 him, has a passion 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 visit 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 a case 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.

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