PRACTICE OBSERVED

Good Practice

What is a good GP?

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The good GP will treat patients both as people and as a population.

Treating patients as people

It has been said that "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."[1] What this implies for good practice falls under the following four headings.

Assessing patients' problems realistically—Making a precise diagnosis is not always necessary or always sufficient. It is all too easy to focus on a disease process in one part of the body and to neglect the "owner" of the body and his or her physical, psychological, and social circumstances in their entirety. Unless these aspects are considered, not only may many factors that affect the aetiology and natural history of the disease and the choice and effectiveness of treatment go unnoticed, but so may the patient's real reasons for consulting the GP.

Responding realistically to patients' problems—Just as the assessment of patients' problems should often include more than clinical diagnosis, so should the response entail far more than prescribing drugs and referring to consultants. It may, for example, mean helping the patient to get financial, psychological, or social support. Of course, the GP cannot be self sufficient in these areas: he or she must recognise, respect, and use intelligently the skills not only of hospital consultants but also of non-doctors in the primary care team, in departments of social services, and in voluntary agencies such as marriage guidance councils, opportunity groups for handicapped children, religious organisations, and self help groups. The GP should also be willing to receive referrals from such sources. Diabetic clinics, for instance, should be able to refer many patients to GPs for continuing care.[2]

Ability to collaborate and communicate—The good GP will also understand and be understood by patients and their lay carers. By being a good listener and giving appropriate explanations of problems and treatments, the GP will support each patient, their carers, and indeed the whole family, and seek their cooperation in dealing with these problems.

Sensitivity to ethical issues—Treating patients as people entails respecting their autonomy. This implies helping them to retain as much control of their bodies, minds, and lives as they can—for instance, by letting them help to choose what responses should be made to their problems.[3]

Treating patients as a population

The policy of the National Health Service of paying each GP a capitation fee for each registered patient rather than a fee for each service implies that the GP has a responsibility for all these patients and not merely for those who are being treated. The good GP will therefore aim at preventing, curing, and alleviating disease in the whole practice population as well as in those who seek treatment. This means pointing patients towards healthy lifestyles (by example as well as precept); achieving and maintaining high immunisation rates; being quick to notice miniepidemics and evidence that environmental causes of diseases may be prevalent and doing whatever is indicated to protect those at risk; and offering screening for conditions such as cervical intraepithelial neoplasia that are curable and for those such as visual, auditory, and foot problems in the elderly that can be alleviated.

These population-oriented activities differ from other patient contacts because they are initiated by the doctor rather than the patient, which means that the GP should undertake only those

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activities that can be expected to be of appreciable net benefit to the population to which they are offered. Screening procedures in particular need to satisfy many criteria before being introduced.[4] Deciding whether to offer a procedure to patients only when they consult for other reasons or to invite them to attend specially may also be difficult. GPs therefore need to keep abreast of published work on the benefits, risks, and costs of the preventive and screening procedures with which they are concerned. They cannot rely on personal experience alone since this will hardly ever yield enough data to be conclusive. There is a place, however, for within-practice assessments of preventive measures, such as studies by questionnaire of patients' smoking habits before and after an antismoking initiative. Furthermore, population-oriented practice heightens the need for GPs to computerise their records of patient contacts so that these can be used efficiently to detect variations in morbidity owing to environmental hazards and to identify patients who are due for preventive or screening procedures.

Conclusions

The government's consultative document on primary health care suggests introducing a good practice allowance for GPs who provide effective preventive and screening services and satisfy other criteria.[5] This might encourage GPs to treat their patients as populations, especially if suitable computer systems and training in using them are also provided.

The government may not be able to do as much to promote the treatment of patients as individuals. GPs might have more time to give to each patient if list sizes were further restricted and primary care teams expanded. Adding social workers and others with counselling skills to primary care teams would also encourage GPs to refer patients to such workers. More importantly, entrants to the medical profession should be selected for compassion as well as intellect and be encouraged to treat patients as people by the example of the clinicians on whom they model themselves. "If I know all mysteries and all knowledge but have not love, I am nothing."[6]

References

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6 *Holy Bible (Revised Version)*. I Corinthians XIII, 2.