A Difficult Case

Disengagement from medical care

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"I understand that Mrs Clapdew has transferred herself to your list, and accordingly I enclose her copious notes, which she has written in her previous general practitioner. Her active problems include a hiatus hernia for which she attends the gastroenterologist, myocardial ischaemia of which she complains bitterly on occasions but she has no pronounced electrocardiographic changes; haemorrhoids, which are not too troublesome at present; but undoubtedly her most serious complaint is of severe intracranial pressure, a pain which she relates to an operation to remove a lipoma from her buttock some nine to 10 years ago. Her perineal pain has been extremely well investigated by the surgeons, who have been unable to find any cause, and by neurosurgeons, urologists, orthopaedic surgeons, physicians, and a few other specialists have all been equally unsuccessful. The psychiatrists were the only people who came up with a logical explanation for her pain. Looking through her notes, I feel that in a masochistic sort of way it will be a pity to lose Mrs Clapdew, but I am sure that I will eventually manage without her. She is a pleasant lady and, although her psychoneurotic problems have proved troublesome over the years, I have never had an angry word with her, although I could not say the same for her husband, who tends to be disgruntled and quite intolerant of the fact that the medical profession seems unable to cure some of his wife's ailments."

Mrs Clapdew fully lived up to the promise contained in this letter of introduction, with the added difficulties posed by her husband's complete lack of insight, and by his remaining on the list of a different family doctor.

The change to a new general practitioner afforded an opportunity to review, coordinate, and limit Mrs Clapdew's complex and repeated hospital follow up appointments. Because they all seemed to be unnecessary, disengagement was effected with the cooperation of various specialists, despite the occasional hiccough when the computer continued to spew out appointments.

Disengagement

If we believe disengagement from the doctor at the earliest appropriate opportunity to be an essential part of rehabilitation medical practice provides many opportunities to influence events at each of the two main levels of medical care in the United Kingdom—hospital and primary care. Disengagement at hospital level is contingent on a decision by (secondary) care hospital specialists that a patient may safely be returned to her general practitioner's care. Such a decision should ideally be made by a senior, not a junior, hospital doctor, preferably in

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consultation with the patient's general practitioner. At general practice level, where care is shared, disengagement requires decisions by both secondary and primary care doctors that a patient should be released from medical care altogether. Such a decision is often delayed through confusion over responsibility—for example, the patient who is convalescing from an uncomplicated herniorrhaphy. "How do you feel about going back to the office next week?" asks his general practitioner. "I can't do that," replies the patient. "I'm still under the hospital, and my appointment to see the surgeon is not for another three weeks." Such a patient may see the surgeon who actually performed the operation, but it is more probable that he will be seen by a junior whose knowledge of the hard circumstances and work environment is less than that of the family doctor.

Of course there are patients, like Mrs Clapdew, who are unwilling to disengage. Such folk seem constantly to need to be in the "sick role," or at least to be frequently consulting their family doctor about various symptoms. Sometimes the general practitioner's defence is to relocate them to the "repeat prescription list." Yet, even with relatively simple and self-limiting conditions, like influenza or otitis media, several constraints operate. All medical students are taught—indeed, are required to learn—lists of complications: influenza may lead to depressive illness or pneumonia, otitis media to glue ear and deafness. This teaching is, of course, right and proper, but there is the possibility that because of the hospital setting and illustrative patients (prescribed by the seriousness of their conditions) the future doctor is biased towards an unduly pessimistic prognosis. Hence, the time honoured parting shot: "Come back if it's not better," or "I'll see you in a week for a further check up."

There is always the possibility of complications. Certain chronic diseases, such as diabetes mellitus, pernicious anaemia, and hypothyroidism, clearly warrant continued contact indefinitely for the twin purposes of medical supervision and the maintenance of supplies of medication. But for bowdler, secondary antidepressant drugs be prescribed, and when should diuretics or beta blockers be discontinued in elderly patients?

Health behaviour

Illness behaviour has been defined as the ways in which a person perceives, evaluates, and acts on—or does not act on—symptoms.¹ By analogy, "health behaviour" might be defined as the ways in which doctors perceive, evaluate, and act—or do not act—towards patients. The process of disengagement may help to restore the patient more rapidly to health if the doctor makes a positive decision, matching the positive help seeking decision made by the patient.

Absence of norms

Part of any difficulty that a doctor may experience in disengaging may reside in the relative absence of norms. The new

First Five Years in Practice

Finding resources and space to work

JOHN ROBSON

The east end of London, where redundant dockland has given way to the characteristic decay of so many urban and industrial areas, did not appear to be the most sought after location for practice. But when I completed vocational training in 1979, securing a principality in the area posed problems. The family practitioner committee was sympathetic but pointed out, firstly, that in the absence of a retirement age and planned exit at the end of professional life it could hardly advise on planned entry at the start. Secondly, a singlehanded practice was unlikely to be secured at that time without at least two years' experience as a principal. This was something of a Catch 22. From 1911 to 1966 payment per person was essentially the rule and heads split income. In a densely inhabited area with a declining population, the inhibitory effect on group practice had had a continuing legacy. In 1977, 57% of practices and 35% of principals in the city and east London were still singlehanded.

An underfunded vacancy arose, however, as a salaried partner in a two man practice from a terraced house. Spurred on by the proximity of an as yet unoccupied health centre (built from Docklands urban aid), and the absence of a written partnership contract was no deterrent. Facilities were basic. A telephone, sink, albeit without hot water, a desk, chairs, and a converted kitchen table that served as an examination couch constituted the sum of surgery equipment. Two weeks after I started an elderly patient seeking analgesia for a broken arm fell down the stairs and fractured her leg. Although the court found us not to be negligent, consultations with the more infirm attenders were held in the hall at the bottom of the stairs, thereafter.

Eighteen months later prospects for the practice moving to the new health centre looked bleak, and with around 700 new patients I moved in alone. No basic practice allowance and a small list made finances tight and every night on call added to the problems of an uncertain future. Money was supplemented by concurrent work for a local singlehanded general practitioner who was unwell. The break came after a year at the health centre, when in succession two more practices and two students joined general practitioners retired. There was no shortage of applicants, though the story might well have ended differently in Liverpool or south Wales. By 1982, after constant juggling with locums and staff, we constituted a new four person partnership, a list of just under 8000. Half the practice, however, had to be housed in a council flat (lacking either hot or cold water in the consulting rooms and split on two floors) as the health centre was too small to hold us.

Perhaps our greatest surprise was our retired predecessors. They bore no resemblance to the indifferent and perfunctory "look up" we had been told to expect in hospital practice. We took over from a dedicated, kind, and prudent group of practitioners, who, despite an extraordinary workload and severe privation of resources, had maintained both their standards and

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the enduring loyalty of their patients, with many of whom they maintained social contact long after retirement.

Priorities in practice

As a new group our priorities were, firstly, to meet our patients. All patients requesting repeat prescriptions were seen, reviewed, and documented, and we got to know many of the household and those with chronic problems. All calls out of hours are dealt with by the practice and not by deputising services. Secondly, we ordered our notes. Every set was chronologically sorted and tagged before insertion in A4 files, complete with problem list, data base, and flow charts for prevention. In conjunction an index register was created and obviously redundant notes put on one side.

Thirdly, we began to organise the queue outside the door. Appointment systems were introduced with benefits acknowledged by both doctors and patients. Consultation rates and visits could then be documented. In 1983 the average consultation rate was 4.1 per patient a year and 21.3 per 1000 patients a year were visited at home between 11 pm and 7 am (both underestimates due to list inflation). In practice we found it difficult to organise planned and systematic contact for prevention within the welter of routine surgery, with their mass of assorted and competing problems. Retaining our personal lists, we set up clinics for preventive tasks with continuing review at staff meetings. Antenatal care and preventive care for school children, a weekly per week per doctor, a weekly child health clinic with the health visitors with one doctor doing the checks paid by the district and employed as a clinical medical officer and the other immunising, paid by the family practitioner committee for our own patients; a hypertension clinic held every two weeks; and a weekly contraceptive and cervical smear session complete the clinics at present, though a community psychiatric nurse and diabetic support nurse both relate to the practice. All new patients are seen at registration, and data including blood pressure and smoking habit are recorded. Case finding based on routine surgeries is also under way.

At the health centre office equipment, an electrocardiograph machine, a nebuliser, and a dip slide incubator and steriliser have been obtained through the district and urban aid (battered by vociferous requests). Costs of the A4 records, surgery equipment, telephone, and computer are met by the GPO service is not reliable enough for transfer of out of hours calls) have been borne by the practice, as well as all equipment in the council flat "surgery. We have begged, borrowed, and dug deeply into our own income to achieve this bare minimum. Where are the resources for the next five years to come from?

The next five years?

Anticipatory care is finite. Demand is not unlimited and effective responses have a floor, below which treatment has not

entrant to general practice is often acutely aware, at least in his early days, of this absence, which he soon makes good, often in an idiosyncratic way and by modeling himself on his predecessor. Since follow up consultations are an important determinant of workload, this may be one reason for the astonishingly wide variations in consulting rates among doctors, so characteristic of studies of workload in general practice.²

Disengagement and the consultation

A common way of ending a consultation in general practice is to hand over a prescription, which may act as a signal to patients that they should leave and may also confirm their belief that they are ill. Although such action may be appropriate, we believe that there are other, often more suitable, ways of terminating the consultation. So long as medical students and trainee general practitioners are taught more about diseases and their treatment at the expense of learning about the process of consultation and the maintenance of health, the problems of disengagement will remain unsolved.

Conclusion

Follow up of patients with specific diseases, according to established criteria, must be encouraged in general practice where it will relieve much of the pressure on hospital clinics.

Diary of Urban Marks: 1880-1949

During the canvass it was announced that Dr Rhys Davies had been taken ill and was therefore unable to attend to the members. The executive members of the ten met at once and from the doctors applying for the post selected Dr Trevor Evans and myself for a short list. We were asked if pending the election we would treat any member. No payment was offered for this but naturally Trevor agreed and I did also. I have said that Trevor did but actually it was his father who was managing things for Trevor, who was not actually in practice at the time. Trevor was completing a course as house surgeon to a nose and throat hospital in London and was settling down in Swansea into his father's practice at the end of the year. Dr John Evans was the deputy school surgeon and was a name which I was clever as the doctor. He had been in practice here for 30 years or more. His advantage over me was therefore tremendous, but I persevered hoping for the best. One of the biggest men of the executive of the Unity Tent was William Owen, who at that time had just been elected as a guardian. One morning, during the period John Evans and I were acting for Dr Rhys Davies, Owen walked in to see me and asked me to examine his chest. I did so and told him what the matter. He then said that Dr John Evans had told him the same thing. I, of course, asked him whether he had come home to see me and asked me to examine his chest. He admitted this and then I went off the deep end. I told him a few things about himself that perhaps he did not know about himself and then told him that he was a name which I was clever as the doctor. He admitted this and then I went off the deep end. I told him a few things about himself that perhaps he did not know about himself and then told him that he was a name which I was clever as the doctor.

thing the canvassing did for me was to bring me before a large section of the public—a thing I could not have done otherwise. It was a far better method than being called out of the theatre or a church or chapel. It was legitimate advertising.

ONE HUNDRED YEARS AGO An assistant-master in the Harrow Board School was recently charged with assaulting and beating a little boy, aged 11 years, by striking him on the hands, and giving a "cut on the back of his head, which raised a large bump." It appeared that the boy was suffering from an affliction which rendered him unable to do his school work. The assistant-master frequently told him "go out" or "suffering from an affliction." No doubt schoolboys of that took place. The magistrates found the charge proved, and, evidently considering it an aggravated case, inflicted a fine of twenty shillings, the costs amounting to £2 10s. 6d. We refer to this case because it seems to point a serious moral. Anybody who has, as sometimes happens to most of us, been compelled to witness the turn-out of some, at least, of the board and power of degrading his mind to his lessons frequently lay, and glad of any excuse to leave the schoolroom; but the masters ought to exercise a good deal of discretion, and to remember that a child who is suffering from an affliction, which has made him unable to do his school work, is a child who is suffering from an affliction, which has made him unable to do his school work. The task before the teachers of the primary schools of the country is a vast and important one, and it becomes daily more evident that a body of men to whom such important interests are entrusted, should receive some judicious teaching from competent persons in the laws of health, and in the biological principles which govern the ordinary physiology of the human body. The boys should hear no more of schoolmasters hitting little boys on the head with the cane, or boxing their ears (and sometimes making them deaf for life), and much less of the "obstinacy" of other little boys who are completely tender-mindedly infirmity, to seek frequent relief. *British Medical Journal* 1884; 2(2).

been shown to be of benefit. There was a ceiling, above which death or disease is more and more likely, and walls, which encompass a defined and listed population. There is a discrete and ascertainable number of pregnant women, patients with hypertension and diabetes, smokers, women needing cervical smears, patients susceptible to rubella, unimmunised children, and so on. We have started some of this but with our present resources cannot do more of it.

We would like to undertake our preventive work in the context of nationally agreed strategies, as already exist for antenatal care (of dubious efficacy) and child immunisation. But where are the district protocols, working out in conjunction with an applicable to general practice? Is not the evidence on the control of risk factors for respiratory and cardiovascular disease far more convincing than that for cancer? We need more than a few muddle along with our own dietary warnings, threshold and treatment for hypertension, and policies on rubella and screening for cervical cancer. There is no forum where we can discuss targets for intervention with our colleagues and district staff and ways of achieving them under local circumstances.

For the present and the future we need purpose built premises where we can work together with district and hospital staff and patients, putting flesh on the bones of an expanding team that already includes district nurses, health visitors, physiotherapists, psychiatric nurses, speech therapists, midwives, hospital consultant obstetric staff, and patients' groups. They just will not all fit into a converted council flat.

As we are unable to maintain accurately more than three

manual card files, we need an online microcomputer (which is available and has the capability) not only to indicate what are doing but, more importantly, to tell us what we are not. Health visitors look after children with families and some of the elderly patients. District nurses in the main do standard nursing duties (and our staff are among the best). There is no one other than the general practitioner who has day to day responsibility for the anticipatory and preventive care of adults. We need a preventive nurse, not for the delegation of mental tasks to mental people—there aren't any—but someone who will take an active and reciprocal part in health promotion. Nationally, general practitioners are eligible to employ an additional 20 000 staff for reception or nursing duties. For specific purposes such as prevention would the districts be prepared to meet the 30% of salary for those that do not as yet employ their full complement and an additional whole time equivalent for those that do?

In distance the space between our two surgeries is half a mile, in time and conception they are separated by half a century. The contents of the 1965 family doctor charter, which did so much to rejuvenate practice over the past 20 years, has been largely exhausted. Will the current generation of practitioners demand a similar package to meet the needs and workload to 2000?

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