GALE MEMORIAL LECTURE 1979

Just a GP

D. J. PEREIRA GRAY, MA, FRCGP

General Practitioner, Exeter; Senior Lecturer in-Charge, Department of General Practice, Postgraduate Medical Institute, University of Exeter.

I WOULD like to thank the South-West England Faculty of the College for inviting me to give this Gale Memorial Lecture. I appreciate that this is our Faculty's highest honour and I am well aware how distinguished my predecessors have been. It is a special pleasure for me as a Devonian to give this lecture in the newest postgraduate medical centre in Devon.

Although I never knew Arthur Gale, I have a happy link with him through my appointment as part-time Regional Adviser for Devon and Cornwall with his old department in the University of Bristol.

Twenty-five years ago when I was a medical student, I was often asked: "What are you going to specialize in?" When I replied that I was going into general practice the conversation usually petered out! The point was finally driven home when a senior colleague at Cambridge said, "Good heavens, you were President of the University Chess Club, there is no need for you to be—just a GP!"

Only last year a trainee who had just finished a three-year course and passed the MRCGP examination was introduced to some non-medical friends. "Finished training in general practice," one of them said, "does that mean you are not just a GP?"

"Just a GP" is a statement of a relationship. It is usually used about an individual doctor but it really refers to the role. It does not suggest incompetence as a doctor but it does imply inferiority to other doctors, particularly specialists.

Since the formation of our College in 1952, general practice has been busy defining the nature of its task and in its anxiety to emphasize how different it is from hospital practice, it has shied away from discussing the relationship between the two kinds of doctor: why general practitioners are seen as inferior, and whether this need be so. So this is my theme and in tackling it, I am speaking personally and not for the College, the Faculty, or the *Journal.*

The 1979 Gale Memorial Lecture was delivered on 30 September 1979 at the Postgraduate Medical Centre, Barnstaple, Devon.

Evidence for inferiority

The evidence for the inferior position of general practitioners in relation to specialists does not depend only on general social attitudes or phrases like "Just a GP" but has been confirmed independently both from within the profession and by external observers.

Interprofessional relationships

When Lord Moran (1960), who was one of the most distinguished doctors of his time, was giving formal evidence to the Royal Commission on Doctors' Remuneration, the Chairman asked him whether he agreed that general practice and consultancy were not senior or junior to one another but level. He replied: "I say emphatically 'No'. Could anything be more absurd? I was Dean of St Mary's Hospital Medical School for 25 years . . . all the people of outstanding merit, with few exceptions, aimed to get on the staff. There was no other aim and it was a ladder off which some of them fell. How can you say that the people who get to the top of the ladder are the same people who fall off it? It seems to me so ludicrous."

Furthermore, general practitioners are neither elected nor appointed to many important positions, although they have always outnumbered consultants by two or three to one. Since the war there has never been a general practitioner President of the General Medical Council, the Royal Society of Medicine, or incredibly the British Medical Association (*Journal of the Royal College of General Practitioners,* 1975).

Sociology

As recently as 1968, Mechanic, a leading sociologist, in a professional analysis of the relationships within the medical profession noted that "by whatever criterion one wishes to impose—complexity of work, independence from government, status, or pay—the consultant clearly occupies the upper tier in the medical hierarchy" (Higgins, 1979).

Literature

The literature of general practice has developed only in the last 20 years. We still have only one journal in Britain concentrating on original general practice research. Old-fashioned publishers still advertise books as "suitable for medical students and general practitioners"!

Research

The standards of practice in any profession always depend on research. A constant flow of new information is vital if changes are to be made and standards raised.

As an Editor I have had the privilege of seeing several thousand articles from general practice during the last 10 years and I am afraid that clinical research work in general practice is still clearly inferior to that in many specialties. This weakness has contributed to the low esteem in which we are still held by some hospital colleagues.

Pay

In this College we have always been a little shy in talking about pay. We have rightly recognized that this is a responsibility which properly belongs to the British Medical Association and the General Medical Services Committee. Nevertheless, we cannot avoid the simple truth that pay is a fundamental determinant of status, as every trade union negotiator knows.

The differential in pay has existed throughout the centuries. Although recently the gap has been closing, the Review Body on Doctors' and Dentists' Remuneration (1974) showed that the career earnings of the average general practitioner were £41,000 less than those of the average consultant for the year 1971/1972. I believe this adverse differential is now more than £50,000. For the most able of our recruits the gap is substantially wider. At least once a year pay scales are blazed across the television screen showing every member of the public the inferior position of general practitioners (Review Body on Doctors' and Dentists' Remuneration, 1978, 1979).

Working relationships

There are still many difficulties among general practitioners about their working relationship with specialists. For example, whenever generalists and specialists work together in the same team or in the same physical environment it is the generalist who works as the junior. In hospital clinical assistantships, general practitioners are legally and professionally inferior and subordinate to specialists.

Education

Training for general practice is a subject dear to my heart, but I am the first to admit that much of general practice training is inferior to specialist training.

First of all, it is not even necessary. Any doctor, even if ill suited for general practice, can become a principal, our highest grade, after just a couple of preregistration posts.

The Royal Commission on the National Health Service (1979) has underlined this problem by noting that family practitioner appointment committees are legally required to appoint a sole applicant to a single-handed practice even if the appointment committee considers him or her to be unsuitable.

There is still no lecturer in general practice, let alone a department of general practice, in our nearest medical school, and in many universities our departments have pathetically few resources.

When we look at the training that we do have, we find that of the four years after qualification, including the preregistration year, only a quarter of the training takes place in general practice itself. With holidays and study leave it is now quite possible for the entire postgraduate training in general practice to be completed in 44 weeks. In addition, alone among the main branches of the medical profession, our graduates are not individually assessed after training. Our training is shorter than that for any other of the main branches of medicine, and what we do have has been determined both in length and balance by medico-political rather than educational factors (Horder and Swift, 1979).

Further problems facing general practice

Specialization

All this is a matter of fact rather than for debate. However, I suggest that as generalists we face further problems—the first of which is our attitude towards specialization. Specialization means drawing a boundary, or limiting a field. It can be depicted as a V-shaped wedge cut into the body of knowledge—the deeper the cut, or deeper the specialization, the better it is, with more benefit for the patient. One-operation surgeons function better than surgeons who do that operation only occasionally. Specialization, therefore, implies depth, with vertical and hierarchical connotations.

We have to be very careful as general practitioners, however, not to allow that thinking to spill over into our branch of medicine. General practice is not the sum of a series of specialties practised at a superficial level.

General practice has spent the last 25 years defining its role and content and has now almost got it straight (RCGP, 1972; Leeuwenhorst Working Party, 1977). Our role depends on the six principles I outlined in my Mackenzie Lecture (Pereira Gray, 1978)—namely primary care, family care, domiciliary care, and continuing care—all designed to achieve preventive and personal care. We see the patient as a whole person and this involves breadth of knowledge about each person, not just depth about the disease. For us it is as important to know the kind of person who has the disease as the kind of disease the person has. Therefore, specialization in

disease or age groups may actually be harmful for generalists because it detracts from this breadth of view.

Whilst it is clear that a general practitioner with a particular interest may well look after patients with a particular condition better than he would have done otherwise, difficulties arise the moment he becomes specialized enough to distort referral patterns within the practice.

Take, for example, the interesting paper by Gallow (1979). He described how he arranged in a big group practice for all the patients on anticoagulants to be seen by just one partner. He reported how the patients and staff liked this arrangement, and the control of prothrombin times improved.

At first sight this kind of organizational change seems greatly to be encouraged, but on reflection we find that it conflicts with several of the important principles of general practice. First of all, patients are allocated to a doctor not in the light of their previous relationship with him, not in the light of the doctor's knowledge of the spouse, family, or home, but entirely because of a particular specialized treatment the patient is currently having. Patients are being trained to see the general practitioner anticoagulator and to assume that this must be the best way of arranging such care in general practice. Dr Gallow reports that he is in close touch with the hospital, where policy is originated, and all his patients go there as well from time to time. In a way the care in the practice has become more an outpost of a hospital anticoagulant clinic than a personal and continuing general medical service.

My theory is that the considerable short-term advantages for Dr Gallow's patients may be offset by a loss of experience by his partners in anticoagulant therapy and also disruption of the doctor/patient relationships of the other partners.

Do we want patients to come to us in future asking for their children to see the general practitioner paediatrician, and their wives to see the general practitioner gynaecologist? Do we expect to have a steroid partner and an anticoagulant partner, and perhaps a hypertension partner as well?

Introducing such systems may produce a useful improvement in standards in the short term, but may nevertheless strike at the very base on which general practice stands.

This analysis may explain why our College and the General Medical Services Committee rejected the concept of the general practitioner paediatrician recommended in 1976 by the Court Committee (*Journal of the Royal College of General Practitioners,* 1978; RCGP, 1978). Partial specialization within a group practice paradoxically may diminish partners, not enhance them.

However, Dr Gallow challenges those of us who wish to be true generalists. If we do not control our patients' prothrombin times, blood sugars, peak flow rates, and blood pressures a great deal better than we do now, we can expect partial specialization in age groups, diseases, or treatments to proliferate.

I believe we really are at the parting of the ways: general practitioners cannot be generalists and specialists simultaneously.

Bad general practice

There are now those both inside and outside the profession who are writing about bad general practice. Horder (1977), for example, referred to "the medical slum" of doctors who kept no notes and had no washbasins, Irvine (1978) identified two populations of general practitioners, and Mrs Robinson (1979), of the Patients' Association, recently wrote: "The best practices are getting better almost unbelievably fast; by contrast the rump of general practice is getting worse and worse."

Bad general practice is not necessarily associated with the occasional major clinical error: that can happen to any one of us at any time. Education can help, but we are all human.

Bad general practice represents those few general practitioners who are at war with their patients. It has been said that American patients hate their doctors—some British doctors certainly hate their patients!

The result is that such doctors make no effort to organize either their method of working, their premises, or their staff. They take no pride in the care their patients receive. In short, they have not defined standards of care. They work so fast that they see two dozen patients regularly within a couple of hours. Although all of us can and should do some five-minute consultations, I personally do not believe that it can be done constantly without either trivializing the patients' problems or restricting them solely into a single physical, psychological, or social dimension. I have now watched over a thousand consultations by colleagues, both principals and trainees, and have not yet met a doctor who can maintain that rate without using considerable authority and limiting the patient's right to discuss and participate in the consultation. After all, Allbutt's (1912) comment about us was: "Perfunctory care by perfunctory men!"

It is particularly unfortunate that some bad practices are on the doorsteps of the big teaching hospitals and this small minority affects consultants and students quite out of proportion to their numbers.

"No man is an island". No general practitioner is either. We are all to some extent interdependent. The isolated, out-of-date colleague may not only be failing to serve his own patients' best interests, he may also be spoiling the reputation of general practice and setting unfortunate patterns of expectation for patients. For example, in some parts of London now, patients are coming to expect primary care from accident departments (Inwald, 1980) and domiciliary care from deputizing services (Scurr, 1979).

Some specialists are reacting simply by taking over

great tracts of responsibility. There are an ever increasing number of open-access services ranging from casualty to child guidance. Bad general practice breeds them. There are a growing number of direct admissions to hospital and ever increasing hospital-based follow-up and surveillance services. Weak practices hardly notice their responsibility going, and when they do, they tend to breathe a sign of relief because they keep their capitation fees and have less work to do themselves. We face unprecedented problems in providing personal and continuing care, which may become similar to those of family physicians in North America and the rest of Europe.

I conclude that the great nineteenth century consensus between the two main branches of the medical profession—the referral system—is now beginning to break down.

Gresham's law states that bad money drives out the good. Bad general practice could still drive out good general practice and there is therefore an urgent need for good general practice to defend the right of patients to receive it and doctors to practise it.

I sense a new tension between good and bad general practice. The silent expansion of our discipline in the 1970s will, I suggest, give way to angry activity in the 1980s.

Does inferiority matter?

Could it be that the attitudes of general practitioners to consultants over the years have come to reflect a group inferiority complex, and if so, does it matter? Is our sense of inferiority perhaps just hurt pride? I suggest that it does matter—for four reasons.

1. Patients

First, and most important, it matters to patients. The modern management of most common diseases is now well within the competence of an interested general practitioner. Patients can reasonably expect to be treated efficiently, caringly, and quickly in or near their homes. In many of our practices the majority of patients with, for example, asthma, coronary thrombosis, diabetes, and depression can now be treated at home. Many patients go to the doctor because they fear they may have a disease, not always because they have one. Excluding disease and reassuring patients is therefore a key role for primary physicians.

However, this can be done only if the doctor is seen by the patient to be clinically competent and to have the authority to reassure. Confidence is equally important for those patients who have physical disease. If the patient cannot fully trust the doctor, he is always looking over his shoulder for further investigation or a second opinion.

If this happens once, the pattern is likely to be repeated on future occasions. Patients with doctors they do not respect tend to get their treatment provided less quickly and effectively, and thus suffer more anxiety and have their fears allayed more slowly.

2. Specialists

Our specialist colleagues have a similar problem. They depend for their clinical skill on concentration of experience, that is, on appropriate selection of patients. Specialists need highly competent generalists in the community, whom they can trust, otherwise inappropriate referrals, such as 'problem' patients whom they feel are being off-loaded on to them, will dilute their specialist experience and tend to make them more like specialoids. An important achievement of specialist medicine has been a shortening of hospital admission times, but early discharge depends on the consultant's being able to refer the patient back to a competent primary health care team. Day care surgery depends on a good domiciliary service.

3. The Government

The Government now has a vested interest in the competence of general practitioners. It is becoming increasingly aware of the cost effectiveness of good general practice and the price being paid for the bad.

There is growing evidence, for example in the Second National Morbidity Survey, that practices with above average standards have lower than average referral rates (OPCS *et al.*, 1974) and lower prescribing costs. The Birmingham Research Unit (1978), albeit reporting from an atypical self-selected group, showed that only 4·24 per cent of 64,986 consultations led to a referral.

If a doctor is under pressure he is more likely to prescribe unnecessarily, to ask for further investigations, or refer to a specialist, all of which erode precious NHS resources.

Governments are unlikely to allocate additional resources if general practitioners appear as inferior clinicians, and the proportion of money devoted by successive governments to general practice in the NHS has been falling steadily since 1948 and is now only about six per cent (Office of Health Economics, 1979).

4. General practitioners themselves

Lastly, if general practitioners have no sense of their own role and low morale they are obviously less likely to take a pride in their work. We have seen the effect of a mass sense of inferiority in the 1960s when the morale of general practice was so low that in 1964 there was a net loss of 100 general practitioners and as many as 241 principals under the age of 44 left the medical list from a total entry of all ages of only 850 (Office of Health Economics, 1966).

It therefore seems that the continuing inferiority of the general practitioner is a matter for concern: it is bad for patients, worrying for specialists, more expensive for government, and demoralizing for the general practitioners themselves.

Possible solutions

Having listed the problems with inferiority and decided that they do matter, we must all now begin to search for solutions.

Research

One of our main problems is weak clinical research. Browne and Freeling (1967) have contributed greatly to our understanding of the doctor/patient relationship and the science of teaching. Apart from Howie (1972), Morrell (1972), Kay (RCGP, 1974) and Tudor Hart (1975) we have not yet greatly illuminated the sciences of management or treatment. Our best research has often been broadly based. Can we think broadly across the specialties in clinical medicine too?

For example, my own records have reflected new ideas coming into general practice. In the early 1960s I saw medicine within a pathological framework of disease. My notes at that time are littered with diagnostic labels with '-itis' endings, such as cystitis, bronchitis, vaginitis, and mesenteric adenitis. Prescribing seemed easy and some labels, like cystitis and bronchitis, were triggers in my mind to antibiotic treatment.

In the mid-1960s I became fascinated by psychosomatic medicine and was greatly influenced by Balint (1957), learning for the first time the importance of non-organic factors in medicine. I began for the first time to see patients as people rather than as vehicles of disease. The main practical result was, I suspect, many more prescriptions for tranquillizers!

By the late 1960s, depression became a common diagnosis and my notes from that time show a switch from prescribing tranquillizers to antidepressants.

By the early 1970s, the focus had changed again. I gradually became aware that 'depression' is no more a diagnosis than 'anaemia', and that each requires investigation to find its cause. Treating depression with antidepressants now seemed no more logical than merely treating anaemia with iron.

I began to realize for the first time that the majority of depressed people are experiencing unsatisfactory human relationships usually at home, but often at work, or they are people who are out of step with their own stage of development, or at odds with society in some way. Gradually relationship problems, especially marital and parent/child emerged as dominant problems. Suddenly psychotropic drugs appeared not only less often indicated, but as distractions from the fundamental problems of human attitudes and behaviour and with psychological side-effects of their own such as evasion and dependency.

Now, in the late 1970s, the wheel is going full circle. My current interests are in the surveillance of chronic diseases like asthma, epilepsy, hypertension, rheumatoid arthritis, and myocardial infarction and increasingly in the possibilities of practical preventive medicine.

I find now that what I used to call bronchitis is usually asthma, what I used to call cystitis is often a sexual problem, and 'vaginitis' may prove to be a physiological secretion. Mesenteric adenitis was never much more than a label and Apley (1975), one of Arthur Gale's colleagues in Bristol, showed that children with recurrent abdominal pains often had emotional problems. Managing these conditions is now difficult and antibiotics seem almost irrelevant.

Thus one of the intellectual satisfactions for generalists may be that, provided we can free ourselves from the limitations of over-specialized diagnostic labels and record honestly what we see in the light of our total knowledge of the patient, we may yet be able to bring to medicine a useful clinical contribution.

It is encouraging that many trainees are now undertaking clinical projects. As more and more do so in future this will set a pattern and we shall all benefit from their new ideas (*Journal of the Royal College of General Practitioners,* 1979).

Finding the time

Since shortage of time is acknowledged by many general practitioners to be one of our main problems, we must as a profession review critically our use of time. Giving 150 patients a week, say, seven and a half minutes each, instead of only five, means finding an extra six and a quarter hours a week. Where can they be found?

It has always been assumed that it must be good for general practitioners to work sessions in hospital. In Whitfield's survey (1980) both general practitioners and consultants supported clinical assistantships for general practitioners, the latter by 20 to one.

The recent Royal Commission (1979) reported that there are now as many as 9,000 general practitioners doing on average more than a whole day a week in the hospital service—about 20,000 hospital sessions every week of general practitioner time. Two sessions a week does represent seven hours and would therefore make good the additional time needed in many practices to give our patients seven and a half minutes each with us. Hart (1977), in his book *Child Care in General Practice,* has used effectively the experience of some general practitioners working in hospital, and Waine (1979; personal communication) has impressed me with the way he is improving child care in his practice by using his experience as a clinical assistant in paediatrics. Nevertheless, I am unimpressed by the objective evidence that general practitioner time is *usually* effectively spent working in hospital assistantships.

Let us look at it the other way round. Would we consider it wise for 9,000 consultants to work for two sessions a week as clinical assistants to general practitioners? Would it really be an effective use of their special skills and experience?

Improving care in hospitals and in general practice is now so urgent that I believe neither branch of the profession can afford to send about a twelfth of its total

manpower (whole-time equivalents) to work for the other (Royal Commission on the National Health Service, 1979).

Working relationships

Of course I am in favour of an active dialogue between the different branches of the profession. Indeed I believe it is now more urgent than ever before. We desperately need consultant input, but we need to be partners and not always pupils (Brook, 1978). A crucial need is for general practitioner and hospital clinicians to sit down together and discuss plans and standards of care for the common conditions.

Generalists

Specialization within general practice, however, is not the answer. It must conflict sooner or later with the principles of personal and continuing care. The educational solution is first to free ourselves from the idea that generalists are inherently inferior, and secondly to free ourselves from the temptation to become mini-specialists or specialoids. Only then can we mature and concentrate on becoming better generalists.

After all, there is nothing inferior about generalists as such. Lennard (1963) in his Gale Memorial Lecture was one of the first to emphasize the value of using the word 'generalist'. Medicine is indeed the last science to suggest that part of the man is more important than the whole man.

Outside medicine, in all societies vital decisions are entrusted to those who have breadth rather than depth of knowledge. From the western democracies to the totalitarian states, the specialists in war are always subservient to the will of political generalists. No society allows its specialist generals to declare war.

Nor are jobs in the front line dealing with a wide range of practical problems always inferior to jobs concentrating on a more limited field. Hodgkin has already noted that the coal-face worker in the mining world carries high, not low, prestige. In most armies the élite troops with the highest esprit de corps are those who do battle in the front line—the infantry. In the battle between man and disease, the primary care physician is in the front line of the medical army. We are the medical infantry and our spirits are rising. The hospitals represent the high technology tanks and artillery. Whoever heard of the infantry being paid less than the gunners?!

Pay

Up till now it has been possible to argue that the inferior training and inferior standards of general practice deserved inferior pay. However, now, for the first time, we are recruiting doctors of comparable calibre to those entering the other specialties and training them professionally. We would be breaking faith with our own trainees if we did not now try to secure for them parity of career earnings. As Lane (1969) has written, general practice needs its fair share of the best brains in medicine.

In 1977 I drafted a motion: "That the career earnings of doctors practising the specialty of general practice should be no less than those practising other specialties." This radical move sought to abolish the financial differential of centuries and was passed by the Devon Local Medical Committee in May 1978. In fact, it was not debated by the Conference of Local Medical Committees until 1979 when it was proposed by Dr Jane Richards, a fellow of this faculty and a member of the General Medical Services Committee. She began: "Mr Chairman, I have but three minutes to persuade the Conference to change the attitudes of 300 years!" The motion was passed and is now the policy of our profession (*British Medical Journal,* 1979a).

However, in the 1960s, the consultants publicly opposed the narrowing of the differential and recently a discussion document from the Hospital Consultants' and Junior Hospital Doctors' Associations (Morrison and Goddard, 1978) published a diagram which equated general practitioner principals with registrars!

So we must be ready for conflict in the 1980s when the consultants come to consider our new policy. Additional tensions will come if the National Health Service paymaster—the Government—should respond with one obvious reply: "We will grant you parity of career earnings with consultants if general practice can guarantee consultant clinical standards!" Are we ready for that reaction?!

Raising clinical standards

Two Royal Commissions

A Royal Commission reporting at the end of the 1960s said in effect to general practice: "You are a branch of the profession in your own right, now get on and organize your own postgraduate education" (Royal Commission on Medical Education, 1968). And we did—within 10 years we had succeeded and vocational training throughout Britain is now a reality.

Now, however, another Royal Commission reporting at the end of the 1970s has said, in effect, to general practice: "You are a branch of the profession in your own right, now get on and control your own standards" (Royal Commission on the NHS, 1979).

The similarities are obvious, but the differences are disturbing. The 1968 Royal Commission on medical education endorsed a consensus of progressive thinking within our profession. From London to Land's End we had thought it out and there were groups of us ready throughout Britain to get vocational training going, once the resources were released.

Today it is different. The recent Royal Commission has no consensus to endorse in either the College or in the British Medical Association. We have been left at the start of the standards race and caught unprepared by the starter's gun.

The challenge is to provide as good clinical care on average in our discipline as the consultants do in theirs. I doubt if we have more than a decade or two in which to do it and they will certainly be decades of difficulty and debate.

Education

The solution, I suggest, must lie first and foremost with education and training. During the last hundred years, general practice has moved from the shadows of the hospitals to the centre of the medical stage. It is now seen by patients and government alike as absurd that patients should be exposed to a tiny minority of doctors who are too reckless or too lazy to train. Compulsory postgraduate training, which has existed effectively in the specialties for generations, was therefore essential (NHS (Vocational Training) Regulations, 1979).

If the 1960s and 1970s were primarily concerned with vocational training, I predict that the 1980s and 1990s will increasingly be concerned with continuing education for established principals.

Mrs Robinson is right. Good practices have found ways of improving their standards. On analysis all these ways boil down to self-help. Our history shows that as a general rule all the main pressures to raise clinical standards have come, like this College, from within our own ranks.

Our College, the *Journal,* and trainer groups can all be seen as self-help mechanisms, stimulating learning from peers. We have had to pull general practice up by its boot straps by listening to each other. Ideas are spreading fast, especially in small groups with communication across wider groups. Groups imply breadth and have horizontal and non-hierarchical connotations.

College groups and trainer workshops are a new solution and have created an important mechanism which may offer a model for the rest of the century. Above all, they are peer groups and they are providing a local intellectual challenge, particularly for young principals, based on the discipline of general practice itself.

Self-control

As family doctors we encourage families to control themselves and to discuss together within the family the behaviour of its own members. Society intervenes only when the family cannot cope, but the ultimate rules or laws about acceptable behaviour are made by society, not by the family.

I suggest by analogy the same is true for the medical family. Society prefers self-government by the profession, but will control our behaviour by law if the profession fails. Self-help as individuals, therefore, is the main way of raising standards. Self-control as a profession, however, is also necessary.

I suggest that through the 1858 Medical Act general practitioners achieved membership of the new medical profession only by paying the price of becoming the bottom tier of the medical hierarchy. During the nineteenth century general practitioners had virtually no control over themselves and such controls as there were were exercised by senior specialists at the top of LRCP/MRCP/FRCP-type hierarchies.

Nowadays, however, general practice has become so important that its standards can no longer be ignored, but the new price of this importance is the need for controls. However, many general practitioners are so concerned to oppose any control at all that they are blinding themselves to its inevitability.

If we study the other branches of medicine we find they have achieved considerable self-control. Where the profession controls itself strictly, as in the specialties, then Parliament, the Government, General Medical Council, and the public accept and endorse the solution. Indeed, professional controls such as Royal College specialty assessors have been built into the constitution of the NHS consultant appointment committees. The surgeons safeguard the standards of surgery and pathologists pathology. General practice has been slow to do the same but Irvine (1975) in his William Pickles Lecture spoke for our discipline when he said: "We are no longer prepared to be the dustbin of medicine." Controls, whether educational or ethical, are mainly concerned with minimum standards and protect patients, governments, and the great majority of practitioners.

I conclude that it is when professional self-control fails that governments step in. Because we have failed to deal with a small number of very poor practice premises, health authorities are now being advised to take over inspections themselves. The only premises which have been systematically visited, assessed, and recorded have been those of the 10 per cent of practitioners who have been assessed by their peers as potential trainers (JCPTGP, 1976).

Government controls could come quite quickly. There is already talk about regulating through Parliament professional practices including prescribing and counselling (Abortion (Amendment) Bill, 1979). If we delay on standards, we could slip into subservience to civil servants.

Alternatively, specialists may start to control general practice during the next century as they did in the last. If hospital-centred services continue to take over more and more of our responsibility in primary, family, and domiciliary care, clinical freedom for generalists will wither. We could become like housemen in the field.

G. K. Chesterton once wrote: "It's not that they can't see the solutions—they can't see the problems"! General practice must face its problems. Who is to control what Horder has called the 'medical slum' and Robinson the 'rump' of our profession? Is it to be done by general practitioners themselves or by external bodies such as specialists or government?

My thesis is that we have one or perhaps two decades to decide to control ourselves. My hope is that we will do it and retain our clinical and professional freedom. It

is encouraging that the Conference of Local Medical Committees has now accepted this principle of collective self-control through its adoption of "clinical audit of professional standards in general practice" (*British Medical Journal,* 1979b).

We have already made a start. Within the last 11 years we have established three new forms of general practitioner self-control: the MRCGP examination in 1969, trainer appointment procedures in 1973, and inspections by the Joint Committee on Postgraduate Training for General Practice in 1976. Any inaccuracies or injustices which come to light in any of these now need to be vigorously challenged to ensure reforms, so that our newly emerging professional self-control becomes as fair as possible.

Charles Péguy stated that everything begins as mystique and finishes as politics (O'Brien, 1979). I suspect that the mystique of the renaissance of general practice and the mystique of vocational training in its early years are now finishing as medical politics.

I see the formation of the Joint Committee on Postgraduate Training for General Practice as the visible symbol of the politicization of vocational training. It represents an inevitable partnership between the College and the Conference of Local Medical Committees, a partnership on equal terms of the two executives, the Council of the College and the General Medical Services Committee—the two wings with which the plane of general practice training now flies. The history of the last 20 years suggests that it has been the College which has set the direction and the Conference which has controlled the pace. The amateurs are giving way to the professionals and there has been a decisive change in the relationship between general practice and government.

Catastrophe or education?

H. G. Wells summed it up in a sentence: "Human history becomes more and more a race between education and catastrophe." The same, I suggest, is true for the history of general practice. The catastrophe of the 1950s would have been the catastrophe of extinction, an extinction which actually happened in the USA and which led to a so-called 'new' discipline of family practice having to be re-invented in 1969 (Geyman, 1979). Extinction was narrowly averted here only through self-education.

Our catastrophe in the 1980s could be second-class medical citizenship or permanent inferiority. Let us face facts: we are running a race which we could still lose. Catastrophe for the generalist now, if he does not provide a satisfactory service, and provide it soon, will not be extinction but external control.

Education therefore is the key—the fulcrum on which the future of general practice turns. Education is the counter to catastrophe, and education for generalists does not mean specialization.

The world does not owe general practice a living. If we choose education, not just vocational, but now continuing education as well, then we can lead ourselves in groups to clinical standards, and through professional self-control we can retain clinical and professional freedom. In this our decade of destiny, we can still choose between education and catastrophe.

I am optimistic that we will make the right choice. Generalists are more flexible than specialists and have a long tradition of adaptability. The decision of our faculty this year to review its functions, to face its failures, and to form two new faculties is one example.

Conclusion

On this occasion, we remember Arthur Gale not as a distinguished epidemiologist, which he was, but for his work in postgraduate medical education. He first welcomed our founder members as partners (University of Bristol, 1953) and opened the educational dialogue between our faculty and the universities, a dialogue which we still need to foster.

Ever since Arthur Gale's time the phrase of the day has been, "Just a GP". Now however, we are poised for the final step to stand, in Horder's words "on the same level" with consultant practice.

For over 100 years, between 1858 and 1976, we general practitioners had an excuse. Whenever our standards were found to be low we were able to say: "But we never had a fair chance"—we had no university departments, no books about general practice, a small share of the real resources, nobody had ever shown us the job. We had never been trained by our own people for the task we had to do.

Those days are over. For the first time in our history we are now recruiting a fair share of the most able graduates and we have the chance to train professionally all our new entrants ourselves. From now on the fault will increasingly lie, not in our stars, but in ourselves, if we are underlings.

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Addendum

This was the last occasion on which the Gale Memorial Lecture was delivered to the South-West England Faculty, as the Faculty was dissolved on 31 March 1980 and divided into two new faculties, the Severn Faculty and the Tamar Faculty.

Home confinements

The Homestyle Delivery Programme, an alternative birth service at the University of California David Medical Centre, Sacramento, is presented. The programme was developed jointly by the departments of family practice, obstetrics, and paediatrics, in response to the needs and desires of patients and physicians to participate in a more natural family-centred birthing process. A brief description of the programme and data from the first one and a half years of operation is given. This programme, in contrast to many other alternative birthing programmes, involves physicians in training; that is, residents in family practice and obstetrics who are being taught during their obstetrical training how to create and facilitate an intimate family-oriented home-like birthing. Satisfaction with the programme on the part of the participating families as well as physicians and programme staff has been very high. Today, more families in this society are demanding this kind of alternative birthing experience; the Homestyle Delivery Programme meets their needs and to date has demonstrated no increased risk to mother or infant.

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