accepting and promoting their pastoral rôle in relation to staff as well as patients. Is this another quality which is *sine qua non* in the selection of leaders for group practice?

Social psychology of general practice

The classic study of Isabel Menzies[2] on the factors underlying wastage among nursing trainees in a large general hospital began a fundamental re-examination of the training and rôle of the nurse which is still evolving. It was an influence leading to the report of the Salmon Committee and subsequently to the report in 1968[3] on 'Management development of senior nursing staff in the hospital service'. This report argues cogently for the need for management training for nurses at three levels of responsibility and its recommendations have already been energetically carried out in many parts of the country.

Equivalent education in management principles and techniques is being actively promoted by regional hospital boards for hospital doctors at all levels. Local authority staff have similar opportunities. In view of the increasing complexity and sophistication of the organization of primary medical care in group practices it is important to bring a similar insight into the processes of management in these practices.

This might well be started or accompanied by an examination of the social psychology of general practice and its practitioners at a similar level to that of Isabel Menzies' study of nurses. At the present time we appear to be lagging behind in this field of knowledge and its practical applications. We have a moral obligation to the community to use well the resources with which we are entrusted and we should presumably take care to explore every avenue which can possibly enable us to use these resources to their best possible effect.

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General Discussion

The chairman stressed that this conference was really to look at group practice, not health centres. They were very close to each other but were not quite the same. He believed that by the end of 1970, seven per cent of all doctors would be in health centres, which would number about 271 by then.

With regard to the scope of para-medical help, what was the purpose of this? It was in order to have a better, more efficient method of delivery of medical care—community medical care. He did not know what the future pattern would be after the 'Green paper' reorganization. General practice was in the transitional stage; so were health visiting, social work and all the other disciplines. The doctors in general practice and the health visitors were probably the most involved in this respect. The social worker was new to the scene but she would change, and much more easily than the general practitioner, family doctor and health visitor, who had traditional rôles and were all well steeped in them. Nobody liked change, doctors and nurses least of all.

In discussion it was suggested that if there were to be large group practices there would be a great deal of administration to be done in an intelligent and understanding way, requiring a fairly high calibre of person to do it. Such a person did not need to be medically qualified. In time there would be not three administrations but one and within the next year or so there should be scope for experiments, with somebody at about the level of deputy hospital secretary, or medical records officer, spending two or three years administering a group practice. It would help the group practice and also the hospital service. There must be similar posts in the local authority.

Dr Lask said that, though he had found the last paper the most valuable of all, there was no clear definition as to what was the final product of the organization known as group practice. Was it a matter of manning a service, earning a living, or dealing with ill-health in the community?

Medicine seemed to be practised in a number of categories. There was the sort of highly-scientific, highly-skilled, highly-advanced medicine practised. The patient was really the vehicle through which they hoped to advance medical science. There could be sickness-orientated medicine; there could be doctor-orientated medicine, where the organization was planned for the most efficient use of the doctor's time. There was patient-orientated medicine, where the patient was not simply coming with a disease but with a life of history, a path to present and future. When the patient was seen as a total human being, with past, present and future problems, and family problems, the method of work began to change. Everything said earlier about the organization of group practice and the administrator, the reception area etc., tended to omit this item of the psychology of the group practice. They had heard about the anatomy and the physiology of it but should spare a moment for considering the psychology of it. What were they really wanting to do? What were the realities of what they were doing?

Dr D. E. Cullington referred to Dr Reedy's comments in the division of loyalty of attached staff and said that the first thing to remember was that they were all working for the patient. There was no difficulty here in the hospital situation. The nurse was responsible to a matron and ultimately to the hospital management committee for the overall standards of the nursing services, but in the treatment of the individual patient the nurse worked under the clinical direction of the consultant, and this was exactly the same position as existed in the community. It just so happened that at the moment it was the local authority, through the chief nursing officer, who had this responsibility for maintaining these overall standards, for making sure that the nurses had sufficient of the right sort of refresher courses, and providing them with cars and so on, but where the individual patient was concerned, the general practitioner to whom that nurse was attached had full clinical responsibility and there should be no division of loyalty whatsoever.

Dr Reedy emphasized that all organizations which had been discussed would evolve in their own particular way. None of them were standardized, and one of the last things which should emerge from a conference of this kind was the idea that every single kind of activity and attitude in group practices should be standard from one end of the country to the other. But each organization would modify its responses according to what was around it, so that a partial appointments system, which did not work in the majority of cases, might work very well for some kind of clientele of practice area, though the assessment of success must not be emotional, but based on comparable figures and achievements.

They all knew that doctors—and their wives—had difficulties. The sociologists had been having a field day in the last ten years. There was the question of defences against anxiety. They all had an enormous number of anxieties, whether patient-orientated or not, in their private lives. How did they cope with them and how far were they expressed through the medium of their inter-personal relationships with their partners, health visitors and others? Was this a reason for being unable to accept the rôle of the health visitor? An inquiry of this kind would be useful.

All those having anything to do with nurses should read Isobel Menzies' clinic report, which dated back to 1960 but was still relevant.

In reply to the question of developing groups of practitioners, Dr Reedy said that Dr Forman considered that the optimum team dealing with patients was one doctor, one nurse, one health visitor. These could be within the ambit of an organization that forms groups or health centre teams. There were good grounds for saying, in terms of communication theory and what was called the span of control that this was an optimum sort of grouping, because the depth of communication of facts in this group was great. If it were enlarged to four or five it took up a great deal of time each day to communicate facts in depth to patients, and one could very quickly get into difficulties, but again these difficulties can be overcome by deliberate organization. All organization requires a sort of discipline and submission on the part of all members of such an organization. Doctors do not accept this too readily at the moment for the general-practice situation.