ation might lead to a wrong diagnosis or wrong treatment being given. The record card thus gave them a written record of their health and disease for future reference.

(b) *Discussing new health problems*—The health interview gave an opportunity to discuss problems not normally taken to the GP. Topics ranged from the best age to give sex education to children to the suitability of hormone therapy for symptoms of the menopause. There were surprising glimpses of patients' views of normal physiology. "I wouldn't normally have bothered the doctor, but I haven't had a period for 18 months, and I just wanted to check it was all right."

(c) *Health education and screening*—The record card provides a written record of the date of the last cervical smear, and in the health interview smoking and alcohol consumption are discussed and the blood pressure checked. The new patient card aims at emphasising preventive health and screening.

Other aspects concerning the record card and health interview have become apparent. (1) *Population profile*—Many of our "new" patients are young and healthy. There may be little important information to enter on a record card unless they have had a chronic illness since childhood. We plan to offer the card to other groups in the practice: (a) There is a group of patients with "fat folders" of past medical records. A good proportion of them have multiple disease and are on multiple drug treatment. (b) Patients recently hospitalised for conditions that are likely to require continuing treatment—for instance, myocardial infarction.

(ii) *"The ones that got away"*—Many of the most difficult patients have both severe health problems and are reluctant and non-compliant, making them unsuitable for health education and preventive measures. Such patients often refused to fill in the questionnaire.

(iii) *Ethical problems*—Communication between doctor and patient is often difficult in those areas of medicine to which

stigma and fear are still attached. Psychiatric illness and a past history of neoplasia presented problems of what to discuss at the interview and what to include on the record card. They were often omitted in the patient's questionnaire either out of ignorance or embarrassment. No attempt was made to tell the patient about a diagnosis of malignancy if the patient had not been told before. Some patients who had been cured of cancer seemed proud of their record and almost wished to celebrate their victory in black and white. Several patients were reluctant to have details of a past history of depression or anxiety recorded.

Conclusions

This pilot study to introduce a personal medical record card has been tried out on only a small sample of patients. There is a growing interest in personal health among the general public. The Department of Health sees patient awareness as an important part of preventive health. It is hoped the record card will help to make patients more aware of their own personal health histories to help both the medical services and themselves.

The record card and health interview may help to convince patients that we have a comprehensive enough history of their health to regard them as "whole persons." It may also help to dispel the mysticism of much medical record keeping by making the information available to the patient. There will be occasions when for ethical reasons we divulge only part of the patient's medical history and other occasions when for personal reasons the patient will want the health history kept secret. For the most part, however, patients seemed happy to have a written record that can remind them and other health workers of important facts in their medical past and present.

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SUGAR IN THE BLOOD OF DIABETIC PATIENTS MM Vaquein and Legéard d'Eschepare recall that, taking the advantage of the admission of a woman, fifty years of age, labouring under diabetes, into the Hotel Dieu . . . they decided to put to the proof the assertion made in the *Dictionnaire des Sciences Médicales, article Diabète*, relative to the presence of sugar in the blood of patients affected with this disease, an assertion which, although in conformity with the views of certain physiologists, is in direct contradiction to the results obtained by many skilful experimentalists, particularly MM Dupuytren and Theaudo. In consequence of inflammatory symptoms rendering two large bleedings necessary, the blood was analysed twice with the utmost care, but it was not possible to discover a single atom of sugar, although the urine which the patient passed, to the amount of nine or ten pints a day, contained a seventh part of this substance. The saliva, also examined at two different times, was entirely free from sugar. It is scarcely necessary to observe that this result does not prove that the sugar is formed by the kidneys. It may, in fact, exist in the blood, and yet may not be detectable by our methods of analysis. ("Medical and Physiological Intelligence." *The London Medical and Physical Journal* 1825;58:163-4.)

SEX, SEA-BATHING AND STAG-HOUNDS "Some weeks ago, I read an account (for the truth of which I can of course not vouch) that the king's stag-hounds had been sent to Brighton for the benefit of sea-bathing, by the order of the master of the hounds, and that this order was given because symptoms of madness had shown themselves amongst them. I was much astonished to find, that in our days, sea-bathing could yet be placed, even by a layman in the healing art, on such a remedy as sea-bathing, in such a disease as hydrophobia, and the wish that some more rational method of treatment than we at present possess might at last be propagated, was strongly raised in me. This brought to my recollection, that the professor, whose veterinary

lectures I attended on the continent, once stated that the probable cause of the *rabies canina* was the disparity of the number of female dogs who were suffered to live to the males, and the consequent impossibility with many of the latter of fulfilling the call of nature for sexual intercourse. As some proof for the truth of this position, he further stated that all the individuals to whom he could ever trace the origin of hydrophobia had been invariably male dogs. As I do not remember having heard this circumstance mentioned since I have been in this country, I am desirous of submitting an account of it to your numerous readers, in the hope that, if it is really new to them, some one might be instigated to further inquiry." (K Lang, letter to the editor. *The Medical and Physical Journal* 1821;46:257.)

Diary of Urban Markis: 1880-1949

In my early days in London I went to Woolwich Arsenal Theatre where Jack Rayner—a relative of mine—was stage manager. Taking very minor part in comedy was a very ugly girl who was the quintessence of fun. Her name was Nellie Wallace, and Jack remarked to me that some day she would be a leading comedienne. She was a prophet.

The Rayners lived for some years in Queen's Club Gardens in West Kensington. Harry Rayner, the father, was my father's own cousin. His wife's name was Agnes, always called Nannie. There were two children Jack and Ethel. Harry was a traveller in pianos and was doing very well. Jack took to the stage. He could sing a bit and dance a bit and occasionally appeared in a musical. A good deal of tennis was played in Queen's Club and although I did not play the game it was a change to go there and have tea with the Rayners as well as staying Sundays with them.

practice diagnostic index. Until recently few practices had such a simple and useful thing. With the use of computers in general practice updating becomes more relevant.

One of the commonest criticisms students have of GPs is their overuse and inappropriate prescribing of penicillin and other antibiotics. Of course, it takes longer to explain to patients how to deal with virus infections than to write out a script. The extra time taken to explain pays dividends, however, if the patient can deal with the self-limiting virus when they are treated. If drug treatment can be kept to a minimum, hopefully there will not be as much iatrogenic disease.

Conclusions

I think that the running of the practice should be disrupted as little as possible by having students. It does not bother me that I am too busy to do the job of educating students properly because that is an important lesson that the job is often done superficially. There is too little time for so many patients.

General Practice in 2000

Two-tier system of primary care

ANN McPHERSON

It is only 17 years till the year 2000, when I will have been qualified for 33 years. Before looking forward, however, it is worth glancing back 19 years to John Fry's *BMJ* article "General practice tomorrow." Fry began with pessimism: "... it has been suggested that because of our changing world with its tremendous advances in the basic and applied medical sciences and with the inevitable increasing needs for specialisation and super-specialisation, the general practitioner is an outdated and out-moded anachronism, out of touch with modern social and cultural concepts and unable to apply modern techniques to his work." Far from accepting this picture, however, Fry stated that the future of general practice was assured and that the most urgent needs were instead to carry out continuous fact-finding on which to base planning for the future; to educate future doctors to know and to understand more of the problems, needs, and roles of general practice; to encourage the formation of viable health teams working together from modern premises; to facilitate closer relations with hospitals; and to work out an agreed career structure.

On the whole, these prophecies and needs are being fulfilled. With the advent of recognised training programmes for general practice, the establishment of academic GP units, and the gradual development of research and self-audit primary health care has become an attractive, valuable, and holistic alternative to the overspecialisation of hospital medicine, though there is still much to be done. America may act as a predictor of some

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Sometimes I tell the students that general practice is much more a way of life than a job. At the end of a consultation I hope that the student has seen some of the broad and snappy of general practice—the red cardrums, measles, shingles, etc. I hope that they feel confident in distinguishing between physical and psychogenic illness. I hope that they have seen sufficient interventions to realise that what the patients present with often bears little relation to their real problem. (The hidden alcoholic is an example.) I hope that the students get a general impression of the way the practice is run and that the GP is a part of the team of district nurse, health visitor, medical social worker.

My impression is that patients' slightly recent students, in the way that doctors slightly recent drug representatives. But, overall, having students improves the quality of patient care by making the doctor justify his decisions and arrest the sloppy cutting of corners. Once I had a student who was silent all week, and I was very curious what was going on in his head. He had, in fact, been giving me a lot of thought and came to the conclusion that in hospital practice personality must be subdued, whereas in general practice it is all important.

future trends. Primary care in the USA has, of course, only recently been recognised as a respectable specialty. Nevertheless, the population of the States is very much more sophisticated in its attitude towards preventive medicine, and it is here that the British GP of the year 2000 will have to be more knowledgeable and assertive. Diet, exercise, and screening will become part of everyday medical practice. Moreover, as has already happened with smoking and the anti-smoking lobby, there will be wider medical-political concern in poverty, unemployment, and the threat of nuclear war.

At a practical level, cervical screening, which has already been proved beneficial, will be more efficiently carried out, and blood pressure screening will become more popular, with the emphasis on self-monitoring—the many vaccinations between chemical and alternative treatment and beta-blockers and their side-effects being relegated to museum shelves. Child health surveillance, which GPs are now under pressure to take on, will, because of appropriateness and cost, have passed to the health visitor. Practices will offer routine screening for breast cancer in their "well person clinics," using a low cost (and probably Japanese) bit of microtechnology, and they will have a similar machine to detect cancer of the testes.

Over the past few years there have been many changes of fashion in the medicalisation and demedicalisation of different aspects of everyday life, and, hopefully, in 18 years' time sex, contraception, and abortion will have been demedicalised (the last having become rare, safe, and chemical) and all relegated to the chemist's counter. This move may be welcomed by some GPs and mourned by others, who see the passing of their earthly powers to give moral judgment. At the same time predicting the outcome of pregnancy should improve, with the few being the subject (and not the object) of ever-increasing technology.

The GP and the Medical Student

Sheffield: non-academic teaching practice

CYRIL GREAVES

My grandfather started the practice at the turn of the century, and his two sons carried it on after his death. It is an old-fashioned, urban family practice with a woman doctor and myself attending 4000 patients. The premises are cramped and consist of an office, waiting-room, and two consulting rooms. The student must sit in on consultations and has not the luxury of a private consulting room. The question is whether nineteenth century medicine in nineteenth century surroundings has credence for a medical student in the twentieth century. I believe that it has and will attempt to justify this view.

I once spent a day in the practice of an enthusiastic Californian family practitioner and had the pipe-dream of an exchange between our practices. His office was full of gadgetry—he had a device for measuring pressure in the middle ear, he was screening the whole of his practice for rectal diseases with a fibroscoposcope. With this in mind, I suggested to him that he might be frustrated by the lack of equipment in the average "office" over here. His reply was, "Well, I've worked in Vietnam." This comparison of our famous National Health Service to Vietnam amused me. One hopes that a reasonable standard of care will compensate for our lack of technology. I do not have an electrocardiograph, though we have access to one at the local hospital. The basic equipment is stethoscope, sphygmomanometer, ophthalmoscope, and auroscope. It is more rewarding to consider the practice as being timeless than out of date. General practice is a public service—this is the first lesson for the student to grasp. Much frustration and unhappiness in the profession arise when this fact is forgotten or ignored—that is, doctors do not like to think themselves as servants nor do they like to behave as such. This magnificent service that the public receive round the clock, 365 days a year, is often appreciated only by British citizens who have travelled extensively abroad. In comparison with other countries we are extremely well off.

Introducing the student

The aims of introducing medical students to the grass-roots of medical practice must be defined. First, is it important? I think that it is important both for the potential GP and for the potential specialist. I remember well a supervising student who was "treating water" until he followed on in the long tradition of eye surgeons in his family. I doubt that he gained anything from the experience in general practice, though I was enlightened by his total uninterest in all principles of primary care.

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Our function as teachers is not to teach medicine—it is taught much better in hospital—but to demonstrate how the anxious, distressed patient can leave the surgery with some satisfaction. One of my colleagues had his mundane life transformed by the discovery of "preventive medicine." Though personally I find the effort of constantly nagging people to drink less, stop smoking, lose weight, and take exercise singularly unrewarding, one cannot ignore this responsibility.

Listening is the most important skill for the student to cultivate. At the interviews between patient and doctor a barrage of symptoms is presented, which may be quite overwhelming for both student and doctor. But out of this must be sifted the salient points. We are in the business of people. For someone who wants a career in general practice an interest in people is mandatory, and if one likes them as well, that must surely be a bonus. There is an ancient quotation that everyone requires something to do, something to love, and something to hope for. I thought that I might stick the quotation on the waiting-room wall for the patients to contemplate, as most patients are deficient in one or all. The average patient must be a bit funny to want to sit in a doctor's waiting-room. One can overlook the odd occasion, but not when they make a habit of it. At the initial interview with the patient I extract basic information, such as age, marital state, employment. Patients appreciate the interest in them as people, and only rarely do they question the relevance of such questions. It has constantly surprised me that trainee doctors can have long sessions with patients without learning whether they were Miss, Mrs, or Ms, or what their occupation was.

The public seem to like a "proper examination," and apparently only hospitals can provide this. The reason that GPs are thought to be bad at giving proper examinations is because of a packed waiting-room. Dressing and undressing take up a lot of time. I have known old people to decline to see specialists because of the time they take to undress. Hence, the diagnostic triangle—the area below the neck, bounded by the lapels, which is just large enough to admit the chest piece of a stethoscope. Even such a perfunctory ritual can be a relief to the patient, not being touched. The only chance that some people have of being touched is in a visit to the doctor. Although it is probably impossible even in the best centres for every patient to have a proper examination, that is what we should strive for—and include measuring the blood pressure and examination of the urine. Rectal and vaginal examinations are criticised as being infrequently done and often inadequate.

A colleague used to write on the top right-hand corner of the patient's notes a short epithet such as "gracious," "moaner," "pleasant." When I used to visit his patients these labels were helpful. Diagnoses are important and one must always strive to reach one. GPs sometimes discuss among themselves which consultants are best at making diagnoses. There seems to be a wide range among them, some appearing never to make diagnoses. Having students in the practice has encouraged us to produce a

and the many being allowed to follow their own tastes, supervised by the midwife and GP. Geriatrics, on the other hand, will be a growth area, both in numbers and in medicalisation, with drugs being used in the elderly as in the young. The result, resulting in a panorama of side effects on emotions and physiology, though perhaps our priority should be the 200 000 extra people over 75 who will be unable even to bath without help.

Psychiatric disorders, especially those associated with old age, will continue to take up much of the GP's time, but—like now—often more by demand than by interest. Time-consuming and evaluated psychotherapy will, however, have replaced traditional "values" in some practices, while in others the new "miracle, non-dependent, no-side-effect" drugs will continue to seduce the prescriber and the prescribed alike. This prescribing, from a more limited number of drugs, will still be done from surgeries which, because of costs, will show little change from their present appearance.

A scenario for 2000

Thus, a scenario from a busy practice of four partners, each with a list of 1500 patients and considering themselves to be lucky to have a job, given the state of medical and other unemployment, might be:

The doctor arrives by bicycle for her surgery, which one again is crammed between her postgraduate update sessions, tutorials with "the doctor who is going to be with us for a year," self-audit sessions, communication sessions, practice management sessions, and negotiations with the practice participation group. Already exhausted by her morning jog, her meditation, her breast self-examination, and chewing her high-fibre, low-fat breakfast along with the mandatory aspirin, she walks in past walls covered with exhorting messages and posters from health education and the patient participation group.

Diary of Urban Markis: 1880-1949

Other visitors to the Queen's Club had been Daisy and Wallace Foote. These two were brother and sister and very remotely were descended from the Brotherhood of Yorkshire. They were therefore very distantly connected with me, but the exact relationship I do not know. On one of my periodical visits to the flat for tea Nannie opened the door and remarked how very glad she was to see me. She took me into a room and showed me Daisy lying dead on the settee. To say that I was startled is to put it mildly. I told course asked what had happened and under the promise of secrecy I was told the following remarkable story.

Mr Foote, Daisy's father, was a shipowner and fairly wealthy. Daisy had no need to earn a living, but like many other girls the day she was married she was married to a man who was a drunkard. He was Russian and entered a family living in St Petersburg. Here she taught English. The family had come to the best circles and during the social round Daisy met a young Army officer. They were eventually secretly married but Daisy continued to live with the family. The young husband became mixed up in some intrigue and was sent to Siberia. Daisy returned home and time went on many years passed. Daisy sought her marriage. But to them she could not listen. Her father became impatient with her. At Queen's Club she met a man much older than herself. His name was William, and one day we heard that she had eloped with him and married him. At the time I knew her she passed under the name of Williamson.

The true story was this. Williamson had a wife who was incarcerated in an asylum hopelessly mad. Being frequent visitors to Queen's Club, Daisy and he became friendly and eventually must have told each other of their mutual love. Daisy being pestered by her father to marry and she of course could not tell him why she refused so many good offers. The old man was a martinet. Daisy saw her way out of the

Collapsing, she gates at the blank screen of her video display unit, longing for the bygone days of bursting tatty brown envelopes, still used only in those practices that had missed out on the Department of Health and Social Security's computer hand-out was back in the early 1980s. Her morning list is the usual number—four patients, three over the age of 75. But not being together long before the mutual attraction waned, Williamson took to drinking and eventually Daisy had not enough food. She developed consumption but she would not seek help from her father because after the elopement she would have nothing more to do with her. She was attending a hospital for her disease as she could not afford to pay a doctor privately.

On this dark afternoon she had come to tea with Nannie. Daisy had a sudden haemorrhage and Nannie, who was always of a calm, collected temperament, sent one of the neighbours for a doctor but he arrived too late. Daisy was free from all her troubles in this world. All round the room were pools of blood. I helped Nannie to clean up the mess and to lay Daisy out. The undertakers had been sent for and they were due at any moment. All the rest of the Rayner family were away and Nannie begged me to stay with her. I did so, and when the undertakers' men arrived I assisted to put Daisy into the wooden box. Then arose the problem. What had Nannie done? Daisy almost with her dying breath had told Nannie that Williamson was on a drinking bout and Nannie therefore knew that it would be useless to send for him and furthermore knew that she had not money enough to bury her. We debated over tea the best course to pursue. We decided to telephone to her father. I did so and boldly informed him of the sudden death of his daughter. I also informed him that Williamson could not bury her and he gruffly told me to send the body to his house. We did so and I understand that Daisy was buried at his expense. What became of Williamson I never knew. He had the good sense to shun Queen's Club and none of us ever saw him again. No one except myself and Nannie knew the true history of Daisy.

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