your partners and friends. Show them your paper beforehand and ask for criticisms. Ask them especially about your audibility, your mannerisms and presentation and then heed their advice. Many good teachers do this, especially before important meetings. In short, don't just be a Boy Scout and "Be Prepared" but be a wise old owl and "Be Well Prepared".

The teaching of general practice presents a challenge to us as individuals but it presents a special challenge to the College tutors who are being appointed to the various postgraduate centres. It is they who must seek out our potential teachers, persuade them to start teaching and encourage them to keep on teaching. Only in this way, as Dr Byrne has said, can general practice become a discipline in its own right.

I should now like to leave the question of improving standards and turn briefly to the second part of my subject—assessing standards.

I take it that the words 'assessing standards' mean something akin to the five-yearly "re-boarding" or 're-examination' of general practitioners proposed by the American Academy of General Practice and also by the American Willard Report on Training for Family Medicine. My attitude to this proposal may be summed up in three words—"I'm agin it". I sincerely hope it never becomes a reality. To decree that our more mature and even our younger colleagues should undergo the traumatic experience of having their livelihood placed at risk every five years by means of a multiple choice question paper or some such method is surely abhorrent to us all. Advice, encouragement, aid and even criticism are more in our tradition than coercion.

I am told by my American friends that these proposals have come about because of public disquiet at the standards of practice in certain parts of America, and have been initiated and fostered by lay pressures and opinions. If this is so, surely it must mean that general practice in this country is faced with a warning as well as a challenge. If we do not put our house in order it is possible that others will try to do it for us—possibly in a way that we do not like. Our best insurance against interference of this kind can only be by renewed efforts to improve our own academic standards and to this end, I submit that one of our main and most rewarding endeavours will be to take an active part in the teaching of our fellows.

Discussion

Dr Bernard Lewis (*Swansea*): Would the panel care to comment about the use of a computer in general practice?

Dr Byrne: Basically the computer can be used as a tool for recording in prospective studies, and there are many practices already doing this, including our own. The computer can further be used to co-ordinate recording between hospital, general practice and local authority. When we inherited the university practice, we found that the local authority records of our five attached health visitors were all on the first floor, the general practice records were all on the ground floor, and there was a scurrying up and down stairs when antenatal clinics or well-baby clinics took place to try and tie the two together.

Dr Harvard Davis: If, as Doctor Swift suggests, a general practitioner can act as a registrar in many hospitals, is not this demanding that he be a specialist in two fields? Is this possible?

Dr Swift: There are one or two points here. The first is that when I am talking about registrars I refer to the first-year registrar, not the senior registrar, who is to become the consultant of the future. The second point is that what has been lost in general practice, particu-

larly in the towns though retained by quite a number of doctors practising in the smaller hospitals in the country towns, is the ability to give our best possible general-practitioner skill to our patients. Many patients are going into district hospitals who require medical skills best given by the doctor who knows them, and I hope that we can in some way get back to this principle. As an example, a new district hospital is opening in Basingstoke which has always had a tradition of general-practitioner beds; with the new hospital, the general practitioners were fearful that they would lose their hospital beds. In fact we are not going to try and provide a general-practitioner ward for them, but we are going to provide facilities for them to use beds in the wards of the general physicians. The cases they will treat will be the ones within their competence. The difficulty is to work out exactly the competence of the general practitioner. A general practitioner may have a great contribution to make to inpatients other than his own patients if he has, during his general professional or further professional training taken a special interest in some branch of medicine, an obvious one being obstetrics. If general practitioners were members of a central obstetric unit (I use the word 'central' and not 'specialist' advisedly) they could be perfectly competent to confine women-at-risk groups, providing that the risk did not appear. If the risk appeared they would call in their consultant colleague or the senior registrar training to be a consultant and ask him to take over the management of this particular confinement.

Speaker from the floor: I would not like Dr Swift to go home with the wrong impression of what the College thinks about the place of the general practitioner in hospital, but although he has made his point about the registrar general-practitioner in hospital, many of us feel that this may well be a retrograde step. Having satisfied our patients that we are now specialists, if we are going to go back into hospital as registrars, somebody somewhere is going to say, 'Well he is only a second rate doctor after all'. This may appear quite childish but I think it is in the mind of a lot of us. If we do go back to hospital we want to go back at a reasonably good grade with charge of beds.

Dr Swift: We can upgrade ourselves by demonstrating that we are capable of treating our own patients in hospital; a selected few will want to develop a special interest and do special work in hospital. There are general practitioners doing that now, and there is no evidence that general practitioners with a special interest are doing any particular harm to general practice.

Dr Byrne: I suggest that a hospital should be divided into a specialist area, a generalist area and an intensive care area, with services such as pathology, laboratories and so on around these areas. The health centre attached to the district general hospital was proposed by the Dawson Report in 1920, and we have not got one in Britain yet. It would have its satellite centres and the patient could be admitted into the specialist area at a cost of £55 per patient week, or might sometimes go straight into the intensive care area with the possibility of very high costs. Surgery is so safe now that after the first postoperative 48 hours, the patient does not need the whole team at £55 per week; he can be transferred to a generalist area which is much less heavily serviced and can cost between £20 and £25 per week. Donald Crombie showed that nearly 50 per cent of the patients in a big district hospital in Birmingham were there for one reason, that being the lack of an able and willing relation in the home. The general practitioner can treat his patient in the generalist area of the hospital just as he would at home. That area can feed the intensive care area or it can feed to specialty, and with the health centre on top of the hospital the doctor can work in both situations. This kind of arrangement can even be built into the Victorian monuments that we have as our district general hospitals throughout the country.

Dr Harvard Davis: The Dawson Report had a primary health centre which is equivalent to the district general hospital and this was just for specialists; it was the secondary health centre which had the general beds.

Dr Duncan Davies (*Morriston*)*:* Does Dr Byrne's concept mean that the general beds would be progressive patient care beds? This does still seem to relegate the general practitioner to a secondary rôle.

Dr Byrne: I do not think that this would be releagtion to a secondary rôle, because the word progressive would be right providing the progression was each way. A patient whose needs for the highly-serviced specialist care no longer exist can progress into the generalist area, the patient from the generalist area whose specialist care becomes defined could progress

the other way. What it does mean is that the general practitioner is functioning from his general base. A man trained as a generalist over several specialties plus his own distinguishing features can practice his art and his medicine in the patient's home or in that situation in hospital and he does not attempt to go into the much more highly-differentiated specialties.

Dr Maybin (*Belfast*): Could I please pursue our eminent speakers just a little because I think they are evading the point? We do not ask the obstetrician to do a few sessions in the skin department, we do not ask the surgeon to do a few sessions of psychiatry, and we do not ask the physician to do a few sessions in casualty. The general practitioner is a specialist in his own right, so why should we ask him to do any of these things?

Dr Byrne: Because he asks us.

Dr Gilmour (*London*): Surely it is a matter of the relationship with the patient. The general practitioner with the generalist beds is still in whole command of his patient but he may be asking for specialist help with a particular part of that patient. The patient's concept is going to be, "my own doctor is looking after me but he is getting specialist help for the special bit that needs special attention", The relationship with the patient is going to be closer than before and more meaningful and the general practitioner is not going to be in any subsidiary rôle in the patient's eyes.

Dr Smith: I can only endorse what Dr Gilmore has just said but let us get away from this word 'secondary rôle'. What we are trying to aim at is that the best doctor for that particular period of illness shall be in charge. I am quite sure that the best person to take out a cerebral tumour is a neurosurgeon and I am also quite sure that before very long the best person to help this particular person to recover is his own general practitioner who knows his family, knows his house, knows his job and can see that he is rehabilitated in the best way.

Dr Kerr: The general practitioner is in charge of his patient and is somewhat analogous to the householder. If the householder wants a specialist he calls in a plumber or an electrician but he still remains in charge of the house. The general practitioner is in charge of his patient, if he wants a specialist he calls in a neurosurgeon or an obstetrician, but he is still responsible.

Dr David Williams (*Anglesey*): Attaching a trainee to a general practitioner practising in close proximity to a teaching hospital obviously has its advantages. Would the panel comment on the suggestion that part of any attachment—say three months—should be out in a periphery where the problems and experience gained can be very different?

Dr McKnight: This is a very good idea and is what we do in Ulster. During the general-practice-registrar year we send our general practice registrars to two other practices each for a period of 14 days. If the registrar is attached to a large city group he is sent down to a rural single-handed practice or a practice in a small country town and vice versa. We think this is an excellent thing and it takes up one month of the general-practice-registrar years.

Dr Byrne: We do much the same. There are about 21 local medical committees with training-practice committees in the region and they have all accepted suggestions which include detachment from a practice of a particular nature to others which show quite different arrangements. General practice is protean and part of the training programme is to help young people to make their minds up as to what kind of practice they want to go to and work in, just as much as it is to prepare them for it.

Dr John Hughes: Rather than having a majority of general practitioners adopting obstetrics as a special interest, ought we not to recognize that this subject might well be better removed from our sphere of activity altogether, particularly if we are to aim at so much higher a standard in general medicine?

Dr Swift: The first point is,—What is a consultant obstetrician to be? I think he should be a person who can give general advice on running an obstetric service which will include midwives and general practitioners, but with particular skill in handling abnormalities. If all obstetrics is to be done by specialists, only ten per cent of the patients they are seeing will be abnormal and as a consequence they will not have sufficient experience of the abnormal. They will be back more or less to where we were when we qualified and all abnormal obstetrics was done by general practitioners. This would be a terribly retrograde step in the obstetrics service. The other alternative is to have a super obstetrician for abnormal cases and an inferior obstetrician for normal cases; the latter would not even be a family doctor, for he would not even know

the people he was dealing with. I maintain that normal obstetrics should remain a normal part of general-practitioner medicine.

Question: Is it not a fact that midwives do most of the obstetrics now?

Dr Swift: You all sign a form saying that you are going to be responsible for the confinements of all your patients. Whether you attend the confinement or not is your business but at least you do take the responsibility. I am not saying that general practitioners would be present at the confinement of every person but they would make the decision whether it was a midwife's delivery or one they wanted to be present at. We must make the decision whether the woman is to be delivered by ourselves, the midwife or the consultant.

Speaker from the floor: This morning we were given an idea that the future general practitioner would really be a general physician, providing general medicine to a higher standard; I believe that McKeown has suggested that this might be done by having patients up to a certain age looked after by one sort of general practitioner and after a certain age by another. To me there is no sense in this; to raise our standard of general medicine and still be specialists in various fields is inconceivable and unrealistic.

Dr Swift: Not all general practitioners would be doing obstetrics. Many would have interests in other branches of medicine, but I think it is still possible to have a special interest within family medicine and be a good general physician. However, you cannot be a good general physician unless you have opportunities to practise in a hospital.

Dr Byrne: We should also remember that when we talk of a general physician we are not referring merely to expertise in internal medicine. For example, there is a medical part of obstetrics, and paediatrics is largely medicine applied to a particular age group, so that a good general physician should be skilled in *the* general medicines. I also want to see him skilled in handling the emotional problems of his patients. He does not need to be trained in the depths of science; it does not matter if he thinks the Krebs cycle is an inferior form of Lambretta as long as he can manage his diabetics properly.

Dr Ratcliffe (*Bristol*): Will the Royal College of General Practitioners representatives, in negotiating the terms and conditions of vocational training, see that we abolish the description of general practice as a 'specialty in its own right' and substitute the much better term of a "*discipline* in its own right"?

Dr Byrne: Providing we are regarded as being capable and efficient whether we talk about a specialty or a discipline makes little difference. We are representatives of a distinguished branch of medicine, the content of which we are now beginning formally to define. We hope to produce within the next few months from the College a series of definitions of the 'basic general practitioner' with a breakdown into the various areas where training would be necessary. I do not feel strongly about the terms 'specialty in its own right' or 'discipline in its own right', but I think I prefer the latter.

Speaker from the floor: I do not want to get involved in a semantic argument any more than Dr Byrne does, but to our specialist colleagues the idea of our thinking of ourselves as specialists is just another form of empire building. We also run the risk of giving our patients the wrong image.

Dr Byrne: I do not think so. In our own teaching school in April last year there appeared in the minutes of the senate a comforting phrase which said that "now that general practice has established itself in the university it shall be treated as any other medical specialty". It must be a specialty if we are able to define its content in particular terms; I do not think our patients mind whether we are regarded as specialists as long as we behave as general practitioners.

Dr Swift: I am very grateful indeed to Dr Ratcliffe for his suggestion. I always have extraordinary difficulty in explaining to consultants that we now think that we are a specialty. It is going to be very much easier in the future if I can say we are a 'discipline in our own right'.

Dr Hambury (*Swansea*): Minor and medium injuries are a high proportion of our daily work. What should the general practitioner's position be regarding their care? This comes back to the problems of where general practitioners are going to work, what the team is going to be, what the premises are going to be, and the geographical position of their place of work. Quite clearly, in the future, cases of major trauma will go to accident departments but many of

us nowadays have not really got the facilities to stitch up wounds or the time to boil up all the instruments to treat minor injuries. This comes back to the health centre, if we are going to have well equipped places with nurses, we should be able to play a greater part in dealing with minor trauma.

Answer: Many general practitioners are interested and competent to deal with minor trauma. I would like to see experiments with general practitioners undertaking casualty duties in big casualty centres. Many of the cases there could be directed back to their proper place, to general practice. The general practitioners would be in a far more authoritative position than the pre-registration or junior hospital staff assuming responsibilities that they are not trained to take. A mature general practitioner could alter the picture of many casualty centres.

Dr Phillips (*Neath*): A recent development in general practice has been the appointment system. I know of no practice which gives appointments of longer than ten minutes each. In the opinion of the panel, is it possible to give instruction under these circumstances?

Dr Byrne: I have had experience of this both in a general practice where for many years one took students, and now in a teaching practice where our appointments are no longer than ten minutes. If you know that you are going to have students in your practice, then it is possible to make quite different arrangements. One of the things that we ask when we are inviting practices to take students is, will the practice itself support the nominated teacher working at a slower tempo so that he can find time to teach. The first thing one expects the student to produce in his practice is a notebook; in the notebook go little notes about the things that we have not time to deal with in the surgery, and these we will discuss over coffee in the morning or over lunch or in the evening. A last point is that most appointment systems make provision for patients to come for a long appointment, which may be for a psychotherapeutic session or a complicated history or the first appearance of a new patient; there are often one or two of those situations a day. Some adjustment could cover these situations relatively easily.

Dr G. Koch, *Resolver:* If the full training of a new general practitioner will take about 13 years, will there be any who will not prefer a specialty instead? So far, most general practitioners decided on general practice because not much previous preparation was necessary. Surely this would end general practice.

Dr Swift: This is in the minds of us all at present. There is some evidence that many doctors do not go into general practice because there is no specific training for it, though admittedly there are a few who have wives and children and go into general practice because they need money quickly. If we really think that it needs training to become a general practitioner we must say so. If we do not we are never going to raise the standards of general practice. There is one other factor. In the past the young student was brought up in an image of hospital medicine and he thought that hospital medicine was proper medicine. With departments like Dr Byrne's and Dr Harvard Davis's, we are going to get a generation of young graduates who are going to make a positive approach to general practice.

Dr McKnight: Over the past two or three years I have interviewed about 27 youngsters who have told me that they want to go into general practice and come into our three-year training scheme in Northern Ireland. These boys and girls welcome a planned training for general practice, which they regard as a challenge, and many of them feel that they would not like to enter general practice without adequate preparation. I do not think there is any fear that this period will put them off. The Todd report said that 66 per cent of the doctors going into general practice did so over the age of 30, when they had already completed several post-graduate years of training.

Dr Byrne: In Britain we have the youngest age of graduation of any developed country in the world. The average age at entry into medical schools is 19.9 years, 23.9 at qualification and 24.9 at registration; five years on that is 29.9. The American student enters his premedical college at 18, he becomes a baccalaureate at 22, he spends four years in medicine (26), he spends a year in internship (27), and now many of the states are beginning to demand that he does a three-year residency which makes him thirty. They also have a national specialty board qualification in family medicine. In Australia each of the six states has accepted the training programme of three years laid down by the Royal Australian College, and that brings them to about the same age. In France and Germany and most of the continental countries, you are

not allowed to give unsupervised medical care to an unsuspecting public before you are about thirty. I agree that the youngsters welcome this challenge and they welcome much more the possibility to get a definitive qualification which shows that the challenge has been met.

Dr Gilmore: Since I left general practice I have spent the most interesting part of my time starting a career advisory service in the British Medical Associaton and I am getting more and more round medical schools talking to people either just before or just after qualifying. My experience endorses the view that we have coming up cohorts of graduates with a healthy scepticism for the attitude that they have sometimes seen in their clinical teachers in medical schools about the place of general practice. They have some doubts about the value of general practice as a rewarding clinical career, and what does more than anything to quell these doubts is to be able to offer them a series of meaningful training programmes in general practice. I have just done a pilot scheme in Glasgow on those who have just qualified. Half of the 90 per cent who have responded put general practice in their first three choices of career.

Dr Byrne: At the moment we are compiling a list of all the three-year and shorter training programmes in the U.K. for next year; there are 82 possible three-year programmes and nearly 60 of these are being organized by the three of us here to one degree or another. They are springing up now all over the country and our fear that we would not get applicants is diminishing all the time.

Speaker from the floor: I do not think anybody would argue that this vocational training is an improvement but I think many people have tried to go into a good group practice when they have done a year as an assistant and then time as a junior partner. Evidently they have been trying out a form of vocational training in general practice in a good group practice, and learning almost as apprentices.

Dr Byrne: This is absolutely true and people have done magnificent jobs for themselves. But with 3,500 graduates a year by the end of the seventies, and formal arrangements for the vocational register we shall need something more. The views of future students are much more important than our own, and we should try and plan our programmes to meet both their wishes and the needs of education.

Speaker from the floor: What is going to happen in the three years while you get this off the ground? There are not enough people going into general practice now and unless I have misunderstood this, you are going to have a period of three years with nobody going in.

Dr Byrne: That is not so. We do not know what sort of rush there will be to get on the vocational register before it becomes mandatory. If anyone can help us with something that will bridge the gap, we will be grateful to hear about it but we must do that which we believe in.

Dr Swift: The one point that has not come up is that you cannot just produce legislation to say that tomorrow everyone must have done A, B, and C before going into general practice. There must be a bridging period in any legislation which comes out.