Job-loss and the use of medical services

THERE is considerable literature on the link between unemployment and health but it is contentious and ultimately inconclusive. While it would be perverse to suggest that unemployment could have a beneficial effect on health, the adverse effects of unemployment on health remain uncertain and the relationship between the two is unclear.

Unemployment and health are deceptively simple terms. While the majority are unwillingly unemployed, perhaps for long periods, the unemployed also include those who voluntarily leave their previous employment and those who are accustomed to short periods of unemployment. Problems immediately arise when attempting to describe the health of this heterogeneous group as there are many ideas about what constitutes health and researchers have to select measurable indices which may relate to health.

Three main categories of study have been undertaken to investigate the possible association between unemployment and health. Fagin and Little examined small numbers of people in an intensive fashion;[1] the results are persuasive but provide little evidence of the impact of unemployment on society. At the opposite extreme, studies such as Brenner's, which reviewed the data on mortality and the national economy from 1936 to 1976,[2] are difficult to interpret. Most useful is a longitudinal study of selected groups, although even here problems arise if groups of unemployed people are selected retrospectively because it is then difficult to establish whether unemployment or poor health came first.

The paper by Beale and Nethercott, in this issue of the *Journal,* is particularly valuable because it describes a study in which it was possible to define the sample population before job-loss occurred.[3] In addition, the list system which operates in general practice in the United Kingdom enabled the authors to monitor the use of medical services by the study group and by the control group both retrospectively and prospectively. The authors have avoided the difficulties of defining unemployment and health by concentrating on job-loss and the use of medical services. The paper clearly demonstrates that the anticipation of possible redundancy as well as job-loss itself affect the use of medical services by the employees and their immediate family.

What is the relevance of the paper by Beale and Nethercott and the general issue of unemployment to us in our work as general practitioners? Large-scale studies can only lead to political action and some doctors believe that the profession should speak out on what they see as a major health problem. It is at the clinical and personal level that general practitioners can do most to help patients who have lost their jobs. This paper reminds us that we should be aware of the job security of our patients. In the past, little emphasis has been placed on recording the patient's occupation, thus making it difficult for general practitioners to take potential job-loss into account in consultations. Doctors have one of the most secure jobs of all and this may prevent them empathizing with patients and understanding the devastating effect that job-loss can have on their health. Jackson and colleagues in Sheffield[4] have looked at unemployment and psychological distress in young people, and established general practitioners are becoming aware of the anxieties and pressures felt by trainees as they look for jobs. The loss of a job can be an extremely important life event and there are obvious parallels with others, such as retirement and bereavement. The effect of such events on individuals can be slight or catastrophic. It is to be hoped that further follow up and analysis by Beale and Nethercott will enable us to identify those patients who find it particularly difficult to adapt to their changed circumstances after the loss of their job.

References

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Personal lists

THERE has lately been much talk about the quality of care in general practice. One important point which seems to have been given little emphasis is that a personal list system can facilitate better care than a combined list. In a personal list system each partner has a list of patients who are registered with him and who see him on all occasions, except for out-of-hours calls and when he is on holiday. The doctor sees the patients on his list even if all his appointments are booked on that day and his partners are underbooked. Similarly, each partner visits his own patients at home regardless of how many house calls are requested on any one day. In a combined list system, although the patient's preference is usually accommodated, he may have to see another partner if his own doctor has no appointments available. It should be stressed that in a personal list system a patient may change his doctor within the partnership at any time, assuming the preferred partner is prepared to accept him, but he must formally register with that partner. The patient may also obtain a second opinion from another partner, but then returns to the care of the doctor with whom he is registered.

The advantages of personal lists are so considerable in terms of the potential for better patient care, greater patient satisfaction, and greater professional satisfaction on the part of the doctor, that it is surprising that so few practices operate a true personal list system. This may be because the more senior partners in an established partnership have no desire to alter a comfortable system in whose maintenance they have a vested interest, and which may seem to be the natural order. However, patients undoubtedly prefer having a personal doctor, rather than seeing whichever one of a number of partners happens to be available. Patients like to get to know the availability, style, strengths and weaknesses of their own doctor, whom they feel knows and understands them. Dissatisfaction with a combined list system is often expressed by such complaints as 'You never see the same doctor twice' or 'He is always fully booked when I want to see him — I have to wait several days for an appointment'.

It is also to the patient's advantage that in a personal list system the responsibility for his care is clearly defined. A difficult problem or a late visit cannot be passed from partner to partner. Furthermore, personal lists are the antedote to the 'collusion of anonymity' which refers to the failure of any one partner to accept responsibility for a difficult patient with the result

that deeper personal or emotional issues may be evaded and the patient may drift from doctor to doctor, year after year. In a personal list system, the knowledge that the patient will return to his own doctor, and to no one else, means that that the doctor has little choice but to get to know the patient and to make the necessary effort to help him. Patients who see the same doctor on almost all occasions are more likely to comply with recommended treatment and are less likely to be subjected to the perils of polypharmacy than those who see several doctors.

The advantages to the doctor are equally significant, especially if he is a more junior partner. A personal list system prevents the establishment of a hierarchy and, assuming that the lists are approximately equal in size, results in a fair and equitable distribution of workload. No one partner is obliged to take all the unpopular or extra patients and late calls. In a combined list system the doctor who works the fastest is often asked by the receptionist to see the unbooked extra patients, regardless of whose patients they are, while the doctor who consults at a more leisurely pace is not troubled. One partner can fill his appointments with unnecessary and undemanding follow-ups so that he soon becomes fully booked, while the partner who is more disciplined finds himself seeing all the acute problems. In addition, a dominant partner can make receptionists feel that they cannot ask him to see an unbooked patient or carry out a late visit. Understandably the receptionists approach a more compliant partner. A personal list system eliminates all these sources of friction, and makes for a happier working environment.

A personal list system recognizes the differences between doctors and eliminates the need for unsatisfactory compromises resulting in 'lowest common denominator' medicine; there is no need to accept lower standards because of a complacent senior partner or an unenterprising junior partner. This system motivates effort and enthusiasm, as each partner has a commitment to a limited number of patients and is prepared to make a greater effort to care for the patients on his list. It encourages innovation in the way each partner manages his patients, rather than a dull conformity. Each partner can provide his patients with consistent advice on the management of minor self-limiting problems, thus reducing unnecessary consultations and prescriptions while increasing the self-reliance of his patients. He therefore has more time for those patients who really need his attention. He can critically review his repeat prescribing, and can adopt consistent policies in the management of chronic conditions, knowing that these policies will not be altered by his partners should they see his patients in his absence.

Personal lists also appear to reduce the risks of litigation. According to the Medical Defence Union report of 1982, complaints are encouraged by 'the very existence of group practice ... in which a patient can pass through many hands with little if any personal relationship with "his" doctor. A close relationship with a personal doctor renders the patient more forgiving, more tolerant of error and less liable to resort to legal remedies.'

Of course a personal list system can only work if the partners make themselves available to patients for most of the working week. The system breaks down if a partner is involved in other medical activities and spends several sessions away from the practice. A partner should not routinely be absent from his practice for more than one session per week, in addition to his half day — a personal list system implies a belief in and a commitment to the primacy of general practice, giving it priority over all other medical activities.

A personal list system reconciles the patient's need for a personal doctor with the doctor's need for the advantages of partnership, providing the best basis for high quality family medicine. Doctors in practices operating a combined list system might like to consider the alternative, both in their own interest and in the interest of their patients.

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Policy statements — a new series

THE College's publishing activities have been growing steadily over the years and now include a series of books (white covers), *Reports from general practice* (red covers) and *Occasional papers* (green covers). This month the College publishes two documents in a new series to be known as *Policy statements*, and copies of both are enclosed with this issue of the *Journal*.

Why has a new series been introduced and what is its purpose? *Reports from general practice* have a long and distinguished history, having been started during the editorship of Dr R.M.S. McConaghey and published originally by the *Journal* office of the College at that time. They included statements of College policy and in particular important documents such as the College's evidence to the Royal Commission on medical education[1] and College documents about vocational training.[2-6] More recently the *Reports from general practice* series has included documents which, although not formally representing College policy, have carried the imprimatur of the College and have clearly covered developments that the College wished to foster. The five *Reports from general practice* on preventive medicine[7-11] and the most recent *Report* published in July this year, *What sort of doctor?*[12] are examples of this.

Meanwhile, the College has been growing in size and stature. Membership has been rising year by year and the recently published *1985 Members' reference book* shows a total membership of about 13 000.[13] The College's influence has if anything been growing even faster and extends not just to general practice but to other specialties and increasingly to government.

A reflection of the growth of the College's influence is that an increasing number of individuals and organizations have been asking the College for its views on a wide variety of subjects. In order to document these, the *Members' reference book*[13] has this year tried to bring together details of many of the statements of College policy produced in recent years.

Despite all this, the need has emerged for these views to be made more readily available not just to the profession but to government, public and the press as well. To meet this need, the new series of *Policy statements* has been introduced. These will include only those documents which have been formally endorsed by the Council of the College and which deal with matters of concern to the discipline of general practice. It follows that readers can be confident that they are not just expressions of intention but are formal statements of policy of the Royal College of General Practitioners. To underline their significance the series will include the names of the members of the relevant Council of the day and will usually include a preface by the Chairman of Council.

The first such *Policy statement* is a reproduction of the evidence given by the College to the Royal Commission on the National Health Service. This was published in the *Journal of the Royal College of General Practitioners* in 1977[14] but is