FIRST SESSION

A future in general practice

WELCOME

Professor Gittins welcomed members of the symposium in his capacity as Vice-Principal of the University College.

OPENING REMARKS

Dr John Hunt, *C.B.E.*, M.A., P.R.C.G.P., F.R.C.P., F.R.C.S.

WE have a very interesting programme this morning. First of all, John Fry is going to talk to us about common world problems of medical care. Many countries have the same problems and we can learn a great deal from each other. They include the academic organization of general practice in different places; there are now 15 or so national colleges and academies of general practice and we are beginning to have joint meetings at which we exchange views and learn from each other. In April 1970, we have a joint meeting with the Australians in Aberdeen. In parts of Australia, 30 to 50 per cent of the general practitioners have come from this country during the last 15 years, and in Tasmania I believe the figure is more like 50 per cent. There are all sorts of reasons for this. One is the hospital-bed problem but this is by no means the only one, and if we can analyse the reasons why our doctors, many of them good ones, are leaving here and going to Australia we shall be in a position to try to reverse this flow. We want to have the best doctors coming here, and not many of our best ones going out.

When I visited Australia I was impressed by their general-practitioner hospitals. In one at Bunbury, south of Perth, 13 general practitioners have charge of 150 beds. It is a magnificent hospital. There is a general-practitioner floor—a pilot scheme—in the Queen Elizabeth Hospital in Adelaide with 50 general-practitioner beds within a teaching hospital. This whole floor is given over to general-practitioner beds where the students can be taught by the consultants *and* by general practitioners together. The Minister of Health for South Australia told me that he thought this experiment had been an enormous success, and that it may be copied in other parts of Australia.

Dr Harvard Davis is going to talk to us about patterns of practice,

which lie at the root of our problem: and following him will be Professor Alywn Smith who will talk about hospitals and community services.

There is a paragraph in the *British Medical Journal* of today about community nurses and their attachment to general practitioners. It says:

> The more we study this subject the more striking we find the similarities between nurse attachment to general practice and traditional concepts of courtship and marriage. There is good statistical evidence to support a suspicion of the durability and quality of shotgun matches. The same may be true of attachment schemes. Many of the criticisms of attachment can be levelled at an inadequate period of preparation or 'courtship'.... The role of the medical officer of health as 'matchmaker' at this stage is important in defining expectations. Equally important is follow-up by the medical officer of health or chief nursing officer, particularly if this takes place after the initial 'honeymoon' period, when the novelty of attachment has subsided.

This is an interesting concept of the medical officer of health as a 'matchmaker' and I shall be interested to hear what Professor Alwyn Smith says about this, because it is always important to get the right people together.

Medical care, common world problems and dilemmas

Dr John Fry, M.D., M.B., B.S., F.R.C.S., M.R.C.S., L.R.C.P., F.R.C.G.P.

WE are at the end of an era and it is as well that we pause and ask a few questions before we go into the next era. We have just passed through a time of crisis and gloom during which the Royal College of General Practitioners has played a vital part in a holding operation that has ensured that general practice has a future. It is because of this holding operation that we can now meet and discuss this future in general practice. It is appropriate at the end of this era that we should pay tribute to our president, Dr John Hunt. History will show that he was largely responsible for the birth, growth and development of the then College of General Practitioners, and we owe a great debt of gratitude to him in guiding us through this period of gloom, depression and despondency. In considering our future, it is important that we take a broad view and have a look outside to see what is going on in the world beyond our shores. It is rather comforting to see when one travels abroad that the grass is certainly no greener on foreign fields; in fact it is a very murky dark brown as far as general practice is concerned. There is obviously an acute crisis in medical care in the United States; the crisis is in providing care for people. It is not just a matter of cost but of getting doctors, not just general practitioners, to leave the big cities for the vast vacuum between the east and west coasts and to get them to practice in communities with less than 10,000 people.

A general practitioner from Bergen, Norway, told me that the problem there is that no one wants to go into general practice; we complain about lists of 3,000, but they are having to cope with 5,000 and 6,000 patients in Bergen because there are no young people coming into general practice. Australia and New Zealand are also facing problems, in that the general practitioner, in looking to the future, has a problem of identity—what sort of doctor should he be, a pseudo-specialist or 'specialoid' if you like, working part-time in hospital and part-time outside, or what? In Russia and Eastern Europe they are facing a problem of non-identity because they have already passed that stage and