THE FIRST FORM OF CARE

NEW ideas are emerging about the first form of care that patients receive. In the decade of the 1960s general practice was called ' primary medical care '. This was the title of an important publication by the British Medical Association in 1970, and recently Dr J. A. Forbes at the University of Southampton has been given the title of Professor of Primary Medical Care. The words ' primary care ' assume that general practice is the first form of care. Is this true?

The College (1973) in its new Report from General Practice No 16, *Present State and Future Needs*, third edition, sets the place of general practice differently. Here it is seen as the meat in the medical sandwich between the hospital and specialist services on one side, and self-care, lay care and para-professional care on the other. If this is so, much more attention needs to be paid to the very first form of care that patients receive. This is what Dr Elliott-Binns has now done in his interesting paper published today.

Going to the doctor

It used to be thought that in Utopia patients would consult their own personal physicians for all their symptoms. Self-treatment was expected to wither away and die.

There were three assumptions behind this: first that people failed to go to their doctor because of the existence of barriers; secondly, that patients could never be expected either to diagnose the nature or the severity of their condition; and thirdly that seeing the doctor was inevitably a ' good thing '; self-care seemed second best. All three assumptions are now being questioned.

Self-treatment and barriers

The two main barriers to medical care have historically been poverty and ignorance. After nearly 25 years of the National Health Service the need to pay the doctor has been eliminated and the need to pay for drugs vastly ameliorated, simultaneously British children and adults have been exposed to health education on a scale greater than ever before. Self-treatment, however, far from disappearing has thrived.

At a time when the cost of general-practitioner prescribed drugs exceeds the doctor's income and expenses combined, it is true that for every two pound's worth of medicine prescribed the public paid another pound on medicaments for themselves. Were the old barriers not as important as was thought? Or are new barriers appearing?

Historically the rise of general practice can be seen as the rise of the apothecary because the physicians of the day became remote from the people whom they served. Could it be that general practitioners, seeking to be physicians, are now becoming more remote from the public they serve, through ancillary staff, appointment systems and deputising services? Are the apothecaries once again stepping into the medical vacuum?

Self-diagnosis

Theoreticians have long argued that patients cannot be expected to assess their own symptoms. Most general practitioners will have seen patients treating their myocardial ischaemia for ' indigestion ', and dosing ' altered bowel habit ' associated with carcinoma of the colon with purgatives.

The purpose of a health service is to serve the patient's health, and this means offering treatment where it is effective. Many have shown the mass of unmet need in the community—especially among the elderly. Hypothyroidism, diabetes, depression, glaucoma, hypertension and cancer are among conditions where patients still need to receive earlier diagnosis. Early diagnosis, however, may often depend on the patient consulting early.

However, does a cold in the nose or non-productive coughs of a few hours' duration need a doctor's opinion? How valuable to the patient is such opinion? If professional advice is needed is a doctor always necessary?

If the Government and profession can unite to support an advertising campaign encouraging people with influenza to treat themselves without calling a doctor—a condition involving headache, fever and malaise—why is this policy not right for other conditions? Thus the mere existence of symptoms does not necessarily imply that a medical consultation is appropriate.

Hence the patient's dilemma. When is it right to go to the doctor and when is it right to treat oneself at home? The critical question of the appropriateness of consulting a doctor has attracted remarkably little attention from the profession, the public, and the press.

Cartwright and Dunnell, however, in their recent book, *Medicine Takers, Prescribers and Hoarders*, report that as many as 50 per cent of the doctors interviewed regarded 25 per cent of their consultations as inappropriate. This is not the professional seeking to reduce his workload, as the same doctors considered that patients ought to have come to them for conditions which the patients felt inappropriate.

Could it be that one of the main aims of health education in the future is to synchronise the expectations of the public and profession?

The significance of self-care

The third assumption—the inevitable benefit of medical care—is now also being questioned. On the technical side there is pharmacological concern at the ever-increasing number of side-effects and drug interactions. Many are not being identified; many more have not yet even been discovered.

Vast quantities of antibiotics are being prescribed for minor upper respiratory tract infections often of viral origin, and psychotropic drugs are now being consumed by one sixth of the British population. All this may not necessarily be promoting the health of the nation.

General practice can, however, be credited with having seen the danger and it is already reacting—one in three of all consultations in general practice does *not* involve a prescription.

The significance of self-care is becoming clearer. For two of the major health threats of our time, cigarette smoking and obesity, the extent the individual cares for himself is all important. Parish (1971) showed a fall in the prescribing of anorectic drugs in general practice. This may well indicate a consensus view among general practitioners that obesity is one area where a shift of responsibility away from the doctor and his drugs towards the patient and self-care is now appropriate.

Quite apart from the drugs, some patients become dependent on their doctors. Providing 'support' will always be a major part of continuing care, but can it be overdone? Promoting emotional maturity, in both children and adults, is also important and inappropriate dependency may impede emotional development. Is it possible to

evaluate different forms of management in terms of the patient's subsequent dependency or self-sufficiency?

Interesting implications for the future arise from Cartwright and Dunnell's finding that it is particularly younger practitioners who are encouraging self-care by suggesting that patients buy more of their own medicines.

Sources of advice

The various sources of advice in the community now need detailed consideration. Whitfield (1968) examined the pharmacist's role in the first form of care and Elliott-Binns confirms that this was one of the most often used and most valuable sources.

The public should, however, be further protected at the point of sale. Phenacetin could well be banned and the profession should now be pressing some continental authorities to prevent chloramphenicol being freely available over the counter.

Nurses may sometimes fail their friends or patients, particularly by needlessly engendering anxiety—but how many nurses have been properly trained for this role? Nurses already often advise on the appropriateness of consultation with a doctor and so all community nurses should have specific training on the scope, the opportunities and the limitations of modern general practice.

Indeed, advising other professionals and the public in this way may well prove a significant new responsibility for general practice, and in the long term may greatly improve the quality of the first form of care.

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GENERAL PROFESSIONAL TRAINING

FIVE years ago this month the report of the Royal Commission on Medical Education was published. This was one of the most important documents of the decade and outlined a new concept of general professional training in its blueprint for the future. The principle was simple—that all doctors would undergo a three-year training programme after completing their pre-registration year and before beginning intensive (specialised) ' further professional training '.

This report was warmly welcomed at the time of publication and although much has already happened in the university world as a result, nevertheless during the last year or so somehow the idea of general professional training is being left on the shelf. It is therefore particularly encouraging to read a recent report of a working party of the Scottish Council for Postgraduate Medical Education.

The Scottish Council foresees a continuing trend towards further integration and a progressive weakening of the current rather rigid categories of doctor. It firmly endorses the Todd concept of general professional training: " we believe the concept of ' general professional training ' is right in principle and that it should be implemented in practice ".

In looking at ways of assisting implementation it is noted that the present system