have tried to define good general practice. After nine years the members of the College could not be said to be in agreement. It seems it will be longer still before anyone dares to define the ideal wife for the general practitioner. Most of us hope that a good deal of latitude will be left in both, the selection of the man for this calling and the choice he has of a wife.

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ANCILLARY HELP

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Discussing the advantages of having a nurse in the surgery team one day, an unconvinced general practitioner told me that he liked to do his own ear-syringing and bandaging. "It gives me time to talk to my patients", he said, "and so to know them. And it provides a restful moment in the day!"

Much as I like this particular practitioner, I find him blind. If I were asked "what is the chief stumbling block to better practice today?", I should unhesitatingly say—"lack of time". We need facilities—equipment, better training, better continuing education, and much else besides. But none of these will bear fruit if we have not time to use them. There is at present a widespread will to improve general practice. There is no lack of ability to achieve this improvement if the right conditions are forthcoming. But lack of time, and fatigue, continue to keep the standards lower than they need be.

A good many years ago, when I was new to general practice, and before I had the support of a nurse in the surgery, an elderly countryman, whom I knew slightly, came in at the end of a long evening surgery. I didn't make much of him. He looked ill-at-ease and was not communicative, but mentioned several unimpressive symptoms, and continued to sit at my desk as if waiting for something to happen. I had had a long and tedious surgery, including time-consuming procedures in the dressing room; more work was waiting outside; and the pressure was on. I looked over him on the couch and found nothing, became a little impatient, and sent him off with a request to come in again in a few days. But the look he gave me as he left the room, and the resigned way he said, "all right then doctor", stayed with me. He shot himself about six o'clock the next morning.

I have learned a good deal about endogenous depression since that night. But here is the point—this is the man that needs my time and yours; not our friends with wax in their ears again.

The administrative mind seems slow to appreciate the speed of

change in medical sciences and its effects upon us. We in general practice are armed, as we have never been armed before; and the gates are wide open for the application of the new knowledge in domiciliary practice. " To cure, seldom; to relieve, sometimes; to comfort, always ". The old saying can already be partly re-written —" To prevent, often; to relieve, usually; "—but still, and not to be forgotten in this materialistic age, " to comfort, always ".

Hand in hand with our need for more time to practice goes the need for increased time for keeping up with scientific change, not only on annual courses or week-end refreshers, but for day-to-day reading and discussion around the work we are doing. The need for this will be progressively felt in the future.

I have dwelt on this because I believe that this insidious and progressive demand on our time is still only half realized. And the rate of increasing demand on our time is accelerating.

If we are to avoid the role of signpost to the specialists, or admitting defeat in the unequal struggle to remain informed clinicians in our own field, we urgently need to make time both for day-to-day education, and for day-to-day practice of the new medical knowledge. For the art of general practice *must* be supported by up-to-the-minute knowledge of what the medical sciences can do for our patients.

And I think I will have your agreement in believing it fundamental to the future well-being of the profession that there should flourish a large and able body of *general-practitioner clinicians* within it; the more so in an age when specialization is forced upon medicine, and is necessarily and rightly being developed in parallel.

How then are we to find the time we need? Of course the ultimate answer is a sufficient number of general practitioners (and I believe we should be pressing for this with much greater vigour than we are doing at present). They will come; but too slowly.

Meanwhile, I believe we should look to the provision of adequate time for clinical practice by organizing fuller ancillary help. Our present conceptions of " full ancillary help " (as the advertisements for trainee assistants read), are only a beginning, and I believe we have to think much more radically about organization in general practice. In this thinking there are two principles which should be firmly grasped: First, if delegation of work to ancillaries is a sound method of giving us the time we need for clinical practice, then our aim should be to delegate to the fullest extent. We must pass on everything that can be done as well, or better, by ancillaries than we do it ourselves.

Second, in surrounding ourselves with ancillary helpers, we must beware of losing personal touch with our patients, or of becoming

inaccessible. This implies that in the case of group practices or partnerships the whole team must be small enough to retain the personal flavour of general practice, and to enable the development of close co-operation between all its members. There are strong reasons in this context for retaining in future our present freedom to select whom we like for work in the surgery, a freedom lost in the health centre conception of organized practice. I say whom we "like" advisedly. We select a partner as much because we *like* him, as for his abilities. And with good reason. The same reasons apply in selecting ancillary help.

We can break down ancillary help as it is now understood into three basic components. First, the receptioinst/telephonist/secretarial sphere of work: second, nursing: and third, book-keeping and accountancy—a necessary field which is not part of a doctor's work. To these may be added, fourth, dispensing, still commonly a feature of practice here in the south-west, but applicable to some practices only, and fifth, the humbler, but in my view essential, part-time service, the messenger, a job suited to anyone who can ride a bicycle and can offer an hour or two hours in the day at appropriate times.

The covering of the receptionist/secretarial/telephonist work will depend on the local conditions and personalities around which the team is built. But certainly as members of this College we should aim at a high standard. The help should be sufficient, in my view, to provide an appointment system for all surgeries, and to ensure that we leave for every round with visiting lists prepared and the record card for every patient on it in the car. Record cards must be on the desk for us when surgery is started, and subsequently refiled for us. Hospital reports must be clipped together in chronological order before filing in the record envelopes. We must be relieved of all appointment-making, long-hand letters, and the routine paperwork that is steadily growing around us. There should be enough slack in the receptionist's time available for sidelines such as ageing and sexing of the practice, and the extraction of information for research. This is far from an exhaustive list. But service of this type is going to be essential for us all if we are to remain clinicians.

Nursing. I believe that full nursing cover in the surgery is a *sine qua non* for the good general practice of the future. Two things happened when a nurse came into our practice. First, she saved us much time, and, secondly, the standard of nursing procedures improved out of all recognition. (And this tends to raise one's own standard of technical performance.)

I should like to support my contention of time saved in the surgery by an impressive statistical calculation. But there are so many

imponderables. And besides, I have always cherished a suppressed regard for the man who said, " Sir, there are lies; damned lies; and statistics ". I have however some figures to offer from work done in my own practice, and some suggestions to make on my own and other people's experience.

The background to my picture is a group practice of seven principals working from central premises in a market town. Some of the partners hold hospital appointments, so the size of the general practice is less than is suggested by seven principals. We calculate that it would be comfortably run by five whole-time general practitioners, and it is this size of practice that our nurse (or rather, sister, as she is) covers. She has occasional help. She is a widow with a child to bring up, and therefore not in the running for hospital nursing; and she has now been with us for over ten years. I mention this as there must be many like her in the country, the employment of whom in this sort of work would not reduce the nursing strength of the hospitals.

The following figures give a picture of the volume and content of sister's work. I quote the average annual figures for the six years 1956 to 1961 inclusive.

She has dealt with an average of 9,988 attendances per annum. This represents 1,997 attendances per doctor, per annum, or 38 attendances per doctor per week—quite a lightening of the load when it is remembered that most of these types of attendances are time-consuming. And to this saving of time has to be added that of having a sterile syringe and towel service and prepared equipment, and no washing up or sterilizing for oneself. (I am quite partial to a congenial washing-up session at home! But I do resent it when pressed for time in the surgery).

The breakdown of the services given by sister reads thus expressed in percentages:

	Percentage
Immunization (triple antigen or equivalent, polio and vaccinations	32
Dressings	34
Injections (other than immunizations)	18
Ears syringed	5
Ears treated	2
Eyes, prepared for examination, or treated	2
Minor operations	1
And a miscellaneous group: including catheters passed, vaginal pessaries changed, carbon dioxide snow for warts, preparations for examination, venesection for blood count, throat swabs, and so on	6

Perhaps her biggest single contribution to the efficiency of the practice is the running of the immunization and vaccination service for infants. Her aim is to immunize and vaccinate every infant born

into the practice and record it on their N.H.S. record (the new summary card is used), and also in her own indexed file; they are of course reported to the local health authority in the usual way. She writes to defaulters, or if necessary pursues them into the country by car, thus achieving a very high percentage of immunity, and providing a service we could not possibly provide without her. The small number of infants immunized at county clinics present a recording difficulty, but most health visitors now keep us informed of what has been given to our patients; I may say that in some unaccountable way it has been very difficult to establish this, and it illustrates the sort of time-wasting rub that could be washed out by better integration of services.

This list could be extended, but I will not insult your imaginations by more detail, except to mention the influence of an experienced nurse on the general conduct of surgery affairs; and the security of having a hospital-trained colleague in control when a partner is not immediately available in crisis.

Sister takes no part in midwifery or domiciliary nursing except in emergency. We are well supported by the midwives and district nurses, and there seems no point in overlapping.

To come back to the ancillary staff as a whole, what staff is necessary for our basic needs? As a guide—and one can only discuss this point in general terms, because so much depends on personalities and local conditions—my experience leads me to think that the ratio of one ancillary to one doctor should be regarded as the minimum, and acceptable even at that only out of necessity. It is to my certain knowledge insufficient for the proper cover of the work I have described, and for future planning figures must be revised upwards. This excludes cleaning staff, caretakers in the case of central premises, and dispensers, where these are employed purely as such. The Teaching Unit at Edinburgh University run by Dr Richard Scott, which as is well known is composed of two working practices, employs an ancillary team in the ratio of three ancillaries to two doctors.

This level of ancillary help is taken for granted, and in fact far exceeded, in hospital practice. No business house could afford to operate without such help, and if we do not wish to become administrative officers in the Medical Civil Service nor can we.

Now, can we pay for a staff of these proportions out of our present-day incomes? This is not the time or place to discuss financial detail, nor to enter medicopolitical fields. But we should have some idea of what can be done at present.

Broadly, it can be said that staff in the ratio of one to one can

be paid for out of practice earnings, provided that the list is not a small one, and we are prepared to forfeit something from our pockets in favour of better working conditions.

Both finance and organization are made easier by group practice from shared premises. For the single-handed practitioner, or for partnerships working from separate premises, perhaps some distance apart, both are more difficult. For the small-list practitioner it may be quite impossible to provide ancillary help to cover the sort of work I have described, purely on financial grounds. All too often the gap is still filled by his wife, who has plenty to put up with in the life we lead in general practice without becoming embroiled in surgery work.

It is a commentary then on the present conditions of general practice in the National Health Service, that in order to finance adequate ancillary help, there is pressure to increase the size of our lists, when these should, by common consent, be falling in size. A moderate sized practice needs to take on more work to finance full ancillary service, and often it is not in a position to do so. If it is, such a move will free the principals from secretarial and nursing duties and allow him to spend his day on clinical practice. But the extra burden involved will rob him or her of much chance of shortening the day's work. And goodness knows we need some leisure as well, and we should look to better organization to ease the strain as well as to give us more time per patient. No less, it should take the weight off the shoulders of our wives.

A contribution to this problem is being made by the current experiments in the attachment of nurses, midwives, and health visitors to practices, notably in Hampshire. I have more to say about this shortly. But from the angle of finance, it is one example of how the general practitioner's ancillary team can be augmented without new monies from the public purse.

So far, I have outlined the ancillary help which I believe we should regard as basic for the future, though it may often be a struggle to provide it at present. Now, before I end, I want to cast the net wider and mention other gaps in our needs, which sooner or later will have to be filled.

I think most present will agree that *domiciliary physiotherapy* ranks high, especially in geriatric practice. The present shortage of physiotherapists is a bar to early improvement. But I hope planners recognize future needs in domiciliary work. And I wonder if something could not now be done by releasing a physiotherapist in each area who could perhaps instruct district nurses, even voluntary workers, and certainly relatives, in the simpler methods of treatment. For example, one session with a hemi-

plegic's family with subsequent supervision by the district nurse would be worth having.

Perhaps even more important than physiotherapy is our lack of call on *an almoner*. I use this word for want of a better one. I personally feel the need for a helper who would have the time, where I have not, to research into the background of an individual or a family's ill-health. The facts required might relate to their financial state; or to the pressures at work behind emotional illness; or a variety of other matters. There really is a mass of work in this field, which none of us here can cover single-handed, and which, not done, leads to much ill-health and petty crime, ill-health and crime which might never develop if its origins were discovered in embryo.

The almoner would have to be primarily a confidential assistant of carefully selected personality with basic knowledge of almoning, psychiatric social work, and of the social service generally. Above all she would need to be a humanist, and have understanding and experience of local people. She would keep touch with all the specialized social services in the area, and act as an informed link between them and ourselves. This is perhaps less formidable than it sounds. Most of us learn a lot of social and family history about our patients from our experienced receptionists—a most valuable contribution which often goes unrecognized. This "Almoner" is no more than a recognition and extension of this service. In the health visitor attachment experiments I gather that this kind of service is coming from them, and is proving valuable.

Lastly, I want to mention the need for the services of *a technician*. We need a sterile syringe service, and sterile towel service, and we need a fairly *large volume* of *routine* pathological tests on urine, blood, and faeces. To this may be added technical help with routine electrocardiography. This last may sound a tall order; but I believe that this is a field which we have to develop for the future. All these needs are *increasing*. These important services are provided at present, if they are provided at all, by ourselves (and how I resent the time I spend in venepuncture in the antenatal clinic, or in collecting blood three times a week for prothrombin ratios at home), by various members of our ancillary staffs, or by hospital or laboratory services.

Physiotherapy, —"Almoning",—Technical Help;—these three needs are with us if we are to pursue the policy of maximal delegation, and free ourselves to develop the clinical work that we alone are trained and able to perform.

What hopes are there of obtaining these services? Some functions of the almoner service can be obtained by attachment of health

visitors, and this is certainly one way of starting the ball rolling. However, it is a method born out of history, by expediency, and the offspring, though no doubt a willing horse, is not likely to be a thoroughbred. We need specifically trained personnel for a specific and exacting job, and I would prefer to see a new scheme designed to do this.

It is not within the scope of this paper to discuss how such ancillary help might be organized and financed in the future. But it is worth taking a closer look at the Hampshire experiments. The past separation from us of the local health authority's health visitors, district nurses, and midwives, administratively, geographically and all too often, professionally, has always seemed to me an abysmal historical legacy that should be terminated. The present experiment comes as a breath of fresh air; I hope this puff forecasts a good sailing breeze in the near future. These experiments make it possible, at last, for doctors, nurses, midwives, and health visitors to work, on the same group of patients, and form a team working from day to day in professional integration. Particularly in midwifery is it satisfactory to see one doctor and one midwife handling one patient throughout pregnancy, confinement, and the postnatal period.

The essence of our work is a personal service; and our team must be orientated to groups of persons—not to tidy geographical areas. The practice is the logical unit, not a mapped area of the town.

The system is easily applied to group practices and the larger partnerships. For single-handed practices there are difficulties (one of the answers to which is to form more groups) but I see no reason why one health visitor, one district nurse and one midwife should not attach themselves to two single-handed practices. This is better than ten health visitors, ten district nurses and ten midwives working sporadically with ten different general practitioners. Here the frequency of contact drops to negligible proportions.

I see two disadvantages in the scheme. First, the general practitioner loses his freedom to select his own ancillary team—they are posted to him by the local health authority. And second, I am not convinced that the health visitor's present training is correctly orientated to the work we should have for her. With a nurse and midwife in the practice I would settle for less midwifery and nursing, and more almoning and psychiatry in her training. For these reasons I would like to see other experiments carried out in parallel with the present ones, in particular, in regard to training an almoner type of helper. And I should like to see methods of financing ancillary help explored, which would leave the selection of staff in the hands of the practitioner who is to work with them.

I have in mind a model team representing one approach to future

organization.

In my little Utopia I should have five general practitioners working in partnership from central premises. Three nurses would handle not only the surgery nursing, but also the domiciliary nursing for the practice. Three midwives would cover both domiciliary and maternity-home confinements for the practice. Three or four secretary-receptionists would cover their side of the work, preferably with a call on part-time occasional help from outside. A half-time book-keeper would handle the accounts, wages, and related matters; and I should not forget my cycling messenger's two hours a day. One almoner, one physiotherapist, and one appropriately trained technician would complete the team in the approximate ratio of three ancillaries to one doctor. (Note that this higher ratio covers domiciliary nursing as well as surgery nursing, midwifery, almoning, physiotherapy, and technical help, none of which were included in the old ratio of one to one.) I have purposely omitted mention of a health visitor, as I feel our needs naturally divide a health visitor's work into almoning in a broad sense on the one hand, and nursing on the other.

In such a team, where a high degree of understanding should develop between everyone in it, one can well visualize nurses and midwives relieving us of some of the routine follow-up visiting. Those of us who have distant country patients know well how reliable support in this way can free us for other work awaiting our attention. And so often, the diagnosis made, what is wanted is a little planned nursing, rather than the brief appearance of an over-travelled doctor, probably in the middle of lunch, or after everybody has given him up and gone to bed.

Who is to pay for this improved service, and how, is not our business. But we should know what we want. If anyone regards my suggestions as excessive, be it noted that even in Russia, where perhaps the standard of general practice has not reached that in the West, each general practitioner visits with his own nurse-secretary in tow.

In conclusion, I would like to pay a tribute to our ancillary helpers. Sandwiched between the patients and ourselves, and called upon in every crisis of the day, they give us the time and support which make it possible to concentrate on our clinical work. Future standards in general practice will depend very much upon their continued help, and their excellence.

There has been recent talk of specialized training for the ancillary posts, possibly associated with diplomas. For the almoner-cum-psychiatric worker, I am sure there is need for this. On the other hand, nurses, midwives, and physiotherapists are already fully

trained in their specialities, and would not need more than an apprenticeship, or introduction to, domiciliary practice. But without prejudice to carefully designed training and examinations, where they are needed, I hope enthusiasms for them will not blind us to old-fashioned virtues like reliability, thoroughness, and a pleasing personality, as *prima facie* qualifications for work in our surgeries.

" . . . I have been constantly employed since I came here. I get up about ½ past 7, go downstairs and put the Laboratory in order. At eight we have prayers which the Doctor *reads* in the morning (I think they are Jay's), then breakfast with *beefstaeks*, etc. After that for an hour or so I post the books, transferring the medicines from the Daybook into the Ledger. By this time the Gig is at the door and in we get, driving to Brompton, which is about 2 miles off and consists almost entirely of the dockyard, the two Hospitals, and the Barracks, and their natural accompaniments Alehouses. Here there are a great number very ill of a low fever which some would call typhus, but which I do not think in any degree contagious. Then he comes home about ½ past 11 and writes a page or two of prescriptions and is off again, leaving me to make up the medicines. This keeps me generally busy until ½ past 1 when we have dinner, and you may tell grandmother a dinner every day as much like in every respect and as simple as Janet's, with this improvement, that there is plenty of home-brewed ' Nutbrown ' ale. By the time that dinner is over there are 10 or a dozen of patients waiting. These all have their *mixture* or draught or powders, and they pay to *me*. As soon as they are away and the morning's medicine sent, the Doctor gives me another page, and this is sufficient for me till 5, when Coffee is announced. After that medicines have to be filled up and the *books* arranged. I have generally a little time to myself for reading the Newspapers before supper and writing out cases. Dr. Martin gets the *Times* and is a thorough-going reformer in Church and state . . . " *Dr John Brown To His Father* (1831)

Letters of Dr John Brown. Lond. 1907. p.10.