THE GENERAL PRACTITIONER AND THE HOSPITAL

THE history of the relationship between the general practitioner and the hospital has considerable historical, organisational, and medicopolitical interest. The last hundred years show that this relationship is constantly changing: the trends suggest that change will continue.

The 1940s

The introduction of the National Health Service in 1948 was a significant historical landmark. In the short term, it induced many general practitioners who had developed special interests to leave general practice and become hospital consultants. In the longer term, by developing and encouraging a professionalised and highly trained specialist it made it harder for generalists to work in hospitals in the consultant grade. So difficult did the process of changing streams become that in the late 1940s the barrier between the two parts of the profession was described as an 'iron curtain'.

Stevens (1966), who has analysed the power struggle between the two parts of the profession, has coined the useful summary that *the consultant won the hospital bed and the general practitioner won the patient.*

The 1950s

In the early 1950s it was felt that this demarcation represented victory for the specialist because at that time 'real' medicine was widely seen as the prerogative of the hospital. Those seeking solutions to the problems of general practice suggested involving the general practitioner more with the hospital. Thus the Cohen Committee (1950) recommended that general practitioners be enabled to attend hospitals as 'clinical assistants'.

Such clinical assistantships were soon introduced in a wide variety of specialties and proved popular: indeed, almost a third of all practitioners have worked in hospitals in such a capacity. These posts were seen at the time as a means of keeping general practitioners in touch with hospital work, of educating them and developing a special interest for them. By 1953 there were more general practitioners working as clinical assistants than there were working in general practitioner hospitals.

The 1960s

It was in the 1960s that the role of the clinical assistant in hospital began to be challenged. Now it was suggested that such a post, since it was only one of an assistant to a consultant, represented a position of inferiority; simultaneously new emphasis on the development of general practice in its own right led to suggestions that hospital practice might become much less relevant to the future role of the generalist. Thirdly, analysis of the assistantships available increasingly suggested that these posts were more designed for the service needs of the hospital than the educational needs of the general practitioner.

The 1962 Hospital Plan represented the crystallisation of one concept of the relation-

ship. Specialists and specialist equipment were to be concentrated in large district hospitals which were seen as being administratively attractive and economically efficient.

This thinking postulated the withdrawal of the specialist into ever bigger administrative units and led in the early 1960s to an adjustment largely accepted by both sides of the profession. Hospital doctors did not look outside the walls of their buildings and the general practitioners, apart from their assistantships, did not look inside. The two branches of the profession prepared to tread the future along parallel but separate paths.

Four new ideas

Into this millpond of adjustment four ideological stones have recently been thrown. The ripples that they have created are still disturbing the previously fixed ideas about the relationship between the general practitioner and the hospital. We publish today three papers, each of which illustrates one of these new ideas.

Together they explain why increasing emphasis on patient-centred medicine and holistic care has led to the demarcation described by Rosemary Stevens being interpreted in a different light. The deal which had seemed so favourable to the specialist in the 1950s has come to be seen as more favourable to the generalist in the 1970s.

Consultants working in group practices

First came reports of consultants leaving their hospitals and joining on equal terms general practitioners in consultative sessions in general practice. Such reports stress the advantage to the patient in being more at home and more forthcoming. In addition, considerable professional advantages accrue. It is possible that such meetings may not only be a significant further method of providing continuing education for general practitioners, but an entirely new method of providing continuing education for consultants.

Use of the hospital services

The second development was the increasing trend of general practitioners of analysing their own use of hospital facilities of all kinds. There was a progressively increasing demand for diagnostic services both pathological and radiological. Between 1953 and 1964 pathology tests initiated by general practitioners doubled. Similarly, in diagnostic radiology more than ten per cent of all the work in hospital is now done at the request of general practitioners.

Simultaneously there has been an increasingly critical evaluation of the reasons why general practitioners admit patients to hospital beds. In this *Journal* today, Torrance *et alia* record the reasons which led practitioners to refer patients for medical admission. They also asked what hospital doctors thought of these same admissions and what alternative services in the community might have averted the need for a hospital bed.

This concept is the key. Starting with the radical 1959 Mental Health Act a new idea has arrived. The hospital is no longer seen as the ultimate and logical final step for either physical or mental illness, but now, to some extent, as a failure of the community services. It is coming to be seen that care is more humane, cheaper and more efficient if delivered wherever possible in the patient's home.

General practitioner hospital beds

Few general practitioner beds outside midwifery exist in general hospitals with some notable exceptions such as East Birmingham. Even fewer are planned in new hospitals although North Devon has proved this possible.

One of the side effects of the district hospital concept was the corollary which followed, that small peripheral or 'cottage' hospitals should be closed. If the big central

hospital was good and efficient, then the small peripheral hospital was seen as bad and inefficient.

The progressive attempts to close such hospitals led inevitably to protest, not only from general practitioners, but from whole local communities. At first, such objections were negative in the sense that they attempted merely to defend the *status quo*. One of the more interesting new developments has been the increasing readiness of general practitioners to invite inspection of their work, to show its quality and its quantity—in other words its value. The fundamental concept of the exclusive provision of hospital services through the large district hospitals is thus being challenged, and the protagonists of such new thinking have moved from a defensive position and are seizing the initiative.

We publish today a paper by Dr I. S. L. Loudon which provides factual data in support of this thesis. This paper is notable for its positive approach and well illustrates the morale of general practitioners providing such care. It is clear that this concept needs further study.

New role inside hospital

As if all this was not enough, an entirely new role for general practitioners within the hospital has recently been outlined.

The idea that the general practitioner has a continuing responsibility within the hospital walls is not new, and Sir George Godber has been widely quoted in stating that in his view general practitioners had a share in the care of all patients in hospital. Today, however, a paper by Dr D. G. Illingworth in conjunction with his consultant colleagues in Edinburgh introduces a practical method of implementing this idea. He works in a hospital not as a consultant, not as a clinical assistant, not as a part-time specialist—but as a generalist. He states his objectives, outlines some of the difficulties, and indicates some of the areas of success. In particular he demonstrates the ability to bring to the patient symptomatic treatment at an earlier stage than would be otherwise possible, and the ability to save specialist resources by, for example, not calling an ophthalmic surgeon to every stye or a psychiatrist for all anxiety. It is too early to judge what is at present an experiment, but this concept too, needs further study.

Twin themes

All these four ideas are leading to changes in the relationship between the general practitioner and the hospital. On analysis, it can be seen that all the four contain two themes. First is the increasing readiness of general practitioners to provide data about their work, and their readiness to discuss its quality and significance. The second is the trend towards increased integration between the generalist and the specialist branches of the profession—integration despite some formidable administrative hurdles. It is interesting that in all cases it is integration as equals.

Five years ago a generation of general practitioners was growing up who saw the hospital as something quite apart from their work. They accepted the 'iron curtain' and were adapting their lives accordingly.

Now it seems that even iron curtains can be drawn. Some new and exciting developments are taking place which may yet produce an entirely different pattern for the future.

REFERENCE

Stevens, Rosemary (1966). *Medical Practice in Modern England.* New Haven and London: Yale University Press.