

## References

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## The power of relationships

Sir,  
Believing that spinal manipulation can alleviate sciatica, I have in the past agreed to my patients seeing an osteopath. I have now discontinued this practice because of a disquieting development of osteopathy which is not widely publicized.

A female patient of mine consulted the osteopath for back pain. Several months later I discovered that he had moved on from skeletal manipulations to a 'deep soft tissue manipulation' of the abdomen. The lady suffered severe abdominal pains for a week, but was reluctant to come to the general practice.

I confronted the osteopath, who said he had diagnosed a 'displacement of the uterus to the right' by abdominal examination and sought to correct it. Although I pointed out that medical training considers any palpable mass arising from the pelvis to be potentially pathological, for example a large ovarian cyst, the osteopath was unrepentant, indeed hinted that his training led to superior diagnostic abilities. He went on to say, 'As holistic medicine gains in popularity, osteopaths are extending their treatment to include soft tissue manipulation, naturopathy and diet! I am currently checking one of his severely restrictive six-week diets with a National Health Service dietician, but I make the point here that doctors have no control over the treatment or advice given once our patients consult a practitioner of 'alternative medicine.

Dr Pietroni's call for a 'cautious introduction of alternative therapies' (April *Journal*, p.171) is unrealistic; the floodgates of quackery have already opened. I doubt that Balint would have flirted on the fringe, but would instead have focussed on why patients turn from general practitioners to pseudo-experts, and perhaps on why general practitioners turn away from patients.

My call would be to encourage general practitioners to understand the concepts

of spirituality better so that they do not dismiss as neurotic those who look beyond themselves for a meaning and purpose to life. Is the skill of the quacks to appear to provide a whole person treatment while in fact merely giving an hour of 'relationship' while rubbing their feet, dangling pendulums and asking about the east wind?

The British Medical Association have shown courage and wisdom in resisting the tide of 'holistic' medicine. But let us not dismiss the whole phenomenon without looking deeper for its causes. If the NHS has failed to meet certain needs by encouraging five-minute appointments, what wider resources should we be looking to if not to fringe medicines?

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## Patients' expectations of primary care

Sir,  
The simple survey carried out by Donald and Gillian Gau into patients' attitudes to their doctors, practice staff and the consultation (Letters, *May Journal*, p.227) has a lesson of vital importance to the future of general practice and the training of general practitioners.

The survey demonstrated a mismatch between doctors and patients when asked the question 'What were your expectations from your doctor/practice and have these expectations changed?' Doctors and practice staff felt that patients wanted to be cured or made better; patients wanted to be listened to and taken seriously. In other words the patients were expecting a degree of care from their doctor and not always a solution to their problems.

There is much discussion at the moment about the Government's green paper<sup>1</sup> and the future structure of general practice. The 'good practice award' is talked about with emotions ranging from fear and rage to smug self-satisfaction. Parameters for this award abound, for example age-sex registers, recall systems and repeat prescribing systems. What worries me about this is that we seem to be losing sight of the fact that general practice is about caring for people and not always about running an efficient health machine.

A couple of months ago a patient of mine was berating the treatment his family had received from another doctor while they were away on holiday. It seemed the doctor had acted correctly from a medical point of view, but the consultation had lacked sensitivity. My patient turned

angrily to me and said, 'If you doctors don't care, then you're nothing!'

Perhaps it is not lack of factual education that is wrong in general practice but that doctors are unable to cope with the demands put upon them by the patients who need care. Perhaps as a profession we have to look at how we teach doctors to care and to cope with the emotional demands put upon them.

Approximately 70% of all consultations are for self-limiting illness. Why then do the patients come? If they want a sympathetic ear this suggests that they know they have a self-limiting illness but nevertheless need care and reassurance from the doctor. Having somebody care about you is flattering and reassuring and many of our patients may come for a dose of this, rather than a prescription from a disinterested doctor.

I feel we are in danger of becoming bogged down in the measurables — immunization uptake rates, prescribing habits, practice facilities and so on. These are so essential to modern general practice that they should be mandatory anyway. What really helps patients is support from a doctor who cares about them as human beings and who is prepared to care for them in order to allay their fears and reassure them of their worth.

Primary care is about caring for the primary person in the consulting room; the patient.

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1. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Primary health care: an agenda for discussion (Cmnd 9771)*. London: HMSO, 1986.

Sir,  
I was interested to read the account by Drs Gau and Gau on the expectations of patients in their general practice survey (Letters, *May Journal*, p.227). They mention that whereas doctors thought patients wanted to be cured, 70% of the patients surveyed wanted to be listened to and taken seriously, and they then go on to conclude that patients were more interested in the process than the outcome. I would like to argue that being listened to and taken seriously may from the patient's point of view be an outcome and not a process at all.

This illustrates the dilemma that faces the College in its quest for quality of care in respect of outcome — who defines outcome, the patient or the doctor. The findings of Drs Gau and Gau that patients wanted to be listened to and taken seriously will come as no surprise to

psychotherapists. Often our patients come not wanting to understand but to be understood. It was Fairbairn<sup>1</sup> who pointed out that people are not motivated primarily towards tension relief as postulated by Freud, but rather towards self-expression in relationships with other human beings. Since Fairbairn, object-relations theory has developed increasing respectability<sup>2</sup> and there has been a resurgence of interest in the importance of empathic listening.<sup>3</sup> In view of the fact that patients' expectations of the doctor in terms of object relations are a primary personality drive, I am less than convinced that an explanation of what the doctor expects will have any effect on the patient as Drs Gau and Gau suggest. Indeed in their survey the patients already knew only too well the expectations of the doctor. My experience of analysing videotaped general practice consultations is that such educational exercises seem harmful to the doctor-patient relationship especially in terms of the patient's perception of the doctor's empathic rapport.

It seems probable that the experience of being empathically listened to will actually improve outcome as traditionally defined by doctors in terms of symptom relief, as well as increasing patient satisfaction; this needs further research. In a recent study in Gateshead we replicated the work of Goldberg and Blackwell<sup>4</sup> in estimating the prevalence of emotional disturbance in general practice. Our preliminary findings show emotional disturbance in more than 40% of consecutive consultations based on a survey of over 1000 patients. If these patients are to be listened to and taken seriously, then organizational changes will have to be made in practice, both in terms of the time taken with patients in the consultation and in terms of training the general practitioner in the listening skills necessary to achieve empathic consultation.

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## General practitioners and hospitals in Nigeria

Sir,  
In the UK we have become accustomed to a form of general practice which is largely excluded from hospitals, apart from access to certain diagnostic services. Dr Blair and colleagues have shown from their experience in Perthshire (*August Journal*, p.359) that there are still important exceptions to this and they make a good case on the grounds of cost-effectiveness and convenience for patients for 'extending the capacity of the surgical side of general practice hospitals, and their use as low-technology medical units.' In the same issue of the *Journal* Roger Jones commented (*August Journal*, p.346) on the variety of systems in operation around the world.

In Nigeria the specialty of general practice was accepted as a discipline before the separation of general practitioners from hospital work. Doctors are few, and the population large — 9000 doctors for 100 million people. The range of casualty and surgical services provided at Blairgowrie is not too dissimilar from that accepted as part of general practice in Nigeria where the 'low technology medical unit' with high cost-effectiveness is referred to as secondary care. The fully departmentalized high-technology hospital service, staffed by specialists, is regarded as tertiary care. Primary care in urban areas is provided by doctors in hospital casualty and outpatient departments, and private clinics, but in rural areas most primary care is provided in health centres and aid posts staffed by nurses, midwives and community health personnel, with only an occasional medical visit. The refinements of primary care which have so greatly improved general practice in the west, have yet to make much impact in Nigeria.

In Nigeria the low technology medical unit has been found ideal for the first two years of the four-year general practitioner training programme. The entire hospital is subject to inspection and accreditation, rather than just approved posts, as in the UK. Learning to manage a wide range of conditions with a limited range of drugs and a minimum of technology is a vital part of the training, and prepares doctors for medical work in isolated areas.

Could general practitioner hospitals be used in training in the UK, perhaps on an elective basis, as in other western countries? Certainly, doctors with the MRCGP and experience of such centres in the UK would have attitudes and skills of great value to training hospitals in Nigeria and other developing countries.

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## Primary health care in Italy

Sir,  
As an advisor in primary health care to the Tuscan Region and the Chianti Health District, I would like to refer to Dr Jefferson's letter (*June Journal*, p.291).

Most of us will join Dr Jefferson in his condemnation of unnecessary and even iatrogenic interventions offered to cancer patients in the private sector. However, this is unfortunately not confined to Italy. We frequently hear of families impoverished by fruitless visits to 'great specialists' in France, Switzerland, Germany, the UK and even the USA, against the advice of their general practitioners in the Italian national health service.

It is true that the Italian national health service, which is only six years old, has many problems still to solve, including severe shortages of personnel and funding. This may account for some of the nursing deficiencies suffered by Dr Jefferson's mother in a private ward in one of our local hospitals. However, every Italian citizen has the right to the services of a general practitioner of his or her choice and all necessary specialist and hospital care, as in the UK.

In our experience, the majority of doctors, nurses and other workers in the health service are battling against considerable difficulties to raise the standards of care. Recently in our own local hospital a seminar on terminal care was attended by consultants, hospital doctors, general practitioners, nurses and members of voluntary organizations, and we are as concerned with this difficult problem as our colleagues in the UK, though none of us would claim to have solved it.

Recently the Società Italiana della Medicina Generale was founded with considerable help and advice from the RCGP. An important minority of general practitioners is actively seeking to improve the quality of care in general practice in Italy. This is the theme of our International Conference in Florence from 27 to 30 November 1986, in which Dr Crombie and other leading members of the College hope to take part. Simultaneous translation will be available and we will be delighted to welcome other British colleagues to Florence, this year the cultural city of Europe, and I will gladly forward details to anyone interested.

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