" LORD MORAN'S LADDER "

A study of motivation in the choice of general practice as a career

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ON THE 17 January 1958, Lord Moran of Manton, who was at that time Chairman of the Awards Committee administering merit awards for consultants in the National Health Service, was giving evidence before the Royal Commission on Doctors' and Dentists' Remuneration.[1] He was defending the principle of merit awards against a certain amount of criticism by the members of the Commission and he made the point that those selected for these awards were chosen from a group of doctors, the consultants, who had already distinguished themselves from the rest of the profession by achieving that status. He described the process by which they did so and mentioned " a ladder which people are constantly falling off ". The chairman then asked him the following question: " It has been put to us by a good many people that the two branches of the profession, general practice and consultancy, are not senior or junior to one another but they are level. Do you agree with that? " To which he replied as follows: " I say emphatically ' No '. Could anything be more absurd? I was Dean of St Mary's Hospital Medical School for 25 years . . . all the people of outstanding merit, with few exceptions, aimed to get on the Staff. There was no other aim and it was a ladder off which some of them fell. How can you say that the people who get to the top of the ladder are the same people who fall off it? It seems to me so ludicrous ". In reply to further questions the noble lord made evident his distaste at having to discuss such contentious matters in public but he stuck to his guns and maintained that his " ladder " was real enough, although this did not imply that general practitioners did not include amongst their number men of ability doing spendid work in their own field.

Lord Moran's remarks obtained great publicity in both the daily

and the medical press and there was a great deal of indignant outcry amongst general practitioners who felt that an attempt was being made to split the profession into two branches, one of which was to have a status inferior to that of the other. In fact a fair reading of the evidence shows that Lord Moran was giving a picture of the existing state of affairs as he saw it and expressed no opinion as to whether the situation was satisfactory or desirable.

Most of the other evidence on the subject given before the Royal Commission seems to have suggested that there is no real difference between the intellectual and the professional status of general practitioners and consultants, the two branches being parallel offshoots of a common trunk, each equally endowed with men of ability who had entered one or other branch at will or possibly because of the pressure of external forces beyond their own power to control. It occurred to me to wonder whether this was indeed true or whether Lord Moran was right in suggesting that consultant practice was something to be achieved only by those able to overcome the obstacles set by the need to pass examinations and by financial and social barriers. Was general practice in fact ever a vocation, or was it the final resort of those who did not possess the attributes required to climb up the ladder and enter the higher branches of the profession?

The opportunity to satisfy this curiosity came with the award of an Upjohn Travelling Fellowship by the College of General Practitioners. This provided a sum of money sufficient to cover the expense of leaving my practice for three weeks and of travelling around the country to interview general practitioners regarding the circumstances in which they entered general practice. It also allowed me to obtain by post personal data concerning these practitioners from which might be deduced some idea of their social, financial and intellectual status. Finally a group of consultants, matched in certain respects with the general practitioners, were invited to answer similar questions and also to state in writing the reasons that had led to their entry into consultant practice. The consultants were to be used as controls whereby the importance of environmental and other factors in the choice of general practice as a career could be assessed, and by which could be tested the validity of the general practitioners' motivations as seen by themselves.

The first problem to be faced was the selection of a representative sample of general practitioners to be interviewed. The time available for this part of the investigation placed strict limitations on the number to be included and on their

geographical distribution. It seemed that the most important variables to be covered were the type of practice in which the subjects were engaged and the time at which they qualified. A rather crude division of practices into industrial, residential, and rural was decided upon and three areas corresponding with these divisions were selected in parts of England remote from one another. The division in time was made between those qualifying in the years 1926-30, who might be expected to have been established in practice before the outbreak of the 1939-45 war, those qualifying in 1938-42, whose careers were necessarily influenced by war conditions, and finally those qualifying in 1951-55 after the institution of the National Health Service. In fact these periods had to be extended somewhat, especially in the 1926-30 group, owing to difficulty in filling the panels, but the basic principles of the division in time were not affected thereby.

Dividing each "geographical" into three "time" groups resulted in the formation of nine sub-groups and it was decided that time would allow for ten doctors in each of these to be visited. In the end, owing to difficulties in filling the panels and to last minute withdrawals caused by sickness and holidays, only 75 were interviewed with the numbers in each sub-group varying from six to ten. The local panel lists were obtained and names selected in alphabetical order from these until each sub-group contained ten names. Certain names were excluded in order to simplify the enquiry and to increase its accuracy and significance; only male practitioners trained in medical schools in the United Kingdom and Eire were included. It was intended that no doctor in partnership with another already on the list should be interviewed as it was felt that this might bias the results of the investigation owing to a tendency that exists to select a man with a similar background to one's own when choosing a partner. Unfortunately clerical error did lead in two cases to partners being included but these were both in the rural area and the partnerships were mainly a matter of convenience, so that it was decided not to exclude them once the mistake had been noticed. In the industrial city only those practitioners having their main surgeries in the working class areas were included.

The selected practitioners were then asked by post whether they would be prepared to take part and where they refused or failed to reply another name was selected from the appropriate panel list and the process repeated until the sub-group concerned was filled or the passage of time made it necessary to close the lists. In the end 82 acceptances were obtained after 124 doctors had been approached. The refusal rate varied very much in the different groups, as shown in the table I.

TABLE I

REFUSAL RATE OF THOSE APPROACHED BY QUESTIONNAIRE

General practitioners	*Approached*	*Accepted*	*Refused*
Rural area	37	29	8
Residential area.. ..	41	27	14
Industrial area	46	26	20
1926–30 group	51	27	24
1938–42 group	41	27	14
1951–55 group ..	32	28	4
Consultants	*Approached*	*Accepted*	*Refused*
1926–30 group	37	25	12
1938–42 group	37	25	12
1951–55 group	25	20	5

These figures are important as they may well give grounds for the criticism that the degree of self-selection is so great as to invalidate the results of the investigation. It is, of course, not possible to know for certain in most cases why doctors refused to co-operate. When a reason was given it was nearly always that the doctor was too busy or that he felt that he was too old for his case to be of significance. I think that the time factor was important in the case of the urban practitioners who seemed to find it much more difficult to fit in appointments than their rural colleagues, but the striking difference in the response of the oldest and the youngest men must surely represent a new attitude towards research not shared by the passing generation, to many of whom such enquiries as this must seem to be the misplaced efforts of the mentally unbalanced! There seemed, however, to be no way of avoiding this element of self-selection with its obvious effects on the interpretation of the results.

In order to save time at the interviews, a questionnaire was sent to each of those who had agreed to take part, on which he could supply information of a strictly factual nature. In due course each was personally visited by me and an attempt was made to determine the principle factors that had led to his entry into general practice. The opportunity was taken to discuss also the doctor's feelings about his professional status, his relationships with consultants, and his impressions of their attitudes towards general practitioners. He was also asked to state what he thought should be the difference if any, between the pay of consultants and that of general practitioners, this being a round-about way of discovering his true feelings regarding his professional status and his importance in the medical world. These matters will be the subject of a further report to be submitted in due course. Seven of those who had accepted could not in the end be interviewed for various unavoidable reasons and the data given in their questionnaires has not been included in the analysis which follows later in this report.

The next problem was the selection of the consultants to be used as controls. Ideally, each would have been a colleague of one of the general practitioners in the survey who qualified with him at the same time at the same medical school. This was obviously impossible to achieve and it was decided that the matching could only extend to the selection of three groups of 25 who had qualified in the same span of years as the " time " groups of general practitioners. No attempt at geographical matching was made, as to select a large group of consultants all practising in one industrial city or at the centre of one rural district would almost certainly cause strong bias, owing to the fact that consultants often have considerable influence on the selection of their colleagues. The names were selected at random from the *Medical Directory*. A start was made at the top of page 50 and the names were scanned until that of a full consultant in active practice was reached. The process was repeated on page 100 and so on to the end of the *Directory*, after which pages 25, 75, etc., were searched. It was thought desirable that the numbers in each speciality invited to take part should compare as nearly as possible with the numbers practising in that speciality in the National Health Service as given in a report to Parliament in April 1962. As the list progressed certain names were excluded when it was apparent that there were already too many members of that particular speciality on the list. This method finally produced a satisfactory number of names in the 1926-30 and the 1938-42 groups, but there was considerable difficulty in obtaining names for the 1951-55 group as few doctors who qualified as recently as this had yet achieved consultant status. It was also apparent that certian specialities, such as psychiatry and anaesthetics, were not adequately represented. As things turned out I had to be satisfied with only 20 names in the 1951-55 group owing to the necessity of completing and submitting the report within a reasonable time. I do not think that this seriously invalidates the results of the enquiry, which are, as I shall point out,

not claimed to be of statistical significance.

The consultants were then asked to fill up a questionnaire similar to that completed by the general practitioners but differing in certain details. They were also asked to give what they thought had been the principal factors which had led each of them to enter his particular speciality. The questionnaire was sent to an adequate number in each group and if they had not been returned after a few weeks had elapsed it was assumed that the consultant concerned did not wish to take part in the investigation. Further consultants were then approached until the necessary number of completed questionnaires had been obtained from each group. The refusal rate was notably less in the 1926-30 group than it had been amongst the general practitioners. Table I gives details.

There still exists some degree of self-selection, the reasons for which cannot be definitely established. It is of interest that a 100 per cent response was obtained from those half-dozen or so on the list who occupy positions of eminence in the medical world. One cannot help but feel that there is a moral hidden here somewhere as these must be amongst the busiest men in the profession.

I feel it necessary at this point to admit the limitations of this report and to anticipate the criticism that firm conclusions are being drawn from data obtained by imperfect methods of investigation. The numbers involved are small and cannot possibly form a statistically significant sample. In the case of the general practitioners it is impossible to say whether the areas chosen are representative of the country as a whole; nobody can say how many practitioners are working in industrial areas and how many in rural or residential areas. The metropolitan area was not covered at all and even in the rural area the spread of suburbia meant that there was much of what might be considered as residential or light industrial practice. The enquiry cannot amount to more than a pilot survey and my conclusions cannot be much more than impressions. Nevertheless they may be of some interest or importance in that they tend to confirm or deny certain generally held views about the origins and background of those belonging to the two main branches of the profession and of the circumstances which direct doctors into one or other branch.

Influences leading to the choice of general practice as a career

Why did you become a general practitioner? I asked this question of 75 general practitioners and, as might have been expected, got 75 different answers. Every happening in human life is probably consequent on the chance coincidence of a number of antecedent events and so complicated a mental process as the making of a decision on how a man's working life is to be spent is hardly likely to be influenced only by one or other simple consideration. Some of those to whom the question was put were able to see clearly the

train of events which had led to their decision; others had to be subjected to a fund of leading questions before they could clarify the matter in their own minds and could analyse their own behaviour in a way that they had never before been interested or curious enough to attempt. In the end there was obtained in each case a reasonably complete but necessarily subjective " aetiology " and an attempt had to be made to arrange all 75 of these into some sort of order.

Any classification of this sort is bound to suffer from a good deal of overlapping and the numbers included under each heading must add up to many more than the number of cases investigated, since there are nearly always several influences present in each case. However, in order to give some idea of the relative importance of each factor, an attempt has been made to determine for each individual one, or occasionally two, influences which impressed me as being of paramount importance. It is also helpful to divide the subjects into two groups; (*a*) those who at some point had a definite intention or wish to enter consultant practice and (*b*) those who had always wished to be general practitioners or who had never had any firm ambition to enter a particular branch of medical practice. It is now proposed to discuss under appropriate headings the answers given to the main question.

1. " *I wanted to be a general practitioner . . .* "

About one doctor in three amongst those interviewed claimed that he had entered general practice because he wished to do so for one reason or another, and not because he had been forced into it against his real desire by some combination of circumstances which he had not the ability nor the strength of character to overcome. The great majority of these doctors had made up their minds to go into general practice at some time before they qualified in medicine but a few were attracted to it by impressions gained when undertaking locum tenancies. Some of this latter group had intended to be consultants until they saw what general practice was like; the remainder had been uncommitted up to that point.

It is interesting to learn what are the features of general practice that make it positively attractive to some. Most commonly it is the conception that one is working with people as individuals and not as somewhat anonymous " cases ". Such sentiments are often seen expressed in writing and I fancy that most consultants, particularly

those in the clinical specialities, would feel that there is an unfair criticism implied therein. As with most abstract ideas the truth is incapable of final determination, but I feel that the doctor who says that he entered general practice because "I want to help people" is getting a little confused. Some honestly feel that general practice is essentially the most important job in medicine and worthy of their talents, and of course they may be perfectly right. Others have a more practical view of its advantages; you can live and work in the country if you wish and if you are shy and introverted you can work on your own without contact with other doctors and hospital staff. One doctor made the rather thought-provoking confession that he liked general practice in his semi-rural community because it put him in a position to influence the private lives of his patients, a situation which he had enjoyed ever since his Army days. He was one of the most extroverted persons I have ever met, with some unusual but interesting views about other matters which will be mentioned in my report on intra-professional relationships.

There was hardly any difference in the three "geographical" groups and in the three "time" groups between the proportions of the whole claiming this positive motivation, and it seems reasonable to conclude that only one third of the general practitioners in the country ever really wanted to be in general practice. This may possibly explain some of the frustration and dissatisfaction that is expressed in letters to the medical journals and elsewhere. Nevertheless only one in four of the others thought that they had done the wrong thing when they entered general practice; the remainder considered that they had acted reasonably in the circumstances obtaining at the time. Likewise only a similar number now wished to get into some other field of medical activity and only two were making any serious attempt to do something about it. Presumably there are many who find general practice better than they expected, but I suspect that inertia and family responsibilities lead others to make the best of a bad bargain and to swallow their disappointments.

2. "*My father was a doctor . . .*"

Among those interviewed there were 20 whose fathers were themselves in general practice. In six of these cases the father had died before the son qualified, but it might have been expected that in a majority of the remainder the son would have joined his father happily and willingly in the natural course of events. In fact only two of them did so; half-a-dozen others went unwillingly into their

fathers' practices, either because the father was ill or overworked or because of financial difficulties to which this course seemed the most obvious solution. There were three others who entered general practice elsewhere entirely as a matter of choice and who ascribed their desire to do so to what they had seen of their fathers' work. There was also one who had been similarly influenced by his grandfather, although his father had not himself been a doctor. Twelve of the 20 had originally wished to be consultants. Obviously family tradition is not so strong a factor as might be supposed and it is a sad reflection on general practice, even as it was in pre-National Health Service days, that so few sons of general practitioners should wish to follow in their fathers' footsteps; yet, as will be shown later, even fewer consultants' sons do so, a finding which will be discussed in its appropriate place.

3. " *An opportunity came my way and I took it . . .* "

There is a tendency in some quarters to discount the importance of chance as a significant factor in any man's career. It may merely open a path to a destination which the individual will reach in any case by one route or another. However that may be, there were eight amongst those interviewed in this survey who felt that the most significant factor influencing their entry into general practice had been an opportunity to do so in advantageous circumstances at a time when they were still intending to do something else. In two cases a friend pointed out an unusually promising area in which to " squat ". In two others the doctor was approached by a friend who was looking for a partner. In three more he went as a locum tenens or temporary assistant, with the intention of earning a little money between hospital appointments, and was persuaded to stay. The last was a doctor whose father, thinking he knew what was best for him, bought a practice without consulting him and told him to get on with it, which he seems to have done without raising too many objections!

There were as many as 19 others whom chance had directed to a particular practice but who had already made up their minds to be in general practice somewhere, either willingly or by force of circumstances. Some of these might well have been tempted into general practice by these opportunities even if their sights had been set on other targets. An interesting case was a doctor whose general-practitioner-consultant chief in hospital was accustomed to give a present to each of his housemen when they left. On this

occasion no present was forthcoming and the doctor thought that he must have been a notable failure, until a few days later he was asked by his chief to call on him and, on doing so, was told that he had so impressed the latter that the present was to be his private practice, from which he was retiring, free gratis and for nothing! The other cases were similar to those described in the last paragraph, most being invitations to join practices where the doctor was acting as a locum tenens, or in a district where he was a houseman at the local hospital and was known to his future partner. It is interesting to note that of 27 cases in all coming under the heading of this paragraph only two were in the industrial area. Presumably housemen in such an area never get known to the local practitioners and conditions do not tempt locums tenens to put down their roots even if they are invited to do so.

4. "*I could never have passed the examinations . . .*"

All the opinions given by the subjects of the enquiry were, of course, their own views of the situation seen through their own eyes and containing, no doubt, a good deal of rationalization. I repeatedly found myself wondering how many of them, especially those who claimed to have a vocation for it, would have entered general practice had a necessary qualification been a minimum period of postgraduate apprenticeship and the passing of an examination no less difficult than that required for a specialist diploma. There were in fact three men who said that they had become general practitioners only because of failure to pass higher examinations, and three others who had done so because they had experienced so much difficulty in passing their final qualifying examination that they had realized at that point that erstwhile ambitions to specialize were unattainable. These six could see no other insuperable obstacles that would have stopped them from becoming consultants. Three others had experienced failures in higher examinations but thought that other circumstances would have made it impossible to have achieved consultant status. Altogether it seems that less than one general practitioner in ten has ever attempted to obtain consultant qualifications, a matter that will be discussed later in this report.

5. "*I could never have made a success of consultant practice . . .*"

Amongst those who had, during their student or early postgraduate days, harboured ambitions to become consultants, there were a number who maintained that they had turned towards general

practice without attempting their higher examinations because of a conviction that, even if they had passed, they could not have got appointments. On most of the younger men in this group the " failed registrar " problem seems to have made a big impression. The curious thing is that I did not come across one actual failed-registrar amongst all the doctors that I interviewed. There are several possible explanations for this. It may be that most of these men qualified in the years immediately after the war and were therefore not included in any of the " time " groups covered by the survey; it might also be that most of them failed to get into general practice and are now abroad or in " non-career " posts in hospitals. There remains the possibility that the whole problem was exaggerated and that the numbers involved were so small that chance alone determined the fact that none appeared on my lists. However, there seems no doubt that, whether real or legendary, the " failed registrar " encouraged many others to stop before they started. Other reasons given for failure even to make the attempt were the inability to obtain a house appointment at a teaching hospital, a retiring personality not suited to the " rat race ", and an inability to work harmoniously with seniors. Five of those interviewed felt that influences of this sort were the major factor which resulted in their turning to general practice as a career. A number of others thought that such impressions had played a minor role only in determining their course of action.

6. " *I did it for my wife and children . . .* "

During the interviews frequent mention was made of the question of money as a major influence in forcing men unwillingly into general practice. In most cases the doctor associated this with the fact that he was married or contemplated marriage and that in some cases he already had children. It was taken as a primary assumption that it was impossible to study for higher degrees and to wait for consultant status if in the meantime there was a family to support and there were no private means available. Nine doctors, all of whom had hoped to be consultants, gave marital obligations as the principal reason why they were general practitioners and in 15 other cases family needs had been of some lesser importance. Some of these men had married while serving in the Armed Forces and it is easy to see why they felt that a further period of financial stringency could not be accepted. Nevertheless, being short of money does not necessarily justify the giving up of ambitions, and

one wonders whether there were any particular circumstances in these cases that differentiated them from others in apparently the same position who carried on and became consultants.

More than ever before one hears arguments nowadays about the necessity of ensuring that early marriage should not be a bar to professional success or achievement. Hospitals are required to provide married quarters for housemen and similar accommodation often has to be provided if a doctor is to obtain the services of an assistant. Some may think that the defection of a number of keen, would-be consultants to general practice is a loss to medicine; others will say that it is an excellent thing that such economic considerations should ensure that general practice gains what the hospitals lose. There is a good deal of planning directed to forcing the stream to flow one way or other. The pay of house officers and registrars has been substantially raised as a result of the Royal Commission's recommendations; now, in contrast, there is a move to diminish the differentials between the earnings of general practitioners and consultants. The tug-of-war goes on and everybody takes it for granted that considerations of this sort do make a real difference to the numbers and calibre of those entering the two branches of the profession. But do they or, at any rate, have they done so in the past? To examine this point it is impossible to avoid arguing from the general to the particular. There may have been something special in the circumstances surrounding the men at present under consideration, but there were quite a few of them and there were no other obvious similarities between them. If we assume that they are typical of the whole mass of general practitioners and that considerations of money and finance do determine the choice of a career in a significant number of cases, then there should be certain differences in the life histories as between general practitioners and consultants that should underline this fact. Consultants should, on the whole, be more likely to have a strong financial background, to have qualified early and to have married late. The tables given below summarize the facts as determined by this survey. The term " career age " means the age at which the subject took what might be considered as a final step determining his future career. In the case of a general practitioner it is his age when he first entered general practice as a principal; in the case of the consultant it is his age when he acquired the higher degree or diploma that qualified him to engage in his particular speciality. It seems that this is a reasonable comparison because, as we have

already seen, some general practitioners might have continued towards a consultant career had they succeeded in passing the necessary examinations. Most consultants did obviously make up their minds to follow a speciality long before they took their higher qualifications but any one of them might have turned to general practice had he failed to obtain these (table II).

TABLE II
PARTICULARS CONCERNING MARRIAGE

	Married before qualification	*Married between qualification and " career age "*	*Married after " career age "*	*Unmarried*	*Average age at qualification*	*Average age at marriage*	*Average years between qualification and marriage*
G.P. 1926–30	0	13	8	2	23·6	30·6	7·0
Cons.1926–30	0	12	12	1	23·2	28·6	5·4
G.P. 1938–42	0	19	7	1	24·4	29·7	5·3
Cons.1938–42	0	15	9	1	23·6	28·0	4·4
G.P. 1951–55	6	12	6	1	26·5	27·4	0·9
Cons.1951–55	3	15	1	1	24·0	25·5	1·5
All G.P. ..	6	44	21	4	24·9	29·1	4·2
All Cons. ..	3	42	22	3	23·6	27·7	4·1

Examination of the tables shows that there is hardly any difference between the number of general practitioners and consultants who were already married when they reached this most significant stage in their careers. In other words there is no evidence that consultants as a whole were better able to carry on with their predetermined careers because they had fewer family responsibilities. There has been recently a general tendency amongst all doctors to qualify later and to marry earlier than they did in the days of 40 years ago, but at all times the future consultants have done both at an earlier age than the future general practitioners and, once again, there is no evidence that by delaying their marriage they have improved their future prospects. This is, of course, a generalization but if there were any special circumstances in the cases of the general practitioners who claimed that family obligations drove them into general practice, there should be somewhere amongst the consultants a balancing group with similar problems who managed to

overcome them somehow. One is driven to the conclusion that the essential factor in these cases is not the actual existence of the family obligations but rather the unwillingness on the part of the doctor or his wife to accept the hardships consequent on such relative poverty as the price to be paid for ultimate success.

7. " *I needed the money . . .* "

It is not always to support a wife and children that money is urgently needed. Sometimes it is a matter of repaying a father or some other relative who has loaned money to enable the doctor to qualify and to get some postgraduate experience but who has now fallen on difficult times. Five of the practitioners who were interviewed gave this as the main reason why they discarded their ambitions and turned to family doctoring. They differ in my opinion from the last group in that most of them were already married and this was an additional burden and one that they had not foreseen. Several others mentioned such obligations amongst minor factors affecting their choice of a career. It is the nearest to pure bad luck that was found throughout the investigation.

8. " *I was too lazy to be anything else . . .* "

Surprisingly enough there were six men who thought that they were in general practice because they were " too lazy to be anything else ", the presumption being that such a career required nothing more than a qualifying degree and a chance to get started somewhere. They all felt that they had the ability to pass examinations but just could not be bothered to do so. Many others felt that, with the present set-up, an unwillingness to continue studying had something to do with their choice of career but was not the principal reason for it. More will be said later about the whole question, which seems to be fundamental when the future of general practice is considered.

9. " *It was too late to be anything else . . .* "

Three doctors were in general practice much against their wishes, principally because they were too old when they sought to become consultants. Two had considerable surgical experience, one as a medical missionary and one in the Indian Medical Service, but neither possessed the F.R.C.S. and it is extremely unlikely that they would have got consultant appointments if they had acquired such a higher qualification. Neither really liked general practice but they had little alternative if they were to earn a living. The third qualified

relatively late in life and would have been middle-aged before he had completed specialist training. It may be remarked that there were one or two others who would have been in the same situation had it not been that general practice had always been their goal.

10. " *My wife needed my company . . .* "

A really unexpected explanation of the failure to pursue consultant status came from two men who said that they had feared that their marriages might have broken up had they devoted too much of their spare time to study. They were both most agreeable men who had other much more cogent reasons for having gone into general practice and I think that they may have been doing their wives less than justice! I never met the ladies and I had no chance to find out.

11. " *I was beaten before I started . . .* "

There was one who said " I am a general practitioner because I have got second-class brains ", and another " I am a general practitioner because I could see that nothing else was within reach ". It seemed to be a combination of several other reasons put together and they might have been included under one or other heading. What distinguished them to me was the air of resignation with which they accepted what they obviously looked upon as their " fate ".

One or two men did say that in their opinion they had suffered bad luck whilst serving in the Armed Forces by being appointed as general duty medical officers, whilst others, no better qualified, were directed to specialist posts for which no qualified man was available. It was perhaps a minor factor but there is no doubt that service in such a capacity over a considerable period did damp the enthusiam of some young would-be specialists and that the opposite turn of events made consultants out of some who would otherwise have been very willing general practitioners.

12. " *A consultant's life is not a happy one . . .* "

Last, but not the least interesting, is a small group of men who became general practitioners because they actively disliked some aspects of consultant practice. I have separated them from the first group on this list because they were not so much enamoured of general practice as they were opposed to the alternative. In only two cases was it the major reason for entering into general practice. One had been a consultant for some years; his appointment entailed his spending much time travelling from place to place and he had not

found work in his speciality very interesting or satisfying. The other was the son of a consultant who had held a semi-administrative post and he had grown up with a vision of consultant practice being mainly concerned with non-medical work. Usually it is the reverse of this that prompts the choice of a medical career; it is the general practitioner who is supposed to be bogged down with paper work! The doctor realized that he had a rather lopsided view of things but the antipathy to consultant practice remained. Amongst those who have been placed primarily in other groups were a doctor who resigned from a full-time hospital job after 13 years because he could not get on with the new superintendent, and another one who had given up a surgical career in its early stages because of one or two unfortunate incidents which had undermined his confidence in himself as a surgeon.

I have deliberately kept statistics down to a minimum when discussing these various reasons doctors enter general practice. The numbers are small and percentages are misleading in such cases. The picture may seem confusing but this is inevitable when dealing with such abstract and subjective matters. It may help to summarize these results under a few broad headings as given below:

Wished to be consultants but afterwards voluntarily changed to general practice	4
Wished to be consultants but forced unwillingly into general practice ..	35
Always wanted to be in general practice	19
No definite wishes either way; forced by circumstances into general practice	13
No definite wishes either way; " drifted " into general practice	4

Motivation amongst the consultants

It was not possible in this survey to visit the consultants who were to be used as controls and the enquiry had to be made entirely by post. I thought that the simple question " Why did you enter consultant practice? ", if so worded, would in most cases elicit the reply " Because I wanted to do so ", or words to that effect. For this reason a definite list of possible influences was submitted for a " yes " or " no " answer and the subjects were also invited to enlarge on the matter if they so wished. Eight of those who replied had been in general practice as principals at some time, all of them in a group who had qualified in the years 1926-1930. Most of them had been general-practitioner specialists until 1948 or thereabouts and had then decided to continue with their specialist work only; only one had deliberately set out to get higher degrees and to change over

when these had been obtained. There was not one case of a man who qualified in the 1938-42 group having been a principal and there has not yet been time for any of the post-war graduates to have been both a principal in general practice and a consultant. I doubt whether the present National Health Service organization will ever allow for transfers from general to consultant practice as a practical proposition.

Apart from these eight there were only two men who said that they had at any time firmly intended to become general practitioners. One had worked for his membership with the idea of improving his knowledge of medicine and had, in his own words, " drifted into consultant practice " as a physician. The other had been side-tracked into anaesthetics whilst serving in the Armed Forces during the war. Neither was full of regrets at the turn of circumstances. No less than 61 out of a total of 70 claimed as a major factor a definite interest or vocation in their speciality, which had arisen in 13 cases before they had ever left school and in the remainder whilst a medical student or soon after qualification. This is in sharp contrast to the case of general practitioners where, as we have seen, only one third had any positive urge to devote themselves to the work in which they were eventually engaged. In the few remaining cases consultants had gone into their specialities as a result of a chance opportunity which had arisen whilst serving as a house officer or in the Armed Forces. Many others admitted that such chances had come their way and had been a contributory factor but they already had their sights set on one or other speciality, and these opportunities merely opened a door through which they could enter their chosen place in the medical world.

Consultants were asked whether a positive dislike of general practice and a desire to avoid it at all costs had influenced their choice of a career. Thirteen admitted that this was so. Three had previously been in general practice as principals and eight had undertaken locum tenancies. Only two seemed to have depended on hearsay for their aversion to general practice and neither of them was a doctor's son. Asked whether a desire to obtain a relatively high income had influenced them, 12 had replied in the affirmative; some others thought that the opposite might be true and one even supplied a balance sheet comparing his life earnings with that of an average general practitioner. There were a number of miscellaneous reasons given by others as secondary factors leading to their choice of a career. Amongst these were family traditions, mentioned in

seven cases, an uncle who " knew the ropes ", experience as a physicist before entering medicine, personal illnesses which led to an interest in the condition from which the doctor had suffered, a change from neurology to psychiatry owing to the limited opportunity in the former speciality, and finally the surgeon who epitomized it all by the remark " I must have had a mental aberration! "

When planning this survey it was suggested to me that consultants could not be considered as a homogenous group and that I might find significant differences if I divided them into those in " major " specialities and those in " minor " ones. The difficulty was to decide which specialities fell into each of these groups. I decided that the only criterion was the proportion of members of each speciality who were receiving merit awards, those in which this figure exceeds one third of the whole being considered as " major " specialities. This worked reasonably well, the following being classified under this heading: general medicine, neurology, paediatrics and infectious diseases; general, neuro-, plastic and orthopaedic surgery; obstetrics and gynaecology. Consultants in other fields may feel offended at being defined as belonging to " minor " specialities but the division is purely arbitrary and offers an opportunity to test the theory which led to its being adopted. In fact there is no significant difference at all in the motivation leading to the choice of a career when the two groups are considered separately, but certain minor differences do emerge in other matters and will be referred to later.

The background of general practitioners and consultants

Certain more objective characteristics of general practitioners and consultants will now be considered in an effort to determine whether there are differences in background and in educational opportunities and achievement.

1. *Occupation of father or person responsible for upbringing and support.* In the great majority of cases this was one which fell into the Registrar General's groups I and II, corresponding to the professional, managerial, and shopkeeping classes. Sixty-five out of the 75 general practitioners came into this category and 60 out of 70 of the consultants. In group III, the skilled workers, there were nine general practitioners and eight consultants. There was one consultant whose father was in group IV (the semi-skilled workers), and one with a father in group V (the unskilled workers). In the case of the general practitioners these relatively lower-class origins

were confined to those in the residential and industrial areas. Overall there were no significant differences in this respect between the various " time " groups. Amongst the consultants they were commoner in the later " time " groups and amongst the " minor " specialists, but the numbers are too small to be of definite significance. It is possible that some of the self-selection of subjects for this survey might have been due to an unwillingness on the part of doctors to reveal such humble origins, but I do not think that this is likely to be of much importance or to have differed much between the two branches of the profession. The important point is that there is nothing to support the idea that consultants had the advantage of wealthier homes and such evidence as there is would suggest the contrary.

It interested me to find that of the 27 doctors who were sons of general practitioners only eight were consultants, and that in each group there were only two doctors who were the sons of consultants. Furthermore the largest number of these were to be found amongst doctors who qualified since the war. It is perhaps not surprising that most general practitioners' sons who enter medicine should

TABLE III

PARENTAGE

	G.P.	*Cons.*	*Other Group I*	*Group II*	*Group III*	*Group IV and V*	*No occupation*
G.P's							
Rural ..	8	1	4	12	0	0	0
Residential ..	6	1	6	8	4	0	0
Industrial ..	5	0	3	11	5	0	0
1926–30 ..	5	0	7	9	1	0	1
1938–42 ..	4	0	4	14	5	0	0
1951–55 ..	10	2	2	8	3	0	0
Consultants							
" Majors " ..	3	1	10	15	2	1	0
" Minors " ..	5	1	7	18	6	1	0
1926–30 ..	4	0	5	15	1	0	0
1938–42 ..	2	1	7	11	4	0	0
1951–55 ..	2	1	5	7	3	2	0
All G.P's ..	19	2	13	31	9	0	1
All Cons. ..	8	2	17	33	8	2	0

themselves become general practitioners although, as we have seen, they do not for the most part do so for choice. That 27 in all out of the 145 doctors in the survey were general practitioners' sons suggests that in former days the financial and social position of the general practitioner was such as to make his sons willing enough to follow in their father's footsteps. It is curious therefore that so few of my present subjects should be the sons of consultants. Even if we allow that there were not so many consultants in the past, the proportion of 27 to four seems remarkably high. The explanation may be entirely statistical; if the enquiry had been confined to consultants in the older specialities I might have found a much larger number who had fathers in the same field of medicine. Otherwise four possible explanations come to mind; that the sons are discouraged from trying to emulate their fathers who have already reached the top of their profession; that the sons are not in contact with and influenced by the father's work as they are in the case of general practitioners' sons; that the social position of the consultant leads to openings in business which are more financially promising than a professional career; that " rags to riches and riches to rags in three generations " applies at least at an intellectual level. There is certainly no universal explanation for this rather unexpected finding.

2. *Schools attended.* There is no official definition of a public school but it is commonly accepted that they are those whose headmasters belong to the Headmasters Conference. On the whole they are more expensive than other fee-paying schools and to attend one of them generally indicates a substantial financial background. Thirty-eight out of 75 general practitioners attended such schools; this figure was kept down by the relatively small number who did so in the industrial city where many of the doctors were locally born and where there was only one public school, although there were several grammar schools where fees were payable in former years. Thirty-one out of 70 consultants, almost equally divided between " majors " and " minors ", went to public schools but only five out of 20 in the 1951 to 1955 group did so. There is therefore not much in it either way in the two older " time " groups but in the group who qualified since the second world war, the general practitioners would seem to have held a distinct advantage. Furthermore only three general practitioners, as opposed to 10 consultants, went to schools where no fees were payable.

3. *Boarder or day boy.* It is more expensive to be a boarder and

scholarships rarely cover more than a proportion of the fees. Thirty general practitioners, of whom only two were in the industrial area, and 24 consultants had been boarders. Again the difference is small, except in the case of the 1951-55 group when the general practitioners again held an advantageous position.

TABLE IV

TYPE OF SCHOOL ATTENDED

	Public school	*Other fee-paying school*	*Local authority school*	*Foreign country*	*Boarders*	*Day-boys*
G.P's						
Rural ..	17	7	1	0	15	10
Residential	16	8	2	0	12	14
Industrial	5	19	0	0	2	22
1926–30..	12	11	0	0	8½	14½
1938–42..	13	11	3	0	10½	16½
1951–55..	13	12	0	0	10	15
Consultants						
" Majors "	16	11	4	1	13	19
" Minors "	16	15	7	0	10½	27½
1926–30..	15	5	5	0	12	13
1938–42..	11	12	1	1	8	17
1951–55..	6	9	5	0	3½	16½
All G.P's	38	34	3	0	29	46
All Cons...	32	26	11	1	23½	46½

4. *Scholarships and grants held at school.* It was found impossible to differentiate between " scholarships " and " grants ", the two terms being rather vague and interchangeable. Twenty-one general practitioners had held such an award compared with 33 consultants, of whom 21 were in " minor " specialities. This is obviously a significant difference which may be due to there being more outstanding scholars amongst the future consultants even at an early age but which may be partly due to the fact that the future general practitioners were better off and might not be granted scholarships on account of this.

5. *Prizes won at school.* Thirty-four out of 75 general practitioners and 35 out of 70 consultants, 22 of them " minors ", won prizes at school. Again the future consultant showed up slightly better, especially those who went into " minor " specialities.

6. *Performance at school-leaving examinations.* Attempts to assess these proved difficult, mainly owing to the impossibility of comparing performance at English, Scottish and Irish examinations where the ages at which they are taken and the general arrangements are different. A further problem was the inability of many doctors to remember in how many subjects they had passed and it was therefore decided to make no further use of the information obtained on this point.

7. *Scholarships and grants held at medical school.* Here the numbers were 30 general practitioners and 35 consultants. Twenty-two of these were in " minor " specialities. This, and a good deal of the other evidence on the point, tends to dispose of any suggestion that whereas those in " major " specialities might show up well in comparison with general practitioners, those in " minor " specialities would not do so. Once again the same picture emerges of a slightly better performance on the part of the future consultants.

8. *Prizes at medical school.* Sixteen general practitioners and 23 consultants, 14 of them " majors ", won these. The difference in favour of the consultants is becoming more definite as they get nearer their goal. This is to be expected, as to win a prize at a medical school probably brings a man to the attention of his chiefs and improves his chances of advancement after qualification.

9. *Qualifying degrees.* There were no significant differences between the qualifying degrees of the two branches. When a man had qualified with a diploma only and had subsequently taken a degree, the latter was considered to be his primary qualification, even if some time had elapsed before he took it. Eleven in each branch had an Oxford or Cambridge degree; 12 general practitioners had diplomas only, but rather surprisingly ten consultants also possessed no university degree and five of these were in " major " specialities. One wonders at what stage they fell off that particular ladder and why! Some more precise but relatively unimportant details of these qualifying degrees are given in the tables appended to the report.

10. *Marital history.* This has already been discussed earlier in the report and it suffices here to repeat that there is no evidence that early marriage is a hindrance to the achievement of consultant status.

TABLE V
PARTICULARS OF PERFORMANCE AT SCHOOL AND MEDICAL SCHOOL

	Scholarships held at school	*Prizes won at school*	*Scholarships held at medical school*	*Prizes won at medical school*
G.P's				
Rural ..	8	8	10	7
Residential	4	12	9	6
Industrial	9	14	11	3
1926–30	5	15	7	5
1938–42	8	6	7	6
1951–55	8	13	16	5
Consultants				
" Majors "	12	13	13	14
" Minors "	21	22	22	9
1926–30	11	13	12	12
1938–42	11	9	8	7
1951–55	11	13	15	4
All G.P's	21	34	30	16
All Cons...	33	35	35	23

TABLE VI
QUALIFYING DEGREES

	Oxford and Cambridge	*Other English and Welsh universities*	*Irish universities*	*Scottish universities*	*College diploma*
G.P's					
Rural.. ..	4	9	1	7	4
Residential ..	7	9	2	4	4
Industrial ..	0	14	5	1	4
1926–30 ..	3	9	4	3	4
1938–42 ..	5	8	3	6	5
1951–55 ..	3	15	1	3	3
Consultants					
" Majors " ..	5	14	3	5	5
" Minors " ..	6	9	4	4	5
1926–30 ..	4	12	0	4	5
1938–42 ..	3	12	5	2	3
1951–55 ..	4	9	2	3	2
All G.P's ..	11	32	8	12	12
All Cons. ..	11	33	7	9	10

11. *Higher qualifications.* It is obvious that most of the consultants possess these. Among those in " major " specialities all but two held a higher medical degree or one of the higher diplomas of the Royal Colleges. Two of the " minor " specialists held no higher qualification at all; of the remainder well over half held only the diploma appropriate to their speciality. Only three general practitioners held a " major " higher qualification; 18 others held postgraduate diplomas, in most cases the D.OBST.R.C.O.G. Twelve others had attempted something beyond the qualifying degrees (usually the D.OBST.R.C.O.G. and including the primary fellowship in several cases), and had failed completely. The majority had never tried anything, apart from their qualifying examinations.

12. *Experience of general practice.* Apart from the eight consultants who have already been mentioned as having been previously engaged in general practice as principals, there were 37 others who had spent at least a few weeks in general practice as locum tenens. About half of those destined for consultant practice still undertake such temporary work, mainly perhaps as a means of earning some money between appointments. A curious finding is that of the general practitioners only 35 had undertaken locum tenancies. Only one consultant had been an assistant, apart from those who were former general practitioners. Among the general practitioners 43 had been assistants, 30 of them for over 1 year, before entering practice as principals. Even this figure seems undesirably low, especially as there is no evidence that it is becoming less common to become a principal without such previous experience.

13. *Experience in junior hospital appointments.* Although no specific enquiry was made in the matter, it is assumed that all consultants had held junior hospital appointments for some considerable time. Only seven of the general practitioners had never held such posts and almost half of them had spent at least 18 months in hospitals after graduation. Those in the industrial areas tended to spend less time in hospital than those in the other areas.

14. *Duration of " apprenticeship ".* Unfortunately I omitted to obtain from the consultants information as to when they first received appointments in that grade, but it is common knowledge that it seldom takes less than 10 years of postgraduate work before such status is achieved. In the past there were exceptional cases of accelerated promotion but under the National Health Service this is impossible, however brilliant the candidate.

By contrast, no less than 38 of the 75 general practitioners in the enquiry were principals in less than 5 years from the date that they qualified. The number would undoubtedly be greater had it not been that several of the men in the 1938-42 group had their entry into general practice delayed by war service. Most striking is the fact that, despite the alleged difficulty of finding openings, no less than 17 out of 25 of those who qualified after the war were principals in less than 5 years.

Conclusions

How right was Lord Moran? Is there a ladder, and if there is, where did the general practitioners fall off it? The great difficulty in discussing this problem is that no general conclusions can be taken to apply to any particular doctor. If, for example, we were trying to decide whether consultants were better looking than general practitioners, it might be concluded that as a group they were indeed much handsomer, despite the fact that the three best looking doctors in the land were all general practitioners. The significance and limitations of findings based on statistical evidence must always be examined with a critical eye, lest the general be allowed to obscure the particular or *vice versa*. Despite all this, we cannot escape from the fact that at an official level each member of any group in society has generally to accept the social and financial status of that group as a whole. General practitioners have underlined this in a remarkable and surprising fashion by refusing even to consider the question of merit awards. It would therefore be wrong to condemn Lord Moran's contentions as lacking in truth merely because it is possible to find a number of exceptions to the general rule.

It is quite evident from the results of this survey that the great majority of medical students and recently qualified doctors wish to become specialists. Over half of the general practitioners and virtually all of the consultants had wanted to do so. As a contrast, only a third of the general practitioners claim that they had experienced positive leanings towards general practice. The principal reasons for this preference for consultant practice seem to be the more obvious opportunities which specialities offer for treating the really ill patient and the freedom from the necessity of dealing with trivialities. Many doctors who prefer general practice seem to be more interested in sociology than in pure medicine as such; it seems as though they might well form a completely separate profession

with a totally different training from the very start of their undergraduate years in the same way as dental surgeons are separated from the rest of the medical profession. Few consultants will admit that they were influenced by a desire to obtain a higher income. There may be an unwillingness to confess to a motivation so morally suspect as this but it is an easily observable fact that cultured young men are not on the whole too much worried by a desire to earn high incomes, a trait which comes later in life, engendered by an increasing cynicism and the need for creature comforts.

There seem therefore to be two ladders. There is a long one, to climb which there present themselves the mass of recently qualified doctors. On the way up about a third of them fall off; some might think it kinder to say that they step off but the hard fact is that the return to earth is seldom a voluntary or a welcome act. The important point is that they are once again at ground level where they unwillingly join two other smaller groups, one of which is eagerly waiting to step on to the second ladder whilst the other is about to do so without enthusiasm, mainly because this ladder is much shorter than the first and it is essential to get off the ground somewhere. It does not take much in the way of effort to climb it; at times it is more like a lift than a ladder! The two ladders lead to different worlds and the life in the one at the top of the shorter ladder is such that some of those who fell off the first one wish that they had hung on somehow. At times they go down to the ground and try again and sometimes they succeed, but few ever climb right down the long ladder again to attempt the short one, unless they have become too old to exist in the rarefied atmosphere at the top.

Various excuses are made by those who fall off the long ladder or by those who never attempt it despite the fact that they do not relish what is at the top of the short one. There are some who admit quite frankly that they lack whatever it is that enables a man to make the long climb. There are others who say that what is at the top is not worth the effort and that too many of their predecessors have slipped when they were nearly there. Much more commonly they say that somebody was hanging on to their feet, or that nature had been unfair and had given them weak ankles in the first place. The short ascent is an attractive prospect, especially when the lift is working, and the temptation to accept it is too strong.

How valid are these excuses? My enquires have brought forth not one shred of evidence that advantages of birth or of educational opportunities are necessary if a man wishes to climb to consultant

status. As a group the consultants have, if anything, been less well-endowed with these advantages than have the general practitioners. On the other hand they do seem to be rather better equipped with intellectual ability, as judged by their success in winning scholarships and prizes at school and at university. Equally without confirmation is the idea that early marriage and continuing professional progress are incompatible; the evidence suggests that the very opposite is the case and that a wife and family are actually an advantage to the man striving upwards towards his goal.

Nevertheless the difference in achievement as students is not overwhelming and it would seem that there must be something else that distinguishes consultants from most general practitioners. It can only be the possession of a quality that is a combination of ambition, determination and staying power in the face of difficulties and discouragement. A man may possess some of these attributes but unless he has them all he cannot get to the top. Good luck may help him on his way but will seldom take him the full distance; the lack of it need never stop him from getting there in the end.

I think that Lord Moran has been proved by this enquiry to have been substantially right in his contention that most of the able men in the profession are to be found amongst the consultants and that they have achieved that status because it attracted them and they had the necessary qualities to reach their goal. What then of those who claim that a place in general practice was always what they sought? Are there not amongst them men who, had they so wished, could have climbed to the heights of their profession? It takes no formal enquiry to see that such men do exist; the names of some of them are familiar to all those who follow the affairs of the British Medical Association and the College of General Practitioners, and there are others whose colleagues recognize in them men of outstanding knowledge and ability. Yet to the public and to the Government, to whom they must look for their social and financial status, they are indistinguishable from the mass of relative failures with which medicine, in company with other professions, must necessarily abound.

There is no doubt that these men are acutely conscious of this state of affairs which they find regrettable, not so much because of the immediate disadvantages to themselves (although these may at times bear heavily upon them), but because they are proud of their

calling, consider it to be of inestimable service to mankind and are resentful of anything which tends to lower it in public esteem. They are seeking in various ways, but in particular through the activities of the College of General Practitioners, to enhance the status of general practice until it becomes comparable to that of consultant practice and equally attractive to men of the highest calibre. It is my opinion that this enquiry clearly indicates that this can never be achieved unless and until the climb to the top of the two ladders becomes equally long and arduous.

General practice stands at the parting of the ways. There are some who say that it is an anachronism, that its separate parts all belong to one or other speciality and are best dealt with by specialists acting together as a team. Others say that there is a vast field of human illness that involves the whole man, his body, his soul, and his environment, and that this can only be dealt with by a doctor who has made a special study of it and has been suitably trained. If this latter view is to prevail and if the general practitioner of the future is to be that man, he must not only be a specialist but he must be seen to be one. His apprenticeship must be as lengthy and as demanding as that of the present-day consultant and at the end of it he must pass an examination at least as difficult as that now required for entering into a " minor " speciality. Just as the "failed registrar" must now be content in many cases with a permanently subordinate hospital appointment, so will the " failed assistant general-practitioner " have to fill a similar post in general practice, doing useful work but not allowed full responsibility. It may be said that such a formidable prospect may discourage young men from becoming medical students, but the road is already far from easy and despite this there are many more applicants for places in medical schools than can ever be accepted.

The alternative is for general practice to continue in the future as it is today, to a great extent the refuge of the weaker in spirit, though not necessarily in intellectual ability, and, because it is more easily approached, valued less not only by those who practise it but also by those who only observe it. Amongst these will be the medical students and the newly qualified practitioners who will persist in looking upon consultant practice as, in the words of Lord Moran, " the only aim ". We must come to a decision on the matter and we must set a course one way or the other. Great changes in organization and outlook may be necessary, and those to whom the future of general practice is a matter of concern will inevitably have to find

compromises between their aims and their political views. Above all nothing will be gained by indignation or an attempt to pretend that the facts are other than what they have been shown to be. This enquiry may, I hope, stimulate thought on a subject that has not been squarely faced in the past, and if it does nothing more than this may have been worth the effort that it has cost.

Acknowledgement

I should like to express my thanks to all those who have given so generously of their time to enable me to complete this project. In particular I am most grateful to all those general practitioners and consultants who must necessarily remain anonymous but who so kindly furnished me with information about themselves, much of it of a highly personal nature. If any of the general practitioners feel that I have been unkind to them in this report they will, I hope, forgive me and will realize that the kindness and hospitality which they showed me when I visited them cannot absolve me from the necessity to report with truth and integrity all the information which I gathered from them and from their colleagues. I must thank also the Secretary and Librarian of the British Medical Association for the loan of documents, my own secretary, Mrs O. Boyle, for coping with a great deal of the clerical work involved in this survey, and Drs A. E. W. Brooker and K. R. Lown for help in planning the questionnaire. Finally I must thank Messrs Upjohn Ltd and the College of General Practitioners for the generous help which made the whole thing possible.

REFERENCE

1. Royal Commission on Doctors' and Dentists' Remuneration (1960). Evidence of Lord Moran of Manton.

How often are we told as undergraduates, " 50% of you will be going into general practice! " How often are we asked, " Are you going to specialize? " Does not this make general practice appear dead and non-intellectual, something that you might unfortunately have to do? Why has this attitude arisen?

No longer are we living in the nineteenth century when the undergraduate course was comprehensive enough to produce the desired standard. General practice is a now a special form of Medicine which has seen as many advances as other branches. In the past the practitioner has to learn from experience, but is this adequate enough nowadays? " The industrial revolution in medicine has passed general practice by; it remains a cottage industry ". It is in need of a " Beeching ".

Extract from the Editorial on General Practice in *Surgo*. Glasgow University Medical Journal. 1963. Vol. XXXI: No. 1.