ASPECTS OF PRACTICE

Our practice guidebook

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In partnerships there is rarely evidence of an agreed collective approach to patient care; its provision still tends to be disorganized and haphazard. Medical decisions continue to be based on conjecture in definition and improvisation in management, both of which are liable to daily fluctuation from partner to partner. A further complication is the fact that there is no agreed best solution for so many of the problems of general practice.

IT is not surprising that occasionally our specialist colleagues express concern about the standard of clinical care in the community. Voluntary bodies also are beginning to voice anger at the apparent lack of organization and interest in general practice for the management of chronic disease. Patients themselves, though by and large satisfied, now increasingly expect better and more service from their general practitioners.

If we really wish to answer our critics and to respond to their expectations, we shall have to start with a re-examination of our long held beliefs and working methods. This certainly implies a reappraisal of our cherished notion of clinical freedom which has often been the excuse for many of our deficiencies. Each practice will have to decide for itself the range of problems requiring solution and the strategies for dealing with them. Once consensus has been reached, to avoid later confusion and doubts, the agreed policy should be recorded in detail for subsequent implementation. The success of such an approach depends entirely on a rigid adherence by partners and staff to the agreed guidelines.

Our experience

In our practice of three partners, we decided to devise a guidebook. At present this is a 40 page loose-leaf binder, incorporating all the major decisions that the partnership has considered and agreed. They range from organizational aspects of the practice, such as the appointments system, coping with the elderly and infirm, duties of various members of the staff, to more clinical topics, such as the care of diabetic patients, hypertension, asthma and the provision of cytology and immunizations.

Each clinical topic is set out in the classical format of diagnosis, investigation and management. The guidelines are not a repetition of hospital textbooks. They are based on their relevance to general practice in general and to our practice in particular. The treatment, when appropriate, includes first and second lines of therapy with a list of specific drugs for use. The clinical procedures that should be followed at each consultation for a particular condition are laid down. The methods for call and recall of patients requiring follow up are clearly defined.

Annual Review

At the end of each year, the effectiveness of each policy in terms of benefit to the patients, the doctor and the practice, is evaluated. If necessary, alterations and modifications are made.

The practice guidebook has been a welcome source of reference for our new trainees who often would like to know exactly how the practice copes with a particular problem. The practice staff seem delighted with the idea as it has reduced the possibility of misunderstanding and friction. It has also provided them with an easily accessible and carefully thought out plan of management for most problems encountered in practice.

As far as the partners are concerned, they now know exactly what the practice expects from them when faced with a specific condition. There is little room for excuse.

With our almost uniform approach to many conditions, patients are now less likely to be confused by our management. This may result in improved compliance. The rationalization in prescribing that has occurred could improve cost-effectiveness.

THE COLLEGE OF HEALTH

A new College was launched in November 1983—the College of Health. Marianne Rigge, the director, outlines some of its aims and views.

PRIMARY health care is the accepted jargon for what you get when you go to your general practitioner or when the health visitor calls on you. In fact of course, the real primary health care is what people provide for themselves. It is not just a matter of treating our own coughs and colds, bruises and burns, but of the way we live our everyday lives. The woman in the supermarket who opts for wholemeal bread rather than the white sliced variety and gets her children to eat fresh fruit and vegetables, the middle-aged jogger puffing round the park, the adolescent eagerly reading a magazine article about how to lose weight or get rid of spots, the pregnant woman who says no to a cigarette, the people who sign on for evening classes in yoga or dance: all these people are the real providers of primary health care. Quite rightly they do not think of themselves as patients any more than they think of themselves as health cranks.

Change of image needed

But take any of these people and put them in a doctor's waiting room or, worse, the outpatients' department of almost any large hospital and their view of themselves will have undergone a change. They will more than likely have

College of Health

Chairman, Lord Young of Dartington
Vice-Chairman, Dr Anthony Bowyer, Consultant, Torbay Hospital
Director, Marianne Rigge

Vice-presidents
Dame Elizabeth Ackroyd, *Chairman, Patients' Association.*
Alberic Fiennes, *Clinical Research Fellow, St George's Hospital.*
Professor Charles Fletcher, *President, Action on Smoking and Health (ASH).*
Sir George Godber, *Former Chief Medical Officer.*
Peter Goldman, *Director, Consumers' Association.*
Dr Andrew Herxheimer, *Editor, Drug and Therapeutics Bulletin.*
Naomi Honigsbaum, *Chairman, Paddington Community Health Council.*
Dr John Horder, *Former President, Royal College of General Practitioners.*
Lady Lovell-Davis, *Director, National Association for the Welfare of Children in Hospital Charity (NAWCH).*
Professor Ian McColl, *Professor of Surgery at Guy's Hospital.*
Eirlys Roberts, *Former Editor, Which? Magazine.*
Jean Robinson, *Lay member, General Medical Council.*
Dr Tony Smith, *Deputy Editor, British Medical Journal.*

been transformed into passive recipients of someone else's decision about what they should take, or do or have done to them. Look up the word 'patient' in Roget's Thesaurus, and this negative image is confirmed:

> 'Sick person; sufferer; inpatient; outpatient; case; stretcher case; hospital case; mental case; madman; invalid; chronic; valetudinarian; hypochondriac; martyr to ill-health; crock; old crock; cripple; weakling; sick list.'

Part of the problem which needs to be overcome if people are to play a more positive role in the promotion of health care is that they—patients and doctors— all too easily accept the fiction that there is a sharp line of distinction between the illness or disease which may suddenly strike and the rest of their lives.

One of the main reasons why every one of us should be better informed about health and the health service is that we shall be very lucky (and certainly depart from the norm) if we never find ourselves at the receiving end. *That being so, the longterm aim of the College of Health will be to change the image of patients—both their own self-image and the image professionals have of them.*

Improved communication

Ignorance and misunderstanding can too easily prevent patients from making the best of the resources of the health service. Cooperation with the medical professions will be essential—indeed the College of Health will rely on doctors, nurses, health visitors and others to give much of the practical advice needed by its members. Improvement of communication could help both sides—patients to understand more fully the role of doctors and doctors to understand why they sometimes fail to get their message across to patients.

As the recent initiative of the Royal College of General Practitioners in setting up a Patients' Liaison Working Group has shown, doctors are increasingly concerned that patients should have a greater say in the provision of health care. That is to be welcomed. The people most qualified to judge whether care—or at least the manner in which it is given—is satisfactory are those at the receiving end.

The College of Health will seek to improve communication between patients and the medical professions in a variety of ways:

Education. The College will provide courses which people interested in health can follow in their own homes and in their own time with the back-up of qualified tutors and with tapes and video cassettes where appropriate.

Information. The College will publish a quarterly magazine covering every aspect of health education, promotion and care and will encourage as much lively debate as possible between lay people and professionals.

Research. The College will encourage and promote research on the needs, points of view, understanding and misunderstanding of consumers of the health services. Though studies carried out in virtually all Western countries have reported high levels of patient satisfaction with health care there are no grounds for complacency. Research has also shown that patients are more critical of the inadequacy of information they receive from doctors than any other aspect of health care[1] and that they particularly appreciate being involved in making decisions about their health care. The benefits of greater patient participation would by no means be one-sided. Patients and doctors could and should speak with one voice on the need for more and better resources for health care. And by working together much could be done to improve the use of existing resources. Some at any rate of the preliminary work for research projects could be done by members of the College, some of whom could, in this as in other respects, become trained laymen. As such they would represent a valuable additional resource in the health service.

Promotion of self-help groups

Self-help groups are a rapidly growing phenomenon and one which the College of Health will seek to encourage and promote. They have been formed for almost every disease, disability and misfortune that can befall people. Self-help groups are a thriving example of how patients can help themselves and one another but they are also a reminder that despite the tremendous advances that have been made in modern medicine there are still countless people for whom it can do little or nothing. What self-help groups offer that professionals cannot is a bond of shared experience. The most sympathetic doctor in the world cannot fully understand the feelings of the patient who is diagnosed as incurable or of the parent of a handicapped child or of an addict who is suffering the agonies of withdrawal. It is only a fellow sufferer who can do that. In a self-help group the distinction between helper and helped is blurred and the patient ceases to be a passive recipient of someone else's specialist knowledge. Indeed the very illness or handicap which would normally be regarded as a stigma becomes a qualification for joining the group in which the true specialist is the one who has the experience of the illness or handicap. That is not to say, of course, that professionals do not have a role to play. Many self-help groups work closely with doctors and many doctors acknowledge and welcome the contribution of the self-help movement. The College of Health will certainly not attempt to introduce unnecessary demarcation lines but will encourage greater awareness all round of the possibilities for improved health care.

The alternative health service

As the self-help movement has grown in recent years so too has the practice of what has come to be known as alterna-

tive medicine. Some people turn to osteopaths, homeopaths or acupuncturists only when orthodox medicine has failed them, others become interested in the more positive aspects of health promotion that they offer. The medical profession, being as conservative as any other, has been a good deal less enthusiastic about acknowledging the contribution of alternative medicine than it has that of self-help groups. By the same token there is a tendency among adherents of the alternative health movement to adopt an anti-NHS stance. The College of Health will encourage bridge-building between the two medicines, conventional and unorthodox, and greater awareness of what each has to offer.

Membership

It is hoped that in time local branches of the College will be set up by groups of members interested in promoting health care and education in their own communities. A number of people with whom we have had preliminary discussions have expressed an interest in helping to promote local activities. We hope too that people who already belong to local groups such as self-help groups and community health initiatives will join the College. Membership will be open to anyone with an interest in health promotion and care, and medical as well as lay people will be encouraged to join. The initial subscription could be £10 per annum. In return members will receive the quarterly magazine and have the right to buy booklets, hire videos and participate in courses at a reduced rate. They will also have the right to elect a national committee.

Advisory services

In general the College of Health will concentrate on building up links with existing organizations and networks so that wherever possible people could be referred to the most appropriate source of help near their homes. Where a national organization has particular expertise we would seek to work closely with it.

Reference

1. Pendleton D. Patients' views of general practice. *J Roy Coll Gen Pract* 1983; **33:** 5-7.

LETTERS

Letters are warmly welcomed as an important feature of News and Views. Contributors may wish to express opinions about previous articles or letters in the Journal. In addition, ideas, experiences and (clinical) observations about patients or practices may be very relevant and of interest to other members.

Editor, News and Views.

Doctors and the Pharmaceutical Industry

Sir,

Only if you believe that the post-marketing surveillance of drugs is an unimportant activity can Professor Howie's letter be justified. It is certainly a very difficult enterprise and it might be reasonable for him to say that it is so difficult and so unlikely to give benefit that we should not embark upon it. Of course, I disagree, but that would be a tenable view for him to express. He has, however, expressed neither of these points, and his letter could only be considered constructive if he had suggested better ways of carrying out post-marketing surveillance.

I know that Professor Howie takes a rather narrow view about epidemiological studies in general, and that he is much more comfortable with a tightly controlled clinical trial. I can understand and respect that view, indeed I would probably feel more comfortable myself in that situation, but it has not fallen to my lot to conduct that type of study.

The object of the early studies is to get a feedback in a comprehensive way, about the experience of general practitioners and their patients when using a new drug. In this particular case (Suprol) it happens to be a drug from a group which has given rise to perhaps more problems than almost any other, and so there is a particular need to monitor it. No, it is not naive to record the clinical indications for which the drug is used. Given that a doctor has agreed to use it, it is entirely valid to collect information about the conditions he has felt were appropriately treated with the drug. Professor Howie's view that 'efficacy, safety and overall acceptability' cannot be assessed outside a double-blind controlled clinical trial is negated every time he sees a patient and assesses the response to treatment. Of course the assessment is subjective, both on the part of the doctor and the patient, but it is that subjective response which it is valuable for us to collect. He implies that that would give an inevitably favourable view of the drug under investigation. There is absolutely no justification for that opinion. An adverse impression is equally likely to be obtained.

He has completely misunderstood the third objective 'to record the incidence of clinical events'. The whole point of this exercise, which has been termed event-monitoring, is that everything that the patient reports to the doctor should be recorded without any presupposition that it is causally related to the treatment being given.

I hope Professor Howie will now read my paper in the July issue of the *Journal*. If he has any comments on this, I should be delighted to have them.

Finally, he speaks in his last paragraph about the 'launching of unnecessary and otherwise unsellable new products'. Now he is being naive. Does he really think that any company would spend nearly £50 million on launching a drug which it believed was unsellable, or which was in fact unnecessary? We would not be having another nonsteroidal anti-inflammatory agent if any of the existing ones were really effective.

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Rural versus Urban Parasuicide

Sir,

Dr Hughes' paper (October *Journal*, p.637) presents some interesting facts but leaves some questions unanswered.

Confining a study of parasuicide to patients resorting to drug overdose alone probably underestimates the total rate in a community by about 10 per cent. It is hard to see why other forms of deliberate self harm should have been excluded.

The distinction between urban and rural patients seems tenuous. Some study patients must have lived close to