THE RENAISSANCE OF GENERAL PRACTICE

In Great Britain, at present, our impression of general practice is coloured by the National Health Service, which was launched in rather a hurry for financial and political as well as for medical reasons. I am not concerned here with the pros and cons of this service at its present stage of development. Some are satisfied with it, others are not.

If we look to the future we must realise that to be successful and permanent, with a contented profession doing its work well, it must give doctors a satisfactory wage, favourable settings for their work with enough time and the right instruments to do it properly, and encouragement to keep up to date. If, ten or twenty years from now, the National Health Service in this country satisfies these three conditions it will be successful and survive. If it does not, it will be replaced by something better—by some other type of service first developed, perhaps, in another land whose politicians will have been proved in the long run wiser than ours. Let us all be clear in our minds that the present service is in the nature of a long-term experiment, and that it is on trial in the eyes of the world. With good medicine, based on good general practice, as our primary aim, we should constantly compare progress with that of similar experiments in other countries and learn all we can from them; in that way we shall develop a medical organisation in the British Isles second to none.

The renaissance of general practice, to which I refer in the title of my paper, stretches out beyond local health services and party politics. It is a world-wide movement concerned with the academic welfare and the scientific encouragement of family doctors in every continent. It is a movement which recognises that *modern medicine, to do its greatest good, must reach patients promptly in and near their homes.*

We have heard and read so much lately to the detriment of general practice in the British Isles that I would like to put on record something to its credit.

Definition of a general practitioner

General practice is usually, but not always, synonymous with family doctoring; some families have different doctors for the father, the mother and for the children. A great deal of thought has been given in recent years to the definition of a general practitioner. I would like to suggest the following: *A doctor in direct touch with patients, who accepts continuing responsibility for providing or arranging their general medical care, which includes the prevention and treatment of any illness or injury affecting the mind or any part of the body.*

This definition covers the essentials of the general practice of medicine in the depths of the country or in the heart of a great modern city like Manchester; in a family, school, or university; in the merchant navy or the armed forces of the Crown; in a factory, prison, or other institution, at home or overseas. As the name so clearly implies, it is the general nature of the work which is characteristic, and part of it may be connected with neither illness nor injury—for example, infant feeding, marriage guidance, normal obstetrics, and the management of old age.

Direct access of patient to doctor is even more important than that of doctor to patient. Continuing care may be from day to day, from month to month, from year to year or from generation to generation. Some specialists, it is true, such as ophthalmologists, dentists, and psychiatrists, have both direct access to patients and their continuing care, but the extent of this care is limited to one part of the body.

Early development and continuity of general practice

To see general practice in its proper perspective it is helpful to consider how the first family doctors may have developed, some hundreds of thousands of years ago, when

prehistoric men, women and their families lived in small groups, getting what food they could from plants and from hunting. One can visualize some of them having to treat an ill child or a wounded adult, or perhaps one poisoned by unsuitable food, or with a boil, a splinter in the hand, a foreign body in the eye, a broken bone, frost-bite, or a burn. These medical ancestors of ours were the most *general* practitioners of all time; they did everything, with whatever instruments, dressings, splints, or drugs that were handy or they could make themselves.

The specialists must have started hard on their heels. It is wrong to think of specialism as a product of the last hundred years. Some of these prehistoric men and women must have become adept, beyond the average, at extracting teeth, splinting bones, or delivering babies; we know for certain that some were trephining skulls many thousand years ago. Herodotus tells us that in ancient Egypt, with its full-time medical service, specialism was rife[8]; and you will remember that Hippocrates in his oath said, "I will not use the knife, not even on sufferers from stone, but will withdraw in favour of such men as are engaged in this work".[19]

One can imagine these early specialists even developing small clinics of their own: but nature has never dispensed illness or injury in a tidy manner entirely suitable for clinics; people have been ill at any time or place, and many of them have had to be cared for in their homes, especially the children, pregnant women and older folk. So general practice gradually developed. Family doctors and specialists have worked together, on the whole happily, for tens of thousands of years, and I believe that they will continue to do so.

Scope of general practice today

Today we still have at one end of the scale truly general doctors, like those working single-handed on the islands off our coast, in the bush of Australia, or as missionaries in Central Africa, who cannot limit their doctoring at all and who have to turn their hands to any surgical, medical, gynaecological, or psychological problems that crop up. At the other end of the scale we have highly trained specialists studying small fields in microscopic detail: for example, Professor C. I. Thomas, of Cleveland, Ohio, has just written a book of 1,318 pages, with 400 illustrations, on the cornea—a part of the body one millimetre thick and 12 millimetres in diameter.[50] In between these two extremes there is every type of doctor.

However good the microscopes, the naked human eye with its breadth of vision will always be essential for every-day life. No matter how clever the consultants or how excellent the hospitals, it is the efficiency of the family doctors, and the work they do in and near the homes of their patients, which will determine the calibre of the medical services in any country.

One sometimes hears the suggestion that general practice may be slowly disappearing, especially in the United States; but a recent survey there[6] shows that 82 per cent of the population claim to have a personal or family doctor—one whom they usually call first—which is probably as high a figure as ever before. In Great Britain in 1955 Mr Ian Macleod, then Minister of Health, said: "I think we ought to make—and for it to be seen that we are making—the general practitioner the king-pin of the whole of the National Health Services in this country".[24]

As medical science has become more complex, the tendency throughout the world has been for general practitioners, like their specialist colleagues, to limit their techniques and share their work with others, so that they themselves may be more efficient in that which they elect to do. This trend is not new; it has been there from the beginning, but the rapid growth of medicine during the last 100 years has made it more evident. In large communities, now, no family doctor can possibly be truly 'general', giving his patients that excellence of care and attention in every branch of medicine which modern science leads them, rightly, to expect as their due.

In this respect general practice today does differ from that of our ancestors long ago. A considerable part of what was once done in a simple way by a family doctor must now be carried out by teams of experts, under his direction. This has tended to reduce one severe handicap of the past—the isolation of the general practitioner.

Medicine, which was once as simple as a dug-out canoe, is now as complicated as a modern battleship. Both need to be guided. The family doctor of today has to work, on his patients' behalf, in close and friendly co-operation with many different people, who include his general-practitioner colleagues (perhaps in partnership or in a group practice), all the specialists and consultants in his area (several of whom may be concerned in the diagnosis of even one difficult case), and all those ancillary services which are essential for his own task—secretarial, receptionist, nursing, the laboratory service, medical officers of health, and the personal health services of local authorities (maternity, child welfare, and school health with their personnel—health visitors, midwives, district nurses, home helps), and the special services for patients in particular categories (the tuberculous, the blind, the mentally ill, the aged and chronic sick). To these must be added all other parts of the hospital service (including almoners, dieticians, chemists, dentists, oculists, physiotherapists, chiropodists, etc.) and also the instrument makers, pharmaceutical manufacturers, school-teachers, parsons, lawyers, and so on.

This is a long list, and it could easily be made longer still; its length underlines the point I wish to make, which is that the activities of all these different people must be co-ordinated and correlated by the general practitioner to ensure that all of his patients' particular needs are met. In the general practice of the future this guidance of patients by their family doctors, and this team-work, will be needed still more; and all our plans must be based upon them.

Dr Richard Scott, of Edinburgh, in his concept of the family-doctor team and the personal relationships between doctors, their helpers, and the patients they serve, lays special emphasis on the need for reinforcing medical skill with that of the trained medico-social worker or almoner; and he points out how much is achieved and how much time is saved by regular personal discussions between members of this team.[44]

It is a pity, and a mistake, when the personal and human nature of these relationships is forgotten. On 21 July last year, a doctor in the south of England wrote to the President of the College of General Practitioners saying that he had just received a letter from a certain executive council addressing him on the envelope as "Dr 2126".

The art of general practice

You will have observed that in my definition of a general practitioner I have put care of the patient's mind before that of his body. This was done deliberately, because I know we all agree that the family-doctor's awareness of what patients think and feel is vitally important for the whole of his or her work. I should now like to discuss the future of the doctor-patient relationship and what is popularly called the 'bedside manner', and also the parts to be played by more formal psychology and psychiatry in the general practice of tomorrow.

The bedside manner

In treating almost every illness there is need to strike a proper balance between science on the one hand and the art of medicine on the other; and much of the latter is to be found in the manner of the doctor by the bedside of his patients or in his surgery. It is true that, occasionally, either the art or the science of medicine may be paramount.

When one is treating a mother who has lost an only child, or helping someone else in the last stages of cancer, compassion and sympathy may be all that really matter and science may hardly enter into the problem. On other occasions science and technique are all-important, as when a surgeon is doing a difficult operation, or a physician is treating

an unconscious patient. By and large, we must agree with Dr Geoffrey Barber when he says: "I would rather be in the hands of a man with an accurate knowledge of medicine, and with but little of the milk of human kindness, than in the care of the kindest man imaginable who didn't really know his job"[3]; but luckily it is often possible to have the two together, because both the science and the art of medicine play essential parts in the care of nearly every patient.

Not long ago a patient of mine had a baby girl who was born with a hare-lip and cleft-palate. We asked a famous plastic surgeon to talk to the mother a few hours after the child arrived, and I wish those who believe that modern science and a good bedside manner are incompatible could have heard what he said; the mother will remember it with gratitude all her life. No matter how much science develops during the next few hundred years, the need for the art of medicine will still be there. As Sir Arthur Hall wrote in 1941: "The need for it is as great today as it ever was or ever will be, so long as human sickness continues".[25]

The courtesy of a good doctor is not something he puts on like a white coat when approaching a patient's bed, or in the surgery, or when speaking to him on the telephone; when that is so it will inevitably be artificial and insincere. Doctors with the best bedside manners—and it is largely a question of manners—are those who are their own natural, decent selves with their families, their friends, servants, nurses, secretaries, *and* with their patients. It is a paradox that the doctor with the best bedside manner is the one who puts on no special manner by the bedside of his patients.

Let us try to analyse what we mean by this term 'bedside manner', which is now out of date and a target for the wit of the music-hall artist and the caricaturist; and let us see what others have thought about it in the past. Although there are very few papers on it, several references are to be found tucked away in the journals.

It is something that gives confidence to patient and doctor alike, and helps them both. Like charm, it is almost impossible to define. Its components, I think most people will agree, are personal interest, kindness, sympathy, friendliness, understanding, cheerfulness, and humour; beyond this the list may easily deteriorate into a dull one of all the virtues, missing the important points. Oliver Wendell Holmes, nearly a hundred years ago, added: "Good dressing, quiet ways, low tones of voice, lips that can wait, and eyes that do not wander . . . to belong to the company you are in".[26] Sir Archibald Garrod in 1926 supplemented this with "tact, resourcefulness, courage and prudence . . . patience with fads".[23] This last, I think, is important. Good doctors are often those with 'high boiling points'.

Sir Francis Walshe, a scientist of renown and a Fellow of the Royal Society, added "vigilant and humane insight . . . and at times . . . firmness". I agree with him there. It is no use trying to please everyone. One cannot help feeling that if Hippocrates himself was now a doctor in Manchester or London there might be several who would not want him as their personal physician. Sir Francis deplored the fact that the term 'bedside manner' was so vulnerable to the simple-minded jester. "Long experience", he said, "has taught me that those who most readily make wisecracks about the bedside manner are, themselves, when sick, commonly most exigent of what they conceive this manner to be. They like to eat their cake and have it".[52]

There are other attributes which are helpful. One is a good memory for names. Dr William Pickles, the first President of our College, whose practice is in a Yorkshire dale at Aysgarth, has told us recently that he used to know the Christian names of every man, woman, and child in all the villages in his dale.[39] To be able to do this one must be fond of one's patients; and Francis Peabody epitomized the whole matter when he said, "The secret of the care of the patient is in caring for the patient".[38]

The point I wish to make is that scientific medicine and a good manner by the bedside

are not incompatible; indeed, they are really complementary to each other. The best clinicians of the future, as in the past, will be those who can combine them to the fullest extent; they are both essential to all good doctoring. This idea is not at all new, but it is sometimes forgotten. There is an urgent need for some of the scientific and organised medicine of today to be infused with more of the wisdom, courtesy, and charity of our predecessors, to bring up to date the psychological insight of the family doctors of fifty or a hundred years ago.

Psychology and psychiatry in general practice

This brings us to the part that more formal psychology and psychiatry play in general practice. Psychology has been defined as "the science which deals with the mind and mental processes",[47] and psychiatry as "the recognition and treatment of diseases of the mind".[47]

The attitude of general practitioners towards patients with nervous symptoms should, I believe, be based primarily on normal psychology and on study of variations in normal behaviour, rather than on psychiatry and mental disease. The limits of normal behaviour are far wider than was at one time thought. The Kinsey Reports,[30 31] based on the sexual behaviour of normal men and women, illustrate this; and honest reports on other aspects of human activity and emotions show the same wide range of normality.

It can be argued that the great majority of behaviour problems in children and in adults which confront family doctors, and many cases of emotional disorders with anxiety and depression arising from the disappointments, frustrations, anxieties, and sorrows of everyday life, fall within this wide range of normality, and should be regarded fundamentally as physiological rather than as pathological or psychiatric. In so many of these cases the patient, his relatives, his friends, and his family doctor know that he is not really mentally 'diseased'; and it is natural that they should all dislike the idea of the patient being under the care of one who specializes in mental illness, which is, by definition, what treatment by a psychiatrist implies.[37 47]

I believe that this fact is at the root of much of the distrust and resentment which have for so long surrounded the management of these particular cases by psychiatrists. A much wider popular interpretation of the word 'psychiatry' is required. A definition said recently to be 'fairly acceptable' in America is 'the study of interpersonal relationships'.[21]

Wise family doctors of the past have nearly always been depicted as elderly men who, by long experience in a life of general practice, came to recognise the wide range of normal behaviour—to 'understand human nature'. The same has applied to specialists. W. E. Fothergill has told us that David Lloyd Roberts was "A born healer, it did people good merely to see him; he could not only help those who were ill, but he could also cure those who were well—a much more difficult matter".[22]

This wisdom can be learned, as Dr Lindsey Batten has charmingly put it, "from the professors or from the poets, the novelists, the Bible, and your own experience, or you can mix them all; but you must not suppose that Psyche is an illusion, an invention of the psychologists, or that you can afford to neglect her. She has a finger—sometimes a fist—in every medical pie".[4]

Given the opportunity, many older doctors still learn this lesson in time; but all medical students, especially those who are to enter general practice, should be given more instruction than they get at present concerning the surprisingly wide range and variation of normal human behaviour and emotional reaction. Some medical schools are already doing this—especially Leeds, Cardiff, Guy's, and the Middlesex—teaching psychology from the dynamic point of view, imparting an understanding of the principles underlying good mental health.

Students must also be taught the art of listening, which can be acquired. It is not

unknown for doctors to talk so much, and to ask so many questions when taking a history, that the patient learns far more about the doctor than the doctor does about the patient.

With adequate training and a charitable disposition, a family doctor, even if he is rushed and has little time to spare, can manage fairly well many of these behaviour and emotional problems. When he can do this himself the result is often better than when such patients are referred to a psychiatric clinic, there to mingle with some who are really mentally sick with more severe personality or behaviour upsets, neuroses, depression, hysteria, psychoses, organic cerebral disease, etc. One would like to see the general practitioner of the future an expert at recognising and dealing with more of these normal variations—a wonderful field for further observational research.

The treatment of these emotional upsets by general practitioners raises the problem of how much time they can spare for it. The 'time versus service' difficulty is one that confronts every practising doctor nearly every day; each must solve it for himself. There is little doubt that every new patient should be allowed, one time or other, at least half an hour's conversation with his doctor. In some circumstances the history can be taken on one occasion and the examination done on another. Four sessions of a quarter of an hour may sometimes be nearly as good (though not quite so good) as one hour at a stretch; and by adding together even shorter periods a full history and examination can in the end be made, if there is order behind the investigation and if suitable notes are taken. In certain circumstances, when personal problems are being unravelled, an hour or more of uninterrupted conversation may be required; but these longer sessions are not so often needed as is sometimes supposed and, when they are, time can usually be found for them by planning ahead.

It is impossible to state categorically the number of patients whom any general practitioner may look after well. Doctors and patients vary so much—in different age groups and in different communities—that each doctor must decide for himself, at each stage of his career, how many patients he should rightly have under his care.

General practitioners with special interests

In cities and large towns, family doctors, whether they work on their own, in partnership, in group practice or in a health centre, can get their specialist assistance from hospitals or consultants working near by. The advantages and disadvantages of these different types of practice have been discussed elsewhere.[29 35 36] Over much of this country, however, and indeed over a great part of the world, consultants are further away, and groups of practitioners are working together more in teams, developing special interests among themselves so that they can help one another by pooling a variety of experiences, skills, and techniques.

Let us take obstetrics as an example of one of these special interests. Not all the members of a partnership may have the inclination, time, or training to do midwifery. If one of them has taken the trouble to train himself carefully in this subject he may be of inestimable value to his group. In its memorandum to Lord Cranbrook's Committee, presented this year, the Royal College of Obstetricians and Gynaecologists said about the maternity services in the Oxford area: ". . . Every encouragement is given to those general practitioners who have fitted themselves by postgraduate study to practise obstetrics, and general-practitioner maternity units are encouraged and are regarded as integral parts of the area department . . . These general-practitioner obstetricians can become highly skilled and exert a powerful influence over the work of their colleagues both in the maternity unit and in domiciliary practice".[43]

From their memoranda to the Cranbrook Committee, the Royal College of Obstetricians and Gynaecologists and the College of General Practitioners[17] seem to be in complete agreement regarding the role of the general-practitioner obstetrician, whose future seems likely to be assured. The problem and its solution is much the same for family doctors with one or more special interests in other branches of our profession—medicine, surgery, anaesthetics, paediatrics, geriatrics, dermatology, rheumatology, psychiatry, allergy, public health, tropical medicine and so on.

Every group practice of the future must borrow from the specialties as much of their knowledge and technique as is applicable to family doctoring. To call these general practitioners with special interests 'general-practitioner consultants' as has been done recently[42] is, I believe, wrong. They are primarily general practitioners who have studied, in a limited way, one or more particular fields of medicine. The more complex the specialties become, the more will these general practitioners with special interests be needed; but it is extremely important that they should remain first and foremost general practitioners, and that they should limit themselves strictly to the general-practice aspects of their special subjects *as these apply to family doctoring in and near their patient's homes.* Their success depends on the proper limitation and supervision of this special work.

One of the main advantages of this type of group practice is that its members can teach each other as they go along; each of them leavens the whole group. A specialist appreciates a general practitioner who uses him efficiently; and often there are no greater friends or more loyal colleagues than a general practitioner with a special interest and a consultant in that subject, be they neighbours or many miles apart. They speak the same technical language, and learn from each other every time they meet. Such close and friendly co-operation between general practitioners and consultants is possible in all branches of medicine, and is much to be desired.

The encouragement of general practitioners with special interests, so that a group may fulfil all the functions of the family doctor as we have known him in the past, is the way that general practice in many places, especially those far from hospitals and consultants, can keep in step with the rapid expansion of modern medicine. It is a logical development, and one that is already working well in a great many parts of the world. It helps patients by saving them much travelling and time, and many visits to hospitals; it helps groups of family doctors by making general practice more interesting, by easing their burden of responsibility and in many other ways which have been described elsewhere[29]; it helps hospitals by relieving crowded outpatient departments and inpatient waiting-lists, giving consultants more time to do their own work properly.

Many new types of group practice are being tried out at present in this country—in Bristol,[54] at Corby,[32] and at Harlow,[49] among others. At Harlow the family doctors are doing nearly all the work of the maternity and infant welfare clinics, and running the industrial health service. In future, emphasis must be more and more on prevention, early consultation, and early treatment; and it is a pity that the statutory term 'health centre' applies, now, only to one form of group practice.[29]

Diagnostic and therapeutic aids for general practitioners

One of the most essential needs of every family doctor is direct and easy contact with diagnostic and therapeutic procedures—pathological, radiological, nursing, or minor surgical. This is his right, for with them he can diagnose and treat many of his patients more quickly, more fully, and more cheaply than has hitherto been possible.[28]

One of the medical lessons we have learned in this country during the last ten years is that when family doctors are given these diagnostic and therapeutic aids they do not squander them. The recent reports of Dr F. N. Marshall, of the Manchester Regional Hospital Board,[33] and of Dr H. W. Ashworth and others, of the Darbishire House Health Centre,[2] have shown this again.

Patients and their doctors, consultants and their hospital departments, all benefit. Considerable progress has already been made, but there is still a great deal to be done to help general practitioners in this way, especially in places far from a general hospital.

General practitioners in hospitals

General practitioners visit hospitals, or work there, for five main reasons, which may overlap:

(1) to diagnose and treat their own patients or those of their partners;

(2) to visit or consult over their patients;

(3) to foster their own general postgraduate education;

(4) to acquire and maintain experience in a special subject in which they are interested;

(5) to teach undergraduate medical students.

Here I would like to comment briefly on the first three of these; the fourth has already been discussed and the fifth is mentioned later.

(1) *Diagnosing and treating their own patients*

In small hospitals in country districts, family doctors for many years have done excellent work on their own patients who, for purely social or economic reasons and not because they need specialist care, have had to be moved from their homes into hospital beds. In larger towns and cities, family doctors do the same work as their country colleagues, their patients have the same straightforward complaints, some of which may be difficult to treat at home; and yet, in towns, for a reason never properly explained, it is considered that family doctors should have few, if any, hospital beds.

Throughout England and Wales each general practitioner has, on an average, one third of a share of one hospital bed.[34] This means that many consultants, specialists and their assistants are doing general-practitioner jobs, spending their valuable time being responsible for the treatment of patients in hospital who do not really need their expert knowledge and attention and who, in many instances, would prefer to be cared for by their family doctors. Overseas this anachronism does not exist to such an extent, and in time it will, perhaps, be corrected in the British Isles.

(2) *Visiting and consulting*

Every opportunity should be taken by general practitioners to visit their own patients who have been admitted to hospital under the care of specialists; to talk to the house officers and nurses in charge; to be present at a consultation in an outpatient department, a ward, pathological laboratory or elsewhere; and to attend an operation or perhaps the post-mortem room. This entrée of family doctors to hospitals, and the contacts thus made with hospital staff and consultants, may sometimes be difficult to arrange and be time-consuming for all concerned, but they are well worth while.

(3) *Fostering postgraduate education*

For their continuing education general practitioners may learn much from attendance in hospitals—at lectures, ward rounds, clinical demonstrations or other meetings which have been enumerated elsewhere.[16]

They can also work with specialists in hospital outpatient or inpatient departments as senior or junior hospital medical officers, or as clinical assistants, for one or two sessions a week.[16] If these appointments in hospital departments are held in rotation, several subjects may be covered in a few years. This may not help the hospital as much as when a general practitioner works in one department permanently, as he may do if he has a special interest, but it is almost certainly better for the doctor's general postgraduate education.

It should be remembered that the primary object of this particular hospital work by a family doctor is to help him to keep up to date, and not to use him as a convenient source of extra help when there is a shortage of staff, or when the specialist is busy or away; that is a job for a trainee consultant. The temptation must be resisted to make use of family doctors, as has recently been suggested, "to keep the hospital services going" or as "pairs of hands for . . . relieving the junior staff of much routine work".[42] In an emergency, or at specially busy times, general practitioners will nearly always be most willing to help a hospital; but with all their responsibilities in the homes of their patients—their first concern—they have more than enough of their own work to do.

The College of General Practitioners

In many countries general practitioners are developing academic headquarters of their own. The Americans were first with their Academy of General Practice in 1947; we were second with the foundation of the College of General Practitioners in 1952; and the Canadians third with the College of General Practice of Canada, founded in 1954. The Netherlands, Germany, India, the South American states, Australia, and other countries are following these examples. There is talk of an International Committee of General Practice to co-ordinate the activities of them all.

If our College had, in fact, been formed a hundred years ago, as it nearly was, the development of general practice in this country and the part which family doctors play in the National Health Service would have been, I am sure, different from what they are today.

The response to its foundation on 19 November, 1952—over 1,200 members and associates joining within the first three weeks, the steadily growing membership since then (it is now 4,152), and the co-operation of the Ministry of Health, the General Medical Council, the British Medical Association, the Medical Research Council, the Society of Apothecaries, and many other institutions—has made it abundantly clear that this College was needed, and that it has an important part to play in the future of medicine in this country and in the Commonwealth.

When we began it seemed to us, as Dr G. F. Abercrombie said at our last annual general meeting, that "the home of our College would have to be in the hearts and minds of men"; but the generosity of an anonymous donor, and the foresight and co-operation of the President and Council of the Royal College of Surgeons, have made it likely that we shall, before long, have a fine building of our own.

During its first four years the College has developed 35 regional faculties, 13 of them overseas—in Eire, Australia, New Zealand and Africa. It has published 14 issues of a *Research Newsletter*, of more than 1,000 pages, with Dr R. M. S. McConaghey as editor; it has a research register of more than 500 general practitioners interested in doing original work. A college Records Unit is being developed; a general-practitioner teaching register is being drawn up of those family doctors who are willing to take students and to lecture; and a list of those diseases and injuries which are met significantly often by general practitioners in this country has been prepared. A ten-page questionnaire on the continuing education of family doctors has received more than 2,000 replies. Each month a list of postgraduate lectures, demonstrations, and courses in London and the home counties is circulated as a Postgraduate Information Diary. A College Research Fund has been opened.

The College is represented on many academic bodies, and has worked in the closest possible liaison with the Ministry of Health in England (and the corresponding departments in Scotland, Northern Ireland, Eire, and Australia), with the British, Irish, and Australian Medical Associations, and with the British Postgraduate Medical Federation of the University of London. It has been invited to submit reports to the General Medical Council on the 'Medical Curriculum' and to the Ministry of Health on 'Medical

Manpower', 'General-Practitioner Obstetrics', and 'Psychiatry and the General Practitioner'.

It has been presented with the annual James Mackenzie Lecture, the Butterworth Gold Medal, the Pfizer Postgraduate Grant, and the Public Welfare Foundation Grant, and it has been invited to adjudicate for the Benger Prizes for original observations by general practitioners. The College hopes to help young doctors with their equipment and premises. Twenty thousand copies of an obstetric record card designed by members have already been distributed, and other cards, charts and diet sheets are being prepared.

Dr F. M. Rose said at our first annual general meeting that doctors have joined the College "not because we think we are good practitioners but because we want to be better ones". On 17 June, 1954, on the occasion of the foundation of the College of General Practice of Canada, our first President, Dr W. N. Pickles, sent a recorded message across the Atlantic: "It is my firm hope and belief," he said, "that the inauguration of our Colleges will be a turning point in the history of general practice, and that the patient endeavour of each will inevitably raise its standard and perpetuate the high ideals which we associate with this great branch of our profession".[13]

It is not only the foundation and other members and associates of our College who believe sincerely in its future, and in the good work that it will do; thousands of others, both within the medical profession and outside, think so too. It is right and fair that everyone should now co-operate with us and help us to carry out our difficult task.

I would ask all individuals and institutions to search their hearts and their records for what they themselves have done during the past half century to encourage, academically, family doctors in active general practice; and I would invite them to compare their lists with what our College has achieved during its first four years.[11–15]

Teaching general practice

In spite of attempts to prove otherwise, by juggling with figures and definitions, there is no reasonable doubt that the majority of students still enter general medical practice of some sort or another—at home or overseas, in towns or in the country, in schools, factories, or other institutions, or in the armed forces. While this remains so—and it is unlikely to change—it seems illogical that students should not be taught something by those with personal knowledge of this important branch of medicine.

Our College is encouraging general practitioners to teach, and the majority of the medical schools have already accepted this idea. The report of the British Medical Students' Association last year showed how well the schemes of student-attachment to family doctors, and lectures by general practitioners, were developing—supplementing and not replacing in any way specialist teaching. In some teaching hospitals in this country (St. Bartholomew's and others), and also in Canada[7] and in the U.S.A.,[41] general-practice resident appointments are being developed for those who wish to become family doctors. In Australia the attachment of students to general-practitioner hospitals is becoming popular.

Dr John Ellis, who has had so much to do with the recent reports of the Royal College of Physicians on Medical Education, said in his Goulstonian Lectures last year: "The standard of medical care in this country depends upon the standard of general practice, and medical schools must regard it as their first duty to ensure the best possible undergraduate education and postgraduate training for their students who will take up general practice . . . This branch has for centuries attracted many of the finest men in medicine, and it will continue to do so".[20]

Teaching hospitals have departments allotted to many different subjects, and it is probable that before long a department of general practice will be considered an essential part of each medical school in this country, as it already is in medical schools in the

United States[1] and Canada.[10] Last year the House of Delegates of the American Medical Association unanimously approved a resolution directing "that all possible means be taken to stimulate the formation of a department of general practice in each medical school".[5]

All that it may be possible to have, to start with, in some of the teaching hospitals in our country may be a small room, perhaps shared with another department, where a general practitioner of experience, preferably one who works near by, can give advice on any problem connected with general practice to anyone in the hospital—from the most junior student to a full-time professor or other member of the staff. These problems may be concerned with family doctoring in the neighbourhood of the hospital or further afield, with the selection of students, with the teaching of general practice through student-attachment to family doctors or through lectures by them, with the problems of the pre-registration year, the difficulties met with by young doctors entering practice in this country or overseas, and with the continuing education of old students of the hospital.

From these small beginnings—with a part-time practitioner in a single room—this service will be given a chance to prove its value. Its future development will depend on the needs of that particular school, the response from the students, and the enterprise of the general practitioner concerned. Departments in different medical schools will develop along different lines; and it is likely that in time they will all prove as valuable as the general-practice teaching units have already done in Edinburgh[45 46] and at Darbishire House in Manchester[2] for conveying to students a proper appreciation of general practice. Before long, perhaps, one of our enlightened universities will found a Chair of General Practice as an example for others to follow.

The less a medical school has taught its students about general practice, the more will they need to learn about it after they have left their teaching hospital. Paucity of training in this subject may be one of the reasons why such a small proportion of general practitioners return to their own medical schools for help and advice once they have left.

A department of general practice in each school, keeping in touch with its old students year by year, would supply a permanent centre of information and assistance which, if properly organised, would do the school and its sons and daughters a great deal of good. Until such departments are formed the Regional Faculties of our College, which are nearly all based on a medical school, may do much to help students and young doctors in this way.

Continuing education for general practitioners

A new attitude of mind towards the continuing education of family doctors is developing, and our College is particularly interested in it. The academic status of the general practitioner of the future will depend very largely upon his keeping up to date. As Dr E. G. Housden has said: "If we wish to be thought of and treated as a learned profession we must live to justify it".[27] Medicine is changing so much, and so quickly, that if the family doctor is to contribute his proper share to the well-being of his patients he must know about recent developments as they occur, not only in diagnostic and therapeutic techniques but also in public health, preventive medicine, social and industrial medicine, and so on. The need for this postgraduate training was stressed recently by the Canadians,[9] who have shown that about 90 per cent of prescriptions written now by family doctors could not possibly have been written twenty years ago, because the drugs did not then exist.

Nowadays, in a maze of specialties and new forms of specialist treatment—many of them frightening and some of them dangerous—*the general practitioner has got to be his patients' trusted guide.* This he cannot be unless he keeps in touch with each major diagnostic and therapeutic advance, unless he knows his patients and his judgement is sound. A broad education, wide experience, and a deep understanding of medicine and

personalities, and the knowledge that he has kept himself up to date, will establish him as a competent and responsible leader of his patients' medical team.

Apart from keeping in touch with these recent advances, he needs also much revision. His time is limited, and one must remember that he has the whole of medicine to cover. If he can do one hour of formal postgraduate training a week he has done well, though this is a total of only 52 hours a year. This is too little time for an enormous job, so that the subjects for his postgraduate classes must be chosen carefully and be limited to those of interest to him. Postgraduate courses must be organised thoughtfully and integrated one with another; anyone who has tried to do this will realise what a stupendous task it is. A country-wide general-practitioner postgraduate curriculum is really what is needed.

Less than half of the varieties of postgraduate education for general practitioners are measurable[16] or formal enough to allow the Ministry of Health to pay for them. One doctor may keep much more up to date by reading his journals carefully, seeing his patients with consultants, and attending meetings of his local medical society, than does another who goes to formal intensive or extended courses once or twice a year. The second programme may be paid for by the State, while the first is not. Official postgraduate courses are by no means necessarily the most important part of the continuing education of a general practitioner; we must remember that all the rest is important too—carrying on his practice efficiently, attending consultations and meeting consultants elsewhere, reading, going to medical society meetings or lectures, demonstrations, or ward rounds, working in hospitals, taking students, entering for prizes or travelling scholarships, doing research, and so on.[16] Family doctors must learn to teach themselves and each other more, and not look to specialists for all their instruction.

The part played by general practitioners in the work of medical societies is steadily increasing; the recent development and success of the General Practice Section of the Royal Society of Medicine is an outstanding example of this.

Travelling fellowships may be of greater importance to family doctors in future: and so will correspondence courses for those in outlying areas, especially abroad.

Publications for general practitioners

For the last half-century many of the articles and books published for general practitioners have been written by specialists. At first they were generally acceptable, because the writers had themselves been in general practice and known its problems; but in recent years many of these authors have spent little or no time as family doctors, and some of their writings have become less and less applicable to the work of those for whom they are intended.

For example, in a recent textbook on the practice of medicine published in this country, and in by no means its first edition, there are scores of pages on diseases which the average general practitioner in the British Isles may not meet even once in his professional lifetime, while such important things as insomnia and breathing exercises are omitted from the index and from detailed discussion.

Books

There is an increasing need for books on general practice to be written by general practitioners and specialists working in co-operation. This will ensure that the content and the emphasis of the articles will be correct from the family-doctor's point of view. Many general practitioners are taking an interest in one or other of the different specialities—about one quarter of the members and associates of our College have obtained a higher diploma in a special subject that interests them, others have studied special branches of medicine that have no diploma—so that it should not be difficult, in time, to find a general

practitioner to cover every article. Several excellent books have been written recently by general practitioners and by those closely connected with them,[18 40 48 51 53] and there has been a marked increase in the number of articles by family doctors appearing in the medical journals.

Journals

This leads to another matter of concern. From the mass of medical literature now published each year, how may good material best be picked out and kept for future use? Our recent questionnaire has shown that no fewer than 75 medical journals, published in different parts of the world, are taken regularly and read by members and associates of the College of General Practitioners.

No doctor in practice has time to read more than a few of these, though he may perhaps glance through several others. He cannot attempt to remember all he reads. Few bind their journals or have room in their houses to store them; fewer still are in close touch with a medical library. What, then, should the average general practitioner do with the articles he wishes to keep. The easiest solution is for him to tear them out of the journals and file them, as many already do. The tearing up of journals has now become almost essential for those who wish to keep articles for easy reference.

Many journals are bound in such a way that tearing out pages is easy; in others it is well-nigh impossible to do so without leaving an untidy, jagged edged which frequently tears into the script. The *Proceedings of the Royal Society of Medicine* and the *Canadian Medical Association Journal* are among the most difficult in this respect. It may be cheaper to bind these journals as they are, but it must reduce their value to many a busy doctor, who may not always have a pair of scissors or a penknife at hand while he reads them. It is surprising, too, that some journals still fail to give an adequate reference (to the journal, year, and volume) on the first page of each article, yet this is most important if articles are to be filed.

It is hoped to develop soon a general-practitioner library service, in connection with the College, perhaps with a full-time director and secretary. This service will give general practitioners much literary help in collecting references and extracts from journals and monographs, and photostatic copies of papers. It should be of great value, too, in the continuing education of family doctors.

Postal advertising

I cannot leave the subject of publications without mentioning a form of literature for general practitioners which is steadily increasing in size—that which reaches us at our breakfast tables six mornings a week, as leaflets, pamphlets, booklets and blotters from pharmaceutical firms. It has been described somewhat cynically as our 'blotting-paper reference library.' That from the reputable firms contains much useful information about new drugs and preparations which is sometimes difficult to find elsewhere. Much of it is as scientific, well set out, and documented as one could wish, and I am now thinking particularly of some of the recent booklets on the new hypotensive drugs. General practitioners can help themselves greatly, when filing information about the proprietary medicines they prescribe, by being highly selective and by using as few preparations as possible of any one drug. Selective replacement in one's files is much more helpful than frequent addition.

I would make a plea to the pharmaceutical industry not to flood us general practitioners with too much paper—smothering useful information with advertising technique—to avoid mixtures as much as they can, and not to duplicate preparations more than is absolutely necessary. Doctors and patients are easily bewildered and confused by too many different names for the same substance. I have weighed the literature from the pharmaceutical firms which has reached me by post during the past year; it comes to about half a hundredweight. Those doctors who have worked out some plan of campaign

for making good use of this mass of postal information can gain a great deal from it; but if the volume increases much more it will defeat its own object, because we shall all be forced to consign it at once to our 'round files', as an American once described to me his wastepaper baskets.

Research by general practitioners

The idea that family doctors can do research, and good research, is not new. That they can be successfully encouraged to take part in large-scale investigations over a period of time has been shown recently to be possible.

One of the most valuable and stimulating contributions which the College of General Practitioners is making to medicine at present is concerned with such organised general-practitioner research. As Dr R. J. F. H. Pinsent has written: "Never before have general practitioners in this country had an opportunity to develop a sense of corporate endeavour in their work, nor have they had the inducement to apply themselves to research into the problems which they encounter every day".[40]

The recent Measles Survey, the work of the Epidemic Observation Unit under the direction of Dr G. I. Watson, the Obstetric Survey of the South-west England Faculty, and the National Morbidity Survey carried out with the help of Dr W. D. P. Logan of the Registrar-General's Department, are good examples of this. Hitherto it has not been practicable to arrange a study for a whole year of morbidity in a hundred general practices scattered over England and Wales; all previous studies have been limited to a handful of doctors over a short period of time. This latest investigation has been on a scale so much greater than anything ever attempted previously, anywhere in the world, that it may well prove to be a landmark in the history of collective investigations and an example for other countries to follow.

The College Records Unit, mentioned already, will seek to carry on the work of this National Morbidity Survey, attempting a continuing study of the morbidity met by family doctors; and it is hoped that this will reveal changes in the patterns of disease in the community as soon as they occur.

Joint investigations by small groups of practitioners interested in a particular subject, working perhaps even in different continents, open up vistas of research on unusual matters never before attempted. A report from one study group on acute chest infections has already been published; others are still at work. Many faculty-sponsored investigations are also under way. By means of the Register of Research Interests, compiled by our College, its members and others can now be put in touch with general practitioners who are prepared to help in the study of particular problems.

Investigations by single individuals, too, have been encouraged. The Benger Award of annual prizes worth £500, for original observations by general practitioners, may lead to some fascinating and unexpected discoveries.

There are proposals for developing, through the College, a central organisation to help with the planning and analysis of individual and collective research in general practice, especially in epidemiological problems. There is also a need to increase the number of 'research practices' (some of them subsidized perhaps by the Clinical Research Board) in which the doctor is given a grant to enable him to employ trained assistance to carry out observational research into epidemiology, therapeutics or other subjects according to his bent or capacity.

Conclusion

We are living in exciting times for the medical profession, academically and politically. Everyone in our country now has a family doctor and can receive attention without financial embarrassment. There are, it is true, certain disquieting signs—excessive resort

to hospitals and to specialists, the partial avoidance of responsibility by some general practitioners and their subsequent loss of efficiency, the incursions of clinics, the deadening effect of a uniform and universal capitation fee, and now money-squabbles with the State—all of which threaten the future welfare of medicine in Great Britain.

We must see to it that these setbacks are only temporary. Unless conditions become such as to stimulate initiative and enthusiasm, to open out the possibilities of advancement, and to create the maximum sense of responsibility, there is a danger that many general practitioners will soon find themselves doing mainly routine sorting work.

Fortunately there are signs of a new birth too, of which I have tried to tell something in this lecture. Modern science has equipped us as we have never been before; whether we reach our patients by car, on foot in the jungle, by breeches buoy between ships at sea, or by air as a flying doctor, we now have drugs for treating them in their own beds, or while they remain at work, that were undreamed of 30 years ago. We have many more helpers, both within the profession and outside it, co-operation with whom should bring lasting benefits to our patients in and near their homes; and several new types of group practice are being successfully tried out.

The academic renaissance of general practice that is taking place throughout the world, just now, is a very real thing; and among its most convincing manifestations has been the foundation, growth, and vitality of our new College and of its sisters overseas. They have all made tremendous progress in a short time; their future is bright, and in many other places there is enthusiasm to follow their example.

We inherit from our predecessors a better concept of the art of family doctoring than any other country in the world; and a great responsibility rests on us all—doctors, laymen, and politicians alike—to ensure that here and throughout the Commonwealth the present opportunity is seized to regain for general practice its rightful place as one of the finest branches of our profession and one of the most interesting and satisfactory in which to serve.

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