The personal doctor 1975 *

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IT is now 16 years since Theodore Fox published his paper *The Personal Doctor* (Fox, 1960). During this time not only has general practice survived, but attempts are being made elsewhere, especially in the United States, to restore and recreate primary care. There is an air of self-congratulation about our wisdom and prescience in preventing its disappearance. Yet, despite the Royal College of General Practitioners, its survival has depended more on historical accident, its supposed economic advantages, and the strength of general practice as a political lobby than upon any inherent virtue or conscious decisions.

These 16 years have seen many changes. The number of single-handed doctors has diminished and the number of health centres and group-practice premises has increased. There has been an increase in the number and variety of ancillary staff either directly employed or working with practitioners. Groups are larger and deputising services often provide cover for nights and weekends. Organised vocational training is now established, but its effects on the quality of practice will not be apparent for some time. The College's Royal prefix and the growing number of university departments now provide an aura of academic respectability which largely remains to be justified. Reference is frequently made to these changes as signifying a renaissance of general practice.

Nevertheless there is little evidence that this renaissance has been welcomed by a society which grows daily more critical of its doctors. These criticisms are not about paucity of skill or lack of knowledge, but about the failure of the profession to respond to a human need which Theodore Fox identified in *The Personal Doctor*.

Patients' needs can be listed as:

(1) Protection from preventable disease,

(2) Accurate diagnosis of serious and life-threatening disease,

(3) Appropriate treatment,

(4) Reassurance,

(5) Help with " living with their human condition " (Illich, 1974),

(6) Certification of illness and confirmation of sick role (McCormick, 1972).

Value judgments

None of these needs can be adequately met without knowledge of the patient and the exercise of judgment in the sense of " the critical faculty, discernment, understanding, and good sense " (Onions, 1972).

Galbraith (1971) has written:

" The condemnation of value judgments . . . is one of the devices by which scientific pretension enforces adherence to traditional preoccupations." Denigration of judgment by the tautological addition of value has done medicine a disservice. Impressions about

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the quantifiable are no substitute for measurement. " In my experience " is no substitute for a controlled trial, but controlled trials depend upon measurable interventions and measurable outcomes. Much that is important is not amenable to measurement, but cannot be discarded without error. It is no longer necessary to argue the case for diagnosis in psychological and social as well as physical terms, but whereas physical diagnosis can to a considerable extent be expressed in terms of quantifiable abnormality, the ability to quantify psychological or social diagnosis does not extend much beyond intelligence quotient and income. Diagnosis requires judgment, the ability to discover the whole truth, to weigh all the evidence.

Protection from preventable illness extends beyond determining the advisability of giving triple antigen. The decision to treat minor degrees of hypertension must be made in the light of the likely side-effects, the cost of long-term therapy, the hope of compliance, and the risks of hypochondriasis. Such decisions cannot be generalised; they must be made in the light of individual needs. Health education and the modification of addictions also require an approach which recognises individual attitudes and specific problems.

The need for accurate diagnosis must be subject to considerations of the cost of investigation, the discomfort involved, the distress of a hospital admission, the extent to which it may contribute to useful intervention, or alter management.

Appropriate treatment must take account of cost, the risks of side-effects, and of inducing drug dependence. Rehabilitation after myocardial infarction requires courage on the part of the doctor as well as the patient and an assessment of relative risk.

Reassurance is effective only if based on trust. It must be directed at the proper target: vaginal discharge may symbolise either cancer, venereal disease, or sexual difficulty, and reassurance about the absence of venereal disease is little help to the cancerophobe.

" Help with living " requires knowledge of the problem and a delicate judgment. Counselling can readily become directive and marriages may be destroyed and jobs changed to no useful purpose.

Certification of illness not only gives entitlement to benefits, but also confirms a state of ill health. This, if illness does not result in economic deprivation and if job satisfaction is minimal, provides a major incentive towards adoption of the sick role and a major disincentive towards rehabilitation.

Appropriate knowledge of modern medicine is essential and provides justification for our present kind of continuing education which relies on the specialist. Despite the deficiencies which can readily be demonstrated, patients seldom come to lasting harm because of lack of knowledge of this sort. Much of the harm which does ensue is the result of injudicious drug therapy rather than failure to diagnose myocardial infarction, perforation of a duodenal ulcer, or other serious or life-threatening illness.

Knowing the patient as a person

Adequate knowledge of the patient as an individual can be acquired only by spending time, by continuity of care, and by domiciliary visiting. The increased mobility within our society, which in some towns can rise to 30 per cent a year, is a threat to continuity, but the relationship between practitioner and patient built on a series of brief encounters can nevertheless develop quickly into one of value.

Delegation and referral

The obvious way to create more time is to delegate, yet the act of delegation diminishes the opportunity for personal contact. As Theodore Fox pointed out: " Unquestionably

the practitioner needs helpers in his surgery or office and should be able to call on a wide range of skilled ancillaries outside: but the particular object of his independent existence may be defeated if he leaves all dressings to the nurse, sympathy to the receptionist, messages to the secretary, and the solution of home problems to the social worker. If somebody else is to do all the small things for the patient under the doctor's distant supervision, personal contact will be reduced to a minimum: and if this happens, the patient might just as well go to hospital."

The existence of a team makes it relatively easy for the doctor to reject some patients or their demands by rationalising this rejection as referral. The mental mechanism of rationalising rejection as referral is by no means confined to general practice, but in this setting it can lead to unnecessary outpatient attendance as well as to nurses and social workers being asked to cope with problems for which they are not properly equipped.

Doctors, by reason of their training and their role perception (McCormick, 1975) are unwilling to delegate responsibility for the diagnosis and management of physical ills. Yet a nurse has been shown to be an adequate and acceptable provider of primary care (Spitzer *et al.*, 1974; Moore *et al.*, 1973).

The doctor in society, be he witch-doctor or neurosurgeon, is granted status because of a belief in his powers and because of a belief that under all circumstances and at all times the doctor will subjugate his personal needs and desires to the needs of patients. For this reason the current naked negotiations about overtime payments and salary are rapidly undermining the privileged position of the profession. Similarly the organisation of practice and the refusal of doctors to respond to night calls and emergencies are seen as conflicting with society's expectations. It is difficult to deny that the recent changes in general practice have done more to improve the lot of doctors than of patients.

If general practice is to survive and justify a future for the discipline which is based on anything more than dubious economic advantage, it must redefine its task. In a sense the *Future General Practitioner* provides such a definition but its translation into action requires that doctors accept a new role (Royal College of General Practitioners, 1972).

This new role involves relearning the art of judgment and restoring to our patients their autonomy. It is no accident that many important judicial decisions in our society are not vested in experts, but in a jury. The Professional Standards Review Organisation in the United States and the large number of voluntary societies founded to protect and help those with a wide variety of disorders are symptoms of dissatisfaction with expert medical judgment.

The general practitioner is, because he is a generalist and because of his opportunity to know and see his patients' whole, best placed to help patients " live with their human condition." His significant contribution lies in weighing the physical, psychological, and social elements to provide wise counsel.

By comparison with nurse or social worker he has more knowledge of the nature of disease, available therapy, its side-effects, and its dangers. Provided that he uses delegation in order to make use of special skills and devotes the time so created to increasing his knowledge of the patient and to communication, he can help his patients to reach wise decisions as adult autonomous human beings. He can help them interpret the advice of specialist colleagues, he can protect them from both the enthusiast and from the incompetent. He can enable them to come to terms with pain and the fear and fact of death.

He can restore to them their sense of individual and unique importance. He can rejoice to be a ' personal doctor '.

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HAZARDS OF POTENT TOPICAL CORTICOSTEROIDS

Topically administered drugs are just as liable to leave unwanted side-effects as drugs administered by other routes. This is notably true of the fluorinated steroids, and dermatologists are becoming increasingly aware of the drawbacks of these potent preparations.

Burry has highlighted the problem by describing eight patients in whom prolonged application of fluorinated corticosteroids proved detrimental. In three of them ringworm and candida infections were masked and perpetuated. The two with ringworm infection, because of their previous treatment with topical steroids, had rashes that were unlike ordinary tinea—the lesions recalled those in a group described by Ive and Marks with ringworm of atypical appearance and extent due to steroid treatment and designated tinea incognito.

One patient in Burry's series had a rash on her face resembling rosacea which improved when beta-methasone cream was stopped and systemic tetracyclines and local hydrocortisone were substituted. The effects of the potent corticosteroids on rosacea are extraordinary. Patients seem to be ' addicted ' to these agents because in the short term they relieve the discomfort of rosacea and apparently suppress the inflamed papular and pustular lesions. It seems that the dermis of these patients may be particularly prone to the atrophy-producing effects of corticosteroids and that consequent loss of connective tissue leads to exposure of the subpapillary venous plexus, with increasing erythema and telangiectasia. This would explain both the relief from the inflammatory lesions and the increasing redness of complexion.

It would not, however, account for the sudden flare of the disease after abrupt withdrawal of steroid treatment. This rebound may explain why patients, once having started topical-corticosteroid treatment, find it so difficult to stop. The fluorinated corticosteroids may possibly play an aetiological role in the development of the rosacea-like condition known as perioral dermatitis, which was present in another of Burry's patients. Whether this is true or not, they seem to induce an ' addictive ' state, as in rosacea.

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