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WHO IS MY PATIENT?

I work in a three-partner practice with about 5100 patients. We have open lists so any of these could be under my care and therefore qualify as mine. Many of these never come to see me, and others will be looked after by colleagues from other practices if they fall ill out of hours. In the same way, I cover patients outside my practice area on weekend shifts and in my hospital work in the local neurology department. Consultants usually see local patients but they may receive referrals from out of the area or even abroad if they have an international reputation. Many newly arrived immigrants have access to our health system, while I have treated patients during overseas work in Afghanistan, Africa, and New Zealand. We all share a responsibility for people who fall ill when we are the nearest medical attendant, even if we are on holiday! The last time this happened to me I looked after a Frenchman having a heart attack in California.

Hippocrates wrote that:

'I will use my power to help the sick to the best of my ability and judgment.'

As a GP, how should I interpret this worthy piece of advice? It can be easy to be territorial and develop a fixation with geography — our practice boundaries, the scope of our proposed consortium, our national borders — but the previous paragraph shows that how we classify someone as one of our patients is much more fluid. If we define 'the sick' as those within our sphere of influence whose health could be improved by simple, cost-effective interventions, we suddenly have a global population to consider.

The latter part of that definition is easy to justify; inexpensive 'horizontal' programmes of primary care have the potential to save and improve millions of lives in poor countries. In one analysis of preventable deaths in children across 42 countries, it was estimated that 63% of deaths could have been prevented by fully implemented primary care.¹ Mosquito nets cost roughly £1 each, while a basket of simple drugs to treat worms, vitamin A deficiency, and trachoma costs just 50 pence per child. Compare this with the ceiling of £30 000 per quality-adjusted life year used in assessments of medical interventions by NICE.

What GPs in the UK may find harder to digest is the idea that such people are within our sphere of influence, especially when we have so many domestic issues to concern us. We may not be fully aware of the benefits that primary care can bring to health systems, but there is abundant evidence of this; besides the paper from Jones *et al.*,¹ Starfield's summary from 2005 is compelling,² a recent editorial in the *BJGP* may help provoke discussion around how to improve health outcomes in poor countries,³ while low cost primary care expansion has just proved highly successful (again) in Brazil.⁴

The '15 by 2015' campaign lobbies for a larger share of aid to be spent on the expansion of primary care through so called 'horizontal' programmes (these also build infrastructure for other services) rather than expensive 'vertical' ones which concentrate on single diseases. It is supported by agencies including the European Forum for Primary Care and WONCA (you can sign their petition online at www.15by2015.org or lobby the RCGP to support the campaign). Of course there are many more agencies that aim to provide clean water, support for farmers, microcredit, and other useful interventions but this one is taking our specialty and trying to spread it more widely and where it is most needed.

Unlike Hippocrates, we are developing a clear view of poverty and health inequality around the world. As doctors we are in a good position to advocate for improved global healthcare for 'the sick': we should be proud of what primary care can achieve, and encourage the development of systems abroad to improve the health of those patients whom we may never see, but who would benefit from our efforts all the same.

Christopher George Tiley

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