

The future rôle of the general practitioner in the hospital

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GENERAL practice in the United Kingdom has its roots in the early part of the nineteenth century. In those days the function of family physician was carried out by a number of people of different origins and training. The more wealthy were looked after by "learned physicians" whilst those of more moderate means received "physic and advice" from the apothecaries, or the apothecary-surgeon. The very poor often went unattended or suffered the attentions of untrained "druggists" and "irregulars". However, by the mid-victorian era someone more recognizable as a general practitioner, as he is understood today, had emerged. In Poynter's words (1961) the victorian general practitioner had ". . . a grasp of the whole knowledge of his profession, and a personal influence over the whole family from birth to death. . . ."

Ever since these early days the function of the general practitioner has been slowly changing. In an effort to find a title that recognized this change reference is often made to alternatives such as 'family physician', 'personal physician', 'primary physician', 'doctor of first contact' and 'generalist'. All these titles are appropriate descriptions but the real point is that the general practitioner is all of them by turns. As Dr John Hunt said in the centenary number of *The Practitioner*, there seems little point in making any change from the traditional title until we can be sure that we have a better one.

However, before it is possible to consider the future place of the general practitioner in the hospital, it is essential to have some idea of what his overall rôle is going to be. This is best considered under several different headings:

1. *As doctor of first contact.* There does not seem to be much likelihood of any change in the general practitioner's rôle here. It will therefore remain essential for his knowledge and experience to embrace something of all branches of medicine. The only serious alternative of dividing primary care between a geriatrician, paediatrician, obstetrician and general physician, as suggested by McKeown (1962) has received little support in this country.

2. *Clinical content of the work.* The sort of cases that the general practitioner can look after himself in a domiciliary setting is changing all the time. It will doubtless change in the future and only a knowledge of what new discoveries science will bring can determine what these changes will be. The most striking feature of medicine in the present century has been its fragmentation into specialties. It seems likely that this will continue as technical skills become ever more sophisticated. Hospitals will no longer be staffed by physicians and surgeons but by cardiologists, rheumatologists, gastro-enterologists and so forth. Similarly it has become fashionable to speak of the 'speciality' of general practice. In the sense that general practice has methods and a philosophy of its own, and in the sense that it must be taught by general practitioners and in its own setting, this is not unreasonable. Yet in some ways it is a contradiction in terms to talk of specializing in being a generalist. Indeed there is something to be said for taking the opposite view—that the strength and the justification for the continued existence of the general practitioner lies in his ability to remain a generalist; that he must continue in a central and co-ordinating rôle, providing a

continuing service to his patients rather than treating isolated medical episodes, and that he must fill the vital need for someone who can look at the whole field of medicine and interpret it to his patients. The present system of British medicine is based on the principle of referral and this is likely to continue. However, if it is to continue successfully it must be based upon the mutual co-operation of specialists and generalists as equal partners in the care of the patients who need their skills.

In many fields the scope for treatment outside the hospital has been reduced, but the great exception to this has been in the fields of general medicine and therapeutics. There is every reason to hope that radiodiagnostic and pathological facilities will be universally available to general practitioners within the next decade. This will further increase the scope for patient investigation in the community setting. In short, it seems probable that the future general practitioner will above all else become a general physician practising predominantly in the community.

3. *Organizational changes.* Group practice had its origins in Britain principally in partnerships of doctors in medium sized market towns like Banbury, Newbury, Leamington Spa and Winchester. Such practices were usually much concerned with the running of a small local hospital. The writer, for example, belongs to a group which in the 1920–1940 decades consisted of a general physician, a surgeon, an anaesthetist and even a pathologist. Such groups were not of the type envisaged by McKeown (1962) for each of these part-time specialists was also a generalist or family doctor to his own list of patients. The National Health Service put an end to such groups because most of these part-time specialists became full-time specialists under the new scheme. It is worth recording however, as Godber (1968) reminded us, that general practitioners rarely held hospital posts in any capacity except as part-time specialists.

There have been many changes in the general pattern of practice organization in recent years. Group practice now has a different meaning, and has brought with it the pooling of resources in custom-built premises, appointment systems, rota schemes, together with a team concept for the delivery of medical care. All this has a great potential for the provision of a better service for the patient. However, it is important that means and ends shall not be allowed to become confused—good general practice will in the future, as in the past, be judged by the quality of each individual consultation between doctor and patient. The important thing about good organization is that, properly used, it gives the doctor more time. One way in which this extra time can be utilized is in doing hospital work, either in the care of certain patients in the hospital wards or in developing a special interest through a hospital attachment.

4. *Vocational training and general practitioner attitudes.* Every survey carried out so far confirms two things about attitudes. Firstly that the majority of general practitioners wish to do hospital work of some kind (Wessex R.H.B. 1964; Evans and McEwan, 1969; Oxford R.H.B. 1969), and secondly that this view is most strongly held by those who are younger or more recently qualified. It is true that this may be a reflection of the fact that at the present time medical education is hospital orientated. Only when vocational training for general practice is truly vocational will it be possible to say whether this is the whole truth. However, anyone who has read the comments that general practitioners are prone to make on the questionnaires used in these surveys cannot but be convinced that the desire for some hospital association, especially the care of patients in hospital beds, is very deep seated indeed. With increased facilities for outpatient investigation, there is no doubt that the practice of medicine in the community can be a more rewarding career than it has been in the recent past. However, it is unwise for anyone to dismiss the desire for hospital work as being solely the product of hospital orientated training. It is more likely that it arises from a deep and fundamental desire, common to all who want to be doctors rather than laboratory workers, to treat patients up to the limit of their capacity, and where possible to the

point of recovery. The frustration of this highly desirable emotive force has been one of the causes of dissatisfaction in general practice in the United Kingdom since the war.

The fundamental case in relation to the tripartite structure of the National Health Service

As already stressed, the success of the division of services into hospital, domiciliary and local authority services depends upon the acceptance of specialists and generalists as equal partners. If the recommendations of the Royal Commission on Medical Education are acted upon, there is hope that this will be achieved in the future. Specialists cannot operate efficiently unless supplied and supported by a competent body of general practitioners. For the best possible results to follow from this mutual dependence some current attitudes need examination.

First it is surely illogical to assume that there is something fundamentally different about patients and their illnesses when they are admitted to hospital. Historically British hospitals have always been staffed in the main by specialists. It is administratively convenient but there is no medical logic in placing the division of responsibility at the hospital gates. Many patients would benefit from the continued interest of a generalist, some indeed could be managed entirely by their own family doctor. Others may need specialist care for some time after they have left the hospital. In addition there is a clear need for joint research schemes in the community. It is short-sighted for doctors in any field to look upon such developments as intrusions into their particular preserves.

In short, there is a fundamental case for an overlap of staffing in the three branches of the National Health Service. An overlap is better than trying to achieve co-operation

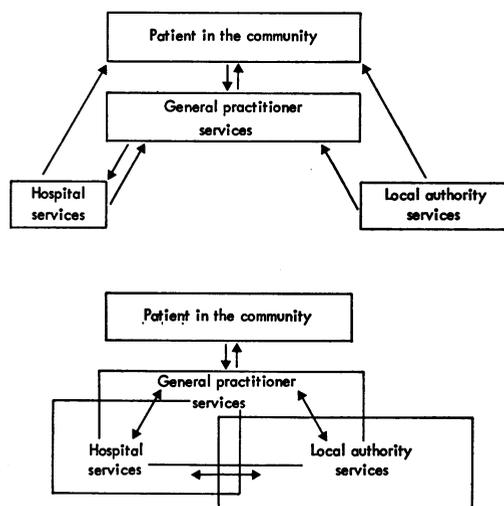


Figure 1

by communication. Integration cannot be complete until specialists and generalists work side by side at least some of the time. In fact the tripartite structure should be redrawn as 'B' instead of, as now, 'A'.

His place on the hospital staff as a generalist

General practitioners in the Oxford Regional Board survey (1969) were asked the question as to whether they were interested in "Association with hospital team bringing the expertise of the general practitioner into the hospital". The survey showed that this was the most popular type of association of all those suggested. Hospital doctors are tending to become more-and-more highly specialized and it does indeed

seem possible that the general practitioner will have an increasingly valuable place in the hospital as the only member of the staff who is fitted by training to take a wide and detached view. There may be times when he may need to protect his patient from the narrowly based specialist and the experimentalist. However this may be, it would seem only reasonable that some generalists should be among the staff of every hospital. It is improbable that they would be appointed solely in this capacity, but some might be appointed (for example) to have care of some of their own patients in the wards and thereby form part of the hospital team in their capacity as generalists, and in the teaching hospital as teachers of general practice.

General practitioner care of patients in hospital wards

The sort of patients that should be regarded as suitable for general practitioner care is no easy problem. In the first place the training of individual doctors in general practice is widely different at the present time, and their skills and expertise vary considerably. It is the future that is being considered here. As has already been stressed, the next generation of general practitioners should emerge with a broadly-based training. In the words of the Todd report (para. 119) the aim is to produce "A first rate clinician in the field of internal medicine". In other words it seems likely that he will emerge as the general physician of tomorrow. General medicine will no longer be looked upon as a 'special' interest, but the most important part of the general practitioner's profile. It is inevitable that a high proportion of the doctors with this sort of training are going both to want, and to be capable of, the care of some of their own patients in hospital, especially those in the medical wards.

There has been a tendency in the past to regard 'social' admissions and 'acute' admissions as entirely separate—that the former come within the scope of general practitioner care, and that the latter need specialist care. This is not the case. More and more general practitioners are finding that in general medicine it is the need for nursing care that determines the need for hospital admission. In such a situation it is incongruous that the general practitioner should be rigidly excluded from continuing the care of the patient who needs admission for this reason.

Estimates of what proportion of hospital admissions come within the scope of general practitioner competence inevitably vary. In the survey of all hospital admissions in the south-east England (College of General Practitioners, 1967) 14 per cent were considered to need only general practitioner care without specialist help. In the medical wards the figure is higher and with improved training it could be higher still. This does not mean that the general practitioner will in any sense replace the specialist physician. On the contrary, it means that he should become a partner with him in the care of patients, and relieve him from the care of those who are not in need of specialist skills.

The location of beds

1. *The Cottage Hospital.* An advertisement in the *British medical journal* offering a vacancy in a practice which has access to beds in a cottage hospital always brings a flood of answers. There is no doubt, therefore, that the cottage hospital is still popular with general practitioners. Collings (1950) after studying British medical services made the comment that general practice "improves in scope and quality in proportion to the distance away from large hospital centres". There is no doubt that a cottage hospital increases the scope considerably. It is this fact, together with the fact that in the cottage hospital the general practitioner is in full clinical charge, that accounts for the popularity. However, in these times medicine is becoming more and more a team effort. In a recent attitude survey in the Midlands (Evans and McEwan 1969) for example, all the first five-year general practitioners in one county were asked whether they wanted to look after patients in hospital beds. To this 58 (97 per cent) replied in

the affirmative. Of these 58 only eight expressed a wish for 'cottage-hospital beds', whereas 25 wanted 'beds in general-practitioner units attached to the district hospital', and 28 'beds in the main wards of the district hospital in conjunction with specialists and consultants'.

The cottage hospital will continue to play a useful part in British medical services in the more difficult and remote areas for many years yet. However, its isolation is an important drawback which is already apparent to the younger doctors in general practice. There may, therefore, well be a case for the continuation of cottage hospitals in some modified form, such as 'community care centres' or as 'health centres with beds' (Stranraer, 1968). In such centres the element of isolation is much reduced and they would still have great general practitioner appeal. Moreover, if the hospital plan (Minister of Health, 1966) is ever fully implemented there will be quite large distances between the full sized district hospitals in some areas. The need for some kind of community care centre which provided casualty, specialist outpatient and diagnostic facilities as a minimum will then become acute. A good case can be-made out for some beds to be available in such centres (in press) and these might most appropriately be under general practitioner care.

2. *The district general hospital.* Logistics are bound to affect the ability of the general practitioner to play any part in the care of patients in the district hospital. With the *Hospital Plan's* proposals for larger hospitals more widely dispersed, travelling time may make this impractical for some (Minister of Health, 1966). This should not be allowed to impede the prospects of those more favourably placed.

It is often assumed by the authorities that the care of patients in hospital beds by general practitioners means the building of new separate general practitioner units or wards (Oxford, 1969). This is not necessarily true. The general practitioner wing of the East Birmingham Hospital (Wilkinson, 1968), a much publicized example, really amounts to a cottage hospital in the grounds of a general hospital. It has all the advantages and disadvantages that go with that concept—for despite its proximity to the main hospital it is in some senses isolated. The doctors there had, for example, to club together to buy their own ECG machine. A separate general practitioner wing only serves to accentuate the supposed inferior status of the general practitioner; it does nothing to help the integration of general medical and hospital services. For the full benefits that *can* come from general practitioners taking a part in the care of patients in hospital beds, they must work alongside their specialist colleagues, in the main wards and particularly in the acute medical wards. In this way the hospital work becomes a continuous teaching experience. It would enable some general practitioners to keep abreast of developments in internal medicine; it would ensure that their standards of treatment were checked, maintained and enhanced and it would provide the opportunity for them to play a part in the education of aspirant general practitioners doing hospital resident appointments. Finally, as pointed out by McWhinney (1967) this approach to the problem would not require any new building and could be started, at least in the form of pilot schemes, at any time.

What sort of cases should general practitioners look after?

It has already been pointed out that the general practitioner's place in the care of patients in hospital should be concerned basically with those patients, currently admitted, who are not in need of specialist care. The majority of these are undoubtedly in medical wards, acute as well as chronic and geriatric. There is a limited spread of general practitioner interest into all other specialities, particularly paediatrics, psychiatry and gynaecology. In the Oxford Regional Hospital Board survey (1969), 129 general practitioners said that they had had experience in one or more specialities at 'registrar' level. It is likely that the general practitioners interested in following a special interest

in these fields will find more scope as members of the specialists' teams—in appointments of the 'clinical assistant' type.

Normal midwifery is a special case. It was extensively investigated by a working party of the Royal College of General Practitioners (1968). Conclusions 10 and 11 in this report are relevant to the subject of the care of patients in hospital beds in general:

10. Beds must be so situated that as many general-practitioner obstetricians as possible have access to them. The ideal place for a general-practitioner unit is within the specialist maternity hospital.

11. Beds used for uncomplicated cases must be transferred to general-practitioner obstetricians whenever there are suitably-trained practitioners willing to accept them. This means a higher proportion of obstetric beds under the care of general-practitioner obstetricians.

It would be difficult to argue with these views. Fortunately the notion that normal midwifery is a part of the general practitioner's proper rôle is now generally accepted. This favourable situation is no doubt due in large measure to the high standards of vocational training already achieved by general practitioners in this field. It is now almost obligatory for the new recruit to general practice to have passed his D.Obst., R.C.O.G. before he will be accepted as a principal in a good practice. Moreover, he has every encouragement in this because there are good prospects that he will have access to maternity hospital beds.

The tendency for a higher proportion of deliveries to take place in hospital will almost certainly continue. General practitioners will doubtless play their full part in this development. Perhaps one might add to the working party's conclusions that ideally the overlap of responsibility between specialist and general-practitioner obstetrician should be complete, i.e. that they should be working in the same wards and in the same antenatal clinics, wherever this is a practical possibility.

These conclusions with regard to normal midwifery bear a close resemblance to the views earlier expressed with regard to general medicine. When vocational training in general practice itself becomes mandatory there should be an improved chance that general practitioners will be able to look after other patients in hospital whose care comes within their sphere of competence.

Methodology

In situations where the general practitioner already has full clinical responsibility as in cottage hospitals, and certain other small units, no change of organization is either necessary or desired. However, with the tendency for hospitals to become larger and more centralized there is an urgent need to consider his possible place in the future district hospital. The presence of general practitioners in the wards of such hospitals would undoubtedly raise new problems. In the first place only pilot schemes in this concept will exist. A few have already started, and it is through experience in these that the right terms of service will be determined. A few general principles are worth considering however.

1. Although in theory the care of their own patients in hospital beds ought to be an automatic privilege, this is not really a practical method. In all probability the first doctors would in effect be self selected, but in addition one must bear in mind first that many general practitioners have not had the necessary experience in this sort of work, or have been out of it for a long time. The overall responsibility for the ward will rest with the consultant. Initially at any rate, selection should be made by a committee of consultants and general practitioners appointed for this purpose.

2. Particular beds would not be set aside for general practitioners. Admission would, as now, be dependent upon the patient's need. Responsibility for his care would depend upon whether or not he needed specialist care.

3. A consultant would continue to have overall responsibility for the efficient running of the ward, and have access to the case-notes of all patients.

4. It is anticipated that those general practitioners interested in this sort of work would attend ward rounds and present cases for discussion. In this way any attempt to misuse the facilities (either in the clinical sense or the economic one) would soon come to light.

Not least of the potential advantages of such a scheme are the educational possibilities. Specialists and generalists could learn from each other's experience. The extra knowledge gained by the general practitioners would rub off amongst their colleagues in the group practices to which they were attached. The presence of general practitioners in this sort of teaching situation could have beneficial effects upon the attitudes of hospital staff to medicine outside the hospital, and contribute materially to the vocational training of future general practitioners at both the graduate and postgraduate levels.

It would be unrealistic to suppose that there are no disadvantages to these proposals. First there is undoubtedly some opposition from consultant physicians upon whose support they will initially depend. Neither is it easy to dismiss lightly the difficulties of the relationship between resident medical staff, general practitioners and ward sisters. With the safeguards mentioned above these become problems of human relationships and as such are not insuperable. A careful study of the use made of the general-practitioner wing of the East Birmingham Hospital suggests that initially only about one general practitioner in every four or five living within 3 to 4 miles would use hospital beds if offered. The effects on the working of the medical wards would, therefore, be marginal at first, but the significance of such a development would be great; it might herald the beginning of a new era in which general practitioners would have a place in the general hospital, for the first time in history, in their own right as physicians.

The rôle of the general practitioner as a part-time specialist in the hospital

General considerations. So far, the rôle of the general practitioner has been discussed in relation to the care of his own patients in hospital beds. The point has been stressed that in normal midwifery and in general medicine this is justified on the fundamental grounds that these are normal areas for general practitioner responsibility. It is illogical to suggest that general practitioners can look after home confinements and not look after normal cases with the better facilities that the hospital can offer. Similarly it makes little sense that general practitioners should look after patients with pneumonia and heart failure in their own homes and yet be completely excluded from having anything to do with the care of similar patients in hospital beds. But whether general practitioners should extend their interest deeply into hospital-based specialties is an entirely different matter. There is no fundamental case for it, indeed the opposite is true to the extent that any doctor who involves himself deeply in a narrow field must weaken his position as a generalist. If he spends much of his time in some speciality in hospital sessions, this must mitigate against his ability to maintain the personal basis of his family care. In this connection the Porritt report (1962), para. 409, went so far as to suggest that one or two sessions a week is as much time as a general practitioner should spend away from his practice. Perhaps that is too tight a restriction but the principle is right.

On the other hand there is much to be said in favour of general practitioners being allowed to follow a special interest. This has a great educational advantage, both to the individual, to the hospital and probably also the group of doctors with whom each is associated. It will obviously be even better if the special interest has a direct relevance to daily routine work. Thus there is a special advantage in practitioners spending some of their time in such areas as medical, psychiatric, antenatal and paediatric clinics.

Here they can be useful to the hospital and at the same time gain experience which is valuable in their care of patients in the community.

It is more doubtful whether general practitioners should specialize in subjects which have less relevance to their daily work. Yet many do combine general practice successfully with several such sessions—for example as anaesthetists. Satisfactions can arise here, both for the patients, who are relieved to see a familiar face when they come into the operating theatre, and for the general practitioners, who are able to follow at least a proportion of their patients through a hospital experience.

In addition there is little doubt that the very presence of a few general practitioners on the staff of any hospital in any capacity at all is a good thing. It takes them into the wards and they meet hospital doctors and discuss cases with them, and it helps to promote mutual understanding and respect for each other's problems. Many general practitioners feel this gives them a unique opportunity to interpret general practice to hospital doctors and especially to help residents to see the other side of patients' problems.

In this connection, general practitioners have always been free to visit their patients in hospital. Experience shows however, that they will rarely do this unless they have some responsibility which brings them into the wards. General practitioners with sessions, no matter whether they are in the casualty department, in anaesthesia or any other department, tend to have a close relationship with the hospital and its staff, and particularly with the resident staff, which is not easily achieved in other ways. In short, there is more value in general-practitioner hospital-session work than any quantification of their actual work can show.

The present position—the clinical assistant

With the abolition of the senior hospital medical officer the clinical assistant post has become in effect the only one normally open to the general practitioner in the hospital service. Many have found some satisfaction in these posts, but any careful analysis of them reveals numerous inadequacies (Evans and McEwan, 1969). There has been a tendency on the part of the hospital authorities to think of this grade as a means of solving certain staffing difficulties. Consequently the sort of posts advertised reflects the hospital needs only and the educational possibilities envisaged by Cohen (1950) have been neglected. Thus although about 20 per cent of general practitioners hold such appointments (Oxford, 1969) the majority are in anaesthetics and casualty which are purely service appointments. The tendency to try and provide general-practitioner cover in these and similar areas will inevitably increase so long as present staffing difficulties continue.

From the point of view of the postgraduate training of the general practitioner, this is surely wrong. All too often the clinical-assistant post neither enables the general practitioner to extend the depth of care of his own patient nor does it advance his knowledge of clinical medicine. Neither on the other hand is it a specialist-career post for it has no security of tenure, no specific status or responsibility and no promotion prospects. Indeed in no report on the hospital service has it ever been treated as a hospital grade at all, despite the fact that it contains the equivalent of 966 full-time doctors (Oxford, 1969). Clinical assistants are neither listed under junior hospital staff, nor under senior hospital staff in the appendices of the Platt report (1961).

In short, the clinical assistant rarely gets any training and as a specialist career post it is quite inadequate. There can be little doubt that it is the most abused grade in the history of the hospital service since the inception of the National Health Service.

Possible future developments

1. *Staffing needs.* If the recommendations of the Todd report are accepted and acted upon there would indeed be a significant improvement but it is difficult to feel

optimistic because similar recommendations were made by the Platt (1961), Porritt (1962), and Gillie (1963) reports and the only result so far has been the more expensive use of the clinical assistant grade to plug the gaps in the hospital staffing structure.

General practitioners on the liaison committee of the Birmingham Regional Board have made recommendations which if accepted could lead to substantial progress. Basically these recommendations (Evans and McEwan, 1969) point to the urgent need for training posts to be separated from service posts on the one hand, and for some appropriate career post to be open to general practitioners on the other. It does not seem to be sufficiently well recognized that current objections to the medical-assistant grade as a full-time appointment do not apply to the part-time general-practitioner specialist. The new look given to this grade in the Todd report as a specialist grade with responsibility for patients would fulfil all the requirements for a satisfying career grade for the part-time general practitioner, and would also serve as an admirable platform from which the occasional general practitioner could change course from being a generalist to becoming a full-time specialist.

In short, if the general practitioner is going to play any part in the specialist teams in the hospitals of the future, the needs are absolutely clear. First there must be a training post in which he really has an opportunity to learn, and in which his time is not fully occupied in service needs. Secondly, there should be some career grade open to him of the type described as the specialist grade in the Todd report. Every general practitioner who wished to do part-time hospital work (except possibly the casualty officer) must inevitably fall in to one or other of these categories. There should be no place for such a vague category as the present clinical assistant—the temptation to abuse the keen young general practitioner as an additional pair of hands to provide cover for hospital departments should have no place in the future of hospital staffing.

Such a straightforward solution may appear obvious, yet obvious solutions do not always get recognition. As a nation we have a habit of producing first class reports—and of taking no action on them. However, if there is one factor in the future which may force the issue, and improve the prospects for a change on these lines, it is that the vocational training programme for general practitioners will in itself produce better-trained doctors. Such better-trained doctors will not accept complete exclusion from hospital work so long as they have the alternative of emigration (Ministry of Health Interview Board, 1968).

2. *Individual hospital departments considered.* In general medicine, psychiatry and paediatrics there is a clear case for giving general practitioners every possible opportunity to extend their experience by work in the hospital. In other words, there is a special case here for training posts. These will help to fill any gaps in the general practitioner's training and enable him to study subjects of his choice in greater depth. As experience grows some will undoubtedly want to go on into career grades, perhaps working as members of the specialist's team and also in the care of some of their own patients in the wards.

It is difficult to estimate just how great a demand there will be for career posts of this kind. Certainly the formation of larger groups of general practitioners will give some of them greater opportunities. On the other hand the concentration of hospital care into fewer and larger hospitals which are more widely separated is going to make travelling a greater problem for those in the rural and semirural areas.

In the general medical subjects there are also possibilities for specialists and generalists to get together in research projects. Already it is being realized that general practitioners have unique opportunities to study the natural history of disease. The study of a subject like hypertension must be incomplete if it is done entirely either by specialists or general practitioners working alone. The chances of their working together on

research projects of this kind is itself enough to justify their occasionally working together from the same clinics.

In midwifery the chances are that hospital sessions will arise in the opposite circumstances. The more remotely-situated doctor may find scope for a special interest here because distances prohibit the immediate availability of consultants. There may be a special case for a few training posts in the bigger centres to augment vocational training programmes, but normally general practitioners who make a special study of midwifery should be well trained and have permanent career posts as assistant obstetricians.

There will almost certainly remain a place for the general practitioner anaesthetist. It is not suggested that this is the ideal sort of special interest but it is one, none-the-less, that he has been seen to do well. Here, as in any other highly specialized field, he will need to accept the hospital disciplines and this almost certainly means that he will need to have completed a double vocational training—as an anaesthetist as well as a general practitioner. It also means that far from restricting himself to a minimum time in anaesthesia, he will need to undertake a minimum number of sessions in this speciality rather than a maximum. It is probably necessary for a doctor to do at least three sessions a week in order to maintain proficiency in this sort of subject. However, with the type of group practice envisaged, with 12 partners, such a division of labour is a practical possibility provided the doctor who specializes has a restricted list of patients. He might be responsible for the group's obstetric anaesthesia, and play a large part in dental anaesthesia. Here again the faults of the present career structure are clearly shown. There is no place for a training post for general practitioners in anaesthesia, but there is a small and important place for trained part-time anaesthetic specialists in the hospitals of the future.

There is no need to deal with all the other specialities in detail. Clearly the day of the general-practitioner surgeon is nearly over. Whether some will wish to continue to play a part as gynaecologists or ophthalmologists also looks doubtful. One reason for this is that the type of hospital training which general practitioners are going to receive in their vocational training will tend to direct their interests away from specializing in a narrow field. It would be unwise to restrict or define precisely the limits which general practitioners' special interests should follow. The National Health Service cannot afford to lose skills and experience by emigration or in any other way. The principles are clear and these will become mandatory. Firstly there will be training posts in the subjects relevant to general practice. Secondly general practitioners with appropriate training and experience in any field should be able to apply for part-time posts in a career grade. There will however, be no place for those without such training in the future.

3. *The general practitioner casualty officer.* Strictly speaking a casualty officer can hardly be described as a specialist. However, it is convenient to consider his place here. As a person who is dealing with undifferentiated medical material the general practitioner is well qualified for this sort of appointment. It is also different from other clinical-assistant appointments in as much as there is evidence that both sides have been making a convenience of each other in these posts. The younger general practitioner will often accept a post as casualty officer at his local hospital until such time as his practice takes up too much of his time to allow him to continue. Perhaps here also, as a service post of limited tenure, the clinical-assistant grade is the appropriate one. However, they are seldom permanently satisfying. Few doctors seek to make casualty posts their careers, least of all when major trauma is excluded as it usually is. It is difficult to see what the future is to be with the fuller and more medically-slanted vocational training that future general practitioners will receive; it is unlikely that they will seek out posts in the casualty departments from choice. Equally the hospitals are going to find greater difficulty in staffing these departments. One possible answer is that a

period in the casualty department is good training for the aspirant general practitioner, and it might be that the hospitals will be glad to offer such posts as part of the future general practitioner's vocational training.

Summary and conclusion

In assessing the future rôle of the general practitioner in the hospital it is anticipated that the National Health Service will continue to be manned by doctors who are differentiated as either generalists or specialists. It is anticipated that this distinction of function will not in the future determine their spheres of activity with the same degree of rigidity as has been the case so far. Specialists and generalists must be equal partners in the care of patients who need their skills. The responsibilities of both groups of doctors must neither begin nor end at the hospital gate.

The general practitioner's rôle in the hospital is best seen as falling into three natural places:

First, with his increased education, especially in internal medicine, he will find a natural if limited place in the wards in the care of his own patients. From small beginnings it is anticipated that a move in this direction will gather momentum until he occupies his rightful place as general physician to his own patients whether inside the hospital or outside.

Secondly the hospital will continue to play an important rôle in the education of the general practitioner. The total unsuitability of the majority of service appointments in the clinical assistant grade has been stressed. There is a need for a true training post in which the general practitioner has training tailored to his vocational training needs, and this means particularly in the general medical subjects. In addition the converse will apply, with general practitioners themselves playing a greater part in the teaching programmes.

Thirdly, a change in the general practitioner's rôle as a specialist in the hospital is forecast. No great increase in numbers is anticipated, perhaps even the reverse. The present tendency for hospital authorities to think of general practitioners as useful stop-gaps when they have staffing difficulties will cease. The new vocational training programme, together with the greater flexibility that will come from doctors working in larger groups, will both assist the evolution of a few properly-trained part-time specialists who will be able to play a useful part in the hospital team. This is seen as a subsidiary movement best regarded as the gradual replacement of the present large number of 'amateur' general-practitioner specialists by a rather smaller number of professional ones. Not many are likely to want to change course and become hospital consultants, but it is important that there should be a bridge between general and specialist medicine.

The extent of the change in the general practitioner's rôle in the hospital is not seen as very great. However, the changes that are anticipated are important and fundamental. They will help to complete a functional and logistic integration of two main pillars of the National Health Service, an equal partnership between specialist and generalist. They will make general practice a more rewarding career, enabling its practitioners to satisfy that deep-rooted desire to investigate and treat at least some of their patients in depth. Finally, and by no means least, the very presence of general practitioners on the staff of hospitals could bring a new dimension to the teaching of medicine.

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ASSES' MILK

Artificial.—There are several ways of preparing this; but two will suffice.

1. Boil in three pints of water till half wasted, one ounce each of eryngo root, pearl barley, sago, and rice; strain, and put a table-spoonful of the mixture into a coffee-cup of boiling milk, so as to render it of the consistence of cream. Sweeten it with sugar or honey to suit the taste.
2. Take two large spoonfuls of good hartshorn shavings, two ounces of pearl barley, one ounce of eryngo root, the same quantity of china root, and preserved ginger; boil the whole in three quarts of water till reduced to three pints. Then boil a pint of new milk, mix it with the rest, and put into it half an ounce of balsam of tolu. Dose, half a pint morning and night. The milk of the ass and the camel, and in northern countries that of the goat, is principally employed for medicinal purposes. When infants are nursed on cows' or asses' milk, it is of the greatest importance to give it directly from the animal, as the atmosphere speedily makes a great change upon this delicate fluid. If this be not possible, it ought to be carefully covered and kept warm, by placing the vessel containing it over boiling water. This is generally done when asses' milk is given as a medicine, and is probably one great cause of the good effects arising from it. A pint of warm milk from the cow, with a little sugar or honey, and a table spoonful of good rum, has frequently been found in many cases successful in chronic debility, when the milk of asses or women had failed.

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