STATUS OF THE GENERAL PRACTITIONER PAST, PRESENT, AND FUTURE*

BY

I. D. GRANT, C.B.E., M.D.

Chairman of Council of the British Medical Association and past president of the College of General Practitioners

General practice is regarded as that branch of medicine which provides continuing care for the patient, calling in when necessary the help of the consultant. It is generally agreed that fully 80% of illness can be treated adequately by the general practitioners of to-day.

The art of general practice, which is something rather different from the science of practice, goes back for many centuries, and when reading a volume on the history of medicine I found some general guidance on the practice of medicine delivered by Archimetheus to his students in the year 1100 which may be not without interest for us to-day: "Entering the sick room you should have neither proud nor greedy countenance. You should commend the arrangements of the house and, if it seems appropriate, the likeability of the family. Then turning to the patient you may ask how it goes with him. At first there may be a difference between your own state and that of the patient either because he is excited at your arrival or because he is worried about the size of your fee. You should then with care examine the patient, after which you should promise him that with the help of God you will cure him. But as you go away you should say to the family that he is very ill, because if he recovers you will receive very great credit and if he dies they will remember that you despaired of his health from the beginning. Meanwhile I counsel you not to turn a lingering eye on his wife, his daughter, or his maidservant, as this sort of thing blinds the eye of the physician and averts the favour of God." As a member of the General Medical Council I suggest the last sentence is singularly apposite to-day.

Looking Back

In my youth, spent in a Highland parish, the three people who exercised the greatest influence on the life of the community were the minister, the doctor, and the dominie or teacher. Each of them placed service before self. Each of them occupied an honoured place in the hearts of the people and each of them were happy and contented in their work. To-day the prestige and the status of all three have been grievously impaired. To what extent this is due to a changing world and the changing conditions of the welfare State and how much to our own change of outlook it is perhaps difficult to assess, but since the inception of the National Health Service there is little doubt that the doctor-patient relationship has altered.

The more unintelligent members of society, who have no sense of personal responsibility for themselves or their families, frequently regard the doctor almost as their servant, on tap at any time like water and electricity, who can be summoned whenever any trivial illness affects themselves or their family. They are only aware that they pay large weekly contributions towards

social security, and the symbol of that security is the general practitioner, who, the politicians assure them, is at their service at any hour of the day or night. The status of the doctor in their eyes has gone down, and their demanding attitude towards him is responsible for much of the resentment and frustration that is sometimes expressed by practitioners in the poorer industrial areas.

It has been said that the practice of medicine has been bedevilled by mechanization, specialization, and commercialization. Through no fault of our own we have had to wage an almost constant battle with the Governments of the day over terms of service and remuneration, and this has gained for us much unwanted publicity and criticism. But it is, I think, fair to say that we have emerged from these battles as reasonable and responsible people who were not making unjustifiable demands. Danckwerts awarded us 90% of our claim and the Royal Commission about 85%.

Status has been defined as "relative standing, rank, or position in society," and when discussing our status as general practitioners I would like to regard it from two aspects—our status with the general public and our status with our professional colleagues.

Club Practice

The past is always nostalgic, but, although we are apt to forget it, general practice in the early years of this century was at a very low level in the industrial areas. Club practice was rampant and the appointments were almost auctioned to the lowest bidder. In the cities, the 6d. doctor was a common phenomenon—medicine and advice for 6d. When the doctor offended the club committee he was dismissed summarily, and so low were medical ethics that his place was immediately filled by one of his neighbours. There was little pretence at real prescribing. The club contract included attendance and medicine, which was usually supplied from one of six stock mixtures suitably diluted. McKenzie records that when he commenced practice in Burnley the most popular remedy in the dispensary was a mixture of burnt sugar and ginger. It gripped, it had a robust colour, and was regarded as a specific for all diseases of the alimentary canal.

Midwifery was done under appalling conditions. Puerperal fever was common. The most skilful doctor was he who could do a forceps delivery at the earliest stage, and lacerated cervixes and perineums were the rule rather than the exception; the status of the general practitioner was justifiably low. In country districts a much higher standard of practice obtained, and even to-day there is little doubt that the country practitioner gives a fuller range of personal service to his patient than does the city practitioner, who can and frequently does refer his more difficult and interesting cases to the out-patient department. The country practitioner generally occupies a much higher status and regard in the community than does his city colleague.

National Health Insurance

In 1912 National Health Insurance was introduced, and, although it was violently opposed by the profession, there is no doubt that it brought much financial and clinical advantages to the practitioner. He was now able to prescribe adequately and he was freed from the evils of club practice. Between the two wars his status and influence greatly increased. He obtained posts on the

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hospital staff—in Scotland even on the teaching hospital staffs—and he frequently obtained a higher qualification and graduated from general practice to full consultant status.

During that period almost every teacher in a Scottish medical school had many years' experience in general practice, and when application was made for a senior hospital post experience in general practice was regarded as an advantage rather than a handicap. The junior hospital posts were invariably occupied by general practitioners who did part-time work in the hospital. They were altruistic and dedicated doctors and were unpaid for their hospital work. They increased their knowledge of their chosen specialty and thereby were able to give a more efficient service to their patients and were able to charge modest fees for these services. To become "a professor" meant a tremendous increase in status and prestige. To compete with these men almost forced the average general practitioner to maintain a high standard, and at the time of the second world war the whole profession occupied a position of respect and even affection in the life of the community.

The Present

With the advent of the National Health Service the profession was placed almost completely under State control, and, worse still, it was arbitrarily divided into three almost watertight compartments—hospital practice, public health practice, and general practice. Those general practitioners who had for many years worked in their local hospitals were edged out, forced out, and sometimes even kicked out of positions they had filled satisfactorily for many years. They felt embittered and frustrated. Their status in the eyes of the public was lowered. They were wearied after the hardships and restriction of war, and the future seemed drab and uninspiring. They lost their old enthusiasms and they succumbed to following the line of least resistance.

General practice began to lose ground rapidly. Much of our work was taken over by out-patient departments of the hospitals and less and less clinical work was undertaken in our surgeries or the houses of the people. There are many who feel that at that time we lost our freedom in medicine and became cogs in the administrative machinery.

Freedom is perhaps rather difficult to define. We have certainly lost our freedom to transfer from one area to another and we must now pursue our vocation under strictly defined terms of service, but I think we have still retained our clinical freedom, which I would define "as the ability to treat our patients to the best of our ability in accordance with our knowledge of the science and art of medicine and in conformity with our insight into the patient's general conditions of life." "Freedom," said Bernard Shaw, "incurs responsibility. That is why so many men dread it." It is because freedom alone permits responsibility that our profession must retain it. The proletariat are very well aware of their rights and their entitlements, but they are very little aware of their duties and their responsibilities.

College, Fellowship, and B.M.A.

Most of us will agree that our biggest problems arise where a third party (the State) intervenes between us and our patients, and we must constantly be on guard to limit this sphere of activity. At this gloomy period

in general practice two beacon lights appeared to lighten our darkness. Your Fellowship for Freedom in Medicine, under the inspiration of Lord Horder, was founded and the College of General Practitioners was established and accorded an enthusiastic welcome by all who felt that the continuance of private practice was essential. Your aims were partly political and partly academic. The aims of the College were almost entirely academic. Many of us felt that the outcome of the battle even for clinical freedom was in jeopardy.

Lord Taylor, in his book *Good General Practice*,¹ states: "By their standards of work and by their conduct the general practitioner must deserve to be free." This is the challenge. The foundation of the College was accorded a welcome both from inside and outside general practice. Here at last was an academic institution dedicated to uphold the clinical traditions of the family doctor, leaving to the British Medical Association the mundane and financial difficulties which required negotiation. Already the influence of the College and the Fellowship is apparent and by each much has been achieved. The decay has been arrested. Frustrations have lessened. Despondency has been translated to hope and considerable progress has been made towards the re-establishment of general practice in its rightful sphere.

The status of the general practitioner is again on the upgrade. Perhaps the most outstanding contribution the College has made in upgrading the general practitioner is the establishment of the Research Foundation. It has become increasingly apparent that so many of the early signs and symptoms of disease are seen only by the general practitioner, and that in an attempt to establish the aetiology of disease the contributions made to research by the general practitioner can be of inestimable value.

McKenzie it was who said: "No instrument can replace the finger, the experience, and the reasoning powers of the doctor himself. The early stages of disease are insidious and are indicated mainly by subjective sensations. The patient, conscious that something is amiss with him, does not as a rule seek help from the hospital physician but rather from his family doctor. The bulk of patients in the early stages of disease are never seen by those who are systematically engaged in the investigation of these diseases." These early investigations are now being correlated into their respective channels by over 700 general practitioners on our Research Register, and the worth of their observations has been freely acknowledged by full-time research workers.

This activity perhaps above all others has raised the status of G.P.s in the eyes of our consultant colleagues. Our student attachment scheme has been taken up wholeheartedly by senior students in all the medical schools. Our preceptors are carefully chosen, and after one or two weeks spent with a good general practitioner the average student is amazed at the interest and variety of cases which he encounters in the day-to-day work of practice. The status and prestige of the general practitioner have for him increased considerably when he sees the excellence of the work done usually without any ancillary help.

Throughout the years the B.M.A. has striven to maintain the honour and interests of the medical profession. Ever since the inception of a partial health service in 1912 our Association has waged an almost

constant battle with successive Governments to maintain our independence, our freedom, and our proper status in society. The General Medical Services Committee keeps careful watch over our terms of service, sometimes winning, sometimes losing the argument.

In recent years, to promote our scientific knowledge, the B.M.A. has organized further scientific meetings and postgraduate lecture discussions, all of which have been well attended and outstandingly successful. They have attracted very favourable comment in the press and have improved the whole status of medicine with the general public. I venture to suggest that some of our distinguished consultants who address these meetings are pleasantly surprised at the knowledge and clinical acumen of the general-practitioner speakers.

It has been my privilege to read both for the B.M.A. and for the College essays submitted for our annual prizes, and I have been thrilled and astounded at the very high standard of excellence shown by the authors. They are indeed men and women dedicated to their work and are successfully upholding the great traditions of British medicine.

The Medical Services Review Committee (Porritt Committee) is undertaking a very difficult task. It is impossible to forecast the contents of its report, but the Committee has already served one very useful purpose by ventilating the problems affecting the different sections of our profession. Attendance at its meetings has enabled consultants to appreciate and become cognizant of the obligations of the practitioner and has impressed upon practitioners the problems of their hospital colleagues working in overcrowded out-patient departments. I hope that the report will pinpoint the defects of our National Health Service and that the Committee will have the courage to suggest remedies, even though they may be unpopular and politically impracticable at present.

What of the Future ?

In recent years much lip-service has been paid to the general practitioner. He is the foundation on which the National Health Service is built. He is in the vanguard in the attack on disease. He is the backbone of the profession. But, after three years of intensive investigation and meditation, what did the wise men of the Royal Commission think about him? Personally, I was rather shocked by the denigration of general practice in its report. The general practitioner's status and his emoluments were in no way comparable with those of the consultant.

I am one of those who consider that the good general practitioner is of equal value to the community, as is the good consultant. The one is complementary to the other. The one has generalized knowledge—the other has specialized knowledge. The financial rewards to the consultant are, on average, £1,000 a year more than to the general practitioner, and when differential payments are suggested—a euphemism for merit awards—one practitioner in 22 is considered worthy of a minimal award whereas one consultant in three can expect recognition of merit.

The student of to-day is far-seeing, and with this difference in status and income how many students of outstanding ability are going to make general practice

their first choice? If only the mediocre are going to make general practice their career more and more will inevitably devolve upon the hospitals, which in time may well become the foundation on which the National Health Service is built. There will be performed all the most interesting medical work, much of which could, with adequate diagnostic facilities and suitable incentives, be equally well done by the general practitioner in the homes of the people.

I do not wish to discuss the merits or demerits of the capitation payment, but I am sure that some financial incentive must be provided to spur the ambitious and keen general practitioner to undertake more than the routine services which are so often all that is provided to-day. We must realize that the more we relegate to hospital without full and careful investigation by ourselves, without at least a tentative diagnosis, and without a carefully written letter, the more our status with our consultant colleagues will depreciate.

More Time

What the general practitioner requires most of all, if he is to fulfil his proper destiny, is more time. Time to take a careful history, time to make a complete examination (looking back on our mistaken diagnoses, are not the great majority of our errors due not to lack of clinical acumen but to a hurried and careless examination?), time for postgraduate study, time to meet our colleagues at ward rounds and symposia, and, above all, time for some leisure and recreation—a tired and physically weary doctor cannot give of his best.

The divorcement of the general practitioner from hospital has undoubtedly lowered his status in the eyes of the young consultant, who, having himself no experience of domiciliary treatment, is quite unaware of the difficulties in treating patients at home with no ancillary services at his behest. I am sure it would be of infinite value to registrars if they spent a period of six months working with a good general practitioner in the capacity of a trainee assistant.

The recommendations of the Platt Committee² on the employment of general practitioners in hospital on a sessional basis have met with a good deal of criticism both from hospital staff and general practitioners. Probably not more than 10% of general practitioners would wish for these appointments, and for the busy practitioner even in partnership it would be difficult to give more than three sessions per week to hospital work.

If the scheme is to attract the keen and enthusiastic young practitioner back to hospital he must be accepted as a full member of the hospital team. He must be given responsibility comparable to that of a registrar, and for his part he must make attendance at his hospital sessions a prior charge on his time. This return to hospital work will enhance the status of the general practitioner both in the eyes of the public and in the esteem of the consultant and will be of infinite value in teaching students.

Impersonal Institution

Under the National Health Service a hospital is essentially an institution, and an impersonal institution. An ever increasing number of people are born in and die in hospital, and these two events of basic importance in every human life now take place outside the family

circle. Many patients who enter hospital for investigation ultimately require operation, yet if he is a National Health Service patient the surgeon rarely discusses the proposed procedure with the general practitioner or even notifies him that the operation is contemplated. Once the patient is admitted to hospital the responsibility of his family doctor is ended, and at a major crisis in the patient's life he has not the opportunity to discuss the prognosis with the man who best knows his history, his constitution, his virtues, and his vices.

If an hour could be set aside once or twice a week when the general practitioners could visit hospital, perhaps be welcomed to the common room, be given an opportunity to discuss the progress of their patients, and even to examine the patient, how much would their knowledge be increased, how much help might be given to the consultant, and how much their status with the patient would be exalted. We all know how much mutual benefit is derived from a similar procedure with private patients.

T. S. Elliot wrote: "If you have not the strength of character to impose good conditions in life then you must accept the terms it offers." Nowhere is this more evident than in general practice. We can still with our own patients and with our own colleagues ensure our proper status, although in doing so we may tend to lose an appreciable number of patients who are unreasonable in their demands and pay scant respect to their doctors.

The scope of general practice has altered in the past decade and will continue to do so. The clinical boundaries are changing, and we must learn to adapt ourselves to them and try to influence them. We have lived through a social revolution and have created the welfare State. Whether that paternalism is in the best interest of our people only time will show. It has certainly destroyed our old pride of independence. As general practitioners we must evolve methods by which we will accept more and not less responsibility. The public must be made to realize that hospitalization is only for serious illness, and that in their G.P. they have a doctor who can treat adequately the great majority of their ailments.

It is fashionable in these days to decry the skill of the G.P. and to arraign the attention he provides for his patients. The answer to this charge is overwhelmingly in our favour. Each year the G.P.s provide for the patients on their lists some 300 million attendances, and during 1960 only 374 complaints were received—and of these 295 were discharged as frivolous. Of the remaining 79, after full investigation, penalties were imposed on only 35 doctors. I wonder if any other profession or industry can show an equally satisfactory achievement. Whatever our status may be to-day our record of service should be counted high.

Conclusion

I would like to leave two thoughts with you. The first is from Professor John Jewkes's memorandum of dissent³ in the Report of the Royal Commission on Doctors' and Dentists' Remuneration: "his [the general practitioner's] life is one of the most arduous and exacting of all . . . it does not seem to me likely that sufficient doctors of the right calibre will be forthcoming unless the special pressures of their kind of life are recognized and properly rewarded." And the other

from an address given by Professor David to his students in Montreal a few months ago and which seems to me equally relevant to us in Britain: "The youth of to-day is desperately seeking after truth in an age which confuses all values by reducing them to one common denominator—money. If this materialism enters our hearts as doctors, if our major preoccupation is to acquire material possessions, then we must not be surprised if we are all levelled in the rigid frame of a Government agency. But if we sincerely believe that medicine is not a trade but a vocation, the road to the future will be wide open and fruitful. We will retain our freedom only so far as we are judged worthy of it. We will lose our freedom if ever a majority of our profession consents to use medicine as a mere spring-board for financial advancement."

REFERENCES

- ¹ Taylor, S., *Good General Practice*, 1954. Oxford University Press, London, New York, Toronto.
- ² *Medical Staffing Structure in the Hospital Service, Report of the Joint Working Party*, 1961. H.M.S.O., London. Price 5s. net.
- ³ *Royal Commission on Doctors' and Dentists' Remuneration, 1957-1960*, Cmd. 939. H.M.S.O., London. Price 15s. Memorandum of Dissent, by Professor John Jewkes, p. 159.

APPROVED NAMES

The last supplement to the consolidated list of "approved names" was published in the *Journal* of August 19 (p. 516). A new supplement, dated October, 1961, is printed below. Communications relating to "approved names" should be addressed to the Secretary, British Pharmacopoeia Commission, General Medical Council, 44 Hallam Street, London W.1.

Approved Name	Other Names	Notes
Ampicillin ..	6-[(α -Aminophenylacetamido)penicillanic acid [(α -Aminobenzyl)-penicillin] "Penbritin"	Antibiotic
Benzphetamine ..	<i>N</i> -Benzyl- <i>N,N</i> -dimethylphenethylamine "Didrex" is the hydrochloride	Appetite suppressant
Butylated hydroxyanisole	A mixture of 2- <i>tert</i> .butyl-4-methoxyphenol and 3- <i>tert</i> .butyl-4-methoxyphenol	Antioxidant
Butylated hydroxytoluene	2 : 6-Di- <i>tert</i> .butyl- <i>p</i> -cresol	Antioxidant
Droxypropine ..	1-[2-(2-Hydroxyethoxy)ethyl]-4-phenyl-4-propionylpiperidine	Cough suppressant
Nicocodine ..	6-Nicotinoylcodeine	" "
Oxethazaine ..	2-Di-(<i>N</i> -methyl- <i>N</i> -phenyl- <i>tert</i> .butyl-carbamoylmethyl)-aminoethanol	Local anaesthetic
Piritramide ..	4-(4-Carbamoyl-4-piperidinopiperidino-2 : 2-diphenyl-butyrone)trile	Analgesic
Plasmin ..	The proteolytic enzyme derived from the activation of plasminogen "Actase" is plasmin (human)	" "
Propicillin ..	6-(α -Phenoxybutyramido)penicillanic acid (1-Phenoxypropyl)penicillin "Brocillin" is the potassium salt; "ultrapen" is the potassium salt	Antibiotic
Rifomycin ..	Antibiotics isolated from a strain of <i>Streptomyces mediterranei</i> (specific substances are designated by a terminal letter; thus, rifomycin B)	" "
Syrosingopine ..	Methyl 18-(4-ethoxycarbonyloxy-3 : 5-dimethoxybenzoyl)-reserpate "Singoserp"	Treatment of hypertension
Tolpropamine ..	<i>N,N</i> -Dimethyl-3-phenyl-3- <i>p</i> -tolyl-propylamine	Antihistamine
Troxonium tosylate	Triethyl-2-(3 : 4 : 5-trimethoxybenzoyloxy)-ethylammonium tosylate (Tosylic acid is the trivial name for <i>p</i> -toluenesulphonic acid)	Treatment of hypertension
Troxypyrrololium tosylate	<i>N</i> -Ethyl- <i>N</i> -2-(3 : 4 : 5-trimethoxybenzoyloxy)-ethylpyrrolidinium tosylate (Tosylic acid is the trivial name for <i>p</i> -toluenesulphonic acid)	" "
Vinblastine ..	An alkaloid extracted from <i>Vinca rosea</i> "Velbe" is the sulphate	Treatment of Hodgkin's disease and chorionepithelioma