

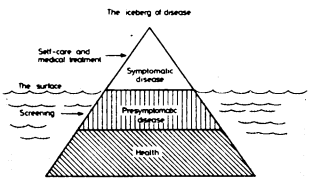
PRACTICE OBSERVED

Practising Prevention

What does it mean?

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The traditional view of the doctor's role is changing. Managing symptoms is no longer adequate and the scope for doctors—particularly general practitioners—to influence the health of their patients by preventive medicine is being acknowledged more and more.



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Primary, secondary, and tertiary prevention

The ideal form of prevention is removing the cause—to call primary prevention. Much illness today is due not to external agents but to unhealthy human behaviour. Diseases related to smoking are an obvious example, and avoiding cigarette smoking is the most important form of primary prevention.

Screening

Screening is synonymous with secondary prevention. Screening is the scrutiny of a population to find those who have risk factors for a disease or have the disease itself. Case-finding is a form of screening in which the initiative is limited to the opportunistic approach: the patient seeking advice from the doctor about symptoms in which at the same time questioned, examined, or investigated for an unrelated condition.

Two views prevail about screening. The evangelists argue that doctors should be more committed to screening procedures than they are. The cynics, on the other hand, maintain that few

- of the screening procedures that have been properly evaluated have not been shown to be valid. The criteria that should be satisfied before screening is adopted have been listed by Wilson:—the condition screened for should be an important one;—there should be an acceptable treatment for patients with the disease;—facilities for diagnosis or treatment should be available;—there should be a recognised latent or early symptomatic stage;—there should be a suitable test or examination;—the test or examination should be acceptable to the population;—the natural history of the condition, including the development from a latent to a declared disease, should be adequately understood;—there should be an agreed policy on whom to treat as patients;—the cost of case-finding (including diagnosis and subsequent treatment of patients) should be economically balanced in relation to civil expenditure on medical care as a whole;—case-finding should be a continuous and not a once-for-all project.

Ethical considerations

Screening and case-finding impose obligations on the doctor over and above those to which he is normally subject. In the conventional consultation concerned with illness the patient seeks the doctor's help, and though the doctor accepts the obligation to try to fulfil the patient's needs, there is no commitment to success. In screening or case-finding, on the other hand, it is the doctor who takes the initiative and thus implies that his intervention will benefit the patient. There is a presumption not only that the abnormality that is sought will, if present, be detected, but that detection will lead to effective treatment. Moreover, there may be costs to the patient—anxiety, inconvenience, possible discomfort, and even potential harm.

Health education

Preventive medicine in the nineteenth century was based largely on changes in the environment. Because much disease in the twentieth century is caused by the unhealthy habits of individuals modern prevention depends on achieving changes in human behaviour. Smoking, overeating, alcohol abuse, lack of exercise, and accidents are major contributors to morbidity and mortality. Health education is the first step in achieving healthy behaviour. Cynics may dispute the effectiveness of health education in producing healthy behaviour, but there is accumulating evidence of such effectiveness. General practitioners may also be reluctant to see themselves as health educators but should remind themselves that the word "doctor" means teacher and that "of all the many and varied sources of health information available to the adult population it is the GP who is the most trusted and whose advice has most impact."

Role of the GP

There can be little doubt that if preventive medicine is worth while general practice provides important opportunities to practise it. The GP and his team are available and accessible to the vast majority of the population. Most importantly they have contact with people who are least likely to seek preventive help themselves, yet whose needs are the greatest. The credibility of a GP's advice is high and the role of health educator therefore all the more important. Continuity of care—the continuing relationship between the general practitioner and the patient—is as important to preventive as it is to therapeutic medicine.

References

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The usual method of reducing a dislocated jaw, is to fit the patient upon a low stool, so as an affiant may hold the head of the patient against his breast. The operator is then to thrust his thumb, being first wrapped up with linen cloths that they may not slip, as far back into the patient's mouth as he can, while his fingers are applied to the jaw externally. After he has got firm hold of the jaw, he is to press it strongly downwards and backwards, by which means the clasped heads of the jaw may be easily pulled into their former cavities. The prelanis, in some parts of the country, has a peculiar way of performing this operation. One of them puts a handkerchief under the patient's chin, then turning his back to that of the patient, pulls him up by the chin so as to suspend him from the ground. This method often succeeds, but we should think it a dangerous one, and therefore recommend the former.

We cannot however make the false observation with regard to poisonous vegetables. These abound every where, and prove often fatal to the ignorant and unwary. This indeed is chiefly owing to carduelisks. Children ought early to be cautioned against eating any kind of red berries, or berries, which they do not know, and to be directed to plants to which they can have access, ought, as far as possible, to be destroyed. This would not be difficult a task, as some people imagine.

(Buckan's Domestic Medicine, 1786.)

Organising a Practice

Advantages of deputising services: a personal view

J S K STEVENSON

By the summer of 1977 I had completed 22 years in practice and throughout had provided out-of-hours services for patients. Over the years I had developed and accepted other medical interests and responsibilities and had come to realise that night and weekend work had not only become less exciting and satisfying but indeed a positive hindrance to my making the best use of my normal working day as a family doctor. It was not just that I was getting older or that my sleep was disturbed that made me hate being on call but the fact that I could not convince myself that it was important for my patients that I should personally take my turn on the night and weekend rots.

Few issues have polarised medical opinion more than deputising services. Individuals are seldom neutral, being either strongly for or strongly against. The debate seems to have been spurred by the lack of public recognition of the key issues that have led first to rots and then to deputising services. Among these issues are the contractual independence and isolation of the general practitioner, the calculation of remuneration item by item, the difference between city practice (where deputising services flourish) and practice elsewhere (where they do not exist), doubts about how continuing care equates with continuing responsibility, and the recent but universal expectation of more time for leisure and recreation.

The debate so far

The most comprehensive examinations of the effects of deputising services have been carried out in the Sheffield area, and were reported on between 1973 and 1977 by Williams and his colleagues.¹ Their first conclusion was that the concept of personal doctoring was not being threatened. Secondly, throughout the period, despite the increasing use of deputising services, they could find no substantial evidence of shortcomings in the care provided. Lastly, they suggested that if deputising activities were reviewed regularly the limitations on their use could be lifted.

Fry's criticism of the first Sheffield report on the grounds that the quality of service had not been assessed in any detail. But this criticism could be levelled at most other parts of general practice and indeed Fry's own case against deputising services, and although the evidence on which he based his conclusions was without producing the evidence to condemn. Critics have appeared from time to time in the lay press, and though these cannot be ignored they have been mainly anecdotal, describing

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single incidents when the service had been found to be wanting. Indeed a lay survey by *Which?* magazine in 1974² found that few patients complained about deputising services.

An editorial in the *Journal of the Royal College of General Practitioners* in 1976³ supported the view that out-of-hours work should be done by those responsible for day-time work but concluded that the onus was now on those who supported this policy to produce the facts to justify it. There is no evidence that this challenge has been taken up. Crowe and his colleagues⁴ suggested that members of a partnership covering their own out-of-hours calls could provide a more personal and economic service. But they then cast doubt upon that by assuming that, since 53% of patients who contacted their practice out-of-hours received advice, in an emergency most patients wanted advice and not a visit from a doctor.

Many letters have appeared in medical journals concerning deputising services on the grounds that they interfered with continuing patient care. Indeed, Murray and Barber⁵ concluded that deputising services and continuity of care were incompatible. This criticism is rarely applied to group and team practice, where the same must hold true. I have discussed the issue of continuing care^{6,7} and agree with Hall's⁸ suggestion, based on his report on the off-duty arrangements of general practitioners in four European countries, that the case for continuing care being fundamental to good medical care cannot be made without further research.

On balance, it seemed that there was as much objective evidence in favour of deputising services as against. This lessened the feeling of guilt that I had had when I first considered using a deputy. My decision to do so, however, was taken after retrospectively reviewing the way my partners and I had dealt from September 1976 to August 1977 with the out-of-hours requests of the 5200 patients in the practice, which is run by the Department of General Practice at Edinburgh University.

Doctors' response to out-of-hours calls during one year before employing a deputy

I defined out-of-hours work as requests for home visits made and dealt with between the hours of 1900 and 0700 Monday to Friday and between 12 noon Saturday and 0700 hours Monday. During the year there were 550 requests. They were evenly spread among the five practice doctors. Our records showed which doctor was on call, on how many occasions he visited, and how many times he gave advice. The proportion of visits done to advice given varied greatly among the five doctors. One of my colleagues visited on 97% of the times he was called, whereas when I was on call only 64% of requests resulted in a visit being made. The difference was even more marked in the case of the 123 "out-of-bed" requests (from 2300 to 0700 hours) received during the year was considered separately. The same colleague visited every time he was called, while my visiting rate dropped to 17%. The differences were not due to differences in experience. The second highest "visitor" for both overall and out-of-bed

calls was the oldest doctor, and he had been longest in the practice. On the basis of this review I decided that our patients might well be better served out-of-hours by a deputy rather than myself. On 1 September 1977 I therefore started to employ a deputy to do my share of night and weekend work. My case in favour of deputising services is supported by the experience of the next three years when I monitored the work undertaken on my behalf by the deputy.

Results of using a deputy for three years

Between September 1977 and August 1980 I engaged a deputy for the hours 1900 to 0700 for each week night I was called and between 12 noon Saturday and 0700 hours Monday when I was on call at weekends. For the first year (September 1977 to August 1978) I attempted to visit and reassess, either on the same or on the following day, each of the 76 patients seen on my behalf. Three of the 76 patients were admitted to hospital by the deputy and three were referred to the local accident and emergency department for x-ray after minor trauma. Of the remaining 70 patients, 23 were not seen at all when I visited, and were not seen again during that episode of illness; 40 required no further follow-up; eight required further visiting in their home by myself or one of my partners; and nine subsequently attended surgery during the same episode. Thus 53 (70%) of the 76 patients seen by the deputy required no further follow-up during their episode of illness. Only one patient—previously known in the practice as being "difficult"—was dissatisfied with the deputy's management.

As a result of this I stopped revisiting all the patients seen by the deputy unless he thought it necessary, but continued to record facts about the deputising service either to confirm or refute some of the main criticisms levelled against it.

During the next two years (September 1978 to August 1980) a further 138 patients were visited by the deputy. Added to the previous 76 patients this made a total of 214 deputy visits. Twenty-four per cent of calls were for children between the ages of 0 and 5 years, though they represented only 10% of the practice population. There were no other significant differences in the "expected" distribution of requests by age or sex. Using information from the records of all 214 patients I examined five common criticisms of deputising services.

Common criticisms of deputising services

(1) *Deputies take too long to answer calls*—The average time taken from the patient's telephone call until the deputy arrived was 61 minutes. The variation was between six minutes (for a patient with chest pain when the deputy was nearby) to 4 hours 11 minutes (for a child prescribed penicillin for tonsillitis earlier in the day at the surgery and thought by the parents "not to be better yet"). On no occasion did a patient complain of the deputy delaying in answering a request for a visit.

(2) *Deputies do not have access to the patients' records*—This was not reported as a difficulty. In 54% of patients the reason for the call was a completely new episode of illness. In others the labelling of prescribed medicines made identification easy. The majority of calls were for common self-limiting illnesses of the upper respiratory tract (36%) and of the gastrointestinal tract (19%).

(3) *Deputies either overprescribe or prescribe inappropriately*—For 34% of patients no medication was prescribed by the deputy; 38% received only one item of medication; 25% received two and 3% three items. All the medication prescribed by the deputies seemed appropriate except that three patients were given antiarrhythmic preparations containing non-absorbable antibiotics, which are expensive and are now widely reported as being unnecessary.

(4) *The patient does not see his regular doctor*—To examine this criticism I defined a patient as having a regular doctor if he or she had seen that doctor on six or more occasions in the previous 10 contacts. On this basis, 11% of the 214 patients visited by a deputy in my behalf had a regular doctor but, as would be expected, for only one fifth of these was the regular doctor myself.

(5) *Deputies interrupt the patient's continuing care*—To answer this criticism I again examined the patients' records to find out which doctors had been concerned in the previous five contacts with the 214 patients: 60% of the patients had not been seen by me at any of their five previous contacts; 18 of the patients had been seen by five different doctors; 73% had been seen by at least three doctors. Only six patients had seen the same doctor at all five previous contacts (1 was the doctor concerned for only one of these), and 14 patients had not been long enough in the practice to have had five contacts.

It is true that our practice is atypical, being staffed to take account of our other academic activities, but, on the other hand, since many "full-time" doctors also have activities that take them outside their practices during the day and join with others to form rots for night and weekend cover the end result may be the same in "average" practices.

Deputy's work load

During the three years of the study a deputy acted as my locum on 125 nights and 23 weekends. On 55 (44%) week-nights there were no requests for visits. On 54 nights a deputy did one visit, on 14 nights two visits, and on two nights four visits. Forty-nine visits were done on Saturdays and 75 on Sundays. Forty-three (20%) of the 214 visits were between 2300 and 0700 hours. Advice was given or requested on 23 (10%) occasions without a visit being made; six of these were between 2300 and 0700 hours. The morbidity seen by the deputy corresponded closely with reported patterns of illness. His behaviour in response to out-of-hours requests over the three years was matched with that of the other four practice doctors and showed that the deputy ranked second highest in the proportion of visits made (90%) to advice given (10%).

Cost of employing a deputy

Our practice was reckoned to be of a size that would normally support three doctors and I was charged by Air Call as a casual user on this basis. Each night was charged as a single unit and each weekend as three units. During the three years of this study a deputy was therefore acting for me on 194 units of time (125 + 3 x 23). In addition there was a surcharge for every visit made between 2300 and 0700 hours. All charges were subject to an annual increase throughout the period.

The total cost over the three years was £1581. This could be broken down as follows: £6-67 for each time that either a visit was made or advice given; £40 for each visit made; or £8-15 for each unit of time. The total amount would normally be reduced to about £1200 by the doctor claiming night visit fees for the 43 qualifying visits, and in addition £1200 would be regarded as a practice expense for income tax purposes.

Conclusion

The publication in 1978 of a code of practice for deputising services⁹ and the introduction of professional advisory committees to oversee these has meant that all deputising services are now subjected to continuous review from outside. If my case in favour of deputising services with two final thoughts. Could other elements of general practice, let alone other forms

