PRACTICE OBSERVED

Good Practice

What is a good GP?

GORDON JACKSON

Not only are 97% of people in Britain actually registered with "their own doctor," but even with the growth of larger practices most patients probably see their own doctor for most consultations. This is a level of personal service that other countries have been unable to emulate. In developed countries it is the most cost effective way to deliver a high standard of primary health care so far discovered. Despite the present state of the National Health Service, almost fatally battered by the twin forces of rising costs and rising expectations, the general practitioner service remains one of its two true glories. The other one is the extraordinary level of commitment shown to the service by all its staff, which applies as much in the hospital service as in the community.

Recognising the best

In its recent "agenda for discussion" on primary health care, the government discusses general medical services and states its objective to "raise the general quality of these services nearer to that of the best."[1] Pausing only to express the unlikely hope that the government actually intends to fund such improvements that it intends to bring about in a service which is already highly cost effective, it becomes pertinent to ask how we might go about recognising those best GPs whose services the others should seek to emulate.

The government sets great store by the GP's personal availability, both during and outside normal working hours, and puts this top of its own list of criteria for excellence. Obviously availability is important—you can't be a good GP if your patients are never able to get to see you. Nevertheless, from my point of view working in a city hospital, it is the availability of the GP *during* normal working hours that is of major importance. I do not get the impression that there is a gross disparity between the sort of emergency referrals that we get from the deputising services and those of patients seeing their own GPs, or at least doctors from their own practices. Obviously it is sometimes helpful to speak to the doctor who has been looking after the patient in the past, but for the most part people ring up about the patients of their partners or patients with new problems. The quality of general practice does not depend so much on the decision to send a 45 year old man to hospital with his myocardial infarction but rather shows in the level of support that he and his family receive after this crisis. All the good work that a good GP can do in these circumstances can be done in working hours.

Hospital doctors pause for thought before they discharge patients from the outpatient clinic back to the care of their GP. It is always disconcerting when patients claim that they have had to wait for ages to get an appointment to see their own doctor. Of course a patient's perceptions about this may be wrong, but it is the perceptions that matter. Again it is the availability within *normal* working hours rather than the emergency service that matters.

It makes sense for people with chronic diseases to be followed primarily by their GP. Effective recall systems, which are likely to be computer based, are essential to do this. As such systems become widespread throughout general practice it will be possible to go in for the sort of GP care that the Royal College of General Practitioners envisages for diabetes, for example.[2] If this is thought to be a desirable development then it does not need to be tied up in some arcane "good practice" mechanism, it simply needs to be asked for and paid for when it is delivered.

Not what you know

Like the government in its green paper, however, I too am messing about on the edges of the question. What is it about a GP that makes me jump when they say they have a problem that they don't know what to do with, and which also makes me relax when they are happy to take the reins over again?

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Essays on Practice

Value of case discussion groups in vocational training

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The release courses from clinical work for trainee general practitioners of several vocational training schemes have been described in detail,[1] and surveys of a few courses have been carried out.[2 3] Yet little is known about the educational process on most of the courses. I wrote to all of the course organisers in England and Wales with a view to visiting many case discussion groups. My chief aim was to examine whether such groups were likely to help trainees to learn to practise patient centred medicine, and if so whether this could be done without too much stress.

There seemed to be four broad types of case discussion on the 34 schemes that I visited. I illustrate each type with examples that the participants considered to be reasonably typical of their course.

Topic case discussions

In topic case discussions the aim was to use cases that trainees were dealing with to illustrate a theme. Any material that was not connected with the theme of the session was therefore deemed to be irrelevant. In most of these discussions the leader's role was to ensure that the group kept to the subject and that a good range of cases was covered in the time. The most useful learning seemed to occur when the leader or visiting "expert" was able to show similar principles illustrated by contrasting cases. Thus at one session on "late calls" the group was able to see how often late calls occurred for patients who were already under medical care, and in a brilliantly resourced session on adolescent problems two highly contrasted cases of anorexia nervosa brought out a range of important features of that condition. The pitfall of this approach was that it offered no opportunity for the problem of a particular patient or doctor to be considered. For example, one trainee was clearly shaken by the attempted suicide of his patient the day after he saw the patient, but his experience was used merely to construct a list of approaches to potentially suicidal patients.

Course organisers who frequently used this method were most concerned with covering the content of general practice rather than looking closely at the educational needs of the trainees.

Supportive case discussions

The broad category of supportive case discussions was the commonest that I saw and included sessions of both random and problem cases. Few course organisers had clear aims for this type of session, and their priority usually was that trainees should feel comfortable working in a small group. Often one or two "interesting" aspects of a case were discussed in a little detail. For example, the case of a problem family that was divided by the current miners' strike was introduced as causing the doctor exasperation. I counted eight topics that were touched on in the 20 minutes spent on this case. Snippets of learning on subjects such as how to write the appropriate certificate for a patient to claim benefit when looking after a sick relative or how to organise a practice to minimise emergency calls certainly might have occurred, but no attempt was made to understand the problems of the family being discussed. An extreme example of this approach was at a course in another deprived area when a trainee easily managed to present in an hour's random case analysis the cases of all eight patients seen at a recent surgery. No one seemed to want to know about—let alone criticise—his management of, say, a battered wife with symptoms of depression.

Another common theme of this type of discussion was to reassure the doctor who was presenting the case. For example, one trainee, faced with a patient with strange symptoms in the throat, decided to refer the patient to an ear, nose, and throat surgeon even though she sensed that the problem was non-organic and the patient had already seen a consultant who had found nothing. Her very reasonable doubts about whether she had done "the right thing" were drowned in a chorus of reassurance by her colleagues.

Such discussions rarely had an active group leader, and challenges to group members were usually avoided.

Problem solving case discussions

The emphasis in problem solving case discussions was on looking at the quality of care and examining evidence. Random cases were often discussed. The approach was along the lines described by Marinker.[4] There was some attempt in the supportive case discussions to use this method, but only three sessions that I saw using "problem solving" seemed to achieve a high standard in Marinker's terms. In each of these group members were invited to comment at various key points in the narrative. The course organisers ensured that evidence was sought by group members to support any controversial statement and that the options in each situation were explored in detail. For example, a trainee described how she was called to a patient with "confusion." She decided that the "confusion" was dysphasia and that the patient had suffered a stroke. The group asked the presenter to justify her failure to perform a more complete examination to exclude other causes of confusion. Other key issues were similarly examined in detail, and almost an hour was spent discussing this one home visit.

Balint style discussions

The essential aim in Balint style discussions was to "understand the real problems of the patient rather than produce solutions to the problems the patient is creating for the doctor." Such groups usually met weekly for over an hour throughout the three year training period. The method was to bring cases that were causing problems for the doctors and to examine the doctor-patient relationship. The leader's role was complex, and all the Balint style leaders I saw (mainly in the London area) had spent years in a Balint group before attempting to run a trainee group. Camplan has recently described the aims and methods of these groups in some detail.[7] Two cases are described.

A trainee presented the case of a 72 year old man with a myocardial infarction. Because she seemed very anxious about the case her colleagues kindly reassured her that she appeared to have done nothing wrong. The leader pointed out that the group would do better to explore the presenting doctor's anxiety. In the fascinating discussion that followed many important issues emerged, ranging from the fact that the presenter's own father was 72, to the "collusion of anonymity"[8] in her training practice, and to the fact that the patient seemed to be a passive bystander within his family.

A young "punk" presented to a trainee in a middle class suburban practice. The doctor had conflicting feelings about his patient. On the one hand he felt sorry that the patient had been unemployed for a long period. On the other hand, he felt angry that the patient did not turn up as requested for a follow up appointment. The doctor had reluctantly agreed to prescribe diazepam to help the patient face the job he had just acquired. He was sharply criticised for this by a more senior female trainee. The leader immediately asked her what she would have done, and she had to concede that she would have prescribed as well, though probably propranolol. Later in the discussion the leader mused, "I'm impressed with the patient's implication of, 'you trust me but not the reverse,'" which caused the presenter to respond: "I wondered about homosexual problems. Perhaps that's why he didn't want to talk." This led to other aspects being explored and understood. The leader's method here seemed parallel to the "flash technique" described in Balint and Norell.[9]

Discussion

The way that the case discussions were conducted usually reflected the philosophy of the organisers of the release course. Therefore, even if it were possible adequately to assess the progress of trainees through such a course it would hardly be possible to work out which components of progress were due to participation in case discussions. Nevertheless, just as we attempt to examine and improve our approach to patients despite finding it difficult to characterise precisely the "good" general practitioner, so it seems legitimate to look at the strengths and weaknesses of case discussions, even if subjectively.

Thus in most discussions in the last two categories the patient seemed to "come alive" and the thoughts and feelings of group members were used to further their understanding both of the patient and of themselves. In the "supportive" discussions, on the other hand, the reassurance given and the diversions in search of "interesting" topics sometimes prevented the trainees from posing any problems that they may have had, let alone using such problems to help understand the patient. (Compare, for example, the case of the patient referred to an ear, nose, and throat specialist with the case of the 72 year old with a myocardial infarction.) Although superficially the trainees may have felt supported, it is difficult to believe that such discussions were ultimately satisfying or that they helped to improve the consulting skills of the trainees. Unfortunately, few courses that offered this type of discussion seemed to use any other method for acquiring such skills. (At least they made some attempt. Of the 100 programmes sent to me by course organisers, less than half included sessions of case discussions or analysis of consultations.)

The successful discussions depended on skilled leadership. I was struck by how much there was in common between such leadership strategies and the skills of the consultation in general practice.[5] One course booklet lists a few such strategies. An integral component of the leadership was deflection of destructive criticism (such as in case of the young "punk"). This was important in avoiding undue stress in the participants. It was undoubtedly also one of the reasons why the trainees whom I questioned all seemed to think that their discussions were valuable, even if they did not always look forward to them.

Few course organisers have participated in these types of discussion or have been able to acquire the necessary leadership skills, which may explain why case discussion is used to its full potential on only a few release courses. The recent formation of the Association of Course Organisers may help to bring about welcome change.

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Good doctors are obviously masters of the technicalities of their trade. For a GP the breadth of knowledge required is formidable, as with anyone else the important thing is to know the limitations of your knowledge; it is not what you know that matters so much as whether what you know is right.

Clearly, differences in the way that GPs use the hospital must have something to do with the difference between the best and the less good. Physicians can certainly receive some fairly inappropriate referrals from the least good. It seems to me, however, that referral patterns have much less to do with the essence of a good GP than might be expected. Good GPs will have different levels of experience in different specialties, and a GP may show a variation in referral patterns at different times in his or her career. The availability of appropriate services in the community will vary from time to time and from place to place. I have a horror that some mandarin in the heart of the Department of Health will dream up a catch all referral pattern index by which you qualify for the good practice allowance if you score less than 236.

In the end it seems to me that there is a fairly simple, though banal, answer to the question. The thing that characterises good GPs is that they care about their patients' wellbeing, and what characterises the bad ones is that they do not. I often ask patients sitting in front of me for the name of their GP, even though it is written in the notes. The answer nearly always comes back with some pretty firm opinion attached to it.

There is no doubt that there are plenty of GPs who would confess to certain lacunae in their appreciation of the cutting edge of technological medicine but who are liked and trusted by their patients. Patients are more than happy to turn to such doctors with a problem in the justified expectation of a sympathetic hearing and an appropriate response. Good GPs extend a high level of personal concern to their patients that the patients fully appreciate. One way in which this concern is manifest is by procuring the best available treatment for the patient's problems.

The good GP is thus a master of a wide range of clinical skills, and sensitive to the needs of the patient, especially those unstated needs that underly so many consultations. If there is a cardinal virtue it is that the GP shows a high level of personal care and concern for the wellbeing of his or her patients. For such care to go unrewarded in any putative good practice allowance would be a travesty.

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Practice Research

Doctors as nutrition educators? Part IV

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How much do you know about food related disorders? Try our final quiz this week.

(1) Which of these products is suitable as a milk replacement for a child on a milk free diet?
Plamil
Formula S
Coffee-mate
Marvel
Wysoy
Granose

(2) Is gluten free bread prescribable for
(*a*) Multiple sclerosis?
(*b*) Coeliac disease?
(*c*) Wheat intolerance?

(3) Hycal is a well known supplement. Does it provide
(*a*) Protein?
(*b*) Carbohydrate?
(*c*) Protein and carbohydrate?

(4) Which is the food additive that causes Chinese restaurant syndrome?

(5) Where would you find information relating to "E" numbers in foods?

(6) If you suspected a patient had coeliac disease what would you do?

(7) Would you advise low salt substitutes for patients on "no added salt" diets?

(8) What are the indications for using a low fat diet?

(9) In which ethnic groups would you suspect lactose intolerance in children?

(10) Which two nutrients must both be present in adequate amounts to prevent osteomalacia?

(11) Which of the following surgical procedures would you recommend for permanent weight reduction?
(*a*) Jaw wiring, (*b*) stomach stapling, (*c*) ileojejunal bypass.

(12) What dietary advice would you initially recommend for patients suffering from:
(*a*) Urticaria
(*b*) Eczema
(*c*) Dermatitis herpetiformis
(*d*) Gout

See page 1544 for the answers.

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Doctors as nutrition educators? Part IV

Answers to quiz on page 1542

(1) Formula S and Wysoy
(2) (*b*) Coeliac disease
(3) (*b*) Carbohydrate
(4) Monosodium glutamate (MSG)
(5) *Look at the Label*. Ministry of Agriculture, Fisheries and Food. HMSO, London. July 1984
E for Additives. Maurice Hanssen. Thorsons, Wellingborough, Northamptonshire. 1986. ISBN 0-7225-1150-7
The Allergy Diet Book. Elizabeth Workman, Dr John Hunter, and Dr Virginia Alun Jones. Martin Dunitz, London. 1984. ISBN 0-906348-70-6
(6) Refer the patient to a consultant paediatrician or gastroenterologist. *Do not alter the diet in any way.*
(7) No, because they contain high levels of potassium (K^+).
(8) Acute cholecystitis
Presence of symptomatic steatorrhoea in obstructive jaundice but not other cases of obstructive jaundice, jaundice, heart disease, or obesity
(9) Afro-Caribbeans, Africans, and Chinese.
(10) Calcium and vitamin D
(11) None—all patients relapse, and all the procedures increase morbidity and mortality.
(12) (*a*) Colouring free } given that there may be other
(*b*) Cow's milk protein free } non-dietary factors.
(*c*) Gluten free
(*d*) Gradual weight reduction

And, finally, can you answer:
Q What are the minimum requirements for a dietitian to be eligible for state registration?
A Four year degree in nutrition and dietetics,
four year degree in dietetics,
or three year degree in a related science—for example biochemistry, physiology, plus a two year postgraduate course in dietetics.

Have you contacted your nutritionist or dietitian? Have you referred any patients to him or her? All health districts have at least one nutritionist or dietitian, based usually in the district general hospital, who will be willing to help you with nutrition education.