Editorials

[1]THE ORGANIZATION OF GROUP PRACTICE

THE report of the working party on group practice has been awaited with some impatience. Rumour had it that its comments and recommendations on the future of general practice would have an impact similar to that of Dame Annis Gillie. The report is long and painstakingly thorough, but it has few suggestions on how the practice of medicine in general practice could be changed for the better. Perhaps it was expecting too much when the ground had been so fully covered by the earlier report. The working party under the chairmanship of Dr Harvard Davis has nevertheless made a large number of recommendations and arrived at a number of conclusions.

The working party had the advantage of knowing that the three branches of the health service were to be unified in the foreseeable future, and in its report the concept of a community health team is a recurring theme.

A group practice requires greater skills in organization than does a single-handed practice or one of two partners; but every practice has to be organized to be able to meet the work load placed upon it. This is nothing new. What is relatively new is that the government has realized that it has a responsibility to general practitioners in this matter no less than that which it has to the hospitals which it owns. Having accepted this responsibility the Department of Health has a duty to the public to see that the domiciliary health services play their part to the best interests of the population which it serves. Health centres, indeed the general practitioners' surgeries, are for the people no less than are hospitals. This is stated in the report of the working party—"The primary object of all medical care is to meet the health needs of the individual and the society in which he or she lives". In any organization the objects of the exercise must always be kept clearly in mind. In organizing a medical practice there is a danger that the object—the care of the patient—shall be lost sight of and the aim diverted towards making the life of the doctor more easy. Admittedly the two things are not self excluding, but where interests do conflict the needs of the patient must come first. The doctor must not, like the commander of a beleagured garrison, sit tight behind his defences, but this seems to be happening in some groups. We have recently heard complaints by patients of quite long delays before they can get an appointment to see their doctor. This should not be allowed to occur in a well organized practice. Good organization should, if we accept the premise "to meet the health needs of the individual" make it easier for the patient to see his doctor. We admit that while there is still a shortage of general practitioners this ideal may be difficult to meet in some areas.

The working party agrees that 2,500 patients are the maximum that a general practitioner should be able to care for adequately. It points out that, whilst the health visitor and the district nurse relieve him of some of his work, these ancillaries also bring to his notice other work by virtue of their function as case finders. It believes that a case can be made out economically for an increase in the staff–population ratio in group practices.

[1]The Organization of Group Practice: A report of a Sub-bommittee of the standing Medical Advisory Committee. London: Her Majesty's Stationery Office, 1971.

The report will repay long study. Those who have the advantage of a cottage hospital in their area will welcome the opinion of the working party on the advantages of the cottage hospital, a title which they reluctantly discard in favour of "Community Nursing Unit". Without indulging in semantics we believe that, though all hospitals are units which nurse patients, it is best to call them hospitals. "Cottage" is certainly not what they are, but it is a term understood by the communities which they serve—and which will when required subscribe generously to their maintenance. In blue books and white papers call them what you will, but let the time-honoured names of these hospitals remain.

The working party has studied the pharmaceutical services in relation to group practice and health centres. It makes no firm recommendations, but goes so far as to suggest that it might be necessary in some areas to site pharmacies adjacent to the health centre—it postulates that these might be run by a "consortium" of local pharmacists. There are obvious advantages, it says, if the pharmacist could work in the same premises as the doctor. The great difficulty here lies in the fact that the pharmacist is an independent contractor and his customers should not be directed to one favoured person. Similar remarks about co-ordinating the services are made in relation to dentistry. The traditional separation of the dentist from the doctor is acknowledged in the report but ways of co-ordination are looked at.

This report is one on which to build for the future. There is little in it which is revolutionary, and for this we may be grateful, but there are guide-lines for the future.

A NEW MEDICAL SCHOOL

SOUTHAMPTON University admitted its first 40 medical students this October. Much thought and planning has gone into this new medical school, only the second to be opened in the United Kingdom since 1893, when the Welsh National School of Medicine was founded in Cardiff. With so long an interval the opportunities to bring new ideas into medical education were not to be denied. In 1893, bacteriology was still in its infancy, Lister's antiseptic and aseptic techniques were still regarded as new fangled, abdominal surgery was regarded as risky, the mechanism of the heartbeat was imperfectly understood, hospitals were for the poor. The more well to do were investigated, treated and operated upon in their own homes or in ill-equipped nursing homes. The medical student attended lectures and "walked the wards".

Since then the two main disciplines of British medicine have slowly evolved—those in hospital having little opportunity of seeing what is going on in the homes of their patients, and those in general practice being unable to continue the kind of medicine which they laboriously learnt as students in the teaching hospitals. Dr E. D. Acheson, the Dean of Medicine in the new school and those who planned this new venture have taken pains to ensure that the student will learn fully what is going on in both disciplines. The student is to be introduced to patients from the first year of his studies. Throughout his course he will be kept in touch with all aspects of domiciliary medicine and the work of the community physician and his staff.

The doctor who will emerge from the school should have a wider basis of knowledge on which to build his vocational training for whatever branch of the profession he may choose. We wish Southampton University, its teachers and its students the success in their venture which they deserve.