

The RCGP and other countries: a beginning

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SUMMARY. *This article describes the earliest links of the Royal College of General Practitioners with other countries, using an historical and geographical sequence. It analyses the methods and content of exchanges and looks at the balance between what has been exported and what has been imported.*

Introduction

GENERAL practice is strongly influenced by the context in which it takes place and there is much to be learned from examining other health care systems and from the experience of general practitioners abroad. Over the next few months the *Journal* will be publishing a group of papers which look at primary health care in other countries. This article sets the scene by reviewing the links which the Royal College of General Practitioners has forged with other countries, and, by doing so, focuses on the proposition that general practice, as promoted by the College, is a valuable British export.

Early links with the Commonwealth

In retrospect it seems surprising that there was an international dimension to the College almost from its beginning. At the time it was taken for granted that the College's involvement extended to the Republic of Ireland and the English speaking members of the Commonwealth — Australia, Canada, Kenya, New Zealand and South Africa. It was assumed that doctors in these countries shared common experiences and values. Canada was the only one of these countries whose college did not originally form part of the College of General Practitioners. In 1961 there were branch councils in all of these countries, each of which became independent at various later dates. Thus large was John Hunt's conception.¹

Both John Hunt, as honorary secretary of the College Council, and Ian Grant, when president, were assiduous commonwealth travellers.²⁻⁴ These pioneering tracks have subsequently been followed by many other College officers and members.

From these early links with Commonwealth countries the College began to be involved, from 1960 onwards, with world institutions and then from 1970 onwards with European institutions and countries. There are now in addition close contacts with a cluster of countries in the middle-East and with Hispanic countries on both sides of the Atlantic. Of course this sequence, as described above, imposes an artificial simplicity on a complex reality and omits entirely the United States of America, which will be discussed separately.

Links with WHO and WONCA

Within 10 years of the foundation of the College, three members had acted as consultants to expert committees of the World

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Health Organization at Geneva. Each committee required a year of work, ending in a publication suited for simultaneous use in countries at very different stages of development — an aim which now looks unrealistic. The publications were: *The role of public health officers and general practitioners in mental health care*,⁵ *Training of the physician for family practice*⁶ and *General practice*.⁷ Given the very wide and varied readership which these reports were directed at, it is not surprising that they had to be written at a level of abstraction which was bound to limit their usefulness in any one country and to make them hard reading. Nevertheless, they undoubtedly conveyed ideas in tune with College thinking at that time.

Subsequent contacts between the College and the World Health Organization have been almost always in the European region. College officers have visited Copenhagen, the headquarters, and various members have held WHO travelling fellowships and played important parts in regional working groups.

The WHO's Alma-Ata declaration of 1978 — 'Health for all by the year 2000' — has unquestionably provided a background of support to all that the College has tried to promote.⁸ Above all, it has trumpeted the need for primary care in a world which has been giving pre-eminence to secondary and tertiary care and which has allowed specialization to distort the balance between the technical and the interpersonal aspects of health care as much in developing countries as in highly developed ones such as the USA.

The World Organization of Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA) was set up in 1972. The initiative came from Australia and the USA and at present the organization seems to have a special influence in the world east of Suez. Its most important scientific contribution has been in creating systems of disease classification, notably *ICHPPC — the International Classification of Health Problems in Primary Care*.⁹ The College has consistently played an important part in WONCA. A series of College officers have held office and the eleventh international conference of WONCA, held in London in 1986, was memorable as an example of superb organization; indeed the conference left a surplus, which has since been used to fund international scholarships.

European links

In Europe, differences of language still create barriers between the UK and certain countries, despite their nearness and despite the increasing unification of the European Community (EC). The College's links have not been confined to countries of the EC. One of the earliest was with Austria, where a country practitioner, Robert Braun, was developing a classification of morbidity in general practice which paralleled similar work by the College research committee.¹⁰

In 1972 the European General Practice Research Workshop was set up, stimulated by a conference in 1971 for countries bordering on the North Sea. Representatives of the College made an important contribution from the start. The first member countries were Belgium, Denmark, Finland, France, West Germany, the Netherlands, Norway, Sweden and the United Kingdom and this group has continued to meet at regular intervals. It had to begin by dealing with basic problems of

terminology and shared meanings. These overcome, it has recently become possible to move on to such projects as an international study of hospital referrals.¹¹⁻¹³

The first Leeuwenhorst European Study Group, like its successor, the New Leeuwenhorst Group, was concerned with education. It started in 1974, arising out of a conference in the Netherlands, organized by the Dutch college, with help from the Danish college and our own. Twelve countries were represented (the same ones as for the research group, except Sweden, but with the important additions of Austria, East Germany, Hungary and Yugoslavia). The College has provided financial help for representatives to attend every six-monthly meeting. Before education or training could be discussed, it was essential to reach a shared definition of the role of the general practitioner in these countries. This was achieved surprisingly quickly and proved to be much the most important work of the group.¹⁴⁻¹⁶ It owed a great deal to work already done at Manchester University and in the College.^{17,18}

The first Leeuwenhorst group dissolved itself in 1982, inviting a younger doctor from each of the same countries to take over. The New Leeuwenhorst Group expanded and now includes members from 22 European countries, on both sides of the iron curtain.¹⁹⁻²¹

The Societas Internationalis Medicinæ Generalis (SIMG) was originally a German-speaking society involved in continuing education from 1963. It had been preceded by the International College of General Practice.²² More recently it has widened its geographical coverage, included languages other than German, and has provided a forum for original research. It is one of the few groups in which British general practitioners can meet French as well as German and Austrian colleagues. Again, members of the RCGP have made great contributions to this organization.²³

The Union Européenne de Médecins Omnipraticiens (UEMO) is a political organization representing the interests of general practitioners in the countries of the EC, particularly in dealings with the EC Commission in Brussels. Founded in 1967, it recently celebrated both its 20th anniversary and the passing of the second directive on medical training under the Treaty of Rome. This directive was concerned with the preparation of general practitioners in their early postgraduate training (the first directive had been concerned with undergraduate training).²⁴ Representatives from the UK are appointed by the British Medical Association, which normally invites one representative from the College.

Involvement of the RCGP with individual countries in Europe began with the Netherlands and has remained closest with that country and with Denmark and Norway. Whether this is mainly due to similar patterns of medical care organization or to the fact that most doctors in those countries speak fluent English is hard to judge. In the last 15 years both Finland and Sweden have made decisive changes which have favoured the development of primary care as we know it here.^{25,26} Previously, no European country had gone further than Sweden in promoting direct access to specialists for its population.

During the same period, strong links have been forged with the recently formed associations of general practitioners in Spain and Portugal. The developments in Spain, which will be described in a future issue of the *Journal*, have been paralleled by those in Portugal (Ramos V, Rebelo L. *Preparing for the future — four years of general practice in Portugal*. Associação Portuguesa dos Médicos de Clínica Geral, 1986. Horder JP. Report to the King's Fund on a visit to Portugal. RCGP, 1984). The mainly young members of the associations in these countries have had their enthusiasm tempered by the problems caused by over-supply and under-employment, as in most other European

countries.

The College now has a faculty in Malta and College representatives have recently helped Maltese doctors to develop primary care in the island.

Contacts have been weakest with France, Belgium, West Germany, Switzerland and Italy, despite the efforts of many individuals.

In Eastern Europe, contact with the School of Public Health in Zagreb, Yugoslavia, has been notable and sustained since 1960 because of a common interest in training courses,²⁷ likewise with Czechoslovakia.²⁸ Contact has been negligible with the USSR, indeed almost confined to a formal visit by John Hunt in 1963.²⁹

Other links

The United States of America

Early exchanges with this huge, varied and rich country were few and not particularly fruitful, despite the existence of the American Academy of Family Practice. Overall, the USA seemed to represent the dominance of specialist medicine, to be strongly opposed to our National Health Service and to have little interest in primary care. A valuable comparison of general practice in the USA and the UK was published in 1976.³⁰

The first significant American influence came through Patrick Byrne's visits to George Miller and his associates in Illinois around 1970; these inspired the contributions which Byrne and his associates made to research in medical education.^{31,32} In the last 10 years the influence of the USA has become substantial and most of what we know and use in quality assessment and assurance comes from this source.³³⁻³⁶

The Middle East

Contact with Israel has been frequent since 1960 and was much reinforced in 1989 by the twelfth WONCA conference which was held in Jerusalem. A visit to Egypt by College members in 1978 led to the important contributions to the training of Egyptian practitioners which have subsequently been made by Guy's Hospital Medical School.³⁷ A similar visit in 1980 eventually led to the setting up of the RCGP/Kuwait fellowship and to the very successful work in developing general practice in Kuwait.³⁸ Similar work has been done in Sri Lanka, Saudi Arabia and Bahrain.

Missing links

It is, of course, impossible for the RCGP to maintain an equal intensity of exchange with all countries of the world. Areas with which contact has been most sparse have so far been China, India, the USSR, the South American continent and most of the African continent.

Methods of exchange

The record of the College in supporting or securing support for members to travel has been impressive, notably through the Nuffield fellowships, the Stanning fellowships, the Wolfson professorships and the Kuenssberg travel awards. There were four Nuffield fellowships each year between 1961 and 1972, three for outward, one for inward journeys, each lasting six months. There were many valuable reports from these early visits.³⁹⁻⁴¹ Support has often been given to essential visits by officers and senior members of the RCGP, but it has been equally important that opportunities have been given to younger doctors to visit other countries and see their own work against a wider background.

Only the Nuffield and Update fellowships paid for doctors

from other countries to contribute to the College. There may have been missed opportunities for involving foreign visitors other than general practitioners; Avedis Donabedian's visit in 1985, financed by the MSD Foundation, showed the value of such help.⁴² Although a number of honorary fellowships have been awarded to distinguished foreigners, those who receive them are seldom involved subsequently in the work of the College.

The most important single method of exchange is through the *College Journal*, which is to be found in most large medical libraries in all comparable countries. By concentrating on the publication of original research it has become an increasingly influential export. The international journal, *Family Practice*, was started in 1984 with support from the College; it too has built up a reputation through its publication of original research. The journal also circulates the quarterly news bulletins from WONCA.

The content of exchanges

It will already be obvious that education and research have been important areas for the exchange of ideas. But almost from the start the College was concerned with something fundamental to both, the role of the general practitioner in an increasingly specialized world, a problem which affects every country. To quote the American historian, Rosemary Stevens,⁴³ 'The role of the generalist in medicine has been and remains the most important single issue in modern medicine, for the structure of the medical profession hinges on whether, and how, general practice is recognized'. Hunt defined the role (for the use of the College) with admirable simplicity in 1957: 'A doctor in direct touch with patients, who accepts continuing responsibility for providing or arranging their medical care, which includes the prevention and treatment of any illness or injury affecting the mind or any part of the body'.⁴⁴ The first Leeuwenhorst group's longer definition in 1974¹⁴ has been accepted and used by the European Commission and has been influential in several European countries. But a recent paper written in Sweden for the New Leeuwenhorst Group shows that the question of role definition is still not fully resolved (Rudebeck CE. Essentials of general practice. Unpublished manuscript, 1987). There are still also difficulties in countries which allow direct access to specialists, for example, France or the USA, where roles are blurred. A related problem arises in some highly developed countries because universities look for unique characteristics when admitting a new discipline to a medical school on equal terms with those already included; thus an ill-informed prejudice against general practice, particularly in certain Latin countries, continues to exclude it.⁴⁵

Postgraduate 'vocational' and continuing training have formed particularly fruitful fields for exchange with many countries. Our own most sustained practical contribution has probably been in Kuwait. In Europe our three-year training has been the leading example. The RCGP has probably been influential in advocating the small group as a more appropriate learning method than the magistral lecture typical of European universities in the past. The earliest example of this, the Balint group,⁴⁶ though not originating in the College, has been a successful export to a number of countries on both sides of the Atlantic.

Hitherto no other country has been more successful than the UK in producing worthwhile research from general practice, although there is now impressive research work being done in Canada, Finland, the Netherlands and the USA, in particular. Cooperative research with other countries has developed slowly but steadily in the European General Practice Research

Workshop. In a statement in 1983, it classified research in general practice into these five categories: clinical; epidemiological; operational; behavioural; educational (each category being then subdivided). This makes it easier to answer the challenge of universities requiring evidence of original contributions to a distinct discipline before admission.⁴⁷

A valuable export?

I proposed at the start of this article that general practice is a valuable British export. How can this proposition be justified?

I recently had a chance to question a group of well-informed general practitioners from five different countries in Europe about what, if anything, originating in the UK had influenced general practice in their own country. The development of research was mentioned by all five and usually mentioned first. Publications — the RCGP *Journal* in particular — received the next most frequent tribute. The reasons for both choices ranged from the influence of our research on work in universities in other countries to its practical value in helping to solve clinical and organizational problems. Research is clearly fundamental for the development of general practice in the future.

A recent article from France about the influence of the College highlighted both vocational training and research.⁴⁸ It stresses research as a necessity if general practice is to be accepted and taught within universities.

It is difficult to separate the RCGP and its influence from the national context in which it exists. General practitioners in other countries whose horizons are not confined to their local problems recognize that their own branch of medicine is actually pivotal in the UK system of medical care and that this is here no longer a matter of lip service. The whole population is registered with general practitioners and has case notes which move with them. The strong tradition of referral and referral back supports the gatekeeper function and limits the direct access to specialists which weakens general practice in many other countries. I know of no other country where there has been so dramatic a shift in the career choice of final year medical students towards this branch of medicine; this has already changed the value which other doctors in the UK place on the role of the general practitioner.^{49,50}

If general practice is stronger in the UK than in most other countries, it is due to many different influences, institutions and people. I would claim only that the RCGP has played a central part and that this is how it appears to interested observers from other countries. Perhaps it is not surprising that foreign doctors who know 14 Princes Gate do sometimes speak of it as a place and a symbol in which they themselves have some share.

But my proposition is dangerous. People — doctors included — usually start from the assumption that the way things are done in their own country is the normal and the best way. If they travel to other countries they meet colleagues who start from the same assumption about the way things are done there. Those who make medical journeys abroad should look for what can be learned. They should teach only if invited.

We do indeed owe debts to other countries for what we have learned. Among them I want to mention only a few because they are the most familiar to me — Yugoslavia for ideas and for a practical demonstration of vocational training at a time when we scarcely had any; the USA and the Netherlands for emphasizing and developing the 'family' dimension; the USA and Canada for most of what we know about the assessment of quality.

If we want to go on exporting ideas, we must keep a careful eye on developments in other countries. Those aspiring to leadership must always be open to the disturbing effect of new ideas.

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Acknowledgements

The identity of a royal college cannot be separated from the people who are active on its behalf. I want to pay tribute both to those fellows, members and associates of the College whose work with other countries is described in this article without mention of their names and equally to those whose work may not have been acknowledged, despite its value. References 19-21 are available from: Huisartsen Instituut, Virje Universiteit, Post Bus 7161, NL-1007 MC, Amsterdam, The Netherlands.

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RCGP

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**TEMPORARY
CLOSURE**

As part of its continuing process of updating stock and making it accessible to users, the College's Information Resources Centre will shortly be completing a project involving the transfer of stock and will therefore be closed from 21-25 May 1990.

The closure is intended to minimize disruption to members by allowing the transfer to be completed as quickly as possible. During the time a helpline will be available for members with urgent enquiries on telephone number 071 581 3232 ext 220/230.