WHAT KIND OF COLLEGE?

The future of the College

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SUMMARY. The College should now plan its future policies according to the following six principles: (1) Preventive and therapeutic services must be integrated. (2) Such action falls naturally to neighbourhood doctors. (3) A positive practical approach to health should replace the traditional disease dominated emphasis in medical training. (4) There are important manpower implications for general practice, both for doctors and their staff. (5) The need to alter the life-style of patients means that practical preventive medicine increasingly means achieving change in human behaviour. (6) The Royal College of General Practitioners should increasingly emerge as the voice of progress by publicizing successful developments in general practices and by campaigning for public support for these principles.

Introduction

THE achievement of our College in defining positively the role of the neighbourhood doctor is immense. We are now rightly concerned with what we should do with the skills we have defined. I believe that for the foreseeable future our main aim should become the creation of a new ideology of medicine centred on the preventive and anticipatory care of local defined populations. The elements of this ideology may be expressed as follows:

1. Unification of preventive and acute medical care

The unification of preventive, caring, and acute work is central to the advance of medicine as a whole. There is a long-term trend for symptomatic disease to be diagnosed and treated earlier; for presymptomatic stages of disease to become recognizable and preventable; and for high risk groups to become identifiable so that they may be helped in specific terms to avoid serious outcomes.

The advanced disease and social breakdown seen and taught in hospitals and other institutions is a bad model for anticipatory care. It demands a body of knowledge and attitudes concerned more with conservation of health than with a crisis response to end-stage disease. Separation of preventive, caring, and acute response functions has isolated the knowledge of causes from the knowledge of effects, and has divided our responsibility to the patient into ineffective compartments. Unless we unite these three functions at neighbourhood level, not rhetorically but in a reality that shows itself in a redistribution of resources, the advances made possible by medical science will not be realized in practice.

2. Neighbourhood doctors

Responsibility for this task falls on neighbourhood doctors, because they are uniquely able to bring about change in the *content* of all medical work. Their actions initiate pressures from below on the entire superstructure of hospitals and other specialized agencies. The dismantling of the old public health services leaves the responsibility for prevention to general practitioners. If we welcome and support this opportunity, we can release the initiative of doctors more centrally in the service, but if we are hostile or indifferent to it, we shall condemn everyone else to inactivity.

3. Importance of prevention

The present medical ideology gives universal priority to crisis and salvage medicine, whether or not it is effective. It has roots in the beginnings of modern medicine in the nineteenth century, and in the nature of medical trade at that time. The real content of care was then largely illusory—illusion maintained by faith and occasional spectacle. The excitement of prevention is not being taught in our medical schools, because it depends on a love of people and their health and hatred of their disease. It places the highest value on social motivation and skills, rather than personal ambition and technical skill (necessary, but secondary). Our

© *Journal of the Royal College of General Practitioners,* 1978, **28**, 501-502.

medical schools still teach students to be bored with health and fascinated by disease, to play contrived games rather than solve real problems. This pervasive ideology is the most serious obstacle to unification, and the College should accept responsibility for developing an alternative.

4. Manpower implications

Conservation of health in the community defined by the general practitioner's list imposes new tasks and more work on staff already overstretched by the responsibilities of symptom and crisis response. This will remain broadly true whatever may be achieved by delegation and teamwork. Preventive work at an individual or local community level is labour-intensive and impossible in hurried conditions. In competition with symptom and crisis response, anticipatory care must always be the loser. Its sturdy development requires the highest skills and prestige available, particularly at this early stage when the old ideology remains dominant, among patients and nurses as much as among doctors.

College members are innovators, and when they take on this task, a large part both of local planning and of the work itself must be done by them and cannot be delegated. This has major implications for medical manpower and average list size, which will have to be accepted by any government that recognizes prevention as centrally important, rather than a low cost alternative, to the NHS. There is a national need for an expanding labour-intensive service sector to complement the falling demand for manpower as machines take over more of industrial production.

Unless the College accepts the logistic implications of a unified and prevention-centred service and helps to press for the means to be provided, health conservation will remain an idiosyncratic activity carried out by a few general practitioners and feared by a majority who lack the resources to carry it out.

5. Need for changes in human behaviour

Prevention will depend on changes in behaviour, on a collective as well as an individual scale. Some of this change may be brought about within the traditional doctor-patient transaction, but individual behaviour has a social base. The 'behavioural sciences', as presently taught, tend falsely to individualize choices in ways that we know to be ineffective in practice. Effective preventive work in primary care will depend on shifts from the attitudes dominant in present society, as expressed in priorities for production and consumption, commercial licence, and some personal risk-taking.

A shift from these priorities will depend on the emergence of the College nationally as an effective pressure group for alternative attitudes, including a more open view of professionalism and frank admission that medical science is built on measured doubt, rather than faith or certainty. Our members need to emerge as local spokesmen for these more open, more self-critical attitudes in practical terms. We need new styles of work, reaching groups and communities as well as consulting individuals. The general practioner will have to become his own medical officer of health and find the means to reach and to listen to his patients as a group.

6. The College as the voice of progress

The College should emerge as the main voice of progress in medicine, the main source of social experiment in practical terms, the exponent of a unified approach to prevention, care, and acute response. We should assist individual members to develop preventive and educational programmes by publicizing those that exist, and by obtaining for them the practical help they need. We should gather data on the implications of accepting responsibility for prevention, in terms of medical and ancillary manpower, new job definitions and educational policies, new sources of recruitment, the design and supply of new premises and equipment (particularly of new information systems), and use these to formulate a campaigning policy to secure public support for its implementation. I see no reason why we should not press the political parties, or our local candidates and MPs, to incorporate our ideas in their programmes.

Conclusion

The main trend of thinking in the College, particularly as expressed in the published work of the more innovative practices in the *Journal,* is already consistent with these points. These conclusions are implicit in much of our present style of work and thought. The nature of the NHS, with its long tradition of relatively stable registered populations, gives us the material basis and some of the body of custom required for active care of the parish, rather than passive shopkeeping. This could become the main theme of the work of the College for a generation, and become the basis of its appeal, not only within the profession, but to the nation as a whole.

Sexual knowledge and attitudes of general practitioners in Wessex

A survey of the sexual attitudes and knowledge of general practitioners in Wessex found that general-practitioner trainees and those in practice for less than ten years were less conservative and better informed than doctors in practice for 20 years or more. The results suggest that the attitudes of the doctors are determined by their early environmental influences rather than their clinical experience.

Reference

Elstein, M., Gordon, A. D. G. & Buckingham, M. S. (1977). *British Medical Journal,* 1, 369-371.