The Review

First do no harm:

frequency of illness depends as much on family dynamics as on material factors

'First Do No Harm' is a series of twelve brief monthly articles with internet footnotes about harming and healing in general practice. Each instalment is based on one of the 12 RCGP competency domains, this month's being:

9. Community orientation: the management of the health and social care of the practice population and local community.[1]

'All diseases of high incidence may be said to have a "social" as well as an "individual" pathology.'[2]

INTRODUCTION

GPs are on firmest scientific and ethical grounds responding to symptoms brought to us by patients;[3] we're on shakier ground when it comes to biomedical surveillance of the population.[4] We can't avoid being involved in such surveillance, however, and can contribute in two ways. We can take account of psychosocial factors that, as much as biomedical factors, affect the health and behaviour of patients.[1,5,6] And we can convey how benefit/risk equations change as we move from reactive care of consulting patients to pro-active care of the non-consulting general public:[7] symptoms have different predictive values, interventions have the same risk but less benefit, lead-time may lengthen morbidity but not longevity, benefit may be statistical rather than clinical, disease-specific mortality may be reduced but all-cause mortality unchanged, and — because of delay in benefit and immediacy of harm — some people die before benefiting.[8,9]

HARMING

Managing each episode of illness as an isolated event, being profligate with resources, prescribing antibiotics regardless of the development of resistance, medicalising, converting people into patients by prescribing,[10,11] encouraging dependency,[3] colluding with avoidable worklessness[12] and perceived disability. Targeting symptomless people — in a state of pre-disease — through product-branding marketing strategies.[13] Threatening the integrity of the family, weakening the position of parents, and undermining the security of children.[14]

HEALING

Taking account of the antecedents, consequences, and ramifications of the consultation. Being aware of the interplay between individual and family.[5,15] Seeking clinical, rather than just statistical, benefit.[3] Providing palliative and terminal care.[16]

ATTITUDE

Having faith in humankind's capacity for betterment while being sceptical, but not cynical, about how medicine can contribute to this.[17]

KNOWLEDGE

The family is a living and developing unit of interdependent members: frequency of illness depends as much on family dynamics as it does on material factors like hygiene, housing, and finances.[5] The most frequently cited barrier to returning to work after a period of ill-health is anxiety.[12]

SKILLS

Finding out who's with the patient in the consulting room ('hello, I'm so-and-so, and you're ...?'), in the waiting room ('who came with you?'), and at home ('what do your family/friends say about this?'), ensuring confidentiality ('I usually see patients alone for some of the consultation — can I ask you to sit outside for a few moments?'), and identifying the real patient.[18] Using the seven 'E' questions to broaden the agenda of the consultation from the narrow biomechanical to the psychosocial.[3]

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Supplementary information
The internet footnotes accompanying this article can be found at:
http://www.darmipc.net/first-do-no-harm-footnotes.html

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