Evidence to the Royal Commission on the NHS

FROM THE ROYAL COLLEGE OF GENERAL PRACTITIONERS

Summary

1. It is the right of everyone in the UK to have access to personal and continuing primary health care of a high standard (para. 4.1).

2. The primary health care service should be built on general practice (paras 2.3 to 2.10, 4.1 to 4.3).

3. The nature of the most important health problems today means inevitably that the main burden of care will fall on the primary health service (paras 3.2 to 3.7).

4. It follows that the NHS must be reorientated around primary health care; the functions and size of the hospital service will then depend on the responsibilities of the primary health care sector (para. 4.2).

5. It also follows that primary health care must attract a higher priority in the allocation of resources (paras 4.4, 5.2 to 5.8).

6. Setting standards of performance is a high priority for all the health professions and the NHS itself (paras 3.6, 3.7).

7. In medicine, professional standards will not improve unless medical education is radically reshaped by the implementation of the recommendations of the Committee of Enquiry into the Regulation of the Medical Profession (para. 5.4).

8. Inadequate care by some general practitioners today is acknowledged (paras 2.12, 2.13); the main causes are examined (para. 2.15) and remedies are suggested (paras 4.4, 5.4 to 5.6).

9. The special problems of primary care in parts of conurbations are described (paras 2.14 to 2.17); a proposal to deal with this exceptional situation is made (para. 5.7).

10. Primary health care should be provided normally by functionally integrated teams of general practitioners, nurses, health visitors and, where appropriate, social workers, supported by receptionists and secretarial staff (paras 2.4, 2.10).

11. Within the primary health care team ultimate responsibility must rest with general practitioners (para. 4.1).

12. To provide good primary health care we need:
i) Appropriate manpower (para. 5.2).
ii) Adequate premises (para. 5.3).
iii) Effective education (paras 5.4, 5.5).
iv) A modern record/information system (para. 5.6).

13. General practitioners should remain independent contractors so that patients have an independent medical adviser in a State dominated health service (para. 4.7).

14. The administration of the NHS should work on the principle that bureaucratic interventions between patients and the health professions should be kept to an absolute minimum (para. 4.4).

1. Introduction

> "The essential unit of medical practice is the occasion when in the intimacy of the consulting room or sick room, a person who is ill, or believes himself to be ill, seeks the advice of a doctor whom he trusts. This is a consultation, and all else in the practice of medicine derives from it."
>
> Sir James Spence

1. The Royal College of General Practitioners believes it is the right of every man, woman, and child in the UK to have access to primary health care of a high standard provided through general practice.

We acknowledge that the service given by some general practitioners today does not achieve the standards which are possible and desirable. Nevertheless, general practice is a well established part of national life in the UK. It is economical; it has vitality, and is showing itself to be flexible and able to adapt to changes in society, to patterns of illness, and to medical technology; it is accepted and valued by most of the population (Cartwright, 1967; Consumers' Association, 1974; Kincey *et al.*, 1975); and by reason of its unique system of patient registration it has enormous potential for providing accessible, cost effective care, and preventive medicine.

*Austria, Belgium, Denmark, France, German Federal Republic, German Democratic Republic, Hungary, Netherlands, Norway, and Yugoslavia.

2. General practice today

2.1 Britain is unusual and fortunate in continuing to have general practice as its main provider of primary medical care. Countries in which general practice has declined are now beginning to recognize the difficulty of coping with contemporary health care problems by specialists alone. This is why there is such interest in reviving general practice in North America and parts of Europe.

In contrast with other countries we already have a more even distribution of general practitioners, district nurses, and health visitors, most of whom live in or near to the communities they serve.

2.2 Morale in general practice today is higher than in the 1950s, when it reached a low ebb. At that time many leaders of the profession dismissed it as unscientific, inefficient, incompetent, and uncontrollable, and thus a poor way to provide primary medical care when the benefits of care by specialists alone seemed evident to them. However, in 1950, penetrating yet constructive criticism from Joseph Collings stimulated some general practitioners to reconsider the nature and quality of their service to patients. As a result important changes occurred which we summarize.

Our assets listed

2.3 A personal medical service

General practice should provide patients with a service which is personal, continuing, accessible, available, and effective because:

a) General practitioners meet unsorted clinical problems; part of their job is to identify potentially serious conditions at an early stage and distinguish these from the harmless and self-limiting ones.

b) Continuity affords general practitioners the opportunity to watch the unfolding natural history of illness; this is an advantage in diagnosis and management less often enjoyed by hospital doctors dealing with outpatients.

c) Since they work for a relatively small and static population general practitioners can get to know their patients well; they use their knowledge of people as individuals to modify the way they gather information and to formulate ideas about the nature of their patients' problems.

d) Through their unusual knowledge of many families, often through several generations, general practitioners are able to recognize features in the behaviour of individual members which can cause illness, or alter its presentation, course, and management.

e) A relaxed, continuing relationship between doctor and patient is not only rewarding to both but gives confidence to many people, especially young families and the elderly. Confidence and continuity are essential when doctors need to influence their patients' behaviour and way of life, and so try to prevent or minimize the effects of certain diseases.

f) General practitioners inevitably meet more than one problem, frequently involving more than one person or more than one specialty, in a single consultation. For patients, having one doctor to handle all these problems is more efficient and more convenient.

g) Patients being cared for at home with chronic or terminal illness need their own doctor to sustain, help, and comfort them and their relatives.

h) People with unrecognized disease may be more effectively identified by their general practitioner than through occasional community screening programmes.

2.4 A team service

The attachment and employment of district and practice nurses, health visitors, receptionists, and secretaries in general practice, and the development of closer links with social workers, should greatly extend the range and quality of services available to patients outside hospitals. The general-practice team is relatively new; its potential as well as its limitations have yet to be fully realized, but we have substantial evidence (Reedy, 1977) that these are now better understood.

2.5 A willingness to change

General practitioners, whether in single-handed or group practice, have revealed a capacity to adapt and innovate. For example:

a) In the past 20 years group and partnership practice has become usual rather then exceptional; more than anything else it has facilitated the organization of work and administration through a team approach.

b) The need for purpose-built and suitably adapted premises has been recognized, and patchy rebuilding has started.

c) Some general practitioners are using better equipment in their own surgeries.

d) Some aspects of our work have diminished with changes in clinical practice: for instance, fewer babies are now born at home and fewer practitioners are involved in intranatal care. Other functions have expanded: for example, immunization is now carried out systematically; 2·35 million women in England and Wales are registered with 20,600 general practitioners for contraceptive advice; most cervical smears are now taken by family doctors; and most episodes of psychiatric illness are diagnosed and managed entirely in general practice.

e) General practitioners have secured access to hospital diagnostic laboratory services in order to improve their efficiency as clinicians.

f) Appointment systems pioneered by a few have now become commonplace; when they work well they are a boon to patients and doctors because they give time for unharrassed consultations.

g) General practitioners have recognized that their education has been largely inappropriate for their work. The College, collaborating with the BMA, the NHS, and the universities, has been leading the introduction of reform. In particular:

i) Vocational training for general practice has been introduced and is shortly to become a statutory requirement for practise as a principal.

ii) A standard is being set through our examination for membership of the College; the attainment of this standard of competence is becoming accepted as a criterion of good general practice.

iii) More general practitioners take part in continuing education; experiments in the use of small group methods of learning and in the value of peer group review are pointing the way to a new approach which should help guarantee the quality of the ongoing performance of doctors.

iv) More medical students see the work of general practice; and the departments of general practice established within the last decade are defining the contribution of general practice to basic medical education.

2.6 These extensive changes had modest beginnings. The new ideas of the 1950s and 1960s about the structure and organization of general practice came from doctors who wanted to improve patient care; innovators then and now invariably work at their own expense. Ideas recognized as useful became even more widely adopted, leading eventually to pressure on government to provide new funds. The Charter of 1966 is a good example of a formal agreement by government to finance improvements most of which had been pioneered by a few doctors from their own resources. The pattern continues. Vocational training, for example, is the result of the efforts of a tiny minority; ten years ago these enthusiasts began to prove their ideas and they were supported by their own practices and families. Today vocational training has been accepted by the whole profession and is an NHS responsibility.

2.7 We have described ideas which were widely adopted. Many more have been tried; some have been taken up by enthusiasts, and others have been abandoned Modified record systems, age/sex registers, and diagnostic indexes are examples of tools which have acquired a selective but important use, first by researchers but more recently by trainers and others who see their potential in teaching, screening, and health education. Contemporary ideas being tried include programmes of health education; the screening of at-risk groups; ways of improving prescribing; experiments with patient participation in the management of practices; and a growing interest in medical audit. Some of these ideas will justify general acceptance and therefore need financial support.

2.8 Economy

Nothing we will say later about the financial implications for the improvement of general practice alters the fact that it is a relatively economical way of providing primary health care because:

a) It relies mainly for its effectiveness on the knowledge and skill of the doctors and nurses themselves.

b) It uses relatively inexpensive buildings.

c) It provides a domiciliary service for both the acute and chronic sick which helps to keep patients out of hospital. When specialists and practitioners have worked closely together home visiting by general practitioners and nurses has facilitated earlier discharge, reduced the number of admissions, and impressively reduced outpatient follow-up.

d) The list of patients registered with a general practitioner, which is a unique feature of NHS general practice, offers patients an obvious way into the Health Service when they need it. It ensures reasonable continuity, provides the basis for a practice information system, and is central to epidemiological research in the practice setting.

e) The referral system has enabled general practitioners and specialists to concentrate on their respective jobs. It helps to protect patients from unnecessary investigation and treatment, and dissuades a minority of patients from wastefully canvassing a variety of doctors about any given complaint.

2.9 Hospital care

Community and cottage hospitals enable patients who do not need intensive investigation or specialized treatment, but who cannot be nursed at home, to be near their relatives and friends. In these hospitals general practitioners, working in co-operation with local specialists, look after their own patients and provide a continuity of care which is satisfactory to both.

Some general practitioners care for their patients in general-practice wards of district general hospitals and attend their own obstetric cases in specialist units.

Papers by the DHSS (1974),the Royal College of General Practitioners and the Royal College of Physicians (1972), and the Scottish Home and Health Department (1973) have shown how these developments can reduce the unnecessary use of specialized hospital resources. Practical experience in, for example, the Oxford region and at Basingstoke supports this view (Loudon, 1977).

2.10 The functions of general practice summarized

On the initiative of the Royal College of General Practitioners (1972) several national academic bodies in Europe have produced the following definition of the work of general practitioners. The definition commands general acceptance in the UK and in many European countries (see footnote, page 197).

> "The general practitioner is a licensed medical graduate who gives personal, primary, and continuing care to individuals, families, and a practice population, irrespective of age, sex, and illness. It is the synthesis

of these functions which is unique. He will attend his patients in his consulting room and in their homes, and sometimes in a clinic or a hospital. His aim is to make early diagnoses. He will include and integrate physical, psychological, and social factors in his considerations about health and illness. This will be expressed in the care of his patients. He will make an initial decision about every problem which is presented to him as a doctor. He will undertake the continuing management of his patients with chronic, recurrent, or terminal illnesses. Prolonged contact means that he can use repeated opportunities to gather information at a pace appropriate to each patient and build up a relationship of trust which he can use professionally. He will practise in co-operation with other colleagues, medical and non-medical. He will know how and when to intervene through treatment, prevention, and education to promote the health of his patients and their families. He will recognize that he also has a professional responsibility to the community."

Our main liability: poor care

2.11 Our picture of the assets of good general practice must be balanced by the frank recognition that care by some doctors is mediocre, and by a minority is of an unacceptably low standard. We have listed what we believe are the main faults, and have looked for underlying causes. We accept that correction of these faults is a professional responsibility.

2.12 Incompetence

a) This leads to wrong diagnoses and bad management and is a particular hazard in prescribing, the commonest single therapeutic activity in general practice. The results of our own examination for membership of the College show that some general practitioners who fail have a level of knowledge and skill which we regard as unsafe.

b) Failure to communicate

The relationship between patient and doctor in general practice is crucial. Evidence from medical service committee hearings (Klein, 1973) suggests that many problems begin when practitioners apparently fail to ensure that patients and their relatives understand adequately the situation and the plans for future action.

c) Neglect

Some doctors who have the required knowledge and skill fail to use it.

d) Bad records

General practitioners who are the subject of formal complaint are invariably found to have poor records (Medical Defence Union). It has been suggested (Cormack, 1971; Dawes, 1972) that the general standard of record-keeping could be improved by regularly recording the quantity and dose of drugs prescribed, entering details of home visits (which are often made to the most sick people), and unscrambling the muddle of the record folder contents so that important information can be identified quickly.

e) Badly run appointment systems

Some appointment systems do not work for reasons which are well known (RCGP, 1975). These bad systems not only obstruct and inconvenience patients but also bring appointment systems in general into disrepute.

f) Poor deputizing arrangements

The difficulty of finding some general practitioners 'out of hours', and the standard of care given by some deputizing arrangements, is another common public complaint. General practitioners are divided about the nature of their out-of-hours' commitment. Some practices insist that reasonable continuity of care can be preserved only when partners deputize for each other or with neighbouring practitioners with whom communications and relationships are good. Others, especially in cities, hold that since emergency care at night and at weekends is such a small part of their total workload they should be relieved of it.

The College agrees with the Godber Committee (1974) that, whatever the arrangements, it is the responsibility of the profession to provide deputies who are competent and an organization in which communications ensure continuity.

g) Carelessness

Some doctors slip into work habits which can lead to quite unnecessary mistakes.

2.13 Some causes identified

a) Poor or inappropriate education

The medical schools and their teaching hospitals, our 'centres of excellence', must share responsibility for the shortcomings of many general practitioners today. Until recently, basic medical education was claimed to produce the safe general practitioner, and medical students, taught entirely in hospital in their clinical years, were encouraged to believe that general practice was a second-rate occupation in which standards were unimportant. University postgraduate organizations have furnished a token postgraduate education programme normally unrelated to the clinical needs of general practice. Thus the universities have created the conditions for a self-fulfilling prophesy. The surprising thing is not that there are some bad general practitioners, but that there are so many good ones; the latter are self-taught men and women who have survived to become good doctors despite the influence of some of their teachers.

Happily a few university hospitals, notably outside London, are beginning to accept that they have a wider responsibility to doctors working in their neighbourhood communities.

b) Isolation

This is a special hazard of general practice primarily due to the privacy of the consultation. It is very easy to

become uncritical and careless in attitudes to work because of professional isolation, even within groups. Doctors so isolated tend to get worse rather than better, since they become defensive and unwilling to expose their work to the scrutiny of their colleagues.

The College has pioneered the special measures required in general practice to overcome this difficulty by devising group activities which follow the precedent of the hospital ward round and case conference.

c) Motivation

Attitudes to work in general practice largely determine the quality of care. General practice has attracted many highly motivated people but it has also acquired a group of doctors for whom it has been a second or third career choice.

It has also attracted more than its fair share of those doctors who are simply less able because it has failed so far to agree on the need for generally applied postgraduate standards.

d) Responsibilities ill-defined

Terms and conditions of service today, although legally required, cannot determine standards of patient care. Defining responsibilities and setting standards is a professional task which we have now begun. Until it is nearer completion and the results have gained general acceptance, there will be difficulties in defining more precisely levels of competence required.

e) Incompatible personalities

Every general practitioner will fall out with some of his patients at some time. The fault may lie on either side or with both parties. It is a fact of life and should be accepted as such because these occasions are fortunately uncommon; unfortunately they seem to attract the media.

f) The sick doctor

Doctors may become ill, or become alcoholics, or drug addicts. Recognizing the potentially dangerous sick doctor is particularly difficult in general practice. In our view the existing arrangements for identifying them are inadequate and the way of dealing with them subsequently is punitive rather than helpful.

2.14 Central parts of conurbations: an unsolved problem

Our description of contemporary general practice would not be complete without special mention of the difficulty of providing good primary health care in the central parts of some of our largest cities. The section which follows is based on the views of our members who live in London, and is supported by two good studies (Sidel *et al.*, 1972; Hardie, 1976); the comments could apply equally well to Glasgow and similar cities.

Our suggestions for action come later (paras 5.3 and 5.7).

2.15 Special characteristics and needs of patients

a) In some parts of London the population contains a high proportion of patients who are transient, elderly, single, immigrants, tourists, homeless, rootless, or destitute. Most of these atypical groups share the following characteristics: an absence of support or nursing from a close family or a close neighbourhood; little chance of continuity in medical care; and a particular need for services which deal simultaneously with health and social problems.

b) In some areas there is exceptional poverty and particularly low standards of housing—neglected ghetto areas still persist.

c) The population of the city centre is declining but it is largely the social casualties and the disadvantaged who are left behind.

d) There is particular need for services for the chronic sick, the elderly, the mentally ill, the mentally handicapped, and the destitute. Existing services are geared to provide well only for acute illnesses.

e) There is a predominance of people in social classes 3, 4, and 5 in some areas. Social class 5 patients, in particular, have a higher death rate and a lower ability to use health services to their best advantage, compared with social class 1. Expectations of health and welfare services are high, yet it is not always those who are most in need who come for help.

2.16 Special characteristics and needs of those who provide primary health care

a) Although London has a large number of general practitioners, many restrict their general medical services because of other commitments. In some districts a high proportion are single-handed older doctors. Because their average age is high, many will retire or die in the near future, yet most young doctors do not wish to take up single-handed vacancies. A severe shortage of general practitioners is expected, for instance, by the City and East London Area Health Authorities.

b) Too few graduates trained in the UK are applying for practices in the London area.

c) It is always difficult to live 'above the shop', but some parts are particularly unattractive for doctors because of housing, schools, and neighbours. As a result, some doctors live far from their practices and this encourages the use of deputizing services.

d) The high cost of housing, transport, and staff salaries with London weighting contributes to the difficulty of creating primary care teams. Antiquated premises, lack of suitable sites for new premises, and the low priority given to funding these, compound the problem. There is a shortage of health visitors and district nurses.

e) The high turnover of disadvantaged patients needing combined medical and social work support tends to increase the workload.

f) The North-East Thames Region has the highest referral rate to outpatients in England (266 per thousand population compared with the lowest, 132, in South-West England). This is certainly uneconomic and possibly implies that practitioners in general are not doing all they could. Hospital policies in some cases may be to blame (see para. 2.17), but the region also has the highest number attending accident and emergency departments (210 per thousand compared with the lowest, 124 per thousand, in East Anglia), which is partly attributable to the large number of commuters entering the area during the daytime.

g) The transient nature of some of the population discourages personal medicine because of insufficient opportunities to follow patients and develop a personal relationship over a period of time. There can be an annual turnover on a doctor's list of as much as 30 per cent. This favours a casualty department style of practice.

2.17 Special characteristics of the hospitals

a) The proximity of large teaching hospitals is still a discouraging influence on primary care in the metropolitan regions. An overriding concern with secondary and tertiary care, an emphasis on high technology medicine, and the need to provide patients for conventional teaching has caused one teaching hospital to question the value of a high standard of general practice nearby, lest its casualty and outpatient departments (claimed to be the largest in Europe) have insufficient 'good cases'. This hospital is one of the last to hold out against establishing any sort of department of general practice.

It is not surprising that this lack of concern for comprehensive primary health care in the neighbourhood of most London teaching hospitals has had a destructive influence.

b) The relatively large number of general practitioners in the conurbation and the ever changing middle-grade staff in a teaching hospital combine to make personal contact between generalist and specialist transient or non-existent.

c) There is inadequate hospital provision for the old, the chronic sick, and the mentally ill. These hospital services are inadequately staffed. Most psychiatric beds are sited at a great distance.

3. Influences on health and health services

3.1 Before looking at general practice in the future, we note what we think will be the main influences on health, and their implications for our health services in the foreseeable future.

3.2 Demography

Although the accuracy of predictions about the size, age structure, and geographical distribution of populations is, on past form, not impressive, the implications of official predictions cannot be ignored.

The Office of Population Censuses and Surveys (OPCS, 1975) has recently offered four different estimates about the population of Great Britain in 2011, each based on differing assumptions about fertility and migration patterns. The total population of Great Britain may be as low as 53½ millions or as high as 62½ millions. The annual birth rate may be 615,000 or 986,000. There may be 7½ million fewer or 1 million more children under 15 than there were in 1974. People of 63 years and over will increase by ½ million, and the number of elderly over 75 years—a high dependency group—will double.

Local demographic changes will influence patterns of health and illness, and the need for health services. The OPCS has also forecast that many people will move. It suggests, for example, that there will be a large outflow from some conurbations: 20 per cent of the population of London, 15 per cent of Merseysiders, and 6·5 per cent of people in Tyne and Wear are expected to move out by 1991. At the same time, the population in East Anglia should increase by 25 per cent, the outer south-eastern part of England by 20 per cent, and other areas less spectacularly.

Although our knowledge of the effects of environment and social conditions is incomplete, there are abundant data to show that how and where people live affects mortality and morbidity. The OPCS predictions may be significant in this respect.

3.3 Patients at special risk

At the risk of over simplification we note four important groups of people who will make a heavy claim on resources:

a) Those who are handicapped by congenital defects or prenatal damage.

b) Those with the major degenerative diseases, such as coronary and cerebrovascular disease; degenerative diseases of the locomotor system; and malignant disease.

c) Those who have remained alive though handicapped as a result of trauma.

d) Those with persistently disabling psychological illnesses.

These illnesses share a common characteristic—they cannot be cured. However, some of the most important are potentially preventable because their causes are to a variable extent linked with personal behaviour and lifestyle, and are thus under the control of the individual rather than the community at large.

3.4 Changes in the technology of medicine

A prominent feature of post-war medicine has been the expanding use of technology in diagnosis and treatment. Certainly science and technology will continue to alter patterns of mortality and morbidity if, for example, more reliable ways of detecting congenital defects before birth can be devised, the range and scope of repair surgery can be extended, or if more effective anti-

viral agents are discovered. On the other hand, the known hazards of technology in medicine should be recognized and the effectiveness of expensive methods should be established more thoroughly if technology is not to distort priorities in the delivery of health care to the community as a whole.

3.5 Changes in our understanding of health

Society's perception of what is health and ill health, its understanding of what is medical and what is social, and its expectations of health professions is not static or uniform. Moreover, the boundary between what is clearly medical (for example, appendicitis) and clearly social (for example, unemployment) has become wide and ill-defined, and many conditions (for example, alcoholism, battered babies, delinquent behaviour) could fall legitimately into either or both categories.

3.6 Criteria of quality

The traditional measure of health care, life expectancy, is no longer adequate alone since it does not reflect the quality of life. In future, new indicators of the quality of health care will also have to take account of such variable and sometimes conflicting criteria as morbidity, the restoration of function, sickness absence, the economic effects of illness, patients' satisfaction with their doctors and nurses, the expectations of the health professions, the potential scope for prevention or early diagnosis in a given situation, and the realities of a finite national budget. Without the development of better criteria for measuring the effectiveness of medical care, health service management will remain haphazard, influenced sporadically by consumer, political, and professional pressures, with decisions being made largely on the basis of ancedote, conjecture, prejudice, or expedience.

3.7 Criteria of effectiveness cannot be developed without a record system which, while preserving confidentiality, permits the retrieval of relevant information. They will also be useless without a system of education which helps the health professions to understand their relevance, and to respond.

3.8 Prevention emphasized

A serious attempt should be made to reduce the incidence of those conditions (such as lung cancer) which are susceptible to primary prevention, and improve the control of those potentially disabling diseases (such as high blood pressure) whose effects can probably be alleviated by early diagnosis and treatment. This will involve measures which will extend well beyond the boundaries of medicine. Nevertheless, within medicine, it is the general practitioner with his continuing relationship with his patients who is well placed to act.

3.9 Capacity for change

A service which has to deal with such diverse problems, and problems which can change within given areas quite quickly, needs to have a structure and organization which is sensitive to changing needs and capable of a rapid, local response.

Primary health care tomorrow

4.1 Our general philosophy

Primary health care of a high standard should be available to all. Just as the surgeon cannot function effectively without a team, so we hold that primary health care should be provided normally by functionally integrated teams of general practitioners, district nurses, health visitors and, when appropriate, social workers, supported by clerical and administrative staff. Within this team clinical responsibility must rest ultimately with the general practitioner.

4.2 The nature of the most important health problems (para. 3.3) today means inevitably that the main burden of care will fall on the primary health service, because only this part of the health service provides a local service which is also readily available in people's homes. We hope the Royal Commission will accept the far reaching implications of this fundamental point. It means an NHS which will be reorientated on primary health care; this in turn means that the functions and size of the hospital service will then depend on the responsibilities given to the primary health care sector and the effectiveness with which these responsibilities are carried out.

4.3 We believe that the responsibilities of primary health care should become extensive and comprehensive, and will become so especially if general practitioners and nurses develop special interests. For this reason we shall examine the proposals of the Court Committee (1976) with close interest.

Some general practitioners have already anticipated this trend, and moreover the pattern of vocational training in our most advanced schemes is moving in this direction. We believe that a similar approach is needed for the care of the elderly, the mentally ill, and in preventive medicine, if these relatively neglected areas are to be improved.

General practice would be strengthened by better links with those specialties such as paediatrics, psychiatry, and general medicine with which it has most in common. There is much to be said for more experiments with specialist consulting sessions in health centres and privately owned practice premises.

4.4 Conditions for success

If primary health care is to give the service we think the public has a right to expect, five conditions must be met:

a) All the health professions concerned will have to order their affairs so that mimimum standards of performance can be guaranteed, and standards of excellence can be fostered. For general practitioners, the College believes this means providing thorough postgraduate training and education; setting realistic stan-

dards for doctors wanting to work in this field; identifying to patients and contracting authorities those doctors who have achieved the required standards of entry through an indicative specialist register; and accepting medical audit controlled by the whole profession as a necessary part of continuing education for maintaining the clinical standards of established doctors. These are essentially professional matters, but the public has a direct interest which we think it should exercise through a reconstituted General Medical Council.

b) The Government and the administration of the NHS must be prepared to give primary health care a higher priority in the distribution of resources. In effect this means a substantial shift from hospital to community. We have said that the general-practice team approach is economical; we want to make it abundantly clear that economy is relative and is not to be equated with the provision of a cheap but substandard service. To do the job properly, primary health care will need to be adequately staffed, equipped, and financed.

c) The administration of the NHS should work on the principle that bureaucratic interventions between patients and the health professions should be kept to an absolute minimum. One reason why morale in general practice today is higher than in hospital is that general practice, because of its relative independence, has not become enmeshed in the reorganized structure.

d) If standards of care are to advance, career prospects in the primary health care professions should reward work with patients as highly as administrative, teaching, and other related activities. We have noted with dismay that the career structures introduced in nursing, health visiting, and the social services have inevitably taken too many of the most dynamic and able practitioners in these professions away from patient care because administration has become the only pathway for promotion. Primary health care also needs incentives to ensure that those with the qualities of leadership will teach and research always from the solid base of their own professional practice with patients or clients. For it is largely through the efforts and by the example of such individuals that working standards will be set, attitudes formed, and a high morale secured throughout the service as a whole.

e) The individual must accept his or her own responsibility for maintaining good health. Moreover, the public must be helped to see that much self-limiting disease needs less treatment than it may think, and that minor ailments can often be self-treated with minor remedies.

4.5 Responsibility

The right of general practitioners to diagnose and manage their individual patients must be preserved. The College will resist any attempts to interfere through restrictive legislation with the clinical and therapeutic freedom essential to the satisfactory relationship between doctor and patient.

We recognize that decisions made about individuals will be constrained by more general judgements taken at different levels about priorities in medicine. We believe that as doctors we should be involved like other citizens in determining priorities in the NHS. We expect to contribute as informed people and with additional authority when technical or professional advice is sought.

4.6 Choice of doctor and patient

The right of choice for patients and doctors must be preserved. The main responsibility for maintaining the integrity of the doctor/patient relationship rests with the doctor as a professional. However, there are inevitably times when this relationship goes wrong, and both parties should have the right to end it.

4.7 Independent contractor status

The majority, though not all, of our members are anxious to see the independent contractor status of the general practitioner retained. We believe that the preservation of this status is not only consistent with the responsibilities of the primary health care service we envisage in the future, but essential if patients are to have an independent medical advocate and adviser in a State dominated health service. Furthermore, in seeking the flexibility required for a quick reaction to changing local needs, we appreciate the value of freedom from the bureaucratic constraints which have so depressed morale in hospitals.

Money and manpower

5.1 In these paragraphs we summarize the main areas of expenditure and point to additonal resources we think will be needed.

5.2 Manpower

Manpower is by far the most expensive part of our service, it is also the most difficult to comment on. In addition to the variations in workload (Howie, 1977; Fry, 1977; RCGP and OPCS, 1974), and the unsettled question of the division of work between the health professions involved in primary health care, there is also uncertainty that at present we cannot quite see how far our responsibilities may be extended in future. We suggest that manpower requirements cannot be determined on a once and for all basis, but will require ongoing review. However, the following are general points we hope the Commission will take into account:

a) Throughout our evidence we have included primary medical care as part of primary health care. We believe that if given the choice people who are ill will wish initially to consult a doctor. We hold that all people should continue to have this right.

b) Within the next decade the division of work within primary health care, and between primary health care and the specialist hospital and social services, should

become much clearer. We suggest the guiding principle should be the avoidance of a wasteful overlap of work.

c) Trainee general practitioners, at present regarded as supernumerary to establishment in general practice, should now be included in the manpower figures since they make some contribution to the service. However, the needs of the service must not smother the needs of education in what is a training grade. We have no wish to see the trainee period in general practice abused in a way typical of many junior hospital training posts today.

d) Staffing levels for established principals should allow for continuing education. If continuing education is to be taken seriously, we should not continue to rely on doctors doing this largely in their leisure time.

e) Many more women graduates will enter general practice from now on. Their family responsibilities and the time these take will also have to be reflected in the assessment of manpower.

5.3 Premises

Purpose built or suitably adapted premises are fundamental to better general practice. Without adequate space under one roof the concept of teamwork cannot flourish. Both the health centre building programme and more realistic support for the development of premises owned by doctors themselves must be strengthened.

We single out the special problem areas we have already mentioned as in need of urgent attention. In these areas premises for primary health care have often attracted an unusually low priority because of the capital requirements of teaching hospitals, which are usually in the same vicinity (para. 5.7).

5.4 Better education

The College believes that medical education needs radical re-shaping to place much greater emphasis on continuing education and medical audit (Royal College of General Practitioners, 1974 and 1975). This is necessary to maintain a doctor's competence over the remaining 35 years of his career life and to provide a framework for learning within which he can constantly reassess his attitudes to the needs of patients, and the quality and effectiveness of his service to them. It is necessary also because we think the undergraduate period is too long and therefore too expensive.

The Merrison Committee (1975) made sensible and far-sighted recommendations which, if implemented, would provide the foundations for reform. The College has endorsed these proposals wholeheartedly. We think that the means to implement them should be found; the opposition to reform from some sections of our own profession should not be a deterrent.

5.5 Because we think the educational system we are steadily building up in general practice is the key to the elimination of poor standards of care, we shall require the following resources to sustain our professional effort:

a) Adequate funds to ensure that vocational training for general practice is a success. Training budgets should be separated from funds for continuing education.

b) Continuing education which is funded to service medical audit and the need of general practice for the small group methods which help reduce the effects of professional isolation. The existing level of funding, and the use to which these funds are put by the postgraduate organizations, is depressingly unrelated to contemporary needs. Regional postgraduate organizations are spending about £10 per general practitioner annually on continuing education (Irvine, 1977). The Health Departments pay in addition the travelling and subsistence costs of doctors attending courses.

c) The funding of university departments of general practice is unsatisfactory. Neither the NHS nor the University Grants Committee have accepted their responsibilities for this new discipline which represents the largest branch of medicine. We believe that departments of general practice should now be resourced to the same extent as the other major clinical disciplines.

d) Training posts in general practice must be created and funded so that doctors entering other specialties can acquire experience in primary health care as part of their training. If communications within the profession are to improve and lead to better understanding and better use of resources, common experience gained through common training will be important.

e) By the same token, educational funding should be flexible enough to enable all the health and social service professions in primary care to learn together at appropriate stages so that mutual roles and responsibilities become better defined and accepted.

5.6 Records

We have two compatible objectives: first to provide an efficient record for everyday use, and secondly to provide a system whereby simple information relating to a doctor's practice can be collated and compared with information from other practices, without loss of patient confidentiality. These data are essential to medical audit.

To meet both objectives we urgently need better records. The present folders, designed and introduced in 1920, are out of date. Simply to change the form of the printed record could be a temporary yet extremely expensive palliative, and thus we think the implications of a computer-based system should be examined carefully. Much of the development work has already been done.

5.7 Central parts of conurbations

We have described areas in which primary health care presents special problems. Nevertheless, we maintain that primary health care based on group general practice such as we have described offers the best solution,

and to this end we welcome the initiative of the DHSS in inviting the General Medical Services Committee and the College to examine a DHSS analysis (1977) of the situation in London.

To make progress we believe that it will be necessary to cut through the many conflicting professional and administrative barriers which exist. We suggest that the establishment of old conurbations commissions, similar to new town commissions, should be carried out specifically to deal with primary health care.

5.8 Research

Research in general practice has to date been mainly at a descriptive level, originating from the work of individual practitioners. Major studies have been few in number.

We suggest that it is now timely to invest in studies which will help more effectively to evaluate the work of primary health care and will contribute more positively to an understanding of those diseases and illnesses which can best be studied in this setting.

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Appendix

The Royal College of General Practitioners was founded in 1952 by general practitioners who recognized the need to improve the quality of the care of patients in general practice.

The object of the College is "To encourage, foster, and maintain the highest possible standards in general medical practice and for that purpose to take or join with others in taking any steps consistent with the charitable nature of that object which may assist towards the same."

There are 7,801 fellows, members, and associates, 6,944 of whom are in the UK.

Children of low birthweight in the 1946 national cohort: behaviour and educational achievement in adolescence

Among 12,468 legitimate single births in the first week of March 1946, 163 weighed 2,000g or less (LBW group) and, of these, 80 survived to 18 years. Six of the LBW survivors emigrated with their families and five have not been traced since birth. The remaining 69 were followed up to the age of 15 at which time two early school leavers were lost to the study. There is evidence that none of the survivors who emigrated or left the sample had serious physical or mental impairment.

Compared with individually matched controls, the LBW children showed similar proportions with severe physical, mental, or behavioural handicaps. There are small and statistically non-significant differences in favour of the controls in ability and attainment scores at 15 years and in the level of academic qualifications gained by the age of 18. If the mean ability and attainment scores are expressed as an 'intelligence quotient' with a mean of 100 and a standard deviation of 15, the LBW group has an average IQ of 93 and the controls, 97.

Hospital stay after childbirth was much longer in 1946 than today and many LBW children spent more than three weeks in hospital. These long stays are not associated with adolescent problems of behaviour or learning.

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