1. SUMMARY

THE findings are presented of an enquiry in which nine tenths of the principals in general practice in an inner London Borough gave an extended interview about their personal background, their work and their attitudes to it and to various topical issues.

The predominant picture is of ageing, single-handed doctors, many of them trained in central European or Mediterranean countries, working in isolation from inadequate premises and by-passed by many of the innovations in the delivery of medical care. Many of the features of practice in the Borough appeared characteristic of metropolitan general practice.

Within the Borough, a minority of doctors present a strong contrast to this general picture. On the whole they are younger, practise in some form of partnership, perform a greater variety of clinical procedures routinely and are in much closer touch with each other, their medically-related colleagues and their profession in and outside hospital. These characteristics were most commonly found among doctors in the larger practices.

The possible implications of these findings for the future of practice in the Borough are considered.

2. INTRODUCTION

Great Britain faces considerable problems in providing high quality general-practice services for its citizens. The growth of specialisation and its attraction for the young medical graduate has jeopardised general practice. The structure of the National Health Service provides a framework within which the general practitioner has a definite part to play as the personal doctor providing first-line and continuing care for patients who register with him; but this branch of medicine has barely attracted enough young physicians to replace the numbers leaving it and this at a time when the population is steadily increasing[1].

At the same time, the proportion of total health services expenditure spent on general-practice services has declined[2]. The shortage of general practitioners has been most acute in the industrial towns in the north of England and the poorer areas of London and other great cities; in such places, considerable numbers of patients are known to bypass the general practitioner and seek their primary medical care in the casualty departments of general hospitals[3].

These disquieting trends have thrown into question the future of general practice in Britain. Some argue that the signs are ominous and that if it were not for the provisions of the National Health Service, general practice would not survive, at least in its present form. They suggest that no effort should be made to shore up the present structure of the general-practitioner services, and propose that in the future first-line care should be delivered by specialists in paediatrics and internal medicine working either from a hospital or from a health centre base comparable to the poly-clinics of some Eastern European countries[4].

On the other hand, there is also increasing concern about the system of delivering health care in the United States and some other countries where general practice has become woefully inadequate and where ambulatory care is provided, if at all, by paedia-

tricians and internists working either from hospitals or from doctors' private offices[5]. In the centre of the urban areas of the United States there are special problems of recruitment of health manpower for the first-line medical care of the poorest sections of the community. Neighbourhood family health centres, staffed by paediatricians and internists, supported by doctor assistants or nurse practitioners and by locally recruited family health workers are now being created in many poverty areas in an attempt to increase the quantity and improve the quality of front-line care given to ghetto populations.

The existence of difficulties in countries in which considerable proportions of the population do not have continuing care from a personal doctor has strengthened the arguments of those in Britain who feel that the system whereby patients have a continuing relationship with a general practitioner is essentially a sound one. They believe the present weaknesses of general practice are not inevitable and can be eradicated.

Some believe that salvation lies in bringing the general practitioner back into the orbit of hospital medicine by enabling him either to admit and treat his patients or to spend part of his time in a hospital specialty[6]. Others emphasise the need to train new entrants in psychosocial as well as clinical skills and knowledge so that they can gain respect for their unique contribution to medicine[7].

Nearly all, however, believe that general practice which is well equipped and staffed will be better able to meet the challenge of medical care in the future[8]. They hold that such a development is only possible if doctors work together in groups rather than single-handed or in two-man partnerships.

Objects of the study

Hence we decided to interview all National Health Service general practitioners with surgery premises in a segment of inner London, namely the London Borough of Camden.

Our purpose was threefold:

(1) to describe the structure and organisation of general practice in an inner London Borough and compare it, where possible, with general practice in other areas of London and of Great Britain;

(2) to consider how general practitioners worked, with particular reference to their use of certain medical procedures, their relationships with medical colleagues and other health and social service personnel, their use of hospital facilities and their extra-general practice medical work and interests;

(3) to elicit attitudes to certain crucial issues in health service provision, such as the relationships of general practitioners with hospital and social service personnel, the satisfactions and dissatisfactions derived from some aspects of work, and the future for general practice in the area.

On 1 January, 1968 there were 138 general-practitioner principals with surgeries in Camden who had National Health Service contracts: 123 (89 per cent) of them were interviewed by one of four interviewers using a standardized questionnaire and answered all or nearly all the questions put to them. A further five were seen but did not answer all the questions and three talked informally to the American doctor but refused to have their answers recorded. There is no reason to suppose that failure to secure a 100 per cent response has led to any serious distortion of the results.

The standard questionnaire used in the study made use of questions from other recent surveys of general practice,[9, 10, 11] making it possible to compare the results in Camden with those obtained in other areas.

3. SOCIAL AND HEALTH CHARACTERISTICS OF THE POPULATION SERVED

In 1966, the London Borough of Camden had a population of 217,090[13]. The northern part of the Borough housed a mainly upper middle and middle-class population. By contrast, the south forms part of the business area of central London, and its relatively small population is composed of both working-class and professional people. The centre is more mixed. Many of its inhabitants are engaged in manual occupations of a skilled, semi-skilled or unskilled nature, but in certain districts there are households which would be described as middle class or upper class. Throughout the Borough there are many non-manual workers who are employed in the commercial and business pursuits of the larger metropolitan area.

There was about the same proportion of elderly people in Camden's population as in Greater London and in England and Wales, but a comparatively small proportion of children (Table 1).

TABLE 1

PERCENTAGE DISTRIBUTION OF THE POPULATION OF CAMDEN, GREATER LONDON AND ENGLAND AND WALES BY AGE, 1966[13]

Age group	*Camden*	*Greater London*	*England and Wales*
0–14	*15*	*20*	*23*
15–44	*45*	*40*	*39*
45–64	*27*	*28*	*25*
Over 64	*12*	*12*	*12*
Total	*99*	*100*	*99*

On the other hand, Camden had a relatively large proportion of single, widowed and divorced men and women in the age groups from 25 to 64 (Table 2). These characteristics of the adult population accounted at least in part for the lower birth rate in Camden in recent years compared with the rate for England and Wales. In 1967 it was only 62 per cent of the national rate[14].

TABLE 2

PERCENTAGE DISTRIBUTION OF THE POPULATION AGED 25–64 OF CAMDEN, GREATER LONDON AND ENGLAND AND WALES BY SEX AND MARITAL STATUS, 1966[13]

Sex and marital status	*Camden*	*Greater London*	*England and Wales*
Males			
Single	*28*	*15*	*12*
Married	*67*	*82*	*85*
Widowed and divorced	*5*	*3*	*3*
Total	*100*	*100*	*100*
Females			
Single	*27*	*13*	*10*
Married	*62*	*78*	*82*
Widowed and divorced	*11*	*9*	*8*
Total	*100*	*100*	*100*

Households in Camden had several distinguishing characteristics (Table 3). For example, about one out of three were single-person households in contrast to less than one in five in Greater London and one in seven in England and Wales as a whole. Camden also had relatively more who lived in shared dwellings and shared such domestic amenities as a cooking stove and kitchen sink.

Overcrowding was also greater; more than one in ten of the households lived at densities of more than one person per room. In England and Wales as a whole nearly a half of all households occupied dwellings which they owned, and the proportion was not much less in Greater London: in Camden, only one household in eight was an owner occupier and over two thirds occupied privately-rented dwellings compared with just over one third in Greater London and just over a quarter in England and Wales. Together these statistics suggest that housing conditions constitute a major problem in the Borough.

TABLE 3

SELECTED CHARACTERISTICS OF HOUSEHOLDS IN CAMDEN, GREATER LONDON AND ENGLAND AND WALES, 1966[13] (PERCENTAGES)

Household characteristics	*Camden*	*Greater London*	*England and Wales*
One-person households	*34*	*19*	*15*
Households in shared dwellings	*46*	*24*	*7*
Household without exclusive use of stove and sink	*7*	*3*	*1*
Percent overcrowded (more than one person per room)	*11*	*7*	*6*
Owner occupied	*13*	*38*	*48*
Rented from local authority	*20*	*22*	*26*
Rented from private landlords or other	*67*	*40*	*26*

Residents from overseas

Another distinctive feature of the population of Camden was the proportion of residents who were born overseas[13]. In England and Wales the proportion was less than four per cent of the population. Not surprisingly, the proportion in Greater London (9·3 per cent) was considerably greater than in the country as a whole. However, in Camden nearly one in five of the population (19·9 per cent) was from overseas. In this group, a small proportion (5·7 per cent) were temporary visitors to the capital, most of them students.

Of those residing 'permanently' in the Borough, who were not born in the British Isles, nearly a half were from countries of the British Commonwealth: Cyprus, Pakistan, India, and the West Indies being well represented. The remainder were born in foreign countries, the single greatest proportion coming from Europe.

Mortality rates

With the exception of infant mortality,[14, 15] age-specific death rates for the Borough are not readily available, and the relatively small numbers of deaths which occur annually in a population of just over 200,000 make comparisons with national figures by causes of death unreliable.

The infant mortality rate during the five years 1966–70 was consistently somewhat higher than that of Greater London or England and Wales. In 1967, for example, there were 20 deaths per 1000 live births in Camden[15] compared with 18 in Greater London and in England and Wales[14].

The perinatal mortality rate, however, (i.e. still-births and infant deaths occurring

in the first seven days of life as a proportion of total live and still-births) was no greater in the Borough[15] than in Greater London or England and Wales[14].

Suicide rates

An earlier study by Sainsbury[16] showed that the number of suicides was greater in Hampstead, one of the constituent parts of the Borough, than in most other London boroughs; the 1967 Camden figures suggest that there is still an excessive number of such deaths[15]. Deaths from cirrhosis of the liver were also relatively common[17].

It seems probable that these deaths reflect the marital status of the population shown above, as studies elsewhere suggest that single, widowed, and divorced adults are more likely to commit suicide and suffer the effects of alcoholism than married people[18, 19].

4. HYPOTHESES AND METHODS

The data obtained from the respondents were used to test three hypotheses. These were:

A. That the practitioners and practices in Camden would differ markedly in many important respects from practitioners and practices elsewhere in England and Wales, and in important respects, but less markedly, from those in other areas of inner London;

B. That, within Camden, differences in the 'type of practice' (that is, single-handed, partnership of two, or group) and in the 'area of practice' (that is, middle-class or working-class)[20] as well as other structural factors would be associated with differences in the methods and attitudes of the practitioners.

C. That, within Camden, differences in the personal characteristics of the general practitioners, such as their age, family background and educational experiences would be associated with differences in the type of practice, in the area of the Borough in which they practised and in their methods and attitudes.

The variables about which we obtained information and which we used to test these hypotheses were of four main kinds:

i. *Personal and background characteristics of the practitioners*: age, sex, place of birth, family structure, upbringing and education, career preference at the beginning and end of medical education; marital status; and site of medical training.

ii. *Characteristics of the practices*: type and area (as defined in B above), number of assistants, trainees and other staff; nature of premises; size of National Health Service list; number of private patients; presence of an appointment system; and cover during off-duty time.

iii. *Processes and methods used in the practices*: number of surgery and home visits per day; number of patients referred to casualty and outpatient departments; number of other doctors and other health workers with whom the practitioner conferred about patients; procedures performed in their surgeries; hospital-based procedures to which they had direct access; and provision of obstetric services.

iv. *Attitudes of the practitioners*: satisfaction with general practice; views on working with other doctors in general practice; views on their relationships with hospital staff and with local authority staff; opinions on the future of general practice.

Limitations

Some of these variables, such as type of practice and location of surgeries, could be reliably determined from public records. Others, such as age, were elicited from the practitioner himself or inferred from public records. For others, such as information on

patient contacts, procedures performed, and attitudes, we were dependent upon the responses of the doctors interviewed.

This dependence imposed severe constraints upon us. We were not able to observe the doctors at work, examine their records or ask them to make special records for us[21, 22, 23]. This meant that our measures of workload or performance of clinical procedures had to be based entirely on what the doctors told us.

Consistent discrepancies between their responses concerning the numbers seen on a 'typical' day and on the last full working day (which following Mechanic[10] we called the index day) suggest that our measures have low validity. Similarly, a doctor's statement as to whether he used certain diagnostic or therapeutic procedures in his practice (following Cartwright[9]) 'more often than not', 'occasionally' or 'never', may not be a valid measure of the extent to which he indeed performed certain kinds of procedure in his own surgery.

Moreover, our view of doctors' practices is one-sided since we did not interview their staff or their patients. Thus we were limited to a consideration of the technical aspects of practice and have no measure of the components of it which depend upon personal skills and relationships. General practitioners argue rightly that interpersonal communication and confidence is of prime importance in general practice; technical competence is a necessary, but insufficient base for it. We recognise the justice of this claim and are aware of the limitations imposed on us when we come later to consider the quality of care.

In assessing attitudes to various issues in general-practice work this study was also subject to great difficulties. A number of studies by sociologists and social psychologists have shown that there is a tendency for respondents in interviews where standard questions are put to them both to interpret the questions in different ways and to give the interviewer the answers which he thinks are required of him and not necessarily those which really represent his views[24, 25]. Furthermore, it may be that the attitudes recorded at an interview are expressive of the respondent's mood at the time rather than of any long-lasting orientation. They may not reflect, as they are generally expected to, the respondent's actual behaviour in defined situations[26, 27].

In a long interview conducted by a skilled interviewer, in which the respondent is encouraged to talk freely around the issues under consideration, it is possible to guard against some of the sources of error. We were not able in this study to secure such optimum interviewing conditions because the general practitioners' time was limited; but, as far as possible, we tried to avoid the most obvious errors. For example, we first invited doctors to comment freely on matters of opinion and then allowed them to give a more considered view after presenting them with a range of alternative answers.

Nevertheless, we are aware that doctors may not have previously considered some of the issues we raised. Consequently their responses may have been tailored to what they believed the interviewer wanted to hear and may not have truly reflected either their attitudes or their actions in given situations.

5. INTERPRETATION OF RESULTS

It was clear at the outset that many of the variables were likely to be closely correlated and confounded with each other. It therefore became necessary to choose a small number of variables as primary categories into which the data could be regularly stratified and to study the other variables before and after the stratification into primary groupings. Based on our hypotheses, it seemed appropriate to use three variables—type of practice, age of practitioner and area of practice—as recurrent groupings for stratification.

These variables, as well as whether the doctor was trained in Great Britain or abroad appeared important in many specific contexts and were used repeatedly as the 'independent' variable against which other 'dependent' variables were compared. We are not, however, able to conclude that any particular causal sequence operates between any sets of variables; we are only able in general to draw attention to the associations between them. In very few instances is it possible to speculate with any confidence about the causal connections between variables.

Finally, since we were studying all the general practitioners in Camden and not merely a sample of them, we did not consider it logical or appropriate to use tests of statistical significance in the analysis of our data[28]. Since we studied the universe of Camden general practitioners and had a high response rate, the differences amongst practitioners really existed and could not be the result of sampling errors. Similarly, the differences between Camden and other areas could not be due to sampling errors and reflected real differences in these characteristics.

Since the differences shown in this survey were 'real' ones, the basic issue is their magnitude. Generally speaking we have considered that differences of ten per cent or more in the dependent variables are worthy of comment.

6. THE RESULTS

Differences between Camden general practice and general practice elsewhere in England and Wales

Our first hypothesis, that general practice in Camden would differ in many ways from the pattern of practice elsewhere in England and Wales, was amply confirmed. The major differences which we found between Camden and the whole country as ascertained by other investigators are shown in Table 4(a) and (b), which also show their order of magnitude.

In the notation we used, a percentage difference of the order of 50 per cent or more *in favour of the Camden figures* was scored (+++), one of 25 per cent to 49 per cent (++), one of ten per cent to 24 per cent (+), one of five to nine per cent ($\pm$). Conversely, differences *in favour of the national figures* were scored (−−−), (−−), (−), ($\mp$) respectively. When the differences between the two were less than five per cent, a score of (0) was given.

Practice organisation

In England and Wales, half of all practitioners in 1968 were in partnerships of three or more and less than a quarter were single-handed. In Camden, in sharp contrast, only one in seven were in partnerships of three or more and over half were single-handed.

This basic difference in mode of practice was reproduced in many other features of practice organisation and procedures. For example, the general picture in Camden compared with the country as a whole is one of poorly-housed and ill-equipped premises. None of the doctors were operating from purpose-built premises; many were housed in lock-up shop front surgeries which lacked adequate facilities for the examination and comfort of patients. They were less well provided with supporting staff in the way of both secretarial-receptionist help and employed or attached nurses and health visitors but much more commonly had medical assistants. A smaller proportion than on a nation-wide basis had appointment systems for patient consultations; more used commercial, off-duty, emergency-care services rather than rota systems with partners or neighbouring doctors.

TABLE 4(a)

COMPARISON OF GENERAL PRACTICES IN ALL ENGLAND AND WALES WITH THOSE IN CAMDEN
(for ratings see text)

	Percent in Camden	*Camden compared to England and Wales*	*Date and source of comparative data*
Personal characteristics			
Age of practitioner			
(% 44 or less)	*33*	(−−)	1968, D.H.S.S.
(% 65 or more)	*26*	(+++)	1968, D.H.S.S.
Sex of practitioner			
(% female)	*15*	(+++)	1967, Cartwright
Training			
(% trained abroad)	*23*	(+++)	1967, Cartwright
(% postgraduate qualifications) ..	*14*	(−−−)	1969, B.M.A.
Structure of practice			
Type of practice			
(% single-handed)	*52*	(+++)	1968, D.H.S.S.
(% in groups of 3 or more) ..	*15*	(−−−)	1968, D.H.S.S.
Assistants			
(% with one or more)	*24*	(+++)	1967, Cartwright
Size of list			
(% with small lists)	*21*	(+++)	1968, D.H.S.S.
(% with large lists)	*26*	(−−)	1968, D.H.S.S.
Number of private patients			
(% with 20 or more)	*57*	(+++)	1967, Cartwright
Premises			
(% with purpose-built surgeries) ..	*0*	(−−−)	1969, B.M.A.
(% who own their premises) ..	*35*	(−−−)	1969, B.M.A.
Ancillary staff			
(% with some staff)	*77*	(∓)	1969, B.M.A.
Appointment systems			
(% with system for at least some sessions)	*42*	(−−)	1969, B.M.A.
Cover for off-duty time			
(% using rota)	*29*	(−−−)	1969, B.M.A.
Practice and procedure			
Obstetrics			
(% on the obstetric list)	*28*	(−−−)	1967, Cartwright
Access to hospital beds			
(% with direct access)	*0*	(−−−)	1969, B.M.A.
(% without access who wanted it) ..	*53*	(−)	1964, Cartwright
Procedures			
(% with score of 5 or more) ..	*19*	(−−−)	1964, Cartwright
(% with score of 0)	*27*	(+++)	1964, Cartwright
Special interests			
(% mentioning psychiatry)	*13*	(−−−)	1969, B.M.A.
(% mentioning obstetrics and gynaecology	*10*	(−−−)	1969, B.M.A.
(% mentioning paediatrics) ..	*10*	(−−−)	1969, B.M.A.

List sizes were, in general, smaller in Camden than nationally as were the numbers of patients seen on an index or sampled day. Camden general practitioners also had a smaller ratio of home visits to surgery consultations than did their counterparts elsewhere in London and the South-east region. Nevertheless, Camden practitioners less often undertook clinical diagnostic and treatment procedures, especially those involving

TABLE 4(b)
COMPARISON OF GENERAL PRACTICES IN ALL ENGLAND AND WALES WITH THOSE IN CAMDEN
(for ratings see text)

	Percent in Camden	*Compared to England Wales*	*Date and source of comparative data*
Other medical work			
Hospital appointments			
(% with part-time appointments) ..	*16*	(−−)	1964, Cartwright
(% with part-time appointments) ..	*16*	(−−−)	1969, B.M.A.
(% without appointment who wanted one)	*34*	(−−)	1964, Cartwright
Non-hospital appointments			
(% with at least one)	*44*	(−−)	1969, B.M.A.
Attendance at courses			
(% attending at least one in last 5 years)	*75*	(++)	1964, Cartwright
(% attending at least one in last year)	*55*	(+++)	1964, Cartwright
(% attending at least one in last year)	*55*	(−−−)	1969, B.M.A.
Reading *The Lancet*			
(% who do)	*34*	(+++)	1966, Mechanic
Teaching			
(% who do)	*27*	(−)	1969, B.M.A.
Research			
(% who do)	*22*	(−−)	1969, B.M.A.
Publications			
(% who published in last 5 years) ..	*15*	(+++)	1969, B.M.A.
Membership of the Royal College of General Practitioners			
(% who are)	*31*	(++)	1964, Cartwright
Enjoyment of general practice			
(% who enjoy practice 'very much')	*65*	(++)	1964, Cartwright

minor surgery, than did the doctors responding to a nation-wide enquiry, and were more likely to refer their patients to hospital casualty departments. They were much less likely to hold hospital appointments or to undertake obstetrics.

Many doctors were unaware of their right of direct access to diagnostic facilities based in local hospitals. Presumably ignorance of this right meant that those of their patients who could have benefited from investigation were either denied these facilities or transferred directly to consultant care through referral to the outpatient clinic of a hospital.

At the same time, Camden general practitioners were more likely than those questioned in a national survey to have private patients, to undertake other extra-National Health Service general-practice professional activities, to read a widely circulating journal concerned with advances in medical science and accompanying practice, and to have published papers themselves.

Professional satisfaction

We also hypothesised that the general level of professional satisfaction expressed by general practitioners in Camden might be less than that expressed by the generality of doctors in this branch of the profession throughout Great Britain. In practice, however, we could not show this to be so. Indeed the responses we obtained to a general question suggested that the level of expressed professional satisfaction was even greater than that among a sample of doctors responding to a national postal enquiry some years previously[9].

We do not set great store by this finding, however, because we are aware that the difference may be an artefact of differences in the method and context in which responses were elicited. There are great difficulties in assessing the level of a doctor's satisfaction with his work from the statement he makes during an interview. When we asked each doctor whether he enjoyed general practice very much, moderately, not very much, or not at all, we sometimes received answers which were not at all in keeping with our subjective impressions which took into account his tone of voice, gestures and other more subtle indicators of attitude. These impressions suggested that many general practitioners were not as contented as their response to a general question about enjoyment indicated.

Comparisons with other areas

So far we have contrasted practice in Camden with that in England and Wales with evidence from several national surveys. There is less available information about the structure of practice in other areas of London or other urban areas with which we could compare the Camden position. The comparisons we were able to draw are shown in Table 5 where we have used the same notations as in Table 4 to demonstrate the size of the differences between Camden and the other specified areas.

TABLE 5

COMPARISON OF GENERAL PRACTICES IN CAMDEN AND OTHER AREAS

	Inner London[29]	*Outer London*[11]	*Other Cities*[29]	*England and Wales*
Age of practitioner				
(% 44 or less)	(0)	(−)	(−)	(−−)
(% 65 or more)	(+++)	(+++)	(+++)	(+++)
Sex of practitioner				
(% female)	(0)	(++)	(++)	(+++)
Training				
(% trained abroad)	(+++)	(+++)	(+++)	(+++)
Type of practice				
(% single-handed)	(+)	(+++)	(+++)	(+++)
(% in groups of 3 or more)	(−−−)	(−−)	(−−−)	(−−−)
Assistants				
(% with one or more)	(+++)	(+++)	(+++)	(+++)
Size of list				
(% with small lists)	(0)	(+++)	(+++)	(+++)
(% with large lists)	(−−)	(−−)	(−−−)	(−−)
Number of private patients				
(% with 20 or more)	(+++)	(+++)	(+++)	(+++)
Obstetrics				
(% on the obstetric list)	(∓)	(−−−)	(−−−)	(−−−)

Drawing upon unpublished data made available to us by Cartwright in inner London and other English cities from her 1964 survey *Patients and their Doctors*, and for Bexley and Bromley (headed outer London in the Table) from an unpublished survey by Talbot Rogers, it would seem that Camden practitioners and their practices had more characteristics in common with those of the whole of inner London than of outer London or other English cities.

Inner London, like Camden, had fewer doctors aged 44 or less than outer London or other cities, and more practitioners with small lists. It also had more doctors of 65 and over, more who had trained overseas, and more who had at least 20 private patients although not quite as large a proportion as Camden. It had more single-handed practitioners and fewer on the obstetric list, although again the contrast was not quite as great between it and outer London as was the contrast between Camden and that area.

On the other hand, inner London contrasted sharply with Camden in the proportion of its practices which were in groups of three or more, employed assistants and had large lists. In all these latter instances, Camden was the odd man out, inner London as a whole approximating more closely to the position elsewhere.

In sum, our hypothesis that Camden would resemble the patterns of practice in the whole of inner London was partly supported; but on the comparisons available to us, Camden, taken alone, showed a more marked contrast to outer London and other English city areas as well as to England and Wales as a whole than did inner London as a whole. It seems probable, therefore, that within inner London there may be considerable contrasts between different districts, some showing Camden's characteristics to a greater or lesser extent and others showing those of outer London or other English cities.

Differences between types and areas of practice within Camden

Our second hypothesis was that we would find substantial differences within Camden between practices of different types, that is, single-handed practices and partnerships of different sizes, and between practices in different kinds of neighbourhood, that is, predominantly middle-class and predominantly working-class neighbourhoods.

It turned out that single-handed practice was more common in Camden than any form of partnership and that only 21 doctors in five practices were in receipt of the group practice allowance payable when three or more doctors work in close association from a common main surgery.

It is clear that statistical generalisations based on these 21 doctors as a distinct subcategory would be dubious, although the differences between them as a grouping and both one and two-handed practices were real ones. We have therefore only tabulated comparisons between single-handed practitioners and doctors in any form of partnership but drawn attention in the text to instances where the 21 group practitioners differed strikingly from those in two-man practices.

The first part of this hypothesis, that type of practice would distinguish practitioners on many scores, was in general confirmed. Differences among Camden practitioners in single-handed, practices and partnerships of two or more in respect of a number of characteristics are shown in Tables 6, 7 and 8.

TABLE 6

PERCENTAGE COMPARISONS OF PRACTICE TYPES WITHIN CAMDEN—PERSONAL ATTRIBUTES AND PRACTICE STRUCTURE

Characteristics	*Single-handed* (N=65–72)*	*In partnership* (N=56–66)*
Personal attributes of practitioners		
Age 44 or less	*19*	*48*
65 and over	*31*	*21*
Sex Women	*10*	*21*
Structure of Practice		
Employ medical assistants	*28*	*20*
No employed or attached ancillary staff	*38*	*8*
Receptionist or secretary only	*53*	*62*
Attached or employed nurse or health visitor	*9*	*30*
List size: 1,500 or less	*26*	*15*
2,500 or more	*36*	*15*
Private patients: 20 or more	*62*	*50*
Premises owned	*43*	*25*
surgeries in own residence	*33*	*20*
Appointment system used	*22*	*63*
Commercial off-duty relief system	*69*	*54*

*The number=100% varies since some doctors did not answer every question.

TABLE 7

PERCENTAGE COMPARISONS OF PRACTICE TYPES WITHIN CAMDEN—PRACTICE PROCEDURES

Characteristics	*Single-handed* (N=65–72)*	*In partnership* (N=56–66)*
Practice and procedures		
On obstetrics list	*21*	*36*
Took cervical smears in past two months	*22*	*49*
Performed vaginal examinations 'more often than not'	*52*	*68*
Stitched cuts 'more often than not'	*22*	*14*
Patients seen in surgery on index day		
less than 20	*24*	*31*
41 or more	*26*	*14*
Home visits per 100 surgery consultations in index day		
0–9	*45*	*39*
20 or more	*22*	*36*
Use of hospitals		
Knew of direct access to five or more facilities	*58*	*83*
Believed had no access	*12*	*3*
More than five referrals per fortnight to outpatient departments per 100 surgery consultations on index day	*34*	*59*
Arranged consultant domiciliary visit in last month	*36*	*45*
Contacts with health professionals		
Verbal contact on index day about patients	*44*	*85*
Verbal contact in fortnight with local authority home nurse	*60*	*75*
Verbal contact in fortnight with local authority health visitor	*47*	*58*
Special medical interest exercised in practice	*31*	*57*

* See note to Table 6.

TABLE 8

PERCENTAGE COMPARISONS OF PRACTICE TYPES WITHIN CAMDEN
PROFESSIONAL ACTIVITIES OUTSIDE GENERAL PRACTICE AND ATTITUDES AND OPINIONS

Characteristics	*Single-handed* (N=65–72)*	*In partnership* (N=56–66)*
Appointments		
Hospital	*10*	*21*
Local health authority	*13*	*31*
No postgraduate lectures or courses attended in last five years	*31*	*18*
Current research activities	*17*	*27*
Current teaching activities	*10*	*46*
Published a paper in last five years	*10*	*21*
Membership of Royal College of General Practitioners	*23*	*40*
Not attended meeting of any professional association in last three months	*47*	*26*
Attitudes and opinions		
Future of general practice encouraging	*23*	*41*
Advantages outweigh disadvantages in general practice	*60*	*88*
In favour of charging patients for prescriptions	*65*	*54*
Interviewers' assessments		
Premises warm, comfortable, cheerful	*27*	*40*
Premises efficient, tidy, modern	*20*	*47*
Premises inefficient, messy or dilapidated	*17*	*5*
General practitioner 'happy'	*33*	*54*

* See note to Table 6.

Practitioners in partnership

The figures in Tables 6, 7 and 8 show that for most of the characteristics listed, partnership practitioners differed markedly from single-handed practitioners. In most of the instances listed, group practitioners differed more from single-handed doctors than did partnership doctors as a whole, especially where structure, practices and procedures were concerned. They also differed from all other doctors, including two-man partners, in various ways which are submerged in Tables 6–8; for example, more group practitioners had postgraduate diplomas and other qualifications; they referred fewer patients to casualty departments; fewer were foreign-born or trained; and fewer had hoped to have a hospital career at the time of qualification.

These attributes of group practitioners in Camden, which distinguished them from other doctors there, are not necessarily distinguishing characteristics of group practice on a country-wide scale, although evidence from a survey of general practice undertaken by the British Medical Association Planning Unit in 1969 had similar findings[12].

We have not listed all the comparisons we undertook: with some of the characteristics investigated, there were only marginal differences amongst doctors in different types of practice; for example, almost equal proportions of each type of practice were readers of *The Lancet*, and had had parents in medicine. However, the characteristics analysed which failed to distinguish doctors in different types of practice were much less numerous than the characteristics which did.

This finding in itself lent support to the impression which we gained while undertaking the survey that there were substantial differences in the type of practice conducted by practitioners working in different settings as well as in their attitudes to their work, and that those working in partnerships bore a closer resemblance to the overall national picture than did those in single-handed practice.

Middle and working-class areas

On the other hand, the second part of our hypothesis, that there would be differences between those working in middle and in working-class areas of the Borough, did not find such strong support. On most of the measures, there were no sharp contrasts between those working in the two types of area.

However, more practitioners in middle-class than in working-class neighbourhoods practised from premises which were rated by the research worker as 'warm and comfortable' and 'efficient and modern'. They more often undertook minor surgical procedures themselves, were more aware of the diagnostic services to which they had direct access in local hospitals and were more likely both to invite consultants to domiciliary visits and to accompany them on such visits.

On the other hand, there were no fewer single-handed practitioners in middle than in working-class neighbourhoods, the main differences between them being that more of those in the middle class than in the working-class areas were foreign-trained, had private patients and practised from their own residences.

It was the presence of more foreign-trained doctors in the middle-class areas with a generally conservative pattern of practice which seemed to us to account for the lack of overall support for our hypothesis that the practice arrangements in these areas would show a closer resemblance to the national picture than would the practice arrangements in the less salubrious parts of the Borough.

Personal characteristics of practitioners associated with differences in practices

We have already indicated that Camden had a higher proportion of elderly practitioners and of doctors who trained overseas than had England and Wales or inner London. We

have also shown that older men and those from overseas were more likely than younger ones to practice single-handed and less likely to be in group practice.

In Tables 9 and 10, we summarize both the main distinctions between practitioners aged less than 44, those aged 45 to 64 and those aged 65 and over as well as the distinctions between British and overseas-trained doctors.

The proportions given in these tables suggest that the age of the general practitioner and place of his medical training were associated with his style of practice and his

TABLE 9

PERCENTAGE COMPARISONS BY AGE AND BY PLACE OF BIRTH OF PRACTITIONERS WITHIN CAMDEN

Characteristic	*Age*			*Birth place*	
	44 or less	45–64	*65 or more*	*In British Isles*	*Overseas*
	(N=46)	(N=56)	(N=36)	(N=84)	(N=50)
Private patients 100 or more ..	*24*	*28*	*19*	*19*	*41*
On obstetric list	*39*	*27*	*20*	*29*	*26*
Took cervical smears in last 2 months	*63*	*28*	*12*	*32*	*26*
Performed vaginal examination—'more often than not'	*73*	*57*	*47*	*62*	*57*
Stitched cuts 'more often than not'	*17*	*23*	*13*	*19*	*17*
Use of hospitals					
Knew of direct access to 5+ facilities	*86*	*74*	*41*	*72*	*66*
Believed had no access	*2*	*0*	*29*	*NK*	*NK*
More than 2 referrals per fortnight to casualty department per 1000 National Health Service patients	*39*	*36*	*51*	*NK*	*NK*
Contacts with health professionals					
Verbal contact on index day ..	*80*	*61*	*44*	*70*	*52*
Verbal contact in fortnight with local authority home nurse ..	*58*	*74*	*65*	*72*	*60*
Verbal contact in fortnight with local authority health visitor ..	*51*	*58*	*42*	*60*	*38*
Activities outside general practice					
Hospital appointment	*33*	*11*	*0*	*18*	*13*
Local health authority	*32*	*18*	*12*	*28*	*11*
No postgraduate lectures or courses attended in last 5 years	*18*	*18*	*45*	*23*	*29*
Current research	*34*	*21*	*7*	*28*	*11*
Current teaching	*43*	*29*	*3*	*32*	*20*
Published paper in last 5 years ..	*17*	*19*	*7*	*19*	*9*
Membership of Royal College of General Practitioners	*50*	*22*	*19*	*32*	*28*
Not attended professional meeting in last 3 months	*17*	*37*	*66*	*34*	*42*

stated enjoyment of it. Doctors in the age group 44 or less were more likely than older ones, and in particular, those aged 65 or more to carry out procedures such as vaginal examinations or to take cervical smears; to know of their right of access to hospital diagnostic facilities; to contact other doctors and health workers in the course of their daily work; to hold a hospital or local authority appointment; to attend lectures, participate in research and teaching; to belong to the Royal College of General Practitioners

TABLE 10

PERCENTAGE COMPARISONS BY AGE AND BY PLACE OF BIRTH OF PRACTITIONERS WITHIN CAMDEN (ATTITUDES, OPINIONS AND INTERVIEWER ASSESSMENTS)

	Age			*Birth place*	
	44 or less	45–64	*65 or more*	*In British Isles*	*Overseas*
	(N=46)	(N=56)	(N=36)	(N=84)	(N=50)
Opinions on general practice					
Enjoy general practice very much ..	*73*	*59*	*67*	*64*	*67*
Future of general practice encouraging	*45*	*22*	*30*	*31*	*27*
Advantages of general practice outweigh disadvantages	*83*	*83*	*55*	*79*	*71*
In favour of charging patients for prescriptions				*56*	*70*
Interviewers' assessments					
General practitioner 'happy' ..	*55*	*37*	*38*	*56*	*40*

and attend professional meetings; both to claim they enjoyed general practice very much and appear to the interviewer to be happy; and to see the future of general practice in Camden as encouraging. Doctors born in Britain generally were more likely than overseas-born ones to share these characteristics.

Associations or determinants?

In Tables 6–10, we have demonstrated the association of three variables—type of practice, age of practitioner and birth place—with many measures of practice organisation, of the use of certain clinical procedures, of involvement in activities in and outside general practice and of attitudes to work. However, we have also shown that these three variables were themselves inter-related.

The small numbers in the study made it impossible to examine each variable independently while holding the others constant. However, the partial analyses we could do, provided support for the hypothesis that both type of practice and birth place were associated with some outcome variables independently of age. For example, while single-handed practitioners in the youngest age group were more like younger doctors in partnership than like older single-handed doctors, older doctors shared more characteristics with younger ones if they practised in groups rather than other forms of practice. Similarly, doctors born overseas were generally more likely than those of the same age born in the British Isles to adopt more conservative patterns of practice.

We feel able to conclude, therefore, if somewhat tentatively because of the small numbers involved, that age, birth place and type of practice were each independently related to the patterns of practice we found in Camden.

Having said that, however, it is still impossible for us to throw light on how these three variables were related to practice procedures and attitudes. For example, doctors of different ages have clearly had a multitude of different experiences of life and of medical practice and the longer their lives the more diverse these experiences are likely to have been.

The simple variable age may mask for those who qualified before the war such potentially influential factors as the second world war, the advent of the National Health Service and the rapid pace of advance in medical science and technology. We have much anecdotal evidence that the war disrupted the careers of many doctors now in their

middle or later years, especially of those who had to flee from Europe and resume their careers in this country. Doctors of these ages also had to face changes in their style of practice when the National Health Service was introduced and when antibiotics and a panoply of new drugs became available.

Any one or all of these events could be expected to influence the practices and attitudes 20 years later of those who lived through them. In short, the mere process of biological ageing may be the least important of the many influences which are subsumed under the simple term age. Similarly, the significance of birth place may subsume differences in training, in early expectations of practice, in the disruption which fleeing one's country and settling in another involved for some but not for others, or in a host of other unknown factors.

The extent to which partnership practice may be a determinant of other characteristics of practice must also remain an open question. Clearly the cost of innovation is less for groups of doctors than it is for those on their own; for that reason, the desire to innovate is likely to be related to whatever influences doctors to enter partnerships rather than single-handed practice in the first place.

7. DISCUSSION

The characteristic features of general practice in Camden suggest that in many respects it resembled more closely the nation-wide general-practice structure of 20 years ago than it did the pattern which had emerged as the dominant national one by the late 1960s.

To what can this relatively conservative pattern of delivering medical care in Camden be attributed? Although our data do not allow us to identify the causal sequence, it seems clear that it is likely to be related closely to certain characteristics of the body of general practitioners and of their practice organisation which distinguish them markedly from their counterparts throughout the country generally.

Age structure

The first distinguishing characteristic of the body of practitioners in Camden in 1968 was its age structure. The slowing down in the rate of recruitment to general practice which has been a general feature of the last 20 years has inevitably increased the proportion of older men and women in this branch of the medical profession on a national scale.

Compared with Camden, however, the national body of general practitioners appears positively young, and there is ample evidence from our survey that it was the older doctors, and particularly the quarter who were over the age at which most men retire and have a statutory right to draw their pensions, who tended to practice in the most conservative ways. Indeed, if the age distribution in Camden had been comparable to that of general practitioners on a nation-wide scale it is fair to hazard the guess that most of the differences in practice organisation and procedures between Camden and the rest of Great Britain would have been considerably reduced. So too, but to a lesser extent, would have been the differences between Camden and inner London as a whole.

Overseas training

Age, by itself, however, was not the only personal characteristic which distinguished Camden practitioners from those of England and Wales as a whole, and to a lesser degree from inner London. There was an additional difference between Camden and the rest of the country which compounded and complicated the differences between them and also helped to explain internal differences in practice organisation—that is, the substantial proportion of Camden's doctors compared with those elsewhere who had trained overseas.

Doctors trained overseas and particularly in central and eastern Europe constituted a more than proportionate section of the elderly doctors and a smaller, but still significant, proportion of those aged 45 to 64, and, in many respects, their practice organisation and procedures differed from those of their British-trained counterparts, even after age had been taken into account.

Factors attracting doctors to the area

While the peculiar age structure and the high proportion of foreign-trained doctors in Camden may help to account for many of the differences between Camden and the rest of the country in practice organisation and procedures, it is not possible with the data at our disposal to say with certainty whether it was the presence of older men and foreign-trained doctors which determined the characteristics of practice or the nature of practice conditions which attracted to the area individuals who wanted to practise in particular ways.

In all probability, both kinds of causes were operating. We know, for example, from other studies [9, 10, 11, 12] that the characteristic patterns of practice of older general practitioners in Camden were more like those of a similar age in other areas than they were like the practice patterns of younger men in Camden or elsewhere. Such a relationship would suggest that it was the relatively high proportion of elderly general practitioners in Camden which determined the pattern of practice there rather than *vice versa.*

Equally, most foreign-trained doctors probably settled in the area because there was a relatively large number of their fellow countrymen living there, who could form the nucleus of their practice. It is possible that they carried over from previous experience in their own country some of the practices which were more characteristic of their country of origin than of the United Kingdom: for example, foreign-trained doctors were more likely to have considerable numbers of private patients than were British-trained doctors.

On the other hand, some of the particular characteristics of the health services in Camden may have played a part in attracting and retaining the services of doctors who had a preference for particular kinds of practice arrangement. It was noticeable, for example, that no doctor had access to hospital beds for the care of his patients, and, in contrast to the position elsewhere, very few practitioners, including younger men, wanted rights of hospital admission or clinical appointments in hospital.

Studies elsewhere have suggested that patients living in the vicinity of teaching hospitals tend to use casualty departments as an alternative to their general practitioners for the treatment of minor conditions which patients elsewhere would take to the doctor with whom they are registered[30]. Certainly, this study suggested that general practitioners of all ages and all types of practice unit were less inclined than those elsewhere to undertake minor surgical procedures. Again, the fact that many surgeries were situated in lock-up shops, and that the population of the Borough contained so many transients and one-person rather than family households, may have deterred those who wanted to practise medicine in a setting where long-term relationships could be built up with whole families, while attracting those who set less store by the establishment of long-standing relationships with patients.

It was interesting in this connection to find that, at least compared with Bromley and Bexley, an outer London suburb, there were more doctors who were themselves single and hence, possibly not so family-orientated.

Age of recent recruits

It is perhaps natural that an area where the population has been gradually declining as a result of re-housing at lower densities would not attract younger men who are keen to

innovate, particularly when the opportunities for owning and improving practice premises are restricted by the high price of land and buildings. Such men might well find their task easier elsewhere. Most of the older men had been in practice in the area since the beginning of the National Health Service in 1948.

However, it was interesting to note that not all of those who had begun to practise in the Borough in the last ten years were young. Indeed, a substantial proportion of the recent recruits were between 45 and 64 years of age. As far as we know no data are available for other areas, but given the tendency for principals to stay in the same practice rather than move to improve their career prospects, as do specialists in most branches of hospital medicine, we would expect that those who opt for general practice at an early age generally settle in the area where they started to practise. It may be easier for those who change careers or locality in their middle years to settle in a place like Camden than it would be to settle elsewhere.

8. THE QUALITY OF CARE

What light, if any, does this study of general practitioners in Camden throw on the quality of the service provided there? A study such as this which has revealed such considerable differences between the general provision of general-practitioner services in Camden and Great Britain as a whole, as well as differences between practitioners within the Borough, inevitably invites the question "so what?"

Do the differences signify that the quality of the service, that is, its ability to meet the needs of its users efficiently, effectively and humanely, is generally better or worse than that practised elsewhere, or that some practitioners within the Borough were providing a better standard than others?

Previous reports

In 1950, a New Zealand doctor made a number of sharp criticisms of the professional standards of British general practice[31]. He described it as badly housed and poorly equipped with few modern diagnostic and therapeutic aids: he reported that patients were not normally given a thorough examination, were seen only for a few minutes, were seldom asked to undress, and were treated symptomatically on the basis of their own short description of their complaints. He also found what he believed to be great dissatisfaction if not demoralisation among general practitioners. He concluded that the British system of providing primary medical care through general practitioners resulted in both a low level of care and a disgruntled body of professional workers.

The reaction of the British Medical Association to this report was not to deny altogether that poor standards existed but to suggest that the prevalence of these standards was not as widespread as Collings had implied. However, another study which the Association sponsored in 1951, painted only a slightly less gloomy picture[32]: both reports suggested that the poorest standards of practice were to be found in the large industrial cities and particularly in those areas inhabited by the poorest industrial workers and their families. No observational studies have been undertaken in Great Britain since then, although some investigators in the United States[21] and Canada[22] have used rigorous criteria to observe and measure the standards of clinical practice attained by general practitioners.

Variables

We were not in a position to observe the clinical practices of the doctors we interviewed, and as we observed earlier, we are wary of judging the quality of a practice merely in terms of the technical procedures and attitudes of its practitioners.

Nevertheless, professional organisations like the Royal College of General Practitioners[35] as well as many individual writers on general practice[36, 37, 38] have inferred that certain types of practice arrangement can be taken to indicate either greater or lesser efficiency in caring for patients or a greater or lesser consideration for the patients' comfort.

The information obtained in this enquiry allowed us therefore to ask first whether the frequency of certain kinds of practice arrangement considered by those who are now setting standards for general practice as desirable or undesirable differed in Camden from the rest of the country, and second whether they differed within Camden as between general practitioners with certain personal or mode of practice characteristics.

The variables which we decided could be regarded as indicating a more or less desirable quality of care and about which we had information were of four kinds:

(i) those related to practice premises;

(ii) those related to practice organisation;

(iii) those related to practice procedures;

(iv) those related to general-practitioner attitudes.

Premises

As far as premises are concerned, it may be legitimate to assume:

(1) that those which appear to an investigator to be warm and comfortable are likely to enable a higher standard of care to be delivered than those which are not;

(2) that those which appear modern and efficient are better than those which are not;

(3) that those which are purpose-built are better than those that are not;

(4) that those which have a wide range of diagnostic and minor surgical equipment are better than those which have not.

Practice organisation

As regards practice organisation, it may perhaps be assumed:

(1) that the doctor who organises an appointment system is able to practise a higher standard of care than one who does not;

(2) that a rota system for off-duty cover is better than an emergency call service provision;

(3) that the employment of secretarial and receptionist staff and the attachment of health visitors enables the doctor to work more efficiently and effectively than in the absence of such staff.

Work procedures, habits and patient care

Where work procedures, habits and patient care are concerned, one could say:

(1) that the doctor who regularly performs a range of the simpler diagnostic and therapeutic procedures in his own surgery is providing a better service for his patients than the doctor who does not;

(2) that too great a tendency to refer patients to hospital casualty departments reflects a poor standard of care;

(3) that direct use of a hospital's diagnostic procedures and comparatively frequent referral of patients to specialist outpatient clinics for a second opinion reflects a better quality of care;

(4) that the arrangement of domiciliary consultant visits to patients, especially when the general practitioner is also present, is an indicator of good patient care;

(5) that frequent contact with medical men and other colleagues is an indirect indicator that the doctor is taking measures to keep himself abreast of medical knowledge, and to provide patients with the help of social support services;

(6) that the doctor who has and is able to exercise a special medical interest, involve himself in research activities, find time to read suitable medical publications and belong to the Royal College of General Practitioners is one who indicates his concern for maintaining and improving his practice standards.

Attitudes

Finally, it may be assumed that certain expressed attitudes are related to the quality of care provided; in particular

(1) that doctors who recognise the usefulness of teamwork involving non-medical as well as medical staff are likely to provide better care than those who do not;

(2) that those who feel that patients' behaviour is a frustrating aspect of general practice are less likely to provide them with the care they require than those who do not;

(3) that those who enjoy their work very much are more likely than those who do not to give a good service in the course of it.

It must again be stressed that these are assumptions only about the quality of care and refer merely to the technical aspects of practice, ignoring altogether the personal dimension. Furthermore, we have no means of validating them. However, we can claim that they reflect some of the criteria which have begun to be accepted by professional bodies like the Royal College of General Practitioners in assessing the quality of general medical practice.

Conclusions

Taking all these variables together into account, three conclusions emerge from our data:

Poor average quality of care

First, the overall frequency of most of the features of practice which have been assumed to be associated with good standards of medical care was lower in Camden than it was in Great Britain generally. Conversely, there was a relatively greater frequency in the Borough than in the country as a whole of features which, it has been suggested, denote low standards (Table 4). It seems reasonable to conclude, therefore, that the differences between Camden and the country generally denote a poorer average quality of care in the Borough than pertains nationally.

Two standards of care

Second, within Camden itself, each of the variables denoting a better than average standard of medical care tended to be associated with most of the other variables which, similarly, were suggestive of good care; that is, those practitioners who exhibited any one of the good features of practice were likely to exhibit all or most of the other good features. Conversely, practitioners whose standards were low on any one of the criteria used were likely to be low on most or all of the others. It would therefore seem reasonable to conclude that it is possible to speak in a general way about practitioners who had relatively high standards of care and those who had relatively low standards.

Three distinguishing characteristics

Third, following from this second general conclusion, our analysis suggests that it is possible to distinguish certain of the characteristics of those doctors with relatively high standards from the characteristics of those with relatively low standards. The distinguishing characteristics of the first group were their comparative youth, their training in British as opposed to overseas medical schools, and their tendency to practise in

groups or partnerships rather than in single-handed practice. Conversely, the distinguishing characteristics of those with relatively low standards of practice were their comparative agedness, their overseas training, and their tendency to practise as single-handed principals.

9. IMPLICATIONS FOR THE FUTURE OF GENERAL PRACTICE IN CAMDEN

What is it legitimate to infer about the future of general practice in Camden from our conclusions about its characteristics? Before answering this question, it is necessary to consider some general factors concerning the Borough which are likely to influence the shape of its primary medical care service in the future.

Population predictions

First, as we have shown, Camden in 1966 possessed a relatively high proportion of single, widowed and divorced persons compared with Greater London and England and Wales as a whole. It had many more single-person households; many more rented dwellings; more shared housing and domestic amenities; much more over-crowding; a slowly declining population; and many residents who had been born overseas. While definitive information is lacking, certain measures also suggest a population with a proportionately greater need for health and social support services than those of most other areas of London or the country as a whole.

As far as we can forecast, the population of the Borough, and particularly that part of the population living in the least salubrious parts, will continue to decline slowly as a result of changes in land usage and the Borough's policy of re-housing at lower densities individuals displaced by slum clearance. The decline will be accompanied by parallel changes in the composition of the Borough's population. There is likely to be an even smaller proportion of intact, working-class families and a larger proportion of executive-type, geographically mobile, younger people living either in communal, non-family or in single-person households, as well as more upper and middle-class families. In short, patterns characteristic of Hampstead households at the present time are likely to spread gradually to the southern parts of the Borough, replacing the existing patterns there.

At the same time, the Borough is still likely to attract temporary residents, mainly students, from overseas although the number of new immigrants from Commonwealth countries proposing to settle indefinitely in this country is likely to diminish. On the other hand, the Cypriots, Indians and Pakistani already settled in the Borough may well remain well-defined communities, resisting total integration with the rest of the Borough's polyglot population.

Little continuity of care for family groups

If these predictions are correct, it may well mean that the medical practitioner who values highly a form of medical practice based on continuity of care for whole family groups will be unlikely to be attracted to general practice in Camden, at least if it continues in its present form.

Hospital changes

Second, general practice will undoubtedly be affected by the changes which are beginning to take place in the work of the hospitals in the area. In particular, the proposal that the two teaching hospitals situated in the Borough should become district general hospitals serving the population in defined areas will have repercussions on the work of general practitioners.

University College Hospital's defined area includes the southern part of the Borough as well as parts of the neighbouring Borough of Islington; the Royal Free Hospital,

housed on its new site in Hampstead, will serve the northern area, and the Whittington Hospital, which is already used by University College Hospital for teaching purposes in several specialties, the north-eastern section.

These proposals, coupled with the view that all medical students should be exposed to systematic teaching in the problems of clinical medicine which are treated on a domiciliary or ambulatory basis, presage a reaching out of the hospitals into the community and the need for a closer, better-defined relationship between the hospital and the community-based health services.

Local authority services

Third, the reorganisation of the local authority's domiciliary based, personal, social services[39] will influence the relationship between the general practitioner on the one hand and these services on the other. Domiciliary nursing, midwifery and health visiting will in all probability become the responsibility of the new area health authorities under the executive authority of the community physician, who will take over these responsibilities from the Medical Officer of Health to the local authority.

On the other hand, services which until 1970 were administered by the local authority health department—home helps, mental welfare and day nurseries are among the most important—are since 1971 the responsibility of the social service department which, in Camden, proposes ultimately to organise them from area offices situated throughout the Borough and serving a defined population.

10. POSSIBLE CHANGES

In these circumstances, it is pertinent to ask what changes can be made in the existing pattern of the general-practitioner service in Camden if it is to be helped to tackle the needs of the population in the foreseeable future?

Older doctors

The problem as we see it largely hinges on the plight of the older doctors, discussed earlier, which seemed to underlie their isolated style of practice and which often seemed to us to amount to demoralisation. At least on the technical side, their standards of practice seemed to be inferior to those who were not so affected by their background and past experience.

It is difficult to see how to deal with this situation. Doctors in this position are unlikely to welcome new forms of organisation or incentive: nor is it certain that their practices or patients would benefit from an attempt to 'bring them into line' with current thinking. As far as we can see, the only solution to the problem raised by the presence of such doctors is the passage of time. In the nature of things many of them will drop out of practice in the next few years.

Younger doctors

Among younger doctors, there were some in single-handed and two-man partnerships who appeared to sustain a high level of technical competence, whose premises were warm and comfortable and who derived a great deal of satisfaction from their work; they did not feel that combining in large units would improve their practice of medicine in the community, and we were inclined to agree with them.

There were others, however, whose practice arrangements seemed inadequate and who seemed overwhelmed with difficulties. Some of these were willing to consider changes but appeared not to have the resources or drive required to achieve them.

It is in the interests of this last group and their patients, perhaps still the majority in Camden, that beneficial change may be possible. What direction should it take?

Need for new premises

As we see it, the most difficult problem these practitioners face concerns their premises. The cramped accommodation from which many of them work provides a stumbling block to any hopes they may have of changing their style of practice. For example, it would be difficult, it not impossible to attach paramedical staff to such general-practice units. The numbers of such staff mean that each one must cover two or three general-practitioner lists and this is well-nigh impossible when the general practitioners work from different surgeries.

Moreover, the premises of most of the doctors are so restricted in room-space that few could provide the additional accommodation required adequately to house paramedical staff even if most of their time were spent in domiciliary visiting. Cramped conditions also make it impossible for them to house the equipment required to undertake simple diagnostic or surgical procedures, let alone to play a part in the systematic training of medical students.

The need as we see it, therefore, is to assist these practitioners to regroup themselves in larger, shared premises where their problems would be soluble. While this does not necessarily imply consolidation into one partnership of the principals sharing such premises, it is likely that many of them would find advantages in partnership, once co-operation over the sharing of premises had been found a constructive experience.

What prospects are there that such regrouping can be achieved in the foreseeable future in an area like Camden?

One of the major problems of creating larger general-practice units in the Borough is undoubtedly the acute shortage of suitable sites for new purpose-built premises and the high cost of purchasing and adapting existing buildings to this new use.

It is significant that only those general practitioners whose surgeries were in their own residences owned their practice premises: it is thus unlikely that even a consortium of general practitioners would be willing, even if they could, to raise the capital to buy and adapt an existing building or construct a new one. Private property developers, presumably given the nature of the British National Health Service, have not so far shown any great interest in developing purpose-built premises for the provision of primary medical care services.

Health centres

The only body able to command the resources to purchase and equip premises of an adequate size is, at present, the local authority. Camden Borough Council has deservedly a reputation for forward-looking social policies, and has used its powers under the National Health Service Act 1946 (Section 21) to construct one health centre, which, when it opens in 1973, will house 12 general practitioners in two groups and health personnel employed by the local authority as well as nursing, receptionist and secretarial staff employed directly by the general practitioners.

Another comparable health centre to serve the West Hampstead area is on the drawing board, but so far has not received the necessary planning permission from the Department of Health and Social Security.

It would be a tragedy if the statutory authority's contribution to primary medical care in the Borough were to end with the erection of only two health centres, particularly since the first one built will not draw together single-handed or two-man partnerships, where the need is greatest, but enable two units which are already practising in groups of five and six doctors respectively to improve their practice arrangements.

If the local authority's powers to build health centres are transferred to a new Area Health Authority, it should certainly accord high priority to the development of the primary medical care sector which, in Camden, is in more urgent need of improvement

than the hospital services. Indeed, the people of Camden may have come to rely at too great an economic cost on the comparatively plentiful services provided by the teaching and other hospitals in their outpatient and casualty departments. People will continue to make demands on these latter facilities, which the hospitals themselves are anxious to shed, in the absence of satisfactory alternative services.

Hospital-based unit

It has been argued[7] that the serious deficiencies of the primary medical care provision in the inner city areas immediately surrounding teaching and other large hospitals might be resolved by constituting a primary medical care unit as a separate department of the hospital staffed by general practitioners who would serve a list of patients registered with them.

The major and probably overwhelming difficulty of achieving such a development in Camden, which we would favour on many grounds, is the restriction of space. For example, there is little undeveloped land in the vicinity of University College Hospital, and the development of a general-practice unit there would require either the diversion of space used for other medical purposes or the compulsory purchase of a building in the surroundings at present used for non-medical purposes. The former solution would, we expect, be unacceptable to the hospital authorities and the latter would require a major commitment to the idea, not to speak of the persuasion of the Department of Health and Social Security, which would be necessary. Fortunately, the new Royal Free Hospital, which is rising on a cleared site in Hampstead, may allow for such an experimental development.

GENERAL-PRACTITIONER STAFFING

If the need for fewer and larger units to replace the many which now exist is recognised by an Area Health Authority, how likely is it that the general practitioners will be found who are willing to man these units?

The answer to this question rests on the answers to two further ones. First, how far would general practitioners at present working in the area be prepared to alter their present practice arrangements, and second, how easy would it be to attract new general practitioners to the area?

Established practitioners

First, with respect to practitioners already working in Camden, we have already stated our opinion, that a minority of practitioners would, for various reasons, be unlikely ever to agree to change their pattern of work.

The remainder, however, might be wary of doing so too radically or too swiftly. While most doctors recognised the advantages of teamwork and considered that they were likely to outweigh the disadvantages, their response to other questions appeared to conflict with these sentiments; for example, the majority expressed a preference for working independently of medical colleagues rather than in a team. These doctors must not be forced prematurely into new arrangements. In sharing new premises with neighbouring but independent practitioners it may well be that they find their own ways of developing constructive links.

Another stumbling block may be the relationship of the practitioners to the local authority. Seventy per cent of the Camden practitioners expressed a desire to own their own premises and over half of them were concerned about security of tenure in local authority-owned health centres. It may be that some of their fears will be reduced if health centres in the future are owned and administered by a new Area Health Authority

rather than the present local authority. General practitioners' fears and suspicions of local authority control die hard; but a new authority in which the medical profession is directly represented may instil more confidence.

New recruits

As far as new recruits are concerned, there is little doubt in our minds that health centre-type practice would prove attractive to many of those likely to qualify in the next decade and choose a career in primary medical care.

Evidence from our own survey as well as elsewhere suggests that the majority of young general practitioners who propose to practise in urban areas see their future as lying in group practice well supported by community health and social services. Not all of them will opt to practise in an inner-city area like Camden; but to many the metropolis is attractive as a place to live, and, if they are no longer deterred by having to meet the high price of adequate practice premises entirely by themselves, they may well welcome the particular challenge of meeting the primary medical care needs of a population which lacks the social stability of many other cities, suburbs, towns and villages in the United Kingdom.

At present, there are few vacancies for such young practitioners in Camden; but a substantial number of practices will probably fall vacant within the next few years. If the newcomers can be offered both the challenge of developing appropriate services in adequate premises with supporting staff and equipment, and the necessary material and capital resources with which to do so, then perhaps their efforts and those of their established colleagues will in time provide a solution to the problems of primary medical care delivery in this metropolitan area.

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FURTHER INFORMATION

1. Copies of the following documents are available at a small charge from the Secretary, Social Research Unit, Bedford College Annexe, Peto Place, Marylebone Road, London, NW1. (mark envelope G.P.S.):

   The questionnaire
   Letter of introduction to general practitioner
   Distribution of interviews among interviewers
   Classification of street types used in categorising district of practice.

2. I.B.M. cards containing the coded data from interviews are stored by the Social Research Unit. Any investigator who may wish to use data not fully analysed or not reported here should write to Professor Margot Jefferys.

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