

# Strong medicine:

## research, education, and patient care in general practice

The fact that strong general practice is an essential component of a high quality and cost-effective healthcare system is a message that has never been fully absorbed by successive ministries of health in the UK. (The over-worked and almost meaningless term 'primary care led' seems to have been used in the mistaken belief that it just meant cheap.) Ironically, it is a message that has been stated clearly in the US, where Barbara Starfield, the distinguished health services researcher at Johns Hopkins, has published high quality research to make the point<sup>1,2</sup> and where Don Berwick, President of the Institute for Healthcare Improvement, wrote in his essay celebrating 60 years of the NHS that, 'General practice is the jewel in the crown of the NHS. Save it. Build it'.<sup>3</sup> We have done neither but instead, with the encouragement of the government, have half-dismantled it and sleep-walked into a time of peril for general practice and for patient care.<sup>4</sup> Almost all of the core characteristics of general practice identified by Starfield are in danger of becoming eroded by successive and often poorly-informed lurches in health policy.

General practice in the UK was never perfect — there was never an unalloyed golden age — but primary care problems do not require tertiary care solutions. Instead, they require the engagement of primary care clinicians, educators, and researchers working together to protect and develop the structures needed to deliver high quality patient care and to support high professional standards. Two recent publications provide valuable food for thought.

The first of these is *Tomorrow's Doctors*,<sup>5</sup> the most recent iteration of the General Medical Council's (GMC's) guide to the attributes required of medical practitioners and the educational means needed to instill them. The new edition considers the role of the doctor as a scholar and scientist, as a practitioner and as a professional. It places a strong emphasis on probity and professionalism, on

accurate diagnosis in conditions of uncertainty, on communication and leadership, and on patient safety.

The importance of general practice and the community as undergraduate educational settings has long been emphasised by the GMC, and general practice has often led the way in the quality of student experience provided in medical schools.<sup>6</sup> In some areas adjacent to medical schools, up to half of all practices are involved in undergraduate teaching, and this work is at present adequately supported through educational funding streams for hospitals and general practices. Contact with general practice throughout the curriculum is becoming the norm and, besides its educational value, provides an important opportunity for undergraduates to experience general practice and to think about it as a career option. Whatever happens to educational funding and the commissioner-provider relationship in the future, the involvement of NHS GPs in teaching the next generation of doctors will remain essential, not least if we are to eventually see off the unhelpful tribalism that still develops among GPs and hospital doctors shortly after qualification. There must be respectful collaboration across today's shifting primary-secondary care interface.

The second recent document to emphasise a key aspect of general practice is a report published by The Academy of Medical Sciences entitled *Research in General Practice: Bringing Innovation into Patient Care*,<sup>7</sup> which reports on a seminar where the contribution of primary care research to patient care was described, and the future needs of general practice research discussed. Widely regarded as world-leading, general practice research in the UK has made a difference to how we look after patients in many ways. It has helped to clarify the distribution of illness in the population and identified the fears and expectations patients bring to the consultation when they decide to see the doctor. It is increasingly providing valuable

information to support rapid and accurate diagnosis and has provided an understanding of the importance of negotiating with patients about management plans and prescriptions. Many of the drugs used to treat common complaints have undergone clinical trials in general practice, and the principles of chronic disease management have been developed in research on disorders such as diabetes and asthma. Our role in health promotion and illness prevention has been clarified by community-based research. The measurement of quality (and the definition of many of the Quality and Outcomes Framework criteria) has been guided by GP researchers. This Journal has been instrumental in disseminating much of the best of general practice research from the UK and internationally over the last 40 years, including much of the work referred to in the Academy's report.

A disproportionately small number of GPs hold academic posts in university departments when their numbers are compared with those in many other specialties; and academic training structures for interested graduates remain inadequate and need more investment. However, financial support provided to primary care research networks by the National Institute for Health Research, along with project and programme funding, offers practices an exciting opportunity to contribute to these endeavours. The development of academic health sciences centres in some medical schools provides new ways of forging closer linkage between service and academic general practice.

When the President of the Royal College of General Practitioners (RCGP) wrote that 'Only general practice can save the NHS',<sup>8</sup> I don't think she was over-stating the case. If we stand aside and allow general practice to be further disabled by clumsy reorganisation and desperate financial manoeuvres, we will see the NHS become at once less effective and less affordable. Instead, we need to work together — service general practice, the RCGP,

educators and researchers in university departments and the Deaneries, and others — to emphasise the importance of the jobs we are doing, to train the next generation of doctors to do them even better, and to provide the evidence on which to base what they do for their patients. The *BJGP* will continue to provide an expanding platform for the best general practice research from across the world, an opportunity for important developments in academic medicine to be widely communicated, and a focus for analysis to lead the debate about the future of health care and of the profession.

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**Provenance**

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# Doctors' non-verbal behaviour in consultations:

## look at the patient before you look at the computer

**INTRODUCTION**

Verbal communication in medical consultations is well recognised as being important to the delivery of medical care and is usually easy to interpret and analyse. It is discrete with clear endpoints, it occurs in a single mode, it is mostly under voluntary control, and communicates our cognitive thoughts more than our emotions. In contrast, non-verbal communication is less easy to interpret: it is continuous even in silence, can occur in several modes at once, operates at a less conscious level, leaks spontaneous cues, and is the channel most responsible for communicating attitudes, emotions, and affect.<sup>1,2</sup> We should not be surprised, therefore, that non-verbal communication plays a significant role throughout the medical

interview and is an important variable in doctor–patient interactions. Non-verbal communication helps to build the relationship, provides cues to underlying unspoken concerns and emotions, and helps to reinforce or contradict our verbal comments.<sup>3</sup>

Non-verbal communication is at its most significant in the medical interview if it contradicts the message from verbal communication. When the two are inconsistent or contradictory, non-verbal messages tend to override verbal messages.<sup>3</sup> This explains why a closed question accompanied by effective non-verbal communication will often lead to an open answer, and why patients do not necessarily believe a reassuring verbal comment if accompanied by contradictory facial expressions and vocal hesitancy.

Two intimately related aspects of non-verbal communication in the interview require consideration: the non-verbal behaviour of patients and the non-verbal behaviour of doctors. As doctors, we need to recognise and explore patients' non-verbal cues in their speech patterns, facial expressions, and body posture. But we need to be equally aware of our own non-verbal behaviour: how the doctor's use of eye contact, body position and posture, movement, facial expression, and use of voice can all influence the success of the consultation.

The article from Marcinowicz *et al* in this month's *BJGP*<sup>4</sup> reminds us that patients are carefully observing their doctors in consultations and picking up a range of non-verbal cues. In this observational study from Poland, doctors' tone of voice