Special Article

THE GOOD GENERAL PRACTITIONER AND THE NATIONAL HEALTH SERVICE

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During the course of a survey into the reasons why good general practitioners enjoy their work it became apparent that there were serious sources of dissatisfaction with various aspects of the National Health Service, and some of the results of the survey may be of general interest.

A random sample was taken of 100 members of the College of General Practitioners who work in the United Kingdom and have been qualified 10 to 20 years.

A circular letter with a questionnaire containing over 30 items was sent to each doctor in October/November, 1962, and a reminder in November/December to the 25 who did not reply. Three questionnaires were sent out in early January as one of the original doctors had died, another was not in full general practice at the time, and another had retired. Eighty-seven completed questionnaires were returned. Seven doctors who qualified over the age of 30 were excluded from the main analysis, which therefore comprised 80 doctors. Table I shows the geographical

TABLE I.—*Geographical Distribution of Practices*

	Cities and Large Towns	Towns 10,000-40,000	Rural	Total
Greater London	9	—	—	9
Rest of England	27	11	9	47
Scotland ..	6	5	5	16
Wales ..	3	1	1	5
N. Ireland ..	2	1	—	3
Totals ..	47	18	15	80

distribution of the practices. These 80 doctors, including two women, were mainly in their late thirties and early forties, and most of them had spent 10 to 15 years in general practice. This group is thought, therefore, to be representative of young but experienced family doctors who entered general practice after the start of the National Health Service.

Sixty-eight of the doctors were married, with two or more children. Of the 11 in single-handed practice without assistance (Table II), one has since moved overseas and

TABLE II.—*Mode of Practice*

Single-handed ..	11 doctors
" with an assistant ..	2 "
In a partnership of two ..	33 "
" " " three ..	18 "
" " " group practice (four to six partners) ..	15 "

another was the sole member of the group in entirely private practice, leaving only nine in National Health Service practice. Personal commitments ranged from 1,500 to 3,250 patients and the average size of the National Health Service list was 2,350. Only six National Health Service doctors depended on private practice for an appreciable part of their income (Table III).

TABLE III.—*Size of Private Practice*

No private patients ..	36 doctors
Fewer than 10 private patients ..	22 "
Ten to 30 private patients ..	15 "
Fifty to 200 private patients ..	6 "
Entirely private practice ..	1 doctor

The last part of the questionnaire dealt with the doctors' attitude to general practice and medicine. There were four questions, as follows:

Do you enjoy general practice very much, definitely, moderately, not very much, or not at all?

Would you prefer to do general practice elsewhere in the U.K. or overseas?

Would you prefer to practise in a different branch of medicine if you had the opportunity?

If you had your time over again would you choose:

(a) General practice? (b) Another branch of Medicine? (c) Something else?

Results of Questioning

Just over three-quarters of these doctors were enjoying their work (Table IV). Only 22 stated that they were satisfied with general practice in this country at the moment and

TABLE IV.—*Enjoyment of General Practice*

Enjoyed general practice very much ..	30 doctors
" " " definitely ..	31 "
" " " moderately ..	14 "
" " " not very much ..	4 "
	61
	18

would choose general practice if they had their time over again. The main cause for dissatisfaction with general practice of the other 39 doctors who were enjoying their work are set out in Table V. Several doctors come under two or more headings.

TABLE V.—*Causes of Dissatisfaction with General Practice in this Country among those Doctors who Enjoy their Work*

Would prefer to practice elsewhere in this country ..	8 doctors
" " " " overseas ..	6 " (one now in Canada)
Generally dissatisfied with conditions of work ..	3 "
Financial dissatisfaction ..	7 "
Larger lists than thought ideal for their practice area	13 "
Would choose a different profession if they had their time over again ..	2 "
Would choose a different branch of medicine if they had their time over again ..	12 "

That only about one-quarter of keen, experienced doctors in the prime of life should be completely satisfied with general practice in this country and almost another quarter should not really enjoy their work is a staggering indictment of their working conditions. Many good, experienced doctors have not joined the College of General Practitioners and some doctors have joined it from a variety of motives, but I think that the general level of enthusiasm shown by its members can be said to be higher than that of non-members. In this small group, for example, 44 out of the 80 have done some research since qualifying and 48 regularly give interviews out of surgery hours. General practitioners as a whole are therefore likely to be even more dissatisfied than this particular group.

There seem to be three major causes of dissatisfaction: (1) financial, (2) conditions of work, and (3) lack of freedom of movement.

Financial Dissatisfaction

There were no questions concerning remuneration, but of those who claimed to enjoy general practice seven specifically mentioned financial dissatisfaction and another 13 have a larger list than they think is ideal for their own practice area. Not surprisingly, most of those who are dissatisfied financially come from the group who do not enjoy general practice much. Of these 18 doctors, eight had specific financial grumbles, while five others have a higher list than they think is ideal for their practice area. The average list of those who enjoy their work is 2,290 and of those who do not 2,570. Five of the eight who have a list of 3,000 or over do not enjoy their work. Large lists

of course may be the *result* of lack of enjoyment of work rather than the cause.

Most of these doctors think that a list of 2,000 or less is ideal for their own particular area of practice (Table VI).

TABLE VI—*Size of List Thought by the Doctor to be Ideal for Area in which he was Practising*

2,000 or less	..	..	..	..	31 doctors
2,000 to 2,500	..	..	..	..	36 "
Over 2,500	..	..	..	..	12 "

Dissatisfaction with Conditions of Work

Mode of Practice.—Single-handed practitioners seem to be as satisfied as those in partnership, and most of them probably work alone by choice.

Hospital Facilities.—Most of the doctors have open access to pathological laboratories (75 out of 80) and to radiological facilities (60 out of 80), and these proportions will undoubtedly rise in the future. From these small numbers there is no evidence that lack of these facilities is an important cause of dissatisfaction. *Thirteen out of the 15 doctors with access to general hospital beds enjoy their work*, and one mentioned that he would not like to do general practice again if he were denied this facility.

Ancillary Help.—The employment of ancillary help definitely appears to facilitate enjoyment of work. Forty-one out of 48 doctors with ancillary help enjoyed their work, but only 13 out of 21 without help enjoyed their work, and one of these said that he would like ancillary help if he could afford it.

Examination-room.—The survey does not support the theory that an examination-room is essential for good and enjoyable general practice (Table VII). From these figures

TABLE VII.—*Use of Examination-rooms*

	Total	Enjoy Their Work	Do Not Enjoy Their Work
Doctors using an examination-room	38	24	14
" " a screened couch ..	26	24	2
" " neither ..	14	12	2

one could argue that an examination-room is a factor militating against enjoyable general practice. The consistent use of an examination-room means that many consultations are broken—that is, one patient is often seen in between the history-taking and examination of another. It seems to me that doctors who adopt this sort of routine are unlikely to get the best out of the doctor-patient relationship, and this may help to explain why so many of those using an examination-room in this survey do not enjoy their work. The desire for an examination-room may perhaps be a symptom of their dissatisfaction in some cases.

Lack of Freedom of Movement

Eleven out of the 80 doctors would prefer to be practising in a different part of the country. Some idea of the lack of freedom of movement can be gained from the fact that *41 of these doctors have been in the same general practice during the whole of their career*. Twenty-nine had a year or two in one or more other practices before settling down to their present one, and eight had between three and five years in one or more practices as an assistant. *Only two have been a principal in two separate practices*. A few fortunate principals manage to arrange a change of practice, but for the majority a move means that they must start again as an assistant with a view to partnership or must apply for a practice vacancy and take over a single-handed practice with more uncertainty about their future prospects.

Discussion

I myself come into the group from which this sample was taken and am surprised to find so much dissatisfaction with the National Health Service. I have thoroughly enjoyed working as a principal in three different practices, as an assistant in two others, and as a locum in about another six. I have worked in partnerships and single-handed: in cities, suburbs, colliery villages, and a small country town. On reflection, however, my enjoyment of my work has been in spite of working conditions rather than because of them. I have been qualified for 19 years and have only just attained complete financial security. I am certain that the quality of my work suffered in the early years from lack of equipment, which I would have bought had I had the money to do so. I have been moderately frustrated by lack of secretarial help until the last five years and by lack of nursing help until the last year. I have, it is true, made two major moves since becoming a principal—one to start again as an assistant with view and the other to branch out into the field of single-handed practice by means of a practice vacancy, but I have been more fortunate than most and have also had to be willing to suffer two financial setbacks to do this.

What Can be Done to Lessen Some of the Grievances?

I put forward the following suggestions for discussion.

Financial.—The recent rise in pay is based on keeping the proportion of the national income spent on medical care at the same level, but as a country increases in affluence it is usual for it to spend a *larger proportion* of its income on medical care in order to attract enough men and women of character, drive, and ability into our most essential of professions. So far as general practice is concerned, the recent rise has widened the gap between consultant and general practitioner. The Government must accept that the family doctor service is the backbone of the health service of this country and make due allowance for the unique conditions under which general practitioners work. It is unjust that an anaesthetist, a pathologist, or a radiologist, who can work regular hours if he wishes, should be paid considerably more than all but the most experienced and successful general practitioners; nor is it fair that the most successful consultant physicians and surgeons should be able to earn about twice as much as the most successful general practitioners (taking into account the merit award scheme for consultants). Family doctors working happily under good conditions can have a tremendous positive influence on the health and productivity of the country, and an increase in the general level of their earnings is essential to stop the flow of good men out of the country and into the specialties. A general increase could lead to a lowering of the maximum list to 3,000 and eventually to 2,500. I suggest in addition: (1) An initial lump-sum payment on beginning general practice to cover the cost of car and equipment, which would be repayable should the doctor not stay in general practice for more than five years. Loans of up to 90% can be obtained from the Medical Insurance Agency, but these have to be repaid with interest over a maximum period of five years. (2) A grant towards the payment of *ancillary workers*. This could be administered easily if a proportion of their salaries, say one-third, were to be repaid. (3) Grants towards new practice premises for single-handed practitioners, and those in partnership with one other doctor on the same lines as for those in group practice.

An increased capitation fee for areas of high morbidity was suggested by two doctors in the survey. These areas

can be ascertained with some accuracy from prescribing rates, notification rates, and general-practitioner morbidity statistics, and I see no reason why this suggestion should not be given serious thought.

Conditions of Work.—The provision of adequate equipment at the start of a family doctor's career and of ancillary help throughout it would be covered if the above suggestions were implemented either in detail or by a rise in the general level of payment. More hospital beds for general practitioners and the setting aside of common rooms and libraries in hospitals for use by resident and non-resident staff and general practitioners are both desirable.

Freedom of Movement.—With such financial improvement more principals would be able to take the plunge and move to another practice.

Summary

One hundred doctors picked at random from among members of the College of General Practitioners who had been qualified 10 to 20 years were circularized with a letter and questionnaire inquiring into their attitude to their work. Eighty-nine eventually replied and 87 sent completed questionnaires, of which 80 were suitable for survey. These 80 doctors were mainly in their late thirties or early forties, married with several children, and had been in

general practice for 10 to 15 years. Only 10, including the one in wholly private practice, were in single-handed general practice without assistance. The average list was 2,350 and only seven doctors had more than 50 private patients.

Just over a quarter of the 80 doctors appeared to be completely satisfied with general practice in this country and would choose general practice if they had their time over again. At the other end of the scale, nearly another quarter did not enjoy their work.

Dissatisfaction appeared to be concerned mainly with the amount and distribution of payment. Lack of adequate ancillary help, inadequate contact with hospitals, and lack of freedom of movement were other sources of dissatisfaction. For the majority of doctors increased remuneration would correct some of the other sources of dissatisfaction.

It is suggested that to produce and maintain a contented body of family doctors working under good conditions the Government must increase the general level of payment for general practitioners and decrease the gap between the prospects in general and in consultant practice. Suggestions are made concerning redistribution of money in the pool and the closer integration of the family doctor and the hospital.

CONGRESS OF CLINICAL CHEMISTRY

[FROM A SPECIAL CORRESPONDENT]

The fifth International Congress of Clinical Chemistry was held in Detroit, Michigan, U.S.A., from August 19 to 23, 1963. It was attended by about 800 members from at least 19 countries.

Drs. O. P. GRAY and R. A. SAUNDERS (Cardiff) gave an account of the biochemical findings in two infant siblings with severe familial cholestatic jaundice. One child died and the other showed progressive hepatic damage. The serum bilirubin varied from 4 to 32 mg./100 ml., about 60% being conjugated. Alkaline phosphatase levels were raised, and the transaminases, which were initially normal, increased as the disease progressed. Both infants had steatorrhoea and bilirubinuria and excess urinary urobilinogen. Hepatic biopsy was normal, and no extrahepatic obstruction of the biliary tract could be found at laparotomy. It was concluded that these children were suffering from a new defect in the transport of bilirubin in the blood which might be an inborn metabolic error.

Tetracyclines in Serum

Drs. R. L. SEAREY, J. A. FOREMAN, and L. M. BERGQUIST (Los Angeles) read a paper on the effects of tetracyclines on electrophoretic mobilities of serum lipid-bearing proteins. They found that the addition of tetracycline or its analogues to serum produced milky opalescence of the serum which developed most rapidly with demethylchlortetracycline and hardly at all when oxytetracycline was added. When serum tetracycline mixtures were subjected to paper electrophoresis a well-defined fluorescent band migrating just ahead of the γ -globulin band could be detected. This band was found to consist of denatured protein and to contain fat which would normally migrate in the α - and β -globulin fractions. It was not known what relationship these findings had to antibody activity or the toxic side-effects of tetracycline, but the authors suggested that some of the side-effects of prolonged or high dosage of tetracycline might be related to the reactions which they described.

Drs. B. P. MURPHY and C. J. PATTEE (Montreal) described a relatively simple technique for the estimation of cortisol and

thyroxine in the plasma by means of gel-filtration and dilution with isotopically tagged cortisol or thyroxine. Recoveries of added cortisol were in the region of 90% and the results of thyroxine assays gave moderately good reproducibility. In the case of thyroxine the method had considerable advantages over the estimation of serum-protein-bound iodine determinations in that it was highly specific, unaffected by contamination with iodine from extraneous sources, and took only an hour or less to carry out.

Tryptophan Metabolism

Drs. P. HUGHES and B. D. BOWER (Birmingham, England) described their studies of tryptophan metabolism in patients with infantile spasms. They followed the pyridoxine-dependent metabolism of tryptophan after giving 0.2 mg./kg. body weight of L-tryptophan to their patients. They found that the excretion of xanthurenic and kynurenic acids were increased, as was the excretion of 3-hydroxy kynurenine. 3-hydroxy anthranilic acid excretion was diminished or absent. Administration of pyridoxine (a coenzyme of kynureninase) or A.C.T.H. resulted in a reversal of these abnormalities and an increased excretion of 3-hydroxy-anthranilic acid. The full effect of pyridoxine or A.C.T.H. was seen only after administering them for two to three weeks. They concluded that pyridoxine deficiency or lack of responsiveness to pyridoxine was implicated in infantile spasms with oligophrenia, but that the cerebral disorder was not cured by treatment with it. Treatment with A.C.T.H. did however bring about some improvement.

Dr. ISOBEL M. BETT (Glasgow) gave an account of tryptophan metabolism in patients with rheumatoid arthritis. After administration of L-tryptophan there was an increased urinary excretion of kynurenine and 3-hydroxy kynurenine, and to a lesser extent of kynurenic acid and xanthurenic acid. This metabolic abnormality was not correlated with duration, activity, or severity of the disease, nor was it a result of prolonged treatment with salicylates. After treatment with steroids the excretion of tryptophan metabolites became more normal. Administration of pyridoxine either orally or intramuscularly caused a dramatic fall in kynurenine and 3-hydroxy kynurenine excretion, but was without effect on the arthritis itself. There might be a parallel between the abnormalities described in rheumatoid arthritis and the syndrome resembling rheumatoid arthritis which was described as occurring in a