Out of Hours

General practice:

finding a future from the past

“GPs can increasingly practise and develop their clinical skills, perhaps to the level of the general physician who has largely disappeared from the hospital.”

GENERAL PRACTICE: ONCE A RAMSHACKLE SYSTEM

General practice in the '50s and early '60s was in a desperate state. Many GPs were single-handed or in two-man practices. Buildings were totally inadequate and staff were minimal. There was no team and almost no access to diagnostic facilities. GPs were at the beck and call of their patients and were worked to death. Surgeries were crowded, doctors worked long hours, and there were no appointment systems. Average consultation time was about 5 or 6 minutes and requests for home visits had to be carried out. Many problems were trivial. Certification for unfitness to work was a major reason for patients attending.

Entering this ramshackle system after gruelling hospital jobs were vocationally motivated, clinically well-trained young doctors. Many emigrated. And yet within 15–20 years general practice was transformed and became a popular choice for the brightest graduates.

Can anything be learned from this renaissance which can remedy the prevailing unhappiness in general practice today?

MOTIVATORS

Several people had a profound effect on driving the necessary changes: Kenneth Robinson, Minister of Health (served from 1964–1968 under Harold Wilson) — and a GP's son; Sir George Godber, Chief Medical Officer from 1960–1973 — saw general practice as the bedrock of the NHS; and the RCGP Council, which consisted largely of full-time GPs intimately experiencing the problems at the 'coal face'.

The College promoted quality practice-based trainee education and the MRCGP became the hallmark of a good GP. Several practices, especially those in north-east England, began to measure what they were doing. Audit was fundamental. GP organisation and research committees met regularly after evening surgeries.

The *BMJ* accepted publications by GPs about their work (increasingly from 1967 to the mid-90s). *Efficient Care in General Practice* (Oxford University Press [OUP], 1991) was reprinted twice and serialised in *Pulse*. It was one of over 30 GP-oriented books published by OUP during that time.

THE METHODS

Surgeries were enlarged and health centres were built. GPs formed larger groups. Delegation to increased practice staff was vital and the role of the practice manager developed, easing the GPs' bureaucratic burden.

Many primary healthcare teams comprising nurses, midwives, health visitors, social workers, counsellors, and physiotherapists met under the same roof. This had important consequences: minor illness was shared with nurses; home visits were greatly reduced; and consultation time increased appropriate to the clinical gravity. In addition, record systems became computerised and open access to hospital diagnostic services facilitated in-depth clinical medicine.

Some practices worked with statisticians and research assistants. The structure of practices began to change and family planning, antenatal, postnatal, paediatric, and well-man/woman clinics, all largely run by nurses, began to operate. Patient groups were formed and GP 'visiting professors' were in demand in the US. It was a happy time!

ADDRESS FOR CORRESPONDENCE

Geoffrey Marsh
19 Briar Walk, Blackwell, Darlington, County Durham DL3 8QU, UK.

E-mail: geoffreymarsh25@yahoo.co.uk

A NEW STRUCTURE FOR GENERAL PRACTICE

So from this transformation how can general practice develop in the future? With all these facilities, staff, and teams, GPs can increasingly practise and develop their clinical skills, perhaps to the level of the general physician who has largely disappeared from the hospital. Just as they often had a 'special interest', so too perhaps for GPs. Referrals for outpatient consultations could be minimised.

By further all-important audit of their work, practices in different settings could identify the need for new clinics, for example, psychiatric, geriatric, diabetic, respiratory, and cardiovascular, all working with appropriate team members and often following protocols of care.

Practices will vary enormously depending on their setting and patient population. Students and trainee GPs will use these clinics as the bedrock of their training. In hospital they will increasingly consider whether patients need to be there. Hospital specialists will liaise with these clinics. GP follow-up of hospital referrals will be carried out there and hospital outpatient departments will be greatly reduced.

It is necessary that time is allowed for GPs and nurses to visit the chronic housebound sick and the dying at home, and provision of 24/48-hour availability of nurses and doctors must continue. Essential to this restructuring will be expanded premises, many more GPs, and a major shift of funding from hospital to general practice. It could develop piecemeal across the country and probably take 5 or 10 years!

Geoffrey Marsh,
Retired GP, Stockton-on-Tees, County Durham.

E-mail: geoffreymarsh25@yahoo.co.uk

DOI: 10.3399/bjgp16X685897