is the proportion of Health Service expenditure on family doctoring. As for academic progress, how many general practitioners proceed M.D.—a standard qualification in the specialties?

General practitioners now have more time off than ever before, yet almost a third achieve this through deputising services and many patients are finding it harder not easier to get appointments or to exercise any real choice of doctor.

Survey after survey has scrutinised and then criticised medical records, study after study of practitioners' referral letters has commented on their inadequacy, and report after report has highlighted, as does Miss Firth today, some of the gaps in knowledge which must affect the care that patients receive.

For this is the key. At the end of the day it doesn't matter how good the research may be, or even the teaching. Not even evaluated learning is enough. It is the application of learning that counts and the final criterion is the day-to-day care that patients receive in practices up and down the country.

There is great warmth in the ideas generated in the cosy corridors of the College, but sometimes it is cold outside. The chain of the reputation of general practice may be no stronger than its weakest links.

The future

The world does not owe general practice a living. The sole reason for continuing with a general-practitioner based system is that it can be seen to be the best way of meeting patients' needs.

The shape of general practice in the future will be very different from what it is today, yet doctors on training schemes now will practise in the twenty-first century. Are they being trained to tolerate and to adapt to continuing technical and organisational change?

The whole of the next 25 years cannot yet be envisaged, but changes in the next ten years can be considered now. Decisions may soon be taken, particularly in this new money-starved Health Service, which may affect medical care for generations.

Is this the decade when the destiny of general practice will be determined?

GENERAL MEDICAL SERVICES

THE report of the joint working party on *General Medical Services* was the first official appraisal of the quiet revolution, which has been taking place in general practice (Department of Health and Social Security, 1974). The origins of the revolution were rooted in the determination of general practitioners in the 1950s to raise the standards in general practice.

The Royal College of General Practitioners gave direction and impetus to this determination. General practitioners began to examine in a disciplined way, their methods of working. It was obvious that changes had to be made, but the dilemma was how to alter practice organisation without infringing the principles of continuity of care and ease of access by the patient to a personal doctor. There also had to be a different system of financing. This was achieved by the negotiation of the Charter. The public were slow to react to what were radical changes in the provision of medical care. In the last few years there have been rumblings in the press and in Parliament about deputising services. Pressure began to mount for an assessment of the impact of the changes on the patient and so the working party was constituted.

The subjects chosen for study were appointment systems, deputising arrangements,

and diagnostic support. These were obvious and sensible choices because these were the greatest changes that had taken place and where the greatest threat to the traditional doctor-patient relationship existed.

Appointment systems are systems of queuing. For doctors they provide a more orderly way of working. Without them the important function of following up chronic disease would be difficult. They also provide the advantage of time saving for the patient. Their danger is that they can be restrictive.

They have also increased the responsibility of a key member of the primary care system—the receptionist. She has important responsibilities and powers and can either act as a helper or a barrier. The working party has recognised this and has laid stress on the need for training and education of the receptionist. The receptionist, however, only reflects the practice philosophy of her employers—the general practitioners. It is incumbent on them to see she is imbued with the need to combine flexibility and humanity in dealing with the patient.

The thorny problem of reconciling the non-urgent demand of the patient with his real need in fixing an appointment was tackled by the working party, but not resolved. It produced the statement that non-urgent need does not confer a right for the patient to see a doctor at inconvenient times. This is only part of the problem. Courtenay (1974) in *The Lancet* discussed some of the difficulties. He points out that the demand for medical care is dependent not only on the severity of the pathology of the illness, but also on the patient's tolerance to it, which is influenced also by social factors. There seems no clear solution, but it does emphasise the need for flexibility in the running of an appointment system, and the need for constant review, so that undue delays for the patient are not taking place.

There is, however, a responsibility on the patient also to make the best use of the service. This opens the enormous field of education of the public, on how to use the Health Service to the best advantage. The Health Service is a partnership between the patient and the caring professions. It requires mutual understanding and tolerance from both.

The greatest public disquiet was concerned with the deputising services. The public was quick to discern that they constituted the greatest threat to the concept of personal continuing care. Shortcomings were quickly seized upon. However, their rapid growth suggests that they are finding acceptance from the patient and doctor alike. Williams *et al.* (1973, a and b) showed that deputising services can provide an efficient method of providing emergency care. Shortcomings in some of the services appear due to poor organisation, in particular under-manning. Deputising services are, however, only a substitute for the personal doctor. They have arisen because of the difficulties experienced in the conurbations of providing cover by general practitioners who may live away from the areas concerned. There is no doubt that a partner or a member of a small rota group provides the most desirable cover for off-duty time. The extension of a small rota group into a large one led in many instances to under-manning and so favoured the development of a properly organised deputising service.

The danger from deputising services lies in their success. There are pressures to extend them into the provision of a 24-hour service on the lines of the organisation operating in Copenhagen. Such a development might well destroy the concept of the personal family doctor in this country. There can be no place for conflict between commercial and patients' interests in the provision of primary care. The control of deputising services should be firmly in the hands of the profession.

The section dealing with diagnostic support for general practice is, perhaps of most immediate personal concern for the general practitioner. The reorganisation of the

Health Service will dispel the last lingering attitude of some hospitals that their diagnostic services are for the hospital doctor and that the general practitioner is allowed restricted access on sufferance. It is both economically sound and convenient for the patient to be investigated as far as possible without referral to an outpatient department. The hospital service can only exist, especially in present day circumstances, if the threshold of general practice is high. This threshold is directly dependent on free access to the diagnostic services.

The provision of electrocardiographic services appears to be the most difficult to arrange. There is a difference of opinion among cardiologists about the feasibility of providing this service. Those cardiologists, such as Peniket and MacQuaide (1973) who actually provide a service, find it a success. The problem of practice-based electrocardiography is in the interpretation of the tracings. This can usually be overcome by a member of the group receiving continuing training or alternatively, for the hospital to provide a reading service. The capital outlay is a barrier to a practice owning its own machine.

Could area health authorities offer a service whereby ECG machines could be bought at a wholesale price by a practice? This would include servicing facilities at the local hospital, so reducing the time a machine is away from the practice.

The extension of collecting services for pathological specimens to those deprived parts of the country, where it is not already provided, is an overdue reform.

There is no room for complacency in the report. By the nature of things it was written like all official reports in the language of moderation. It gives qualified approval to appointment systems and deputising services. The maintenance and improvement of standards of care, rests in the hands of the profession. This requires a continuing programme of research into practice organisation and clinical audit.

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