EDITORIALS

Systematic surveillance

ONE of the most striking and important changes in general practice since the second world war has been the change of emphasis of many consultations. Throughout the nineteenth century and up until 1939 the vast majority of consultations were initiated by patients. Going to the doctor was seen as a patient's decision: the idea of the doctor sending for patients or seeing patients on a regular basis was hardly recognized.

Starting with antenatal care and then rapidly spreading to child care surveillance, geriatric surveillance, and contraception, an entirely new system has begun to emerge. Increasingly doctors are choosing to send appointments *before* there is illness, usually for some form of preventive medicine. In some practices a doctor-initiated consultation has become the second or third commonest reason for a patient seeing a doctor at all.

A second and quite separate trend has been the gradual emergence of chronic as opposed to acute illnesses in general practice. Slowly improving standards of living and nutrition, coupled with the introduction of antibiotics in the 1940s and widespread immunization, have made many of the common children's diseases such as measles both less common and much less severe. As a result, proportionately more consultations are taking place for behavioural problems and chronic disease. The problems of the chronically handicapped loom larger and larger because of the greater number of handicapped children surviving, the recognition of chronic disorders of childhood, such as asthma, and the rising number of the elderly in the population.

Gradually it is coming to be recognized that patient-initiated consultations are not adequate for long-term supervision of patients with chronic handicaps and the concept of regular monitoring is being introduced. Blood pressure checks, peak flow checks, and testing blood levels for serum anticonvulsants have all become part and parcel of the everyday management of hypertension, asthma, and epilepsy, and are likely to remain so. The trend towards miniaturization with such aids as the mini peak flow meter is probably only a start to a whole new range of devices which will enable general practitioners to measure the progress of chronic diseases more and more accurately in the future.

Surveillance, however, is achieved only at a price. If the doctor takes the initiative and sends reminders to defaulters, an image that 'big brother is watching' is soon created.

Practice management

The concept of systematic surveillance of chronic handicaps, whether in children, adults, or the elderly, coupled with systematic monitoring of relevant age groups—girls for rubella, women for cervical smears—is throwing a new responsibility on doctors for practice management.

Age/sex registers, simple diagnostic registers, and secretarial systems which can comfortably cope with these new arrangements are needed more than ever before. Practical preventive medicine is not possible without them.

The first so-called revolution in general practice took place in practice organization and paradoxically the wheel is coming full circle: the implementation of systematic surveillance for the handicapped and for preventive medicine may now depend as much on good practice organization and records as on medical skills.

Day care surgery

FROM the patient's point of view, much of the inconvenience and disturbance associated with routine surgery lies as much in going into hospital for a week or so as in having the operation itself. For women the disturbance of leaving the home and family can be so great that it can often deter them from accepting elective surgery at all. The case for day care surgery arises partly from these considerations and partly from pressure to save money in a health service in which demand is poured like a quart into a pint pot of financial resources.

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