cant change. More rapid change is to be expected in the field of postgraduate education. Vocational training in general practice has been available for nearly a decade and a half and is now compulsory, but the period spent in the practice is too short. The College's policy statement[4] has highlighted the need for a period of higher training during the first two or three years as a junior principal equivalent to the hospital senior registrar period. By the end of the century we shall see higher training available in half-day release courses throughout the country. These courses will include clinical and operational management and performance review: subjects that are more useful to the principal and that are less relevant to trainees at their stage of learning.

The emphasis in continuing education will move from the postgraduate centre into the practice itself and become directly related to measurable outcomes of patient care. Clinical meetings of the primary health care team, taking place during normal working hours, will involve setting objectives for care, sometimes in association with specialists, and reviewing progress with the aid of the microcomputer.

Management

The key to many of the improvements in primary care lies in effective management. While most doctors are clear that certain things need doing, experience tells us that ensuring they get done is much more difficult. Examples include being reasonably accessible to patients, ensuring high immunization and cervical cytology levels, and making sure hypertensive and diabetic patients are well-monitored and well-controlled. The great advantage of the NHS system is the registered list of patients and this is just starting to be fully exploited.

Conclusion

How then will our changing general practice look by the year 2000? Its team of doctors and nurses with their practice manager will be actively planning their patient care, for higher remuneration will depend on demonstrating good results. Nearly all their patients requiring continuing supervision will receive their care solely in the practice where the local specialists will visit from time to time. Evidence of good long-term care and prevention will be reviewed regularly and the information passed at regular intervals to the district health authority and in a modified version to the local consumer group. The nursing section of the team will have increased proportionately to provide care for a significant number of elderly patients in their own homes.

General practice, as a major component of primary health care, will become the central pivot around which health services revolve because of its major role in preventive and anticipatory care, its relevance to the needs of the local population, and its new developments in management and technology. Although this is the logical route for health service development to follow this depends on general practitioners recognizing three things. Consumers have a right to expect a high standard of care from all general practitioners. Our colleagues in nursing and other related professions have a right to expect to be able to work closely and effectively with us. The health authorities have a right to know what we are doing so that our activities can be seen as part of health services as a whole in a more informed way than they are at present. It should be an exciting time.

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Warm to general practice, cool to Alma-Ata

I HAVE been asked to consider, on a purely personal basis, 'ways in which general practice can help to meet the aims of the World Health Organization declaration of Alma-Ata'; with the rider that the occasion would be 'a good opportunity to speculate on the future of general practice in the United Kingdom'. You can imagine the general dilemma in which this places a retired consultant whose experience of general practice, other than as a patient, is limited to a number of locums done soon after qualifying — an experience which, incidentally, I would recommend to any aspiring consultant who will find himself in the position of discussing patients with their family doctor. But within that dilemma, I have a specific difficulty, which perhaps I can describe best by indulging myself in a flash of tactless honesty. On the one hand, I know little in detail of the present state of general practice in this country, yet I believe its future to be firmly assured; on the other hand, knowing something of the evolution of the Alma-Ata statement, 'health for all by the year 2000', I can only regard it as coming somewhere between a slogan and a noble ideal, and not as a realistic picture of the state of the world in 2000 or any other year. The remainder of this article gives the grounds for my firm belief in the future of general practice in the UK, irrespective of the particular directions which it may take; and also for my scepticism (not, let me underline it, pessimism) on the practicality of the course purporting to be set by Alma-Ata.

General practice

I believe that the aims, and to a large extend the methods, of medical practice are broadly similar, whether it is carried out in hospital or in the community; and indeed the hospital is part of the community, and not part of outer space. What may be different are the conditions in which practice is carried out; but I regard these as peripheral to the essence of good medical practice. These beliefs form one part of the grounds on which I view the future of general practice with optimism; for not only are we getting better entrants to our medical schools, but more of them are opting for a career in general practice.

My second reason for optimism is the recognition among doctors in this country that specialist doctors should see patients only on referral from a general practitioner. This excellent principle is sometimes adduced by critics of our profession as evidence of medical protectiveness; this is a travesty, for it primarily protects the patient from falling into the hands of an inappropriate specialist, a category which could include the specialist who is willing, other than in an emergency, to see the patient who rings his front-door bell.

A third ground for optimism is the development which has taken place in family practice towards team-work, secretarial help, postgraduate training and increased contact with colleagues both in general and in specialist practice. The single-handed

general practitioner, struggling towards a weary old age with no secretarial help, no intellectual refreshment and no contact with colleagues, is now a member of an endangered species, confined to the game reserves of our inner cities or, more idyllically, to the remote valley or glen so beloved of medical teachers as the hypothetical scene of sundry emergencies.

These are a few of the reasons which make me feel secure about the future of general practice, and also proud to be a Fellow of the Royal College of General Practitioners. But you may by this time be saying: Is this some visitor from another planet who knows nothing of our difficulties and uncritically admires all the developments which have taken place? So let me conclude this cursory glance over general practice by expressing one or two concerns, which may or may not be well-founded.

Vocational training for general practice recognizes that it is one of the more demanding specialties; and attention is rightly paid to the importance of communication, to high ethical standards and to efficient practice management. Moreover, my greatly esteemed Manchester colleague Pat Byrne was among those who encouraged us to learn the lessons offered by educational experts. These things are good, but like all good things they may compete with other good things; and I have sometimes worried lest pedagogy and packaging might be taking precedence over the core of practice, which is the corpus of knowledge which predominantly, though not of course solely, distinguishes us from the unqualified practitioner.

The only other worry with which I have space to trouble you relates to what may be a neglected opportunity. I do not know whether our cash-limited, re-re-reorganized and now overmanaged health service is still the envy of the world; but with its high coverage of the population it is still the envy of the world's epidemiologists. Will Pickles showed the way so many years ago; but I would like to ask, as Julian Tudor Hart has done, whether we have been faithful in following it. Of course, social mobility has increased greatly since Will Pickles' day; but even if it is less stable, a general practitioner's list is still a defined population, giving a unique opportunity for preventive medicine and, what is quite as important, for assessing the efficacy of particular measures.

Alma-Ata

At the risk of allying myself with Mephistopheles — *'Ich bin der Geist der stets verneint'* — and being a curmudgeon to boot, I have two reasons for suspicion about the Alma-Ata declaration, and the relevance of general practice to it.

Of course, great things have been done, and will be done, in the conquest of disease; and the WHO, under Dr Mahler's leadership, has played a notable part in such things as the eradication of smallpox and the intensive campaign against tropical diseases. All credit to them, but is it really realistic to suppose that there will be no residual health problems in 14 years' time? So my first ground for suspicion is the total lack of realism in what purports to be a proposal.

My second doubt relates to the relevance of general practice as we know it to the attainment of better health world-wide. In the WHO formulation, the goal is to be achieved 'by primary care'. I find this terminology misleading, for what seems to be meant by 'primary care' has little to do with the practice of individual medicine (still at the core of our family practice), but rather with clean water supplies, adequate and sound food, eradication of vectors and parasites — vitally important matters but not ones closely related to family practice in this country.

To sum up, in this country, which I hope will stay 'developed' and not be turned into a post-nuclear wasteland, we shall not want or need bare-foot doctors; what we shall need, into the indefinite future, are doctors who are both caring of the whole person, and also competent technically and scientifically — in other words, good doctors. And we shall continue to need them, as we already have them, both in general practice and in the specialties.

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General practice 2000

IT is five years since my predictions for 2010 were published in the *Journal*.[1] The invitation now to shorten my vision to the year 2000, gives me the chance to revise my views and to urge caution.

In my earlier paper I was concerned with the impact of the new technologies, notably robotics, and the information technologies on society, and the implications of these accelerating changes for the practice of medicine. Here I have to reflect further on the nature of change and the challenge to general practice.

The sudden advent of the epidemic of acquired immune deficiency syndrome ought to provide us with a sharp reminder about the nature of change. An alteration in the behaviour of a virus, or of a particular community, can at any moment turn society upside down. Our response to this disease seems to me to mirror nothing so much as the response of the stock exchange or the money market to the news that a national football team has lost a game, or that a secretary of state is having a love affair. The cataclysmic alterations in the value of shares or the exchange rate of a currency results not from rational economic appraisal, but from a mass emotional response. What was missing from my earlier appraisal of the future of general practice was the recognition that in reading the cards it is unwise to forget that there are jokers in every pack.

Futurology, then, is concerned not only with the march of technology and the effects of that technology on society, but also with the operation of the unpredictable. Nor is that the end of the story. The next history of general practice, like the last, will be shaped not simply by forces beyond our control, but by ourselves.

It is the will of men and women which brings about change and more importantly their imaginations. On the grand scale of life, my experiences are confined within the imaginations of Plato and Darwin, Einstein, Freud, Mozart and the rest. On the more humble scale of professional life, I recognize that contemporary general practice was created out of the imaginations of Beveridge and Bevan, Mackenzie and Pickles, Cronin and others too recent to name here. This awareness of the primacy of people over historical forces, permits me not to prophesy, but to hope and to urge.

It would be easy, but erroneous, to predict that general practice in the year 2000 will result simply from a linear extrapolation of our current preoccupations. For example, there is a drive to convert the patient into a consumer. This may distract us from the need to encourage a sense not of consumption, but of citizenship. The notion of consumer in Western society is inextricably linked with the role of adversary. In contrast, a citizen has both rights and obligations. A practice population of citizens, in con-