Quality of care

When we were doing vocational training we used to dream of a time when remuneration and quality of care were matched. We used to point our fingers at bad doctors with immense lists of patients and lock-up surgeries who had many outside commitments and who appeared in their practices to meet the minimal requirements, and we noted how these doctors earned large salaries in comparison to the doctor who tried to spend all his time and effort caring for a reasonable number of patients. The Review Body has recently tried to introduce the concept of extra payment for doctors who do their own night work.[4] Surely this is a step in the right direction. Surely it recognises at last that remuneration and the quality of care should be linked. This is an opportunity that should be welcomed with open arms by the profession—and to my astonishment our negotiators turned against this idea of the Review Body. Surely there are some doctors on our negotiating teams who do not use deputising services who can champion this cause.

When doctors are paid for the quality of care they provide and when we agree what is good quality of care, then I think the deputising services will disappear. The vocational trainees of today who have seen general practice and the deputising services from both sides of the hospital/general practice fence will hasten their demise when they take up their posts as principals. Certainly my own vocational training confirmed the suspicions that I had had as a preregistration houseman—that patients admitted to hospital from the deputising services were by and large not getting as good a deal from the Health Service as those patients who were looked after at night by their own general practitioners. I think that this view is still generally held by junior hospital doctors.

Doctors who are in favour of deputising services argue that they need to be bright-eyed and bushy-tailed every morning so that they can devote themselves to their patients in a proper fashion. The use of deputising services is diametrically opposed to my concept of devotion to patients, and arguments about mental freshness are solely a justification for doing less work. Devotees of deputising services compare their hours of work with lorry drivers' and menders of washing machines, and yet surely it is the very nature of our profession that we do work harder and for longer hours and because of this attract a respect, a place in society, and remuneration greater than the majority of our fellows.

Best use of the Health Service

I believe that if these principles are accepted the result will be better care for the patient, less demand for the doctor, and a great improvement in the working relationship between doctors and patients. But even if all these principles were applied there is still likely to be a minority of patients who care nothing for the disruption caused to the doctor's life by trivial out-of-hours calls. The way to preserve the relationship between doctors and such patients is to educate everybody concerned in the use of the Health Service. We as doctors are not good teachers, despite the word "doctor" meaning "teacher." Balancing the expectations of patients against the most efficient way of using the Health Service needs urgent attention and as doctors have obviously failed in this educative task (with some notable exceptions)[5] the task must be placed in the hands of professionals who are able to do it. Doctors would obviously be closely concerned with the content of such education, but the process of getting it across may be better put in to the hands of experts in the art of educating the public. Whether this task is taken on nationally, regionally, or at practice level is a matter for debate.

I argue from the point of view of someone who practices in an area where deputising services are not available, and yet by applying some of the concepts discussed above out-of-hours calls in our practice average two a night and calls between 1 am and 7 am average one a week. Thus with a five-man practice with 11 000 patients, mainly of social classes III to V in a mixed urban/rural area, each partner is called out of his bed once a month. If these figures were returned nationally we would have no real need for deputising services, and personal and continuing care would flourish.

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ONE HUNDRED YEARS AGO The profession will be grateful to the National Health Society for endeavouring to demonstrate the evils of tight lacing to popular audiences. I fear, however, that Mr Treves, in his recent lecture at Kensington, treated the subject a little too confidently from a sanitary and a little too cavalierly from an aesthetical, point of view. I should be very sorry if anything I said could be looked on as an encouragement to tight lacing by ladies; but still I think we should take them into our councils, and discuss the subject in all its bearings with moderation. I think that Mr Treves fell into an important error when he assumed that the primary use of dressing was to cover the body and maintain an equable temperature; and again, when he asserted that a small waist in a draped figure is ugly, and offends our sense of the beautiful in the human form. Now, all anthropologists agree that the primary object of dress was decoration, and this is still the only object of dress in probably a third of the human race. It is an instinct of which the physiologist takes no note, but nevertheless is as potent in High Street, Kensington, as in the centre of Africa or the provinces of North America. The decorative use of dress is not only a fact, but the first fact to be taken into consideration by reformers of the dress of the period. Again, it is idle to attempt to convince women that small waists are ugly, by comparing them with casts of nude figures of ideal proportions. Comparisons are odious, and this is a supremely odious one to women, and, moreover, a very unfair one; drape the figure, and see what becomes of its grand proportions. A custom which is so general must have some *raison d'etre*, although women cannot explain it. Some women think that men admire small waists; and, until the question is decided by a vote by ballot, they will not believe otherwise. In truth, small waists in draped figures are the result of the law of proportion, which is at the bottom of our sense of the beautiful, not only in the human form, but in all other objects. Professor Zeising, to whom we owe the discovery of this law, states it thus: "If the divisions of a whole (made up of unequal parts) appear proportional, the smaller part will bear the same relation to the larger that the larger does to the whole." Now the waist forms the division of the body which gives these proportions. Thus, if we take a well proportioned figure, and represent its total height by 1,000, we shall find the portion below the waist is represented by 618, and the portion above it by 382 parts; and 382 is to 618 what 618 is to 1,000. Zeising's law applies equally well to the hand, the head, the arm, and the leg; and, indeed, to all animate and inanimate objects which appear proportional to us. But in some nude figures, the proportional division is not at the waist, but at the knees. In the Venus de Medici, where the arms are folded across the body, this is the case; hence the charm of young girls with short skirts and no waists (and perhaps of men in frock coats). The shorter the skirts in children, the better the proportion appears; but as they grow up, and their skirts are lengthened, a new division line becomes necessary, and the waist is constricted accordingly. The dress reformers should, therefore, bear in mind that dressing is the instinct of decorating the body, and that a small waist is the result of a law of nature; but within these limits there is ample room for their efforts for improvement; many dresses are fantastic and in bad taste, and most waists are constricted too much even from an aesthetical point of view. (*British Medical Journal*, 1882.)

Practising Prevention

Opportunities for prevention: the consultation

S A SMAIL

Since the inception of the Health Service strategies for preventive care in general practice have often centred on establishing special screening programmes or clinics, such as cervical cytology or well-baby clinics. Yet many doctors now appreciate the wide potential for preventive care that exists in every consultation. About 75%, of patients consult at least once every year,[1] and nearly all patients are seen at least once every five years. Patients not only trust their own doctor's general advice about health but also they expect more explanation and discussion in the consultation.[1] Patients are therefore receptive to advice about prevention during the consultation. Indeed, the "illness interview" may be the only opportunity to discuss prevention with those patients who are unlikely ever to attend special clinics set up to provide preventive or anticipatory care.

Perceiving opportunities

The most obvious examples of preventive care are those related to the problem presented by the patient. Doctors feel most comfortable discussing secondary prevention (screening) and tertiary prevention (treatment), though by inclination and training they may still find it easier to reach for the prescription pad rather than discuss preventive action with the patient. Yet patients can only avoid recurrence of problems as diverse as backache, nutritional anaemia, or attacks of gout if they fully understand the cause of the condition and ways to avoid it. Such explanation and advice has been called "patient education," and its importance in primary care is now widely recognised, particularly in the USA,[2] though it is neglected surprisingly often by British general practitioners.[3] Patients readily accept this type of advice and invariably recognise its relevance.

There are opportunities for preventive care that are quite unrelated to the presenting problem in nearly every consultation.[2] Doctors often feel diffident about discussing primary prevention or health promotion with patients, but nevertheless patients appear to appreciate such advice and there is some evidence that it is effective. It is easy to persuade a patient who has a chest infection or has recently suffered a myocardial infarction to give up smoking, but a surprisingly high success rate can also be achieved by giving the simple advice to stop smoking to all smokers, whether or not they have consulted with a problem related to smoking.[4] Other opportunities might include advice about diet, exercise, or contraception.

Specific screening or case-finding procedures may be carried out during consultations. Most general practitioners now agree that patients over 35 years of age should be screened for hypertension during the consultation, but few actually do it.[5] Patients may also be advised about immunisation or cervical cytology—preventive care that has the added advantage of being potentially profitable for the practice. Although immunisation of infants is generally carried out routinely it is easy to forget that middle-aged and elderly patients may never have had a primary course of tetanus toxoid injections.

Perhaps the best opportunities for offering advice are when patients consult for preventive care—for an antenatal visit or for immunisation—when other topics of primary or secondary prevention can easily be introduced. An initial request for contraceptive advice presents a wide range of possibilities and may require discussion of several of the following points:

—attitudes to and knowledge of contraception, conception, and venereal disease;
—smoking (particularly in relation to oral contraception);
—rubella immunity;
—cervical cytology;
—breast self-examination;
—diet;
—potential risks of genetic disease.

Communicating with the patient

The patient is most likely to accept preventive advice if he (or she) feels that the doctor has fully understood his problem. This is only possible if the doctor has taken the trouble to find out the patient's views and beliefs about health and disease.[6] The patient can then be given advice that is congruent with his or her own beliefs, and there is less risk that the advice will be inappropriate. There are dangers in an over-enthusiastic approach to preventive care, particularly if the doctor gives a great deal of heavy-handed proscriptive advice. There is some risk of alienating the patient, but this can be avoided by showing sensitivity to the patient's own views. After discussion with the patient it is important for the doctor to check that the patient fully understands what he has said. Although patients obviously need to understand advice before either accepting it or acting on it, in fact it is unusual for doctors to check patients' understanding of advice given.

Thus it is essential to ensure that there is sufficient two-way communication in the consultation if preventive advice is to be successful. Many general practitioners feel that they possess ample innate skills in communication, but there is evidence that although a large part of the consultation may be spent in "exposition" to the patient[7] much of the communication is one-way from doctor to patient and may leave patients confused.[8] Doctors can, however, improve their skills in communication, particularly by using audio or video recordings of their consultations to provide feedback of their own performance.[8,9] This should improve the effectiveness of any preventive advice given during the consultation.

To reinforce the points made the patient can be given a simple leaflet so that he or she may refer to it later, knowing that the contents carry the doctor's approval. Practices may wish to design their own leaflets[10]—remembering that the language must be kept very simple—but there are now many leaflets specifically designed for use in the consultation—for example, the "Give up Smoking" leaflet available from the Health Education Council.

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Extending initiatives taken during the consultation

Some general practitioners acknowledge the importance of preventive advice but feel that their consultations are inevitably so brief that it is difficult if not impossible to deal with anything other than the presenting problem. Much preventive advice, however, can be given very quickly, and initiatives taken in the consultation can be extended by other practice staff.

All members of the practice team should agree a list of priorities that may be reviewed at intervals. Initial objectives might include advice about smoking and rubella, and 'flu immunisation. Each member of the practice can then develop his or her own contribution. In the consultation the main task is to identify preventive opportunities. Other staff members may then give further advice or carry out specific procedures—either at the same visit or later. The receptionist can supply appropriate literature and ensure that details of preventive action are entered in the patients' records, and the practice nurse can carry out immunisations, teach breast self-examination, or check blood pressures. The health visitor already has a general responsibility for giving preventive advice to patients but also can reinforce specific advice given during the consultation. The most important step, however, is for every member of the practice to develop a sensitivity for preventive opportunities at each and every contact with patients.

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The GP and the Specialist

Dermatology

LIONEL FRY

Dermatology still baffles many general practitioners, and this probably reflects the lack of tuition and the way that dermatology is taught at both undergraduate and postgraduate levels. The fault cannot be placed at the door of the dermatologists alone: those who plan the undergraduate curriculum and postgraduate training schemes for general practitioners are also to blame. Dermatology also suffers because the body can function reasonably well when the skin is affected by disease, as opposed to organs such as the heart and nervous system, and thus dermatology tends to be considered of less importance than other specialties.

Common mistakes

NAILS

Patients with an abnormality of the nails are commonly referred by GPs to the skin clinic, and this abnormality is usually diagnosed and often treated as a ringworm fungal infection with oral griseofulvin before the patient attends hospital. Abnormalities of the nails commonly occur in psoriasis and eczema, and may also occur with lichen planus and alopecia areata. Psoriasis of the nails may occur without skin lesions. Onycholysis (separation of the nail plate from the nail bed) is a common disorder, and often no cause is found. Unless onycholysis is associated with dystrophic changes in the nail it is not likely to be due to a fungus. Infections of the nail with ringworm fungus are not associated with clinical changes in the nail folds. If the latter are present the diagnosis is more likely to be a monilial infection of the nail fold with secondary changes in the nail.

It is important to establish the correct diagnosis of nail abnormality and not give inappropriate and unnecessary medication.

RASHES IN THE GROIN

Rashes in the groin are common, and in most patients they are either eczematous (intertrigo) or due to a fungal infection (ringworm or *Candida albicans*). As a rule eczematous rashes do not take kindly to antifungal topical preparations, and fungal infections usually spread more rapidly with topical steroids. Topical preparations containing both steroids and antifungal agents do not seem to be the answer. If in doubt, the old fashioned paints, particularly magenta, seem to be effective but remember to warn the patient about the paint staining underclothes.

It is important to establish the correct diagnosis either on clinical grounds or with the help of the laboratory before starting treatment.

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ACNE

One of the commonest mistakes still made by general practitioners is that when antibiotics are used in the treatment of acne they are not given for a sufficient time. Most antibiotics take a month to six weeks to have an effect on acne, and giving antibiotics for less than this time is of no value. Improvement of acne with antibiotic treatment is slow and may continue for up to six months. Many dermatologists consider this as an average duration for treatment.

TOPICAL STEROIDS

Topical steroids have revolutionised the treatment of skin diseases over the past three decades, but over the past few years there has been a swing away from their use. Many GPs are undoubtedly reluctant to use topical steroids, particularly the strong ones. I think that this is wrong and deprives patients of the good results that can be obtained with these drugs. If topical steroids are used correctly they are safe, irrespective of the strength.

The important points to remember are that side effects are dependent on the duration of use and the strength of the steroid. Thus, using a potent steroid for a short duration is usually safe and often produces results, whereas using a weak topical steroid indefinitely does not. Side effects are also related to the thickness and moisture of the skin. The thinner the skin the greater the risk. As a general rule strong topical steroids should not be used on the face or the intertrigenous areas. Finally, some patients seem to have an idiosyncrasy to moderately strong topical steroids: usually young women with seborrhoeic eczema on the face. After using topical steroids they may develop a papular and pustular eruption around the mouth, known as circumoral dermatitis.

THE REFERRAL LETTER

Most patients who have a rash will have had some treatment before referral to hospital. Because such treatments may modify the eruption it is important that the dermatologist is aware of previous treatment. A dermatological history is not complete without knowing what treatment has been given to the patient. Many GPs who are not sure of the original diagnosis are reluctant to reveal their ignorance by stating what they have prescribed. Patients seem to realise more than the doctor that it is important for the dermatologist to be aware of previous treatment, and they often bring a plastic bag with an assortment of ointments that they have already used. These may be topical steroids ranging from weak to strong, topical antibacterial and antifungal preparations, and oral antihistamines to relieve the itch.

What the dermatologist has to offer

It is accepted by the GP, the dermatologist, and sometimes the patient that in some instances patients cannot be cured. The dermatologist's role may be divided into the following three categories.

CLINICAL DIAGNOSIS

With his specialised knowledge and clinical experience the dermatologist may be able to make the diagnosis when the GP has not. This is important so that the prognosis can be given even if the cure cannot. The dermatologist's role is often to give the "second opinion." It is not unreasonable if a patient with persistent endogenous eczema or psoriasis wishes a second opinion of the diagnosis and management of their problem.

INVESTIGATIONS

Dermatology is still a clinical specialty and is not so dependent on extensive investigations as other specialties. However, biopsies and mycological, bacteriological, and virological studies are sometimes necessary to diagnose or confirm the diagnosis.

Patch tests for eczema are helpful for identifying allergens and for advising patients what substances to avoid. The techniques for doing patch tests have improved over the years, and it is important that these tests are carried out by an expert. Patch tests are also helpful in a negative sense: many patients think that their rash is caused by an allergy, and until they have the tests to disprove this no amount of reassurance will convince them.

TREATMENT

Obviously, until the correct diagnosis has been made it is difficult to give appropriate treatment. The "try this" approach is all too common in dermatology. The dermatology department also has specialised treatments, notably photochemotherapy (PUVA), to offer in certain cases.

ONE HUNDRED YEARS AGO Among the exhibits of Messrs Harrison and Brass (Victoria Carriage Works, Elgin and Inverness) at the Crystal Palace are the "Acme Medical Car," and the "Improved Sanspareil Gig," which appear specially adapted to the requirements of medical profession. The principal feature of the "Acme Medical Car," is its easy accessibility, the back seat being on a level with the bottom of the vehicle, while this seat, with the back rest, will fold down and slide under the body of the car, which (the foot-board closing up) is thus converted into a gig. The "Acme Medical Car" is fitted with hand drag, folding leather hood, lamps, and loose apron, and weighs under 4 cwt, being as light as an American buggy, while possessing the great advantage of a full lock. The wheels are of hickory, the tires and body plates of steel, the springs (Armstrong's patent) extremely easy, and the axles (Daker's patent) require no washers, being fitted with a spiral spring at back of the dustpan, and another between the nut and the collet. Thus, not only is the expense of the constant renewal of washers avoided, but the jolt consequent on a wheel getting into a rut is greatly lessened. The "Sanspareil Gig" is fitted with a single axle spring placed transversely, while a spring in the front takes away the knee action of the horse. It is a handsome and strong vehicle, yet weighing only 2¼ cwt. (*British Medical Journal*, 1882.)

Anonymous calls

I seek suggestions on how to deal with the following problem. For some years, when on call at night I have been regularly telephoned by somebody who, after about five seconds without saying anything, puts the receiver down. This may happen three or four times throughout the night. The telephone exchange say that they cannot do anything as my night roster with four colleagues is not regular or constant. Clearly, changing my practice number is no solution, nor can it be intercepted unless it is left open constantly, even when I am not on duty for the practice.—P R SCHOFIELD, general practitioner, Health Centre, Rodney Road, Walton-on-Thames KT12 3LB.