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A FIRST SURVEY IN GENERAL PRACTICE

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THE PRESENT RESURGENCE OF GENERAL practice has been accompanied by a rethinking and re-evaluation of our methods in and approach to general practice. As a result a new speciality is developing which requires its own disciplines and art; yet for the new specialist training is not easy to get and, in fact, is only now beginning to evolve.

Individual general practitioners keep abreast of developments in practice through appropriate books, journals, tape recordings and meetings, and a survey of different aspects of one's own practice is most valuable to this end, for not only can it clarify or alter impressions but it stimulates further study and research into general practice.

Bearing this in mind I decided suddenly one Monday morning in mid-May at 8.55 a.m., to record everything I prescribed for one week in practice and see what I could learn from my single-handed practice of 2,400 in a working-class, Kent–London suburb. Before the day was over it was apparent that not only was there much more forthcoming than I had anticipated but that such schemes usually need more than five minutes to plan. Moreover, by the week-end, observations were beginning to emerge in my mind which, on reflection, showed how I was influenced by personal anxieties, patients' demands, and economic requirements as well as by the true needs of general practice. But most of this is too involved yet in my mind to record.

To test my belief that much of what I prescribed was placebo, I chose prescribing. Having been a single-handed principal for three years I had received from the pricing bureau only two sets of figures. My prescribing costs were 65 per cent and 59 per cent of the local average—the number of prescriptions equalling the local average.

These low costs were due essentially to my belief in specific prescribing, and giving placebos if the patient 'required' something, and not neglecting the psychological background.

The following, in no special order, are some results of the survey. In this particular mid-May week, 14th–20th, 1962, I issued 105 prescriptions for 197 consultations and visits, i.e., prescriptions issued for 53 per cent of consultations and already I am curious to know how these figures compare with those of other doctors.

One hundred and thirty-three (68 per cent) of all consultations were with females. This, on reflection, is not too surprising for this practice has, approximately, 70 confinements a year at home and at hospital; and the majority of men, mainly social classes IV and V come only when ill. Perhaps there are other reasons for the 2 to 1 female to male ratio of consultations and, for a start, I intend to find out the male to female ratio of my practice and then to see how this compares with other surveys.

On the 105 prescriptions 149 articles were prescribed. I considered only 99 to have any specific or symptomatic effect (66 per cent), 34 per cent were placebo. Proprietary preparations accounted for 52 per cent of these articles. It is sometimes difficult to decide whether the drug has a symptomatic or specific effect, e.g., antidepressants, and antihistamines in some skin rashes and morning sickness, but bearing this in mind specific prescribing accounted for between 10 and 15 per cent of the total of scripts and included such drugs as digoxin, gamma-globulin, penicillin, sulphonamides, insulin and ferrous sulphate. Thus, approximately half the scripts were issued for symptomatic relief and these included sedatives, stimulants, antacids, linctuses, analgesics, laxatives, lozenges, and rubifacients, many of which I would normally not give to my own family but which, unfortunately, have become part and parcel of modern prescribing: giving these medicines does not solve problems or cure diseases, and they often do not relieve the symptoms anyway. I do not feel the nation's health or that of my practice would suffer if some of the symptomatic medicaments and placebos were not prescribed, but I doubt if I could get away with it without considerable loss to my practice and also much time spent in explanation, or until such time that patients are better educated concerning medication.

Of course, one week's figures are not a very accurate guide, but they still have some relevance. The average of my prescribing costs is 62 per cent and if some of the placebos and some of the symptomatic treatments were not given, my prescribing costs could well be in the region of 30–40 per cent of national figures.

My own costs are also low because normally I do not initiate

corticosteroid therapy and whenever possible only give antibiotics when specifically indicated, which, in my experience, is not often.

In my practice I do not, as yet, have ancillary help, though soon it will be required. So having read that an average practice could involve no more than 30 hours work in an average week, I decided to review my own findings. I spent 21 hours doing 10 surgery sessions and my antenatal and welfare clinic and 11 hours visiting (there were neither night calls nor confinements). This 32 hours compares with the estimate but does not take into account time spent on the 'phone, visiting patients in hospital, correspondence and administration, reading journals and books, and attending lectures and meetings. In this week I attended a full-day Sunday conference, which just about doubled the time devoted to the full aspects of practice. Further there are civic duties such as local talks, attending sports meetings and I run regular hypnosis sessions; all of which gives a new look to the original estimate of 30 hours. This, and being on call the whole week (excluding half-days and rota week-ends) makes general practice a way of life rather than just a job. Living over the practice is time saving but can be a two-edged weapon.

In this particular week a gentleman asked me to test his urine for sugar. He was only the eighth person to do so since a notice had been placed in my surgery seven months previously, requesting all patients over 40 to bring a specimen for the early detection of diabetes. It is now my routine to give everyone over 40 a wrapped-up clini-stix, and a request to bring me a specimen should the paper turn blue.

This little survey has been both interesting and stimulating and I could go on much longer writing of the different aspects of practice that I have thought about, e.g., the amount of time each week a doctor could or should devote to exercise; the part health visitors play in general practice; what special clinics a general practitioner could do if his practice were well organized and how research could stem from this; the implications of giving and not giving prescriptions; how many patients are sent to the local pathology laboratory, and radiology departments for investigation; how many outpatient appointments this saves; the incidence of neurosis in this practice and the amount of sedatives given—all this from keeping a few simple records.

As I review the list of names, everyone tells a story. How much is psychological? This, no doubt, depends on the doctor's attitude towards psychological illness, but in glancing down Monday's names I wonder if Mr N., who had a coronary a few years ago, really came for a check-up, or as an excuse to borrow 10s. until Thursday! Did Mr K. need a stomach medicine for his recent gastritis or reassurance

that he would eventually get a skilled mechanic's job, even though he was a negro? Did middle-aged Mrs C. need her sedative or would she do better by leaving the tyrant elderly husband whom she married so as not to be alone? Would Miss L. do without her drinamyl for depression if she did not live in such intolerable housing conditions, and would menopausal Miss W. have visited me 22 times in the past six months with a host of symptoms, if her married boy friend had not died suddenly? These and many such I saw on Monday, the first day of this little survey.

The survey has led me to ponder over things more deeply than is usual in matters of general practice and it has enabled me to understand my practice the better. To conduct this survey I recorded surgery and visiting times, patients' names, contents of prescriptions and wrote any relevant thoughts for that day at the bottom of the page. This alone gave me a wealth of material upon which to ruminate and some of which is now this article, but most valuable of all it has given me a concept of method in general practice and how to programme further surveys. Perhaps next year another such survey may reveal interesting comparisons and differences? Perhaps other young doctors may also gain satisfaction from such a survey? Does all this make me a better general practitioner?—I don't know; but it gives me a greater understanding of my own practice and a desire to maintain an adequate standard of medicine.

The International Academy of General Practice—Salzburg

The News-sheet of the International Academy of General Practice notifies members of the Academy and invites them to join one of the working parties: to establish the basic organization for general practice; to establish the workload in general practice; to abstract general practice literature; to examine clinical practice of general practice; and to study individual clinical problems.

It proposes, for instance, that all members should, on that day 15 December, take blood pressure readings of all their patients standing up and lying down. This should produce such a variety of norms by age and sex, that much interesting subsequent follow-up might result.

Another request is to note all the complications of measles in one year, and how many cases were never seen again after two and then again four weeks, as return visits or follow-ups.

This News-sheet also carries three pages of useful and topical medical titles for reading either in current journals or new books, and devotes several pages to basic requirements for record keeping. It contains the programme of the Montreal Meeting in 1967 of the Canadian College of General Practice.