patients, effectively, kindly and safely; who will be capable of doing so throughout their lives; who will be capable of that inter-dependence upon others which alone can confer independence on the doctor of the future; who will be capable of profiting from experience and therefore capable not only of receiving continuing education but also capable of giving it to others. Above all, wherever they work, whatever the stage of illness of the patients whom they tend, they will use the same method of thought as all other doctors. General practice may remain different from hospital practice but general practitioners will not be different from hospital doctors.

DISCUSSION

Dr W. O. Grimms (*Swansea, South Wales*): I should like to ask the speakers what proportion of their time could they safely give to appointments outside their practice duties, such as factory work, hospital appointments, insurance, and so on, without jeopardizing their position as experts in family medicine. I put this to you as a provocate question.

Dr Ashworth: Shall I take the bull by the horns? You see, if you work in a properly equipped health centre, with adequate auxiliary help, you find not that you do less work but that the pattern of your work changes. Therefore, I find that in my life I spend, in accordance with (I think it is) Dr Fry's recent writings, something in the region of 40 hours a week in contact with my patients. I do a maternity or child welfare clinic for a local authority one afternoon a week; I do a very small amount of industrial medicine which occupies me for, I suppose, not more than a couple of hours a week and I find I have very happily filled most of my working days between nine in the morning and a quarter past seven in the evening. It is true, of course, in organizing your life, if you take on the things in which you are interested something else has to go—this was said this morning—and much of what goes is the trivia with which other people can cope very much more efficiently than I can.

Dr Logan: The question is: What is our attitude, what is our hunch, what is our impression? The question was not: What operational study has been done to examine this question? This really is throwing the matter right back because we do not know. But, taking up Dr Ellis's point, the patterns of medical care must be flexible enough to adapt themselves to changes, to maximum need, to maximum use of what we have. I think the question is a very good question, but it is one which the research committee should tackle.

Dr Stewart Carne (*West London*): Last August the college council did a quick study of one week's work load in general practice. I can give you some of the early answers of that study. The average

doctor that week—that is, the total number of patients divided by the 369 doctors who gave answers—saw 159½ patients in their consulting room, and they visited 60½ patients. That meant they saw a total of 220 patients. They spent 17 hours and 28 minutes in their consulting room; they spent 17 hours 55 minutes on visits, which meant they spent a total of 35 hours 23 minutes seeing patients in their practice. They spent an additional 3 hours and 37 minutes on hospital appointments, factory appointments, and similar work. By chance, it comes in fact to a total of exactly 39 hours, and this is not a great result.

A speaker: Most of our speakers have stressed the need for the general practitioner to have adequate personal and family background knowledge of the patient. A thought occurred to me that a valuable source of information is the local press. I have found many details about my patients through reading the local 'rag'. A patient recently wrote to me and said she would like a prescription of a pill because her husband was shortly coming home, and I knew exactly what she meant. I had read in the paper a few months before that her husband had been sent to prison for stealing some copper tube. That is just an example of the information which you can get gratis by reading the local press and it is information which you would not normally be acquainted with.

Dr Corgin (*East Barnet*): I should like to thank Dr Ellis for his brilliant and sparkling contribution. I was particularly glad of the emphasis he laid on a thorough grounding of scientific method. I think that we, and certainly public opinion, feel that the growth of science threatens the general practitioner. But science, while it grows, simplifies. Science makes what is difficult, and what may have to be learnt by growth of knowledge, comprehensible. It is therefore possible with a knowledge of scientific thought, scientific method and scientific discipline to comprehend things which were previously completely incomprehensible. And it can enable a man, while he may not be able to answer about techniques, to employ people to use those techniques. I see that this in fact is going to free the medical student of the future from acquiring so much knowledge unless it has a particular application to a particular technique which he needs in a particular branch of his work.

A speaker: I should like to answer the point made about 39 hours service. I think that no one can take that figure seriously. Thirty-nine hours means time can be set down, but we are doing not only 39 hours; we are doing 24 hours a day in the patient's service—24 hours a day every day of the week. That means we are doing 7 times 24 hours a week, not only 39 hours.

Dr M. E. Arnold (*Wembley*): I should like to congratulate the

speakers on their very lively speeches. I personally agree with all of what Dr Ellis had to say about the education of the general practitioner and the need for even greater education for general practice than perhaps for the other fields of activity. But there is one point that we are all aware of, I am sure, in this assembly and it is so much part of ourselves that perhaps we have missed it. That is that the career of the general practitioner differs so much from that of the would-be consultant—the career needs and the pattern. In other words, the fact that the general practitioner has to look after his own practice, or is one of a partnership who is responsible for a small unit, is a vitally important factor in this question of education. He goes into practice at an early stage. Perhaps he has had quite a bit of formal education after qualifying. But the question of having further education later on is very much hindered or marred by the fact that he cannot hope to get out of practice again to receive such education. Indeed, even for short courses, it is extremely difficult for him to get away. Whereas the doctor in hospital or in the Services, or in any organization such as that can do so, and it is of tremendous benefit to him and indeed to medicine itself. Therefore, it seems to me that before we can hope to aspire to these ideals which Dr Ellis has put forward, which seem to be very reasonable, we have somehow to alter the structure of general practice so that the practitioner can cater practically for the possibility of taking time off for study. If almost anyone in this room were offered the possibility of going away for three months on some course of study, how many would be able to accept that offer, even with considerable financial backing? I would imagine that only a certain percentage could do that. That is something we must somehow overcome, and it is a practical consideration that we must deal with before we can in fact get on with the common question of education.

Dr Ellis: I would say that what I am advocating is that no one—repeat, no one—shall go into general practice until he has finished his training.

Dr Gasgott (*South-east Scotland*): Dr Ellis makes this sound almost painless, he is so persuasive. I would point out a small conflict between what he is suggesting and a point made by Dr Logan. If I have taken the points aright, this is an extended training for general practitioners that is being recommended, hardly calculated to encourage recruitment to the profession at the moment. Dr Logan says that the output of the medical schools is falling and the age of the population is growing. This seems to accentuate the general-practitioner problem, and speakers this morning pointed out that we must improve the method of training the undergraduate. Speakers at various times throughout the day have pointed to heightened efficiency. I suggest that heightened efficiency alone is

not going to meet the situation, and that recruitment as an added resource is very necessary. If this point is accepted, then the annual report of the Collage makes rather dismal reading. In future a subcommittee of the education committee will deal with various problems, in which recruitment and association with the medical schools is not mentioned. The appropriate bodies of the British Medical Association reported in May of last year, and a very dubious result was obtained from 16 out of the 26 medical schools. If this is a critical point in time, and I think it is, I should like the speakers to acknowledge whether they agree with that, and if they were betting, what odds would they put on the College presently adopting a successful course?

Dr Logan: Teachers are faced with the same problem. The child population has exploded and the number of teachers has gone down. But the teachers in the same situation extended their course 30 per cent. They felt they had to. I suggest that the medical profession, as well as the teaching profession have to do something like this. We need only to look at some other countries to see that a doctor has got to look after a list about twice the size of ours, and apparently he gets better health rates than we can achieve; so this is not impossible. So, in brief, I would say that general practice, to survive, to cope with this increase in population, cannot afford to do without this training: it must have it.

Dr Park (*Harlow*): My partners and I work in one of these centres with which most people here will be familiar. We look after an average in our practice of 3,000 patients each, with 4½ doctors. We do child welfare clinics and antenatal clinics and take our part in hospital and industrial work. Some of us take a part in the life of the local community; I do it not only because it interests me. I find that something has to go, and that is the first point I want to make. I get continual reminders by insurance companies and even by patients complaining to me that I neglect insurance reports. I cannot just get around to them. The other point I wish to make is that in the educational programme which was very interestingly outlined there is one thing missing, I think, and that is education in general practice which all consultants and would-be consultants should have. There are a number of hospital consultants who are unaware of what we can do in general practice. This is particularly aggravating in an area like ours where we have some ancillary assistance, partly provided by the local authority and partly paid for out of our own pockets. I therefore feel that in future it is essential that every hospital consultant who has to do with practitioners should have an introduction to general practice.

Dr Gilbert Smith (*West London*): Before these remarks about

figures are taken too seriously, or are perhaps taken up by the Press, I must say that I do not know whether it was fully appreciated that these figures were for the second week in August; in fact, I personally refused to give any figures for that particular date because in that particular week I had a locum doing work for me.

My second point is that I should like to thank Dr Ellis for his paper but should also like to recommend to him that in future he does not talk about the lowest common denominator. Ever since I was asked to serve on the Cohen committee I have tried to concentrate on the highest common factor; and I think that if we can do that it would be a help to Dr Ellis and the Ministry. I would submit that perhaps the basic doctor should be based on the highest common factor, and then we can add the extra specialty of general practice that is obviously needed.

Dr Ellis: I accept that the term " lowest common denominator " with some unpleasant emotional connotations; but it does happen to have a precise meaning. When I am looking at a patient what I am looking for is the lowest common denominator.

Dr Gilbert Smith: We are looking for something higher.

Dr Nash (*Ealing*): May I back up Gilbert Smith's comment about the figures. I think they should be consigned to that basement which is full of facts which nobody knows how to use. The hours of general practice can be relevant only to the quality of the work. The mere quantity of time is not relevant in itself. I should like to go back to the first speakers who commented on aspects of their work. They covered so much of what is ideal in their general practice that it seems hard to apply. However, as regards this rather glossy picture, I think we should recognize the great danger of something being lost, and what is lost is the impact made upon the doctor by communication of relatively important material at the time of first contact. This is tremendously important: the time when the patient first talks about private, painful, emotional matters, and if this is uttered to someone who is not able to use that information a great deal is lost. If the psychiatric social worker or social worker gets that impact and the social background it may help in identification and diagnosis of the patient's problems, but a great deal is missing. This is part of what is called the collusion of anonymity. The more people are concerned with the patient's problems, the fewer are actual responsibilities in the shape of doing something practical. This is rather an erudite point, but terribly important, because those of us who do this work in our practices get very much from the first impact. In this respect I trust that Dr Ashworth will forgive me if I draw his attention to something which he left out. He was referring to the computation of three factors: the physical, the emotional and

the sociological. The fourth he left out, which was in fact the doctor himself—how the doctor felt. Was he relaxed, interested, disinterested, bored, or fed up, and so on?

Dr Ashworth: I am quite aware of the implications of the last speaker's remarks. If I have a medical student sitting by my side, then right away the relationship between the patient and myself is altered. I know of no way of overcoming this handicap. This is one of the ways in which I cannot do all that I would for everybody all the time. Something has got to go. If this kind of situation develops, I am left with the alternative of sending the patient to another of my colleagues in Darbishire House who is better capable of dealing with the patient's difficulties than I am; or I can ask to see this patient at a later date on my own. This is not quite the same thing as dealing with the patient's difficulties there and then when they are bubbling up, but it is the next best thing I can do. My own inclination is to send as many of my patients as I can to my psychiatric colleagues. Some bounce back to me and I have to deal with them whether I like it or not, but, quite frankly, I have tried this kind of work. In only a few cases does it work, and so far as one of my colleagues goes, he says, " You open the door, look at the skeleton within, and then shut the door quickly in the majority of cases ". Let us be quite frank about this—no double talk, please.

Dr Metcalfe (*East Riding*): I should like to ask Dr Ashworth about the way he managed to cut down his visiting–surgery ratio. I find myself that the ratio is one visit for every two surgery consultations, and this is an intolerable situation. What criteria does he apply to himself as to whether, for instance, he will make a second visit, what criteria does he apply when people ask for a visit when he thinks it is unnecessary, and how long did it take him to whittle down his visiting numbers to an acceptable level, and how much re-education of the patients was involved in this?

Chairman: If you were in the Highlands of Scotland the ratio of visits to surgery consultations might be 1 to 1 or even 2 to 1.

Dr Ashworth: Yes. Our speaker is on a pretty good wicket to begin with if only on a 1 to 2 ratio. However, some months ago I became aware that my habits of general practice were becoming too ingrained and I was not remaining malleable enough. Therefore, I began to ask myself: why have I to visit a patient with tonsillitis more than once, having satisfied myself that the diagnosis is right and that I have prescribed accordingly? With modern communications the patient can always ring me up if not satisfied with the improvement. Why do I visit a patient with measles more than once in an epidemic which has few, if any, complications, provided that

I have explained the situation to the mother in the first instance? These are largely matters of habit which we have inherited from our predecessors. When I talk to my older colleagues on this matter they assure me that their predecessors visited measles every day until the temperature came down to normal. So we have to be continually looking round for means to increase our efficiency in general practice.

Dr Little (*South London*): I want to correct an impression I gave this morning. It refers to Peckham. I should not like our friends to go back to Yugoslavia and Holland and Israel with a wrong impression. An experiment in social medicine was started in a house in Peckham in 1926. The people concerned were so inspired that they were doing nearly everything we have talked about today. There is hardly a thing we have mentioned today they were not doing. They moved to a building about as large as the building we are in today, with a swimming pool and a gymnasium. It took a war and a health service to finish them off completely. The war finished and these people started again after the war, and then the health service came in. We took over some years ago a purely diagnostic centre, a treatment centre, and a centre where, above all, doctors could congregate and exchange thoughts. I am glad to see Dr Logan here today because he is my great Chairman; he is my McConochy. When I see him I wonder how I can justify Peckham, whether I and my colleagues are doing the right thing. But we are doing something; at least we are bringing doctors together, and these can do the things we have been talking about today.

Dr W. H. Hylton (*South-west England*): As you know, in the council of the College we are keenly aware of the need, the absolute necessity, to establish as soon as possible a custom in this country that general practitioners, before undertaking responsibilities as a principle in practice, shall have a proper course of vocational training. Dr Ellis was kind enough to refer to our recent publication, *Preliminary Report*. I should like to thank and congratulate Dr Ellis on a wonderful exposition on a carefully thought out theme in broad outline. I would say how much this would mean to us, the working party, and we hope we shall be able to incorporate much of Dr Ellis's thinking in further reports, and, I hope, subsequent action by the College. Thank you very much, Dr Ellis.

Dr Hopkins (*North London*): I want to ask a question of the speakers, particularly of Dr Ellis, because not only am I very worried about general practice, as I think we all must be, but also I am particularly disturbed at the possible drying up of the supply of future general practitioners. However, before I ask a question, I would make just two comments, the first about the recent survey. As it was

taken in August I could not complete it, and even if I had it would not have been representative. Thirty-nine hours a week is way out; we all work longer than that in contact with our patients. Dr Logan referred to 'either–or' when talking about the art and science of medicine. These two words are rather like the word 'psychosomatic'. As regards both of these terms I would urge that we should all think not whether we need to practise science or art, but how much art and how much science. I think we must lose this 'either–or' complex.

My question refers to the problem of the selection of medical students. Could the speakers give some idea of whether they think the College might in future, or should, have some influence on the ways in which future doctors are selected? It so happens that my eldest daughter recently applied for a place in a medical school. Her headmistress advised her to apply to several schools, and she was granted an interview at four. To each school she carried (although I say it myself) the same excellent testimonial from her headmistress. The only one that did not even grant her an interview —the daughter of a doctor, with an excellent testimonial as to her own ability—was the London Hospital. I have no axe to grind because she has accepted a place at one of the other schools, but I did discuss this with consultants and I was told that some medical schools these days are faced with the problem of something like 1,800 to 2,000 applicants for 80 or 100 places. Therefore, one of the first things they do is to say, "We want boys or girls with four 'A' levels".

I wonder whether this is a wise decision. Do we really only want doctors who are so bright and brilliant, or do we want other sorts of boys and girls who do not dislike human beings? I would ask whether some better methods of selection of medical students should be thought up, whether the College should have something to do with it, and whether we should bring some pressure to bear on the Ministry to do something in this way. And, by the way, my daughter was advised by three consultant friends in a social capacity, when she told each of them that she hoped to do psychiatry, "If you are asked what you want to do, for heaven's sake do not say psychiatry; you will never get in". You may laugh, but I do not think it is a laughing matter, because we all know that the large majority of patients require considerable psychological help and understanding, and the need in the future is not going to be for more and more surgeons but for more and more doctors with psychological understanding, including psychiatrists. If our medical schools do not want the sort of boy or girl who is interested in psychological problems, then they are not training the right kind of people to become doctors.

Dr Ellis: I am not the dean of my medical school—he is a path-

ologist. When I was last on the selection committee I asked a bright young lady of 16 what she would like to do if she could not be a doctor, and she said, " I think I should like to be a pathologist "! Of course, there is this problem. We are always hit at any teaching hospitals from two sides. There are those who say, " You will take any doctor's child irrespective of academic qualifications ". It is not quite true because the minimum academic qualifications are the final arbiter. My own school recently took 26 per cent of doctors' children, and the highest figure for the British Isles is 32 per cent, and the smallest is 6 per cent. Then we are shot at from doctors who say, " You did not take my child because she did not have enough ' A ' levels ". The London schools' academic requirements are very low. The highest required are in Birmingham. It should be possible in time that you will see the answer to your question. But as to who should do the selection, I do not think this is the point. We are running at the medical schools about a thousand students short of the doctors we need. We shall need more medical schools than probably are available. I do not think selection in terms of the schools is going to be much of a problem in future.

A student: (*The Medical Students' Association*): I am naturally very interested in medical education of the undergraduate. There has been a great deal of research done about postgraduate education, and everyone would agree with this. In 1957 the General Medical Council more or less gave *carte blance* to the medical schools to reorientate their medical curricula. Edinburgh and Glasgow and one or two others have followed this up, and very successfully. But many other medical schools resist change. I should like to have the views of the main speakers as to how general practitioners and medical students and others can bring pressure to bear on the powers that be in medical schools to improve their curricula.

Dr Ellis: Of course, one way is to give your opinion as to what should be done, always bearing in mind that we hope never to go back to the stage when medical students' schools made general practitioners. But there is another way. There is a body responsible for maintaining the standard of medical education in this country—the one you quoted, the G.M.C. When it gave *carte blance* it went from one form of maintaining standards to another—from prescription to general direction and inspection. The last recommendations were made in 1957. One might have expected there would be an inspection by now to see how things were going on. Presumably, the reason why there has not been is that it was felt that the schools needed the time. The G.M.C. is now going into session again to look at the recommendations once more. Whether or not it will at this stage visit we do not know. But that is the body who has the responsibility.

Dr Ashworth: I see no future for general practice unless we learn to be better organized. I see no future in the single-handed practitioner or partnership; I see a future only in group practice in association with local authority premises or health centre practice. Unless the profession uses the ancillary aids properly and efficiently I see no future for the general practitioner going on being the total family doctor. So far as cost goes, I can tell you that Darbishire House costs twice as much to run as an ordinary street-corner general practice. If you realize that it is heavily over-burdened with teaching and research costing, I think one and a half times the accepted cost is a fair estimate to present for a working, efficient health centre. Every practitioner has to learn what he is prepared to do and not prepared to do, and what he is not prepared to do he must hand over to other people who can do it better than he can. So far as education goes, I think a fortnight, a month or two months is quite enough for undergraduate education. I do not want an 'empire' built up in undergraduate education. I want students to go out from general-practice experience thrilled and excited at the prospect of coming back, and not having laid on the straw that kills the camel in the long run.

Dr Fulton: Most speakers today have been concentrating on two lines, education and organization. It is obvious that one of the difficulties is that the education is in the hands of people who are not general practitioners and that family doctors are outsiders so far as medical education is concerned. This is a broad generalization. Universities and medical schools run undergraduate medical education and, to a large extent, postgraduate education. The attitude of some of these people is hostile; of some, patronizing. There are, fortunately, a few enlightened ones. Those who have tried experiments with general practitioners, however, have found that general practitioners have let them down because it is difficult to be a busy practitioner and still to find time to prepare for teaching. When Glasgow tried this experiment recently they wanted family doctors to take part in integrated teaching, and they were called on at times at one week's notice. These people had no experience and, until they got there, no one knew what they were expected to do. There is no proper organization for teaching. There was no department of general practice which could have arranged to do this. There was the College, which had offered year after year to do this, but they did not realize that we were not part of the establishment and that the link was too weak. This must be put right. Dr Kaskell pointed out another obvious deficiency, and that is the extreme shortage of family doctors. We are being more and more burdened with work. We must find short-term solutions for this, and they must fit in to the long-term plan for improvement and amelioration.

This is where I think that working in centres which could, in those cases where there are medical schools, become a department of general practice will marry these two different streams of thought together, and perhaps enable a solution which satisfies the work requirements and allows our long-term dreams to be given effect.

Dr Logan: After meetings like this, as with the B.M.A. or our meeting last year, I come back to the feeling of faith. There is nothing wrong with the soul of general practice; nothing wrong with the heart of general practice—it is still pumping vigorously. But in these greatly changing times of art and science the head may need some help. Out of conferences like this we do get help.

Dr Ellis: I think the only thing I should like to add is that one is strongly conscious of something being wrong with the profession in that we not only work in different contexts but we are beginning to think in different ways. The whole of my efforts this afternoon in terms of education are really geared to one end: that we should start to think about the same methods again.

CONCLUDING REMARKS

Chairman: All too soon we have come to the end of this fascinating symposium. What a lot we have to think about now! Can we see medical students in a better way? What can we do about preparing for the efforts of general practice? There is the question of time—something has got to go. Talking about time, I was surprised at the vigour with which my good friend Stewart attacked on this subject. Another theme that has run into our discussions is that the time has long since passed when a doctor can sit in his surgery and wait for his patients to come to him; he has to go out and look after them in the preventive sense. We have been doing this for a long time now, and we have to do a great deal more about it—antenatal clinics, problems of adolescence, diabetic surveys, visits to more people, and so on. We have many things to think about.

All that remains for me to do now—and this is a very pleasant duty—is to convey our very warmest thanks to all those who have made this such a very successful symposium. First, all our speakers, this morning and again this afternoon. Secondly, the Wellcome Foundation, and particularly Dr Denis Wheeler, for putting this splendid building at our disposal and for their wonderful hospitality to us. And, lastly, I think we ought to record a very special vote of thanks to the honorary organizing secretary of this symposium, Dr Harry Levitt. I know he is going to be angry with me when I tell you that a few years ago a previous president of our College referred to Harry as " the king of symposia ". Well, let me tell you that his majesty's popularity has by no means diminished; in fact it has