

THE ENIGMA OF GENERAL PRACTICE

Some aphorisms for the art

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AS A BAIT FOR CONTROVERSY this article contains some contradictions and inaccuracies. Should it seem at first like a hotpotch of half cooked aphorisms culled from the stewing pot of general practice then I suggest re-reading it. This might lead to some introspection and reflection and even, it is hoped, to a deeper knowledge of what makes the practice and doctor tick.

Life is said to be turning into a rat race, and this also applies to medicine. But in order to have a relaxed and happy life the racing should be left to the 'rats' behind, while one keeps oneself far ahead by the exploitation of ideas. As an *aphorism*—Let the Jones' worry about keeping up with you.

It is accepted that advertising pays, yet doctors can't advertise. But their patients can do it for them! For this to happen the patient must be satisfied and treated as though his condition merited the doctor's full attention, for even if trivial the condition worried him enough to go to surgery. Supermarkets are successful because customers can quickly get to grips with their shopping in efficient, warm and bright surroundings and it pays the management to see that there are friendly assistants ready to help and advise. It pays in business so why not in medicine! Thus as a business speculation in this working-class suburb a practice suite was built (1960) into the semi-basement of my large Victorian house when I had 1,800 patients. It included the surgery, examination room, secretary's office, and waiting room with foam-rubber bench seating, bright decor central heating, intercoms and such features, but at considerable cost. The bank still holds as security the deeds of my house.

Luck is more likely to be used by those who work with anticipation. The practice grew from 1,200 patients in 1959 to 2,300 in 1963 and a secretary was then employed though this I could barely afford. Yet because of this, six months later it was possible to transfer to my list 1,500 patients from a local practice vacancy without undue strain. Features since added to the practice include maternity film-shows, a small coffee vending machine, a patient's notice and advertising board, a mother's club, an appointment system with receptionist and an office built into the large waiting room for the health visitor. Recently a purpose-built surgery and examination room for an assistant have been built on to the waiting room from the garden. The appointment system has ruined the coffee vending business! A capital outlay of about £6,000 is huge for one principal. Perhaps too much money was spent, but what a pleasure to work under such conditions, and the return of expenses should eventually sort out the debts. Whether or not this leads to good doctoring is debatable? The surgery provides the setting but it is the man behind the desk

that matters. *Aphorism*—General practice should be run on sound business principles.

Practices vary from rural to urban, industrial to garden city and from health centres to single handed, but just as variable is the doctor himself. He may be stern or friendly, organically minded or pastoral; he may be over- or under-anxious, over- or under-cautious. He may be a man of action and logic or he may believe that general practice is the art of temporizing and compassion but no doubt always believing his own approach to be best. Or doesn't it matter anyway?

From my experience in suburban (mainly social classes IV and V) general practice I consider that organic disease is less common than emotional disturbance, and the little serious organic disease that occurs is quickly referred to hospital where efficient treatment is available. One could nearly say that much of our time is spent listening to patients who suffer the symptoms of what they think they've got or who are unable to get what they want out of life and present themselves to us with symptoms. Years ago when a doctor made a visit it could be called an errand of mercy, today many visits could be called errands. Years ago doctors could do little for their patients other than show sympathy and understanding. Today doctors need do little for their patients other than show sympathy and understanding. But the patients are worried or they would not call us. All we do is to supply the public with the level of medicine that it considers it needs. Whether or not this is as it should be, the public will eventually decide, with or without the guidance of their doctor.

What education does a general practitioner need for this sort of work and where should he practise it? Should he go back to hospital and hold his clinics there, as a teaching-hospital consultant said to me over coffee recently. I dread the consequences for the patient. If less time were spent on the basic medical sciences more time could be devoted to the neuroses, geriatrics, child health, contraception, family counselling, preventive medicine and screening procedures, but this is still a teasing problem. I believe there is much to be said for the old fashioned apprentice system (trainee assistant) in picking up these skills. There are numerous postgraduate courses and lectures held for general practitioners. I think the most valuable part of many of these courses is the time spent in discussing practice and its problems with general practitioners before and after the lectures.

When he has finished his house jobs a doctor might be called an immature or pocket consultant and as such is unfit for general practice. Such a doctor, however capable academically, and however conscientious ethically, stands a good chance of becoming a frustrated general practitioner, for he has been ill-prepared for his work. He will use his skills to the best of his ability, when required, but if he has not acquired the wisdom to deal with situations and people he is on the road to frustration and extra work. He may even emigrate, he may return to hospital, or he may simply moan about general practice. Although a financial injection is vital for the survival of general practice, money alone will not solve the problems of practitioners. Extra money could even make matters worse

for doctors will need extra time in which to spend it! Whether or not the general practitioner should carry away with him his surgical skill from hospital is, I consider, debatable. I would prefer my child's appendix removed by the complete surgeon, not the occasional one.

It is a pity that some knowledge about fringe therapies is not available to students for there is little doubt that it has benefits and some patients have sworn by it. My experience with hypnosis and suggestion confirms this. *Aphorism*—It is not always what you give that matters, but how you give it.

A country doctor once told me that drugs were made for patients, not for doctors—a saying with some sense in it, for what the doctor did not have couldn't harm him. Indeed, it appears that 10 to 15 per cent of hospital beds are for iatrogenic complaints, i.e., in hospital because of treatment (this poses the question, how many people are in hospital from lack of treatment?). I believe Hippocrates said "first of all don't hurt the patient" or, as was neatly put to me recently by an itinerant Canadian psychologist, "Patients should be seen and not hurt". Naturally, I try to protect my patients from unnecessary medication and investigation and my prescribing costs which are (February 1966) 28 per cent of the national and 30 per cent of the local average, bear witness to this. But the patient sometimes needs a placebo otherwise my figures would be about 20 per cent of average or lower. A colleague of mine, devoted to his practice, has prescribing figures proportionately five times greater than mine and his patients are drawn from the same streets, indeed from the same houses. Why the difference? Is one of us over- or under-prescribing? Does the patient benefit, suffer or remain the same from this? Instead of the Ministry investigating those doctors who prescribe much let it look into the practices of those doctors who prescribe little. Indeed, the lessons learnt might be most rewarding to the tax payer and even to the patient.

One doctor visits tonsillitis or measles twice—another once. A further doctor asks for the child to be brought to surgery. One doctor takes frequent blood pressure readings and gives therapy for hypertension and a colleague will say nothing to a similar patient. Is one doctor obsessive and the other lazy, or is one concerned with the quantity of life and the other with the quality of life? Or perhaps the actions of some are motivated by a lack of security and a fear of litigation.

Though people live full and healthy lives, thanks largely to preventive medicine, are they any happier? Or is there a type of Parkinson's law which says "all these big illnesses have been eliminated so you must now worry about little ones"? *Aphorism*—Inherent in many people there is a capacity for worry and solving one problem simply leaves them free to worry about the next.

Doctor is derived from the Latin *docere* (to teach); this is what I try to do. It takes longer at first but eventually the patients come less often. Sometimes *docere* is translated as 'to prescribe'. If you teach a patient with a cold, the patient may well not come back with the next one but if you prescribe for such a patient the next cold necessitates a further visit for a repeat prescription. Thus routine prescribing may perpetuate the system of trivial visiting against which doctors so frequently complain.

Now frequent trivial visiting can label a patient neurotic yet the situation might have been created by the doctor. Thus non-prescribing can lead to a situation where anti-Parkinson's law operates. *Aphorism*—The less you prescribe for a patient the less he depends upon a prescription. The correct role, I believe, for a general practitioner is that of a general consultant and educationalist.

There are other spheres of general practice about which patients need educating and this education should come from the doctor himself. Two notices, clearly displayed, offer cervical smears by appointment 'for free'. In the past ten months over 200 smears have been taken though mainly through persuasion. My secretary recalls five people who responded to the invitation, and six responded to 60 duplicated letters posted within the practice: 50 per cent of appointments made are not kept!

More than 500 clinistix have been distributed with instruction envelopes to adult patients. Though approximately five per cent of post-prandial urines exhibit glycosuria, yet only one person from a possible 25–30 has returned with a blue clinistix. Two years ago 300 urines of patients over 40 were tested routinely in surgery and three diabetics were discovered!

R.S.V.P. invitations are sent for film and slide lectures on childbirth, contraception, etc., to between 60 and 80 patients. One or two replies are received and 20 people turn up.

If education, preventive medicine and screening procedures for which pressure groups are crying out are shown to be worth while, to what trouble and expense must we go to convince our patients of this?

When a patient wakens you at 6.0 a.m. on the way to work to request a routine home visit, or 'phones at 11.0 p.m. for a routine surgery appointment next day, one is tempted to ask "Are patients worth while?"

Broadly speaking, I consider illnesses are of two types: major and minor. The major ones go to hospital and the minor ones get better anyway and treatment keeps patient, and perhaps doctor, happy until natural healing is complete. I am sure there is some truth in this. *Aphorism*—In general practice treatment keeps patient and sometimes doctor happy until nature has its way. But then so much depends on the doctor's attitude towards illness for in the *British Medical Journal* of 29 May 1965 a doctor wrote that 50 per cent of 350 consultations in one week were trivial and could be dealt with by his wife who had no medical training. A few weeks earlier another correspondent said that in a little survey in his practice all but two cases were important.

On the subject of hospitals I feel it is the family doctor's duty not only to educate patients but to protect them from hospitals and specialists just as much as he should protect specialists against patients. All general practitioners know of patients caught up on the hospital band-wagon. General practitioners ought to let specialists know relevant social factors for the latter is not always in a position to assess them and it is not rare for the patient to become a referred appendage at the other end of his disease. By missing a social diagnosis and sending the patient to hospital the general practitioner can make the patient ill, the hospital can keep him ill.

In general practice I believe the art of history taking is different from that which is taught and used at hospital. In hospital a high percentage of cases are already diagnosed and organic in nature and the full picture is elicited by traditional methods, but in practice where I think the majority of cases are reactions of people to the life situation in which they find themselves, we must observe how these reactions present as symptoms. It is more effective to listen to a patient until he dries up, by which time the situational diagnosis is often clear. Asking questions interrupts the patients natural flow of thoughts and words, often prevents an emotional catharsis and may keep the diagnosis at a superficial level. Whenever you feel uneasy about a patient always look for depression and suicidal feelings, and try to avoid involvement in their problems. *Aphorism*—Hospitals treat the disease behind the symptoms, general practitioners treat the situation behind the symptoms.

Whatever a patient demands, whether it be a third opinion, the latest drug or stomach x-ray, never argue. Agree at once to give it then let the patient talk. Within a short while and an occasional tactful question or explanation, demands are nearly always dropped and a more relaxed and thoughtful patient leaves the surgery, usually without a prescription. The problem may not have been solved but the patient possesses more insight and his fears are eased. *Aphorism*—The patient is always right, even if you have to teach him how to be right.

The doctor who argues with a patient is like a car driven with the brakes on—much energy is spent in getting nowhere except that the doctor may well be tired out at the end of the day. If the doctor is in a hurry never make it apparent. It is invariably quicker to let the patient have his uninterrupted say, then, if necessary arrange another appointment. Being rushed is readily perceived by the patient and leads to dis-ease in the relationship. If the doctor needs a catharsis he will do better to get it from an aggressive sport than in aggression against the patient.

Now that it is possible to make elaborate investigations and give powerful drugs it must still be appreciated that a little more understanding on the part of the doctor may reveal not only more than a cluster of tests but, indeed, it will help the patient to understand, or even solve, his problem. For medicine is still an art and education by specialists is not creating the wisdom which society needs in its doctors.

Finally, one may well ask 'What is general practice and what is a general practitioner?' In the end the doctor will probably be what the patient expects him to be and what the doctor decides he shall be. My own guess is that the general practitioner will require a general medical training, need not be too brilliant academically but will have learnt human nature through experience as well as through study; he will become a wise man of society who knows how to deal with people, diagnose illness and will also know when to refer to the specialist at hospital. The doctor will be of strong moral fibre for the pressure of the front line weighs heavily upon him. He will almost certainly forget some of his hospital skills which were acquired to help him understand medicine but in the end he will be the most versatile and complete physician.
