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Rural practice

I grow increasingly concerned for the future of small rural practices, particularly those in the Scottish islands. There is a clear probability that as the GPs presently in their single-handed posts retire, they will not be replaced and primary medical care for the island communities will be provided by resident nurses with GPs visiting the islands regularly but infrequently (once a week or, more likely, less often).

The effects of these changes will be twofold: they will save the NHS money (this is doubtless the driving influence) and they will radically alter the role of the doctor in the isles. No doubt the patients will be well and compassionately cared for by nurses, and the nurses will have at their disposal all the emergency paramedic and evacuation facilities. However, the traditional model of health care by a doctor–nurse duo, providing different and complementary skills, has been a very successful one and the standard of medical and nursing care received by islanders is exceptionally high. A nurse on her own would be hard-stretched when she finds herself acting as both nurse and doctor.

Many of the isles have, in recent decades, shown a worrying trend towards falling population: below a critical number the community loses its teacher, its minister, and its doctor, and the character of the community is altered significantly. Incomers, both retired people and young families, have done much to keep the islands alive but they will be less likely to settle in the absence of a school, a kirk, and a surgery.

While it may be thought hard to justify the costs of a GP exclusively for a list of 200 patients or fewer, I think we should acknowledge the immense emotional and social support given by a resident doctor. At least let us achieve a compromise whereby a partnership of two or three GPs look after, say, four or five islands; such a partnership arrangement would allow more frequent island visits and adequate time off for the doctor. With such a scheme, the doctors would remain as day-to-day players on the stage of island life and it would certainly be much easier to attract new GPs to remote practices.

The whole future of the island GP needs an urgent review lest, by default, one island after another loses its doctor and this excellent feature of British general practice is lost for ever.

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Cardiac rehabilitation

I have read the editorial in the October *BJGP* with great interest;[1] I first applied the rehabilitation process in 1945.

Having served in three small ships I was appointed medical officer in charge of a Royal Naval convalescent home and approximately 100 beds for ratings recovering from general surgery, orthopaedic surgery, and medical cases.

Having been inspired by my previous teaching as a house surgeon, by a consultant who, influenced by the Liverpool team practiced rehabilitation and its motto 'Return to Full Function'. Thus fortified, I altered the focus of a 'convalescent home' and together with an excellent chief petty officer physiotherapist we set about rehabilitating every suitable case.

One medical case was an older chief petty officer steward, aged about 50 years, who had suffered a severe coronary thrombosis. He was bed bound and had been treated at the Royal Navy Hospital Haslar; he was sent for my care in the convalescent home in the expectation that recovery was unlikely. I waited for him to settle down and over the next week we gave him very simple hand and arm exercises. Monitoring pulse and blood pressure meantime, there were no sophisticated aids to diagnosis at that time. His response to light upper limb exercises were satisfactory, so progressive exercise over the next 6 weeks gave us hope that the damaged heart muscle had healed. The neurology was intact so he was progressively mobilised and deemed suitable for discharge home. I informed the senior medical physician at Haslar. He was amazed but agreed. It is a pity I was unable to follow him up further. I think he was honourably retired on medical grounds. I tell this story because it brings me to encourage the cult of rehabilitation and the effect it had on my future thinking; it certainly wasn't mentioned at Guys during my training there.

When I joined my practice I visited about 80 older patients, who were either bed bound or chair bound, to give them their 'pills'. This seemed a rather uneconomic way of spending my time so, in order to put some sort of 'clinical label' upon each of them, I arranged to visit them with the nearest relative I could find, examine them from top to toe, suggesting to the relatives that their elders were wasting a perfectly good life, and set about curing them. Once they were all reassured that the 'reaper was not nigh', a great change in situation took place. They got out of their beds by easy stages, out of their chairs, went outside in the fresh air, threw away most of their pills, made

life a lot easier for their relatives (and the doctor!) and started to live again. None of them died except one; who having spent about 18 months out and about had a stroke while walking in town. Her relatives came to me for the death certificate, and I wondered if I would be treated for activating too soon; no, they thanked me for giving her another year of 'full life'! This first 18 months before the NHS started was hard work but rewarding in that rehabilitation won the day. Not only did I have to change attitudes among the 'flock' but in my seniors; I never realised that I had so many resources of tact!

This brings me to Hugh Bethell's article in the October issue, which is mainly related to cardiac disease. I would like to suggest it should have a much wider application. Any disorder which keeps the whole mind and body out of action for a week or more should be treated by simple, easily understood movements of all limbs. There is no magic about it. It does not require medical specialists, health visitors, district nurses, or physiotherapists. We should encourage mental and suitable physical activity to retain the patients interest in recovery of mind. Reading, crosswords, and puzzles are far better than sleeping pills, building up the pace as recovery proceeds.

We need to encourage our health visitors, midwives, district nurses, and relatives to think on these lines. The word rehabilitation may be too big a pill to swallow, so I suggest it is not used for patient consumption.

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Flexibility on work

I agree about the need for flexible training and career development to get flexibility at work through life. It's better to get people into the right job, balancing their careers with other aspects of their lives, both professionally and personally, than have them dissatisfied, underperforming, or leaving.[1,2]

A different way of working means to be motivated, not stressed, but also to use and learn from each other's life experiences.

Involvement in teaching and in management, or simply reducing time involvement as a doctor, will raise the standards of care. So we need protected non-contact time within the working week to stimulate clearly defined roles, responsibilities, and terms of service.

Teaching, research, and management have to be relevant career options, whose status and conditions should receive strong consideration and payment in workforce planning and skill utilisation. These are important factors against burn-out and frustration, mainly visible in GPs more involved in these activities, and also to fulfil the new definition of general practice and GPs as clearly and definitely edited by WONCA, after drafting work by the EURACT Council.[3,4]

It is really strange that some health ministries in some European countries, as the one I am working in now, are still not applying the European directives on flexibility in the workplace. This is concerning a flexible career option, as well as reduced normal clinical time when involved in teaching, research, and management.

Roger Jones[5] wrote about seeing a much bolder attempt to endorse the 'mixed portfolio' approach to general practice in which patient care is combined with other non-clinical activities.

I also think that it should be introduced as a 'wedge-shaped' commitment with substantial work in early years, tapering to a considerably reduced 'working' commitment given to more senior doctors.[6] This would be a chance to reinvent general practice as an attractive career with a progressive career structure.

Flexibility has to suit different stages of life to allow someone not to work absurdly when your forces or your mind are 'conflicting' and, at the same time, permitting doctors with particular options, not to leave the profession for a long while yet. And, as a health system, 'use' their forces and experience.

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