PRACTICE OBSERVED

Overlapping General Practice

Clinical psychologist

D W A JERROM, R J SIMPSON

Since 1945 clinical psychology has become a distinct discipline. Hitherto, general practitioners may have had contact with the educational psychologist through the school medical service. The clinical psychologist is one of many practical therapists who are becoming part of the network of community psychiatric care and will have an honours degree in psychology and postgraduate professional training of two or three years, including a probation course. The specialised application of the knowledge and techniques of psychology to both mental and physical health problems adds a further dimension to treating and managing many conditions.

Ten or 20 years ago there was little overlap between clinical psychology and general practice. The psychologist before this time had a subordinate role and worked in an institution, providing psychological testing for all branches of psychiatry. During the past two decades clinical psychology has become an independent profession treating a greater variety of problems throughout the National Health Service, most recently in community primary care and away from the large institutions. A consequence of these changes in role and function, discussed in the Tretlow report,¹ which has been generally welcomed by psychologists, is that more and more the general practitioner will have a new resource person to refer his patients to, often in the health centre or surgery. The published surveys, investigations, and evaluation of the new role of clinical psychologists generally conclude that it is a useful and fruitful development in health care for the patient, the general practitioner, and the clinical psychologist.²⁻⁴

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Our experience

In January 1979 the Forth Valley Health Board provided funding over three years for a community clinic to provide a clinical psychology service to the 78 general practitioners in one of the health board districts and to the sector psychiatrists and hospital specialists. The clinic was run from one health centre but patients were seen in other surgeries and health centres throughout the district. It was hoped that patients who either might not have had an opportunity for psychological treatment or who would have been referred to the psychiatric services when psychological treatment would have been more appropriate would be referred.

A steering committee, chaired by Professor H Barber, Norrie-Miller Professor of General Practice at Glasgow University, closely monitored and evaluated the project over the three years. An important feature was the management group, consisting of a psychiatrist and a general practitioner working with the two psychologists who provided the service, which was able to allay the fears of both general practitioners and psychiatrists that the independence of the clinical psychologist would create difficulties and helped doctors and psychologists to learn about the skills and limitations of the other. From the outset clinical responsibility was held according to the recognised professional guidelines⁵ and these have proved to be acceptable. The psychologist was responsible for his own methods of treatment while the general practitioner retained primary responsibility for the overall health care of the patient. By the end of the three years 698 patients had been referred—21000 a year for the district. Referrals had been received from 77% of the general practitioners. Those who had not referred were practising predominantly in rural areas where no "on the spot" service could be offered regularly.

The distribution of diagnoses in patients referred was as follows: 70% suffered from an anxiety state or phobia (32% generalised anxiety, 38% agoraphobia, social phobia, or specific phobias), 8% depression, 7% sexual deviation or dysfunction, and the remaining 15% a mixture of psychiatric syndromes, such as obsessional compulsive disorders and

anorexia, habit disorders, or relationship problems. Although the problems tended to be chronic, with a mean length of seven years' presentation, only a third of cases had received psychiatric or other specialist attention before. A questionnaire sent to the general practitioners who referred the first 30 cases showed that in the absence of such a service they would have continued treating two thirds of the referred cases themselves. We have received only three inappropriate referrals, and this low level was undoubtedly helped by a well attended introductory one day seminar. Patients were usually treated individually with either behaviour therapy or cognitive therapy. Treatment was usually given for seven or eight sessions averaging 20 to 30 minutes each at intervals of two to four weeks. A few severe cases were treated for much longer. The psychologist always wrote to the general practitioner about the patient after assessment and after treatment was concluded and sent interim progress reports if treatment was protracted.

We have evaluated the outcome of psychological treatment.⁶⁻⁸ In summary, we found a high level of satisfaction both among patients and general practitioners with the service, and we showed statistically significant reductions in drug usage, consultation rates with the patient's doctor, and severity of self-rated problems after treatment and at six months' follow up. Patients who fared best were young, were not taking medication at the outset, and had less intercurrent physical disease; but there was no relation between diagnosis and outcome. Furthermore, it was often difficult to predict outcome for individuals until four or five treatment sessions had elapsed, which is common with behaviour therapy and other psychological treatments. A major question that remains to be answered is whether in the long term early intervention with psychological treatment will have an appreciable effect on the high consultation rates noted among the few patients with chronic neurotic problems. If indeed the clinical psychologist can relieve the general practitioner of this particularly frustrating aspect of his work, which accumulates with each succeeding year in practice, then his contribution will be doubly valuable.

Further roles for the clinical psychologist in primary care

Some potentially fruitful roles for psychologists in primary care are other than direct concern in patient management and patient education, staff training, and stimulation of patient self help groups. By patient education we mean working with target patient groups in the practice and not general health education programmes, which are the responsibility of health education departments. For example, we are planning brief courses for adolescents with diabetes who have maintenance problems and on non-drug treatment for patients with mild and moderate essential hypertension. Such programmes will require careful design and evaluation; if proved effective, however, they could be provided in future by the general practitioner, community nurse, or paramedical staff.

Staff training covers teaching medical staff, community nursing staff, health visitors, and counsellors about psychological techniques for changing behaviour and attitudes. For example, teaching general relaxation therapy and techniques for

managing insomnia might give general practitioners further opportunities for curtailing the use of minor tranquilisers. In our survey of general practitioners in our health district 60% of them were interested in such training, but opinions on the best method of providing it were equally divided between seminars on general topics and the opportunity to discuss specific cases in the practice with the psychologist.

Self help groups may be used as a resource by general practitioners. We have helped to set up a group for people who suffer from both phobias and depression. Contributions might also be made in antismoking groups or weight watchers' groups working in collaboration with health visitors. It is important to evaluate the effectiveness of the psychologist's contribution to self help groups before either psychologists or other health care staff make a major commitment to them.

The clinical psychologist has a growing part to play as a member of the primary care network treating and managing psychiatric and psychological morbidity in the community. Linking in one practice the general practitioner, health visitor, nurse, and social worker with specialists such as the clinical psychologist, psychiatrist, community psychiatric nurse, specialist social worker, and trained counsellor should lead to more effective patient care. We are fortunate that the Forth Valley Health Board has supported our experimental project and has established the community psychologist service permanently. The most important aspect is that specialist treatment was available to patients who previously would not have received it. We have emphasised repeatedly the need for careful evaluation since we believe that such experiments too often become part of the service without effective evaluation. After five years we think that the value of the community psychologist has been proved in our district, although further work needs to be done to confirm these findings in the long term. There is already sufficient evidence to warrant the addition of a clinical psychologist to the other National Health Service specialists available in the community.

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Practice Research

Is the serological diagnosis of infectious mononucleosis always necessary?

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Abstract

Clinical and serological data from 100 patients who had a Downey lymphocytosis of $\geq 40\%$ of all white cells were assessed over three years. All had clinical evidence of infectious mononucleosis, suggesting that Downey lymphocytosis of $\geq 40\%$ is specific for the illness.

Introduction

Infectious mononucleosis is believed to be a result of Epstein-Barr virus infection, and the disease has distinctive features.¹ The diagnosis is usually not made unless a triad of clinical, haematological, and serological findings are present. The characteristic lymphocyte in infectious mononucleosis has been called "atypical"; however, as these cells may total up to 12% of all white cells in normal patients,² this description is imprecise. The historical term "Downey lymphocytes," in recognition of their detailed illustration by H Downey in 1923,³ is more appropriate. Recently it has been suggested that a haematological finding of Downey lymphocytes $\geq 40\%$ of all white cells is sufficient to diagnose infectious mononucleosis.⁴⁻⁶ This would allow clinicians in certain cases to make the diagnosis without serological evidence, and there would be a saving in each case of at least 57% in the cost of making the diagnosis.⁴

Patients, methods, results

Prospectively, over three years, the clinical and serological data were assessed in 100 consecutive patients in whom there was a Downey lymphocytosis of $\geq 40\%$ of all white cells. To reduce interobserver and intraobserver variation in counting Downey lymphocytes time was spent ensuring that there was concordance in identifying the types of Downey lymphocytes among the haematologists. Then, if at least 200 white cells are counted, the mean coefficient of variation is about 5%. Sera were examined for heterophile antibody by the Paul-Bunnell-Davidsohn test; any serum that did not contain heterophile antibody was tested for antibodies to Epstein-Barr virus capsid antigen, cytomegalovirus, and *Toxoplasma gondii*. Methods were performed as described.⁷⁻⁹

Results of the serological tests were: 81 sera were positive for the Paul-Bunnell-Davidsohn test, 15 had IgM antibodies to Epstein-Barr virus capsid antigen, and four were undiagnosed. IgG antibodies to Epstein-Barr virus capsid antigen were found in all patients with IgM antibodies and in none of the undiagnosed patients. The undiagnosed

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patients were tested three weeks after the start of the illness; two became positive for the Paul-Bunnell-Davidsohn test and two remained undiagnosed. The table gives the results of haematological investigations. All patients had clinical evidence of infectious mononucleosis.¹⁰ Tests showed no differences among the three groups of patients in cervical lymphadenopathy, sore throat, fever, malaise, and fatigue.

Mean (SD) of total white cell counts, lymphocyte counts (and percentage), and Downey lymphocyte counts (and percentage) in the three groups of patients

Patients	Total white cell count ($\times 10^9/l$)	Lymphocytes ($\times 10^9/l$)	Downey lymphocytes ($\times 10^9/l$)
(1) Positive for the Paul-Bunnell-Davidsohn test (n=81)	12.6 (3.5)	69.5 (8.5)	8.8 (2.8)
(2) IgM antibodies to Epstein-Barr virus capsid antigen (n=15)	11.3 (3.7)	72.7 (9.3)	8.3 (3.1)
(3) Remained undiagnosed (n=4)	6.6 (2.4)	62.5 (16.3)	4.3 (2.8)
Mean (SD)	12.1 (2.8)	70.0 (7.1)	6.8 (2.8)

Discussion

Patients with clinical evidence of infectious mononucleosis do not always have haematological and serological features of the disease. This is particularly true in general practice where patients are often seen early in the course of the disease. Diagnosis may be further complicated by the haematological criteria required. Low concentrations of Downey lymphocytes are not significant, and a concentration $\geq 20\%$ of all white cells is required.⁴ In patients with such concentrations, and undiagnosed evidence of infectious mononucleosis serological investigations have shown that 69% have the illness, 5% have toxoplasmosis, 2% have cytomegalovirus, but 24% remain undiagnosed.¹¹ This high level of undiagnosed cases probably reflects the fact that most patients were from general practice.

The degree of Downey lymphocytosis can be useful in the investigation of patients with clinical infectious mononucleosis. Patients with toxoplasmosis, cytomegalovirus, and undiagnosed infections have lower concentrations of Downey lymphocytes, usually in the range 20-25%.^{4,12} Adults and children with these illnesses have similar concentrations of Downey lymphocytes, though children with infectious mononucleosis may have exceptionally high concentrations.¹³ This study was designed to verify the suggestion that all patients with $\geq 40\%$ Downey lymphocytes have serological evidence of infectious mononucleosis.⁴⁻⁶ The only requirement for entry into the study was $\geq 40\%$ Downey lymphocytes, yet I found that all the patients had clinical evidence of mononucleosis. Although serological confirmation was obtained in only 98 patients, the remaining two

patients had identical haematological and clinical features. As some patients may form antibodies to Epstein-Barr nuclear antigen without forming other antibodies¹⁴ the two undiagnosed patients may have had antibodies to Epstein-Barr nuclear antigen for which they were not tested. Thus massive Downey lymphocytosis seems to be specific for infectious mononucleosis. The results of one survey of patients suspected of having this illness showed that in more than a third of cases the referring

doctor (mostly general practitioners) would have had to base the diagnosis on the amount of Downey lymphocytosis alone.¹⁵ The results from my study show that this is a reasonable approach (figure). Apart from the concentration of Downey lymphocytes, the haematologist may also consider other factors that vary during the course of the illness such as leucopenia, neutropenia, and thrombocytopenia.¹⁶ In patients with clinical and serological evidence of infectious mononucleosis $\geq 40\%$ have $\geq 40\%$ Downey lymphocytes.⁴ But in patients with only clinical features of infectious mononucleosis 15% have $\geq 40\%$ Downey lymphocytes¹⁷; this probably reflects the large number of diseases that can produce the clinical picture of infectious mononucleosis. Thus knowledge that $\geq 40\%$ Downey lymphocytes is specific for the disease obviates further investigation and saves much time and money.

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Laboratory and radiological investigations in general practice

III: Abnormal results

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Results

Throughout the study practice C had a higher rate of requests for investigations. We wanted to see if this led to the detection of appreciably more patients with abnormalities compared with the other practices. To allow a fair comparison the numbers of patients in whom abnormalities were detected by each practice during

the six months 1 September 1982 to 28 February 1983 are expressed as a percentage of the number of surgery encounters in that practice over the same period (table 1). We confirmed by means of the χ^2 test that the rate at which patients were investigated was significantly different among the four practices over the six months (see column 3). If practices A and B are considered alone, however, there was no significant difference between them, but there was a pronounced difference among practices A, B, and D. Of the patients investigated by each practice, a significantly different proportion of them had abnormalities (column 5). This difference is lost if practice C is omitted and the calculations repeated; thus practice C seems to have had a higher proportion of patients with abnormalities in its population of investigated patients than the other three practices. The four practices also differed significantly in the proportion of surgery encounters that yielded one or more abnormalities as a result of laboratory or radiological investigations. Again, practice C had the highest proportion, followed by D, and then A and B (column 6).

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TABLE 1—Number of patients giving abnormal results on investigation

	(1) No of surgery encounters	(2) No of patients investigated (abnormal results as percentage of total surgery encounters)	(3) Patients investigated (abnormal results as percentage of total surgery encounters)	(4) No of patients with abnormal results as percentage of total patients investigated	(5) Patients found to have abnormal results as percentage of total patients investigated	(6) Patients found to have abnormal results as percentage of total surgery encounters
A	5 018	440	8.8	116	21.4	1.9
B	8 114	85	0.9	94	22.8	1.9
C	1 651	1 651	100	26	1.6	0.0
D	13 265	151	1.1	392	25.9	3.0

* $\chi^2 = 322.7$, d.f. = 3, $p < 0.001$.
 $\chi^2 = 18.9$, d.f. = 3, $p < 0.001$.
 $\chi^2 = 160.7$, d.f. = 3, $p < 0.001$.

We divided the patients in each practice with abnormal results into categories indicating the type of abnormality and what action was taken after the result was obtained (table 1). There was a difference among the practices in the rate of abnormal results, and their proportional contribution to each practice's total may help to explain this difference.

The categories were as follows: (a) monitoring—included all follow up of treatment in patients with chronic disease, an abnormal result often leading to an adjustment in existing treatment; (b) chronic conditions—included all newly diagnosed chronic complaints, such as heart disease and osteoarthritis, when no referral was made and necessary treatment was carried out by the general practitioner; (c) acute conditions—included all acute conditions that were detected and treated by the general practitioner only, such as urinary tract infections; (d) no further action—included results that were abnormal but for which no treatment was thought to be necessary, such as erythrocyte sedimentation rates in the middle range; (e) referral—included all cases where referral for opinion or admission was made after the general practitioner received one or more abnormal results.

Discussion

Table 1 shows that practice C not only investigated appreciably more of their patients than the other three practices, but that of the patients investigated a higher proportion had an abnormality. We expected the figures for patients with an abnormal result as a percentage of patients investigated to be similar for all the practices. If each practice investigated a similar population with an essentially similar distribution of morbidity you might expect the proportion of abnormal patients detected to be similar irrespective of the numbers each practice decided to investigate. This was so for practices A, B, and D, but practice C had an appreciably higher percentage of patients with abnormal results (29.8%) than the other three. Why should this be so?

In investigating a higher proportion of their patients than the other three practices practice C perhaps selected people who may have been more likely to give an abnormal result—those with existing chronic complaints such as diabetes. Practice C did appreciably more monitoring than the other practices. Such patients with chronic disorders are obviously not certain to give abnormal investigation results, but they may be more likely to than the "ordinary" patient with a non-chronic complaint being investigated. Perhaps the morbidity that the four practices were seeing was different, even though they drew their patients from essentially the same population, but we have no way of knowing if this is the case.

Table 1 shows that as the practices investigated a greater percentage of their patients seen in the surgery (column 3) so the percentage of abnormal results rose (column 6). This may seem logical, but an increase in the number of patients investigated as a percentage of patients seen in the surgery seems to lead to a larger increase in the number of patients detected with disease. That is, investigating more patients leads to disproportionately more patients with abnormalities being detected. Practice C's figures for patients with abnormalities may be inflated owing to a statistically significantly higher level of monitoring. Practice D, however, did not have a statistically

significantly higher level of monitoring than A or B but still had a disproportionately higher number of patients with abnormalities related to surgery encounters than A and B.

Undoubtedly a small percentage of patients with disease will remain undetected, and it would be premature and financially impossible to advocate investigating all patients the general practitioner sees to eliminate this small percentage. There seems, however, to be a case for maintaining a rate of investigation at around the 17% level rather than the 9% level, with doctors making greater use of the open access facilities for monitoring chronically ill patients.

We have already considered monitoring above, but table 11 shows that there is also a statistically significant difference among the practices in terms of the proportion of abnormal results yielded by new chronic and acute cases and also in the level of referrals. No significant difference between the

TABLE 11—Management of patients from four practices with one or more abnormal results

	A	B	C	D
No of patients (%)	No of patients (%)	No of patients (%)	No of patients (%)	No of patients (%)
Monitoring*	12 (12.6)	12 (13.3)	93 (21.5)	54 (13.0)
New chronic	31 (34.7)	47 (52.2)	180 (41.6)	106 (27.0)
Acute conditions	11 (12.1)	67 (74.4)	180 (41.6)	106 (27.0)
No further action	17 (17.6)	11 (12.1)	34 (7.9)	37 (9.4)
Referral	17 (17.6)	11 (12.1)	34 (7.9)	37 (9.4)

* $\chi^2 = 14.07$, d.f. = 3, $p < 0.01$.

* $\chi^2 = 8.9$, d.f. = 3, $p < 0.05$.

* $\chi^2 = 15.07$, d.f. = 3, $p < 0.01$.

* χ^2 not significant.

* $\chi^2 = 0.10$, d.f. = 3, $p > 0.05$.

three practices for the number of new chronic conditions exists if the χ^2 test is applied to practices A, C, and D only. Practice B had a significantly lower level of patients with new chronic disorders, perhaps due to their low use of x-ray examinations (other than chest x-ray examinations). Many of these new chronic patients had conditions such as osteoarthritis, detected by the use of x-ray films.

All four practices differed greatly in the number of new acute cases producing abnormal results. Appreciably more of practice B's abnormal results were the result of acute episodes of illness than in practices C and D, which would have an appreciably higher proportion of new acute cases than practice A. This low level of acute abnormalities for practice A may be related to the level of patients with abnormalities that are referred by the practice. Practice A had an appreciably higher rate of referral on an investigation result (or results) than the other three practices, but there was no such difference between practices B, C, and D. This may reflect a difference between practice A and the other three practices as regards the degree or type of abnormality they were prepared to treat before they considered referral necessary. Practice A may have referred patients at an earlier stage in the natural history of particular conditions than

Family Practice Abroad

Primary health care in Barcelona

GABRIEL J SCALLY

The opportunity to observe health services abroad is widely thought to be beneficial to medical students during their training. All doctors in Northern Ireland who have completed their vocational training in general practice also have the opportunity to see how general practice is organised outside Northern Ireland. This with the help of a grant I spent three weeks in Barcelona visiting various health centres and offices in the city and its surrounding area. The general practitioners, public health doctors, and other health professionals I met fortunately spoke English, thus sparing me having to use my minimal Spanish and non-existent Catalan.

Barcelona is the capital of the historic region of Catalonia, and the discrete Catalan identity has been reinforced by the high degree of autonomy granted to Catalonia in the post-Franco era. The recent transition to democracy has created a climate that has led to questioning the efficiency and effectiveness of all social structures, including health services. Thus primary medical services have been debated and discussed widely and are entering a period of adjustment.

A unified state-run health service, such as we are familiar with in the United Kingdom, does not exist in Spain and there is no universal entitlement to health services. The provision of health services largely with the social security system and is in theory limited to people who are employed and their families. Each employee holds a card (*cartilla*) that entitles him or her and family to free health care. In practice, access to health care is almost universal, although at a time of rising unemployment such access is being threatened.

Preventive health care

Because there is no unified health service a fundamental division in the provision of primary care exists between the preventive and curative services, the former being the responsibility of the local authority. Although there is a legal requirement for local authorities to provide public health services and preventive health care, this is rarely enforced. In many areas, particularly poor working class residential areas, these services simply do not exist. This situation is not altogether surprising since the population of the city of Barcelona is served by upwards of 900 separate local authorities.

The most prosperous local authority covers the city of Barcelona, which has a population of 1.7m. The public health department of Barcelona has a programme of preventive and

public health activities. It monitors food and water hygiene, inspects housing conditions in the city, and provides family planning, vaccination, and immunisation services for the population as these are not provided by general medical practitioners. Health education is a high priority, and a team of four doctors and three nurses work full time on health education. The health department has made a major health survey of a random sample of households in Barcelona, based on the most relevant elements of similar community surveys in Britain, the United States, and Scandinavia, to provide a health profile for planning and development. The department maintains a high public profile and attempts to encourage public awareness and participation in all its activities.

General practitioner services

The working life of a general practitioner in Barcelona differs from that of a general practitioner in the United Kingdom because the scope of general practice is more limited, the pathway of referral to specialist medical care is much more complicated, and the hours worked far fewer. The scope of the general practitioner's work is limited not only by having no responsibility for preventive medicine but also by the existence of the general practice paediatrician. This specialised general practitioner treats children up to the age of 7 years. The division in family care is further complicated by the paediatricians who work in hospitals treating patients up to the age of 14. Referral from general practice for further advice and treatment is not directly to a specialist in hospital but rather initially to a tier of specialists in health centres (*ambulatorios*). These specialists work during direct access to beds and with only limited diagnostic facilities. If inpatient treatment or investigation is required there is a further referral to a specialist in hospital.

The general practitioner spends only two and a half hours each weekday at premises (*consultorios*) owned by the social security organisation, but many spend the rest of the day in private practice. Remuneration for this, admittedly, short day is not compared with that in the United Kingdom (approximately £350/£400 a month) and is based on the number of cards held by the general practitioner. The number of cards does not necessarily reflect the number of patients, however, as a card may also cover an unspecified number of members of the cardholder's family. The average number of persons per card in Barcelona has recently been calculated at 1.98. Such a system obviously makes it difficult to construct practice registers based on population, such as age-sex registers. Although the general practitioners are available for only two and a half hours a day at the consulting room, they are responsible for dealing with emergencies between 9 am and 5 pm. Outside these hours there is a further service (*servicio especial de urgencias*) that deals with emergency calls. It is not based in hospital and undertakes home visits and treats patients who attend its facilities. If the patients require further treatment they must be referred to a hospital.

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the other practices. It has been shown that individual general practitioners have their own "set" rate of referring patients that might be unaffected by most of the external conditions that might be thought to be important.

There was no statistically significant difference among the practices in the number of patients who had an abnormal result and no record of subsequent action in the notes. As well as assuring genuine continuity of care, the other practices, such as here, how assiduously the general practitioners fill in patients' notes. Some treatment or further action may have been taken on

cases recorded in this section but no mention of it made in the notes. To what extent this contributes to each practice's figures in this section we do not know.

This is the third part of a four part paper.

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Diary of Urban Marks: 1880-1949

After a few days at home, having distributed my presents and recounted my adventures to the East, I returned to Swansea as I had promised Dr Nelson Jones so to do. Needless to say, he was very pleased to see me and we commenced to discuss the situation. He told me that at one time he had had a very large practice but as time went on and as competition arose, combined with the inevitable Anno Domini, the practice had gradually dwindled. He had no doubt a younger man would bring grit to the mill but he was very doubtful as to the amount of money I should put into the practice. He suddenly recollected that there was a practice going for sale at Trinity Place. We agreed that I should get into touch with Dr John Davies, who I owned it, and see what the income was and what was being asked for it. I had no intention of buying the practice and my conversation with Davies was merely to act as a basis between Jones and myself.

I rang up Davies and he asked me to dinner to Manelton, where he was living. During the meal he told me he wanted to sell Trinity Place. Davies was 37 years of age and had been married only four months. Some seven years previously he had been in practice at Manelton. His brother Tom had qualified and John had found most of the money for his education. Now John had no particular liking for medical work and was more devoted to engineering. At the time Tom qualified the Trinity Place practice came on the market owing to the death of Dr Forsyth. John bought it and put Tom at Manelton as assistant. He paid Tom so much a year for this and in the meantime John worked at Trinity Place. As John was a bachelor during the whole of this time and can imagine that John did very little work at Trinity Place. He kept no books but paid income tax on £250 as far as Trinity Place was concerned. He did not know whether this had been earned or not. The tax was only 1/- in the pound and this amount did not worry John. In fact, at Trinity Place he worked if he felt like it and more than once had told possible clients to run off. Moreover, it was not said as nicely as I have written this. So this went on for seven years and John got married in November of 1907. He took up his residence with the wife at no 1 Trinity Place but had no sooner settled down than the honeymoon than Tom died of pneumonia. As the Manelton practice was dependent on the Works, which paid three pounds weekly for the wife and children and man, there was a steady income and performance was compelled to go back to Manelton and work the practice there. He had been back for three months when I happened along. He told me that I would have to make up my mind as to whether he was worth £250 for the practice. He guaranteed that he would be able to transfer a lot of sheepdogs to me and also a lot of Boilemmers. The sheepdogs were worth £50 per year and the other dogs were worth £25, so that my rent and rates would be paid by them. The rent of Trinity Place was £40 at the time. Also included in the purchase price was to be the electric fittings and the stock of drugs on the premises.

I hastened back to Jones and when he heard the proposition insisted that I must buy the practice. He said that I could assist him

from there just as much as being on his own premises. He also said that I could not fail to do well at Trinity Place since the district was fairly shouting for a young doctor. I asked him where I was to get the money from. Without a word he went over to his desk and began to write. I suspected what he was doing. He was going to lend me £250 without a penny interest. I thanked him for this but said that I had better consult my father first. He told me to invite my father down, and in the meantime I telephoned Davies to say that I would take the practice at the terms mentioned. I wired to the "old man" and he came down the next day direct from London. He stayed with Jones and after dinner they commenced to talk of everything under the sun except my father. Both the old men were of the same kidney and had much in common, especially the whisky. After some time I ventured to remark that I was the chief subject for discussion. Jones thereupon began to impress my father that the chance now offered to me was the opportunity of a lifetime. He told my "goodness" that he had such faith in me that he would lend me the necessary money but Dad had other views, although he did not forget to thank Nelson Jones for his kindness. He thought that Uncle Urban Asprey would be willing to lend me the money but if he did not so then I could fall back on Jones. Dad returned to London and got into touch with Asprey who agreed to lend the money at 5% interest. I was to pay back the principal as best I could but he suggested that I should pay £5 monthly and the interest could be adjusted as necessary.

I saw Davies on the next day and explained to him that I could not possibly give him the whole of the purchase money at once. We agreed therefore that £100 should be paid at once and £40 at the end of the year. Davies had taken a fancy to me and after some discussion as to how we could work together he actually agreed to take £140 for the practice. No agreement was signed, Davies trusting me absolutely.

The next few days saw me very busy at Trinity Place. I had no need to find a housekeeper. Davies had an elderly female called Elizabeth in charge of Trinity Place. She had been with him for years and readily agreed to stop with me. Her only disability was that she was stone deaf, but nevertheless she never far as I know failed to hear a patient. Her bedroom was already furnished but I had to get the dining room fitted out as best I could, remembering that it would have to serve as a waiting room and a living room. The surgery was in front of the house and I used together with a couch which was rolled up took nicely. An electric fitting was on the wall and this was used to inspect the nose, eye, and throat. A large mirror was in front of the couch and I used together with a couch which was made locally for three pounds completed the outfit in this room. There was a large cupboard which ran through into the dining room. The cupboard was used for dispensing and was large enough to contain all I required in the way of drugs. No water was laid on and I had to use a large filter. My own bedroom was at the back facing George Place. It was very sparsely furnished, most of the things having to be got in the sale rooms. No other rooms were furnished but were left absolutely bare.

General practice workload

The major structural differences in primary medical care between Catalonia and the United Kingdom are paralleled by (and indeed perhaps responsible for) major differences in workload. A result of a survey of workload among general practitioners in Barcelona carried out in 1980-1 showed an average of 9.3 consultations per patient a year, whereas in the United Kingdom the figure is 3.0 from the Second National Morbidity Study in 1970-1. But in Catalonia these consultations occur during two and a half hours a day. On average there were 48 visits per general practitioner a day, so each consultation lasted approximately three minutes. This rapid rate combined with an almost complete absence of appointment systems ensures large queues, which is reflected in the design of health centres where more space is allocated to waiting areas than to consulting rooms. In the same survey general practitioners were asked the reason for consultation: 48% of the visits were thought to be of "bureaucratic" origin, mainly certification.

The family doctors' movement

The years since 1978 have seen the growth of a family doctors' movement inspired by the experience of the Royal College of General Practitioners and the growth of "family medicine" in the USA. Formally recognised as a specialty in 1978, family medicine has grown steadily and now has a vocational training scheme closely similar to that in the United Kingdom. The scheme started in 1981 and will produce 300 trained family doctors a year for the whole of Spain, which is still a small percentage of doctors entering primary medical care. Trainees are taught paediatrics, but owing to the division of care it is not possible to put these skills into practice with children under 7. Entry into general practice training, as with all specialty training, is by examination. Similarly, after completion of training a further examination must be taken to enter state employment. There is, however, a weighting for the candidates who undertook specialty training.

The family doctors' movement has as one of its goals improving the standards of postgraduate training and encouraging continuing education in family medicine. Those in the movement

also believe that a substantial increase in salary would increase motivation and enable the length of the working day to be extended to six hours. The encouragement of teamwork in the primary health care centres is regarded as important, as is integrating preventive and curative services. The family doctors believe that these initiatives would greatly improve the quality of primary medical care. There is concern, however, among doctors working in public health centres that the family doctors have unrealistic expectations of the amount of work that one doctor can perform.

Two encouraging developments, from the point of view of the family doctor, have occurred recently. In a working class residential area, Ciutat Badia, just outside Barcelona city a purpose built health centre has been opened, which provides comprehensive and integrated primary health care to a population of 33 000. This health centre is unique in Catalonia because all the general practitioners work six hours a day. Although extra resources had to be committed to this project, after only six months of operation both the prescription rate and referral rate had fallen. The second initiative is the development and evaluation of an A4 size problem oriented medical record, which would replace a record similar to the "Lloyd George" type still widely used in the United Kingdom.

Conclusions

The primary medical care service in Catalonia is thought by most of those who work in it to be substantial alteration. The possibility of organisational change is facilitated by the fact that doctors are employed and their premises are publicly owned. The example of the experimental health centre at Ciutat Badia shows that there is the political will to innovate and evaluate. This, combined with the growing strength of the family doctors' movement, may provoke substantial change, and the government has said that 1984 will see the introduction of legislation paving the way for a unified health service with universal coverage.

I thank Dr Oriol Ramis for his kindness and help throughout my visit.

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Diary of Urban Marks: 1880-1949

I had a name plate manufactured setting forth my qualifications and consulting hours. The telephone was already in the place and so on 1 February 1908 everything was in readiness to receive patients and I looked forward to the time when people who needed my help would be standing in a queue outside the house. It had been agreed between John Davies and myself that as far as the sheepdogs and Boilemmers were concerned I should act as his assistant until such time as it was safe to announce that I was on my own. John informed the two clubs to this effect and my first patients were naturally from them. At the end of the quarter the money due to me was paid by them to me and I handed John two thirds of the total amount retaining the residue for myself. In regard to the other expenses such as electric light, gas, and rent I paid John one month of the quarter. At the beginning of the next quarter I paid all my own expenses in full.

The house had to be transferred to me and Mrs Forsyth was willing to do so but put the rent to £44 as against the £40 John had been paying. I could not object as the lease was a repairing one and

the house was getting old. But within four years the landlady had to replace all the drains, which had to be done by order of the medical officers. I should say that my initiative, so that the did not get much change out of her money.

To make things safer for myself I asked to be initiated as a Shepherd. Two of the older members proposed and seconded me and in a few weeks I went through the formal ceremony. What it was all about I have forgotten but the idea of the ceremony was to assist the brethren in distress much as the Freemasons do. Only in this case for a weekly subscription a doctor was provided and a certain sum of money granted in illness. I was not so fortunate as a member than it was proposed that I should go through the club starting as secretary and then vice until I reached the chair itself. This suited my book very well and I became the minute secretary. At the end of two years I had held all the offices and then applied for the position as surgeon to the club which John Davies by arrangement resigned at this time. Needless to say, I was appointed "min. con." retained this club until the National Insurance Act put an end to all club work.