PRACTICE OBSERVED

Organising a Practice

"Please reply impersonally": communication outside a rural practice

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The above exhortation, printed at the head of a letter from social services to me, represents the "pits," as Americans would say, of communication about patients between two disciplines of the primary care team. My purpose in this article is to show some special problems and strengths of communication between the practice and the world outside who arise because of a rural location.

The problems of remoteness are both real and acquired. We are 28 miles from the nearest district general hospital, and I am sure that as GPs our contacts with specialists are less personal because we do not know them so well—postgraduate courses tend to be week long affairs, miles away, rather than a lunch-time session at the postgraduate centre. Patients, too, are often intimidated and inconvenienced by the distances to hospital, and some of the older ones even frightened—this must influence referral rates.

The problems we acquire in communication with outside agencies because of our remoteness are rather more daunting, however. Many boundaries drawn up by others make a sense of humour and a large list of phone numbers essential. To name but a few: the council boundary bisects the practice area, this means two separate sets of social services, two ambulance services, two housing authorities, and two parliamentary constituencies. To get a patient in a village two or three miles from Halesworth, but just over the border in another district, into a part 3 home for elderly patients in the town is difficult. The system prefers that he is housed 10 or 15 miles from his home.

We are administered by Suffolk Family Practitioner Committee in Ipswich, but our nurses are run by Yarmouth. The

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cottage hospital is run by Yarmouth, but the obstetric beds are ultimately the responsibility of Ipswich. Emergency transfer can then mean a Norwich ambulance going to Ipswich, and so on. The list of these bureaucratic anomalies is endless.

The title of this article, "Please reply impersonally," while undoubtedly and commendably encouraging team responsibility in the social services, diminishes the quality of care in a rural area where the lines of personal communication are already long. Other problems that our patients have because of their remoteness is communication with what I call lay caring agencies—for example, marriage guidance, Samaritans, Alcoholics Anonymous, Gingerbread, etc. These are all miles away and of little immediate help in a crisis.

Radios and good neighbours

Our country location, however, has definite advantages in communicating with our patients, most of the people in the area being registered with one practice. Firstly, we have an excellent VHF car radio system with a "mobile base station" which can be moved from the surgery to the partners' houses at night and weekends. This also means that the ambulance control can be sure of a prompt response from the practice in case of a road traffic or other accident; we are all provided with equipment by the Suffolk Accident Rescue Service. This radio service has also recently been greatly improved with an extra radio at the cottage hospital to improve communication between ourselves and the casualty and obstetric departments. The money for the hospital radio was raised by the public at events sponsored by the League of Friends.

Secondly, the senior partner headed a committee that organised a comprehensive Good Neighbour Scheme in the town. Each street or part of a street has been allocated a volunteer "good neighbour" with a telephone, whose responsibility it is to keep an eye on the elderly and infirm people in his or her area.

1014

The scheme works well. Each inhabitant is informed who the "good neighbour" is and knows that appropriate help will be forthcoming if the person is contacted. The service includes occasional shopping, transport, and other social help, and the elderly people who live alone are provided with large red RSL signs to display if they are unwell and have no phone. We have a branch surgery that does partner visits once a week. This takes place in the sitting room of a pensioner's home about four miles from the surgery, and we have improved communication with it by installing a phone for her and paying the quarterly rental. This means that patients without a phone in that area find it easier to ask for a visit by sending a message directly to the branch surgery.

Because of the long lines of communication with social services and probation officers, for example, an attempt initiated by the probation officer, has been made to set up quarterly lunches where we, health visitors, social workers, police, teachers, and others meet in the local sports club. There were 39 of us at the last lunch, and I doubt its value without a formal agenda. We meet our own nurses and health visitors daily.

Pathology specimens and results have to go 30 miles to a laboratory, but an excellent van delivery service is provided daily. The cottage hospital ensures good communication of antenatal clinic blood results with an internal mailing system. The cottage hospital records are being linked to the computer

BRITISH MEDICAL JOURNAL VOLUME 285 9 OCTOBER 1982

at the district general hospital, though what tangible benefits this will have for us is uncertain. The receptionists in a rural area provide an excellent unstructured communication system. They are all local girls who live in the area, and the complexities of their family and social lives provide an astonishing amount of intelligence about "what is going on" in the daily work of any general practitioner also centred in the practice area. We provide a printed "hand-out" of surgery times and phone numbers for patients, and this, combined with letters sent by our practice nurse for selective call of patients for screening and the computer cards sent by the community health department for immunisation, complete the communication arrangements.

Conclusion

I have tried to describe the variety of structured and unstructured communication arrangements that occur in our rural area and some of our problems and successes. Of course, good communications have very little to do with good consultations. A great deal of information about the practice is also spread by legend and rumour. I well remember the patient who went quite pale when she saw me in the local supermarket and nearly fainted into the cheese counter. "I heard you'd gone to Australia," she said—she probably hoped I had!

Interesting GPs of the Past

George Johnston: 1797-1855

G A C BINNIE

Berwick-upon-Tweed may seem an unusual source for an interesting general practitioner of the past, and Dr George Johnston at first seems an unlikely candidate. He was born at Simprin, Berwickshire, the 10th of 15 children, of farming stock from the adjoining parishes of Ednam and Eccles, and apart from his student career in the town of Berwick-upon-Tweed and the neighbouring areas of North Northumberland and Berwickshire, with a total of only six weeks' holiday away from his work. But the same George Johnston was given an LLB, honoris causa, of Aberdeen University, was offered a chair of natural philosophy, was on friendly terms with the leading naturalists of his day, and his name is commemorated by Othonia Johnston, named by Philip Gosse to honour "the father of our marine invertebrate biology."

Education

Dr Johnston attended Berwick Grammar School as a boarder (his father was by then farming at Ilderton near Wooler), and

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the successor school has an exhibition in his name from which prizes are still awarded on O level results. His undergraduate career was at Edinburgh University, with an apprenticeship to Dr Abercrombie before obtaining the LMS in 1817; he obtained the MD of Edinburgh University in 1819 with a thesis entitled "De Hydrops," and in 1824 was made FRCGS with a dissertation on "Cancer." This he found a very friendly affair, quite unlike the nerve-racking experiences of today. And there in a sense his medical career rested. He spent a term with the London anatomist Joshua Brooks before putting up his plate in Belford, 14 miles south of Berwick; he failed to establish a practice there and he was married in 1819. George had by then bought the practice of Dr Robert Stevenson in Berwick-upon-Tweed, and there they spent the rest of their married life in the house still known as the "Anchorage," so named, it is said, because he had a share in a ship which sailed out of Berwick.

Natural history

Like most entrants to general practice George Johnston had time on his hands in his early years in practice, and it was then that he developed for pleasure the study of botany, which had

been compulsory when he was a student. This study was put to such good use that in 1829 *The Flora of Berwick* was published, followed by *The History of British Zoophytes* (1838), *The History of British Sponges and Lithophytes* (1845), his *Introduction to Conchology* (1850), and the *Natural History of the Eastern Borders* (1853), which was followed posthumously in 1856 by his *Catalogue of British Worms*. In all he published at least 36 works. His books were illustrated by his wife Catherine, after whom he named Plumaria Catherine, one of his original identifications. While the field was wide open for this type of original research, none the less he took advantage of it to such

good effect that his name was well known to his fellow naturalists, and his botanical collection is preserved in the Royal Botanical Gardens, Edinburgh.

He was offered the chair of natural history in Queen's University, Belfast, in 1845 but declined for family reasons (his second daughter was to die 10 years later of the effects of gross thoracic kyphoscoliosis), but the suspicion remains that it was his liking for Berwick and its environs that prevented the move. When the chair of natural philosophy became vacant in Edinburgh in 1854, however, he applied but his application failed, in company with the applications of Huxley and Hugh Miller. An application for a British Museum fellowship also failed, even though it was supported by a testimonial from none other than Charles Darwin.

He must have maintained some links with Edinburgh after qualification because in the year that his first book was published he issued a challenge to the boys of Edinburgh High School that he would give a copy of his book to any student who could find 20 specimens not listed in his book. A schoolboy took up the challenge and found 26 specimens: this young man

found bigger prizes in Dr Johnston's third daughter, whom he married, and in Dr Johnston's practice, to which he succeeded. He was Philip MacLagan, whose grandson died in 1978, the fourth generation in the practice, and who came from a famous Edinburgh family: his father was physician to HM Forces and president in turn of the Royal College of Physicians and the Royal College of Surgeons of Edinburgh; his brother became Archbishop of York and another brother was lecturer in forensic medicine to the University of Edinburgh.

Berwickshire Naturalists Club

Dr Johnston attended the inaugural meeting of the British Association for the Advancement of Science in York on 29 September 1831; but in fact his most lasting memorial was an inaugural meeting that took place one week earlier on the 22nd. This was the first meeting of the Berwickshire Naturalists Club, the oldest surviving natural and local history society in Britain and which celebrated its 150th anniversary in 1981. The club had originally nine members, including six doctors and two ministers, but Dr Johnston was its founding father, whose initial idea it was and who kept it going through the difficult early years when on occasion he was the only member at meetings. The club has published an annual journal of its doings and of original work since 1831, now has some 350 members, and appears set fair for its second centenary in 50 years. One trend probably not noticeable in Dr Johnston's time is the increasing number of letters addressed to the secretary seeking information concerning the sun and sun-seeking activities of the Berwickshire Naturalists Club.

Civic duties

Dr Johnston was not slow to undertake civic duties in the town of Berwick and was three times mayor, was sheriff in 1843-4, and in Dr Johnston's practice, to which he succeeded. In 1841 what is now the Royal Highland Show visited Berwick and Dr Johnston's efforts were such that his fellow citizens were pleased to reward him with a handsome gift of plate.

Correspondence

He was a prolific correspondent, and his correspondents were sufficiently impressed by what he wrote that they preserved at least 429 of his letters, which were published in 1895, some 40 years after his death and covering 30 years of his life. He writes largely of his botanical work, but the commonplace and amusing crop up. For example, eight months after the opening of the railway line from Berwick to Edinburgh he wrote that he preferred not to travel at such dangerous speeds; and he was greatly refreshed by a three-week change of air—in Spital, on the south side of the mouth of the Tweed and quite one mile as the crow flies from his home in Berwick.

General practice

Little information is available about his medical work in general practice from his own writing, but the minutes of Berwick Dispensary give some side lights. He was appointed surgeon to the dispensary in 1818 (founded in 1814 and now Berwick Infirmary) and became physician there in 1831 by succession rather than by any particular qualifications, and the minutes note that he proposed himself to fill the vacancy of physician at the institution. His work at the dispensary was given freely apart from one shilling and six pence per mile for visits to patients living within 12 miles of Berwick. His comment

1016

in a letter in 1852 that "both my horses are very weary" spoke of the distances he must have travelled on horse back; for example, a patient with a fractured thigh was treated at his home eight miles from Berwick by Dr Johnston on behalf of the dispensary from 16 to 28 February 1832, and he was visited daily; the patient complained because Dr Johnston's success in the dispensary was visited only once in 10 days. When the main east coast railway line between Edinburgh and London was being constructed extra work came to the dispensary, and in 1848 the secretary wrote to the railway directors for payment of £2, the cost for "the effusion of blood by the amputation of William Dickson's thigh rendered necessary by an accident on the railway near Reston which destroyed two of the mattresses." The impression given is that incidents such as these occurred in the daily work of any general practitioner of those times who looked after his patients from birth to death, with second opinions available from general practitioner colleagues. When the railway line was completed, infirmary facilities were available 60 miles distant in Edinburgh Royal Infirmary, which the patient could then reach by rail and then by cab. Dr Johnston was senior physician in the dispensary by 1852, and as such enjoyed the confidence of his colleagues so that his obituary in the *Edinburgh Medical Journal* stated that "he never sought to earn his consulting fee by changing the treatment prescribed by the general practitioner who had

BRITISH MEDICAL JOURNAL VOLUME 285 9 OCTOBER 1982

referred the patient"—a commendation as applicable today as then, even if there is no longer a fee.

Patients attending the dispensary were kept in their proper place. The hours of attendance were between 12.30 and 2.30 on Sundays only, though this was later modified to 9-10 on Wednesdays and Saturdays. The dispensary supplied a visiting service, but requests for visits had to be made before 10 am or else the visit might be delayed to the following day; again this strikes a modern note in the National Health Service with similar exhortations still seeming to fall on deaf ears. Patients coming to the dispensary were "to be as clean as possible in person and clothes." There was to be "no noise or quarrelling in the waiting-room but each was to wait his turn patiently." They were expected to answer questions put to them "modestly and according to the truth" and were to take every medicine according to direction and not to waste or destroy them. They would "behave soberly, attend regularly, and conform to the rules on pain of dismissal." This was no empty threat; as each year in the early years of the dispensary two or three patients were dismissed for irregularity.

Despite the stresses and strains of his medical career, however, Dr George Johnston could still say to correspondents that his life had been "one grand hobby, work continuous but rarely severe," an epitaph which any of today's medical practitioners would be happy to have.

Training in General Practice

Part-time training: is it viable?

MICHAEL VARNAM

Providing part-time training for doctors with domestic responsibilities has been discussed recently.¹ Apart from Swerdlow and Rue's account² of 15 years' experience in the Oxford region, most published comment relates either to the theoretical concept or to personal life histories. Many of the anecdotal comments have aroused considerable passion, as borne out by the correspondence columns of this and other journals.³⁻⁵ This article considers the practical problems of part-time training and suggests ways in which difficulties may be overcome and the educational value increased.

What is the demand?

While not all those who seek part-time training are women, it is likely that the demand will be related to the number of

women undergraduates. These have increased from 20% in 1960, to 29% in 1970, to 34% in 1974,⁶ and for the medical school at Nottingham, 42% in 1981. What cannot be easily estimated is how many of these women will enter general practice, and of these, how many will seek part-time training. Ward's recent paper⁷ on careers of medical women showed that 31% of women in two cohorts (12 years and 26 to 28 years after qualification) were in general practice and another 25% were in "community medicine." The participation index of the 1385 women still practising was 0.73, showing that the average commitment was 73% of full-time work.

A national survey of all trainees in 1980⁸ showed that only 39 doctors out of the 1680 who replied were training part-time, and eight of these were men. Only 54% of trainees responded to the questionnaire, however. Since 1972 there have been 139 trainees on the Nottingham Vocational Training Scheme (37% women), of whom seven (5%) had done either all or part of their training part-time. If the trainees who are in Nottingham now are considered the percentage of women rises to 50%, and those training part-time to 10% of the total. Demand for part-time training may be higher at the moment owing to the requirements of the Vocational Training Act. It seems likely, however, that between 5 and 10% of trainees will seek less than full-time training in the future.

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BRITISH MEDICAL JOURNAL VOLUME 285 9 OCTOBER 1982

What are the problems?

Those who presented their case histories at the Department of Health and Social Security's symposium 'Women in Medicine' indicated that there were three main problems identified with varying responsibilities, and difficult interpersonal relationships. Those who train part-time have different problems, but these are likely to fall into the following categories:

(1) Personal problems. The part-time trainee needs to think carefully about attitudes to domestic activities, finance, and relationships to a spouse (if any). While all doctors will have the same areas of concern, the difficulties facing the part-time trainee are greater and are much more likely to produce conflicts both for the trainee and for close personal and professional contacts. Someone who attempts to be a half-time doctor and a half-time parent usually ends up with a commitment that is rather more than full-time.

(2) Career problems. It is my impression that part-time trainees have not clearly thought out their plans for the future. There is the risk that training may be used as an insurance policy and therefore may be entered into with no clear objectives. Though there may be an element of this in most training programmes, if it is seen as the most important aspect the experience is likely to be less than satisfactory.

What are the opportunities for finding a worthwhile job at the end of training? There are still vacancies for doctors who seek full-time work, but as the vacancies may not be geographically or chronologically evenly spaced they may not be appropriate for doctors with domestic ties. A few of the Nottingham part-time trainees have found it easy to get part-time jobs, but the choice is not usually great. Full-time principals of both sexes often need to be convinced that a part-time commitment to general practice can be useful to the practice as well as to the doctor concerned. Those who seek a part-time vacancy will have to come to terms with the problems posed by a spouse's occupation and the educational and other needs of children.

(3) Administrative. Those who are training part-time will need more help and co-operation from all concerned compared to those working full-time. Few regions have faced this problem and appointed extra personnel to look after the interests of part-time trainees.

Can these problems be solved?

If those who seek, and those who administer, part-time training are keen that it should succeed then most organisational problems can be overcome. It is helpful to consider the parts played by those concerned.

Course organiser. Every part-time trainee must be considered individually. After defining the personal and professional needs as suggested by Faber's training programme one should be designed for the trainee. This is time-consuming but it is something that a trainee should expect, whether full-time or part-time.

Trainer. The practice where the trainee is to work must always be chosen with care. This is even more important when the trainee will be part-time. A trainee working 50% of full-time will require more than 50% of the time usually spent by the trainer. Because trainees working part-time have often had a gap with no medical contact there is the 'return to medicine' syndrome. The trainee will want to discuss cases more often and need more direct help. The teaching time needed will be, if anything, greater than for a full-time trainee. A trainer will certainly earn his reduced training grant. The rewards are, however, potentially greater, in terms of the satisfaction that comes from seeing doctors trained into 'primary care physicians.'

Patients. It is perfectly possible for a part-time trainee to provide continuity of care during training. Surgeries, however, need to be carefully planned. In Nottingham part-time trainees see more patients pro rata than their full-time colleagues. Furthermore, trainees who are known to have young children

have had an extra following among patients who perceive a deeper understanding of shared problems.

Part-time trainee. This training will either succeed or fail in response to the motivation of the trainee. Without a high degree of enthusiasm for practical application no trainee will be effective. Apart from areas already discussed, the trainee will need to be very perceptive about his or her effect on others. Trainees as well as patients have difficulty coping with a high level of expressed anxiety. So while the trainee has to be concerned in self-assessment more than most, some of this will need to be silent. If advice is sought during every consultation patients will soon get the message that the trainee is not worth seeing.

Establishing relationships with the trainee, the practice staff, and the patient is harder for the part-time doctor and so will require greater effort. The personal needs of those with domestic responsibilities are important, but the trainee would do well not to dwell on them.

The part-time trainee's spouse has an important contribution to make to the success of training. Who would otherwise collect children, do the washing, answer the telephone at night, and stand in when a practice emergency arises? If a part-time trainee with domestic commitments does not have a spouse then there will need to be a 'nanny figure' very close at hand for training to be effective.

What is the educational value?

Is all the extra effort of organisers, trainers, and trainees worth while? As it is very difficult to show in a scientific way the progress made by the full-time trainee, we must not expect a mathematical answer to this question.

The part-time trainees in Nottingham (all women so far): (i) can assess their own needs; (ii) can provide continuity of care; (iii) are at least as able to contribute usefully to the half-day release programme as their colleagues; (iv) see as widespread a pattern of disease as their full-time colleagues.

Though there are other aims of training for general practice these four suggest that part-time training can be of educational value.

Conclusion

It is likely that 5 to 10% of trainees will want part-time training. The practical problems are considerable but may be overcome if everyone concerned is prepared to give extra time and effort. Growing subjective evidence suggests that when there is a high level of motivation part-time training can be enjoyable, useful, and of benefit to the trainee, the trainer, and the patient.

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(Accepted 15 July 1982)

1017

BRITISH MEDICAL JOURNAL VOLUME 285 9 OCTOBER 1982

ACCIDENTS

Accidents are the largest single cause of death in this age group (table 11). Road accidents are the main cause, followed by accidents in the home, but drowning, suffocation, and poisoning must not be forgotten. Nearly 80% of children aged 5 to 9 who are killed or seriously injured in road accidents are pedestrians. GPs and health visitors can do much to encourage families to become aware of the risks to their children and to consider reducing hazards in the home and the car, as well as seeing that their young children are well versed in road drill.

TABLE 11—Deaths from accidents, violence, and poisoning (England and Wales, 1978). (Source: Office of Population Censuses and Surveys, 1978)

Sex	Deaths by age group (1978)				Total
	0-4	5-9	10-14	15-19	
All deaths due to accidents, poisoning, or violence	241	135	112	808	1396
Motor vehicle transport accidents	88	138	116	343	685
Drowning	38	39	26	103	206
Inhalation and ingestion of food	25	94	1	7	127
Fall	31	10	2	1	44
Accidental mechanical suffocation	14	7	4	25	50
Homicide	25	1	1	1	27
Poisoning	27	10	9	46	92
	6	3	4	13	26

CONTRACEPTION

Two girls a day aged 15 or under now have therapeutic abortions in England, in addition to the unwanted illegitimate pregnancies that go to term. A quarter of all abortions performed in England and Wales since 1978 were performed on girls aged 15 to 19. By developing a relationship with young patients GPs and health visitors may find an opportunity to raise the subject of sexuality and contraception at an appropriate time. GPs should inform young patients that contraceptive services can be provided without an internal examination. Care must be taken in discussing contraception with the under 15 year olds not to undermine parental responsibility. Some GPs prefer to discuss this with parents and encourage them to raise the subject with their children.

NUTRITION

Improving the nutrition in this age group is fundamental to health, as it is to the care of their teeth. But there is a danger that the discussion of this subject may encourage the advertiser's false message that 'thinness' and not 'good nutrition' is what is desired. The mention of food or of obesity by the GP must be done with care so as not to add to the growing incidence of eating problems, especially bulimia and anorexia.

SMOKING, ALCOHOL, AND DRUG ABUSE

Smoking starts early. Bewley¹ showed in 1973 that in the final year in primary school 60% of boys and 26% of girls were regular smokers in Derbyshire. Attitudes to alcohol, glue sniffing, and experimentation with drugs are also formed early. Here the crucial influences on attitudes in developing children must be the family, the school, the media, and society at large. If general practitioners raise the subject of smoking or alcohol abuse with parents, especially within the hearing of the children, they may be able to counter some of these influences. Some GPs go further and give talks in schools, youth clubs, or on

television. Others feel that as a profession we should bring more pressure on the media to influence the Government's policy, including the soft approach of the Government to the sponsoring of sports by tobacco industries.

EMOTIONAL, BEHAVIOURAL, AND LEARNING PROBLEMS

There is a high incidence of emotional, behavioural, and learning problems in this age group. Every GP can recount his experience of parasydes, anorexia, drug abuse, truancy, learning problems, and abnormal psychological and even criminal behaviour in the children on his list. It is a sad fact that in general practice can do little to buffer our young patients from the influences of advertising, social change, and disintegrating marriages.

England now has the highest divorce rate in the EEC. 'Currently one in four marriages is likely to end in divorce. Some 60% will involve dependent children... in one in five and one in six children born today will witness their parents' divorce before they reach 16.' Many children return to an empty home after school because their mother is out at work. One in seven children are now brought up in a one-parent family. Many children suffer overprotective parents or parents who themselves are depressed and unable to give them the warmth they need. Far too many children suffer from inadequate housing and poor play facilities.

Can the GP do anything to prevent some of these problems?

Here are a few suggestions, largely based on *Prevention of Psychiatric Disorders in General Practice*, published by the Royal College of General Practitioners.

—Attempt to identify 'overprotective' mothers, and avoid encouraging children of these parents to be kept off school unnecessarily after illness.

—Emphasise to overprotective parents what their child can do on his own.

—Encourage as much as you can any form of support for children whose parents are unable to provide warmth, and make an extra effort to avoid hospitalising these children.

—Pay more attention over the long term to the children on the list who are in care and may be experiencing a rapid turnover in adults looking after them, and encourage social workers to have them fostered.

—Identify early and get remedial teaching for children who have learning difficulties or communication problems.

—Identify families where the parents have psychological or sexual difficulties and see if they can face these problems and accept help before it leads to breakdown of the marriage.

—Try to prevent children from being used by their parents as pawns when marriages do break down, by pleading the children's case.

Can busy GPs do these things?

Lists of desirable things that primary care teams can do for any age group are easy to compile. Tivoli service who work in general practice know how difficult it is to implement them. What children on our list need is that we do more than just read about prevention. In deciding if any of these suggestions could be implemented the reader might find the following of some help:

—It seems that much of the GP's time is taken up in advising parents on simple self-limiting conditions, such as colds, diarrhoea, acute vomiting or diarrhoea, dandruff, etc., so that little time is left to deal with children's real needs in the field of prevention. Yet such consultation is an educational opportunity, one that can be extended by written material. The

1018

BRITISH MEDICAL JOURNAL VOLUME 285 9 OCTOBER 1982

Practising Prevention

Children aged 5 to 15

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During the years 5 to 15 many things happen to our patients. They move from home to school. They grow physically, emotionally, and sexually. Their attitudes are formed, and the skills of socialising, learning, and carrying responsibility are acquired. During this process some of our patients have to cope with handicaps and difficult emotional and physical environments. In this article I discuss a few of the areas in which GPs who 'think prevention' can help these patients.

Clinical care (secondary prevention)

It is a mistake to think of prevention as separate from good clinical care (tables I and II). Nowhere is prevention more important than in recognising rare but serious conditions early. The case of meningitis, torsion of the testicle, malignant melanoma, or leukaemia that one sees only once in several years is still sometimes diagnosed late, with serious consequences. Less traumatic conditions that the GP sees more often can, if not diagnosed early, also lead to unnecessary problems—for example, glue ear, appendicitis, scoliosis, and urinary reflux. Good clinical care and prevention also overlap when the GP makes an effort to limit the medication, investigation, or hospitalisation of his young patient. Constantly questioning the need to prescribe drugs such as antibiotics, steroid creams, tranquillisers, or even cough linctuses, not only prevents iatrogenic illness but also prevents the breeding of attitudes in future adults that simple self-limiting conditions require a doctor's consultation and prescription. Prevention in general practice also includes occasional curbing of enthusiasm for that extra investigation or even questionable operation, such as tonsillectomy.

Continuing medical conditions (tertiary prevention)

The periodic supervision of the treatment of patients with chronic medical conditions by the GP and the primary care team can prevent complications. Keeping the morbidity and age/sex registers up to date enables the team to identify and review schoolchildren with diabetes, epilepsy, asthma, or fibrocystic disease and also those with physical and emotional handicaps or those in a one-parent family. Preventing complications in these conditions may be achieved if good communications are built up and maintained with paediatric departments, the school medical service, members of the primary care team, and, above all, parents of the children concerned.

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Primary prevention

In this series of articles on prevention in general practice many subjects have been discussed that are relevant to this age group, but some have special importance.

TABLE 1—Paediatric work load in general practice: percentage of patients and annual number of doctor consultations

Age group (years)	No. of consultations per year	Percentage of patients
0-4	132	65.0
5-14	17.9	64.5

TABLE 2—Childhood illness in general practice. (Source: Office of Population Censuses and Surveys, 1974)

Diagnosis	Episodes in a year (per 1000 population)	
	0-4	5-14
Diseases of respiratory system	1000	521
Acute nasopharyngitis	470	152
Acute bronchitis and tonsillitis	113	106
Acute bronchitis and bronchiolitis	48	22
Symptoms and ill-defined conditions	343	168
Acute vomiting and/or diarrhoea	112	31
Infective and parasitic diseases	209	160
Measles, rubella, chickenpox, whooping cough	64	11
Scarlet fever, infectious diseases	63	12
Viral warts	5	2
Diseases of nervous system and ear, nose and throat	112	161
Acute otitis media	106	13
Conjunctivitis and ophthalmia	70	19
Diseases of skin and subcutaneous tissues	214	150
Acute eczema and dermatitis	113	20
Itch	95	60
Acute dermatitis and eczema	62	20
Lacerations, abrasions, and superficial injuries	49	58
All episodes	2873	1505

IMMUNISATION

Ten to 20% of schoolgirls miss their school rubella immunisation.¹ It is theoretically possible for general practitioners to identify the patients who remain at risk and offer a back-up service to that of the school medical service. Polio immunisation is especially important in older children who are going abroad, as is giving gamma globulin to those who may be going to places where hepatitis is rife.

1020

BRITISH MEDICAL JOURNAL VOLUME 285 9 OCTOBER 1982

refusal of the doctor to prescribe for a cold, the advice to go to a chemist to buy something for dandruff or to advise on a high roughage diet for constipation are educational in themselves—so is handing out a pamphlet, such as *Minor Illness*, produced by the Health Education Council, which has been shown to increase parents' knowledge and reduce the number of surgery consultations.

—Picking out the preventive needs of one member of the family in the age group 5 to 15 is liable to give a false picture. The needs of a child are often the needs of the whole family. Preventing the father having a coronary or mother slipping into a depressive breakdown, or helping both parents to cope with a bad patch in their marriage, or with granny, may help our young patients more than any preventive measure mentioned above.

—GPs who 'think prevention' should heed the warnings of Illich and not undermine but enhance the self-empowering powers of families so that they can carry their own responsibility for preventing sickness and promoting the health and development of all the members of their family.

A new suggestion

The working party that wrote the RCGP's document *Healthier Children—Thinking Prevention*,² suggests that GPs should put aside time for a special surgery to which those aged between 12 and 13—identified through the age/sex register—could be invited. In such a session for older children, run on the lines of the well-baby clinic, GPs could show their interest in the development of these children and provide an opportunity to discuss problems that the patients might have found difficult to present at a consultation. The GP could also do the following during these sessions: check height and weight; check for scoliosis; check for rubella status of girls; check for immunisation status of boys and girls; discuss attitudes to smoking, alcohol, or drugs; discuss academic progress; if appropriate, raise the subject of contraception and attitudes to sexuality and sex problems that may be present; mention the GP service available to his patient, and how the relationship with his general practitioner will change when he is 16 (table IV).

TABLE IV—Checklist for adolescents

History	Physical examination	Problems/abnormalities
Establish relationship with patient	Record weight and height	
Family relationships		
School relationships and progress		
Any other problems		
Review		
Check immunisation status		
Reassess rubella and rheus status		
Teaching topics		
Anti-academic attitudes and advice		
Discuss puberty		
Sexual contraceptive information as appropriate		
Discuss academic and prevention		
Problems, plans, referral		

Adapted from Eggerston SJ, Schoenwiler R, and Bergman JJ. An updated protocol for pediatric health screening. *J Fam Pract* 1980;10:15-21. Published by Appleton-Century-Crofts.

Conclusions

Time does not wait for the developing child. Since the Court Report was published, a generation of children has grown seven years older without any appreciable changes being made in the child care services which, many agree, are in need of improvement. Collectively, GPs, through the Royal College of General Practitioners, have made a new attempt to rekindle the

Tables I, II, and III are reproduced from *Child Health in the Community*, 2nd, 1980, R G Mitchell, editor, with the permission of Churchill Livingstone. Table IV is reproduced from *Healthier Children—Thinking Prevention*, with the permission of the Royal College of General Practitioners.

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Papers wanted for international meeting

The World Organisation of National Colleges and Academies of Family Medicine (WONCA) invites general practitioners in the United Kingdom to submit papers for the next meeting, which will be held in Singapore in 1983. Doctors who submit papers for consideration should be prepared to pay their own way to Singapore. Details may be obtained from the Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU.

Clinical curio: Injuries in the elderly caused by their pets

A 68-year-old woman had a six-year history of seropositive erosive rheumatoid disease. The disease was reasonably controlled by weekly gold injections and the use of a non-steroidal anti-inflammatory agent. She had little early morning stiffness, and apart from some slight soft-tissue swelling around the small joints of both hands her joint disease was quiescent. When on holiday, she was offered to walk their dog, an Afghan hound. Unfortunately, in a manner typical for the breed, the dog took off in pursuit of a distant friend despite being on the leash at the time. The sudden and unexpected acceleration resulted in a severe strain of the patient's shoulder presenting as a rotator cuff syndrome. Despite treatment from physiotherapists and local steroid injections, the shoulder is still giving trouble more than a year later.

Shoulder injuries in the elderly may lead to prolonged discomfort and sometimes permanent restriction of movement. Such cases may be resistant to treatment and prevention is a better alternative. Ideally, elderly people and those with arthritis should not take large dogs walking on a lead. A simple device, however, may lessen the risk of shoulder injury in those who are forced to do so. Leads are available—for example, 'Flexi' leashes—which uncoil from a spring-loaded wheel; a constant tension is maintained on the leash but sudden alterations in strain are not transmitted to the dog handler. A simpler and cheaper alternative is to include a length of shock cord in a standard lead. The use of either such device should be recommended for the elderly and the arthritis—rheumatism, senior registrar in rheumatology and rehabilitation, Harrow.