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PRACTICE OBSERVED

Practice Research

Off the cuff consultations*

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Abstract

Over six months I recorded 198 off the cuff consultations that occurred at social gatherings, at chance meetings, and in medical settings outside my surgery. More men than women made such consultations, roughly two thirds were a request for health information, and just under half of consultations were with other doctors' patients. It seemed that many patients were seeking a second medical opinion.

Introduction

Continuity of care is one of the features of general practice that entitles the profession to call itself a specialty. Most studies of the content of general practice have, however, been based on surgery consultations. A few studies have looked at home visits, and a further series has dealt with out of hours calls.[1 2] In the United States the family doctor may also care for his patients in hospital.[3]

Telephone consultations have received some attention in recent years.[4] This study, however, is apparently the first attempt to describe and analyse chance contacts with patients that took place outside official settings on the street, at the corner shop, and through the car window while waiting for the traffic lights to change.

Methods and results

Off the cuff consultations were defined as medical conversations, other than with a colleague, which occurred outside the surgery and not during a home visit or over the telephone. Every such consultation was noted over six months, and this list was subsequently analysed for age and sex of the patient, subject of the consultation (the person consulting or a third party), place of contact, content, and name of personal physician. For comparison a series of consultations in the surgery was also analysed.

One hundred and ninety eight consecutive off the cuff consultations were recorded. The places of contact fell into three groups: social gatherings (39%), where the patient could expect to meet the doctor, as at synagogue; chance meetings (35%), where neither patient nor doctor could have reliably predicted meeting, such as on the street or at a party; and medical settings (26%) outside the surgery—for example, in the hospital corridor or at the laboratory, places which could be considered "professional territory."

The table gives details of the people who approached me outside the surgery compared with a group of the same size who attended the surgery.

Details of two groups of patients (%)

	Off the cuff consultations (n = 198)	Surgery consultations (n = 198)
Men	56	44
Women	44	56
Not on personal list	40	20
Third party	44	10
For child	25	4
For old parent	6	1

The content of the consultations was analysed by the ad hoc reason for the encounter. (The distribution of complaints by bodily system was unremarkable.) The most common reason (38%) for an off the cuff consultation was a request for information: "After how many years should I change my intrauterine device?" "For how long is my daughter's glandular fever infectious?" "Is it unhealthy to walk barefoot?" "What is CP?" Other reasons were for: follow up (25%), new symptoms (22%), and administration (13%).

Discussion

This small, personal series of consultations is limited by my particular social situation and that of my patients. Thus rural general practitioners who are the only source of medical information and help in their area would expect to be exposed to more informal consultations than their counterparts in the inner city. All general practitioners, however, experience off the cuff consultations wherever they practise and wherever they live. This study was conducted in the belief that objective documentation would lessen, or at least rationalise, the irritation that many doctors express over informal consultations.

The large number of consultations that occurred in medical settings, though informally, might indicate that the patient thinks that approaching the doctor in a professional setting is legitimate—presumably the doctor is "at work" and an approach is not, therefore, an encroachment on the doctor's privacy. In some other contacts, however, patients may have specifically used the deprofessionalised position of the doctor. For instance, during consultations in bathing costumes at the swimming pool some sensitive personal information emerged, and it is possible that it was the equality of the situation which enabled some patients to overcome the difficulties they had in expressing personal pain during formal surgery consultations.

The relative lack of women in the group who made off the cuff consultations might be due to social norms—the reticence of some women to accost a male doctor in the street. But it seems more likely that men in particular find it more difficult to arrange a convenient appointment during consulting hours and may take the opportunity of talking to the doctor when they meet.

Pereira-Gray, in a lecture entitled "The key to personal care," argued that personal care implies that we see few of our partners' patients.[5] In which case, the 40% of the consultations that were not with my own patients were to the detriment of personal care. Indeed, some patients may see in informal consultations a way of side stepping their own doctor, or of obtaining a free second opinion without referral. From an ethical viewpoint there would seem to be no difference between responding to such an approach on the street corner and accepting the patient for a formal surgery consultation. Therefore, a frequent response to off the cuff consultations was: "You'll have to speak to your own doctor about that."

The third parties who consulted on behalf of a dependent relative were often expressing their own anxiety rather than any real need of the patient, and handling this anxiety formed the substance of the consultation. It is understandable, therefore, that so many of the off the cuff consultations were for a third party. A similar experience was reported by Bailey's Balint group with intermediaries in home visiting.[6]

As with telephone consultations, common reasons for off the cuff consultations were early reporting of new symptoms or the follow up of existing problems. These, indeed, extend the continuity of care and are to a certain degree desirable. The most common reason was a request for health information, and most of the patients in this group were on other doctors' lists. The borderline between academic health education and the medical second opinion was not always altogether clear, and the ethical dilemma arose repeatedly.

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Reflections on Practice

Cutting open Newton's apple to find the cause of gravity: a reply to Julian Tudor Hart on the future of general practice

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"There is nothing so practical as a good theory." MARX

Julian Tudor Hart is a rare bird. He is a real general practitioner who cares for his patients. He is also an intellectual, a person who cherishes ideas, and who, following Marx's famous dictum, recognises their practical power. In four recent papers he has told us what he thinks general practice is or should be about.[1-4] Iconoclastic and stylish, this irrepressible eminence rose has caused much healthy soul searching even as far away as the amiable reaches of Western Australia. Hart first suggests that recent changes and developments in general practice have created the conditions for the emergence of a new kind of doctor. Subsequently, he has developed an intellectual framework on which this emergence might be based. The papers are timely; they have important political, economic, and medical educational implications. We salute Hart for the unique mixture of commitment and intelligence that he has brought to this endeavour.

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The new doctor—pro and con

Central to Hart's vision of where general practice is going is his call for a "new kind of doctor."[1] He has also written that general practice may be seen "as *the* major area of innovation for future medical teaching and research."[4] We write this article as people concerned in both of these areas. As such, we essentially agree with his call for a new kind of doctor. In particular we concur with those propositions derived from the work of Balint,[5] which Hart regards as the main foundations of present general practice ideology: that general practice must be placed on a firm intellectual footing and that the training of general practitioners has been inappropriate.[1] In some respects, however, we believe that Hart's vision is both flawed and limited.

The flaw is his suggestion that general practitioners "go beyond the wants of the people, in an active search for unmet needs."[1] He is partially aware of the dangers inherent in this position, for in the interview which follows his article in *New Doctor* he describes the United States' "industry" of routine health checks as one which cannot be trusted.[6] He appears, however, not to have thought his position through and his suggestion is likely to exacerbate the dangers of the "medicalisation of life" so cogently described by Illich.[7] We are not, however, concerned with this particular problem. Rather, we wish to indicate what we see as serious limitations in Hart's view of the "new doctor."

The first limitation of Hart's vision has to do with his notion of medicine. He says: "What once appeared to be . . . (the) central feature (of the Balint movement), psychosomatic medicine, proved to be a shallow concept, and is now at the periphery of serious medical thought."[1] To the extent that psychosomatics is seen as being limited to the study of "neurotics" who "somatise" their anxiety, Hart's dim view is correct. But the central notion of psychosomatics, the interplay between psyche and soma, is one of the most important discoveries (or rediscoveries) of modern medicine.[8,9] Parallel to this is a growing realisation that one of the greatest catastrophes that has befallen modern medicine is the reductionist separation of the disease from the sick person.[10-12] The central concept of psychosomatics, or what Engel has termed the biopsychosocial model of medicine,[13] is that disease, body, mind, society, and culture are profoundly interrelated in the aetiology, presentation, and management of a person's illness. To ignore this and to concentrate on treatment of the physical manifestations of disease is not only a disservice to the patient but also an implicit commitment to the sociopolitical status quo in which the cause of much illness is rooted.

One of the profound ironies here is that the concept that has been called psychosomatics—or, more recently, the biopsychosocial model of medicine—is one that almost every general practitioner recognises as a central notion underlying his or her practice. (Though, given their pragmatic distrust of theories and intellectuals, many general practitioners would express scepticism of the idea, saying it sounds like airy fairy jargon.) Yet when pressed they will acknowledge that what sort of person has the disease is often of singularly greater importance than what sort of disease the person has. Though sometimes "what is the illness" is the question dominating the doctor's task, "who is ill" is what is usually crucial to patient care. As we have discussed elsewhere, time and again the experienced doctor finds that knowledge of the patient, and of his or her social and cultural milieu, completely alters the picture of the patient's illness from that which might be drawn from the painstaking, rigorously organic description of a student.[14] The practising general practitioner may not admit it, but it is the biopsychosocial, not the biomedical, model of medicine that governs the way he or she tries to make sense of the problems thrown up by the complex social beings who walk into the surgery. This implicit model needs to be made explicit and then rigorously examined.[14]

Hart, however, sees things differently. A major characteristic of his new doctor is that the skills of the epidemiologist are fused with those of the primary care practitioner in a new style of clinical public health.[3] Looking closer at what this new kind of doctor actually does (by examining an example of one—Dr Hart himself) we see that the skills of the epidemiologist are applied in devising a screening programme for hypertension or setting up a controlled study of the effects of reducing salt intake on blood pressure.[15] Clearly, Hart's training with such doyens of epidemiology as Doll and Cochrane has greatly influenced his choice of both the objects and the methods of study for the new doctor. "All strategies," says Hart categorically, "depend on the recognition of numerators (of medical acts and events) set over denominators of populations at risk."[1] Though not denying the real contributions made by orthodox epidemiology, we believe that this discipline alone cannot meet the needs of the new doctor. Herein lies the second limitation of Hart's vision. Like the biomedical model itself, in its extreme form orthodox epidemiology is based on the outdated, reductionist Newtonian model of science (P Underwood, R Winkler, A Owen. Replacing the clockwork model—the challenge of the next 25 years. Address given to symposium at University of Western Australia, 23 April 1982).

Adherents of this Newtonian model have often defined science narrowly. They have excluded the "vagaries" of human behaviour from their purview and concentrated on that which may easily be turned first into a simple measurement and then into a statistical construct. This has unnecessarily restricted the fruitfulness of orthodox epidemiology. What the new doctor needs is a social epidemiology based on a wider view of what is subject to scientific investigation. This should not only extend the notion of what is subject to quantification, as has been done in sociology and psychology, but should also recognise the importance of the rigorous collection of qualitative data that characterises much anthropology. By drawing on the insights of the behavioural and social sciences this approach would give renewed recognition to the importance of the whole person.

Such a view has important ramifications. According to Mosley, one of the most experienced observers of international health, the problems of disease in the Third World will never succumb to technical solutions; the central obstacles to progress in health have to do with people's behaviour and the way they organise their societies. New ways of studying these phenomena are needed.[16] Engel took a major step in this direction. In formulating a new model of medical care, he referred to a "systems hierarchy," encompassing a series of levels from the subatomic through the cellular, organic, psychological, individual person, through to the social, and up to the biospheric.[13] Whereas a disease may be examined at any of these levels, the disease process operates dynamically by influencing each level up and down the hierarchy and is itself shaped by processes at each of these levels.

Again, we recognise that such an analysis may seem exotic or pretentious to the practising general practitioner. A good general practitioner, however, implicitly recognises that the systems hierarchy is one of the facts of his working life; it brings him some of his greatest rewards and challenges. Let us give an example from our practice.

An 18 year old man, an intermittent asthmatic, is brought to the surgery distressed and severely short of breath. The immediate problem is anoxia—a problem at the level of the organ and the cell. The general practitioner responds with a salbutamol nebuliser and a hydrocortisone injection. As he recovers it is clear that the attack was precipitated by his having stopped taking his medication, having left home and got into "bad company." The general practitioner knows something of the family problems that have led to this. The family is Anglo-Indian, and their strict views on discipline led to the conflict with the son. The general practitioner now moves to a different level, the psychological and cultural, and by various means endeavours to piece together the boy's identity and social supports, the dislocation of which has "caused" the asthma attack and led to such dangerous consequences for the integrity of tissue and cell.

In this example the doctor knows that he must perform a balancing act, moving without effort from one level to another. Is it any wonder that often the general practitioner views hospital specialists, replete with the latest biomedical wizardry for investigations at the level of cell, organ, and even molecule, with a mixture of respect, envy, and scorn? For it is clear that the reductionist approach, despite its staggering power, loses something essential. A general practitioner might explain this by saying that a person is more than his or her cellular functions, while a theoretician would say that though disease processes are subject to the natural laws that govern phenomena at lower levels, because of the emergent nature of phenomena at higher levels they are also subject to natural laws of their own. Thus illness can no more be reduced to biochemical or cellular pathology than can biological activity to the laws of physics.

If the new doctor is to deal with the whole person the methods that he or she uses must take account of his systems hierarchy and the many factors that affect illness and illness behaviour. The epidemiology to which Hart refers is insufficient to generate such methods. It is not only insufficiently "social," but it tends to ignore the powers of people to manage their own illness. Patients in classical epidemiology studies tend to be seen as "subjects," "machines," or, to use Hart's term, "denominators in an equation." Patients, in fact, struggle to construe their health and illness, and the general practitioner must deal with this for his or her methods to be effective.

Dilemmas in general practice

The direction of general practice is now bedevilled by several dilemmas. Given Hart's position as a starting point and the views that we have expounded above, we believe that a way out of these dilemmas may be found and briefly outline four of these.

Art v science—This dilemma grows out of the view of those who define science so narrowly as being concerned only with that which can be strictly and easily measured (preferably by a machine). Those who hold such a view relegate such matters as the relationship between doctor and patient, patients' attitudes and beliefs, and doctors' attitudes and beliefs to the art of medicine. This art is handed down from teacher to student in arcane rituals bubbling with mystique and recondite symbolism. It is therefore regarded as woolly, unteachable, and irrational. We believe, however, that such a demarcation is fruitless. What is required is a widening of the notion of science. The narrow view that excludes the dimension of the patient's illness and the doctor's behaviour from the study of medicine is not only ludicrous but profoundly unscientific.[17] In Hart's otherwise brilliant critique of medical education[4] this aspect is totally ignored.

Do your own thing in your own place—Some have argued that what is required in general practice is tilling one's own garden. Since the study of general practice is new the priority is simply to describe what happens in general practice as if it were apart from the central controversies and breakthroughs of modern medicine. Much of this research is simply stamp collecting—for example, number of patients seen and case file analyses. It also fails to include in its conceptual framework the thoughts and feelings of actively coping individuals, who shape and are shaped by the groups and society in which they live. The biopsychosocial approach, discussed above, lies at the nub of general practice. To exclude it by simply describing it is to strike at the very roots of general practice. Stott has recently made an outstanding attempt to bridge the gap between theory and practice to establish a structure from which general practitioners can practise and develop their specialty.[18] Such an approach is seminal to a general practitioner's daily work and central to the future of general practice.

Applied v basic research—It is commonly agreed that general practice research must be applied. This is another sign of the insecurity and parochialism of the discipline. If a professor of medicine stopped his staff from making legitimate investigations into the cause of, say, hepatitis, and insisted that they investigate only its treatment he would be laughed out of court. If, however, a professor of general practice says the same thing and insists on only applied research he is judged to be practical, worldly, and showing a caring attitude to patients. If, as we argue, the proper study of general practice is the understanding of disease and illness in peoples and communities there is clearly room for basic and applied research. Both are legitimate—even if at any one time the balance between them varies. Basic research includes the study of how social, cultural, and emotional factors influence the causation, prevalence, and presentation of disease. Applied research includes the analysis of what the general practitioner does as well as what is valuable in what he or she does.

Research v teaching or research v practice—One school of thought (which, sadly, is often vocal in universities, of all places) maintains that general practitioners should only practise and teach. Research is judged to be a peripheral or frivolous activity or suitable only for pompous and pretentious specialists. A gifted teacher and recent visitor to our department of community practice put it frankly: "Research is an élitist paper chase." That speaks volumes on our lack of confidence in and understanding of our own discipline. We argue, after Hart, that the emergence of a new discipline of general practice makes the need for research more pressing, not less. Unless the general practitioner knows what he or she does, understands how and why people come to the doctor, and which things the general practitioner does that are effective he or she will not know what should be taught.

Research and teaching in general practice

Julian Tudor Hart has been gutsy enough to describe not only what his new doctor should do but what he actually does. It would be unfair of us not to do the same. Our research team consists of a clinical and research psychologist (RW), an academic general practitioner with special interests in medical anthropology and psychology (PU), and an anthropologist with a master's degree in public health (DG). We have been closely associated with a social psychologist, a health educator, and a practising general practitioner. The composition of the team reflects a recognition that the problems we study require clinical and research skills that one professional cannot possess. In the past five years we have studied the doctor-patient relationship,[19] the clinical efficacy of self help groups,[20] the attitudes and behaviour of arthritis sufferers,[21 22] the social networks and personality of high consulters,[23] and the connections between cultural attitudes, feeding behaviour, and somatic growth.[24] We are now studying the influence of the patient's personality and behaviour and of the doctor's interpersonal interaction with the patient on the patient's response to treatment of hypertension. In all our work we aim at applying the research methods of psychology and anthropology to common clinical problems encountered in general practice and to attempt to be rigorous, while accepting the complexity of the phenomena under scrutiny. Much of our work focuses on analyses of how the use of the behavioural sciences can promote more effective clinical outcomes. If clinical outcomes are not notably improved by incorporating such knowledge, then our talk of "models" and "hierarchies" indeed becomes mere empty jargon.

This research has not been undertaken in isolation from teaching activities. Engel's biopsychosocial model of medicine has been taken as a theoretical basis for the curriculum in the department of community practice. Thus the results of our own research (and those of others) have been used to show medical students the way in which disease may affect the whole person and his or her family and community. The emphasis has been to direct the students' attention not just on the patients' diseases but on the patients' illnesses[25] and the community and culture in which they live. Our central criticism of Hart is his neglect of this dimension. His view of medicine seems to us too narrowly "technical." We accept that hypertension and asthma, conditions with which he seems obsessed, are important and largely preventable. Successful treatment and prevention of these and other diseases, however, depend ultimately on such simple matters as understanding and communication between doctor and patient. Case finding and treatment are not enough: they have inevitable connotations of the magic bullet and the magic doctor.

We have attempted to produce a critique of Hart's new doctor and to suggest some other ways for general practice to develop. Our concern is to sketch another kind of new doctor. This person would draw on the behavioural sciences and new models in medical science yet remain true to something deeply rooted in general practice—the primacy of the patient's world. If a new doctor can achieve this there is less likelihood that he or she will "seek the cause of gravity in Newton's apple by cutting it up."[26]

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