the hospital and since opportunities for professional exchange are maximal where repeated professional contact is possible, the hospital affords the only effective opportunity for continued professional education. It is possible that neither of these arguments is conclusive. Practice from suitably organized health centres might afford an adequate opportunity for professional exchange, and continuity of patient care might perhaps be better achieved by keeping patients out of hospital as much as possible than by having their medical attendants look after them both in hospital and home. The problem is far from easy and there are no well established models upon whose experience we can draw. General medical practice is almost unique to this country and, even here, is of relatively recent development in the sense in which we have come to use the term. It may be that the quest for hospital employment was in reality a quest for professional status. If this was so, then it should be said that there are now good reasons for believing that the quest has been successful. The image of general practice, in this country, has probably never been better nor has it been better based on reality. The creation of the National Health Service and the development of the Royal College of General Practitioners have been controversial in their time. There is equally no doubt that general medical practice will continue to evolve but the legislation and the work of the College have between them created a body of professional men entirely fitted to undertake the negotiations and development which an effective analysis of the situation will commend to them.

Discussion

Dr Hunt: I believe general practitioners with special interests need more hospital beds than those without, and that these beds should be in general-practitioner hospitals or general-practitioner wards or floors of general hospitals rather than being mixed up with consultant beds in a hospital. The special general-practitioner interests are clear-cut; some want obstetric beds, others who are interested in internal medicine want beds for investigating their patients; those with a diploma in child health can look after children in general-practitioner beds, those with a diploma in psychiatric medicine can look after some of their psychological cases and give them special psychological treatment; doctors with an interest in dermatology can admit patients with severe eczemas and so on. If one has a special interest one needs beds rather more than if one has no such interest. In the USA, and I disagree with John Fry here, there are a great number of doctors still doing general practice. General practice has not died out in the United States; the fact that there are more than 31,000 family physicians who are members of the American Academy of General Practice underlines this. There are a great number of general practitioners with special interests in the United States, as there are in Australia and in Britain, and this is different from what John Fry referred to as the 'specialoid'. My definition of a 'specialoid' is a doctor working full time in a special subject as a consultant or specialist without being fully-qualified academically to work as such. We have a great many 'specialoids' in this country; Harley Street is full of them, people acting as psychiatrists, as varicose-vein surgeons, as skin or beauty specialists and so on. There are probably as many specialoids as specialists and many of them are doing extremely good work. The fact that there is a shortage of specialists makes the position of the 'specialoids' possible. If a man has become expert in operating on varicose veins—if he really knows how to do it, why not let him do this, even if he has not got his FRCS? I think this concept is different from general practitioners working in active general practice for most of their time but with a special interest as many do in America and Australia.

And lastly, there is Professor McKeown with his division of general practice into practising paediatricians, gynaecologists and obstetricians, doctors for the young and middle-aged adults,

and those for old people—practising geriatricians. This sounds fine but when you come to work it out in a practical way it does not prove too easy. It must be difficult to persuade a patient to leave a doctor whom he has known well for many years, to go to a complete stranger just because a child has reached the age of 12 or an adult has reached the age of 60 or sixty-five. In the United States, so impossible has this proved that there are many so-called 'paediatricians' looking after people of 30 to forty. I do not believe that such a change-over will always work, and I do not think that it is in the best interests of family medicine.

Dr Maybin (*N. Ireland*): How does one reconcile the 'iceberg of disease' to which Dr Fry referred with the feeling of many doctors that the majority of patients trouble them with trivialities?

Dr Fry: This point about triviality is really related to the point that a general practitioner in this country is the doctor of first contact for the common diseases that commonly occur. It is fortunate that most diseases in the community are minor and perhaps 'trivial' and that someone, at the moment it is a physician, has to deal with them. The reason we tend to look at them as trivialities is because we have been trained in medical schools where rare diseases are common. It really depends on what one means by triviality and what the doctor's attitude is. We must teach future general practitioners that so-called trivialities are in fact the bread and butter of general practice. At the moment we have to cope with them and they are an essential component of the work of American paediatricians who spend 60 per cent of their time in well-baby care—this is trivial, if you like.

Dr Hart (*Glyncorrwg*): The waiting list at my district hospital (static or growing for the past two years) for the first outpatient referrals is six weeks for general medicine, eight weeks for surgery, nine months for orthopaedics and 11 months for ear, nose and throat. For the past year we general practitioners have had no access to radiology. At the same time consultants in each of these specialties can be seen within a few days on payment of five guineas, and are then invariably followed up in outpatients using hospital diagnostic facilities. If this were not happening in Great Britain we would call it a system of bribery. Is it not one of the obstacles to effective community care, not the most important perhaps, but one we should cease to ignore?

Professor Alwyn Smith: The problem of matching the provision of services to the need for those services is considerable and I think all countries encounter it. Some of the more required services are the least attractive to medical graduates. It is much easier to attract people into neurosurgery than into some more useful branches. I do not mean that neurosurgeons are not useful but they are not as needed, there are not so many problems for them as there are a lot of other things. It is not easy to get into hospital to have varicose veins operated on whereas it is quite easy to get into hospital to undergo a surgical ritual for an inoperable cerebral tumour. It is extremely difficult to know what you do about this. To some extent I suppose we will have to accept direction; there is already a little direction in that available training posts are matched increasingly to need. I do not myself know what one ought to do about the existence of private practice. I would weep no tears whatsoever if both general and consultant private practice disappeared completely, but I recognize that perfectly reasonable and civilized people feel that it is important and it is not a large enough problem to destroy the National Health Service. I do not think the NHS is seriously threatened by private medical practice.

Dr Fry: The answer to this problem is simple. It is a problem that has to be tackled in two ways. The first is to go and see why these patients wait for six, seven, even 12 weeks for an outpatient appointment. Do hospital specialists adhere to the trade union demarcation line so strictly that they only see six to ten patients at a clinic and no more? My father, who is still a general practitioner, tells me that when he was a student at the Brompton Hospital outpatients, where he used to learn about tuberculosis on a Saturday afternoon, the consultant used to go on working until 10 o'clock at night. So let us see why there is this barrier at outpatient level, why the consultant says "I'm only going to see two new patients and 12 old ones at this clinic", is this the rate for the job or the rate for the job at NHS remuneration? The other way of looking at it is, why do we send all these patients to the outpatient department? Logan and Forsyth found that in about a quarter of all the cases referred to the consultant, there was nothing wrong; they did not see why these patients had been referred to outpatients in the first place. This problem is really related to the point I was trying to make about the need for change, the need for shedding traditional ways of working and seeing how we

can resolve it. And the resolution is simple. Let us scrap outpatient clinics in the general specialties and have our consultant in the health centre where we can refer, on a much more informal basis, these cases to him as a friend and colleague. I must say that I tend to use my specialist colleagues as technicians and not so much as consultants these days. Most of the things I refer to them require a technical procedure to be done.

Dr Harvard Davis: Wade and Elmes of Belfast tell us that in their general outpatient clinics, they found it difficult to define the reason for the referral from the letter from the general practitioner; this probably accounts for Logan and Forsyth's 25 per cent NAD., because the consultant did not know why the general practitioner was referring the patient and this is the reason for a face-to-face consultation.

Dr Williams (*Anglesey*): Dr Harvard Davis suggested that a team of three general practitioners was ideal and that six should be a generally accepted maximum. Do you think that three is a sufficient number to cope with illness, holidays, postgraduate training, etc?

Dr Owen: With the advent of the full-time salaried service and 20-man health centres, with patients fragmented anatomically, physiologically and chronologically, how long will it be in the opinion of the panel before general practice in this country is run from hospital outpatient departments or polyclinics, and how long will family medicine survive this pattern of impersonal care?

Dr Harvard Davis: Dr Williams has misunderstood me, I suggested this size because it is small enough to make continuity of care a reasonable prospect. I did not say that I thought six the optimum number; this is just what many other people say. I think the basic team should be two or three because this is probably the number that would facilitate good integration of the health visitor and the district nurse. What we have got to do is to rationalize numbers of the basic team so that effective communication and teamwork can be undertaken by the paramedical workers. Theoretically you can have any number of such teams in the same building, and divide them up for off-duty times in any way that you like; because you have 20 they need not all be in one rota for off-duty work. Dr Owen's suggestion that we are going to end up with a polyclinic is the reverse of what I was trying to suggest, a large health centre with proper organization to provide individual personal care but at the same time have sufficient population to facilitate integration and communication with the preventive services of the local health authority and the hospital.

Professor Alwyn Smith: I should have thought that laying down the law about the size of these things was neither possible nor desirable; in some situations there might be two or three and in others there might be up to twenty. A small county town has utterly different requirements from a re-housing estate, and the size of health centres should be left flexible. I do not think we know half enough about the implications of these things.

Dr Williams: About two years ago we attempted to start a health centre in Holyhead. The county architect's assistant, the medical officer of health and I had been to the MPU symposium on health centres about two years previously in London, and the county architect drew up a set of plans for nine doctors working loosely together as three separate units of three; the ancillary staff were completely integrated in this building, with the top floor taken over by the health authority. The costing for this building was £90,000. In subsequent discussions it became apparent that the three separate groups of three wanted separate ancillary staff facilities including offices and filing systems separated into three, and the new costing came to £200,000. This is the kind of problem I had in mind and it does reflect the kind of thinking and planning necessary in a case like this.

Dr Owen: May I enlarge slightly on the horrible feeling one has in relation to fragmentation by age groups. This is really the thing that frightens me about large health centres. I realize that progress must go on and that in time we will have large health centres, but we must know before-hand the sort of medicine we are going to be practising from them. We must have experiments and research before we accept this as the pattern of future medical care in this country.

Dr Harvard Davis: We are in danger of experimenting for the sake of it, and we are not applying present knowledge. With large health centres, people assume that because they are large the services will be fragmented. This is not so. The kind of medicine that is practised will depend on the attitude of the doctor, not upon whether he is in a large building with other

doctors or not. We have had to make our hospitals large in order to provide facilities economically and we are going to have to do the same thing with our community services.

Dr T. A. Jones (*Swansea*): How much responsibility should a person have for his own well-being, and how much responsibility must the general practitioner have? Is trivial illness really the responsibility of the health educator?

Dr Fry: This question raises all sorts of issues such as the imposition of a fee for service in an attempt to prevent trivialities coming to the surface. The answer is much more in terms of principle, and relates to the personal relationship between doctor and patient. I am not troubled by trivialities because I have taught my patients not to come to me with trivialities that I consider are not necessarily my task. Perhaps this is health education in the widest sense. I do not think that we should be worried about treating trivialities, perhaps trivialities do not really exist if we look at them the right way. I do not think that it is our responsibility to educate our patients to deal with certain things that we feel they ought to deal with. If they come in with something that we think is not in a doctor's realm, dealing with it appropriately ought to ensure that they do not come to us again with that particular ailment. We should not have too many rules and regulations governing what patients ought to bring to us; we ought to interpret this ourselves. If we feel that patients ought to keep fit, perhaps we ought to have a keep fit class or a running track within the health centre where we can exercise with our patients every day.

Professor Alwyn Smith: Not being a general practitioner I have a different view of trivial illness. The only kind of trivial illness that I know anything about is the sort I have myself. It is easy for general practitioners to forget that there are two kinds of trivial illness, those cases dealt with by patients and that he knows nothing about, and those the patient regards as something he requires medical advice for and, therefore, not quite so trivial to him. It is difficult to put yourself in the position of a patient bombarded on the one hand by advice to "see the doctor early for any of the following signs" and on the other hand by advice to deal with things himself.

Dr C. C. Lewis (*Pontypridd*): Could you please define the field of work of the attached health visitor in the future?

Dr Fry: We are considering our rôles and terms of reference for the future and health visitors have an even more urgent need to re-think their own rôle because most of their work is related to what happened 75 years ago. Health visitors were brought in because young mothers could not afford a doctor for their children. There was a battle at that time over their rôle and the compromise was reached that they should give educational advice but they were not to advise on treatment. This sort of feeling still exists. They are considered interlopers in medical care by some general practitioners, yet they are the most highly trained of the paramedical ancillaries; they are nurses, midwives and health visitors. They are the best type of medical social worker that we can have because they understand nursing and they are also specially trained. I think their rôle in the future is in the health team as a medical social worker They are the nearest equivalent to a generalist social worker that we have. Others can be brought in as specialists if we need a children's social worker or another specialist type. The health visitor of the future has to be a medical social worker in the widest sense, working as a member of the general practitioner's team and perhaps to do follow-up and other work the general practitioner is responsible for. I do not see her as a first-line barrier between the general practitioner and his patients.

Dr R. P. Maybin (*Northern Ireland*): The population for a district general hospital is said to be 250,000 to 300,000. Can a comprehensive outpatient department be based on a health centre for 50,000 people?

Professor Alwyn Smith: It all depends what you mean by comprehensive. I do not really see why you should not provide an effective outpatient consultation service in a health centre for 50,000. I find the whole idea rather attractive.

Question: May I quote some figures about trivial consultations in South Wales? In our recent survey of consultations which doctors regarded as trivial, 22 per cent of the 'trivial' consultations were repeat consultations. In a similar survey in South-west England, Wright's figure also gave 22 per cent. What we forget is that, like our patients, we are human beings

and we all vary tremendously; what we may write down as trivial we may have second thoughts about, and ask the patient to come back if we are not absolutely sure.

Dr Harvard Davis: Dr Maybin's question illustrates the fallacy of making generalizations. A 50,000 population will provide sufficient material for most of the general specialties—general medicine, general surgery, paediatrics, gynaecology, on a basis of one outpatient session each week or fortnight. The question is not one of moving outpatients to the health centre, but of each individual specialty. There is a case for keeping surgical outpatients in the hospital, and a much greater case for bringing the medical specialties outside.

Dr Fry: If we look at comprehensive outpatient departments another way, we find that there is one physician and one general surgeon to 50,000 people. This means that these physicians and surgeons do about four outpatient clinics a week. It means also that the health centre looking after 50,000 people warrants four outpatient sessions from these two general specialists at this clinic. If we relate this to obstetricians who do three sessions, dermatologists one session, psychiatrists four sessions and so on, we see there is quite sufficient material for referral purposes for a population not of 50,000 but of 10,000 the size of the health centre that the North of Ireland studies have been carried out on. So there is no logistic reason against moving outpatient clinics from the hospital into the community.

Dr Alan Gilmour (*London*): In the Oxford survey of general practitioners interested in hospital beds what was the breakdown, as regards age and past experience of access to general practitioner hospital beds, of the general practitioners taking part?

Dr Harvard Davis: There was a difference between doctors who had been in practice for some time and doctors who had just come from medical schools or with limited experience. Those who had come into practice recently expressed a much greater interest in looking after acute cases in hospitals, whereas the doctors who had been in practice for some time did not. This is a reflection of medical education.

Dr Gilmour: I asked about previous experience of access to beds because I know of a survey which showed that a majority of general practitioners were not interested in beds; a majority of these people had never used hospital beds, they had full lists and they did not see how they could possibly fit in any extra work. The minority who had previously had general-practitioner beds or experience of them, had a quite different attitude. Obviously one can get the wrong impression from some of these responses. I do take note of Dr Harvard Davis's point that with more remote and larger hospitals only the most local general practitioners can make proper use of those beds, but surely these are not just for social cases. There are many acute cases which a general practitioner can treat, using consultant facilities for the occasional consultation, and this is what a lot of younger general practitioners want. At one time I made a quick survey of our local diagnostic facilities which are excellent. Of 50 general practitioners who used a particular hospital x-ray department only eight used it for other than routine chest radiography and went in for contrast media investigations. So there is quite a range of possible use of facilities when they are available to a general practitioner. The advantage of general practitioners having contact with consultants in their health-centre specialist-clinics is obvious, but the bigger district hospital concept is a potentially dangerous one in that it can remove this close contact between general practitioner and consultant. If we can improve this relationship by having consultants come into a health centre, it will be a most useful thing in the continuing education of both parties.

Dr Chalmers (*Swansea*): Excessive home visiting is in my opinion a feature of general practice in this area. How does the general practitioner tackle this problem without losing the goodwill of his patients?

Dr Davis: I have not tackled it but I think the answer can be shown by a number of experiments that are going on, one quite close to here in Risca. In this valley, about 20 miles long, there were three practices, one at the top, one in the middle and one at the bottom of the valley. A health centre was built in the middle and in order to avoid excessive travelling by the doctors a transport service is being devised to bring patients to the centre. This is working extremely well and I think we have got to make use of this sort of facility. Yet it is important that the doctor should visit the home, and I would not like to go on record as saying that we should cut out home visits. However, we must make the most rational use of time and if we can transport patients to a health centre, then so much the better.

Dr Fry: In trying to produce another edition of the College publication "Present state and

future needs" we contacted about a dozen practices with regular records of visits and surgery attendances over the last 10 to 20 years. One common feature in all the practices has been a gradual fall in home visits. In one practice in Scotland, visits are one third to one quarter the number they used to be. The reasons for this are numerous; they are partly medical, because we have got better methods of treating patients, and partly social. More and more patients come by car to see us, and the answer to the question is really that it depends again on the doctor-patient relationship and education in the widest sense, both of the doctor and the patient.

Dr G. W. Jenkins: Has the panel read '*Medicine and politics*' by Enoch Powell and is it not *absolutely* correct? Is not a totally free service quite unworkable in a democracy?

Professor Alwyn Smith: I have read it, I liked almost everything Mr Powell said. I admire the persuasive skill of the argument and the obvious intelligence behind it, but I find that I am in fundamental disagreement with the conclusions. It is rather short notice to recall his precise argument and reply to it, but I do not myself think it is realistic to suggest that we are aiming at a free medical service. Everybody knows who pays for the medical service, it is the public and everyone is pretty well aware that it is paid for out of general taxation and that it is one of the resources of the country which is paid for in that way like the police force, fire brigade and a number of other important social services which we should not dream of adding a fee for service to. I do not see any incompatibility at all between a free medical service and a responsible democracy. It seems to me to be the right way to do it and perfectly sensible and entirely workable. I think it works fairly well here. One is from time to time critical of the National Health Service, but it works pretty well. The lot of the general practitioner, which the British Medical Association has complained so much about, I think most unwisely, is not half as bad as you would believe if you accepted all the whining statements made by some of your politically-minded colleagues. I think there is an argument for spending a little more money on it. The cost of medical care in this country as a proportion of the gross national product has been falling whereas in most other countries in Western Europe it has been rising. We spend less on medical care in this country than in most other comparably industrially-developed countries. Lots of countries spend more on medical care than we do, and the system they use for financing it does not seem to make a great deal of difference. I have just been on a tour for the World Health Organization which involved looking at the child health services of, on the one hand Finland, and on the other hand Czechoslovakia. It is remarkable how similar the actual end product is. I thought it worked pretty well in Czechoslovakia where the population is much more regimented than it is here. Patients do not really have a choice of doctor except by moving house in Czechoslovakia but I could not find anybody who thought this was a disadvantage, either doctor or patient. I think we have a pretty good and workable system in Great Britain.

Dr Jenkins: Is there not something radically wrong with a service where every year 2,000 doctors qualify in Great Britain and Northern Ireland and 25 per cent of them leave, never to return? Some time ago in the *British medical journal* it was stated that out of 100 applicants for general practice in Great Britain 25 per cent of the people appointed were immigrants. Is that a good service? And furthermore may I say that if the health service is as good as it is stated to be why has it not been emulated by any other civilized, democratic country? There is no other civilized, democratic country in the world in which there is a totally free service.