more effectively. But that begs the question of what the general practitioner should be doing with his time and what is "trivia" and therefore implicitly, at least, wasting his time.

Medical trivia and emotional distress

In Cartwright and Anderson's study[4] doctors estimated that about a third of all consultations were for "trivialities." These trivialities ranged from medical conditions such as colds, scratches, and headaches to family or personal problems. But if the nurse could deal with medical trivialities, what about the personal problems? When asked for reasons why a nurse should not do initial screening some doctors in Bowling's study[5] argued that emotional problems are often camouflaged as trivial medical complaints which would then be missed by the doctor. Thus the assumption is that doctors should be dealing with emotional problems. But do doctors see their role in this way? In Bowling's study 41%, thought it was not their role. Similarly, 33% of doctors in Cartwright and Anderson's study thought that it was not appropriate for people to seek help for problems in their family lives, yet at the same time 92% of general practitioners thought that there was a growing tendency for people to do so.

Many doctors believe then that people inappropriately come to their general practitioner with emotional problems. Furthermore, the average consultation time of six minutes is totally inadequate for dealing with many of these problems (although admittedly general practitioners do allocate longer times for some patients). Do they refer patients on to those who could help them—perhaps social workers, marriage guidance counsellors, and therapists? The answer seems to be no. The impression is that doctors tend to hang on to the patients themselves, and this impression is supported in a study by Stimson.[6] He concluded that "although these general practitioners see certain aspects of their work as troublesome, they do not necessarily wish to relinquish these areas of work." Perhaps this tendency to hang on to psychosocial and emotional problems would not be such a concern, even though it may imply poor quality of care, if it were not also class discriminatory. A member of social class I is likely to know what is available in the social support system and may avoid the general practitioner altogether and refer himself to the appropriate agency; members of social classes IV and V, firstly, may not know what is possible and, secondly, would probably be too scared to go to a new agency directly so go to the general practitioner because they already know him and it is socially acceptable to do so. Thus emotional, psychosocial problems provide one more example of the middle classes knowing better how to "work the system" with the lower classes not reaching the people who really can help. It also causes the medicalisation of all sorts of human distress. To see a general practitioner most people believe that they have to come with a medical label; often, as discussed above, wasting a great deal of the general practitioner's time with medical trivia when that is not their real reason for the visit.

There seem to be two options. Either general practitioners should take on this emotional, supportive, and therapeutic role after more training in these areas, probably given by non-medical teachers, or the number of general practitioners should be greatly reduced and many more counsellors and therapists trained. The general practitioner would then act as a central manager and referral agency—and even for this role would require much more knowledge of what other groups have to offer as well as better management skills.

That doctors are not in general keen to refer to other professionals except doctors (health visitors and social workers may be acceptable, marriage guidance counsellors and nurse behaviour therapists much less so) and that doctors do not want to relinquish their role as first contact suggests a great deal of fear about what is the general practitioner's role. Could it be that the medically trivial and emotional and family problems form the bulk of general practice and that if general practitioners handed over medical trivia to nurses and emotional problems to counsellors there would be a very marginal need for general practitioners?

Developments outside the general practitioner's control

At least some general practitioners have been concerned in the developments discussed so far: some doctors assign first contact visits to nurses; doctors do have arrangements to liaise with social workers; and some experiments have been described in which a variety of professionals have been attached to general practices. There may be other developments in the Health Service or in society over which general practitioners may have much less control.

There is, for example, the change from hospital to community care. Admittedly, the main result of this has been to increase the work of the primary care team, but there is also a trend for hospital services to play a greater part in the community. For example, many day hospitals exist in the community, psychiatric nurses work in the community, and some consultants do sessions in general practices. Particularly in geriatrics and psychiatry, consultants are being encouraged to see the community as their patch.

Another development may influence the balance between hospital and community care in quite a different way. If the number of junior doctors is decreased in proportion to the number of consultants, as planned, this is likely to throw more work back into general practice. For example, already some consultants are keen to have general practitioners monitor diabetic patients, and with a large decrease in the junior staff who man hospital diabetic clinics will these and other "follow up" hospital visits be handed over to the general practitioner?

Out of these conflicting trends how is a new relationship between hospitals and the community and between consultants and general practitioners to be developed? Once again by turning a blind eye and hoping nothing too drastic happens? Or by seriously considering how the hospital and primary care services can develop together to provide a more effective service?

A quite separate development is the change in the attitudes of patients. Patients are gradually becoming more aware about health and also about what they can expect from health services. No longer are people just grateful for what they get; they have adjusted to the welfare state and expect to get something for their taxes. Television programmes on medicine are popular and with health education and prevention being two current "buzz words" patients are bombarded with information about how they should take more control over their health, not least by keen general practitioners. Will patients become both more sophisticated and more demanding? If so, will general practitioners need to act as a central referral point, or will patients expect to refer themselves to medical specialists, other health professionals, or experts in various types of counselling?

Numbers game

All of these developments have implications for the role of the general practitioner, his list size, and the number of general practitioners needed in the country. What are some of the options?

(*a*) *Dispense with the general practitioner*—As discussed above, one option would be to let people select their own specialists and dispense with the general practitioner as referring agent. This option may be dismissed fairly rapidly, however. Countries that have tried it do not find this a satisfactory way of organising primary care and look with envy on the National Health Service. On the whole people seem to like the security of their own general practitioner and the continuing commitment to their welfare that he can provide.

(*b*) *A bigger list size, fewer general practitioners, and more associated staff*—This view has been advocated in a limited

way by Marsh and Kaim-Caudle and Fry.[3 7 8] Many general practitioners would certainly like more ancillary and attached staff (though usually with the implied assumption that they are highly controlled by the general practitioner). If this is taken one step further and patients can refer themselves to a nurse for minor ailments or a specific counsellor for a particular family problem then surely so many general practitioners will not be needed. Perhaps more to the point, even if general practitioners' work were to expand to fill the time available, which is the usual effect, can the country afford so many general practitioners *and* all these other professionals? The drawback is of course that if list sizes did increase greatly then it would be difficult for general practitioners to know individuals and their claim that their major role is to act as a central focus and to provide continuing care to a patient knowing his personal circumstances would be undermined.

(*c*) *Constant or smaller list sizes with at least as many general practitioners*—Another idea is that general practitioners have attacked only the tip of the iceberg of preventive medicine and health education.[9] Thus as gross pathology declines more time may be spent on these activities. This approach can only be supported. Its drawback is that it still leaves doctors dealing with much so-called trivia (emotional and physical) and continuing to complain about it, which is hardly the ideal approach to one's job. Providing preventive health care and health education is also expensive because more general practitioners and more associated professionals would probably be needed.

(*d*) *Muddle along*—The other option is to muddle along, a well-respected NHS activity. It may keep general practitioners in jobs and allow some of the developments described here to be absorbed into the system, but it is surely not the way to provide the best possible patient care. For that it will be necessary to think out clearly where general practice is going and make some, possibly unpleasant, choices.

If there is confusion about the future role of general practitioners they are not alone in this. Society has not really decided what the NHS should be expected to do. Some expect the Health Service to deal only with overt medical and psychiatric illness, while others expect it to fill gaps left by changes in family and community support and to be a refuge for a variety of human distress. General practitioners are at the grass roots level where these conflicts are seen most clearly, and if they can think through what the role of general practice is going to be and how general practitioners may be deployed most economically and effectively then they would be providing leadership in the development of the whole Health Service.

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Diary of Urban Marks: 1880-1949

After being in Swansea a week or so, I discovered that I should have to do all the work I have just described for at least a year before becoming senior house surgeon. The work I was doing was simply that which one did as a dresser while a student. I was learning nothing and simply wasting time. I therefore applied about the end of February for the post of junior house surgeon to Blackburn Infirmary. Lees was the senior man at the time and he had written to me telling me what a good job it was. I was invited to attend but was unsuccessful, the job going to the nephew of a local curate who had been canvassing for him. Nevertheless, I spent a couple of nights with my old friend Lees at Blackburn's expense. Lees soon afterwards settled down in the town as a surgeon and is there at the moment being the senior surgeon in that district.

I returned to Swansea but determined not to stay there unless things were radically altered. Within a few days, Mr Brook, the senior surgeon, came into our room in a furious rage. He spluttered a good deal in his rage and I managed to gather that Groves was not in the hospital and that many cases had gone septic. He enquired where Groves was and I replied that he was probably playing golf. He then asked me why I did not go into the wards. He seemed surprised to hear that I was only allowed there by the favour of Groves. Brook became calmed and I then asked him why the house surgeons were not on an equal footing considering that there were two surgeons. I told him of the work of the junior house man and said that I wondered how any sensible man had held the post for 12 months. His reply was that it had always been so but did not think the junior was doing such minor work. I rejoined that as soon as I could get another post, I should leave Swansea. Then we had a heart to heart talk and my suggestion that the two men be equal appealed to him. He said that if Dr Elsworth agreed, he (Brook) would put the matter before the board, who probably would agree except on one point. This point was that the board would not raise my salary from £50 to £75, which stipend Groves was drawing. I said that did not matter.

Now Elsworth and Brook had not spoken to one another for years. The dispute arose in connection with a nursing home and at this particular moment there were two distinct factions in the hospital and indeed in the town. You had perforce to be either a Brookite or an Elsworthian. One side always opposed the other on principle and this went on until Elsworth's death in 1924. I mentioned the matter to Dr Elsworth and he heartily agreed. The board sanctioned the change but as was expected did not raise my salary. It was therefore arranged that I became house surgeon to Elsworth, since I remained junior in name and Elsworth was junior to Brook. To facilitate matters in the future I was to become senior house surgeon at the end of the half year and Grove was persuaded to relinquish his post altogether at the end of that time, so that a new man would become house surgeon to Elsworth for six months and then change over to Brook for the other half of the year. He would then get experience with both surgeons.

However, shortly after the change had been made, Brook was operating on an abdominal case. The abdomen was open and both Brook and Groves were peering into it. Suddenly a great blob of pus appeared at the end of Groves's nose. The theatre sister saw it at the same time as I did and we were both struck with the same thought. Would the blob fall or be held back? I think in our minds we were gambling on the result and that was it would fall. But we lost our bet. Just at the crucial moment, Groves gave a great sniff and the blob disappeared back to the place of its birth. Sister and I sighed internally but Mr Brook looked up and with the utmost contempt in his voice said, "Good God, Groves. If you want to sniff turn your head away. No wonder my cases go septic." After the operation, Groves was furious and said he would resign forthwith. I urged him to this course for my own reasons and he did so and left the hospital almost at once.

Thinking About the Unthinkable

Disabling illness: a personal account

A L CORBETT

The 27th of January 1980 was a beautiful day, sunny and cool, with a clarity of the air one gets at weekends in this smokeless age at that time of year. The garden was being reshaped and looked like a building site. The 'phone rang. "I'll tell you what it is," said the station officer at one of "my" police stations. "We have this female prisoner who is four months' pregnant." "What's the problem?" I asked. "Oh, no problem. I just wanted a doctor to see her." "There's no rush then," I said. "Well, she won't be going anywhere." So, I went back into the winter sunshine to hack up some more compacted gravel. "By golly, that feels good," I remarked to Jean my wife, later, as I passed through on my way to wash and change. I was on my way across the landing wearing underpants and socks when it hit me. The din was dreadful and a force seemed to be pushing me backwards and forwards. I clung to the banisters for support. This is it, I thought. No, it isn't. It's gone on too long. A grey and white image of my brain, viewed from behind, appeared before me, with two black triangular markers indicating something low on the left. Despite the huge size of the image I could not see what they were pointing at. In other words, my neuro-anatomical knowledge was not up to filling in the details of this hallucination. I did not stop to ponder as I feared "the force" would hurl me down the stairwell. So I lay down. I did not fall, but got down and hung on to the banisters. There my right side tingled and sweated, and I retched and waited for Jean's footfall in the downstairs corridor.

That evening I squeezed Jean's fingers with my "affected" hand. "That's my right hand, so it can't be too bad." The word "stroke" had already been used, but it had not sunk in. The next morning the sister asked me how I was. I told her that my hemiplegia had come back. I was transferred to the intensive care unit of a neurological hospital. The few days there were full of hallucinations. There were parties every night, I left the hospital three times—once to a party at home, once to a police call, and once because they ran out of beds—and there was this fiendish machine they were using in an attempt to detach part of my personality to give to someone else. While on the intensive care unit I was very anxious about some reports I felt I should complete. One of the junior doctors on the unit propped me up, put pen and paper by my useless right hand, and said, "You've had a stroke." Perhaps I needed to be told, but I wonder if then was the right time. By and large I feel it was as well to let me welter in my illusions. I cannot see them delaying such progress as I might make.

What had happened was that I had had a left pontine infarct, caused by a thrombosis in a basilar artery branch. Maybe my cervical osteophytosis started it all.

In practical terms this meant I became chairbound, needed help with all transfers—into and out of bed and on and off the commode—that reading became difficult, due to nystagmus and diplopia, and that ataxia interfered with educating my left hand to acquire competence in such activities as writing, painting, typing, pouring drinks, dressing, and caressing. In the early days I was unaware of how damaged I was. I sent back home from hospital white kit I reserved for squash. I cannot stand without support, let alone walk, so thoughts about squash, apart from nostalgia, are ludicrous.

Before all that, I was a principal in general practice, a trainer, a deputy police surgeon, a Remploy medical officer, student services medical officer to the Borough Road branch of the Polytechnic of the South Bank, and secretary to the education committee of the board of the South London Faculty of the Royal College of General Practitioners. All this gave me a multifaceted professional outlook. I enjoyed it all and got to feel that I was professionally balanced.

On the home front our 1895 house was nearly refurbished, and we had started on the garden. Our three daughters were all nearing the end of their secondary education. Our eldest was within months of A level retakes when I had my "episode," and I was still in hospital when she attempted to upgrade her previous results. How much her failure to achieve her ambitions was due to my illness and how this will affect her next 40 years is conjecture. So, too, are thoughts about influences on the other two. Their big hurdles were yet to come.

In January 1980 I had bought a new pair of shoes and a new waterproof anorak. I visited the Boat Show and brought home boat shoes and brochures about a towable four berth yacht. The day before my stroke I had bought a new pair of riding trousers. It was two years since we had been to California, and we had made plans about what we should do differently on our second visit. Our life was on the verge of changing gear and nothing seemed insurmountable.

Having practised "transfers" into and out of a car, I was asked to go for a drive on Sunday—not my sort of activity—so, I went home for lunch. Six days later, on 30 March 1980, I was home for my second daughter's 17th birthday. I was not at home whole time until September 1980.

Frequently my wife heard that it was easy. A rehabilitation officer, a rehabilitation nurse, an occupational therapist, and a trainee physiotherapist had, together with some grunting, got me into the house. It was not easy. A consultant in rehabilitation told Jean to stop being neurotic and get on with it. How to get on with a wreck of a man who was nothing like the chap she had married was not explained. A year ago it was suggested that my medical knowledge must be helpful in understanding what had happened. Agreed. But it never washes away the psychological need to believe that the day after tomorrow I would walk away from it all. Maybe I needed my fantasies. The one person who did not was my wife, and yet no one explained what the implications were. The person who came nearest was a neighbour. It is not medical knowledge that is gained from living with a doctor. The spouse will not accept

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that it is easy. Whatever "it" is, it is likely to be normally undertaken by a professional. To an untrained spouse it is *not* easy.

To give the spouse too much information does not insult intelligence, it merely assumes, not unreasonably, that he or she has no medical knowledge. Even if the spouse *is* medically qualified, the role of marriage partner to a stricken being is almost certainly new. By the time my wife had sorted out invalidity benefit, mobility allowance, attendance allowance, ramps, rails, Medic-Bath, wheelchairs, car tax concessions, and rates concessions she was surprised to find "trained" workers in this field who had not heard of some of it.

It was quite novel being idle at the age of 48 and drawing a pension at the age of 49. I found it quite droll sitting on my backside all day thinking up things to do, but my wife said that my stroke was never funny. Then in March 1981 we learned—she was told by 'phone—that she has "a mild form" (whatever that is) of multiple sclerosis. Since then my frustration has increased. I cannot fetch and carry, nip into shops, whisk her away, nor be anything other than a burden, when I want and ought to be more attentive than ever.

Many activities previously enjoyed, like riding and lobster fishing, conjectured situations like boat ownership and increased travel, are things of the past. Other activities, like entertaining and joint social outings, have been curtailed. What I do now have is plenty of time to read, write, and paint, but every attempt underlines the fact that everything I do is now done with more difficulty. This even goes for eating and drinking. Although my taste and sense of smell still serve me, the trismus and ataxia do diminish the enjoyment somewhat. They also make me a philanthropic eater—everybody gets some! I now produce laboriously, atactically, and left handedly one painting in about five sessions instead of one in five years. Writing I have thought vaguely about for 20 years. I was not altogether unfamiliar with a QWERTY keyboard, but an occupational therapist at Guy's taught me to type left handed on a modified machine on which I may hit the wrong key, but cannot hit two keys at once. But for my typewriter and the visits to the day centre for painting I would have been beaten by boredom long ago.

What steps can one take when thinking about this "unthinkable?" I took out "permanent health" insurance. I did not insure my wife's health. One can work hard at one's marriage before "in sickness and in health" is put to the test. Membership of the BMA gives access to charitable funds. We were helped over a financial hump by an independent organisation. More important now is the moral support and counselling that we receive. In the mid 'seventies I started buying "added years."

Life becomes learning new things and new ways of doing old things. It beats dying, anyway. It also means watching those about one trying to cope. That seems more difficult. Disasters are not definable as events that overtake other people. In the foregoing I have described one which overtook me

Diary of Urban Marks: 1880-1949

A locum tenens came to us until we could find a permanent houseman, who in those days was hard to get. I forget this man's name but he was an extraordinary individual. He was a stubby man and carried his wife's portrait in miniature strung round his neck and over the heart. He had studied in Germany and in France and had attended clinics for nervous troubles in both countries. He had studied hypnotism and from him I learned how to do this. I practised on a boy called Frank Rainbow who was of a neurotic tendency and made a beautiful cataleptic subject. He could be made quite stiff and made to rest with his feet on one chair and his neck on another. He could be made to drop the letter E from his memory while writing home to his mother and was quite insensitive to pain if I so willed. In fact on the stage with him, I could have made a small fortune. He was subject to post-hypnotic suggestion and would startle the ward sister with suggestions I had made to him. One of these was that he walked up to sister at precisely 10 am and asked for a dose of prussic acid. This was reported to me and I was very glad that my influence had acted since it is said that you cannot make a person under hypnotic influence do anything which his subconscious mind is opposed to. After Frank, I practised on epileptics in the medical ward and on sciatica and neuritis cases in the outpatient department. At the end of the year I had become fairly expert at inducing hypnosis. I at first adopted the principle of staring at a fixed object in the hand but soon gave this up in favour of staring at the patient and suggesting sleep, at the same time stroking the face.

Old Fred Parker had at one time been keenly interested in theatricals and had been stage manager to Madame Patti at Craig-y-nos. He had some knowledge of hypnotism from the stage point of view and could hypnotise various persons. One Sunday night I was at the Parkers together with Mr and Mrs Brooks who were managers of the Grand Theatre. The subject of hypnotism came up and Mrs Brooks challenged Fred to hypnotise her. Now Fred had done nothing in this line for years and was not keen. Mrs Brooks persisted and annoyed Fred saying it was "all moonshine." At the time, they were standing up near the fireplace.

"Oh. Very well then," said Fred. "Look at me." He tilted up her face and pressing with his thumbs over the eyes told her to go to sleep. She fell to the floor immediately but was caught by me standing behind her. She did not hurt herself but Fred lost his head. He moaned and groaned what time Mrs Brook was lying unconscious on the floor. I asked him to pass the influence over to me as he seemed helpless and Mrs Brooks was in a cataleptic state. Said he to her, "You are now passing under the influence of the doctor." I told her to count 10 very slowly and then wake up, assuring her that she would not have a headache and that she would be her normal self. If one is awakened suddenly, he or she is apt to get a violent headache or go into hysterics. Mrs Brooks responded and on coming round said that she thought she had made a fool of herself and everybody else. She admitted that she had been hypnotised and was quite conscious of what had been going on but was quite unable to move until told to do so. She was greatly upset by the collapse of Fred who never again showed his prowess at hypnosis, although he was much interested in my work.

The best subject was my wife. I discovered that she was susceptible shortly after my marriage when I suggested hypnosis as a cure for a headache. She was shortsighted in one eye and did not wear glasses constantly. She was therefore subject to headaches and would not take drugs. To my surprise, she went unconscious at the first attempt and once asleep I had nothing to do except to stroke the head and assure her that on waking the headache would have gone. It was always a successful treatment.

In my first two years of private practice I used hypnosis in suitable cases but as the practice grew I could not find the time, and moreover Trinity Place is not suitable for the induction of hypnosis since there is too much noise. Just as a patient was going to sleep some noise, either the bell, telephone, or passing traffic would waken the patient and I had to start all over again. I found the work too trying to my own nerves and gradually I dropped such treatment. I revived it again in Mesopotamia during the war on shell shock cases and gave a demonstration to the medical officers at Amara on several patients. I was not even mentioned in dispatches for this. I have not used hypnosis now since the armistice in 1919.