LECTURES AND ADDRESSES

An anatomy of general practice

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Dr. J. C. van ES in his inaugural address on taking up his duties in March 1967 as Professor in the Medical Art of the Family Doctor at Utrecht University said that family doctors, in particular, have become so beset with doubt as to the professionalism of their calling that they are quite at sea about their own identity. This is largely due to the fact that the unity of knowledge shared by all doctors has long been disrupted by the unavoidable and very necessary process of specialization. But there are now many signs that there is a great renaissance taking place in general practice. With the advent of the National Health Service and the tremendous growth of the specialties, the family doctor has been passing through a bewildering time wondering what his future role, if any, is to be; and in trying to define his future role he has been called many things by all men. He has been called the family doctor, the community doctor, and the generalist, but with the advent of the Royal College of General Practitioners and its spread to Canada, South Africa, and Australia, it can be taken as settled that he is to be called the general practitioner. What is his role? The Gillie report (1963) describes him as a physician who does not limit his practice to certain disease entities, and who offers his patients of all ages direct and continuing access to his services; as opposed to a specialist who limits his practice to particular disease entities or specific age groups.

Education of the general practitioner

McKeown (1965) has said that for too long it has been taken for granted that general practice can be carried out efficiently by anyone who has obtained a degree and had a year or two of hospital experience. It is now being accepted that the medical curriculum shall produce the basic doctor, and after primary qualification he should do a period of vocational training for whatever branch of medicine he chooses as his career. In the case of general practice it has been recommended by a Working Party (1964) set up by the Royal College of General Practitioners that the period of vocational training should be four years after the pre-registration year. More recently, the Report of the Royal Commission on Medical Education 1965–68 (Todd Report) recommends a three-year period of training for general practice consisting of a series of six-month or 12-month rotating appointments after the pre-registration year. One compulsory appointment early in the period would be in general practice. Other appointments would be in general medicine, obstetrics, paediatrics, psychiatry, gynaecology, anaesthetics, geriatrics, dermatology, ophthalmology, otorhinolaryngology, and physical medicine. Some of these could be combined in a single training period. A sound up-to-date knowledge of therapeutics is deemed essential, and opportunities should be provided for attendance at lectures in clinical pharmacology. On satisfactory completion of this general professional training, a certificate would be awarded, based on progressive assessment of the trainee’s performance. At this stage, in my opinion, he should be examined by the Royal College of General Practitioners, and, if successful, be awarded the diploma of membership, or alternatively, he might sit for a Mastership in General Practice which academically would be comparable with the M.D., M.Ch., and M.A.O. The organiza-

tion of the whole of the training period should be undertaken by the director or dean of postgraduate medical education.

The Todd Report (para. 121) goes on to recommend that after this period of training the young doctor should have two years of further professional training as an assistant principal in general practice. The total period of vocational training is therefore five years. After such lengthy training no one is going to stay in general practice in this country if it is to remain 'a cottage industry'! He will go elsewhere. So the environment for him to practise his skills and training must be created, and if this is not done speedily the whole future of general practice in this country will be in jeopardy.

Content of general practice

Before considering what the proper environment should be, it would be appropriate to establish the content and work-load of general practice. This has been done by the Royal College of General Practitioners in a Working Party Report (1965). In a unit of 2,500 National Health Service patients (the average list size in Northern Ireland given in the annual report of the Northern Ireland General Health Services Board 1966–1967 was 2,019) there is an average consultation rate of five per year, that is, 30–35 consultations per day, and 10–12 visits per day, excluding Sundays. This is the work-load entailed in dealing with the following content of general practice:

1. **Major illness**, i.e. coronary thrombosis, pneumonia, acute bronchitis, severe psychiatric illness, cancers, acute appendicitis, anaemias, and other cardiacs.
2. **Minor illness**. Upper respiratory infection, emotional, digestive, and skin disorders, acute backache, allergic conditions, urinary infections, migraine.
3. **Chronic illness**. Arthritis, chronic emotional disorders, chronic bronchitis, hypertension, peptic ulcers, strokes, epilepsy, diabetes, tuberculosis, puerperal anaemia, Parkinson’s disease, multiple sclerosis, mental deficiency, asthma.
4. **Sociomedical problems**. Geriatrics, broken homes, problem families, illegitimates, disabled, unemployed, divorced.
5. **Preventive practice**. Diphtheria, whooping cough, tetanus, poliomyelitis, smallpox, influenza, antenatal care, obesity, measles.
7. **Obstetrics**. Forty-one deliveries per annum in this size of practice. Sixteen primagravida; one stillbirth; three illegitimates; 12 born at home; 28 born in hospital.

But like everything else in this world, neither the content nor the work-load remain constant. Those of us who have been in general practice for over 20 years know full well how the ‘items of service’ have multiplied. This is gratifying and it is up to us further to develop useful items of service, although each new item increases the work-load. We must accept this challenge and overcome it. This can be achieved through the concept of the general-practice team, and by increasing the facilities for general practice.

The general-practitioner team

We are living in the era of amalgamations in every sphere. Medical disciplines are becoming so complicated that only the team approach and first class organization of all the resources available will be able to deal with the increasing work-load speedily and efficiently. General practice is no exception. There is an ever widening band of services, diagnoses and treatments available, and one man is now incapable of containing this and dealing with it. Hence, circumstances are now dictating the team approach to solve the problem of continuing care. This is no longer doubted by those of us who are fortunate enough to lead such a team. The general-practitioner team should consist of:

<table>
<thead>
<tr>
<th>The general practitioner</th>
<th>The health visitor</th>
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<tbody>
<tr>
<td>The practice nurse</td>
<td>The medicosocial worker</td>
</tr>
<tr>
<td>The domiciliary nurse</td>
<td>The receptionist</td>
</tr>
</tbody>
</table>
The team should be totally committed to, and based on, the practice population, and there should be no geographical boundaries. When the team is established, the work of the practice can be organized into three divisions: (1) curative medicine, (2) preventive medicine, and (3) social medicine and each member of the team can be given special duties in these fields as shown in the following table:

**TABLE I**

<table>
<thead>
<tr>
<th>Curative</th>
<th>Preventive</th>
<th>Social</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Practice nurse</strong></td>
<td><strong>Health visitor</strong></td>
<td><strong>Medicosocial worker</strong></td>
</tr>
<tr>
<td><strong>Domiciliary nurse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injections</td>
<td>Supervision of babies</td>
<td>Home help</td>
</tr>
<tr>
<td>Immunizations</td>
<td>Immunization defaulters</td>
<td>Aids</td>
</tr>
<tr>
<td>Dressings</td>
<td>Antenatal defaulters</td>
<td>Adoptions</td>
</tr>
<tr>
<td>Simple tests</td>
<td>Cervical smear clinic</td>
<td>Problem families</td>
</tr>
<tr>
<td>Specimens for laboratory</td>
<td>Geriatric care</td>
<td>Welfare homes</td>
</tr>
<tr>
<td>Removal of sutures</td>
<td>Health education</td>
<td>Advice on benefits</td>
</tr>
<tr>
<td>Enemas</td>
<td>Practice research</td>
<td>Clothing</td>
</tr>
<tr>
<td>ECG</td>
<td></td>
<td>Housing</td>
</tr>
<tr>
<td>Vitalograph</td>
<td></td>
<td>Social centres</td>
</tr>
</tbody>
</table>

**Facilities needed for the general-practitioner team**

Having determined the amount of work to be accomplished in general practice, and having suggested that the method of dealing with this work-load is by the general-practitioner team, the facilities this team would require in order to carry out the work efficiently must be determined. These should consist of:

1. **Practice premises.** No longer can general practice be carried on from the doctor’s house—‘the cottage industry’ must disappear. ‘Only purpose-built premises, or ’purpose-converted’ premises, will be able to serve the general-practitioner team. These physical changes are taking place now with great rapidity throughout the United Kingdom.

2. **An appointment system.** Makes the best use of everyone’s time—the doctor and the patient.

3. **Laboratory facilities.** To enable various diagnoses to be made, instead of having to increase the work-load of the hospital outpatient department.

4. **X-ray facilities.** Again, to enable simple diagnoses to be made, and screening processes to be undertaken.

5. **ECG.** To be used chiefly as a screening device, but also as a diagnostic aid. This will, in the near future, become just as necessary as an x-ray from the medicolegal point of view.

6. **Physiotherapy.** The usual range, including antenatal classes.

7. **Beds.** Three types of beds are needed—(a) acute medical, (b) geriatric, (c) obstetric.

   **Acute medical.** These are needed most urgently now, because over 80 per cent of illness can be diagnosed and treated by the general-practitioner team. (For further and more detailed information on this subject, one should read *The work of a cottage hospital in a rural community* (1965).)

   **Geriatric.** This is very necessary, since it is only in exceptional cases that the general-practitioner team should not look after their old people. They know them, and have built up a relationship over a lifetime. Old people become unhappy if they are in strange surroundings.

   **Obstetric.** This has become well recognized now, and many general-practitioner obstetric units are being established throughout the country. These should be linked with the area consultant obstetric unit, and regular group statistical meetings should be held. These meetings keep up the standard of midwifery and act as a constant refresher course. Where practical, the general-practitioner unit and the consultant unit should be in the same building.
8. **Age-sex register.**
   
   *(a)* For checking babies not immunized  
   *(b)* For compiling lists of cervical cytology  
   *(c)* For compiling a geriatric register  
   *(d)* For research projects

9. **Geriatric register.** For health visiting of the aged.

10. **Morbidity register.** For research purposes.

### The general-practitioner team in city, urban and rural settings

As long ago as 1920, the Dawson Report recommended area or district hospitals which would be supported by health centres of primary medical care and staffed by general practitioners. This concept of a health centre was even more comprehensive than today's centre, in that it envisaged a few hospital beds. Progress lay dormant for nearly 45 years, but the great renaissance of general practice is now taking place. For instance, it is being accepted more and more that the general practitioner should no longer work in isolation, but as the leader of a team. Since there are places of high and low population densities, the type of building must vary according to whether the team operates in a city, urban or rural setting.

In the city, the accommodation should be that of a health centre. These should not be too large, because if they are, the mistake of Harlow might be repeated. They should be small enough to retain the personal atmosphere. This is very important. They should be linked with the hospital side of the service through open x-ray, laboratory, physiotherapy, and ECG services, and the general practitioner should have hospital beds—obstetric beds either in a general-practitioner obstetric unit or in the general-practitioner wing of a consultant unit; geriatric beds in long-stay hospitals, or in the geriatric wards of the general hospital; and acute medical beds within the consultant physician's unit. This last concept would be analogous with the obstetric unit which is shared by consultant and general practitioner. Wilkinson (1968) describes such an arrangement in the East Birmingham Hospital (The Beaucamp Ward).

In the urban area, the accommodation should also be that of health centre. In this case, if the area has a hospital, then the centre should, if possible, be built in the grounds or even physically linked with the hospital. If the hospital happens to be a cottage hospital, then there is no problem in finding beds for the general practitioners. There is quite a nucleus of cottage hospitals throughout the country, and it would be a great pity if, as proposed under the Hospital Plan for England and Wales (1962), they were closed down and thus a great opportunity for the further development of general practice would be irretrievably lost. Northern Ireland is to be congratulated on its Hospital Plan (1966-75) in that the cottage hospital is to be retained. If the hospital is a general or district hospital, then the centre should be linked in the same manner as the city health centre.

It is in the rural and remote areas that the future pattern of general practice and its accommodation is so difficult to envisage. The pattern of practice will be directly related to the density of population and to geographical distribution. For instance, a village or hamlet would be best served by the mini-health centre, like that at Southowram (M.P.U. Handbook, 1966-1967) which can be staffed by a general practitioner and the 'triple nurse', i.e. SRN, SCM, HV. The general practitioner in this setting should be linked with the nearest urban health centre and enjoy the same facilities as his urban colleagues.

If, on the other hand, the population density is low and scattered over a wide area, then the future needs might be met by having a 'resident nurse' living in a strategic position but being part of the general-practitioner team at the urban health centre. This nurse could do rotating duty with other nurses in the general-practitioner team. She would see all new patients first and would decide whether a doctor's visit was necessary.
This arrangement is not new, as it already exists in places like Rathlin Island, off the North Antrim mainland, and in some of the islands off the west coasts of Ireland and Scotland.

Indeed, looking further ahead, it will become very difficult and in some instances impossible to recruit doctors for the mini-clinics because they and their wives will not want to live in isolation. In these circumstances it might well be that the idea of the mobile surgery will develop and flourish. The doctor and his team would go out to a village or hamlet on certain days per week like the mobile dental surgery, the remainder of the time the patients would travel to the urban health centre to see the doctor. This should not present much hardship in Northern Ireland, as the motor-car population is 250,000, so that two-thirds of the population, at least, has the use of a motor-car, and thus visiting the doctor should become the trend more and more. Ambulances are used to bring patients to see consultants at hospital outpatient departments, so some form of transport might be used to bring in those few patients who have not access to the use of a motor-car.

In the cities the general practitioners should be connected with, and participate in, the running of a postgraduate medical centre. In the country, an urban health centre which is geographically central should have a medical library and lecture-room facilities where the general practitioners of the other neighbouring urban and rural centres could meet and develop the postgraduate side of general practice. These facilities could be used for undergraduate and postgraduate teaching purposes, linked with the university department of general practice, and selected general practitioners could have part-time lectureships in the university.

Some attempt should be made to produce a National General Practice Plan before it is too late—perhaps along the lines just described. There are immeasurably greater opportunities to do this in the field of general practice than in the hospital field, since there are no existing buildings. But if we wait too long, the opportunity will be lost, and this will be tragic.

Size of grouping

In planning to make the best use of the resources available, the patients' feelings should never be forgotten, and their points of view given serious consideration. Our sense of vocation must be preserved and nurtured. The doctor–patient relationship is fundamental to family doctoring. This is a world of complex new technical skills, and the patient now, more than ever, needs 'a guide, counsellor, and friend' to advise him in making decisions affecting his health, his family, and his job. It is this complex medical world which makes it so necessary for the general practitioner to attend refresher courses regularly, to be kept informed, so that he can learn new skills and give advice and guidance.

Other countries like America have tried to do without the family doctor, but they are all reverting again, because the patient needs a doctor for the whole man, not a doctor for one organ or age group.

But it is no good retaining the concept of the family doctor if the general practitioners group themselves into groups so large that intimate relationship between doctor and patient is destroyed.

A group of three doctors, and not more than five, might be considered the ideal size, because all the patients in the practice will know all the partners, and therefore if an 'out of hours' emergency occurs the patient will be seen by a family doctor whom he knows, and even more important, who knows him. Does it ever strike us that when the general practitioner sees his patient in the middle of the night as an emergency, he can produce an immediate mental case history? No doctor in any other branch of medicine can do this. This faculty can be vital for the patient.
Surely it is much more preferable to have four groups of ‘three-man partnerships’, practising in the same health centre, than one group of 12 doctors. This preserves the doctor-patient relationship, and it is this that is so stimulating and so rewarding, and attracts doctors to become general-practitioners and give their lives to it. Literally the family doctor means the person who is the medical adviser to the family, and if we stray too far from this, then we destroy the whole concept and will destroy ourselves.

**Patient responsibility**

Because our patients enjoy the right of free and immediate access to the general practitioner, they must, in turn, accept a duty for using the service responsibly and intelligently. If the general-practitioner service is abused it becomes overloaded, and this creates a chain reaction which affects the whole National Health Service. The general practitioner who is overloaded will off-set part of his burden to the hospital service; and this means that the hospital service is forced to take on work that should be done by the general practitioner. This can become a vicious circle, because the hospital service begins to look for more personnel and bigger hospitals to cope with this increasing work-load from the general practitioner. The resulting increase of hospital medical staff greatly diminishes the potential recruitment to general practice, and this, together with an ageing force of general practitioners, produces an ever-increasing general-practitioner work-load which in turn can only be offset to the hospital service and so the circle completes itself. Tables II and III illustrate these trends in Northern Ireland and demonstrate the tremendous increase in the hospital medical staff since the inception of the health service (+200.5 per cent) compared with the very small increase in the number of general practitioners (+6.84 per cent) for the same period. The ratio between consultants and general practitioners pre-Platt (1961) was 324:749, or 1:2.3, but when Platt is implemented it will be 458:752, or 1:1.6 (Andress 1968).

**TABLE II**

**NORTHERN IRELAND HOSPITALS AUTHORITY MEDICAL STAFF**

<table>
<thead>
<tr>
<th></th>
<th>4 July 1948</th>
<th>Pre-Platt 31 Dec. 1964</th>
<th>31 Dec. 1967</th>
<th>Percentage increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants</td>
<td>110</td>
<td>324</td>
<td>401</td>
<td>264.5</td>
</tr>
<tr>
<td>Other grades</td>
<td>269</td>
<td>669</td>
<td>738</td>
<td>174.3</td>
</tr>
<tr>
<td>Total</td>
<td>379</td>
<td>993</td>
<td>1,139</td>
<td>200.5</td>
</tr>
</tbody>
</table>

**TABLE III**

**GENERAL PRACTITIONERS UNDER CONTRACT WITH THE NORTHERN IRELAND GENERAL HEALTH SERVICES BOARD**

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioners</td>
<td>672</td>
<td>703</td>
<td>746</td>
<td>752</td>
<td>+11.9</td>
</tr>
<tr>
<td>Assistants</td>
<td>103</td>
<td>120</td>
<td>98</td>
<td>76</td>
<td>-26.2</td>
</tr>
<tr>
<td>Total</td>
<td>775</td>
<td>823</td>
<td>844</td>
<td>828</td>
<td>+6.84</td>
</tr>
</tbody>
</table>

All this paints a most interesting statistical picture of the distribution of medical manpower. The way to break this cycle of events is two-fold. First, to educate the patients (the users) in how to make the best use of the National Health Service; and secondly, to produce the proper environment in which general practice will flourish.

In making the best use of the health service, the patients have only to obey two simple rules:
1. Always visit the doctor except when one is too ill. There are still too many home visits in this country compared with the pattern in other countries. The graph shows this:

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. If too ill to attend the surgery, a request for a home visit should be sent in before 10 a.m.

There have been encouraging signs in recent years that our patients are keeping these two rules much better than in the earlier years of the health service.

The setting up of general-practitioner teams, and the prospect of working in health centres with all the increased facilities, including beds, should produce the desired environment and result in greater numbers of doctors entering general practice, and this should therefore reduce the pressure on the hospital service.

The spectrum of general practice is very broad and complex. I have endeavoured to consider its many aspects: the vocational training; the content and work-load; the concept of the general-practitioner team; the facilities that should be provided; the size of practice grouping; patient responsibility; the vicious circle that operates to the detriment of both hospital and general-practitioner services; and some thoughts on regional planning. I hope it will make some small contribution to the further development of general practice, which is one of the tenets of our College. Each one of us who is privileged to be in general practice must bear constantly in mind that it is his duty to set an example of medical practice, so that those who follow may be inspired to bring these ideals even nearer to realization than we have been able to do ourselves.

Acknowledgements

I wish to thank the following who provided me with much valuable information: Drs J. Pearson, Medical Care Research Unit, University of Manchester; R. P. Maybin, m.d., medical adviser, Northern Ireland General Health Service Board; and Miss Margaret Hammond, librarian, Royal College of General Practitioners.

REFERENCES


