Lessons from bad general practice*

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SUMMARY. The paucity of resources for general practice correlates well with high losses through emigration and questions the expensive over-production of doctors now being undertaken.

The variable quality of community care and the absence of a structure yet providing real planning or capital, leads to the uneconomic abuse of hospital facilities and to an excessive emphasis on institutionalisation.

Medicine is becoming depersonalised because unrealistic expectations lead to an overloading of the service. Simultaneously we allocate a low priority to education in the use of the service, have little training in the sociological aspects of medical care, and even less in how best to use the skills of our non-medical professional colleagues.

Introduction

It is the duty of government to get as much good medical care for its people as cheaply as possible. It is the duty of the medical profession wholeheartedly to co-operate, but at the same time to protect professional standards and recruitment in a world competing avidly for rare medical skills. The emigration figures show that the doctors have already co-operated to danger point. Birmingham loses over ten per cent of its medical graduates by emigration and Aberdeen over 25 per cent (Simpson, 1972).

When senior practitioners are asked by keen young doctors where they can work well in community care with reasonable facilities, it is unfortunate that Great Britain is in this field, too, not able easily to compete. Hundreds of good graduates are voting over the years, like Lenin's peasants, with their feet. The hurried expansion of our medical schools is not a genuine solution when what is needed is the creation of proper resources for the general practitioner. This must include hospital or equivalent facilities and their lack is especially damaging in the care of the elderly. The geriatric patient moves badly, especially when ill, and familiar faces, good personal relationships, and a knowledge of the home are all important factors in rehabilitation or in terminal care.

When we look back, it may well be that the absence of good nursing, physiotherapy, occupational therapy, and day-hospitals directly accessible to the family doctor may well prove to have been one of the decisive deficiencies in the medical care of an ageing society. These are available only to a minority of doctors in the small market towns and rural areas. In the cities, where the need is greatest, their absence is for practical purposes total.

With one practitioner to every 2,500 patients and one geriatrician to every 225,000, where these services exist there is little room for jealousies or demarcation disputes. It must be accepted that the best protection for the patient is a well-trained and well-equipped general practitioner. The training is happening now. The equipment must come soon or the new doctors will leave. A country with more skills than facilities is bound to lose—and is losing—her doctors to countries with more facilities than skills.

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We must accept that the first 25 years of the National Health Service were its halcyon days, and that this period is now over. There have been superb triumphs and much levelling-up but much remains to be done that will have to wait.

The hospital service has recently been having a difficult time. Short of nurses and of money, with scores of unskilled vacancies for consultant posts, underpaid by the standards of many countries, with junior medical staff working a shorter week in an era of industrial action uninhibited by any professional attitudes, we have seen demonstrated, as clearly as in any concentration camp hospital, that medicine cannot be separated from the society of which it is a part. Yet this kind of deprivation, which has been so apparent in the hospitals during recent months, has been the lot of general practice less ostentatiously not for months but for decades.

General practice has perhaps not been as neglected as geriatrics or the care of the chronically handicapped, and it is to the eternal credit of the politicians that they refused any longer to accept the inappropriate priorities devised by a medical profession excessively preoccupied with the fascinating problems of acute medicine rather than the needs of the community.

Furthermore, the neglect of general practice has been to some degree a self-inflicted wound. The gulf between general and hospital practice was required by the profession itself. We in general practice have clung so desperately to our independent status. Yet many of those who would have preferred a more integrated approach and even hankered for a full-time salaried service a few years ago have now seen too much of harassed governments who react only to militancy, and whose health care planning uncomfortably mimics the desperate improvisations of a bankrupt travel agency.

Lessons to be learnt from bad practice were not selected for this lecture just to add a small personal cheep to the swelling fugues of economic gloom. It was felt timely because the allocation of resources is to preoccupy those in health care over the next few years just as much as politicians will be debating the redistribution of wealth—and for the same reason: reallocation is so much easier than the creation of new resources or new wealth.

Furthermore there is a tendency for outsiders to think of the College as living among hopelessly atypical practitioners who are dripping with dedication and dietitians, journal clubs and social workers, and problem-oriented medical records—to the neglect of the harsher realities. This image is not only undeserved, but should be seen to be undeserved. Our province is the whole spectrum of primary care.

Let us then, against this background, seek to discuss some of our other major areas of weakness.

General administrative background

The reorganisation of the National Health Service has been abysmally ill-timed. It was however a proper and inevitable response to certain profligate phenomena that could not indefinitely be borne. For example, the hospitals are getting increasingly and expensively specialised at the same time as over a quarter of hospital admissions are indicated apparently only because of the poor resources available in primary medical care (Torrance *et al.*, 1972).

An even higher proportion of outpatients—perhaps up to 80 per cent—were referred without any preliminary, elementary, obviously relevant investigation by the general practitioner, and outpatient follow-up was wastefully continued at any rate to some extent—other factors also come into this—because of the unreliable quality of the medical supervision available in the community. One survey found that 40 per cent of referrals and 50 per cent of follow-ups were probably unnecessary (Wade and Elmes, 1969).

The separation of the family practitioner services has meant that hardly any intelligence-gathering or forward planning for that service could be carried out. The main mechanism for ensuring the continuity of general practice has been through the piecemeal and crisis-intervention routine dedicated merely to the replacement of retirement vacancies. This system in no way encourages or even permits planning to cope with the major movements of population now routine in our major cities. For new estates or towns inducements may be offered, but in the most difficult areas inducements are gravely restricted by the designated area allowance being dependent not on the local needs but on the number of local practitioners. This allowance has failed as it was bound to fail; and there is still a tendency, despite the many improvements over the years, ranging from free disposable syringes to the reimbursement of rates or staff salaries, to have as the most profitable form of general practice the longest list combined with the poorest facilities. The larger the list, the higher the income; and the poorer the facilities, the less they will be used so that the larger list can be more easily dealt with.

Such a situation allows a professional isolation predictably associated with an unsatisfactory standard of care, in which the only real pride left is in the sheer number of patients seen. In such practices it is by no means uncommon for a single practitioner to see well over 100—even 150 patients in a day. Such an excessive workload sometimes is associated with good quality care and usually it is better than we have any right to expect.

Often, however, it leads to concentration on survival rather than on clinical effectiveness, and either to the demoralisation of the doctor or to an excessive adjustment to his predicament and the referral to hospital of every patient who merits any kind of investigation.

The hospital consultant may feel harassed and coerced in comparing his results, his methods, his average duration of inpatient stay with local and national figures, and in defending his management in discussions with his junior staff. Such peer-group evaluation is greatly missed by the isolated practitioner who has time to check over far fewer even than the 52 per cent of patients examined in a university practice survey (Scott *et al.*, 1960). No doctor entered the profession with this sort of cattle-market medicine in mind.

How can we help?

First, the profession must accept some responsibility for the forward planning of primary medical care. Part-time appointments of general practitioners should be arranged, at least on an experimental basis, to work with the administrators of the family practitioner committees and the area health authorities in order to look at such problems as the pattern of imminent retirement vacancies, elderly single-handed practitioners being a special interest and also future needs for health centres. Such an intelligence-gatherer must liaise with area and district plans and with those in charge of rehousing programmes and must not work in isolation, but with the knowledge and approval also of the local medical committee.

The single-handed practitioner operating from his own home or from a modified shop is capable of first-class practice. But new entrants to general practice, who might feel inclined to accept the challenge of rundown areas, will not saddle themselves with the mortgage needed to buy large old houses and elderly doctors defer their retirement in the hope of an eventual purchaser. The small shop-front surgery is rejected because by modern standards it is inadequate and a second, even small, mortgage—one for the home and one for the place of work—is unacceptable in any case to the young doctor trained towards health-centre practice.

A fund of several hundred thousand pounds—but spread over many years—is needed in most of our cities, to buy up these practice headquarters through area health authority funds, in order to put in suitable young doctors chosen through the usual

channels, but linked perhaps with a neighbouring group practice or a university department of general practice, to help initiate and maintain good standards of care until the capital resources for aggregation into small well-equipped health centres become available. Then the old premises can be disposed of or converted to the hostels of which we are in such need. At £15,000 per practice the expenditure should compete favourably with larger-scale projects in cost-effectiveness.

Personal care and our colleagues

The health-centre concept has taken a buffeting recently, but this may be because we confuse performance with potential. Certainly patients seem to find it more difficult to relate to " their doctor " in a sort of dehumanised airport lounge. Bad medicine can still survive in the more open exchanges of a health centre and even if leopards can change their spots, they do so gradually and not overnight.

Receptionists can be ill-trained, ill-mannered under pressure, and inquisitive to an improper degree when seeking to judge—as they must do somehow—the urgency of a request to be seen. The staff will have great difficulty if there is an inadequate number of consulting appointments, and it is not unknown for receptionists to find the post intolerable and the practice to scrap its appointment system and to go back with a sigh of relief to its old ways.

A rigid and unsatisfactory appointments system can be a potent factor in the inappropriate use of accident and emergency departments and a system should be classed as unsatisfactory if there are not something like ten per cent of appointments that can only be booked on that same day.

Some appointment systems have been initiated without adequate staff and without the extra telephones needed. At the same time, receptionists have at times had an excessive and improper delegation of responsibility imposed on them by their doctors, especially in the field of repeat prescriptions. Clearly we must encourage the specialised training available for our secretarial staff in an increasing number of colleges of education and we must help them further by supervision that is neither excessive nor inadequate.

Just as it is desirable for all medical and social work students to work for a spell in an old people's home, so every vocational trainee should have a few hours on reception, dealing with the telephone and the callers, and seeing what his practice looks like from the edge of the waiting room.

Coincident with the increased through-put of patients that can be seen in a well-organised headquarters has been the well-documented decline in doctors' home visiting. The former graciously high frequency of domiciliary consultations was a pre-antibiotic phenomenon when the doctor had little to offer but himself. Before the contractual obligations of the health service, repeated visits were also the way in which the doctor made sure of his income. The laudable personal involvement of the physician carried also an element of staking his claim and it is clearly right that this should not survive today without clinical need. Some figures from across the Atlantic indicate the transformation even in a survey of eight years ago (Gross, 1966) of 1,000 doctors 25 per cent made no home calls and 60 per cent made only one to five house calls in a week. Twelve years ago in Edinburgh one third of the doctors' services were provided in the home (Scott and McVie, 1962).

In this situation the detailed knowledge of the home circumstances of the patient—formerly one of the great strengths of the general practitioner—is becoming spurious and incomplete. The cleanliness of the household, its social atmosphere, its warmth, its stairs, its lavatory, the number of cakes on the table or empty whisky bottles under the sink, all these are clinical signs that cannot be elicited in any health centre no matter how well equipped, and our medicine is the poorer for this loss. The clock cannot be put back,

the doctor's time cannot be dissipated in chauffeuring himself to elderly patients off the bus routes. The answer must surely be to reserve carefully a few visits for oneself so as to keep in touch, and to exploit far more effectively the professional skills of our colleague known as the health *visitor*.

Nurses in general practice

Of course, the health visitor like everyone else varies in quality. There are many superb colleagues whose attachment to general practice is close, valuable, and appreciated. It seems, however, that there are still many attachments in which the health visitor is suspect, and the doctor insecure, rigid, or unhelpful, whilst the health visitor is herself preoccupied with other duties irritatingly irrelevant to the needs of the practice.

District nurses too are not always as welcoming to the health visitor as they might be, and many of these accepted and trusted allies of the doctor could also benefit from instruction in how to exploit the health visitor's gifts. Although two thirds of district nurses wanted to spend more time with their terminal patients, 43 per cent of them thought that health visitors had no part to play in terminal care (Cartwright *et al.*, 1973).

Social workers

No matter how difficult it is for the health visitor to create easy professional relationships with her colleagues, the situation is even more unsatisfactory when we look at co-operation between doctor and social worker.

We know that in an ideal situation a social worker can be fully employed in a two or three-doctor practice. We know that many social services departments are viciously below their staff establishment, the demands on their statutory services are expanding and their capital resources are shrinking. Furthermore, since it is the condescending and unhelpful attitude of the medical profession that helped to provoke the social workers to independence, inter-professional relationships are either difficult or non-existent. As both doctor and social worker are in such similar predicaments, the stage is set for some interesting fantasies.

The doctor thinks of the social worker as a young girl of strange attitudes and even stranger wardrobe, who takes a fiendish delight in not allocating the home help or the place in the old people's home to his patients in obvious need.

The social worker thinks of the doctor as an elderly gentleman smelling of moth balls and sherry, who works a four-day week, reserves all his energies for the golf course, and cannot even remember how to examine a patient. This reciprocal ignorance is something that the community cannot afford. If the medical and social work resources were skilfully integrated and cooperated fully together, they would still prove permanently inadequate.

In one northern city the establishment of hospital-based social workers is said to be far too low; but the ratio of social workers attached to hospitals compared with those attached to the 250 general practitioners is as 40 to one. This surely must be unacceptable to all save the most irretrievably backward-looking cities and professions. In these circumstances the care of the handicapped and the elderly must be both more inefficient and more expensive.

This situation has not been so much constructed as drifted into, and this city is no worse than any other. Both professions have connived at the hostile administrative structure and acquiesced in the psychological barrier that is still being defended and perpetuated. In time this will pass, and younger doctors and social workers, long before the end of the century, will wonder how it ever happened.

Meanwhile brief meetings in practice headquarters, perhaps over lunch, are worth arranging so that those looking after the same people in the same area, but from the different viewpoints of doctor and social worker, can discuss each other's problems. The

sessional attachment of social workers to work in practice headquarters is rarer but more natural. Perhaps an even more fruitful approach would be to get medical and social work students to work together—the joint visiting of cases of drug abuse might be a suitable project—before these professional prejudices have become set in concrete.

The social content

All this is not made easier by the fact that many of the doctor's patients are suffering from a social rather than from a purely medical disability, and the doctor's training in this area is likely to be haphazard and unreliable.

Let us try and demonstrate this problem by quoting from a small survey of psychiatric readmissions to one of our local hospitals. Aproximately 110 consecutive psychiatric admissions were reviewed (Hargreaves, 1974), all of whom had had previous psychiatric inpatient treatment. We found that 43 were under 40, 47 were in the 40–60 age group, and only 21 were in the 60–79 age group. None were over 80 so they were a young to middle-aged group. The dominant diagnosis among the males was schizophrenia (27) and among the females it was depression (29). Of this series 75 had needed admission up to five times, 20 up to ten times, four patients up to 15 times, three patients up to 20 times, and two had needed admission on more than 20 previous occasions. These patients had spent something like a total of 100 years or more in the hospital. It is not surprising that 48 of these highly selected and difficult cases were thought to be in need of sustained long-term shelter or support or that the hospital's readmission rate was said to be between 50 and 70 per cent.

But after discharge the general practitioners stated that they saw only 27 of these intractable cases regularly, 30 occasionally, five very rarely, and four the general practitioner confirmed that he never saw at all.

It seems clear that here there must be a massive social need that is being allotted by default to psychiatrists and to general practitioners who are either unable or unwilling to deal with it. What is needed for these people and their families is community involvement, social engineering, sharing and caring. What they get are tricyclic antidepressives and phenothiazines.

Clearly there is a case—especially since the referral rate of psychiatric cases to the after-care services of the local authority is less than five per cent, so demonstrating that if you do not provide a service, demand for it will cease—for the general practitioner to delegate to nursing colleagues far more than has been routinely acceptable as yet either to the community or medicolegally. This delegation needs to be developed if for no other reason than because community expectations increase while financial resources shrink. Delay has been partly due to the traditional attitudes, but also because of the brutal fact that it has been easier to get hold of a harassed doctor than a nurse. The detachment of psychiatric nurses to the community would probably do more to reduce psychiatric readmissions than any other simple procedure and the use of skilled nurses should of course not be restricted to mental illness alone.

Sickness certification

Social problems occur on an even larger scale in general practice with sickness certification. I quote extensively from a recent fascinating review (Taylor, 1974).

In the year ending June 1972, 324 million working days were lost by medically-certified sickness. These figures exclude all absences of three or fewer days. One hundred million of these days were because of disabled people who were staying on sickness certificates until their attainment of pensionable age. It would ill become a profession, so bad at drawing its own pension for more than 18 months, to carp at the size of this group. Seventeen million working days were lost through industrial injuries. Over the years a

decrease in certificates notifying urinary infections, skin diseases, gastritis, asthma, appendicitis, and pneumonia could be ascribed slightly to fashion, but probably to more therapeutically effective intervention. However, there have been increases in the loss of work certified as due to sprains and strains, intervertebral disc lesions, diabetes in the over 40s, gastroenteritis in patients of the 20–35 years age group, heart disease, neurosis, migraine and, of course, bronchitis. What is more disturbing is the great increase over recent years of short-term absence from work, especially for periods of up to three weeks, by the younger workers who take more time off as they get older.

There are different patterns for the different areas of this small and, one would think, culturally homogeneous country.

What is it that causes an increase in sickness absence rates over the last 20 years in Wales to be 52 per cent, in the North and North-west 46 per cent and 40 per cent respectively, whilst in the West Midlands it is 16 per cent and in East Anglia and the South-east it is only one per cent? Surely the answer will come from the sociologist rather than from the clinician, yet we have failed save in a few centres even to attempt to expand our knowledge. In the meanwhile we are issuing sickness certificates, for practical purposes, on demand.

Infant mortality

We hear rather less about this and much more about abortion on demand, and there is certainly room for anxiety here too—an anxiety in which I share—even though the rate of increase of abortions seems to be levelling out. It is an interesting possibility however that the request for abortions may not be such an undirected or ill-disciplined demand after all, even though the doctors are not fully controlling or directing it.

The infant mortality rate has diminished during the last half-century from 90 per 1,000 live births to 23 in the period 1956–60. It has dropped only minimally since then, being 19 in 1966, 18 in 1971 and 19 again in 1972. There are signs, however, that over the last two years there is a definite decrease—even from 18.8 in December 1972 to 17.7 in December 1973. It may be—and it is of course too early to be sure—that the women presenting for abortions include enough of the grand multipara and the unmarried young mothers—who have babies especially at risk—to cause a decrease in infant mortality. This could be a phenomenon that needs prudence and patience before coming to any final or dogmatic judgment.

Prescribing

It is probably wise to wait also before we judge too harshly our own prescribing performance. Much of the data from Parish's classic monograph (1971) and other surveys (Royal College of General Practitioners, 1973) will be familiar—that each practitioner prescribes drugs to the value of about £8,500 annually, that much of this goes on psychotropic drugs, that cases of intentional drug overdosage are the commonest medical emergency admission, and that in about 80 per cent of these admissions the source of the drugs is the general practitioner (Smith, 1972). The scope of drug-taking and the importance of the repeat prescription are, like the psychiatric readmissions, further instance of medical men trying to deal with the malaise of society by purely, and at times unsuitable, medical means.

These patients are lonely, delinquent, bereaved, deracinated, frustrated, disappointed, under all sorts of stress, labouring under a whole century of winters of discontent. They are not necessarily ill. They need counselling, comforting, supporting, help in social adjustment. We often try to provide this, aware almost subconsciously of their need.

Our problems start when, because patients come to us after our years of hospital-based training, we think that they must be ill. Clearly a very small health service could

have magnificent equipment and ancillary staff if we only dealt with the ill: but the general practitioner has the privilege of dealing with patients and not with pathological processes, and we try to palliate many problems by, when uncertain, giving the patient whatever we have to offer. On 50,000,000 occasions each year, this may be a prescription for the nerves. Since the practitioner has no real resources save his prescription pad, one cannot be surprised that he uses it. But there are signs of increasing awareness by both patient and doctor. It is a matter for pleasure and pride that one local medical committee has supported a voluntary ban on ' Mandrax ' and on barbiturates for all new patients unless they are epileptics. This would have been unthinkable a decade ago.

Calls out of hours

It is natural in a leisure and pleasure-orientated society that our tolerance of patients wears thinner outside usual working hours. Although more elderly doctors or small groups use the deputising to make life more bearable, it is probably not only the diminished work load but also the freedom from the unreasonable late call that has made the deputising services a valued aid to over half of the practitioners in our big cities.

The surveys from the Sheffield Department of Community Medicine showed that about five per cent of home visits, 50 per cent of night calls and rather less than one per cent of doctor-patient contacts were performed by the deputising service in the Sheffield-Nottingham area (Williams *et al.*, 1973).

Of 1,000 night calls analysed (Couter *et al.*, 1953) 25 per cent were unnecessary and 63 per cent were only mildly ill. Another series of 200 consecutive night calls again found that 25 per cent were unnecessary (Forbes, 1955). These are American surveys since this is not an exclusively British or National Health Service problem. In a Saskatoon survey of house calls 28·2 per cent were genuine emergencies and 32·8 were classified by the doctors as reasonable (Wolfe and Badgley, 1972). No treatment was given to 13 per cent, but some follow-up was thought desirable for 67·2 per cent.

It seems that here again we are dealing to a variable degree with social attitudes and fears—with wants rather than needs. To improve our present management of this vast reservoir of demand, calls for the education of our patients, starting in the schools but going on at practice level, from the doctor or the health visitor, or both, through discussions with patients about the proper use of a National Health Service. Surely such training would demand comparatively little effort when compared to the wasted time and energy that could be saved as a consequence. We also require a major re-emphasis in medical education at both postgraduate and undergraduate level, so that the sociology of illness and discussions on sick notes and symptom-control and patient-education would at least rank in importance with the rarer congenital metabolic abnormalities.

Education towards more economical prescribing could be made effective by the abolition of prescription charges, but only for those preparations listed in a modified *National Formulary*. Here again, the involvement of patients in their own destiny would surely in most cases be helpful.

Deputising services can be used for teaching students—this has been done successfully—and because of their speed of access these services could play a valuable role in such tasks as the assessment and treatment of acute coronary emergencies. Training and equipment could more easily be standardised than with ambulance crews whose aptitudes are likely to be more variable. Such teaching and research responsibilities are likely to keep interest and recruitment to a high standard and may well play a part in the up-grading of primary care.

Patients' point of view

Finally let us look from the patients' viewpoint at the attributes desired in the perfect general practitioner.

Continuity of care should come well up in the list, yet it has already been eroded by groups, rotas, and deputising services and in any case 70 per cent of our patients see their doctors for 30 minutes per year or less. In the Milbank Memorial contribution about Saskatoon already quoted (Wolfe and Badgley, 1972) we see that over a period of 15 years more than half of the patients in that area will have moved, and because of doctor turnover over a five-year period one in three patients will have had to find a new family physician. This may, in a few years, be nearer the truth here than Ann Cartwright's finding that two thirds of adults in 1967 had had the same doctor for at least five years (Cartwright, 1967).

The tendency for chronic diseases of real importance to be the responsibility of hospital outpatient departments makes continuity of care nearly unattainable. General practitioners with special experience in such suitable fields as hypertension or diabetes should be part of the hospital outpatient team and given special liaison responsibilities for the return of selected patients to their own doctors for routine day-to-day management. The consultant can then become again a consultant, available for the management of difficulties or for the rare but thorough evaluation of the patient's clinical state.

The Saskatoon patients tabulated their preferred attributes of the family doctor in the following order (Community Health Services, 1969):

He should be a thorough and accurate diagnostician, 78 per cent.

He refers to a specialist when necessary, 73 per cent.

He is willing to visit, 46 per cent.

He is interested in getting to know the patient's family, 43 per cent.

He has modern equipment, 8 per cent.

He is willing to prescribe what the patient wants, 2 per cent.

This last low figure is particularly gratifying. It all seems justifiable enough and does not involve any unreasonable crying for the moon. Could it be that patients are people just like us? Could it be that we lose our way a little if our patients are not our friends?

Conclusion

Let me conclude this very personal and superficial survey and bring the carping into proportion, with two quotations. The first is from Ann Cartwright's *Patients and their Doctors* (1967) and it warms the heart:

> "Eighty-five per cent of patients had a family doctor in that at least one other relative had the same doctor.
>
> Two thirds thought that if they met their doctor in the street he would know them by name.
>
> Ninety three per cent felt their doctor was good about listening to what they had to say, 88 per cent that he was good about taking his time and not hurrying them, 75 per cent that he was good about explaining things to them fully.
>
> Twenty eight per cent thought that, if they were worried about a personal problem not strictly medical, they might discuss it with their doctor.
>
> These are the not inconsiderable achievements of general practice at the moment."

If we can do this now, what with better resources could we not achieve?

The second quotation will perhaps encourage those who agree that the resurgence of

general practice is inevitable and beneficial in this country but that problems of quality-control will be with us for a long time, when a typewriter, a refrigerator or even a vaginal speculum are not possessed by 30 per cent of practices (Irvine and Jefferys, 1971). The second quotation is from that great medical educationist Abraham Flexner who said " The sick man is relatively rare for whom actually all is done that is at this day humanly feasible." Some of you may, like me, derive obscure but genuine comfort in these bewildering times from the fact that those words were written in 1910.

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