PRACTICE OBSERVED

Practising Prevention

Cancer

ANN McPHERSON

In 1980, 70 000 men and 61 000 women in England and Wales died from cancer. A large proportion of cancers are thought to be environmentally induced. The factors concerned include diet, general lifestyle, chemicals, and other extrinsic agents. Many cancers are thus thought to be, in principle, preventable. Evidence for this is that the rates of onset of certain cancers are changing rapidly; there are large differences in rates for the same cancers in different countries; likewise, studies of migrants show that they generally develop cancer rates closer to the population they have joined than to those of the genetically similar population in their country of origin.

Cancer accounts for approximately 20% of the deaths in Britain, and cancers of the lung, gut, and breast account for over half of all such deaths. Moreover, the number of deaths from cancer each year has increased over the past 20 years. This is not surprising, however, since the population is aging and cancer is a disease of old age.

Theoretically, of course, most cancers are preventable, but if one thinks about primary prevention smoking is the only important preventable cause of cancer so far clearly identified in Britain and other western countries. Thus, whereas Doll and Peto¹ have recently calculated that 30% of all cancer deaths in the United States could be avoided by stopping smoking, they estimate that only 3% of people could be saved by avoiding alcoholic drinks, 2% by avoiding obesity, 1% by regular cervical screening and genital hygiene, less than 1% by avoiding inessential medical use of hormones or radiology, less than 1% by avoiding exceptional exposure to sunlight, and less than 2% by avoiding exposure to carcinogens in the occupational context in food, water, or city air. It is likely that similar figures apply to Britain. They also estimated the proportion of cancer deaths attributable to various factors, such as tobacco 30%; diet 35%; alcohol 3%; sexual behaviour 1%.

So, of the most common cancers, lung is the most readily

preventable by decreasing tobacco use. Diet is, however, believed to be important in relation to several cancers—for example, colorectal, endometrium, and breast, with less evidence for ovarian and prostatic cancer. There is growing evidence that diets high in fibre, beta-carotene, and retinol A are helpful in avoiding some of these cancers, but there is not yet sufficient evidence for these to be recommended specifically.

What the GP can do

So what role does a GP have in cancer prevention? In a practice of 2500 it has been estimated² that seven or eight new cases of cancer are likely to be seen each year. This would include one case of lung cancer, one of breast cancer, and one of gut cancer. The other four cases would be drawn from a very wide range of other cancers—for example, one case of carcinoma of the cervix every three or four years, one new case of bladder and kidney cancer every three or four years, one case of cancer of the pancreas and gall bladder every six years. Identifying high-risk patients will enable the GP to be selective, both in the area of primary prevention—that is, through offering suitable advice and information—and also in the area of secondary prevention, through performing such screening techniques as routine cervical smears and breast examinations. A fairly intimate knowledge of one's patients is, therefore, a necessary starting point for prevention. Whether they smoke, what their occupation is, or whether a near relative has had breast cancer will indicate what their cancer risks will be and how they can best be helped to avoid them.

LUNG CANCER

Avoiding unnecessary x-ray investigative procedures is good practice and is directly applicable as primary prevention, but the most obvious issue is that of smoking. Indeed, it might seem that if a patient smokes it is hardly worth discussing other areas of prevention unless the patient is willing to give up that habit. At

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Medical Records

Structuring medical records and constructing a Weaver index: a three-year project

PETER C STOTT

It was in August 1978, when I became a principal in general practice, that I first encountered the 3200 unstructured, unlinked packets that were my patients' National Health Service medical records. Still full of zeal from an inspiring training year, I set about structuring these records and from them to construct a practice "diagnostic index."

Many workers have described various ways of structuring medical records in general practice. This ranges from the extremely structured "problem-orientated" medical record,¹ through the modified problem-orientated FP5/6 record² with or without "improvised" notes layout,³ to modified problem-orientated A4 medical records.⁴⁻⁶ Each system has advantages and disadvantages, and like most things in general practice, what suits one GP does not suit another. Zander⁷ and Stuart⁸ have emphasised that a doctor's aims and requirements need to be defined before any system is initiated.

I thought that I needed to structure my records (a) to improve the quality of my own consultations and medical care; (b) to help the transfer of responsibility implicit in group practice; and (c) to help teaching and research. I wanted to take the minimum amount of work home and so I would do it little by little in the surgery. Where practical I would employ my ancillary staff in the work. (In the event they did, very little.)

My requirements were:

- (1) Very thick folders—that is, those that already required a tight-gusseted NHS packet—should be converted to A4 format and structured (see below).
- (2) Thinner folders—that is, thinner gusseted packets—should be structured. Thus, each record should have (a) a patient summary card—BD1 or FP5A; (b) notes and letters fixed in date order with a treasury tag or paper fastener. When relevant, each record should have (c) a drug treatment card—BD3A; (d) a repeat prescription card—BD3B; (e) flow charts—for example, for hypertension, family planning, anaemia, etc.; (f) Each important diagnosis that appeared on a patient's card should also appear in a master diagnostic index or Weaver index.⁹

Method

I planned to do this in phases and recorded how long it took to complete each phase. I started in August 1978.

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PHASE 1—10 MONTHS

(1A) Very fat folders were converted to A4 by ancillary staff and the records summarised by the doctor.
(1B) Fat folders of regular surgery attendances were structured and summarised by the doctor. The FP5/6 format was retained.
(1C) Repeat prescription cards were inserted by ancillary staff.
Phases 1A and 1B were done slowly, at a rate of one medical record per surgery. There were only 75 very fat folders (light-gusseted packets) out of 3200 (2.5%). Conversion to Milton Keynes A4 folders was done by a member of the ancillary staff according to the plan described by Marsh and Thornham.⁴ Each folder, with letters and inserts, took 15 minutes to construct and a further 15 to 20 minutes of my time to summarise and weed the unnecessary letters and reports. (Time taken: ancillary staff 19 hours, doctor 20 hours.)

There were 250 less fat folders (those already requiring a gusseted NHS folder, about 8%), of the total, and these were structured in the traditional NHS packets—that is, FP5/6. They were processed at a rate of two per day after surgeries, each requiring 10 to 15 minutes of my time. I entered important events in the patient's history—medical, psychological, and social—on to a summary card that was fastened with a treasury tag to the front of the ordered continuation cards. The criteria for the selection of such problems was loose, being "those problems which it is important for the doctor to be aware of in his continuing care of the patient."¹⁰ (Time taken to structure weed 250 record cards: 60 hours.) Throughout phase 1, each time a patient requested a repeat prescription the ancillary staff would insert drug treatment (BD3A) and repeat prescription record cards (BD3B) in the patient's notes. About 500 patients receive regular repeat prescriptions—16% of the patients in the practice. It took the receptionist about one minute to make out one patient and one minute to enter the drugs list. A repeat prescription card was designed and printed for use in the A4 folders. (Time taken for 500 cards: ancillary staff 8 hours, doctor 8 hours.)

PHASE 2—12 MONTHS

The records for all patients who attended during this year were structured, summarised, and weeded before they left my desk. If the patient was present a family, allergic, and social history was taken. This phase was started during May so that the first few weeks of heaviest processing would coincide with the seasonal drop in the number of consultations.

I processed 1800 records—about 40 a week. During the first two months, however, it was in the order of 60 a week, and some were put aside for "quiet periods."¹¹ Important events were entered on to a summary card (BD1/FP5A). Very thin folders with no important history took no time at all, except that to interview the patient. Others took longer (range 90 seconds–5 minutes). (Time taken: about 100 hours over one year.)

PHASE 3—11 MONTHS

I continued to structure, summarise, and weed the records of all patients who attended. I started the diagnostic (Weaver) index.¹² During this year only 300 records appeared which had not yet been

the very least, all GPs in Britain could give anti-smoking advice, backed up by a simple pamphlet and a promise to check on the patient's progress. At any rate, it is apparent that the medical consultation is one of the few situations in which advice against the habit can be given to individual smokers by a person in a position of authority, though the wider social attitudes are likely to have a greater influence. Moreover, inquiry through personal knowledge of the patient into the reason for smoking may establish why, for example, certain groups of their women patients continue to smoke while more of their men patients stop. Doctors obviously cannot make their patients give up smoking, and the blackmail approach suggested by some GPs—that they would not treat patients who smoke—is hardly likely to be productive. Nevertheless, giving them the facts—that 25% of all regular cigarette smokers die before their time because of tobacco—and telling them that stopping smoking before they get cancer does make a difference and reduces the risk of dying from tobacco-induced diseases, is at least a beginning. Moreover, because of the effects of interaction people who are both heavy smokers and drinkers should be told that they are putting themselves at an even higher risk, not only of lung cancer but also of cancer of the larynx and oesophagus.

CANCER OF THE CERVIX

The other area in which there is fairly unambiguous evidence for the efficacy of prevention is that of cervical cancer by screening. Cervical cancer is linked with sexual activity, which theoretically makes primary prevention possible but hardly feasible. The use of barrier methods may afford some protection, but immediate prevention of pregnancy may be more important than long-term prevention of cancer of the cervix when counselling patients about the method of contraception. Over 2000 women die from cervical cancer each year in England and Wales, and the prevention of these deaths may also be seen as a challenge to general practice. In some countries where cervical cancer screening is routine the reduction in mortality has been dramatic. In the USA and Finland, for example, death rates have been reduced by half in 10 years. In England, however, there has been only a modest fall in the mortality rate.

Most deaths from cervical cancer occur in women aged over 35 and mostly in women who have never had a cervical smear. The debate about who to screen, how often, and where continues, but if all GPs ensured that women patients over 35 were screened every five years (for which GPs would be paid) there is little doubt that this death rate would be reduced. Each practice can work out how to do it. One may either use consultations for other problems to take a cervical smear or else approach the problem by, for example, identifying all women over 35 and calling them up at five-yearly intervals. In practices where this has been done routinely over 80% of women have been screened; by contrast, in other practices this has been achieved for only 10 to 20% of the female population. Young women at risk are perhaps more easily identified as they are seen at antenatal clinics or family planning clinics. Though they must obviously not be forgotten, it is the older women that offer the immediate challenge. Another useful tool here could be a "medic card" which, among other things, would tell each woman when she last had a smear and when the next one was due.

BREAST CANCER

If preventive action is clearly worth while for smoking and cervical cancer action as regards breast cancer is more controversial. Breast feeding was at one time thought to prevent cancer of the breast, but it has since been shown that this is not so, although early age of first pregnancy offers some protection against this disease. One is really left with screening in an attempt to pick up cases early and so prevent spread and improve outcome. Even at this level it is difficult to know what to advocate

in the way of screening. Breast self-examination—or "get to know your own breast"—is one possibility, particularly as there is little evidence that GPs or nurses are any better at finding lumps. There have been few attempts, however, to evaluate its use and efficacy properly as regards reducing mortality. When attempts have been made to promote it, breast self-examination has proved difficult to instigate.

Since early diagnosis probably does give a better outcome in terms of mortality, this is an area where GPs could instruct their women patients, especially those with a higher risk of breast cancer—that is, those over 35, those with a mother or sister who has had the disease, and those with previous benign breast disease. In this context it is important to establish a special relationship with the women so that if they do discover a lump in their breast they are not afraid to present it. It is only too common for women to be overcome by fear of bad news, fear of wasting the doctor's time, or fear of the possible treatments. Having said this, however, it would be unrealistic to expect people's attitudes to change overnight.

The usefulness of mammography as a routine screening procedure is also not clear-cut, though studies in America have shown that regular examinations by mammography in women over 50 is beneficial in identifying early lesions, which after treatment resulted in a reduction in mortality. Mammography is not available routinely under the National Health Service, however, and financial constraints may well determine its future availability.

CANCERPHOBIA

Finally, there is cancerphobia. The prevention of unnecessary depression and anxiety about cancer is another area in which GPs have something to contribute. Just as we have patients who do not believe smoking has anything to do with cancer, so we also have patients who think they will get cancer from using an ironing-board with an asbestos stand, from dyeing their hair, or from using fluoride toothpaste. Likewise, the cyclical changes caused by hormones that occur in the breast each month may cause anxiety because of the lumpiness that may occur before menstruation. Thus, general education about cancer can be useful as prevention for psychiatric morbidity.

Summary

Clearly, the opportunities for effective primary or secondary prevention of cancer in general practice are still limited by the dearth of information about aetiology. Primary care has a potentially important part to play in rectifying this, however. We need to carry out studies with epidemiologists to elucidate some of the unknown factors. GPs also represent an effective pressure group to bring about environmental changes—for example, getting smoking banned in certain public places. Finally, since we all have our pleasures or bad habits (according to how you view them), GPs might be forgiven for thinking that they have to advocate a sober, temperate life with no tobacco, little alcohol, and little sex! We must obviously avoid moralising and do it in a way that is balanced against the fuller pleasures of life, and take into account the fact that stress (engendered perhaps by being told to give up these habits) may itself make us more vulnerable to cancer.

Thanks to Klim McPherson, Phil Strong, and Leo Kinken for their help.

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processed. At this point the work load was lower so that the diagnostic index could be started, and the initial period of maximum work load was timed to coincide with the seasonal drop in the number of consultations.

Diagnostic index

There are three main international systems for classifying the health problems in primary care: (1) Royal College of General Practitioners (RCGP) (1981) classification of symptoms (NAMCS);¹³ (2) The United States ambulatory medical care classification of symptoms (NAMCS);¹⁴ (3) The classification of the World Organisation of Colleges and Academies of General Practice Family Medicine (WONCA, 1976) also known as ICHPCC (international classification of health problems in primary care).¹⁵

In addition, the International Classification of Diseases¹⁶ codes definitive diagnoses, which is useful for specialists in hospital but is unsuitable for general practice, where the emphasis is on the history of a collection of symptoms. The RCGP classification, though useful in this respect, "robs the data of much of its significance."¹⁷

The ICHPCC "system-type-organ" coding in which the code specifies the disease system, disease type, and organ affected¹⁸ does not seem to have caught on. The National Ambulatory Medical Care Survey was especially designed to code presenting problems.¹⁹ The ICHPCC retains some system specificity and hierarchy, and classifies known disease, social problems, and presenting symptoms. In addition, its code is more specific than the RCGP's. It is only too common for women to be overcome by fear of bad news, fear of wasting the doctor's time, or fear of the possible treatments. Having said this, however, it would be unrealistic to expect people's attitudes to change overnight.

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Each important problem was given the relevant ICHPCC code, which was entered against the problem on the summary card. Details about the patient, the year of diagnosis, and the code were then entered into the relevant section of a central loose-leaf file, or Weaver index.²⁰ When patients left the practice the code on the summary card was marked and details deleted from the Weaver index.

During this year a further 300 records were structured (time taken 30 hours); 2826 codes were entered into the index (time taken 40 seconds each) from 2019 sets of notes run through (time taken 32 hours); and 180 codes were removed from the index (time taken one minute each, or a total of three hours).

PHASE 4—FIVE MONTHS

I structured, summarised, and weeded all records not yet processed, and transferred codes from these records to the diagnostic index. All records that were coded were marked "coded" and marked with the date of coding. It was thus a simple matter for the ancillary staff to identify the remaining 1067 records not yet coded, some of which had already been structured during phases 1 and 2. I processed these in batches of 100 at home on weekends. Because they were used less often and were thinner than the average records they required less work.

No records examined: 1067
No records structured: 756 (time about 53 hours)
Total No. of codes added from 1067 records: 650 (40 seconds per code; time about 7 hours).

Results

In three years 3181 notes were structured in the basic form described (table) and this required 265 hours of my time. Seventy-five of the fastest folders were converted to A4 size. On average, 12 records were structured in an hour. The diagnostic index took 39 hours to construct, plus three hours in one year to keep it up to date. At times the pace was quite hectic, and it is unlikely that this period could be shortened appreciably unless the principle of "little and often" is abandoned.

Phase	No. of records	Ancillary staff (hours)	Doctor (hours)
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Phase 1: Very fat folders converted to A4 and summarised	75	19	20
Phase 1B: Fat folders of regular surgery attendances converted to A4 and summarised	75	19	20
Phase 1C: Repeat prescription cards inserted by ancillary staff	500	8	8
Phase 2: A4 folders structured and summarised	1800	100	100
Phase 3: A4 folders structured and summarised	2826	40	40
Phase 4: A4 folders structured and summarised	1067	40	40
Total	3181	217	210

Discussion

The process of structuring medical records that I have described makes minimal use of ancillary staff. In most studies ancillary staff have been used to a far greater extent. Marsh and Thornham⁴ employed three schoolgirls who assembled 17 000 A4 folders and contents in five weeks. A secretary filled in demographic details and constructed the summary card and a disease index of 60 important conditions. This took 18 months. I was unhappy with so much delegation and from experience was not convinced that an adequate summary list could be produced by a lay person. Such delegation would also have hindered my "little and often" philosophy. The doctors in Zander's study⁷ constructed summary cards (A4) and a diagnostic index and weeded letters for 10 000 patients in 150 hours. The doctors did the minimum of transcribing. This also required 1714 hours of ancillary staff time for the full conversion to A4. Cornack² found that A4 construction took four-and-a-half minutes and summarising and pruning a further six minutes for each folder (but the variation was wide). In Tallo's practices⁶ it took 10 minutes to construct the folders and a nurse took five minutes to convert to problem-orientated medical records. Tomson⁵ found that summarising took between two and 20 minutes, and Campbell¹¹ thought that about 20 records could be processed and summarised in an hour.

Thus my time of one hour to structure and summarise 12 records is about average. Delegating part of the task to ancillary staff would have reduced my personal effort but might have robbed me of the insight I gained in respect of continuing morbidity and the importance of past history. In retrospect I doubt the value for the average general practitioner of structuring the thin folders of patients who never attend. Between 1978 and 1981 the list size of the practice dropped from 3200 to 2875. Three hundred and six records were structured for patients who subsequently left the practice.

The most important part of the structuring was creating the summaries. The most cost-effective part was the insertion and use of repeat prescription cards (BD3A and BD3B). If my time is costed at £20 an hour (a conservative estimate) then it has cost £6000 and each folder £2. The cost in time must be borne in mind by anyone who considers doing this. After three years of my time I have basic records which help my work, my patients, and my partners. In addition, I have a most valuable research tool—the Weaver index.

Conclusions

Over three years 3181 FP5/6 medical records were structured and summarised. Seventy-five of the fastest folders were converted to A4 format. A Weaver index (diagnostic index) was created over 18 months. Structuring and summarising records took 298 hours. Constructing the Weaver index took 39 hours.

I thank the King's Fund for initial financial help with the conversion to A4 records. My thanks also go to the library staff of the Royal

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The Course Organiser

Day-release courses in the West Midlands

G W THORPE

Training courses for doctors who plan to enter general practice have changed over the past 10 years. This is because more doctors are training for general practice and also because there is a better understanding of teaching methods and of what is required to adapt the knowledge and experience that has been gained in hospital to a career in general practice.

The West Midlands Regional Health Authority covers 5000 square miles, much of it heavily industrialised but also containing country towns and farming country, and has a population of 5m, 2500 principals in general practice, and 130 trainees in general practice and twice that number in hospital posts. The logistic problems of organising effective courses are considerable.

In 1969 Dr Robin Street of Worcester started a voluntary half-day release course for trainees in general practice in the West Midlands, based on the university centre in Birmingham, travelling expenses and lecture fees being covered by section 63. It was realised very early that the strength of this course lay in providing a forum for discussion between trainees not only of problems concerning their training but also of their approach to all aspects of patient care. The first course in Birmingham was appropriately called "Orientation to General Practice" and consisted of informal lectures and discussions on clinical and

allied subjects. Consultants and general practitioners made about equal contributions. Some of those who attended the early years of this course will remember the lively discussions, which were often continued into the evening at a local hostelry. With increasing numbers of doctors the training and the need to keep discussion groups to a manageable size, weekly courses have been developed in nine centres in the region and local course organisers are paid on a sessional basis. This has reduced time spent in travelling and encouraged local expertise.

During the early 1970s interest developed in teaching in small groups, where members of the group are encouraged to discuss their own experiences, thus learning from each other. In 1979 Dr Robin Street of Worcester started a voluntary half-day release course for trainees in general practice in the West Midlands, based on the university centre in Birmingham, travelling expenses and lecture fees being covered by section 63. It was realised very early that the strength of this course lay in providing a forum for discussion between trainees not only of problems concerning their training but also of their approach to all aspects of patient care. The first course in Birmingham was appropriately called "Orientation to General Practice" and consisted of informal lectures and discussions on clinical and

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Organising a Practice

Auditing practice organisation

A J M CAVENAGH

"They must be joking," was my immediate reaction to the invitation to contribute this article. Perhaps my blood runs a little higher than nature. I had been bemoaning the quality of our practice records over coffee, and it seemed that organising our practice, let alone auditing its organisation, lay far in the future. Characteristically, it was our senior, and in many ways most revolutionary, partner who brought me back to earth, his own vocational training had included a spell as a beachmaster in the second world war, and he has, I suspect, been undismayed by chaos ever since. "You don't remember the days when patients were let in by the maid, and all the incoming letters were simply stacked in a drawer," he said. "We've come a long way since then. It was the shortage of good maids which began it."

Nearly 30 years later the organisation of our group practice seems still to be limping out of the maid-and-drawer era, and the blame for this state of affairs has to rest squarely with us. We have failed to grasp the elemental truth that if you must choose between good organisation and advanced medical knowledge, the decision should go to the former. Without organisation what medicine you know cannot be delivered; expectations are disappointed, and misery results—witness the plight of our colleagues in orthopaedics who have been buried in their own cement. The wonderful advance of hip replacement is a tantalum to many of its would-be recipients who perish before they can receive it. Shortcomings in our own organisation stem from failure to ensure thorough delegation of duties, failure of in-service training, and failure to provide adequate nursing and office accommodation. We had simply trusted that good administration would prove to be an easily found trace element, whereas it is actually extrinsic factor—without it the whole organism is doomed to morbidity and early death.

"What we need is a five-year plan," said our Stakhanovite. Yet "audit" still makes the hackles rise. Dudley has described its progress from dirty word to bore, and I suspect that only when it slips into the subconscious will it really become useful. A waiting list is one of the luxuries general practice has to forego; whatever happens today needs to be dealt with more or less at once. But the treadmill of activity thus generated often precludes constructive planning, putting us in the admirable company of most general practitioners in the United Kingdom. Our practice consists of seven partners and two trainees, and any distinction it might claim derives from our GP hospital and, arguably, from what we do there. Our mediaeval premises became a pub in the eighteenth century and are still the theatre of alteration after 20 years as a group practice surgery. What follows are the conclusions of several sessions of collective discussion and brain-storming—definitely the substance of things hoped for.

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Working conditions and timetables

Three-quarters of our discussion centered on working conditions for the staff and the waiting room are produced when only three to four doctors are present. Outside commitments, in our own or neighbouring hospitals, administrative meetings, and holidays were havoc with this arrangement. Henceforth a sub-board in reception will give details of each doctor's whereabouts for the next fortnight. (Routine timetable in black and alterations in red.) Intercommunication in the surgery will be facilitated by an enlarged and much more expensive telephone switchboard, with "dialling out" facilities for each doctor, which will be a major saving of telephonist's and doctor's time. Most of our useful intercommunication occurs at coffee-time each morning, and a better timetable will improve attendance.

Although we have six consulting rooms, the optimal conditions for the staff and the waiting room are produced when only three to four doctors are present. Outside commitments, in our own or neighbouring hospitals, administrative meetings, and holidays were havoc with this arrangement. Henceforth a sub-board in reception will give details of each doctor's whereabouts for the next fortnight. (Routine timetable in black and alterations in red.) Intercommunication in the surgery will be facilitated by an enlarged and much more expensive telephone switchboard, with "dialling out" facilities for each doctor, which will be a major saving of telephonist's and doctor's time. Most of our useful intercommunication occurs at coffee-time each morning, and a better timetable will improve attendance.

Records and repeat prescriptions

We have had a good deal of stick from our regional adviser on these. Initially, we shall keep the Lloyd George envelope and contents, train our staff to winnow this down to size as suggested by Marsh,¹ and follow Campbell's² recommendations on sorting the contents. Maintaining the records will require at least one extra secretary/receptionist, who will be recruited as soon as we have adequate space. Working conditions for our receptionists have been positively Victorian, but an enlarged reception office, a separate records room, and a sitting-room—where they can briefly get away from it all—will change all this. Once the clinical records are in order we can proceed to compile a proper E book and morbidity register and start to make some constructive use of our age-sex register, which was completed last year.

Our repeat prescription card has been a failure, and if a patient is away it is possible to get a frustrating hour of day writing repeat prescriptions, most of the time being wasted checking drug and dosage in the records. A window in "reception" will henceforth be devoted solely to handling prescriptions, and we shall ask for written requests only. All will be entered chronologically in the patient's notes, and a record of those on long-term treatment will be established to reduce the present lamentable lack of surveillance.

For me, after 15 years in practice away from medical school, postgraduate teaching presented various problems. The feeling that the doctors who I was to teach were in much closer contact with new aspects of medicine, and their theoretical knowledge more up to date, was at first threatening. I was able to accept, however, that from my own experience I had something important to teach about the application of knowledge and providing patient care and that teaching and learning at its best is a two-way process. I have often found difficulty in enlisting the help of either medical or lay authorities to lecture or lead a discussion on a topic relevant to general practice, because they lack personal experience of general practice; their remarks may have little relevance to day-to-day patient care. It is interesting to find that a contribution that I thought was valuable received a low rating from the course members—and sometimes the other way round. On reflection, this only highlights the different needs and interests of young and older doctors; it does emphasise, however, that it is important for trainees to have a large say in the content of courses arranged on their behalf, and also that the gap in age between teachers and trainees should not be too wide.

As family doctors we should be good listeners a, well as advisers, but working in small groups I found it difficult initially not to provide both question and answer for the subjects under discussion, thus negating the idea of the group assessing and solving problems for themselves. To prepare a lecture or talk requires thought and time. To answer questions helpfully after such a talk is a test of one's own experience of the subject. To lead a small group discussion on the same subject requires experience and time spent in preparation, with clearly defined aims in mind; the way to achieve these aims must be clearly thought out and based on the experiences of those in the group.

In addition to the weekly half-day release courses a series of optional symposia are held in the West Midlands that introduce subjects which are particularly relevant to general practice and in which some trainees may have little previous experience. These optional courses cover family planning, geriatrics,

rheumatology, psychiatry, practice finance and organisation, industrial medicine, the MRCPG examination, orthopaedics, diabetes, ophthalmology, dermatology and ENT, and psychosexual medicine. There is also an extended course in paediatrics. There is some debate as to how much time a doctor in training should spend away from his or her training practice without losing the continuity of care which it is so important to experience and not to miss the frequent but important occurrence such as an unusual collapse, a mentally disturbed patient or an acute social problem. Courses, however good, can only supplement the year's general practice experience and this should always be kept in mind. In many parts of the country release courses for doctors in hospital training schemes aimed towards general practice are run successfully. Such schemes in the West Midlands have had some success, but conflicting interests make regular attendance difficult. There are, however, obvious advantages in having contact throughout the training period with the ultimate reality of the work for which the training is designed.

Taking time out of my practice has presented some problems, and could have been done only with the support of family and partners. Now that vocational training has an established place in medical education, payment on a sessional basis makes course organising financially viable. It still calls for the continued support of both family and partners, and spending extra hours to maintain the continuity of the care of one's patients.

I believe that the purpose of vocational training for general practice is, firstly, to reorientate previous knowledge and experience to deal with people in their own families and homes; and, secondly, to encourage those in training to recognise areas where their previous experience has been weak and to make these good; and thirdly, to be introduced to all aspects of running a general practice, including the financial and legal implications of employing staff. This can be done only within the framework of a working practice, but having the opportunity to stand back and discuss the issues with contemporaries and others of longer experience can only add to the value of the training.

MEDICAL PRACTICE IN CONSTANTINOPLE There are about fifty medical practitioners in Constantinople. . . of this number perhaps five regularly educated physicians; and two of these are English gentlemen, highly respected by the Turkish people. . . Every *medica* has his allotted quarter: he beats this ground daily in pursuit of patients, and visits all the coffee houses in the district with a circled dogmatism, as interpreter, at his heels, while his occupation is to scent out sickness and to extol the doctor. They are to be found on the most public bench of the coffee-shop, smoking with profound gravity, and prying into the ailments of those around them for a symptom of disease. I confess I had to descend to this degradation to get practice, in order to become acquainted with the domestic customs of the people. The first day my dogmatism, who had just left the service of a Roman doctor, and had been practising on his own account since his discharge (for I got money being doctors) took upon him to teach me professional duty, which he made to consist in never giving advice before I got my fee, in never asking questions of the sick, and in never giving intelligible answers to the friends. I was to look on symptoms with a cold eye, and to limit my prognosis to three words, *In Shallah*, or "Praise the Lord!" for doubtful cases; and *Allahkarcum*! or "God is Great!" for desperate ones. I took my post in the coffee-shop, while my dogmatism entered into conversation with the Turks about us. I soon heard him narrating a history of a miraculous cure, which he had seen me perform some days before, on the body of a dying Effendi: how I had taken out his liver, and put it in, after scraping off the disease; and how the patient got well the next day and gave me five purses. I was exceedingly annoyed. . . A well dressed man, who had been sitting by my side in silence for half an hour, at last recollected he had a wife or two unwell, and very gravely asked me "What would I cure a sick woman for?" I was obliged to the saint of Aberrantia. I inquired after her malady. "She was sick." "In what manner was she affected?"

"Why, she could not eat." On these premises I was to undertake to cure a patient who, for aught I knew, might be at that moment *in articulo mortis*. I visited my patient, whom I afterwards found both old and ugly, but I was doubtful on one point: I saw no part of her form: she insisted on my ascertaining her disease with a door between us, she being in one room and I in another. . . I however could not collect enough from the attendant as to cause me to suspect she had a cancer; and I did all, under such circumstances, that I could well do. I gave her an opiate. This lady was no sooner prescribed for than my attention was directed to the youngest wife, who was pleased to need advice, though her sparkling eyes and smiling lips denoted little of disease. She was extremely pretty, and removed her veil with such confidence, that I saw her face. . . I felt through a piece of gauze. . . I ordered her some medicine which I am sure she did not take, and which, in all probability she did not require. . . I cannot conclude without telling you how all Frank medical men are teased by the Turks for apothecaries, which they denominate *madoun*. I am solicited for it at every corner, and it is unreasonable to observe that hardly a man arrives at the age of five-and-thirty, whose deaucheria has not rendered debilitated, and dependent on adjuvantive excitement for his pleasures. (*London Medical and Physical Journal* 1829;7:374-8.)

THE GENERAL PRACTITIONER I wish by no means to underrate the character and importance of the general practitioner. We are a body of men who exist because the wants of society have raised us up. The pure practitioner of surgery, or of obstetrics, can subsist only in a populous city. The physician, indeed, earns his bread in the country; but there is room for one physician only in every three hundred; but there is room for twenty general practitioners. (*London Medical Gazette* 1830;8: 620.)

Appointments system

To audit the appointments system also needs better records. At present, the day's appointments are simply listed on A4 paper in a loose-leaf folder for each doctor, running up to a month ahead. At least 50% of appointments are made by telephone and our revamped "reception" will have three telephones on the counter instead of the one we now have. We have no record of whether the patient saw the doctor with whom he is registered, or whether he was fitted in as an emergency with another doctor. From the customer's point of view most important of all—we have not yet adopted the common transatlantic practice (typical of the impatient society) of registering the time of arrival and the time seen, which has a galvanising effect on all concerned.

Referrals, library, and training

A significant minority of referrals are inevitably informal, by telephone as an emergency. Kyle's report,³ however, is now more than 10 years old and due for repetition. Even with improved clinical records, a prospective study will be necessary to be fully comprehensive, and the part-time help of an additional secretary will be required.

Two members of the practice constitute the library sub-committee, charged with the task of updating the library and preventing depletion. They are gradually assembling a collection of text books relevant to general practice and teaching. The hospital, which is empowered to spend a fixed sum on books annually, can contribute its own library facilities on special topics. An index of the library and a record of loans will be essential to its survival.

We have now reached the indefensible position of depending heavily on our trainees for the service we provide. But the unhappiest trainees here have been those whose work load was deliberately reduced. The requirements of trainees vary so much that only regular discussion can make sure that their needs are met, and even this sort of meeting can lapse if not regularly scheduled. A training diary, listing topics covered and outside activities (such as special clinics attended), will make for much better use of time all round. The long-term and short-term objectives of each trainee's year need continual review and the timetable adjusted.

Medical students

Attachments of medical students are increasing annually, but we have run these on a hand-to-mouth basis with little forethought. If we believe (a) in our style of practice and (b) that the subversion of youth is a legitimate aim, then we must give more time and thought to the individual student's programme. Most career choices are made by the third clinical year. The earlier in their programme that students are attached, the greater the likelihood of their opting for family practice. More time, however, must be allowed for teaching at this stage. All the students have wished for more direct patient contact than we have given them hitherto, and this must be planned. Our visitor's book is essential for follow-up. Individual diaries and comment provide a valuable record of what has been achieved during the visit and a spur to improvement. Students pull few punches!

Building and finance

Our old pub still has a long way to go before it has been fully exploited. We shall use the whole ground floor with its recent extension of four consulting rooms and a waiting room for clinical purposes, upstairs to be reserved for administration and accommodation. Ultimately all improvements must be

self-supporting. Like most doctors, our business acumen is pathetic. Our accountant, however, is committed to making the whole building earn revenue, as notional rent or otherwise, and will review progress annually. The illness of one partner led to a review of our life and sickness policies, which had become hopelessly outmoded by inflation. Simultaneously the value of our premises has risen, and both these vital factors will henceforth be reviewed regularly.

The appointment of a practice manager six months ago has greatly improved our office organisation, exemplified by a typed agenda and minutes at practice meetings. He came to us from the clear-thinking realms of the construction industry, and it is a relief to see how we ever managed without him. More and more problems are simply piled on to his willing shoulders. Though the most modest of men, he confessed recently that his efforts at improving business methods and financial management have so far saved the practice more than his salary costs us. Now that the supply of experienced executives is better than ever, it is surely the time to encourage other practices to follow suit.

Perhaps it all began with the shortage of good maids, but the wheel of progress has almost turned full circle. The capped and aproned helpers of yesterday are now in their thirties, of their own choosing and are far more concerned in the running of the practice than they were. Were our predecessors to leap from their pictures on the library wall, they would recognise nearly everything we are doing, and most of our mistakes. Deliberate organisation, planning, and audit might have been foreign concepts to them, but they had a more personal knowledge of their patients than most of us will ever achieve. I hope we shall remember this as our five-year plan unravels.

References

- 1 Dudley HAF. Self-examination in vogue. *Br Med J* 1981;283:47.
- 2 Marsh GN, Thornham JR. Changing to A4 folders and updating records in a "bush" general practice. *Br Med J* 1980;281:215-7.
- 3 Campbell IK. Medical records III Improving records in a group practice. *Br Med J* 1980;282:1128-9.
- 4 Kyle D. Contribution to a general-practitioner hospital. *Br Med J* 1971; 1: 148-51.

FEIGNED DISEASES The following extract from a rare book, called the *History of Knaveery*, may give an idea of the art that is frequently practised by rogues, and is a notice published in the year 1702, and in the following words: "That people may not be imposed upon by beggars, who pretend to be lame, dumb, etc. who really are not so, this is to give notice to the public, that they are doing wrong, and to take care, by giving the case of one Richard Alegh, a boy of eleven years of age, who pretended himself lame in both legs, so that he used to go along on his knees, they are hereby notified to be taken care of, and to be backward, so that he never used them from that time to this, but followed the trade of begging; that he usually got five shillings a day sometimes more; that he had been over all the counties, especially the west of England, where his brother carried him on a horse, and pretended he was born so. He hath also given an account that he knows of other beggars that pretend to be lame and dumb, and of some that use their arms in their breeches, and wear a wooden stump in their sleeve. The said president and governors caused his legs to be set straight; and he has now the use of them, and walks upright." *Saunders*, in his *Knaveery*, makes mention of a mendicant who gave to his child all the appearances of *hydrocephalus*, by opening the integuments of the head near the vertex, and then introducing air between them and the muscles. This infamous fraud was discovered by removing the patch which covered the hole, and prevented the air from passing out. (*London Medical and Physical Journal* 1823;8:361-64.)