

## *Annotations*

### THE FAMILY DOCTOR AND THE HOSPITAL

The rise of specialdom, with resulting development of hospital departments, has raised problems of adaptation for the medical profession, and the traditional way of the family doctor has been deeply affected. What should be the relationship between hospital and family practice? And how are doctors outside hospitals to be stimulated to follow modern changes unless an association is maintained? These questions were posed in a lecture delivered to the annual general meeting of the British Medical Association, South Australian Branch, at the Mater Misericordiae Hospital, Sydney, on 24th June 1959.

The lecturer was Dr C. C. Jungfer, president of the Australian College of General Practitioners, who pointed out the increasing exclusion of general practitioners from hospitals, a trend not confined to Australia. The British National Health Service excluded nearly all general practitioners from hospital work by government action in 1948. By contrast, the Americans admit doctors provided they are competent to perform certain clearly-defined categories of work. In general there is a move towards hospitals staffed by specialists only, though in smaller American hospitals the old order persists by geographical necessity. In all countries, general practitioners have opposed their exclusion from hospitals, and in Great Britain, eleven years after 1948, "resentment is still strong enough to make possible some modifications of the system in the near future." In North America, most of the public have an ideal of specialist infallibility.

A balanced approach is difficult, but some factors are clear. There are many patients who can be supervised adequately by general practitioners without continuous specialist supervision—those admitted for social-problem reasons, and those whose treatment is within the general practitioners' competence. On the other hand, administrators concerned with hospital standards doubt whether general practitioners will all adopt the necessary self-discipline required for high quality service.

Thought has thus turned to the means by which hospital standards should be maintained. In America there are regular inspections by a Joint Commission on Accreditation of Hospitals, which has representative membership. More recently, a "Medical Audit" system has been introduced to measure the performance of a hospital by studying its standard of record-keeping and by systematic following-up of all cases, with frequent staff conferences—all

on a voluntary basis. The difficulty is to know how far to check on a doctor's work and how much to leave to his conscience.

As hospitals develop it is likely that they will extend their care into the patients' home. This should be done by increasing the collaboration of the existing services so that a team is formed in which the family doctor plays his part.

Finally there is the question of the hospital as a teaching centre, and the contribution which the family doctor can receive, and give. Student-attachment schemes are becoming popular, and by them students can see what is involved in extra-mural practice, both in organization and in clinical material. All students should be given such experience so that they can see a wider field of clinical medicine than would otherwise be possible. The embryo specialist is benefited as well as the others.

The general practitioner should be brought back into the hospital too. Wards set aside for him would contain those patients not needing consultant supervision. Undergraduates would see more variety, and the general-practitioner teacher would be put on his mettle. All parties to the arrangement would benefit.

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## THE COLLEGE OF GENERAL PRACTICE OF CANADA

### Annual Medical Study Requirements

The Canadian College *Bulletin* for September 1959 details criteria for continuing membership. Studies are graded as Category I or II, and a total of at least 100 hours must be devoted to them in each two-year period; not less than 50 hours must be spent on Category I. A year of grace is allowed to members who through undue difficulties fail to complete their stints on time. Membership cards are issued annually and are designed to serve as records of work undertaken.

Category I studies include attendance at planned postgraduate courses at approved medical centres (at least 25 hours), at National Scientific Assemblies of the College, and at other approved medical association meetings. Publication of original scientific papers in approved journals and presentation of papers or exhibits to approved scientific meetings may be credited from 5 to 25 hours (determined by committee).

Category II studies include attendances at local medical society meetings, hospital clinical conferences and ward rounds, medical teaching, correspondence courses, recorded lectures, book and journal study, and other activities which members may submit.

### Educational Standards for General Practitioners of the Future

The Canadian *Bulletin* reports that the American Academy of

General Practice adopted in April 1959 a graduate training programme intended to produce doctors ready to serve patients over broad areas of medical care and able to co-ordinate consultations according to the needs of the patient. They stress that all doctors should have a sound, balanced education in basic science and its clinical applications. Present educational programmes expose the students to specialty viewpoints. To maintain the objective of providing a sound, balanced education the student must be exposed also to the concept of family practice. A general practice administrative unit is needed in each medical faculty.

At least two years of formal hospital training after graduation is desirable, and should include obstetrics, surgery, emergency room service and management of trauma, outpatient attendance, and care of the newborn. Doctors planning to engage predominantly in obstetrics or surgery should then continue their studies in those fields for a further period.

In conclusion they note that all doctors have a moral and legal right to engage in any aspect of medical care for which they are qualified by training and experience. Consequently, any doctor who wishes to broaden the scope of his practice in any field should be able to do so by taking further postgraduate training.

### **Doctor—newspapermen Relations**

The medical writer of the *Montreal Daily Star* is reported in the *Bulletin* as giving the opinion that professional secrecy is less strict than formerly. This he attributed to the fact that "you meet a better class of reporter now", and this in turn was due to doctors having educated reporters so that they covered medicine better. A doctor could still be discouraged if he "ran into a green reporter with no background in medical coverage. Some of us have found that when a doctor acts shy and difficult when asked for help in explaining a medical point it turns out that he has recently been bitten by a mad reporter".

Reporters and lay editors have much to contribute in educating the public, for instance in encouraging polio vaccination, but do not regard their job as a crusade. They will not use their newspapers to advise vaccination merely because some doctor tells them they should. They aim to present *news*, and must be supplied with the right facts and arguments to prove the case—then they are anxious to publish it. The writer pleads for better information about medicine, rather than about individuals who are ill.

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