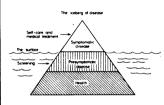
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PRACTICE OBSERVED

Practising Prevention

What does it mean?

The traditional view of the doctor's role is changing. Managing symptoms is no longer adequate and the scope for doctors—particularly general practicioner—to influence the health of their patients by preventive medicine is being acknowledged more and more. General practice provides a good framework for preventive medicine. Virtually everyone in Britain is registered with a general practitioner and, more importantly for prevention, each general practitioner has a defined list of patients. Two-nearly all of them at least once every five years. Every day almost one million consultations take place in general practice in this country. The fact that much disease is "below the surface" is illustrated by the diagram of the "iceberg of disease."



Department of Community Medicine and General Practice, University of Oxford, Oxford OX2 8HE GODFREY FOWLER, BM, PRCGP, clinical reader in general practice

Primary, secondary, and tertiary preven

Primary, secondary, and tertlary prevention

The ideal form of prevention is removing the cause—so called primary prevention. Much illness today is due not to external smoking series of the cause of t

Screening
Screening is synonymous with secondary prevention. Screening in the scrutiny of a population to find those who have risk factors for a disease or later the disease roll and those the disease of the parties of the secondary is promited to the parties of the parties of the parties of the parties sching is of the parties sching advice from the dector about symptoms is at the same time questioned, examined, not investigated for an unrelated condition. This contrast with the more aggressive pursuit of the individual with no complaint to which anarow definition of screening may sometimes be confined and which is a feature of population surveys. The term "anticipatory care" has also been used to describe case-finding.

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

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Organising a Practice

Advantages of deputising services: a personal view

I 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 interests and responsibilities and had come to realise that night interests and responsibilities and had come to realise that night 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 weekned rots. In other circumstances I might have been able to pay one of my younger colleagues to do this work for me but this was impossible, so the alternative was to use a commercial deputising service on a causal basis.

younger consequence was to use a commercial deputising service on canal basis.

Few issues have polarised medical opinion more than deputising service on Individuals are seldom neutral, being either strongly for or strongly against. The debate seems to have been blurred by the lack of public recognition of the key issues that have led first to rotas 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 series), doubts about howerest the service (where they do not 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 extract out in the Sheffield area, and were reported on between 1973 and 1979 by Williams and his colleagues.' '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 envires, they could find from the country of the c

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single incidents when the service had been found to be wanning. Indeeds lay survey by Which? magazine in 1974 found that few patients complained about deputings services.

An editorial in the Journal of the Royal College of General Practitioners in 1976 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 to the consideration of the control of

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

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. Or Friday and between 12 noon Saturday and 0700 hours Monday. During the year there were 500 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 with the doctors. One of my colleagues wisted 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 greater when the uctome of the 123 "out-of-bed" requests (from 2900 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 37%, Difference ware not accounted for by age or experience. The second highest "visitor" for both overall and out-of-bed

of the screening procedures that have been properly evaluated have been shown to be valid. The criteria that should be satisfied before screening is adopted have been listed by Wilson's—the condition screened for should be an important one; —there should be an acceptable treatment for patients with the

—facilities for diagnosis or treatment should be available;
—there should be a recognised latent or early sympton

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 develop-ment from a latent to a declared disease, should be adequately

—the natural history of the condution, including the develop-ment from a listent 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 abould be a continuous and not a once-for-all

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 flough the doctor accepts the obligation to try to fulfil the patient's needs, there is no communication to the patient of the control of the cont

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Health education

Health education

Preventive medicine in the nineteenth century was based largely on changes in the environment. Because much disease in the revenited century is caused by the unhealthy habits of individuals modern prevention depends on achieving changes in human behaviour. Smoking, overstaing, 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 here is accumulating evidence of such effectiveness. Fosteral practitioners may 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."

There can be little doubt that if preventive medicine is worth while general practice provides important opportunities to practice 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 GPs advice is high and the role of bealth 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.

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THE utual method of reducing a diffocated jaw, is to fet the patient upon a low thool, to as an affilhant may hold the head firm by preffing the property of t

We cannot however make the fame observation with regard to posionous vegetables. These abound every where, and prove often fatal to the ignorant and unwary. This indeed is chiefly owing to carelessed, foldern ought early to be caustoned against earing any kind of fruit, roots, or berries, which they do not know, and all position-tous plants to which they can have excess, ought, as far a possible, to be defitoryed. This would not be fo difficult a talk as some people in the proper place; but, as they prove often defluctive to extate, they should be roored out of all patture-grounds. They ought lakewise, for the fastey of the human species, to be destroyed in the neighbourhood of all towns and vallages; which, by the bye, are the places where they most commonly abound. I have seen the positions when the places where they most commonly abound. I have seen the positions within the memory of those livings in it, lad fold their lives by one or other of these plants; yet no method, that I could hear of, had ever been asken to court most; thought this might be done at a very trifling expence.

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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 I September 1971 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

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 on call and between the control of the control

Common criticisms of deputising services

(1) Deputes take too long to answer calit—The average time taken from the patient's telephone call until the deputy serviced was 61 minutes. The variation was between six minutes (for a patient with chet pain when the deputy was nearby) to 4 hours 11 minutes (for a child prescribed penicillin for tonsillitis carlier in the day at the surgery and thought by the parents' not to be the surgery and thought by the parents' not to be deputy as a service of the patient of the deputy delaying in answering a request for a visit.

(2) Deputes do not have access to the patient' record—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 (36%), of calls were for common self-limiting illnesses of the upper respiratory tract (36%) and of the gastrointestinal tract (36%), 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 antidiarrhocal 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 to or she had seen that doctor on six or more occasions in the previous I Ocontacts. 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 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 the different doctors; 17% had been seen by at least three doctors. Only six patients had seen the same doctor 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 scademic activities, but, on the other hand, since many "full-imers" doctors also have activities that take them outside their practices during the day and join with others to form rous for might and weckend cover the end result may be the same in "average" practices.

Deputy's work load

Deputy's work load

During the three years of the study a deputy acted as my locum on 125 nights and 25 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-three (20%) of the 214 visits were between 2300 and 0700 hours. Advice was given or requested on 23 (10%) occusions 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

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
support three doctors and I was charged by Air Call as a casual
such 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 × 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 (1381. This could be
broken down as follows: £6+07 for each time that either a visit
was made or advice given, or £7-40 for each visit made, or £8 15
reduced to about £1200 by the doctor claiming night visit fees
for the 43 qualifying visits, and in addition the £1200 would be
regarded as a practice expense for income tax purposes.

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

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of providing out-of-hours care, survive such scrutiny? And, has the time not come to consider two separate contracts for general medical services—one for day-time care and one for night and weekend work?

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Innovations

Leicestershire: Encouraging specialisation in a general practice

RONALD I THEW

Since the advent of the National Health Service the organisation and content of general practice in Britain has become more and more distanct from that of hospital practice. Today, few Britain the State of the Sta

We have 12 partners, a total list size of 31 000, and are the sole practice in the market town of Melton Mowbray (population 24 000). The community is served by an active cottage hospital (47 beds) at which visiting consultants hold outpatient clinics and operating sessions. There is also a CP maternity hospital (19 beds). The nearest district general hospital is 16 miles away in Leiciester. Most of the partners in our practice are clinical satisfants at the cottage hospital and assist with outpatient clinics and theater lists (table 1). We regard ourselves primarily as OFA and theater lists (table 1), and the control of the con

Melton Mowbray, Leicestershire LEI3 INX RONALD J THEW, MB, MRCGP, general practitioner

The expertise in the practice, which would normally be found only in hospital, enables us to refer patients to GP colleagues either formally at the cottage hospital or informally at the surgery for a surgical, gynaecological, orthopsedic, and obstetric opinion.

TABLE 1-Clinical accitant regions

Surgery Gynsecology	- 5	(1 partner)
Gynecology	2	(1' ")
Orthopaedics	3	(1)
Medicine	3	(1)
Ansesthetics	6	(4 partners
Genistrics	4	(2

TABLE II-Consultant sessions at cottage hospital per

	Outpetient	Operating
General surgery and urology	6	•
Gymaecology	•	4
Medicine (including thest		
and diabetes)	8	-
Orthopsedic	,	2
Physical medicine	4	-
Paychistry	4	-
Paediatrics	2	-
Geriatric	2	-
Dermatology	2	-
Radiotherapy	4	-
Plastic surgery	-	1

Thus, many patients can be managed entirely by us using the resources and facilities of the practice, and beds are available at the cottage hospitals if needed.

If consultant referral is indicated a wide range of outpatient and operating lists enables many patients to be managed at the cottage hospital, and since the clinical assistants are responsible for postoperative care the patient retains contact with the practice (see tables 11 and 111).

When recruiting new partners we often advertise for GPs with particular experience and qualifications. Sometimes our needs are quite specific—for example, anaesthetic experience; at other times an incoming partner is encouraged to develop his own interest.

TABLE III - Operations			
hospital in 1981 (con	sult an : an		
GP assistant			
C	32		
General surgery			
Urology	10		
Gynaecology	26		
Orthopsedic	13		
Plastic surgery	3		
Dental			
Total	86		

One of the partners has the FRCs, and his sessions as clinical assistant include his own operating lists at the cottage hospital (two a week; table IV) and an outpatient clinic. He also has a monthly session for minor operations at the practice premises, when general annesthetis, if needed, is provided by a GP anesthetist. Having a surgeon in the practice not only helps partners to develop their own minor surgical skills, but also helps the medical students and trainers.

Ganglion Pomerov sterilisation	1
Circumcision Signoidoscopy	1
Haemorrhoidectomy	
Sebaceous cyst	
Anal stretch Others	9
Total	

The following abbreviated case histories illustrate the pattern

The following abbreviated case histories illustrate the pattern of practice.

Mrs A presented to her GP with a lump in her breast. The GP surgeon's opinion was obtained and a cyst aspirated the same day in the practice treatment room. Subsequent cytology of the fluid was benign.

Mr B presented with a painful perianal mass. Arrangements were made for the GP surgeon to incise an ischiorectal abuses under general anaesthesis that afternoon, and the surgically-trained district nurse supervised care afterwards.

Mr C, a teacher, presented with an indirect inguinal hernia. We have very compact of the com

We have an open-access GP maternity unit. In theory this means that any GP in the area can book patients and assume

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BRITISH MEDICAL JOURNAL VOLUME 284 27 MARCH 1982 reasonshibity for intrapartum carc. To promote expertise and maintain experience, however, we have voluntarily agreed to delegate all intrapartum work to four GP obstetricians, all of whom are partners in the practice. They have their own separate duty rota. One of the GP obstetricians has the MRGOG, and he supervises the unit, which handles approximately 400 deliveries a year of the GP obstetricians as the service of the GP obstetricians of the GP obstetricians and midwives to agree the place of confinement. The GP obstetricians hold a booking climic and a twice-weekly antennatal clinic at the hospital, shared antennatal care taking place with the remaining partners in much the same way as in a consultant unit. An unusual feature is that other practices in the area refer their patients to us for delivery in the unit, and we share antennatal care with them. These account for about 20°, of the deliveries. A visiting consultant holds a weekly outpatient clinic, but sees only problem cases referred by us.

TABLE V-Deliveries in GP maternity unit

	1980		1981	
_	No		No	٠,
Total No of deliveries	452	100	365	100
Normal	417	92	338	93
Forcens	35	8	26	7
Twins	-		1 (undiagnosed)	
Maternal transfers in labour to district				
general hospital	18	4	8	2
Oxytocin used in labour	73	16	43	12
Induced labours	34	8	25	7
Manual removal of placents	5	1	5	1
Baby transfers to district general hospital	7	2	6	2
Post-partum sterilisation	8	2	4	1
Perinatal mortality (per 1000)	4		5	

It could be argued that these arrangements militate against a GP supervising the whole of a patient's pregnancy. We believe, however, that his is a desirable compromise, enabling us practise good obstetrics yet preserving a small personal unit. Other isolated units operate along similar lines.

GYNAECOLOGY

Two partners have a special interest in gynaecology, one of whom is an MAGOG. We can cope with many minor gynaecological emergencies, which are mainly incomplete abortions (15 patients had curettage for incomplete abortion in 1981). All the partners had curettage for incomplete abortion in 1981). All the partners who general manning, but the two partners who pecialise in gynaecology hold clinics, mainly for the insertion of intrauterine devices and diaphragms.

GP ORTHOPAEDICS AND CASUALTY

All the partners provide cover for the minor accident department of the cottage hospital. One partner, however, holds a midday clinic at the hospital in which he sees same-day referrals of truuma and suspected fractures from his colleagues (a radiographer is there from 9 am to 1 pm). He is also asked to see orthopaedic polymentation of the collection of the

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PAEDIATRICS

We have not followed the notion of GP paediatrics, as suggested by the Court Report, because we feel that paediatrics is an essential part of family medicine. One partner, however, assumes responsibility for neonates in the maternity hospital, and this ensures that someone has continuing expertise in resuscitation on the labour ward.

The four partners who are GP clinical assistants provide an anaesthetic service for visiting consultants, the partnership, the maternity unit, and the town's dentists. They administer anaesthetics for four theatre lists a week at the cottage hospital. In 1981, 101 general anaesthetics were administered on the practice premises.

MEDICIN

Primary care can be delivered to patients more comprehensively and with continuity if suitable facilities are available. We can admit patients to beds in the cottage hoopital when the indications may be for nursing care, terminal care, supervision of treatment, or investigation appropriate to general practice. We have support from visiting consultants. An example: Mrs D, aged 63, had asthma that failed to respond to medication at home, and her elderly husband was unable to with the control of the contr

Conclusion

Conclusion

Many more practical procedures could be performed in general practice, yet few incentives exist. It is an anomaly that in family practice surgical procedures, which are often time-consuming, remain unternumented though an item-of-service fee is paid for administering a general anesthetic. One is often working against a background of political difficulties, threat of closure of GP hospitals, and criticism of GP obsteries from hospitals. Compulsory ocational training, of the properties of the properti

I am indebted to Dr Robin Fraser, senior lecturer in general practice, University of Leicester, for his invaluable criticism, to Mr Bruce Williamson for advice on the work of a GP surgeon, and to Dr Darach Corvin for the audit of obstetric work.

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Contributions to the series "Innovations" are welcome for consider-

Women in General Practice

SARAH BOSWOOD

When at the age of 10 I announced my intention of becoming a doctor my mother's immediate reaction was: "How nice. What a good career for a woman." University, medical school, house lobs, marriage, six years in genome, which was a compared to the property of the propert

London SW4 8AF SARAH BOSWOOD, BM, BCH, general practitioner

rounded hospital experience without having to break into another specialist career structure. The schemes are flexible enough to allow transfers from one to another should a move to another stould a move to under district be necessary. This structure are the structure of the st

ing to a practice taking on such an unlikely candidate. I was happy to accept a salary, making the settlement more flexible and giving a longer trial period to set if the idea was feasible. I was already I-ing in the area and, in view of my husband's job, unlikely to be upproored. In some restricted area family practitioner committees will consider a 'ined' woman partner ioning to the proposed of the proposed o

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ministri MEDICAL JOURNAL VOLUME 284 27 MARCH 1982 employed people in a partnership are not bound by any of the current legislation governing maternity leave and so a thorough understanding among them is important. My personal philosophy has been that, provided my legal agreement is reasonable and I am to have a privilege not granted to my partners, I should hold myself responsible for any additional leave that may be necessary connected with pregnancy or confinement. In exceptional circumstances prolonged absence of this nature may be committeed. Lough is now there were delivered to the committee of the committee of the committee. Lough is now there were delivered to the committee of the commit

the construction of the control of t

Clinical Curio: a recurring irritation

Another year has gone by with people being upset by reactions to the dyes used to re-tim tangernes and satsumas. Early on Christmas Day I attended an aspolagetic and unthappy pattern with quare severe and the same properties of t

W Mitty's father came to see me. His son's medical record envelope was empty, except for the documentation of routine immunisations as a child some 20 years ago. Mr Mitty was annious about his son's behaviour. The boy was doing very well as a free-lance journalist but some things were not quite right. W wasn't exactly lying, but

some of his behaviour wax a little abnormal. For example, he had applied to various publishing houses in the hope of getting a novel published. All had returned overenthusiastic replies, with offers of very large sums of money as advances on future sales. When W* father had looked up the address of one of these publishing houses in the telephone directory he could find no record of it. It was all a little odd. of the letters, all typed on elaboratively headed stationery. There were also letters from various finance houses regarding somewhat grandious exhemes of financing books and other business ventures, which had been found lying around the house in Jack's absence. I examined the heading cumbeled sawy. It had been paintakingly applied by Letraset, and all the complexities of the business correspondence before me represented nothing more than W* vivid unsignation.

When W uruned up a few days later a few minutes of gende probing that the propersion of the complexities of the business correspondence had been appreciated over the gast few months. He has had his chlorpromazine regularly since being admitted to hospital and now looks back on his rather effective forgreies as a bad dream.—PAU. C aversa, general practitioner, Romford, Essex.