the medical profession who had the vision and foresight to plan for group practices are to be congratulated. All the thought and planning that went into the project has been well worth while. This is an excellent service to the community, run efficiently in the community, and with warmth and understanding.

INTRODUCTION

Dr J. S. Clark, M.B., B.S.

IN an introductory talk Dr J. S. Clark (Prospect House Medical Group, Newcastle upon Tyne) explained that he was a member of a group of eight doctors, with 17,500 patients, a staff of eight paid by the practice and five attached from the local authority. That the doctors were still together after 3½ years was some sort of indication of their success to date.

"I worry a lot about general practice, the future of general practice and the future of personal family medicine", said Dr Clark. "I was born and brought up in the house of a general practitioner of the old school and personal family medicine such as he practised is still very dear to my heart. I am sure there must always be a place for such medicine in the future, for single-handed general practitioners and for small practices. I do not think the larger groups can achieve that same degree of personal medicine. At the same time, I cannot see a multitude of small practices answering the voracious demands of the modern welfare state. To answer these demands we have to look elsewhere.

The National Health Service, is here to stay, and talk about resignations and a mass return to private practice sound less and less realistic now to me and my contemporaries and is positively meaningless to the present generation of medical students".

The kind of general practice which succeeded the second world war and ushered in the National Health Service was very much a cottage industry. It had highly uneven standards, it had a built-in inferiority complex, and was quite unfitted to exploit the tremendous advance in medical and business technology which had taken place over the last 10–15 years.

The package deal of three and a half years ago, whatever its motivation, was a genuine attempt to put right what was wrong in general practice and had already started something of a revolution.

If you accept these tenets and desire to benefit from the specific incentives offered by the package deal, and if you believe, as I do, that the National Health Service in concept is quite superb (it is only its feasibility that has ever been in doubt), then to make the thing practical you will have to look at group practice very hard and make it as efficient and humane as you possibly can.

The advantages of group practice are obvious. There must be some benefit accruing from a sharing of brains, talent, experience and resources coupling these with efficiency and productivity. Its disadvantages are equally obvious. There must be some sort of impairment of the personal

nature of the doctor-patient relationship, however hard one tries, and communications must become more tenuous as the numbers of doctors and ancillaries in the group proliferate. But at the moment there is a much bigger danger. The last year or so has seen a tremendous number of amalgamations and consortia amongst general practitioners, and some of these could be taking place simply as a matter of 'joining the trend'. In the under-doctored areas, where people were quite desperate, it might be looked upon as an answer to a desperate and insoluble problem but it is just conceivable that some of these practices were too hastily put together and ill-considered, and not orientated as they should be.

Group practice should be better than this and was a positive step forward—one of the biggest steps forward in community care seen for a long time. The purpose of today's conference is to lay down guide lines for such group practices and to set up some ideals for group practice.

An ideal practice obviously had to have some doctors in it, and they had to have a reasonable degree of competence and a measure of dedication. They had to see eye to eye on major issues. They had to have attached to them a staff who thought along the same lines as themselves and felt very involved in the practice, if the practice were to have any sort of 'soul' at all.

There should be safeguards against human error but the organization should be flexible enough to allow for the human failings of some of the patients and allow them to penetrate the defences, if necessary. "It is the patients that the whole thing is about", Dr Clark reminded the conference, "We tend to forget that at times. If I have any quarrel with the excellent papers which have been circulated in advance of the conference it is that there is nothing about the benefits that accrue to the patients from a group practice".

Turning to another aspect, Dr Clark said that for many years now a vast amount of the medical and social services of the country was being expended on what he estimated to be about 5 or 6 per cent of the population. "I believe", he said, "that this 5 or 6 per cent are demanding, they are unco-operative, they are unrewarding to treat; but because they have dominated the situation for so long we have had the creation of the image of the general practitioner as someone who is rather pathetic, grossly overworked, inadequately equipped. This in turn has tended to deter the very decent 94–95 per cent of the population from seeing the doctor. They develop a guilt complex. They very often avoid seeing the doctor about trivial complaints that all of us in our hearts know are often the precursors of serious pathology. Now we have started to put a few hurdles between the patient and the consultation. They are pretty easily navigated by anybody who so wishes, and the balance, I find, is already swinging. The average, decent patient now welcomes the opportunity of going to a little trouble to arrange his appointment, and the other 5 or 6 per cent (about whom I lose little sleep) still have the opportunity and are even in some cases becoming converted to our way of thinking".

There are still people who would assert that general practice was an anachronism on the face of modern medicine. But no matter how brilliant the hospital team, no matter how sophisticated its equipment, it was powerless while it waited for the patient to reveal himself. In a good group practice the average, decent patient should with reasonable ease arrange a

consultation with his sympathetic family practitioner who would give his case intelligent consideration and arrive at some definite conclusion or give certain advice. This was a worth-while and invigorating challenge. "If four or five years ago, when my colleagues and I started to plan our present group", said Dr Clark in conclusion, "we had had the detailed wisdom in the papers we are about to discuss today, our task would have been very much simpler".

Motivation for setting up group practice and employing staff

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WE began by sending a questionnaire to a selected number of practitioners within the areas covered by the South-west England Faculty, the South-west Wales Faculty and the South-east Wales Faculty. In analysing the replies we realized that the sample of practitioners was too small to draw any statistically valid conclusions and we therefore enlarged it by personal and informal talks with many more practitioners.

The first choice a doctor has to make is between general practice and specialization. The reasons given for choosing general practice were:

1. The type of personal service given by the general practitioner: he is on so much closer and more intimate terms with the patient as compared with other branches of medicine.
2. General practice gives scope for combining special interests with the day-to-day care of patients. Such interests may include clinical assistantships, industrial medicine, public health work, medical teaching, police work and so on.
3. Financial reasons: entry into an established practice, even allowing that most practitioners still have to buy all or part of the practice premises, gives much higher financial reward than can be expected for some years by those who chose specialization.

Having chosen general practice, why join or form a group? This should be considered under two headings: first, joining an existing group, and secondly, joining with other practitioners to form a new group. The doctor joining an existing partnership or group is provided with 'protective apprenticeship' under the aegis of an established and experienced practitioner, betterment over the years and security during the settling down period.

Groups also may be formed by amalgamating with a neighbouring practice, or by enlarging an existing practice by taking on more partners. Amalgamations seem to spring from the desire of the practitioner to practise from good premises and with adequate staff. Antiquated premises, 24-hour responsibility and inadequate ancillary help may be the trials of the single-handed practitioner and it is now the policy of the Department of Health and Social Security to encourage the formation of groups, the