Can this be done by the GP?

Many GPs are already overworked responding to the demands and wants of those who present themselves at the surgery. These demands are likely to increase as the education and expectations of patients grow, as surgeons and physicians discharge patients more rapidly from hospital, and as the proportion of elderly people increases. Every practising GP knows that because of lack of time effective preventive work as described in this article cannot be achieved now. What GPs can do is plan for the future and make a start somewhere, perhaps remembering prevention in the consultation and also attempting to increase their resources by getting extra support from other adults—for example, the self-caring and responsibility of the patients themselves; other health professionals who work with the GP, such as health visitors, district nurse, and midwife; members of patients' families; self-care and voluntary agencies; and adults who decide on health policies.

When general practitioners feel the responsibility of preventive medicine weighing heavily on their shoulders they might remember that each adult ultimately carries the responsibility for his own and his family's health, and that each of the groups above carries a responsibility equal to that of the general practitioner for insuring that in the years ahead preventive medicine becomes a reality in our society.

First priority

There is one adult who's health should, but often does not, take priority in the GP's concern: the general practitioner's own health. If, undetermined, will have an effect on his practice and his family. Even minor physical and emotional upsets can play havoc with the running of the surgery and consultations. The Registrar General's figures for 1978 show that in Britain there are three conditions from which doctors are more likely to die than the general population. These and their respective standardised mortality ratios are suicide 335%, cirrhosis—that is, alcoholism—311%, and accidents 180%.^{1,2} Two of these conditions have a psychological origin, and if combined with the fact that doctors have more marital problems than their families' population, indicates that the doctors' and their families' mental as well as physical health should be our concern.³

Yet how many GPs who practise preventive care include themselves? Apart from the medical profession's success with cigarette smoking (about one in five doctors in Britain still smoke) and the GPs who have attempted to study their emotional response to difficult patients by joining a Balint group, our profession's record is poor (table III).

TABLE III—Items GPs might consider when thinking of their own health

Registering with a GP outside the practice	1976	1977	1978
Taking regular holidays	4220	4638	4918
Working regular hours	463	511	462
Stopping smoking, reducing alcohol abuse, and monitoring emotional responses to the practice	20	18	10
Preparing for retirement	5083	5167	5410

Conclusion

Prevention added to curative medicine is the key to a higher quality of life for many people. It is through adults that changes in attitudes will be brought about. Given the resources, there is much that general practitioners working with their adult patients can do to promote health and to prevent unnecessary physical and emotional illness. To achieve widespread improvement it is necessary to include social change. For it is in housing, employment, civil strife, pollution, and wars that many of the seeds of much ill health are sown. The GP has an obligation,

loss of job/retirement; pregnancy; childbirth; bereavement; and the effects of a major operation.

The evidence shows that we GPs prefer to prescribe rather than talk to our patients. Ann Cartwright concluded in *General Practice Revisited*:⁴ "In 1977 and 1964, two-thirds of the patients came away from the general practitioner's surgery with a prescription... By 1977 the cost of drugs was more than one and a half times the cost of general medical services... As a society we pay less for the advice, listening, and explaining, and the support that general practitioners give their patients than for the pharmaceutical products which they prescribe."

Other people's priorities

GPs may be helped in deciding their priorities with their primary care team by looking at those of others. The Department of Health and Social Security has three priorities: the reduction of cigarette smoking, alcohol abuse, and risk factors for ischaemic heart disease. The RCGP in *Health and Prevention in Primary Care*⁵ states: "In our opinion the most important opportunity for preventive care is at present:

- family planning;
 - antenatal care;
 - immunisation;
 - fostering the bonds between mother and child;
 - discouraging smoking;
 - detection and management of raised blood pressure;
 - helping the bereaved."
- Prevention in all these areas requires that the GP works with adults.

both as an individual and through his professional bodies, to help to change the attitudes of adults in positions of power, so as to bring about for the next generation a society in which the priorities of health are given adult status with those of wealth.

The figure is reproduced with permission from an article by Mr Denis Burkitt, *Update* 1982, 38. Table 11 is reproduced with permission from an article by Barbara Law, *Update* 15 April 1981.

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International Practice

Making a visit: an American GP practising in the NHS

JOHN J FREY

When I was a medical student in Chicago during the 1960s the city sponsored the 1968 Democratic National Convention. One of the more interesting changes I observed was the construction of miles of 10 ft high board fences along the main thoroughfares leading from the expressways to the hotels. These bright blue board fences were the city administration's way of keeping a visitor's eye off of the real Chicago we had come to know and on the high buildings and parks surrounding the downtown hotels. Intermittent signs along the entire length of the walls said, "Welcome to Chicago. Richard J Daley, Mayor"—in case one had any doubt who had been responsible for their existence. These fences lined some of the more desolate streets in the city, where acres of run-down but occupied housing had been levelled in what was cynically called "urban removal," only to be fallow for the next five years or more. It was an example of an urban landscape unable to be resuscitated by Federal money or city politics.

With some exceptions an American's view of the National Health Service has often been the product of the same fast trip through the countryside, resulting in what might be called an "overview." Like the ride through Chicago in the late 'sixties, one had the possibility of seeing only what was meant for one to see.

I was a graduate of the family practice residency programme, which had been newly created in the late 1960s, and had been teaching in a university and practising in an urban health centre for six years. Like many of my contemporaries, my thinking had been influenced by the written tradition in British general practice. This tradition was particularly evident in the large body

of educational literature such as *The Future General Practitioner, Learning to Care, The Doctor-Patient Relationship, and The Doctor, His Patient, and the Illness*.

Trying to get behind the fences of superficial perceptions, I arranged my sabbatical to see and live with the NHS from the perspective with which I was most familiar: that of the practising doctor. As a result, through the Glyncoff Health Centre, the Family Practitioner Committee of West Glamorgan, and the General Medical Council I arranged to obtain temporary licence as an assistant in general practice at the Glyncoff Health Centre for six months.

I chose to work with someone who had strong feelings for general practice and had written about them. I also wanted to look at South Wales, perhaps because that was where general practice work would be most taxing and the resulting stress might reveal cracks in the system. In effect, the Glyncoff Health Centre became a shared practice during my six months in the NHS.

My practice consisted in running joint surgeries on some days with the single-handed GP with whom I was working and, on other days, doing surgeries on my own. My intent was to function as simply as possible in the health centre and to obtain a true sense of the practice itself.

The GP and the patient

It was aware that the major difference between general practice in the United States and Britain was the amount of time spent with patients. The results of studies done in the US showed that the average patient work load for a GP would be 25 a day, or four or five patients an hour in the office. I prepared myself to manage twice that number of patients in general practice in Glyncoff. I was not, however, expecting the difference in actual flow of patients in the office. Most US offices have two or three examining rooms for each doctor, with the physician

moving from room to room, snatching records off the desk just before entering the room. In Britain (with the exception of the "new" way of seeing patients described by the Royal College of General Practitioners), the doctor sits and the patients come to him. I then overcame my rather autistic tendency to examine each patient, ingrained by years of "focused physicals," realising that patients' expectations did not usually include some sort of touching as part of the doctor-patient interaction. As a result, I found myself focusing more on the patient's words as symbols rather than hearing in them only a clue to the organ system to be examined.

I had no idea how orientated I had become towards minor surgical skills until I found myself excited at being able to suture a laceration, incise an abscess, or aspirate a joint. The "quality" of a US family doctor is often measured by the procedural repertoire he possesses. This is apparent in the surgical assisting still done by large numbers of residency-trained family doctors. Thus our continued emphasis on hospital care in the US often finds us influenced by technology, seduced into learning "how to do it." If the "hands-on" part of medicine is less evident in British general practice the resulting attention paid to what is said by patients and their doctors, or the deeper meanings of what is said, becomes the focus of the consultation.

In Wales I found that patients trusted me and that I said far beyond what might logically be due a stranger. In my new behaviour was less a commentary on me and more a perception of the nature of the doctor-patient relationship in British general practice. I consider myself to have reasonable interpersonal skills, but the readiness of patients to confide in me and my passions so directly with me seemed to go beyond the effects of those skills. Patients go to their GPs in Britain for counsel and guidance, as well as medical care, while the prevailing motivation in the US may be more a search for relief.

The practice

The shape and structure of NHS medical records is a source of continual discussion in general practice in Britain. Records in the US are as varied as the eccentricities of the physicians who keep them. The days of the three-five index cards kept in some mysterious order by the receptionist in the front of the office have been replaced by larger pieces of paper in some way related to the problem-oriented record. As more and more groups of family doctors are formed in the US, individualised medical records are being replaced with records that follow a standard format. Records have become a method of communication among doctors more than merely the repository of information of the past. As larger group practices become the rule in British general practice the need for better medical records becomes more important. The A4 record seems to be most compatible with good records, perhaps because it is the smallest and most concise way of getting information quickly.

The necessity for clear, understandable records is more important in the NHS, where records move with patients, than in the US where the records remain the property of the physician. There is no question that giving attached nurses more responsibility for patient care will in part expand the quality of care by letting the group spend more time with other patients. In addition, expanded roles for nurses will facilitate the organised approach to the anticipatory care advocated by Hart.⁶ In most US practices there is a 2:1 ratio of staff (nurses, receptionists, records people) to physicians. This ratio has something to do with the enormous amount of time necessary to process third party bills and patient bills in the US system of private practice. While allied health providers, such as nurse-practitioners, have been very important in the effort to expand access to primary care in the US, their role has not been as extensive as in the US. In the next 25 years will undoubtedly generate heated discussions by health care planners about the advisability of further expanding nursing roles which would put them in competition with physicians for patient care.

The GP and the community

The clear relationship of the GP to a distinct community of patients is the strength of the NHS. Having never functioned in a practice where I could, at any one time, define the population for which I was caring, I found it refreshing to have that definition in the NHS. The movement of general practice towards more anticipatory care builds on this strength and is still something that is more talked about than implemented in the US. The US family doctor must recruit and retain patients to make a living. The resulting "moneyworth" effect finds a large part of practice activity directed at making patients feel they have gotten fair market value for the office fee. In addition, patients often try to squeeze as much out of a doctor-patient consultation as possible. The term "consumer" and the term "patient" are often used interchangeably. While this is appropriate, given the structure of financing medical care in the US, it is perhaps one of the sources of the litigious atmosphere that permeates medical practice. The concern with the "moneyworth" effect is also one of the factors that creates an emotional distance between doctors and patients. This distance, particularly for the general practitioner and family doctor, opposes the need for intimacy and trust that is necessary to care for people in difficult circumstances over many years. The difference, as one of my friends put it, is between a friend in need and a friend in need of my money.

Conclusion

Shared languages and many shared traditions do not result in parallel medical cultures. These separate cultures both affect and are affected by prevailing community and national attitudes about medical care.

It is difficult to be either all inclusive or objective about such an experience as my six months in the NHS. My choosing to come and work betrayed the bias I have toward the implicit values of the NHS. I wanted to be present during the continuing re-examination of those values to help me put any future changes into perspective.

REMOVED DISKES Many years ago, when I resided in the house of Mr Cruikshank, a person brought his son to that gentleman for surgical advice and assistance, asserting that the boy had long been cruelly afflicted with stone, in proof of which he produced several pieces of hard slaty matter, which he declared he had taken from the child in removing from the urethra. Upon my expressing the opinion that these were not urinary concretions, he pretended to be angry, and indignantly left the house, declaring that he would seek a surgeon to perform the operation for the removal of the stone, whose humanity would not let him doubt the assertion of a father, who, though in poverty, would sacrifice his own existence gladly to save that of his son. A few days after this he brought back the boy with a large piece of slate sticking in the urethra, which had torn the inner membrane, and, in consequence, he was unable to urinate. I performed the difficult removal. Satisfied to detect the imposture, I persuaded him to leave the boy in Mr Cruikshank's house, under the pretence that the operation of lithotomy should be performed, if necessary; and was only after the forms of binding the body and bandaging the eyes was gone through, that he could be prevailed upon to confess his father had taught him to introduce these substances, which he procured from coals, for the purpose of exciting commiseration for his pretended sufferings; and obtaining money from the charitably disposed, and, perhaps, in this instance, to have extorted money from the surgeon to conceal his ignorance, had he seriously attempted to perform any operation. (*Medical and Physical Journal* 1821;46:476-95)

PHIENED DISKES A few years ago, a young lady of rank, without any discoverable motives, insisted that she daily passed a large quantity of gravel from the bladder: I saw as much of this as nearly

I found the collaboration and availability of district nurses and midwives to be one of the most delightful aspects of British general practice. Their commitment and work provides the GP with a genuine ally in the daily care of patients and families in the community. The district nurses and midwives in the practice in Glyncoff, for example, provided a remarkable opportunity for me to gather additional important information while I continued to work in the surgery. There are no comparable arrangements in the US, where there are community groups in many cities and towns. There the actual implementation of team care—interdisciplinary, collaborative, and complementary—is on the whole limited to office-based care or ad hoc association with home health agencies and community groups.

House calls have become something of a distant memory for most family doctors in the US. The results of recent surveys⁷ showed that 0.5% of patient contacts by residency-trained family physicians were at home while home visits continue to be a major activity in general practice in Britain. There is a trade-off, however. The time that US family doctors spend in the hospital is comparable to that which GPs in Britain spend doing house calls. My personal bias towards the visit as being a vital source of information with which to care for a family clearly affected my desire to do them. I took every opportunity to see families in their own environments, to the point that I had visited each house on the street where we lived in the village at least once. One cannot deny the enormous value of the visit, if not for the individual patient as much as for the sense of community that one obtains through such activity.

The controversy over the value of the visit is a familiar one. I feel neither authoritative enough to enter nor unbiased enough to argue objectively. An example of the effect of the present economic recession on the practice of medicine in the US and Britain is perhaps the best way of highlighting the differences in the two systems. It has long been pointed out that there is a much larger rate of consultation in areas of Britain where unemployment is highest. Social class also has a great effect on the utilisation of the GP by a given population. The implication is that patients see their GP and the NHS as a resource and a support system, more particularly in hard times. In the US, on the other hand, hard times bring hard decisions for patients about whether they can afford to go to the physician or whether they have other priorities for their salaries. Still the problem of access that plagues the US health care system is exacerbated when the economic situation of the country is such that rising unemployment, with its concomitant financial strain, negatively affects the medical marketplace.

While illness certification remains the bane of every GP's existence, I found that in a rural industrial village suffering from high levels of unemployment my patient work load required 16% certification over the six months. In general, despite certification, the overall amount of paperwork of the practice in Britain was considerably less than that in the US. The practising physician is required to deal with in the US. The bureaucratically and culturally designated role of gatekeeper played by the US physician is less obvious in Britain, or perhaps is dealt with through other means.

One aspect of practice in the NHS that is difficult for the American-trained GP to accept is the lack of choice in consultants who are available to him. Over the years I learned to choose consultants who shared my philosophical approach to patient care. With a number of available surgeons, I could, through selective referral to a few of them, educate them about what I wanted in the consultation as well as develop an important working relationship with the patient. In the US, in contrast, I was dismayed by the loss of that choice through the limited number of consultants and the regionalisation of care. I felt that the strong working relationship that I have with consultants in the US was not as easily developed in the NHS. GPs and consultants in Britain lead less educationally symbiotic relationships than is the case in the US. The resulting communication, primarily through letters, improves the quality of the written word perhaps but may not do the same for patient care.

The value of an exchange between active general practitioners in the two countries is unquestionable. The logistics and bureaucratic details are not insurmountable. It is possible that can be overcome if the people concerned share a commitment to its overall goals. As the discussion of the future of the organisation and delivery of medical care in the US escalates, it would be useful to participate in a system such as the NHS which continues to provide care and support to communities despite the vagaries and destructive influences of a fluctuating economy. The journals of Sturges and Dring, and others who shall and shall not do primary care. It reminds me of a Laurel and Hardy scene where the two are in a boat, swept over the waterfalls because they couldn't agree which of them would throw the rope to the other to help them out on the riverbank. British general practice, on the other hand, has all the prerequisites for a compassionate, personal, cost-effective health system, responsive to the needs of doctors and communities, which should be the true legacy of the NHS.

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I led a half of a pint-bottle, and which she strongly asserted had been evacuated with the urine on the preceding night. It was sent to Professor Brande, who immediately detected the imposture, and found the pretended gravel to be common sand, as is strewn on the floor of kitchen and sculleries; but notwithstanding the detection of this palpable fraud, the young lady long and obstinately persisted in her absurd attempt to deceive. (This must be one of the most common of impostures, for I remember one of my patients, a girl of 10 or 11, who did precisely the same trick of producing a specimen of urine with gravel—in this case gravel from the garden path—in it. In her case the motive was simple and clear. She had recently been admitted to hospital for acute appendicitis, and had enjoyed every visit in hospital so much that she tried to invent a case for her admission.—J.S.L.) (*Medical and Physical Journal* 1821;46:476-95)

PRETEXTS TO PHYSIC AND SURGERY A very large proportion of these practitioners who are acting with the regulars of the medical body are lamentably deficient in professional skill. A country apothecary who had the temerity to officiate in a case of strangulated hernia, begged to know of the surgeon (who judged it expedient to operate) what day he would fix for the operation! I lately saw, in a surgeon's surgery, the unregimented but thickened womb of a young woman, which had been torn from the body by her medical attendant under the impression of its having been a foetus! Another of these clever men sent a note to a surgeon with whom I was intimate, requesting "the loss of a piece of phreopsis" in a difficult case of labour. (*Medical and Physical Journal* 1815;34:188-9.)