Forty years on — and back

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A QUESTION often asked is: why do we need a college of general practice? That same question was posed 40 years ago in 1952 when our College was founded. The answer then — and now — is best stated in the aims of the College: 'to encourage, foster and maintain the highest possible standards in general practice'.[1] General practice in the United Kingdom in the 1950s was, in the main, still cast in a 1920s' mould. The scientific revolution in medicine which had altered hospital practice so radically during the 1930s and 1940s appeared to have passed general practice by. The main advantage general practitioners and hospital doctors shared in common was the introduction of the National Health Service on 5 July 1948.

General practice was under threat. Our critics said there was no place for general practitioners in the new era of scientific medicine. In 1950, in an extensive and highly critical article in the *Lancet,* Joseph Collings, a visiting Australian, presented his views of British general practice based on his impressions of visits he made to 104 general practitioners in 55 practices.[2] He wrote that only specialists could deliver the modern brand of medical care. Nor did the criticism cease. Fifteen years later Henry Miller, a distinguished neurologist, wrote of the 'decline of general practice'[3] and, except in rural areas, forecast its demise. The role of the general practitioner, wrote Miller, was 'the treatment of minor ailments; the recognition of serious illness and its prompt transmission to the appropriate source of specialized treatment; and the domiciliary management of those chronic diseases for which no effective treatment is possible'. Even today there are people who believe the role of the general practitioner to be the separation of the medical wheat from the chaff, sending only genuinely ill patients to hospital.

Changes in medicine and society

The College was founded at a time of great change — both in medicine and society. The UK had just come through the second world war. Though we had won the military battle, economically we had paid a great price. Medicine, too, was in a state of flux. There has probably never been a time of greater change in the way hospital medicine was practised in the UK than there was between 1930 and 1950. It is difficult for those who were born in the second half of the century to realize how totally different were both the practice of medicine and the way society was organized in the 1930s and earlier.

For example, 'pathology departments' in most hospitals before the second world war were based on the post-mortem room. The first chemical pathology department in a London teaching hospital was not opened until 1929, and then it was little more than one room. Most blood and urine tests were done by clinicians themselves in side rooms adjacent to the wards. Probably the most common blood test carried out in laboratories was the Wassermann reaction to diagnose syphilis. When I was a young doctor we did not seek the patient's consent before taking a blood sample for a Wassermann reaction, or for any other test: indeed, the thought never crossed our minds. We did this test on every baby with a runny nose who came to the casualty department at the Queen Elizabeth Hospital for Children in Hackney where I was working from 1951 to 1952, to exclude the chronic rhinitis of congenital syphilis. In fact, during the time I worked at that hospital I did not see a baby with any form of congenital syphilis, either in the casualty department or the wards: routine screening of pregnant women had been introduced and penicillin was, by then, readily available.

Even as recently as the late 1950s the only radiology facility available to most general practitioners was a miniature chest x-ray service in the tuberculosis clinics; and the only pathology facility was the public health laboratory service which mainly provided throat swab cultures for diphtheria, sputum culture for tuberculosis and some stool cultures for dysentry and similar infections. The only way to get any other x-ray or pathology test performed was to refer the patient to the hospital service.

Despite the depression of the 1930s an ordinary general practitioner would be likely to have a cook, a maid and a nanny for his children even though his salary, after correcting for inflation, was modest by today's standards. It was calculated that the average general practitioner in those days earned approximately £1050 a year[4] (equivalent to about £20 000 today). Those calculations were, however, based on tax returns. Many general practitioners were, it is said, in receipt of a large number of unrecorded cash fees to boost that figure. The salaries of domestic servants were cheap: 10 shillings (50p) a week, plus full board and lodging, was a good wage for a resident maid in the 1930s.

There were major changes between 1914 and 1939 but none so radical as the restructuring of society in the UK after 1945. Our political debates at school during the war forecast something akin to Beveridge's proposed welfare state,[5] but no one forecast the end of resident domestic service in ordinary middle class homes.

The National Health Service

The concept of a national health service had been evolving over the previous 100 years. There was, indeed, little that was truly 'revolutionary' in the 1946 National Health Service act as far as general practice was concerned. What it did was extend Lloyd George's National Health Insurance of 1913 to cover the whole population, irrespective of income. It provided care for everyone, whether or not they contributed financially. It even provided care for overseas visitors to this country.

To those who planned the NHS a tripartite service seemed logical: general medical services, the hospital service and the local authority health services. Because the NHS was an evolutionary change it adopted the organizational pattern of general practice which was the norm for that time. The 1948 NHS terms and conditions of service for general practitioners were based on the existing National Health Insurance pattern, written 35 years earlier, before the first world war, which was in turn based on 'contract' practice, so vividly described by A J Cronin in *The citadel.*[6]

Hospitals, however, were changing. Perhaps the greatest change introduced by the NHS was the provision of fully trained specialists in every hospital. In most smaller towns, prior to the NHS, specialists were part-time general practitioners. In 1949, as a final year medical student, I held a locum surgical post for six weeks in Peterborough. The surgeons there also worked in general practice; consultants visited from London about once a month.

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To those who wrote the 1948 NHS general practitioner contract, there was no need to consider pathology facilities for general practitioners, other than certain urine tests with a Bunsen burner which general practitioners carried out themselves, or looking down a microscope for organisms and to count red and white blood cells. Haemoglobinometry, as performed in general practice, was usually crude in the extreme. The Tallqvist test was one of the most frequently used. It was based on comparing the colour of a drop of blood on blotting paper with a 'standard' chart. The accuracy was probably plus or minus 100%. Accurate haemoglobinometers were both expensive to purchase and time consuming to use.

In industrial practice, the name we gave to working in inner city areas, 12–16 consultations an hour were normal, plus about 20 house calls a day. Most general practitioners had only a stethoscope, through which they could hear very little. When I went into general practice in 1954 I bought an American sphygmomanometer and a Gowlland's auriscope and ophthalmoscope from an army surplus store. Many of my older colleagues in general practice thought I was mad to waste my money on such luxuries and the specialists I knew felt I should use the head mirrors they still used. Medicines were mainly symptomatic remedies such as digitalis and thyroid extract. Arsenic was still the mainstay in the treatment of syphilis. It was given as neoarsphenamine — Paul Ehrlich's 'magic bullet'. We believed that hepatitis was a side effect of the arsenic we injected. It was only several years later that we realized that hepatitis was an infection and that it could be transmitted by contaminated syringes and needles.

We should not be too critical of our predecessors who accepted that model of general practice in the NHS. We should first ask ourselves why those who negotiated for general practice in the years leading up to 1948 ignored the need to develop general practice as an independent medical discipline. The answer is simple: the negotiators were concerned with the general practitioner's income. It took Solomon Wand (then chairman of the General Medical Services Committee) four years of tough negotiations before he could persuade the government to go to arbitration.[7] The arbitrator awarded general practitioners a 100% increment above the 1939 calculated pay. Not surprisingly, this was the only time the government has agreed to arbitration over doctors' pay.

The early years of the RCGP

General practice 40 years ago was despised, not only by specialists but also by medical students. We may have been upset when Lord Moran said that general practitioners had fallen off the specialist ladder,[8] but that was the view held by consultants. It was also the view of many medical students and junior hospital doctors when it came to choosing their career. As a consequence large numbers of young doctors opted to emigrate, to work as general practitioners in Australia, New Zealand and Canada. A number also went to the United States of America, though in that country general practice was being replaced by primary care specialists — 'specialoids' as John Fry has so aptly called them.[9] It has been estimated that between 1952 and 1968 some 7000 British medical graduates emigrated to Canada, Australia and the USA.[10]

Those who founded the College believed that general practice was a distinct discipline in medicine, not the remainder after specialists had dealt with the 'important' problems. They believed that to establish general practice in its own right an academic base was necessary. In 1952 there were no academic departments of general practice anywhere in the world. There was, equally, a dearth of knowledge about the epidemiology of illness seen in general practice. We knew very little about the types of disease, and 'non-disease', we treated. We assumed that the disease pattern seen in general practice mirrored that seen in hospital: we were wrong.

In the early years, the College had two major concerns: research and education. Research had not been unknown in general practice: James Mackenzie, one of the greatest cardiologists of his and possibly any age, did much of his research while he was still in general practice in Burnley. His views about the importance of primary care were reflected in his creation in 1919 of the St Andrews Institute for Medical Research, later renamed the James Mackenzie Institute.[11] Tragically, his death from coronary heart disease, shortly after he retired to Scotland from his consultant practice in London meant that we had to wait more than 30 years before the College enabled those ideas to bear fruit.

William Pickles from Wensleydale in the Yorkshire dales is a name equally well known. Our College honoured him by electing him to be its first president. I knew Will and Gertie, his wife, personally. It was Gertie who acted as Will's 'research registrar', keeping all of the meticulous notes that were necessary for his epidemiological studies. I had the privilege of taking the photograph of Will which is used in his biography[12] and he gave me a signed copy of his book *Epidemiology in a country practice*[13] with a personal note which I still treasure.

Under the guidance of Robin Pinsent, Douglas French, Richard McConaghey and Ian Watson, a research advisory panel had been set up by the original steering committee even before the college was founded. A register of those general practitioners with an interest in research was created. Within the College's first year it began to produce a research newsletter, the first of which appeared in September 1953 in the *Practitioner*.[14] In the second issue[15] the name and address were given of a young general practitioner who was to act as the recorder of a College study in respiratory diseases; his name was John Fry.

I took part in one of John's early studies which involved the recording of respiratory peak flow rate. A couple of years ago I sent my original machine to the manufacturers for servicing, not that it needed it; it had given me nearly 30 years of impeccable service. I was intrigued to learn that my Wright's peak flow meter was one of the few original models still extant and it now has pride of place in the company's museum.

The national morbidity surveys, the fourth of which is now under way, form the basis of our understanding of the pathology seen in general practice. It is, therefore, important to remind ourselves that the idea initially took shape during the first year of the College's research committee.[14] The College will forever be grateful to the Birmingham team of Robin Pinsent and Donald Crombie who did most of the original work for the morbidity and other similar epidemiological surveys. Later they were joined by Douglas Fleming who now heads the College's Birmingham unit. Nor should we forget Ken Cross who provided most of the statistical help.

Development of education for general practice

General practice was almost totally absent from the undergraduate curriculum when I was a medical student: its only role, as far as my teachers were concerned, was to act as the butt for some of their humour. It was, thus, a great day for general practice when, in 1963, Richard Scott was appointed to the James Mackenzie chair of general practice in Edinburgh.[16] It was the first such chair in the United Kingdom and the College felt delighted and proud. The College is also entitled to feel proud that there are now departments of general practice in virtually every medical school.

But, important as undergraduate education in general practice was, and still is, more important is the education of medical graduates for our discipline, both the vocational training in the

initial post-registration years and the need for lifelong continuing medical education. In 1949 the NHS had introduced a one year general practitioner trainee assistant scheme. Generally speaking, the training element was minimal or absent, except by example. The selection of trainers was all too often done using the 'old boy' network.

The true story of how the vocational training regulations were introduced is worth recalling. In November 1979 we learned that a question was shortly to be put in the House of Commons about the implementation of proposed obligatory vocational training for general practice. Gerard Vaughan, then minister of health, was apparently going to express the government's lack of interest in this issue. It happened that there was a meeting of the liaison committee between the College and the General Medical Services Committee on the preceding Thursday (29 November). The College and the General Medical Services Committee were united in their desire to have vocational training made obligatory for all future entrants to general practice. It was unanimously agreed that the two chairmen, Alastair Donald and Tony Keable-Elliott, would send an urgent letter by courier to the Department of Health and Social Security. When the minister gave his reply in the House on the following Monday it was to recommend that vocational training for general practice be obligatory. I am convinced that the reason for that volte-face was the unanimity of view of the two major general practice bodies over this question.

Logic demands that there must be some form of assessment for any and every form of training. 'Signing up' at the end of a six or 12 month hospital or general practitioner appointment is not an assessment, neither of the quality of the trainee nor that of the trainer. General practitioner trainers are now assessed and there will have to be a more formal assessment of trainees, either during or at the end of the three years of vocational training: or, indeed, perhaps both formative and summative assessments. We will also have to decide the criteria necessary for membership of the Royal College of General Practitioners in light of the status of that qualification and the impending specialist lists to be produced by the General Medical Council.

Continuing medical education has always been on the College agenda: when we joined the College we all agreed to undertake a minimum amount of regular postgraduate education. Ever since the charter of 1966 the Department of Health has been involved in encouraging general practitioners to undertake continuing medical education. Initially the government agreed to pay not only for the educational component but also (through section 63 allowances) for travel and subsistence. For many years they also made the award of seniority payments dependent on the attendance at a specified number of educational sessions. Under the 1990 contract for general practitioners the rules of the game have been changed, though the principle remains. The new postgraduate educational allowance has a similar objective — to get general practitioners to keep themselves up to date — but the mechanism by which doctors are paid for that activity is different.

Reaccreditation is the logical extension of all these concepts of continuing medical education. It is an idea whose time is about to come. The profession must now determine how reaccreditation is to be applied so that is is acceptable to all four parties concerned: the consumers, who are our patients; the government, who are the purchasers of the service; the General Medical Council; and to us, the medical profession, who are one of the providers of the service. The question we now have to resolve is not whether reaccreditation is to be introduced, but by what method it is to be done and who is going to determine the policy. Are the decisions going to be made — as far as general practice is concerned — by general practitioners? Or are the criteria to be set by others, such as hospital-based specialists and family health services authority managers?

Conclusion

The aim of the College at its foundation, 'to foster, encourage and maintain the highest possible standards in general practice', is equally important today when all professions, not only the medical profession, are under threat. Standards are not cast in tablets of stone; they have to be kept under constant review in the light of both the advances being made in our scientific knowledge and in the context of changes in society. Standard setting is an academic exercise and the correct place for that task is within an academic college. Either we in general practice set and monitor our own standards or we allow others to do it for us. By having its own College, on an equal footing with the other medical royal colleges, general practice is able to present its own case and answer those who challenge our place in the delivery of health care.

I had the privilege of being on the council of the College for 30 years from 1961 to 1991 and to have served as a College officer for 21 of those years. At a meeting of the general practice section of the Royal Society of Medicine I volunteered to sit 'In the psychiatrist's chair' and be interviewed by Anthony Clare. Asked about my involvement with general practice I said that I thought I had been one of the midwives of modern general practice. I had not conceived it nor had I organized it: but I had been of some help in bringing about the developments which have enabled general practice to take its rightful place in the delivery of health care.

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