At the inception of the NHS, junior house doctors were expected to use all the laboratory, X-ray, and bacteriological services of the hospital. When those same doctors went into general practice they were totally cut off from the hospitals and restricted to making bedside diagnoses. When I became a GP in 1954, if I wanted to know the result of a chest X-ray or even a full blood count, I had to send the patient to a consultant in out-patients where the investigation would be ordered. GPs had no status within the profession, were on duty 24/7/52, and were expected to care for 4000 patients. We needed an academic college of our own. It was founded 60 years ago.

Unfortunately we have lost some things too. Perhaps the greatest of our losses was the affection of our patients. We may still even now have their respect, but not the warmth, friendship, and emotional component of the old doctor–patient relationship. It may have been changing our hours of work that scuppered it. Anyone who works from 9 to 5 has a job. Doctors were never thought of as having jobs. Like priests they were perceived to have a calling. So one can hardly blame the public for grumbling about a doctor not doing his job properly resulting, as Gerada and Riley wrote in an editorial in the 60th anniversary edition of the Journal, ‘... we are under constant threat. Barely a week goes by without another report implying that GPs have failed in some way.’ Does this also suggest we are now losing our patients’ trust in us?

So where do we go from here? What can we, as GPs, offer, that other doctors, confined to their super knowledge of one organ or one body system like hepatology or immunology, cannot. What is it that we uniquely offer? We are not, and should never pretend to be, mini specialists in all the other branches of medicine, although we must keep up-to-date with advances across the spectrum of technology.

I suggest that, in addition to our recognised value as the first port of call for patients and the treatments we are able to offer, there are three things we should recognise as special to us.

First: prevention. This includes all the childhood and other vaccinations, obesity, the complications of existing conditions, contraceptive advice, and so on. It is not enough just to do it. It is like justice; it must be seen to be done. It has to be advertised to patients with notices in waiting areas, leaflets sent with any correspondence, and to patients with notices in waiting areas, leaflets sent with any correspondence, and so on. If left to the initiative of the patient, this fundamental aid will largely be lost.

Second: early diagnosis (carcinoma, breast, Alzheimers, and autism) and active searching for latent illnesses such as hypertension, hypercholesterolaemia, and osteoporosis. When patients attend for one condition it is the ideal time to think laterally.

Third: understanding. We are the ones who must understand that the patient’s illness in the setting of their family is different from the consultant’s view of them in the isolation of a hospital ward among strangers. We are the ones who must fit the patient’s illness into the pattern of their life. We are the doctors who must understand that the presenting symptom may mean one thing to us but something different to the patient. Our sympathy for the patient is different from the sympathy shown by consultants.

None of these is exciting and cannot match the drama of, say, open-heart surgery, but collectively they are far more important for the health of the nation than the excellent work done by our specialist colleagues. And if we do not do these things, we could just as well be replaced by computers.

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REFERENCE