Editor's Briefing

PLUS ÇA CHANGE ...

Well, yes and no. I have worked in several practices, following my academic nose around the country — in Andover, Southampton, Newcastle upon Tyne, Northumberland, and Lambeth, and have been privileged to have worked with some exceptional GPs. My much missed and wonderful trainer, Roger Edmonds, was almost unbelievably intuitive, clinically masterful, and caring while, at the same time, never taking himself, or me, too seriously. The primary medical care group in Southampton could almost have starred in their own soap opera, but provided the last word in personal, comprehensive, and high-quality care. GPs were still doing house calls when I worked briefly in the north-east of England, where I witnessed incredible dedication, real Deep End commitment, and altruism.

I led Lambeth Walk Group Practice for almost 20 years and apart from an ugly partnership split towards the end of that time I can say, hand on heart, that I looked forward to going into work every morning. The practice, with a full range of services, was located in beautiful accommodation on the ground floor of a converted art deco bathhouse built after the Second World War for the adjacent council estate, with a medium-sized lecture theatre and some seminar rooms, all with video links to the surgeries. Upstairs were offices for research and teaching staff and a lovely social area where we had some unforgettable parties. I still think that this was inner-city practice at its best — we were accessible, reliable, flexible, and integrated with the local community. We did our own house calls and had access to a community GP hospital. We taught undergraduate students, trained GPs, and were always involved in research studies. I take my hat off to the GPs who worked there through some pretty challenging times and are now leading the practice.

The point being that although the buildings and the personnel have changed over and over again, the values, and the core tasks of general practice haven't. The consultation is at the centre of everything, no matter where you work, and although demography, morbidity patterns, and treatments have all changed, some almost beyond recognition, the central tasks are the same — to be there, to listen, to bear witness, to try to understand, to support. You do whatever you can to make sure that the patient leaves the consulting room if not actually better, but better able to

deal with whatever they have to confront. One of the paradoxical truths of general practice is that the patients who give you the biggest presents are those for whom you probably thought you did the least.

It's difficult to replicate many of these activities on a smartphone screen; 140 characters of text are unlikely to be a satisfactory way of providing a shoulder to cry on for a bereaved parent, and Skype isn't the best way of making sense of complex symptoms, let alone doing a physical examination. We must not be Luddites, but neither must we be seduced or dragooned into using technologies that undermine our central role as personal physicians. If consultation skills become under-valued, they will be under-taught and under-examined in medical schools. Doctors and patients will be left bemused, frustrated, and over-investigated. We must be careful not to over-claim for the humanistic, patient-centred content of our work, but it is so important that doctor-patient interactions and relationships are regarded as being among the most highly-valued aspects of teaching and training. Undergraduate GP placements are excellent opportunities for generic clinical skills training and as a shop window for the profession, but they are also places where students can learn something that is almost unique.

This issue of the *BJGP* is about change — changing the way that primary care professionals work together, changing the way that we approach the diagnosis of cancer, new ways of influencing treatment-seeking behaviour, preventing illness, and improving clinical effectiveness.

Reflecting on some of these themes, John Howie offers an explanatory model of the consultation, and echoes much of what I have said about the centrality of the real-life doctor-patient encounter. We should, however, be open to evolving patterns of clinical contact in general practice and primary care, recognising that the wide range of skills possessed by an extended primary care team has the potential to enhance patient care.

Roger Jones,
Editor

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