The family doctor's responsibility to the individual*

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My practice

THIS essay is about my practice and the way I work. Since the practice has developed as a mixture of inherited customs and ideas, including my own, with a knowledge of other doctors' ways of work gleaned from courses, workshops, and reading, it can be said that my practice mirrors some reflections from every other.

I believe that the family doctor has an absolute responsibility to the individual. Our group practice accepts the concept of one patient one doctor. I feel perhaps more strongly motivated than others in less personalized settings to describe this system, examine its strengths and shortcomings, and substantiate this way of work. Ten years ago, I inherited it as a *fait accompli*. This essay enables me to appraise a method of practice which I have perpetuated and strengthened and test whether it is practicable or desirable for the family doctor to be responsible to the individual, and if so how.

Our group consists of five doctors and 15,000 patients in an urban area. We employ our own staff, have attached staff and work in modernised premises.

A special feature is that each doctor has his own personal list of patients within the group and identifies himself with them. Partners are used for off-duty cover (holidays, courses, evenings, and week-ends) but patients who need a doctor at these times are returned to their own doctor's care as soon as he is available. Hence the illness that is treated on a Sunday by my partners is followed up by me later. Thus we are patient-orientated rather than illness-orientated. The practice has always accepted this system. When I joined, I saw no reason to change and as a young doctor admired the highly personalized style of medicine that my predecessor had developed. My inherited patients also strongly valued this style and sought to keep it.

In the ten years that have passed, all new patients coming to the practice who chose or were allotted to me were told that I would make myself available to them within the limitations of reasonable off-duty. Patients from other large groups have occasionally mentioned the difficulties of seeing the same doctor and have expressed dissatisfaction with an episodic system of care. To me, and ultimately to them, the advantages of personalized general practice have become apparent. By caring for every clinical episode of any significance, and most minor clinical episodes, I learn to know the person more intimately and can put their illnesses in a more accurate setting of personality, psychology, family, and environment. This personalized care of individuals by one doctor is surely the strength of general practice. Hospital medicine, with its orientation to serious illness can never rival it. Responsible and continuing personal care for many minor clinical episodes over a period of time prepares the way for the more important care of graver illnesses. Responsible care of minor illness may also help the patient to reveal his underlying major problems.

Is responsibility to the individual possible?

Is this responsibility too great for one person to bear? That it is great will become apparent, but the recent change from personal doctor care to team care has helped the

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doctor to carry the burden more happily. The nurse, health visitor, midwife or social worker, by mentally nudging, stimulate the doctor to examine the management of his patients more carefully than when he worked alone. By devolving some aspects of patient care onto members of his team, ultimately the doctor's care of his patient improves. The team lightens the weight that has to be borne when caring for the incurable and the chronic patients of the practice. Paradoxically, sharing care enables the responsibility of personal doctoring to be fulfilled. Perhaps the decline of general practice so patently evident in the 1960s was not due so much to lack of financial reward, nor to inadequate premises, but to the fact that the responsibility for individual care, which is the great joy of general practice, was proving too heavy to be borne by the doctor alone.

Moreover, my personal practice is one of five personal practices, and cross fertilisation of ideas takes place from doctor to doctor when problems present. Material advantages flow from the personal list system of care. Separate and even different filing systems can be used by the five different practices. Five separate indexes and research registers can be kept according to individual doctor's interests. Differing operational systems and styles of care can be used and differing analyses made. The enthusiast can enthuse and the golfer can golf without the one feeling inhibited by the other. Separate filing systems, different records, differing interests exist happily alongside each other in my group.

To avoid too much isolation, ultimate broad goals are defined (e.g. total consultation and visiting rates and total group morbidity figures) and bridges can be built from one system to another. Hence freedom of the individual doctor does not result in clinical, operational, and research isolation, nor does it prove divisive.

Availability

Availability is the key to individual responsibility. How much can one truly be available all the time? To achieve as much availability as possible, the practice has changed its organisation considerably.

The introduction of an appointment system six years ago was the most important change. Previously, availability was automatic, provided patients were prepared to wait. However, such a haphazard system had many problems, in that waiting was itself a deterrent and decreased availability. Our first appointment system made it worse as an inadequate number of appointment sessions transformed waiting from a matter of minutes, or at worst hours, sometimes to a matter of days. To avoid this, patients tended to see ' anyone ' rather than their own personal doctor; " we can never get in to see you, you are always fully booked ". Similarly, the initial rigid appointment sessions militated against some groups of patients (notably the over-anxious whose every illness is a matter of urgency) seeing their own doctor. Hence I evolved my current multiple short surgery sessions (up to 90 minutes) scattered evenly through the working day and the working week. Appointments are always available early each day (and preferably until about 1500 hours) to fit in my own ' urgent ' patients. On my half-day, however, my availability ends at 1000 hours.

The practice has, at times, been tempted by the attractions of long off-duty periods such as week-ends starting on Thursday evening or by rotas with other practices to decrease on-call periods to minute levels, but because of our faith in the personal doctor system we have rejected them. I feel, and happily so do my partners, that one week-end in five, and one evening a week on duty, is a reasonable burden, and because of our presence at other times, we find we are able to offer a personal service and accept responsibility for the individual. We have firmly rejected emergency treatment services as a means of discharging our 24-hour obligations to our patients. We feel that when we are not available that our deputy should be an experienced family doctor who knows us and the way that we work. He must feel that he can consult us on the telephone if faced with

a problem that he cannot comprehend, and that he should have access to the patients' records. In this way the deputy can provide more than just short term care. The responsibility for high level care for off-duty calls is increased as these are all patient emergencies often requiring greater expertise and experience in management than those occurring routinely during the working week.

Advantages of the system

So far, the personal doctor seems obliged to give more of himself in order to accept full responsibility for the individual. However, operational benefits do accrue to the doctor from this system. The ability to conduct telephone consultations with known patients; the ability to prescribe accurately as a result of messages left by known patients and relatives; and the ability to appreciate, because of greater knowledge of the patient, the reasons why people do call at night or at week-ends, are some of these benefits.

The strength of my practice is in its direction to individualistic care and the consequential responsibilities. Nevertheless, flexibility of choice is still available to the individual patient. Any patient who wishes to opt out of the system and use the group in a more casual and depersonalized way is free to do so. The system must never dominate the individual.

The extent of responsibility

It is salutory to mention that my responsibility is to the individual and not to the family. Although many whole families are registered with me and look upon me as their family doctor, and although I gain diagnostic and therapeutic clues from a knowledge of the family setting, nevertheless, my primary responsibility is to each individual. My confidences are only shared with the family if the individual concurs.

The mechanics of the practice have been described before discussing the merits of the system. If the system were impracticable then there would be little point in discussing its merits and its qualities.

Assuming that individual responsibility is operationally feasible, what are the family doctor's responsibilities? Medicine itself is a responsible profession; the very act of qualifying brings heavy responsibilities. The family doctor's responsibilities to the individual mean that just ' doing a good job,' is not enough. The job itself has been taught and is comparatively easy to evaluate; the responsibilities come with continuing clinical practice. After nine months collecting material from consultations I learnt that the end was never in sight. Perhaps the first responsibility is to accept that there is no end to new responsibilities.

Responsibility for high clinical standards

It is self-evident that the prime responsibility of the family doctor to the individual is to ensure that his clinical standards are as high as possible. Refresher courses, with yearly attendances far greater than those required for seniority payments, attendance at local postgraduate weekly seminars, involvement in the local activities of the Royal College of General Practitioners operational, clinical or research, practice research projects, practice journal clubs and libraries; all conspire to the maintenance of high clinical standards which is the family doctor's prime responsibility to his patients. Being up to date with the latest advances in therapy may not in recent times have saved lives as insulin must have done in diabetics in the 1920s and sulphonamides in pneumonia in the 1930s, but speedy knowledge about l-dopa and the ability to recall from practice records all patients with Parkinson's disease, has in my own practice transformed the lives of two patients, and given hope to two more.

Using consultants correctly

For peripheral doctors practising remotely from a University centre, the responsibility to the individual for keeping abreast of the latest teaching hospital advances and referring patients there, perhaps even positively avoiding local, peripheral, non-teaching hospitals, is not always understood. The final opinions of the local hospital, especially when the prognosis is poor, must occasionally be challenged by the family doctor by seeking a teaching hospital opinion if doubt remains. The recent referral of a patient written off as a chair-bound rheumatoid cripple by local orthopaedic specialists, to a teaching hospital prepared to insert hinge knee-joints and remobilise is such an example of the family doctor's responsibility to the individual. The referral for urgent admission of a terrified, tearful, solitary 22-year old girl with an abdominal tumour, gross menstrual irregularities and severe sycosis barbae, to the local small hospital, notwithstanding a presumptive diagnosis of arrhenoblastoma, is an example where the responsibility for more appropriate referral, in this case to a world-famous endocrine clinic at the nearest teaching hospital, was not met. The responsibility is to practise in 1971, the standards of clinical medicine available in 1971. A prompt awareness of any new facilities at the local hospital is a responsibility of the family doctor. Such awareness will sometimes affect the doctor's decision whether to refer his patient to hospital at all; there is little point in sending a patient with a coronary thrombosis several miles in an ambulance to a hospital where there is no intensive care unit and where the treatment is merely a prolonged period of bed rest in a busy ward. Here the responsibility is met by keeping the patient at home and monitoring care in a domiciliary setting as intensively as possible.

This leads to the responsibility that the family doctor carries for ensuring that his practice is adequately equipped for the care of such clinical problems. Our recent purchase of an ECG machine has certainly increased the ' incidence ' of coronary thrombosis as a more accurate diagnosis of chest pain is being made. It has been of inordinate help in diagnosing pulmonary embolism in one patient and severe gall bladder pain in another. In retrospect, there is no doubt that both patients would have been diagnosed clinically as suffering from coronary thrombosis, and if the practice had not fulfilled its responsibility to the individual by having the equipment available both patients would have suffered long and unnecessary restriction of their activities.

The responsibility for precision in seeking second opinions is vital, and in this context it is important to remember that where a specialist opinion on a problem would be inappropriate, as in problems arising in the medico-social and psycho-social field, discussions with a general practitioner partner may throw revealing light on a complicated situation.

A new responsibility is the family doctor's responsibility to both expectant mother and unborn child to interpret correctly the clinical and social indications for termination of pregnancy. The purely clinical decisions are comparatively easy (e.g. in a woman with rubella) but the responsibility for helping an expectant mother to arrive at a humane and legal decision about abortion on psychological or social grounds within the terms of the Abortion Act is very much the prerogative of the family doctor; no other person can be expected to bear this responsibility so heavily nor be expected to fulfil it as accurately. Whatever decisions are taken the family doctor's responsibilities do not end with that decision. There follows the responsibility of sustaining and caring for a mother during a pregnancy that she really did not want, or caring for a young woman with guilt following a perfectly legal termination, may go unnoticed.

Responsibility for good recording

Closely linked with the responsibility for high clinical standards is the much neglected responsibility to the individual of good recording. Although the current record envelope is quite inadequate for its purpose as a lifetime clinical record, nevertheless its inadequacy

in size is generally dwarfed by the inadequacy of the clinical records it commonly contains. A serious attempt in our practice at permanently date-ordering the contents of the record envelopes has proved a tremendous advantage. A printed, boxed, diagnosis has enabled deputising partners, and we hope our successors, to appreciate rapidly the earlier history of the patient. The responsibility for the corporate body of general practitioners to try and establish some comprehensive and comprehensible systematic method of recording follows from this.

Not only must the individual records be kept accurately, but the practice should have available at least some simple index, such as the R.C.G.P. 'W' book, so that as new drugs are discovered for old diseases, the index can be consulted and individuals can benefit by being identified and called for consultation. The recall, each September, of all patients with chronic chest and heart disease for influenza vaccination is just one example of this responsibility.

One seldom discharged responsibility (and a courtesy to other doctors honoured more by its neglect than by its commission) is to provide patients suffering from illnesses requiring continuing treatment with a summary of their condition when they move to another area. Here the responsibility to the individual is continued even after he has left the list. Properly discharged, it enables the new doctor to undertake his new responsibilities for that individual promptly. Coupled with this is the responsibility of the family doctor to make some effort to direct his patient to a doctor whom he knows in the new area and who will serve his patient well.

Responsibility for preventive medicine

Encouraging individuals on the list to accept preventive therapy is an increasing responsibility in general practice. More and more family doctors are accepting responsibility for immunizing the children in their practices; this is of greater importance as child welfare clinics decline. The attachment of health visitors and nurses in special children's sessions in the general practitioner's surgery greatly helps this. Some local authorities discharge an overall responsibility by using computer recall systems. A follow-up in our practice of the immunization state of all thirteen-year old girls following an intensive vaccination campaign against rubella, revealed that over 20 per cent of these children had escaped immunization at school and were immunized later in the surgery. In such a situation the responsibility of the family doctor is to the individual, not to the group.

The detection of at risk groups needing special care is increasingly important in preventive medicine. Every new-born child should have a comprehensive examination by a doctor in the first week of life, with special reference to the hip joints. The identification of all patients in the practice over 75 years of age who have not been seen by the doctor for one year, should lead to a visit by health visitor or nurse. Similarly screening for arterial and metabolic diseases in the relatives of the diabetics of the practice is necessary. The identification of women between the ages of 25 and 65 who have not had a cervical smear, and now, those who have not had a cervical smear within the last five years, is a further responsibility of the family doctor. The responsibility in this care is heightened as in addition to being able to undertake the responsibility, there is a need to evaluate from the literature whether benefits genuinely accrue.

What is of certain value in the prophylactic field is the use of contraception in preventing unwanted pregnancies. I make it my responsibility to all the unmarried women in my practice, and especially the age group 15 to 20, to make some mention of contraception during any consultation they have with me. By discharging this responsibility to all such individuals, I believe that family doctors could prevent some of the trauma associated with the unwanted pregnancy in the unmarried. The permissive society is a fact of life. The promiscuous society is also with us to a small but important

extent. It is the family doctor's responsibility to the individuals in such societies that they should know the chances of pregnancy and that the doctor is prepared to prevent this if necessary. It should be unnecessary to emphasize the responsibility of the family doctor to advise on contraception, including the possibility of male sterilisation, at every postnatal and post-abortion examination. This should be normal clinical practice.

Responsibility for health education

The family doctor is learning to deploy his team of workers and to have more formal responsibility for the health education of his patients. With fathers' classes, antenatal films and mothercraft sessions given by the health visitor in our medical centre, our practice is moving tentatively in this direction. High in the list of priorities for health education must be some formal instruction to patients about when to consult their doctor. There is no doubt that often the family doctor's long knowledge of his patient can be helpful, as with contraception for the unmarried. Similarly, he can often elicit other social aberrations such as drug-taking in teenage children and discharge a further educational responsibility by advising about medical hazards. His responsibility to all the smokers in his practice is an important one. It is probable that the chance of effecting long term changes in such habits whilst patients are clinically ill is higher than at any other time.

Responsibility for the whole problem and the whole patient

British patients are an extremely undemanding group compared with their trans-Atlantic counterparts. With no financial payment to measure the care they receive, they tend to be grateful—regardless of the ineptitude of the service they sometimes receive. Coupled with this, is an inborn deference to the professions and to the medical profession in particular—a feature notably absent on the other side of the Atlantic.

These factors all increase the responsibility of the British family doctor to ensure that each incident receives advice and therapy that accurately reflects the need. The trans-Atlantic doctor can rely to some extent on his patient's demands and high expectations and his eagerness to nudge him into correct decisions and occasionally into wrong ones.

In contrast, the British family doctor has to accept full clinical responsibility for appropriate care, quite unprompted by the patient. In particular, because of his deferential patients, he must make himself aware, almost by extra-sensory perception, of the unspoken need. He has constantly to be alert to the possibility that only the iceberg tip of the problem is being exposed. He has to assess surreptitiously the submerged mass and decide whether to expose it or not. Especially with presentations such as headaches, depression, tiredness and non-specific aches and pains, the family doctor's responsibility is not to treat the symptoms symptomatically, but to uncover sympathetically the origins and causes then therapy can begin. With British patients, the responsibility to the individual is to ask oneself as the patient is about to leave the consulting room whether everything has been done.

Quite apart from any clinical shortcomings the British family doctor must encompass a broad spectrum of care; such as local authority sponsored holidays for convalescent mothers and families in social class V, housing modifications for increasingly but insidiously handicapped arthritics, the registration of partially sighted diabetics (with the associated various welfare aids), conferences with works medical officers for job placement of handicapped people. These few examples show the tremendous responsibility to an undemanding and often uninformed public.

The responsibility for caring for the interests of the whole patient as well as treating his disease is essential. The family doctor's responsibility is not to look after a carcinoma of lung or a duodenal ulcer, but to care for people with individual personalities and environments who individually relate to other members of the community—whose

individual life-style is being threatened by a carcinoma of lung or a duodenal ulcer. The family doctor derives added joy from his job as he effects his cure and watches the whole person improve. Furthermore, he will not overlook the development of another disease in addition to the one already known, which is the commonest failing of specialised clinics concentrating on particular diseases.

At times, the theoretically best treatment of the disease may run quite contrary to the care of the whole person. It is the family doctor's responsibility to ensure that it is always the whole person that receives the treatment.

Mr. C. is an arteriopath—gangrene required the removal of both legs, and a stroke removed his speech and the power in his right arm. An intelligent, retired engineer, he sits all day speechless and helpless on his stumps. Recently he developed episodes of diarrhoea. Clinical examination was negative as was a barium meal. To establish a complete diagnosis he requires sigmoidoscopy, barium enema, and if these are negative, a mesenteric angiogram to demonstrate his possible episodes of mesenteric angina. It is my responsibility as his family doctor to prevent him undergoing these unpleasant and incapacitating examinations. Even if the diagnosis of mesenteric angina is sustained there is no treatment for him, and if he is found to have a carcinoma of bowel no surgeon would operate. The family doctor's responsibility is to say enough is enough in such a context.

Responsibility to persist

Flowing from the continuing care of his patients emanates the responsibility to persist in ensuring that the best interests of the patients are being served. Standing as he does at the entrance to all medical care, he must ensure that appropriate facilities are made available for his patients. Persistence can be required in both clinical and sociological contexts as the examples show.

Mrs A is a 28-year-old mother of two young children. She suffers from pseudo-myopathic spinal muscular atrophy which is slowly yet inexorably reducing her to a wheelchair existence. Their home is a low rental council house with three upstairs bedrooms, upstairs bathroom and lavatory facilities and only one downstairs living room. A letter from the teaching hospital was full of compassion, appreciated the need for more suitable accommodation, and intimated that the wheels were turning towards finding this. The A's presumed that everthing was being done. After one month had passed, investigation by my health visitor and me showed that nothing had been done, and apparently that nothing could be done, as three bedroom bungalows in the area in which she lived, and in which she could be supported by a caring family, did not exist. Accordingly I wrote to the newly arrived Director of the Department of Social Services about this major problem of a handicapped young mother with a young family. This produced immediate activity and the solution recommended was the installation of a downstairs lavatory and washing facilities in an older style council house and converting one of the two downstairs living rooms into a bedroom. Unfortunately after high hopes had been raised Mr A found that he could not afford the new rent. I informed the Department of Social Services immediately that the problem still remained. Wheels are still turning. This persistence on behalf of this type of patient who can be so readily disheartened by the obstacles to be overcome, is one of the responsibilities of the family doctor.

Frequently in a diagnostic context the family doctor must persist.

Mrs B is a widow in poor social circumstances, who drinks brown ale steadily each evening at home while her bachelor son does the same at his club. Her increasing anorexia, emaciation and motor incoordination, suggested that the stump of her gastrectomy might be the seat of malignant disease. Alternatively, her deficient stomach might be precipitating a malabsorption osteomalacia. The referral for assessment on two separate occasions in 1969 and 1970 gave completely negative results,—" just a social problem." On the third occasion, in 1971, following further deterioration in her clinical condition and a fairly sudden super-added heart failure, I carried out yet another biochemical profile and some more x-rays of her skeleton. The results at last suggested osteomalacia and this was confirmed at a domiciliary visit by a newly-arrived gastro-enterologist. Now full of calciferol, calcium, vitamin B.12, folic acid and as much 'complan' as she can dissolve in her nightly alcohol, her weight has increased from 39·6 Kg (6 stone 4 lb.) to 45·5 Kg (7 stone 3 lb), her heart failure is corrected, her gait is steadier and her demeanour and life are transformed. There is no doubt that the 'social' diagnosis was correct in 1969 and 1970 but it was the family doctor's was responsibility to ensure that it was reassessed in 1971.

Mrs G had multiple sclerosis. A happily married teacher unable to work, she became increasingly handicapped in her own home. Her husband was a stalwart support. I visited her every month to assess progress, or rather deterioration. An inaccuracy in my visiting book caused her name to be erased from the list and two months later her husband asked a receptionist to remind me that I had not been for some time. This message was, alas, never conveyed to me and after three months without any contact from me her husband wrote to say that he was asking one of my partners to call because of my apparent lack

of interest. He remarked in his letter that although fully aware that I could do nothing to cure or ameliorate this horrible disease, " I had myself to give as a doctor ". This salutory lesson spells out one of the most important of the family doctor's responsibilities—to persist in the care of the incurable, and to give hope to the hopeless.

Responsibility for follow-up

The follow-up of illness has been accepted in the hospital setting for many years. Increasingly this must be the responsibility of the family doctor as the cost of hospital care escalates even at the outpatient level. The postnatal patient who does not attend is probably the one that is in most urgent need of advice about contraception and will be seeking termination if she becomes pregnant again. Alternatively, she is the woman who has never had a cervical smear. It is the family doctor's responsibility, working with his team, to ensure that these people are not overlooked. The routine recall of the occasional patient of the practice with an irradiated thyroid to detect early myxoedema is an important example. The insistence in following up hypertensives must be organised by the practice team.

Responsibility for bewaring the omniscient image

The responsibilities of the family doctor are made greater because his persistent and individual care of his patients enables them to know him, trust him and sometimes even love him. Surrounded by this aura of emotional feeling the doctor runs a considerable risk. His errors can be overlooked. It is therefore an added responsibility to ensure that the trust of his patients does not obscure his treatment of them.

A long treated acromegalic in my own practice might possibly have had the coincidental berry aneurysm of her internal carotid artery ligated if my clinical senses had not been lulled by the trusting aura surrounding her, into believing that her meningitic illness was due to a virus meningitis currently epidemic in the area. Instead it was due to an early ' warning ' subarachnoid leak.

Responsibility for communication

It is a paradox that the family doctor achieves his omniscient aura through discharging another responsibility to the individual—the responsibility for being a good communicator. Although his patients' intelligences, attitudes, manners, personalities and social class vary immensely it is the family doctor's responsibility to modify his approach so that he can communicate accurately with all of them. He is probably more easily able to discharge the responsibility with social class I patients whose intellectual and sociological norms are similar to his own. His responsibility to communicate with the unemployables of social class V is however perhaps even clamant, if he is to fulfil his responsibilities for them.

The family doctor is sometimes asked to intercede in inter-personal problems by patients suffering from resultant psychoneurotic illness. This he must resist. This is of particular importance when dealing with marital discord when often one partner will expect the family doctor to take sides. The family doctor's responsibility is to elucidate the options, clarify the motivations, and appraise the situation from all angles, but in the end it is the patient's responsibility to make the decision. The responsibility is not to assume too much responsibility. It follows that it is most important that the family doctor does not intrude unwelcomed into an individual's privacy. Sometimes the family doctor is well aware that skeletons exist in his patients' cupboards but he should only open them by invitation. Occasionally, individuals have bizarre and unusual ways of living but if harmless and long standing it is a bold doctor who would attempt to alter them, especially when his interference may not necessarily improve the situation.

Responsibility for social awareness

Social change is a constant process; the 1960s have seen not only social change but social

upheaval. It is essential that the family doctor, probably born and bred in social class I or II, and with his formative years in the 1930s or earlier, must constantly stay abreast of social changes so that his responsibilities for the individual are not discharged against a chronologically irrelevant background. It came as a shock to many doctors when the diffident and inarticulate teenage members of their practice entered the consulting rooms with hair shoulder length, side-whiskered and bearded and dressed in modern 'hippie' ways. The doctor may assume a somewhat prejudicial and critical attitude towards these individuals, not always recalling that this is nevertheless the teenage community upon which the future depends. Beneath the 'pop' singers fringe is the same acne, beneath the 'hippie' shirts the same anxiety provoking gynaecomastia, and beneath the long hair the same basic anxieties about sex, morals, drugs and behaviour that have always existed. In a permissive society these individuals are more vulnerable and more in need of help than their parent-aping counterparts of 20 or 30 years ago. The responsibility to such individuals is considerable. Only three years ago I remember earnestly debating with my junior partner whether it was right to give the contraceptive pill to an unmarried 'hippie' couple prior to "hitchhiking to see the world" to Afghanistan (a country currently fashionable). My earlier comments about the availability of contraception to all teenage patients show an updating of social attitude that I have undergone in order to discharge my responsibility to such individuals appropriately. Patience is the key for these members of society with whom one has little in common. This quality is also needed particularly when dealing with old people. The old and the handicapped are frequently trying as they cannot speak quickly, they cannot understand, and they do not accept change.

I was not taught at my teaching hospital that clinical skills would be affected not only by the differing clinical patterns but also by the social class of the patients. The problem of achieving a diagnosis in an inarticulate social class V patient is great when compared with the lucid social class I counterpart. The needs in social class IV and V are often greater but usually less well expressed. The responsibility is to be aware of how the clinical need is met differently in differing sociological settings.

My acromegalic patient was also severely pigmented. Although she had never had a holiday for 20 years she was constantly being asked the origin of her 'suntan,' or sometimes, more hurtfully, whether she came from Pakistan. Social class I patients would have solved this problem by consulting a beautician; social class V patients must just suffer. I persuaded the local skin specialist to unearth an ointment which she could get free on prescription which remarkably altered her colouring. The responsibility to a social class V patient was different.

Other social factors alter the treatment. The use of depo-steroids in small doses is probably justified in patients with severe hayfever during the season in which they take their 'O' or 'A'-level examinations. Agreeing to visit an acute throat infection on a late evening call, and giving intramuscular penicillin—as though it were an urgent affair—is justified when the patient is just about to embark on a foreign holiday. These responsibilities are not purely clinical, but the family doctor's responsibility to the individual must encompass sociological as well as purely clinical factors.

One responsibility which I feel most strongly must be borne, but which I do not undertake happily, for it is frequently time-consuming and embarrassing in its self-exposure, is the responsibility for giving evidence in divorce or other legal proceedings. Often, in divorce the family doctor is the only person who has an intimate knowledge of how deeply split and disillusioned the two parties are, To be able to support one party with medical evidence be it psychological or physical, which could ultimately put an end to a great deal of misery is a responsibility that should be borne by every conscientious family doctor.

Responsibility for saying 'no' as well as 'yes'

As a family doctor, I like to accede to my patients' requests. If they ask for something I

like to be able to provide it. However, often it is the family doctor's responsibility to say 'no' rather than 'yes.' Not starting patients on habit-forming hypnotics but alternatively spending time explaining the vagaries of the sleep mechanism and how to adjust to it is one example. Similarly, with tranquillizers—" something for his widow " —can if too lightly agreed to, convert a normal mourning response into a persistent drug habit. The family doctor should prevent his obese patients from becoming habituated to stimulant anorectics. The family doctor's ultimate responsibility is to create healthy people—not drug or doctor dependent ones.

As he legitimises the absence from work, the family doctor has an indirect responsibility to the community. Many industrialists feel we do not pay enough attention to this. The family doctor's responsibility is, however, to the individual and not the works. It is his responsibility to prevail upon a sick man not to work and likewise his responsibility not to certify incapacitating sickness when it is not present. Many patients although irritated initially by a decision with which they do not concur later learn to respect the family doctor's responsibility for saying 'no' if it was based on a genuine feeling for the individuals' problems—usually after a long discussion.

Responsibility for new patients

The family doctor carries a heavy responsibility for his new patients and his first contact with them may be of inordinate importance. At this consultation some time should be spent allowing them to get to know him, showing interest in them and concern for them, and revealing something of his own personality as he searches for theirs.

Mrs D is 24, has two young children, and has advanced renal tuberculosis. She also has chronic asthma for which steroids are now contra-indicated. She has previously had excellent care elsewhere in England. In my first consultation with her she explained her illness and her limitations to me. As the history unfolded it became increasingly obvious that here was a woman whose clinical problems were considerable. She was going to need me a great deal in the months and years ahead and it was vital that I established rapidly the beginnings of a happy long-term relationship. My responsibility, apart from the clinical aspect, was not to appear dismayed by the frightening situation I found her in, nor yet to be too light-hearted about it. The responsibility was to appraise her condition seriously, express the greatest interest in her, and from this interest she would see my determination to treat her carefully—from this would spring her hope and trust.

Responsibility for the primary consultation

The family doctor also carries the responsibility for the all important first consultation in any of his patients' illnesses. The symptoms then are a confused, disordered and unconnected mixture of truly physical symptoms interlaced with a muddle of fears and emotions. At that time, unstructured and uncanalised, they are possibly of greater value than they will ever be again. Patients all too rapidly learn how to modify their symptoms according to what is expected of them. The subsequent course of the illness is often determined by the skill with which the presenting situation is evaluated.

Indirect and unrealised responsibilities

At times the responsibility to the individual is carried out by sustaining not only the individual himself but also his relatives. Supporting harassed and overstrained people who may occasionally be devoting themselves entirely to a sick patient, and keeping them well informed of changes in his condition and of his day to day prognosis may well do more good subsequently to the individual for whom they are caring than do all the medicines and tablets. One thinks particularly of incurable, sick, elderly patients.

At times one bears unwitting responsibility that does not become apparent until much later.

Miss E, a social class I girl, in labour with her illegitimate child, developed signs of foetal distress during the second stage and the foetal heart rate fell to 60 per minute. I performed a rapid forceps delivery under local anaesthetic, promptly resuscitated a collapsed child and raised its Apgar score from

two to eight within ten minutes. This heartened not only the mother but also me. On the third puerperal day, contrary to what she had decided during the pregnancy she told me she intended to keep her baby and not have him adopted " because the baby had put up such a good fight to live." I little appreciated at the time of giving normal good clinical care what responsibilities I was discharging and what ultimate life patterns I was affecting.

Responsibility for practice facilities

Until 1966 it could be maintained with reasonable justification that the British family doctor was being unfairly treated by his monopoly employer. In that year, however, the British Medical Association negotiated the family doctor charter with the government. This was the greatest leap forward for general practice in the last 20 years. With the inception of rental payments for family doctors' premises, the reimbursement of rates, 30 per cent improvement grants for improving premises, and being able to borrow money for the building of new premises and to expand old ones, from the General Practice Finance Corporation; the family doctor is now firmly responsible to his individual patients for providing the bricks and mortar in which he can fully develop his skills. As an alternative in some areas, the government has encouraged local authorities to build health centres which remove almost all capital commitments from the family doctor and give him adequate premises in which to work. There is now no reason why the personnel of his new premises should not be completely adequate given 70 per cent reimbursement of the wages of his ancillary staff. By endorsing the family doctor charter the government firmly settled the responsibility for providing good care for the individual on the shoulders of the family doctor.

Responsibility for team care

When I began general practice ten years ago, one of the attractions of this particular group was the fact that it employed ancillary help. We were then the proud possessors of three receptionists. We now employ two secretaries and seven receptionists (including two state registered nurses) and we have a local authority team of six personnel attached to us. This transformation from a fairly quiet corner shop group practice to a busy supermarket medical centre has amazed not only the patients but also the doctors. One of the major responsibilities of the family doctor arising from this change is to ensure that the individual patients do not get lost—or feel lost within such an expanded building and surrounded by so many different faces. Increasingly attempts are being made—and will be strengthened as time goes by and as the team attains its full strength—to ensure that the health visitor, midwife, and social worker care is personalized as much as possible. The same nurse should follow-up the same hypertensive for the same doctor. Patients, nurses and doctors then grow to know each other well; nurse and doctor understand how the other works.

When developing and using a team, the family doctor's responsibility to the individual who has to use this system is to explain it to them in an honest and comprehensible manner. Many practices and teams have developed at a startling pace—ours is one—and yet the patients have been told nothing. The possibility of preparing a brochure to tell patients about the new system of team care is well worth considering. Nevertheless the patient must feel and know that it is his family doctor who is co-ordinating this team care and that he is ultimately responsible for it. This responsibility includes ensuring that each team member—be it the newest receptionist or the most senior health visitor—maintains the highest ethical standards and an absolute confidentiality of which not even the doctor would be ashamed. From the operational standpoint there is no doubt that close daily contact at coffee time in the common room in our own practice has proved the best place in which to ensure that such concepts are accepted and the highest standards maintained.

It is perhaps worth remembering in the context of delegated team care that it is the

individual patient who is paying for his care from income tax and national insurance stamps. The family doctor has a responsibility for ensuring that problems are managed at the correct level and that highly paid members of his team are not carrying out humble duties which could well be delegated. Accurate and efficient delegation makes it possible for the more senior members of the team (doctor and state registered nurse) to have more time for either better quality care or care of more patients.

Despite experimental attempts to incorporate nurses, health visitors and other para-medical workers with him in the front line of care it is still to the doctor that patients' thoughts turn when they become sick. The illness can stay solely with the doctor or he can use his team of para-medical workers; he can send his patient for diagnostic investigation; he can refer him to the local hospital or to the more distant teaching hospital; but at the end of the day the patient reverts back to him and belongs to him; the responsibility of the family doctor is to co-ordinate all this care to the individual patient's ultimate benefit. At times opinions will conflict and tests will contradict; the family doctor must sift through the plethora of material, seek further clarification where necessary, and with the whole patient's interest at heart decide upon a course of action.

Conclusion

I hope I have proved that the family doctor's responsibility to the individual is of paramount importance and that it is practicable within the setting of a large group with a complete para-medical team.

There is no end to the responsibilities of the family doctor to the individual—certainly this essay has by no means covered them all. It is however, this very conglomeration of responsibilities which gives such joy to the family doctor in his work. At times the emotional and physical strain of carrying them can become almost overwhelming, but at the end of the day it is their fulfilment in a highly personalized way that gives the family doctor his joy and his reward.

HELPING YOUR DOCTOR TO HELP YOU

The Times on 23 February, 1972 published an article by a paediatrician looking at the relationship between parent and physician. This discussed the role of the general practitioner and the following extracts are taken from it:

" . . . if it is your first visit to a new general practitioner he will need to ask a number of personal questions which may at first sight seem irrelevant to your child's illness. But the general practitioner of today is a specialist in family medicine and to do his job properly he must have a clear picture of the whole family in its relationship together with an idea of your living conditions.

. . . Some doctors are always in a rush—the busy man syndrome. This is seldom the real reason. The good doctor always appears to have all the time in the world to listen to his patients as though you are his only patient that day. The ' busy ' doctor may be one who has not been trained to listen to his patients and can only maintain this state by keeping himself and his patients on the move.

. . . You should feel free to ask for your doctor's help over the most trivial or the most intimate matters.

. . . You should not be afraid to ask for a second opinion and your doctor should not feel hurt if this happens. Doctors ask for second opinions for their own families more often than anyone else.

. . . With the complete relationship with your family doctor of the type I have described it will be obvious that it is always safer to take your ill child to him in the first place rather than the hospital casualty department. The doctor in casualty department will not know the the child or your family and he will probably be a more junior man than your own doctor. The only exception is an accident or poisoning when you should go straight to the hospital."