Royal College of General Practitioners' 40th anniversary: taking stock and looking forward

AS we celebrate the Royal College of General Practitioners' 40th anniversary and prepare to install His Royal Highness the Prince of Wales as the 15th president of the College it is important to recall how far we have come in 40 years. The College was founded secretly in 1952 because of low morale and specialist opposition, yet its influence on the development of patient care has been truly enormous. Forty years ago general practice had no college, no university department anywhere in the British Isles, no postgraduate training programme, no academic journal and no plans or hopes of progress. Since then the pace of progress has been rapid. The College *Journal* was the first internationally recognized scientific journal of general practice in the world, there is now a department of general practice in every medical school, structured vocational training has been introduced and moves have been made towards higher professional training and continuing medical education. Primary care and the family doctor service are acknowledged as the foundation upon which we should build our health service. But the achievements of the past should be a spur to future action not an excuse for complacency. Much still remains to be done.

It was both wise and timely that in December 1990 the College council, when debating a strategy to implement agreed College policies, decided that it should consult widely with College members about the future role of the College. Every member was given the opportunity to contribute to this exercise in consultation, the latest in a long tradition. What has been truly remarkable is the consistency and the constancy of members' views about the overall aims of the College to encourage, foster and maintain high standards of care; the important role of the College in promoting research, education and audit; the College's standard setting role; the key role of the generalist working as part of a team; and the importance of primary care. Many responses have also emphasized the importance of personal doctoring. The feedback from the consultation exercise informed the choice of motto for the anniversary year — caring with compassion — combining the twin concepts of *scientia* and *caritas* which the College expresses in its activities at all levels. The consultation exercise and the action plan which will follow will reconcile the personal needs of members with their collective, collegiate academic responsibilities, particularly in the fields of education and research.

Revisiting the reasons why our founding fathers formed the College highlights the considerable amount of unfinished business still to be tackled. Some issues come immediately to mind: providing care and support for the individual doctor; offering a comprehensive range of services, particularly for new members; refining the principles of sound practice management and promoting their implementation throughout general practice; agreeing the range of services to be provided for patients through general practice and the primary care team; promoting standard setting and performance review as a normal part of a College member's way of life; establishing the MRCGP/FRCGP in the public mind as a hallmark of continuing quality; determining standards for vocational training and monitoring their achievement; establishing effective working relationships with nurses, midwives, health visitors and other professionals in members' practices; and finally creating working links with the General Medical Services Committee, the regional health authorities, family health services authorities and district health authorities so that College members can help tailor the services provided by their practices to the needs of their local communities. These were issues which concerned us in 1983 and were embodied in the policy statement, *Quality in general practice.*[1] They continue to concern us now.

But the National Health Service has changed in eight years. We have seen the Griffiths report,[2] the Cumberlege report on neighbourhood nursing,[3] *Primary health care: an agenda for discussion,*[4] *Promoting better health,*[5] *Working for patients,*[6] *Caring for people,*[7] the new contract for general practitioners,[8] *Nursing in the community,*[9] *Integrating primary and secondary health care,*[10] *FHSAs — today's and tomorrow's priorities*[11] and, just recently, the *Health of the nation*[12] and the citizen's[13] and patient's[14] charters. These have brought with them changes in the management and clinical structures in which general practitioners work; in the way in which the NHS is funded; and in the relationship between medicine and management. The 1990 contract and fundholding have added new dimensions to general practice; NHS trust hospitals and the purchaser/provider split have brought new dimensions to secondary care. Documents coming from the Department of Health[9-11] have increasingly acknowledged the key role of primary care though we still lack a structure to achieve this. Change is always stressful but imposed change particularly so, especially when many general practitioners feel that reforms in the health service have struck at the very heart of general practice — the doctor–patient relationship.

Unfortunately, in the UK there is a tendency to equate primary care with the general practitioner and the associated team of attached staff. Primary care is more than that. It is a concept of a community enabled to tackle its own health problems. It embraces self-help, public health and environmental concerns. It includes community development, group health promotion, environmental advocacy and some health services which need to be practised on a neighbourhood, as well as on a practice. It cannot all be slotted neatly into general practice. There appears to be a concensus that the health service should be primary care led, but to put this fully into effect requires that the balance of resources between the primary and secondary care sector, and the balance of services offered in secondary care, should be determined by the primary care team.

The purpose of hospitals and other specialist services is to support primary care; their role is to respond to the demands of the primary care system and to meet its needs. By its very nature, a specialist service receives only a small part of the burden of ill health and it must recognize that the place of such a service has to be determined by those who see the whole. There is no doubt that general practitioners, in addition to being the doctors of first contact and continuing presence, will assume an increasingly important role as we move through the 1990s.

In looking to the future, major issues will have to be faced. As the role of general practice and primary care becomes more important, as general practice becomes both the frontline and the foundation of the NHS, we must think about the changes needed in medical education to ensure that general practitioners are fully equipped to play this important pivotal role. As a College, we need to be sensitive to the pressures on general practitioners and to seek ways of alleviating these. The role of the generalist in primary care must be promoted and sustained, and we must never forget that in the majority of instances, the strongest bond between the patient and the NHS is the general practitioner. We must seek to ensure that there is a true understanding of what really constitutes primary care.

Therefore the words of Sir Dennis Hill in 1969 are increasingly important:

> 'The family physician's role is a difficult one. If it is to be sustained and developed, the general practitioner must become the most educated, the most comprehensively educated, of all the doctors in the health service.'[15]

Research is certainly important and so too is audit, for education draws on and is fuelled by both. The major challenge for the future is to ensure that the vision put forward by Sir Dennis Hill, a non-general practitioner, is brought to fruition. Therein lies not only the future of general practice, the future of the Royal College of General Practitioners, but more importantly, the welfare of our patients.

COLIN WAINE
Chairman of council,
Royal College of General Practitioners

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Address for correspondence
Dr C Waine, 42 Etherley Lane, Bishop Auckland, Co. Durham DH14 7QZ.

Reflecting primary care in the new Europe

ALMOST since its foundation there has been an international dimension to the activities of the Royal College of General Practitioners. Traditional ties with the Republic of Ireland and the English speaking countries of the commonwealth were quickly extended worldwide. In Europe, College members were happy to contribute to the founding, in 1972, of the European General Practice Research Workshop whose conferences have since provided opportunities to meet and exchange ideas with other European general practitioners who share an interest in research in general practice. Similarly, College members have contributed to the work of the original and new Leeuwenhorst groups which concerned themselves with education for general practice.

Celebrations for the College's 40th anniversary coincide with the dismantling of barriers to trade between the countries of the European Community and with renewed interest in primary care throughout Europe. Attempts have been made by various European governments, including our own, to restrain spiralling health care costs by reforming the structure of health services. Fresh interest is being shown in general practice as the key to good quality patient care and to the most efficient integration of primary and secondary care resources. While the practice of medicine is much influenced by the culture in which it takes place, there is much to be learned from studying the experience of general practitioners working in different health care structures. Such studies reinforce the realization of a common core content of family medicine which transcends differences in national health care systems.

In this issue we publish original work from the Netherlands,[1] and Sweden,[2] a description of the changes in the provision of mental health care in Italy[3] and observations by a British general practitioner on primary care in Italy.[4] The *Journal* is pleased to acknowledge in this way the increasing flow of interesting and relevant papers from European general practitioners. We have long valued the interest shown by subscribers throughout Europe and the support of referees based in European countries.

From the Netherlands we publish a paper showing that women suffering from stress incontinence can be treated successfully if they are prepared to carry out pelvic floor exercises following instruction from their general practitioner.[1] Little is known about telephone consultations compared with surgery consultations in terms of information obtained from the patient and the management decisions made. A Swedish study compares telephone consultations by nurses with surgery consultations by both doctors and nurses.[2] Guidelines for the telephone advisory service used in Sweden may well find application elsewhere. For many years in the UK the process of discharging long term psychiatric patients to the community has continued and psychiatry is gradually moving out of hospitals. Tansella and Bellantuono describe the same process in Italy where it has been more abrupt and comprehensive.[3] However, their call for dialogue between general practitioners and psychiatrists is equally appropriate here and we have much to learn from the Italian experience. Pringle's description highlights the similarities and differences between general practice in Italy and the UK.[4] He concludes: 'We have common problems and are testing common solutions; there is enormous potential for British and Italian general practitioners to learn from each other to the benefit of all our patients.'

Horder reminds us that people usually start by assuming that the way things are done in their own country is the best way.[5] The function of a scientific journal of record is to challenge these assumptions and confront conventional wisdom. The medical journal is the forum where the medical profession can talk to itself in the same way that a country talks to itself in its newspapers. The journal of record is the essential medium for the publication of peer reviewed and fully referenced original research work on which the scientific practice of medicine is based. Such a journal has a responsibility to keep doctors informed on the issues that increasingly affect the practice of medicine. A well informed profession is best able to assess the worth of new technologies and the developments in the pharmaceutical industries. It is also best placed to expose the lack of scientific evidence to support some current ideas on population screening, health promotion and the prevention of disease.[6]