PRACTICE OBSERVED

Good Practice

What is a good GP?

B S MARSTON

One or two special days in our lives stand out above all others. For myself, in the army in the Far East, it was the day when the Japanese surrendered. On that day, I went down with polio.

Now, over 40 years later, memories of those agonising, endless days and nights still haunt me and the physical result—leg paralysis—remains. Within a few years, however, I had acquired a hand-controlled car and a job. I have a pension and can call on the help of the War Pensioners' Welfare Service. While my general health was good the GP played no large part in my life. But during the past 10 years or so (I am now 64) problems have arisen, and I have had to make a realistic appraisal of what I can expect from my GP and what our relationship should be. As Dr Johnson once remarked, the approach of death "concentrates the mind wonderfully."

My first thought is that GPs have a uniquely difficult job, for they need to be equipped with a variety of skills, aptitudes, and insights, some of which may seem to be incompatible with one another. Thus we expect him or her to be highly qualified but not to blind us with science; to run an efficient surgery without giving it the feel of a factory conveyor belt system; to be sympathetic towards us, but not suffer other fools gladly; to listen to all our worries, but not to have any of their own; to take infinite care and exercise infinite patience in our own case, but not to keep us waiting while they do the same for other customers.

Keep us informed

Added to these we would like him or her to go off on courses to keep themselves abreast of the latest medical and scientific developments, but we are of course very cross when their absence makes them unavailable to attend personally to our needs. In this respect I

believe that GPs should do more, however, and supply information; for example, a regular newsletter to explain where they are going and why. Such a newsletter might also deal with topics of general medical interest, such as the cancer "cures" which surface in the popular press from time to time, or explain such worrying disorders as the acquired immune deficiency syndrome. In addition, it could advise on the pros and cons of certain diets, vitamins, tonics, exercise, and so on. The facts about smoking and alcohol, together with some relevant statistics, would also be helpful. The newsletters could be sent to patients or distributed in the surgery, where they would be a welcome change from browsing through out of date copies of *Punch*. In short, I should like to feel that there was a continual communication with the GP and that he or she was not there solely for intervention in a crisis.

Domiciliary visits are a vexed topic. I have seldom asked the doctor to call and never called him in at night. But I do hope that he would come if I did, recognising that only the direst necessity would induce me to do such a thing. Certainly, the personal availability of the GP is a vital factor in my idea of what constitutes a good GP. Regular visits, as a matter of caring routine, to disabled and chronically sick patients would be reassuring and usually welcome. For myself such back up would have been helpful, although in the past I have received most of my support from the Disabled Living Foundation, a Department of Health occupational therapist, and, for advice on wheelchairs, made use of the extensive information provided by the Polio Society and the Disabled Drivers' Club.

Take a broad role

Taking a wider perspective, I also believe that the good GP should be prepared to take on a broad role in the community, for in a rural area in particular he may be replacing both the squire and the parson. By participating in local activities he can get his ear to the ground and learn what is going on among his patients. If he knows what people are like when they are well he will be better able to know when they are ill, or if they are ill how ill they are, or if they are afraid of suffering and thus suffering from their fears. The GP will

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then be better able to treat the whole person, rather than some faltering, failing bit of him or her, and be able to adapt treatments and recommendations to known domestic circumstances. Friendship builds up trust, trust induces confidence, and confidence can be three parts of the cure. In these matters the GP's family may be a great help.

And when all this is said and done there is one overriding principle without which much will be labour in vain. It may be

summed up in the latin tag: *non quod sed quomodo* (not what but how). It is not only what the GP does but how he does it. It is not what he does but what he is that often really counts in this challenging life, where the many occasions of suffering also provide opportunities of combating it. I would like to think that my doctor, unlike my accountant or solicitor, is a personal friend in addition to being a professional adviser. Perhaps this is asking too much, but I hope not.

Practice Research

Attitudes to prescribing iron supplements in general practice

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Abstract

In response to a postal questionnaire general practitioners in the Southampton and New Forest area indicated a considerable understanding of the principles of iron prescribing and use of laboratory tests to determine iron deficiency. Many respondents, however, chose slow release and compound iron preparations as first treatments for iron deficiency. The role of parenteral iron appeared to be poorly understood. The use of and response to laboratory investigations for iron deficiency were generally appropriate, but many practitioners probably do not check for a response to oral iron sufficiently early during treatment or stop prescribing supplements before iron stores have been replenished. There is scope for further education in the biology and management of iron deficiency in general practice.

Introduction

The treatment of iron deficiency is the only major recognised indication for iron supplements, and well defined guidelines are presented for their use.^{1,2} The prescribing data for iron supplements, which Callender reviewed,³ suggested that these guidelines are often not followed. Simple iron salts are recommended as the treatment of first choice, although many other iron preparations are available, including nearly 40 compound iron formulations on prescription.²

We therefore sent a questionnaire to general practitioners in Southampton and the surrounding area asking about their prescribing of iron supplements and use of laboratory tests for patients with iron deficiency.

Methods

Postal questionnaires were sent to 284 general practitioners who were on the mailing list for postgraduate activities at Southampton General Hospital. The area in which they practised included Southampton and the New Forest. A second questionnaire was sent to the practitioners who had not replied within six weeks. Aspects of current practice that were questioned were as follows: (a) The first and second choice oral iron preparations for iron deficiency, the usual daily dose, and the reasons for selecting the preparation. (b) Prescribing indications for oral and intramuscular iron. (c) Which laboratory tests were carried out before iron was prescribed and how often they were requested. (d) The duration of treatment in patients with proved iron deficiency and in patients not proved to have iron deficiency. (e) Monitoring of response.

The results were assessed using the χ^2 test.

Results

CHOICE AND DOSAGE OF IRON PREPARATION

Simple iron salts were indicated as the first choice formulation by nearly three quarters of all respondents, the commonest reason for the choice being their low cost. Among the simple iron preparations ferrous fumarate and gluconate in particular were thought by the practitioners who prescribed them to cause fewer side effects than ferrous sulphate ($p < 0.01$). The practitioners who chose slow release or compound formulations as first choice (74, 28%) claimed to do so because of convenient dosage, presentation of the tablet, and fewer expected side effects ($p < 0.01$ compared with ferrous sulphate). The compound preparations mentioned included a few preparations of iron and folic acid (14 responses, 5% of total respondents). In three cases only the practitioners stated that these were prescribed during pregnancy, although the questionnaire specifically requested information on their use in iron deficiency states. The daily dosage of elemental iron prescribed was lower in the group of doctors who prescribed slow release preparations when compared with ferrous sulphate ($p < 0.01$) (table I).

The pattern of prescribing for second choice preparations was similar, but with a higher proportion (96, 37%) of doctors choosing slow release or compound iron preparations. Sixteen (6%) respondents chose combinations of iron and folate. The reasons for the selection and the doses prescribed were similar within each group to those for the first choice preparations (table II).

LABORATORY ASSESSMENT OF IRON DEFICIENCY

Just over half (137) of practitioners replied that they always requested a laboratory test before prescribing iron. A slightly lower percentage (40%, 105) thought that they requested a laboratory test in at least three quarters of cases; 4.5% (13) admitted that they requested a laboratory test in under

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