My doctor[1]

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This lecture describes what I consider to be the special function of the general practitioner and examines whether personal care in general practice is an ideal difficult to attain or merely a myth. The examples given and the data presented are highly selected.

Personal doctor

I was attracted to general practice by its personal nature. In 1964 Kevin Browne and I stated our beliefs about the special function of the general practitioner: 'the general practitioner and his patient both know that he serves to a greater or lesser degree a function in care which is not merely that of continuity... It is to learn the language of the communications of his patients' (Browne & Freeling 1964).

It is the responsibility of any profession to offer advice based on its expertise. Advice communicated in language which is not that of the patient will often not be followed, presumably because it cannot be understood.

Job definitions

In 1969 the Royal College of General Practitioners extended the concept of personal care to 'personal, primary, and continuing medical care to individuals and families'. In 1974 the concept was further extended by the Leeuwenhorst Working Party: a definition endorsed in 1976 by the College (Leeuwenhorst Working Party 1977) which now provides guidelines for vocational training. The concept became 'personal, primary, and continuing care to individuals, families, and a *practice population*'. Whilst annexing the care of a practice population and abrogating the limits implied by the adjective 'medical', the second definition included other alterations.

The 1969 definition included the sentence 'Even if he is in single-handed practice he will work in a team and delegate when necessary'; the definition endorsed in 1976 seems more restrictive, stating 'He will practice in co-operation with other colleagues, medical and non-medical'.

Oliver Wendell Holmes once said 'People talk fundamentals and superlatives and then make some changes in details'; the addition of care given to a practice population may reflect only a change in detail, but it correlates with increases in the proportions of GPs working in partnership or groups (DHSS 1982) (Table 1).

Removal of the constraint 'medical' extends the GP's remit and may explain why the services of non-medical personnel trained in 'counselling skills' are now offered within general practice settings. In 1980 we mailed a questionnaire to all the teaching practices of South West Thames Region (Freeling & Fitton 1983). One hundred and three (96%) of the practices we circulated gave details of people working in them and 36% had at least one person with counselling skills (Table 2). It seems that these teaching practices, all of which had more than one principal, were delegating some of the opportunities which arise from providing personal care. One of the responding practices has shown some of the benefits which can accrue from having a clinical psychologist in the practice (Robson *et al.* 1984), but the value of delegation as compared with help provided by a trained personal doctor has yet to be studied. It seems as if the more general is the care we claim to offer, the more we seek specialized help to provide it.

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Table 1. Distribution of GPs (%) by number of partners in a practice (England)

	No. of GPs in a practice				
Year	1	2	3	4	5+
1969	22	26	26	15	12
1978	16	20	24	19	22
1981	13	18	23	19	27

Table 2. Training practice: counselling staff (%)

Type	Employed	Attached	Neither
Generic social worker	0	19	84
Psychiatric social worker	1	10	92
Marriage guidance counsellor	0	10	93
Clinical psychologist	3	14	87

Characteristics of general practice

The contention about the language of communication was based on a number of characteristics which together make general practice a unique discipline (Freeling 1983):
(1) It deals with undifferentiated illness and early symptomatic diagnosis
(2) Patients are helped to 'organize' their illnesses (Balint 1957)
(3) It uses relatively low technology
(4) It considers probabilities and threat (Royal College of General Practitioners 1977) when making diagnoses
(5) It makes use of time (Royal College of General Practitioners 1972)
(6) It takes a person-centred approach (Tait 1974)
(7) It recognizes problems of compliance by patients and doctors
(8) It provides continuing care
(9) It has a preventive attitude
(10) It adopts a developmental approach
(11) It makes selective use of resources
(12) It is responsible to a whole community
(13) It tolerates uncertainty (Thomson 1978)
(14) It requires knowledge of the functions of other disciplines
(15) It depends upon high skills in interviewing.

Within the British National Health Service there are two additional characteristics:
(16) It takes care of a defined 'practice population'
(17) It affects money and resources expended.

These 17 characteristics reflect the views of doctors. They seem also to reflect the views of one year's entry of students at St George's Hospital Medical School (Freeling 1982). Two-thirds of responses from students who were asked to report the 'three most important things you have learnt' during the final year attachment to general practice could be allocated to one or other of the 15 characteristics. More than half the students mentioned a 'person-centred approach'; almost as many mentioned management of a specified organic disorder.

Our medical students seemed to recognize that general practice should provide competent care of organic disorder within the framework of a person-centred approach. This is what they see GPs offering patients who sign the one-to-one contract offered. However, the details have to be negotiated after the contract is signed.

Effects of communication

Among the factors which have maintained my beliefs about the special function of the general practitioner are the effects of communications which can be of three kinds: informative (conveying information); promotive (initiating actions); and evocative (producing feelings).

There is no doubt that general practice, in its vocational training at least, has tackled the matter of communication; but it has yet to be demonstrated that acquisition of language by systematized study of videotapes is any more than a preparation for understanding the colloquial intimacy of personal consultation.

I will expand on the phrase, 'understanding the language of our patients' communications'. One application affects the doctor's diagnosis and management and draws on all three possible effects: informing, promoting and evoking, together with their interactions. A second application affects the patient: its minimum level is to obtain what is pejoratively termed 'compliance'. A professional should be able to make communications to a patient which are properly informative and so promote actions judged to be beneficial, and this is unlikely to occur if unhelpful feelings have been evoked in the patient.

Case report

TE, a 36-year-old woman, attended surgery recently with Martin, her tall 12-year-old son. She had been transferred to our practice on the death of her previous doctor 27 months previously. She had not chosen her doctor; she had simply been 'inherited' by us. There were many entries in her notes, mainly for repeat prescriptions for asthma, some when seeing a doctor, some without. I later counted the entries: there were 61, and 34 were for repeat prescriptions without being seen. There was one entry in red in February 1983, 'To be seen before next prescription'.

She seemed short of breath as she asked for an antibiotic because her asthma was getting out of control. I recalled a consultation with her 11 months earlier when Martin was the patient and the opening request had been the same: 'Can I have an antibiotic for Martin? His asthma is getting worse'. When I later counted the entries in Martin's notes there were 35, 21 of them for repeat prescriptions without seeing a doctor.

I asked TE how she was using the drugs prescribed, which were a salbutamol inhaler, a beclomethasone inhaler, sustained release aminophylline tablets and salbutamol tablets. She began to rub occasionally at her right eye and told me that four times a day she took one puff of beclomethasone followed by two of salbutamol; three times a day she took her theophylline; and when she was bad, as she was now, she took a 4 mg tablet of salbutamol 4 times a day also. She continued to rub occasionally at her right eye as she told me this. It was as if her rather heavy mascara was irritating it, or perhaps she had contact lenses or an allergic conjunctivitis. I tried to suggest that many people found it more helpful to use the salbutamol inhaler before inhaling beclomethasone and that, in any case, she could use more beclomethasone.

I was aware that my informative communication was somehow going wrong. TE's eye-rubbing became more agitated. 'Are you certain about using the salbutamol inhaler first?', she almost shouted. 'Yes', I said, 'Most people seem to find that helpful in opening up the tubes for the beclomethasone'. 'Told you so!' said Martin who had been sitting quietly, looking rather smug. TE exploded, jumped to her feet and, almost shaking her fist at me, said 'I didn't come here to be patronized; I came to be helped. I've been looking after my own asthma since I was seven years old and I feel awful – my asthma's very bad and all you can do is give me a lecture. You did that when I brought Martin before and I had to nurse him for 4 days till he got better'.

I must say that I reeled before the explosion. 'I really do want to help', I said. 'I'm very sorry to have upset you so much. It wasn't intentional'. (To this audience I can add, 'not intentional and not very professional either'.) TE quietened down and after saying, 'I suppose it's not really your fault', went on to say how difficult it was to cope with her responsibilities even when she was not suffering from asthma and how difficult things were at work, where she gave help which was supposed to be mainly domestic in an institution for handicapped children. She found the work emotionally draining and was at loggerheads with one of the professional carers.

I had been forced to recognize that my informing had resulted in an unexpected evocation which had, if only temporarily, removed any chance of promoting, by TE, actions more helpful to her management of her asthma. I hope that I had begun to understand the syntax if not yet the language of TE's communications. It seemed that her messages were about control and her need to be helped to maintain it without losing responsibility.

Review of her notes showed that TE had indeed had asthma since she was seven, shortly preceding her mother's death, following which she was looked after by her elder sister. Her mother had died of asthma. TE has two illegitimate children and no permanent relationship with their father. She has had two terminations of pregnancy and has in the past fought bitter battles to recover her children from 'being in care'. No wonder she feels control of asthma is important, and that it is important that she do the controlling. No wonder she resented my bland communications about what I saw as the correct sequence of usage for salbutamol and

beclomethasone. I suppose it is no wonder, either, that TE had not absorbed information given before if she was as desperate as she appeared and if, as a doctor, one chose to duck in order to avoid the violence which lay only just beneath the surface of her communications. That she can be informed was evidenced by her saying at the end of the whole consultation, 'So you think it's better to use the beclomethasone some moments after the salbutamol and I can use up to 4 puffs 4 times a day'.

Hilton & Sibbald (1984) conducted a controlled evaluation of the effects of health education programmes in asthma. The three groups were interviewed again sixteen months later, 13 months after the intervention. I quote from their conclusions: 'A large survey of asthmatic patients showed a low level of knowledge amongst the population. However, a subsequent controlled trial of health education, despite showing improvements in knowledge, has shown little impact on morbidity due to asthma in the year following the intervention... Patients do not like additional contacts with doctors, and thus doctors's contributions to health education will have to be opportunistic... Emphasis might be placed on improving behavioural steps in self-management, with less attention paid to improving knowledge'. In my language these findings read as: 'informative is not necessarily promotive'.

Choosing a doctor?

An important question arises from changes in job definition, and the simultaneous trend towards groups of doctors working with a team of colleagues from large premises. Does an individual contracting for medical services from a named doctor who works in a partnership or group see him or herself as relating to an individual, a number of individuals, a group, or a practice? This has been discussed by Gray (1979) who argues that 'if a patient does not see his or her own doctor regularly, then the care cannot be personal and continuing', and reports some of the effects of changing from a combined list in a partnership of three to a personal list system. If the value I attach to the named doctor/named patient constraint of the NHS has any validity, then identifying someone as 'my doctor' should involve either active choice or evidence of development of a valued relationship which might be called 'loyalty'.

At the end of 1981, as part of a larger study funded by the DHSS (Freeling *et al.* 1984), self-completion questionnaires were mailed to all the patients of a single-handed practice and to a 20% sample of patients aged 16 or over on the list of a partnership practice. The two practices were on opposite sides of a busy road in inner London. The single-handed doctor was aged over 65 and worked from the house in which he lived with his wife who was his only ancillary help. He had no appointment system. The partnership of two doctors worked from a health centre with employed ancillary staff and had ready access to health authority personnel in the same building. They had an appointment system. The senior doctor of the health centre partnership, like the single-handed doctor, had worked in the locality for more than 25 years. The health centre had been opened 7 years before our postal survey.

Among the questions asked of over 16s in the two practices was: 'There are many reasons why people are registered with a particular doctor. Please tick all of your reasons'. We offered 11 structured options, one of which – 'wanted a woman doctor' – could not apply to these two practices. We offered also an unstructured option: 'other – please say'. The age distributions of respondents from the two practices were similar to each other.

Table 3 shows the options in rank order for the frequency with which they were given from the single-handed practice. The right-hand column shows the order in which the questions were presented to the respondents, and it can be seen that question order did not seem to affect responses. The average number of options chosen by each respondent was very similar for the two practices: 2.3 from the single-handed practice and 2.2 from the health centre. The percentage of respondents from each practice giving each reason for being registered was remarkably similar. Unstructured reasons mainly concerned being 'a good doctor' or 'I like him'.

It would seem that people in the part of London served by these two practices place most importance on a surgery being close by and then, in turn, on recommendations of relatives or friends, the arrangements of the practice, and on the doctor being known to be good with children. Each of these four reasons, which indicate some degree of active choice, were given

Table 3. Percentage of respondents from practices giving each reason

SH rank order	Reason for being registered	Single-handed	Health centre	Question order
I	Live close to the surgery	57	61	8
II	Recommended by relatives or friends	27	28	4
III	Prefer his arrangements	24	24	10
IV	Known to be good with children	22	19	6
V	Inherited (previous GP left)	18	20	5
VI	Had since childhood	17	14	1
VII	Was wife's/husband's doctor	15	9	2
VIII	Recommended by neighbours	15	13	3
IX	Dissatisfied with previous doctor	8	9	7
X	Unable to register with any other practice	4	5	9

Percentages have been rounded up. SH = single-handed

by at least a fifth of respondents. The next three reasons, in rank order, indicate perhaps some degree of passivity but may reflect the development of loyalty.

The health centre had opened 7 years before our survey, bringing the premises of the two practices into close proximity with each other and making the contrast in their settings and arrangements more stark. We looked, therefore, at the reasons for being registered given by those who had registered with each of the practices after the health centre had opened.

An important difference appeared in the frequency with which 'known to be good with children' was given as a reason for being registered. About a quarter of respondents from both practices who had registered before the health centre opened gave this as a reason, but only about a tenth afterwards; an unwanted finding in view of the emphasis in job definitions on providing care for families.

It is possible that centralization in the health centre of health authority preventive care for children has reduced the importance to respondents of this characteristic of 'my doctor'. General practice now informs its patients of the benefits to children of preventive care with the intention of promoting its acceptance. Is this another illustration of increased reliance on specialists' skills arising from increasing the range of our responses?

Care which general practice claims to provide

GPs now claim to provide care covering a wide range of approaches as well as a wide range of conditions. I wonder if it is possible for these approaches always to adopt a person-centred perspective and represent what I still hold is the special function of the GP? My doubts arise because in most general practices the range of care is not provided by the GP alone. The range of care to which general practice now lays claim is categorized in Figure 1: the lozenge of general practitioners and the triangles of other carers are intended to represent an arbitrary division of labour which I believe approximates to reality. Let us consider some components in this range.

Anticipatory and preventive care

The increasing emphasis on providing preventive care in general practice (Royal College of General Practitioners 1981*a,b,c,d*) may be related to the adoption of responsibility for providing care for a practice population. After all, 'You can only cure retail but you can prevent wholesale' (Peter 1980*a*). The term 'anticipatory care' (Royal College of General Practitioners 1983) has been introduced and may reflect the need to maintain a personal approach to prevention in general practice. Stott (1983) certainly equates it to the concept of 'opportunistic health promotion' which, with Davis, he introduced (Stott & Davis 1979).

Terminal care

Care of handicap

Care of chronic disease

Care of recurrent illness

Acute care

Anticipatory care

Preventive care

Health education

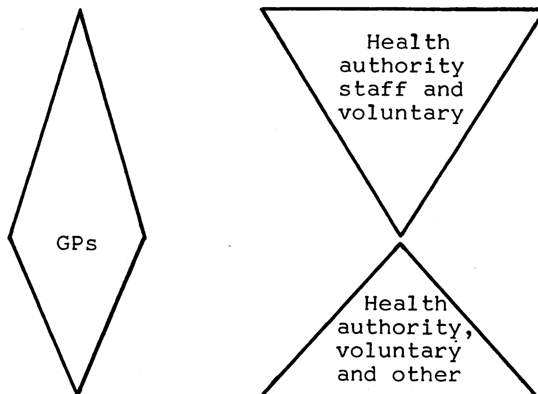

Figure 1. Different types of care and the involvement of different professions

Preventive care is encouraged by payment for items of service (DHSS 1981). In another phase of the study funded by the DHSS from which I have already drawn data (Freeling *et al.* 1984) we looked at the anonymous Statements of Account for the whole of an FPC area for the first quarter of 1981. We found that practices which were single-handed, had two or three partners, or had 4 or more partners had a similar average list size per doctor. We found a considerable proportion of non-claimers for items of service (Table 4).

When claimers only were considered (Table 5), there was no difference in earnings per thousand patients from immunization between practices with different numbers of partners, and single-handers earned most from cervical cytology. When single-handed practices which claimed were considered, those with the largest lists earned most per thousand patients from vaccinations and one claimer with a small list earned the most from cervical cytology. Single-handers with the largest lists earned from cervical cytology the mean for single-handers (Table

Table 4. Number of practices making no claims

	Number of partners			
Item	1	2,3	4+	All
Vaccination and immunization	40	5	2	47
Cervical cytology	68	22	1	91
Total no. of practices	84	56	19	119

Table 5. Claimers: mean item of service (£ per 1000) v. partners

No. of doctors in practice	Vaccination and immunization	Cervical cytology
1	23	11
2,3	20	5
4+	24	6
All	22	7

Table 6. Single-handed GPs, claimers only: item of service cash/1000 patients/quarter

	Vaccination and immunization		Cervical cytology	
List size	No. claiming	Cash claimed	No. claiming	Cash claimed
1500	7	£11	1	£23.50
1500–1999	2	£24	1	£14.10
2000–2499	8	£22	5	£9.60
2500–2999	12	£11	2	£5.90
3000+	15	£39	7	£10.70
All	44	£23	16	£10.80
Non-claimers	40	—	68	—

6). I will offer only two interpretations of Tables 5 and 6. First, many practices in the FPC area we studied were not, at the beginning of 1981, claiming for vaccinations and immunizations nor for cervical cytology. Second, list size did not predict earnings per thousand patients from these activities.

Acute care

However strongly GPs may desire to extend their range of care, we still earn our spurs with our patients by providing accessible, available medical care for needs identified by them. Whether we succeed in earning our spurs is another matter. Our postal survey of the two inner London practices showed, after excluding calls requesting an appointment, that roughly equal proportions, 60%, from the two practices had asked for advice and/or treatment when they last contacted the surgery. Seventy-five percent from the single-handed practice had spoken to their doctor in contrast to only 42% contacting the health centre, and the difference is understandable. Equally understandable, but perhaps undesirable, is the fact that more patients reported receiving advice and/or treatment on contacting the health centre than reported speaking to a doctor.

People are entitled to expect a high standard of care for acute conditions, be they life-threatening or merely inconvenient. A reasonable corollary would be that the more serious the condition the more one might expect to find consistency in its management.

Care of an acute episode of asthma in a child: Acute asthmatic attacks in children are very worrying to parents and very distressing to children. They seem also to arouse considerable anxiety in doctors.

There has been a continuing increase in admission to hospital for childhood asthma in the South West Thames Region (Anderson *et al.* 1980). From studies of case-notes and a household survey (Anderson *et al.* 1981), Ross Anderson and I derived a patient-management problem (PMP) based on the Modified Essay Question (Hodgkin & Knox 1975) of the Royal College of General Practitioners and mailed it to 618 GPs in three contiguous Family Practitioner Areas in South West Thames. It concerned an 8-year-old boy with an attack of asthma which had lasted 20 hours and was 'getting worse despite receiving his usual treatment for attacks of 2 mg four-hourly of salbutamol'. We received completed responses from 321 (52%) of the GPs mailed and have reported the 'substantial variation between general practitioners in their tendency towards hospital admission and treatment at home' (Anderson *et al.* 1983). Thirty-five per cent of our respondents would have admitted the child at the first opportunity offered in the PMP, and another 48% would have done so after 30 minutes if there had been little or no response to the treatment they had initiated. Seventeen percent of responders would have continued to treat at home.

Whatever else, this is variable management of a non-varying case. The variation may be explained by the attitudes of the doctors concerned and their judgment of how best to relieve the worries of the child and his family, let alone those evoked in themselves.

My colleagues Patrick White and Cathy Pharoah, as part of a new and larger study, mailed two more PMPs to Croydon GPs. One concerned a 10-year-old girl, Ann Adams, a new patient with a history of longstanding wheeze over seven years which was inconvenient although not severe. She woke regularly at night with a cough which went on for 20 minutes, had missed 12 days school last year because of wheezing and was unable to take part in her physical education class. Her school reports had been getting steadily worse over the past year. We received 76 completed PMPs from 152 eligible GPs. The management reported was as variable as that for the acute attacks.

Ross Anderson asked 41 hospital paediatricians to complete the PMP on the ten-year-old girl as if they were themselves Ann Adams's general practitioner. The responses of the consultants also showed very variable management. Table 7 shows the decisions about referral for specialist advice at the two opportunities afforded in the PMP.

Both the PMPs mailed had what we call 'strategy questions'. The third read: 'From your experience choose the programme of care which would have the best long-term outcome for a

Table 7. Decisions to refer 10-year-old asthmatic girl

Respondents	First consultation	Second consultation	Neither
Consultants ($n=41$)	22 (53.6%)	10 (24.4%)	9 (22.0%)
GPs ($n=76$)	17 (22.4%)	33 (43.4%)	26 (34.2%)

Table 8. Strategy for programme of care of 10-year-old asthmatic girl

	GPs ($n=76$)	Consultants ($n=39$)
Regular hospital asthma clinic 6-weekly	5 (6:5%)	15 (36.5%)
Alternating hospital asthma clinic and GP 6-weekly	26 (34.2%)	19 (46.3%)
Yearly hospital assessment and 6-weekly GP	23 (30.2%)	5 (12.1%)
Hospital assessment on GP's request only	21 (27.6%)	—

child with chronic severe asthma (requiring inhaled salbutamol, beclomethasone, cromoglycate, and oral theophylline daily)', and offered four options. These and the distribution of responses are shown in Table 8. The GPs did not agree with each other, nor did the consultants, nor did the GPs agree with the consultants. It could be argued that the consultants were drawing on their impressions of GPs who refer patients, whilst our GPs were self-selected for being willing to answer the PMP, but nothing removes the variability.

Terminal care

The care of the dying has usually been considered the province of the GP. The quality of that care has often been criticized (Cartwright *et al.* 1973) because many symptoms go untreated due to problems of communication. The development of the hospice movement from 12 in Britain 20 years ago to 81 now, with 30 more in the planning stage (Smith 1984), may represent another example of the replacement of general practitioners by specialists.

Dr Lea MacDonald, a medical sociologist, has recently conducted a pilot survey for a study being planned at St George's by a multidisciplinary team. GPs in two districts have been notifying patients with cancer when they receive a hospital letter indicating that treatment has moved from the curative to the palliative. Those whom the GP thinks can be approached are interviewed. Review of the data from the first 30 completed interviews has shown many patients with unrelieved symptoms including pain, sleeplessness, and constipation. Among suggestions for improvement of standards of general practice is that doctors should take their own night calls for this group of patients. Caring for dying people is exceptionally difficult. Our responsibility is to understand this, to do our best despite it, and to learn the language of the communcations of preterminal patients and of the relatives or friends who care for them.

GPs and depressive illness

Variability among GPs in their ability to detect those suffering from psychiatric disorder is well documented (Marks *et al.* 1979, Zintl-Wiegand & Cooper 1979) and it has been suggested recently that we should be supplemented if not replaced by a screening questionnaire (Skuse & Williams 1984).

As part of a larger survey undertaken in collaboration with Professor E S Paykel, the General Health Questionnaire (GHQ; Goldberg 1972) was given to all attenders aged 18–65 at the surgeries of a number of collaborating GPs. Those scoring 5 or more on the 30-question GHQ were offered an extensive diagnostic interview, at home if they wished, by a research psychiatrist.

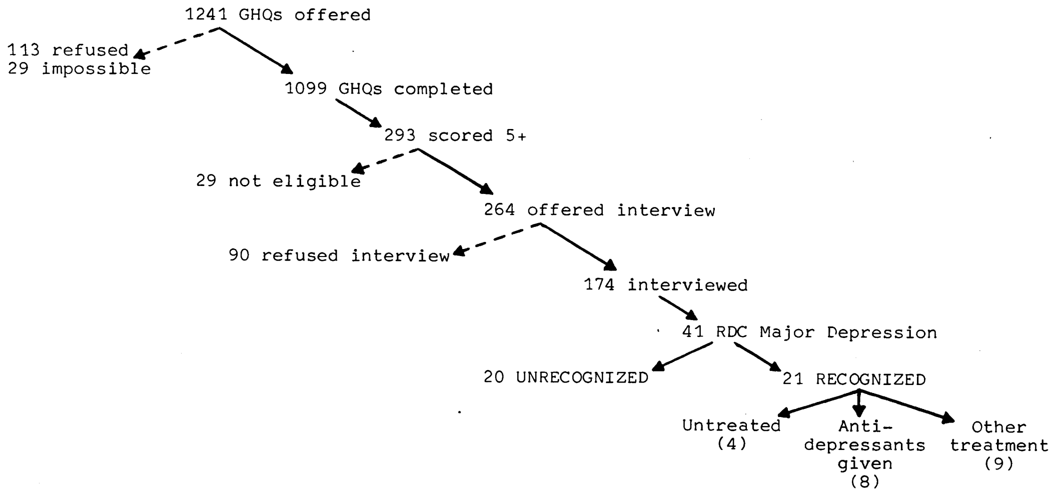

Figure 2. Screening GP attenders for depressive illness. (GHQ, General Health Questionnaire; RDC, Research Diagnostic Criteria)

At the end of the screened surgery the GPs were asked to identify patients started on antidepressant drugs, and those they had thought depressed enough to be given some other form of management or to be given an appointment for review. The results are summarized in Figure 2. Of 174 people interviewed, 41 (24%) had major depression on the Research Diagnostic Criteria (Spitzer *et al.* 1978) half of whom had not been suspected by their GP to be even a little depressed.

To be fair to the GPs, it is not certain that the depression they missed would have benefited from treatment. However, three months later the missed depressives were, on the whole, worse than those who had been treated. The decrement might have been larger if more of those prescribed antidepressants had completed a minimal therapeutic dose of 75 mg a day for four weeks.

Conclusion

I find myself returning constantly to my original belief that the special function of the general practitioner is to learn the language of the communications of his patients and that all else flows from this. If we fail to comprehend what we hear, we will not comprehend how we are heard. If we lead our patients to believe that we can provide things which we do not provide, then we will lose our credibility.

I began this lecture by asking whether personal care in general practice was a myth or an ideal difficult to attain. There seems little doubt that the arrangements we have made to provide an extended range of care to a practice population have increased the difficulty of providing personal care. The task is made doubly difficult by the need to return to those patients who can accept it the autonomy they offer up when they consult us. Those patients who are only temporarily dependent on us (Thomas 1974) must be given independence, whilst for those who cannot accept it we must take continuing responsibility. We must beware of misunderstanding the implications of the possessive usage 'my patient' and so abrogating the contract from which it arises. We must consider most carefully what our contract makes it proper to delegate to others. If this means working with difficult people with easy illnesses, then so be it. You may, as I do, sympathize most strongly with the lady from whom I stole my title. She said: '*My* doctor *is* nice, every time I see him I'm ashamed of what I think of doctors in general' (Peter 1980*b*).

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