*The long approach to general assessment**

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In considering the long approach to general assessment where the data are collected personally by the physician, I rely on my experience which is based entirely on general practice in the National Health Service in England. The subject can be examined in several ways but I have chosen three aspects which outline the main problems: the significance of time in the doctor-patient relationship; the long approach in general practice where there is seldom a single long interview but usually an accumulation of data over many years with many doctor-patient relationships; and the use of the long assessment as a structured procedure in the organised health check in general practice.

The use of time in the general-practitioner assessment

In general practice I see time not just as a linear measure in which data are collected, transactions completed and problems isolated and solved, but rather as a working dimension in which the physical, mental and social factors are considered.

Traditionally, the assessment depends on medical history-taking as a basis for planning the appropriate investigations. The consultation is organised around the present illness, past illness, family history, occupational and social history, and a review of body systems. Subsequently specific investigations are ordered as appropriate. The assessment also includes the patient's feelings and underlying defences about the illness and so allows a total diagnosis to be made. The physical diagnosis is the traditional illness-centred diagnosis where the doctor seeks to understand the patient's complaints and physical signs in terms of pathological lesions of the body or disordered functions of the body; whereas the total diagnosis, sometimes called the patient-orientated diagnosis, records the doctor's understanding of the complaints and signs offered by the patient not only in terms of illness but also as an expression of the patient's unique individuality, his tensions, conflicts, and problems.

Time allows the physician to collect data and permits a dynamic interplay between him and his patient. This is varied both by the personality of the doctor and that of the patient and includes three main parameters, physical, mental and social. These three dimensions can be considered as co-ordinates of a hexahedron where the physical factors are depth, the mental are width, the social are length, and time is the volume which can vary the shape of the model.

Time therefore gives the volume to the doctor-patient relationship and by its proper use enables the doctor-patient transaction to be a dynamic interplay for diagnosis, treatment and health education. The more intense the doctor-patient relationship and the more efficient the diagnostic criteria, the less volume is needed to give weight to the model. The effectiveness of time is therefore proportional to the skills of the doctor-patient relationship and to the selectivity of the appropriate investigations.

An artificial distinction is sometimes made between a diagnostic and a therapeutic interview but I believe that an assessment which is only orientated towards establishing diagnosis can make the patient feel that he is a pathological specimen and inhibit him from revealing his real problems. Indeed in several patients no total diagnosis is possible without some therapy in order to make the deep assessment. It is in the sharing and understanding between doctor and patient that the real needs and hopes of the patient can be revealed; for the doctor uses the emotional interplay between himself and the patient as a diagnostic indicator as clearly as he would use his hands or his eyes to elicit physical signs.

To speed up the interview may be disastrous and time must be used and varied according to the circumstances of the interview. It is this dimension of time which reveals the art of medicine as distinct from its science. An echo which one knows goes back to the famous

* Paper given in 1972 in Australia at the fifth international conference on general practice.

aphorism of Hippocrates: ' Life is short, and the art long, the occasion fleeting, experience fallacious and judgment difficult. The physician must not only be prepared to do what is right himself but also to make the patient, his helpers and environment co-operate '.

Any assessment which does not allow the patient and doctor to co-operate will be sterile. Medical thinking is so influenced by the fear of missing physical illness that the total diagnosis of the patient is often neglected. It is not just the physical disease but what the patient feels about the illness that also matters, and once a range of minor variations from abnormality have been disclosed there comes the greater problem of managing the patient and his feelings about his potential ill health.

Indeed what the patient wants may not be what the doctor thinks he should have. The patient's needs and the doctor's effectiveness can only be balanced if the doctor is willing and is able to allow a long enough approach to allow the patient to communicate.

Medical investigations are costly and produce anxiety for the patient. They are often used by the doctor as a reinforcement of his own potency, so I believe they are best ordered and controlled by the physician who makes the assessment and has insight into his own actions. I was a member of the study of repeat prescriptions in Balint's group at University College Hospital, London, and we found that as the doctor-patient relationship improved the number of referrals to hospital decreased and laboratory examinations were reduced (Balint *et al.*, 1970). Often we found that despite many detailed investigations the real need of the patient was missed because we failed to stop and listen and to allow him to recall why he had come to the doctor.

Time spent in the initial interview may well save much more time in unnecessary investigations later because of the lost opportunity of letting the patient talk and listening to what he has to say. In eliciting this information the general practitioner requires a planned conversational approach in which he clarifies the patient's needs and identifies the problem of balancing these needs against his own effectiveness. This process can be assisted by improvement in medical record keeping and so avoiding repetition of basic data. It is not just what is collected in the assessment but how it is collected that matters. This subject is very ably described by Weed (1971) in his book *Medical Records, Medical Education and Patient Care.*

The accumulated approach

The unique feature of general practice is in the accumulation of open ended doctor-patient transactions of variable duration. The doctor seldom takes a complete history or makes a full physical examination as taught as a medical student, but over many years gradually builds up a profile of his patient's physical, mental and social condition derived directly and indirectly from the patient and also from the environment where doctor and patient often both live. I believe that this is the long approach characteristic of general practice.

For the experienced physician this is not a matter of sizing up the patient but is a gradual understanding of the patient in which making decisions is part of a dynamic relationship. It also provides the basis of primary health care which can be spread over a wide area and for many patients. The National Health Service is built on this concept where the general practitioner accepts the responsibility of a known population on a continuing basis.

The contribution made by doctor and patient to such a relationship was described by Balint (1957) as a capital investment and it is in the proper use of this investment that the effectiveness of health care can be measured. General practice has its own time scale. It is a continuing process in which much of the material obtained about the patient comes from previous contacts and is based on impressions obtained over all these contacts. Indeed the general practitioner's decision making is so rapid that he is often largely unaware how it has occurred, as it has arisen from his vast knowledge of his patient. In such assessments the Royal College of General Practitioners (1972) has described five objectives:

(1) The recognition of acute illness threatening life,

(2) The recognition of early signs of disease which might be aborted or of which complications might be reduced,

(3) The early recognition of complications of disease not otherwise damaging,

(4) The recognition and treatment of a wide range of common conditions,

(5) The recognition of important factors in chronic conditions.

To these I would add a sixth objective, the recognition of the emotional responses of the patient which may cause or modify his illness and his emotional reactions to his illness. These criteria are always in the mind of the practitioner in his continuing relationship with the patient.

I cannot evaluate the time taken in this type of assessment but the doctor can become sensitive to his correct use of time if he is willing to submit himself to analysis by his own peer group. The contribution of Michael Balint to general practice is in understanding the effectiveness of the doctor-patient relationship as exposed by the seminar situation. The doctor in such a seminar soon learns how to make better use of his time with the long approach to assessment of his patients.

Other methods have been used and a number of workers are currently analysing the time spent in different aspects of the doctor-patient transaction. Until more is known about this the efficiency of the accumulated method of assessment cannot be determined.

Cochrane (1972) in his recent book *Effectiveness and Efficiency; Random Reflections on the Health Services* calls for new evidence to be produced by the use of designed randomised controls. The general-practitioner assessment is a suitable field for such a study. In providing health care, effectiveness, efficiency, expediency and equality may be necessary criteria in measurement but the patient is also in need of faith, hope, charity and compassion. Human suffering cannot be measured by efficiency standards alone since the price paid is not only in economic values but also depends on moral, cultural and emotional values.

The long assessment as a formal procedure

The ' on-demand ' relationship described provides only some of the doctor-patient transactions, but some general practitioners are now identifying vulnerable groups and offering health checks. With increasing scientific knowledge there has been a rising tide of expectation by the public about what medicine can do. In addition doctors are becoming better able to identify those conditions in which medical care can be most effective. The identification of treatable conditions has resulted in screening programmes conducted by general practitioners in their own practices and this has encouraged a number of doctors to invite patients for long assessment.

There is value in looking at the apparently healthy not only to detect disease and presymptomatic disease but also to attempt to define the normal range and patterns of wellbeing. Health surveillance can bring the greatest benefit to the patient where it is carried out by his own doctor who can provide a clinical consultation and continuing care.

It has been estimated that if health checks were made on the birthdays when patients were 45, 55 and 65 a general practitioner in the United Kingdom with an average list would have 82 examinations a year, or two a week. Some workers believe that the effectiveness of such assessments would reduce morbidity and make a saving in health costs. However, the value of screening tests is still uncertain and their effectiveness needs assessment.

The importance of such a health check is not only in the routine investigations but in the personal contact between doctor and patient. Burdon (1966) at Paignton carried out a long-term assessment of his geriatric patients and wrote that one of the fruits of his study was the enhanced perception of the doctor.

Laboratory investigations cause difficulties in arranging these assessments. In the United Kingdom few practitioners have their own laboratories, but with open access to district hospitals, x-ray, chemical and other pathological results can usually be obtained. For routine investigations a time lag is not unreasonable but for the patient the sooner the results can be obtained the better.

Some groups such as the young and the old are particularly helped by such assessments. As with the cumulative assessment it is not the length of time but the use of time that matters. I believe that more use of this type of assessment will be made in the future. General practitioners will then no longer need to wait for a breakdown, but will regularly look at their patients, determine their state of wellbeing, assess their physical, psychological and social problems and use their relationship to educate and promote health as well as providing treatment if necessary.

It is implicit in the general practitioner-patient relationship that from the onset the patient gives the doctor permission not only to treat, but also to advise on preventive measures. With an age-sex register a general practitioner can now identify groups and in addition to his routine

work offer organised formal assessments where there are predetermined problems to be solved. Doctors in life-assurance work are well used to this in a limited way and in occupational health interviews use questionnaires. In the routine examination of hospital staff I now take about 40 minutes for such assessments. Such time is effectively used for the assessment of health at work but I believe time could be equally well spent by using an organised assessment for some identifiable problems in vulnerable groups of patients.

Conclusions

I have described the use of time in the long approach to assessment of the patient. Time is a dimension rather than a linear measure to be used as part of the doctor-patient relationship and it will vary for each doctor and each patient. The capital investment of the doctor and patient in their relationship will add weight to the transaction and I have suggested the concept of a hexahedron where physical conditions are in depth, the mental in width and the social in length and time gives volume to the model.

If the concept of the personal physician is to be maintained, then time will be most effectively used if it can be controlled by the doctor who will maintain a continuing relationship. The unique feature of the general-practice assessment is that over many years the doctor not only has an increasing knowledge of the patient but also establishes a deeper relationship which enables a total diagnosis to be established and the real needs of the patient identified.

It is in this accumulated relationship that the real long approach in general practice becomes apparent and time becomes an effective dimension to be used. It is by the skilful use of time in this way that medical care can be most effectively provided for many patients in the community, where the saving is eventually recognised by a reduction in breakdown and emergency care because the basic needs of the patients are being met. The promotion of health then becomes an integral part of the doctor-patient relationship.

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