BRITISH MEDICAL JOURNAL

LONDON SATURDAY SEPTEMBER 26 1953

In the summer of 1950, when the National Health Service had been in operation for two years and the British Medical Association's report on "General Practice and the Training of the General Practitioner" had just been published, the Council decided that an authoritative review of the actual conditions of general practice should be undertaken. For this purpose it appointed a Special Committee "to review the present position in general practice, its difficulties and its trends, both generally and with reference to the two years' experience of the National Health Service Acts, and to the B.M.A. report on 'General Practice and the Training of the General Practitioner,' and to make recommendations." The Committee instructed Dr. Stephen J. Hadfield to make a survey of a random sample of different types of practice in England and Wales and Scotland. His own account of the results of this appears below. The results of the Postal Inquiry answered by nearly 13,000 general-practitioner principals and the Committee's Report appear in a specially enlarged number of this week's Supplement.

A FIELD SURVEY OF GENERAL PRACTICE, 1951-2

BY

STEPHEN J. HADFIELD, M.A., M.B., B.Chir.

Assistant Secretary, British Medical Association

This is a report of a survey of general practice carried out between February, 1951, and March, 1952. I wish to emphasize, in anticipation of a possible objection that parts of the report are one-sided, that my information was obtained entirely in general practices and from general practitioners. Some of the general practitioners interviewed criticized other fields of practice, and these criticisms are set down in the report, but it was not within my terms of reference to seek answers to them from practitioners in the fields concerned.

The approach to the survey was critical in the hope that the discovery and assessment of shortcomings, faults, and difficulties might lead to action which would eliminate them. Consequently these matters are given considerable emphasis. Where this touches the adequacy or otherwise of the practitioners seen, a final assessment is given towards the end of the report (p. 705), and this should offset any inaccurate impression given in the remainder of the text.

Since the report was completed certain important administrative changes in general practice in the National Health Service have occurred as a result of the Danckwerts award, including the implementation of the Spens recommendations for the remuneration of general practitioners. They should be borne in mind when reading certain passages of the report, which have been left in their original form. Their retention will serve to show how necessary were the changes and will perhaps encourage further improvements in the interest of both patient and doctor.

INTRODUCTORY

A Field Survey of General Practice

The field survey was designed to cover 200 general-practitioner principals in England, Scotland, and Wales. This number was chosen, first, as being large enough to

give a representative picture and to ensure that all types of practice would be visited, and, secondly, as being sufficiently small to be surveyed within a reasonable time by one investigator. The practices seen included various types of town practice, rural practices remote and otherwise, a Highland practice, and a practice on one of the islands off the west coast of Scotland. The number selected was such as to make the survey last over one year, so that practices were seen, so to speak, at all states of the tide.

The purpose of the survey was to obtain an objective picture of the varieties of general practice existing at the current time and how they were being conducted, and to obtain information upon which the types and magnitude of the difficulties existing could be assessed. The method of survey adopted was for the investigator to spend the best part of one normal day with each of the practitioners selected.

I sat in the surgery through one surgery session (in some instances more than one) and then accompanied the practitioner on his normal round. The practitioner's views were obtained during the many opportunities for conversation that occurred during the day.

Although I did not suggest it, approximately half of the practitioners invited me to accompany them into the houses they visited. It was interesting to note that, on the whole, neither in their homes nor in the surgery did patients seem to be in the least upset by the presence of another doctor—in fact, after a brief introduction the patient seemed to take no further interest in my presence. Neither did the patient object when the practitioner, as happened in a number of instances, invited me to examine the patient with him and to join in the consultation.

In ten instances the doctor made it a condition of my visiting him that I would not be present at consultations. My visits to these doctors were thus somewhat shorn

of their objectivity, though in some instances I was taken into the patients' houses instead. The reason usually given was that the doctor "could not submit himself or his patients to such an embarrassing situation as would arise from having a third person present." In one case the practice had changed hands three times in the space of four or five years. This practitioner, naturally, was unwilling to agree to anything that might give rise to further rumours which would seriously impede the rehabilitation of the practice.

In view of this diffidence among a few it was surprising that such a large proportion consented to my presence. It was indeed laudable, for I am prepared to believe that some overcame a natural diffidence in the interests of the survey.

The doctors themselves seemed quite unperturbed by my presence, although one or two of them did tell me afterwards that they had not felt entirely at ease. I always expressed my readiness to leave if the patient clearly preferred it. Such a need, however, seldom arose. Five practitioners had no surgery sessions for me to attend.

Method of Selecting the Practitioners to be Visited

As it was considered essential to visit practitioners in all districts the country was divided into 20 regions. For convenience, this was effected by taking the 19 regional hospital board areas, the twentieth area being made by taking separately the geographical area covered by the Metropolitan Branch of the British Medical Association.

Acting upon the suggestion of Professor Bradford Hill, the names of all principals in general practice in England, Scotland, and Wales were placed in alphabetical order and then sorted into the 20 areas, according to their addresses. Starting from a drawn number, every 64th name was taken, working through from region 1 to region 20. The selection was continued through a list of practitioners in entirely private practice; this gave a random selection of 300 names. The list was then reduced to 200 by casting aside every third name. This, incidentally, created a reserve list of 100 names, one reserve name being specifically allotted to every two practitioners on the main list. The 200 on the main list were the ones to be visited. Only in case of death, retirement from practice, removal from the area, or absence from the practice for the period of the survey was a substitute visited and included in the results.

Where there was refusal to allow a visit no substitute was visited. This happened in six cases, and consequently the number visited fell short of the 200. There being only one substitute for each two doctors, it was found on three occasions that both of the pair on the main list were excluded for reasons other than refusal; thus for one of the pair there was no substitute. In three instances where one was required a substitute was found not to be available. The number visited was further reduced by these factors to 188.

A few doctors who originally refused were subsequently persuaded to change their minds, and when visited were found to be at least as co-operative as the others. There were two refusals with no reason given. Reasons for other refusals were as follows: "That it is a misguided policy to imply publicly that an observer is needed to unearth the significant facts; that it is the

particular attitude of mind of each practitioner himself that is important, not the opinion of an observer." This practitioner added that the presence of an observer would be an embarrassment to himself and to many of his patients, and that the whole atmosphere during the visit would be artificial. Another said he disagreed with the method of obtaining evidence and that he hated anyone sitting in the surgery with him. A third was shortly leaving his practice and thought that there was no point in trying to "tinker with the present set-up, which is founded on a false philosophy at variance with Christianity."

By this method of selection visits were paid from Ross-shire to Cornwall and from Caernarvonshire to Kent, and included a large number of industrial, cathedral, and seaside towns, and a wide variety of rural areas. Some of the practices were large partnerships with full lists, while one or two were very small indeed. The majority of practices varied widely between these two extremes.

The programme of visits was arranged so that as many areas as possible were visited more than once, at different seasons. For example, seaside towns were visited both in and out of season; big industrial and country practices were seen both in summer and in winter. The same practice was never visited twice, as time was insufficient; but, generally speaking, each type of practice was seen at different times of the year. The actual arrangement of the journeys, the choice of where to go next, was haphazard and made by me as I worked through the list. So far as possible I tried to make several visits on each long journey.

It was found possible to visit four doctors, sometimes five, in most weeks. Saturdays and Sundays were not used for visits. After seeing nine doctors in a pilot or preliminary "run," the survey proper was begun on February 6, 1951, and the last practitioner was visited on March 4, 1952.

In part the survey was designed to show to what extent the tenets in the Cohen Report were being followed and also to find out as much as possible about general practice in the country.

Facts and opinions were sought on the same subjects in each practice. So far as possible I categorized the answers obtained in order to facilitate analysis. This categorizing was necessarily vague, but I found it possible to place the answers in the correct category without much difficulty.

In this report the large majority of opinions expressed are those of the practitioners themselves. Some are the conclusions come to by me as a direct result of my observations. Where there is expressed what might be called a personal opinion this is clearly indicated.

I wish to place on record my grateful thanks to all those practitioners whom I was privileged to visit for the helpful way in which they enabled me to carry out my task. In addition I would like to thank most warmly those doctors' wives who gave me hospitality during my visits.

Further, I am grateful to the Council of the Association for making it possible for me to have the experience of undertaking this Survey, to the Secretary and my colleagues on the staff of the Association for their assumption of my duties during my absence, and to the clerical staff for their invaluable help.

The Average Practitioner, 1951-2

There are so many variations in general practice that it is perhaps difficult to draw a picture of the average general practitioner. Nevertheless, the attempt may be worth while. Evidence that wide variations do exist in many directions will be found throughout the whole of the report.

The average doctor lives in a house in the area in which his practice is situated. He has his surgery premises either in his house or in a special wing built on, probably by his predecessor, or he may have a lock-up surgery, with or without a caretaker, in a busier street near by. He may share this with a partner or partners, though he usually has his own consulting-room.

His list will be in the neighbourhood of 2,500 in the town or 1,500 in the country. In addition he has a handful of private patients. He takes the administration and organization of his practice in his stride and does not find that this side of his activities worries him much. Unless he is an extreme individualist he will prefer to have a secretary-receptionist to help him with correspondence, with finding and filing patients' record cards and reports, and with the telephone. He may not be able to have such assistance owing to insufficient income or to lack of accommodation, the latter often being due to the impossibility of obtaining suitable premises or of converting his present place.

In any case, his wife has a considerable burden to bear. Over and above the abnormal strains on his household that a doctor's calling occasions, and in the absence of suitable domestic help, she has to see that the needs of the patient are served. The telephone and the door-bell must be constantly answered. Such is the difficult situation in which many a doctor's wife is placed that she cannot embark upon her morning's shopping without considerable forethought and organization. To go out with her husband is a rarity. Even a visit to the cinema or bridge club requires careful planning, if it is possible at all.

The average doctor will usually be able to overcome this to some extent, and also, outside the busy part of the winter, to ensure himself a very little leisure, by arranging a rota system of duties for the evenings or for half-days. Apart from this he will regard himself as more or less permanently on duty. He will have encouraged his patients to send their messages to him before he sets out on his morning round, but there always remains a nucleus of patients who are unaware or unheeding of the need to assist the doctor in this way.

The average doctor, while telling you that he is quite prepared to deal with any emergencies that come along, would be much happier in his practice, and would probably carry it out to the better satisfaction of himself and his patients, if only he could purge his list of this hard core of inconsiderate trouble-makers. He is genuinely fond of the majority of his patients and is anxious to do his best for them, but he will be the first to admit that there are times when the accumulation of trivial or unreasonable demands at the end of a tiring day may well impair this feeling.

Between 8 and 9 o'clock in the morning he will be taking his breakfast and answering telephone calls for visits. He will be in his surgery promptly at 9, and will see patients until, say, 10.30. This is an average time, during which he will see up to 25 patients. There will

be a bit of everything most days. Perhaps 20 of the patients will have minor ailments or come for follow-up, or be calling merely for a certificate. The other five may be more interesting from the clinical point of view and need more attention. Thus he may spend 15 minutes on one patient and then quite properly deal with the needs of five or six others during the next 15 minutes.

When the patient enters the doctor may need to ask the name, especially if the patient has not recently been under treatment. He will get out the record card, if he has no secretary to do it for him in advance. He will then note the patient's complaint and ask what supplementary questions he may consider necessary. He will not as a rule follow the method of approach which is taught to the medical student, except where he suspects there is something more than a minor ailment to deal with. Of necessity he has learnt to short-cut the detailed method. His knowledge of the patient gives him a start. If he has treated the patient year after year he will know just how detailed his examination need be.

The morning surgery finished, he will make out his visiting-list, with final adjustments to include new calls that have come in. He arranges his round geographically so far as is possible. This is sometimes conditioned by messages which have about them a more urgent ring, or by visits to specially ill patients—for example, the revisiting of a patient to whom he was called during the night.

The possibility, or indeed the likelihood, of his day being disrupted by a midwifery case, an accident, or some other emergency will cause him to tell his household or his secretary in what order he proposes to visit his patients. Thus there is at least some chance that he may be "got" in an emergency. When he and all his partners are out visiting, his wife may quite likely receive an "urgent" message later in the morning. On being told that all the doctors are out visiting but that she will get a doctor to call as quickly as she can, the inquirer may exclaim, "There must be a doctor there: I don't believe it. . . . Send a doctor at once or I will report you." Needless to say such messages are rarely as urgent as they sound.

Doctors vary greatly in the time they take over their visits, quite apart from the requirements of the case or the volubility of the patient. Most doctors, in the towns and in the country, will have 15 to 30 visits a day to pay during winter months, when there is no epidemic raging. In the summer the number may be down to about half that of the winter. In the country a higher proportion of the work is done in visiting, while in the town the majority of patients are seen in the surgery—in some practices the great majority. Distance and accessibility for the patient are the factors here. So that, while on the average the numbers of visits paid are the same in both town and country, the country doctor needs more time for the same number of visits, but his surgery sessions are shorter. In a few town practices the visiting-lists are very high indeed, reaching the forties in quite ordinary times. Practices vary enormously, but these big visiting-lists are not within the average.

Nearly all practitioners told me that, since the N.H.S. began, surgery attendances have increased greatly but visiting-lists have, if anything, become smaller; also that late calls in the evening, many of them unnecessary, have increased, while the actual night calls, those which involve rising from bed, have dropped slightly.

The practitioner has perhaps six hours between morning and evening surgery in which to get his calls done, have his lunch and tea, and travel, the average distance being 15 to 20 miles a day. He will get in and out of his car, say, 25 times a day: if he has many gates to open it will be many more. Thus he can usually manage to see about five patients an hour. Rather, it should be said, he can visit five houses an hour. In some houses he is asked to see two, three, or even four patients where he was expecting to see one. This is a development for which the N.H.S. is responsible. I witnessed this in many a home, just as I also saw much of the multiple consultation in the surgery. These things are very prevalent indeed.

If the various members of the family are paraded into the surgery their cases must be gone into one by one, and more often than not they are trivial in the extreme. When prescriptions are requested for absent members of the family it is often easier for the doctor faced with a waiting-room queue to give a prescription than to enter into an argument about the patient having to come to the surgery in person.

There is nowadays little of the old custom of turning the doctor's visit into a social occasion. There are many offers of hospitality, but there is little time for the prolonged chat. Days vary, but often the end of the visiting-list seems far off and there is anxiety whether the list can be finished in time. It is rarely that a visit to a house lasts more than 10 minutes, and many need not be so long. Some practitioners work much more quickly than others—for example, on the day I was there one visited 27 houses, and drove 12 miles in doing so, in 130 minutes. Another visited 44 houses in 190 minutes. These are exceptional.

At lunch-time, which is normally not longer than half an hour, there may be telephone calls to be made to the hospital, to the district nurse, or to the chemist. A general practitioner's lunch "hour" is hardly ideal for the preservation of a good digestion.

The afternoon round follows the same pattern as the morning—that is, if no emergencies have intervened to upset the programme. If they have, the afternoon is almost certainly an anxious rush. The practitioner will usually make time for a cup of tea before starting his "6 p.m." surgery. Many start this at 5 or 5.30, for the patients are already there and the sooner it is started the sooner it is finished.

To have to pay a further visit or two after the evening surgery is common, though if there is a rota system with partners or colleagues the practitioner may have to do this only on certain days of the week. This is a great advantage, for he can then sit down quietly to his supper and face the evening with tranquillity.

If he has not this freedom he may well have to turn out again after supper. In the winter he usually has to forgo his half-day; there is too much work to be done. Yet the work varies. Except in epidemic times there is seldom a period of high pressure for more than three weeks at a time. Just as the general practitioner is beginning to think to himself that the strain will never end there comes a sudden lightening of the burden. This is sometimes all too short, but is nevertheless welcome. There are, of course, some practices that seem always to be hard-pressed. Summer and winter the lists of visits in these practices and the queues in the surgery are long and there seems to be no let-up. Not in these

practices can one partner go away and leave the other to carry on. He must get a locum. Another practice, much the same on paper, will produce about half the pressure of work. I have seen both sorts in the same town. This must have some relation to the personality of the particular doctor, though I have been unable to define clearly the factors responsible for the difference. Some areas of the country seem to produce more illness or more general-practitioner attendances than others. The impression I gained was that this is due, in certain districts, to an increased incidence of respiratory and rheumatic diseases.

(A) THE RANGE OF GENERAL PRACTICE

Continuity of Treatment

Most practitioners are anxious to keep in as close touch as possible with the progress of the patient, even though the responsibility for the treatment has passed temporarily out of their hands into those of the hospital out-patient and in-patient department. They like to be ready to take over the treatment, convalescence, and rehabilitation after the patient's discharge from specialist treatment. A smooth transference of responsibility is more likely when general practitioners are working with the hospital and where the liaison with the hospital staff is good.

Another aspect is the degree to which a patient is exclusively cared for by one general practitioner for either one or all successive illnesses.

Obviously, in the single-handed practice the patient is exclusively looked after by one doctor. The exception is where a single-handed general practitioner has an assistant and uses him in such a way as to depart from the "one illness, one doctor" principle.

In some partnerships responsibility is divided even in the care of an individual illness. Patients have no means of knowing which of the partners they will see when they call at the surgery. There are no definite times when Dr. A or Dr. B will certainly be present. Patients are seen by whoever is there. The lists of visits to be paid that day are pooled and divided up among the partners in a manner suited to their convenience. This may be on a geographical basis or just haphazard, bearing no relation to which doctor has previously visited the patient, either in the current or in the previous illness. The latter method is used by 9% of practitioners. It is defended on the grounds of necessity in order to make the visiting-lists economical of time and thus allow the work to be dealt with. The point is also made that the patient may well get better treatment by having more than one opinion. A number of patients prefer such an arrangement for this reason. In addition, the doctors in a partnership get to know all the patients and to gain their confidence. This is considered to be a great advantage in relation to emergency calls where a rota system is in operation.

There exist all shades of variation in this matter, the general tendency, outside the strictly personal practice, being to take the middle course, in which, on the whole, one doctor continues to attend any one patient for the duration of any one illness. Then there are those doctors who, from my own observation, I feel confident share the knowledge of all the patients so thoroughly that the method approximates to a working together on the case. There is a world of difference between the partnership that starts the day's work with, "I'll do the

west town and the High Street and you do the housing estate," on the one hand, and the partnership of two whose day starts with, "Will you go and see Jim Budd to-day and see what you think? I found some creps yesterday," on the other.

It is stated by some doctors that the majority of patients get used to being seen by more than one doctor and do not mind. I have no doubt, from my own observations, that this is true of a number of patients.

I saw a small number of doctors who did not know the names of most of the patients who came to the surgery and gave no signs of having had any previous acquaintance with them. Although some doctors describe themselves as "bad at names" I found this complete ignorance was not so noticeable in the practices where patients kept to the same doctor.

In one of the best practices that I saw the work has so increased as to make it necessary to depart from the previously existing state of affairs in which the patient kept to one doctor. In another practice the two partners tended to change the visits round, but were finding that the patients seemed to want the practice to develop into a more personal one. I saw one practice run on group-practice lines. The doctor whom I met kept surgical cases to himself. When he saw a medical case he would hand it over for further treatment to his colleague.

In many cases I found that the partners had a fair knowledge of all the patients in the practice. This seemed more common in the smaller practices. This leads me to another point. In the nature of things, and because the terrain demands it, most country practices are, on the whole, smaller. Thus it is easier for the country practitioner to know the patients of his partner than it is for the town practitioner who has a full list. Also, of course, it is so much more important to be able to arrange visits geographically in the country. In the winter it is often essential in order to get the work done. Views vary concerning the desirability of changing patients or doctors during the course of an illness and whether or not the patients lose anything by it.

In considering this item any treatment by a partner in an emergency is, of course, not taken into account.

Health Education and Preventive Medicine

Almost all general practitioners give inoculations and vaccinations, and when opportunities occur encourage mothers to bring their children for immunization. A small proportion expressly advise patients to take their children to the clinic, for they say they feel it is far better for the child to receive a prick at the hands of a stranger than to be estranged from the family doctor because he has hurt him. One doctor said he thought it created a neurosis. Some said they preferred the clinics to do the injections because it saved them work.

Nearly all the practitioners visited give helpful advice on positive health and preventive medicine when asked by the patient. Some spoke of lack of time. The majority confine their activities in this field to taking what opportunities present in individual consultations and, with some, at antenatal clinics arranged by them in their own surgeries. Nine per cent. are enthusiasts and spend much time in educating the public in matters of health. A few gave me the impression that they

could not be bothered with health education. Nearly all the remainder feel that they are too busy treating disease to preach its prevention. In many cases this is undoubtedly true.

Patients are not, as a rule, receptive to positive instruction; they regard it as preaching and treat it with suspicion. I often noticed that when the doctor's remarks veered from the symptoms and the pills to such things as open windows, suitable clothing, and other precautions a curious blank look came over their faces. This applies especially to mothers of children.

Treatment of the Patient as an Individual

The majority of doctors are of course concerned to assess and to treat the symptoms of which the patient complains. They also show, by questions and conversation, a knowledge of or an interest in the family and occupational background of the patient. This interest in the patient as an individual was particularly conspicuous in about a quarter of the doctors interviewed. Some of these are interested especially in the psychological approach. A few isolated practitioners (6%) seem to have no interest beyond the actual symptoms complained of. In one case at least I felt that the practitioner regarded his patients as something of a nuisance.

Diagnosis

I saw a wide variety of diagnostic methods. Most of the doctors (93%) whom I saw at work carried out some sort of examination in some cases: 69% could be definitely classified, on the evidence before me, as leaving no doubt that all patients received what examination was necessary.

I kept constantly in mind that the extent of the examination needed in any case is conditioned by the fact that doctors know the patients and also may have examined them quite recently.

Some of the senior practitioners, though undertaking little in the way of examination, have obviously developed an instinct or sixth sense. This, coupled with a background of long experience, enables them to use a minimum of effort and yet leave one with the feeling that they are unlikely to miss any serious diagnosis. I found the margin a narrow one between such practitioners and those who, through over-confidence, tended too often to put their trust in spot diagnosis. Among these latter were men who expressed to me their feeling of pride in the way they were doing their work.

Among a small proportion (7%) of both young and old there is a need for revision of the methods of diagnosis they use. There is a need for constant vigilance on their part to determine for themselves whether in fact they are doing their duty by their patients in this matter of clinical examination.

It would be easy to cite a few examples where no attempt was made at examination when it was clearly indicated. To do so would create an unfair impression while ignoring the countless occasions when I witnessed thorough examinations. Suffice it to say that I did see a small number of practitioners whose standard of examination was in the danger zone.

The remainder (24%) vary over a fairly wide range. Some of these seem ready now and again to take a chance, and some of them are forced into this position by the excessive demands upon their services. Yet I

observed that some of the busiest men are the most thorough in examining their patients.

I was told by one doctor (and a similar attitude was noted in several others) that some forms of examination—for example, per vaginam—"are not convenient to ordinary general practice conditions." These were left for the hospital to do. Another examines where necessary but considers that surgery conditions prevent its being done easily. Facilities for examination—for example, examination couch—were absent in 11 surgeries. Minor reorganization of the consulting-room or of arrangements for surgery attendances would have made it possible to conduct any necessary examination.

A few doctors have solved this problem by making appointments for "special examinations," as they are called, or by arranging to call at the patient's house. Such arrangements meet with, at any rate, some degree of approval from most. But it may sometimes be forgotten that the patient often comes for such an examination after much marshalling of courage and in the fear occasioned by, say, a mammary lump or an irregular menstruation. The ideal, surely, is for the practitioner to have his premises so arranged that the patient can receive the necessary examination at the first visit and not be sent away with anxiety mounting and having to muster courage all over again. Several times I thought I detected a look of disappointment from this cause.

It was interesting to note how rarely are inspection and percussion used in examining the chest, even among doctors who attain a reasonably high standard of examination in other ways. I was surprised at the prevalence of the method of examining the abdomen through the clothes and with the patient standing. This was adopted sometimes in the absence of an examination couch and sometimes under pressure of work, no doubt backed by a knowledge born of experience as to the time taken by the really well-corseted woman or bewaistcoated man to remove enough garments to permit of a reasonable clinical examination according to the textbooks.

A small percentage of practitioners do not seem to examine their patients except as a rarity. It must be emphasized that their number is very small. Some general practitioners have got into the habit of hurrying through their work. Whereas they may be busy at times, and undoubtedly are, they have developed the habit of not examining patients even when they are not unduly pressed.

A certain amount of spot diagnosis is inevitable in a busy practice, but, as mentioned before, some rely on it overmuch. I saw one doctor in particular try to deal with over a hundred patients in a day. This made thorough examination impossible—for example, it was not possible for him to give a thorough examination of the chest in patients presenting anew with cough.

Let this account of the shortcomings of a few should lead the reader to conclude that the average practitioner does not examine his patients adequately, it should be stated once again that the majority of the practitioners whom I saw left me in no doubt that all their patients received whatever examination was necessary.

Treatment

Over 90% of the practitioners that I saw are undoubtedly interested and careful in the treatment of their patients. They give the necessary advice, super-

vise rehabilitation, prescribe carefully, and do dressings and emergency treatment. Not for them the mere hurried writing of prescriptions that I witnessed among a few.

About two in every five are anxious to undertake, and do undertake, as much of treatment as comes within what has been recognized as the normal scope of general practice.

I ascertained whether or not the practitioners visited undertake minor surgery. The majority (53%) do not or do only a very little. It is noticeable that in the towns only 27% of the general practitioners do minor surgery, whereas in the country 60% do. Cottage hospitals no doubt play their part in this, but some of the country doctors seen were miles from a hospital. Obviously in the towns the proximity of a general hospital is an important deciding factor.

Some doctors declare that it is preferable, in order to ensure asepsis and the best technique, for minor operations, varicose vein injections, hydrocele tapping, and the like to be performed in hospital. The reasons most often given for not doing minor surgery were, however, lack of time (by no means always borne out by the day's work witnessed) and the absence of a special fee.

Two or three of the doctors seen give physiotherapy in the form of light treatment.

Information to Specialists

An overwhelming majority of practitioners send letters to consultants when referring patients. I sometimes saw the letters. They vary in length; most are confined to a statement of facts and a request for an opinion.

Most consultants or hospital authorities will not accept a patient unless there is an introductory note from the general practitioner. Even so, I noticed that this, of all the questions asked, was normally answered in an affirmative that was almost indignant.

One doctor had been told that he writes too much. Another criticizes his partners for the poor notes they write. I saw three who wrote very short and scrappy notes, one almost impossible to read. Another could not be bothered with a proper letter, for, he said, the consultant could find out for himself. He is one of the few who send a visiting-card with either their diagnosis or the main symptom written thereon.

One doctor says he attaches "great importance to the letter in the patient's interest." He regards it as a passport to the consultant, which takes away something of the patient's embarrassment and fear. A woman doctor expresses herself succinctly thus: "The better the letter I send the better the reply I expect, and get."

The forms used by hospitals for general practitioners to make out-patient appointments interested me greatly; some serve as the letter to the consultant as well. There are several variants. One that is satisfactory to some general practitioners is a letter-card, prepaid to the hospital appointments clerk, which is simple for the practitioner and preserves professional secrecy by reserving the inside sealed part to be used for the doctor's letter. The information required by the clerk is on the outside, and the letter is opened only by the consultant himself. The letters and cards used by many hospitals have not incorporated this desirable feature, so that it is possible for any clinical notes to be read by the lay clerks.

Administration

Ninety per cent. of practitioners seem to take the administrative side of their practices in their stride. Some of them complain of the tedium of paper work, but they keep on top of it either by the exercise of a natural efficiency or by employing a secretary.

I saw only five doctors whose enthusiasm for the administrative side of practice was such that it was almost a hobby. There were five who disliked it intensely and were evidently much harassed by it.

A very large number of the practitioners visited complained bitterly of the volume of advertising matter which arrives daily by post. They wonder by how much this excessive advertising increases the nation's drug bill.

Miscellaneous Duties

I found that 13% of general practitioners combine with their practices considerable activity outside the day-to-day care of patients. The single-handed and the partners seem to be equal in undertaking such pursuits. With partnerships the covering for attendance at medical boards—often some distance away—or at hospital sessions is much easier.

Sixty-nine per cent. of general practitioners undertake what must be an average amount of work under this heading, the commonest forms being life assurance examinations and dental anaesthetics. Occasional attendance at schools and factories was noted also with some frequency.

About one practitioner in six, usually by his own choice, undertakes nothing, or almost nothing, beyond the general care of his patients.

I formed the view that the variety afforded by a modicum of extra tasks is of value to the general practitioner. The man who does none seems less contented, and more affected by what has become the humdrum nature of the task. There is an optimum degree of development of miscellaneous duties, consistent with the conduct of a fair-sized practice and with the preservation of some degree of continuity of treatment of patients. I think that the practices of some of those who do a great deal outside the day-to-day care of patients are inclined to lose something of the individual touch.

Non-Medical Advice

Inquiries under this heading were not quite accurately so named. There is much in the way of personal and family advice that a general practitioner can and does give that is partly medical. It often has a bearing on the medical condition, more particularly, perhaps, in psychosomatic medicine. So that I directed my inquiries to finding out to what extent the general practitioner's advice is sought on matters not purely and entirely clinical; to what extent does the general practitioner fill the role of guide, philosopher, and friend on the non-medical and quasi-medical stage.

I find that about nine out of every ten regard this as a part of general practice. They give advice or help when it is asked for by the patient, or sometimes when it seems to be necessary. It may vary from writing letters for the illiterate to advising about a will. These are two examples that I saw in my survey. Of the nine, one general practitioner will be specially active on the

more social side of his patient's affairs, including activities which properly come into the field of social medicine.

The remaining practitioners (14%) do nothing in this way. Some have too recently started in practice or are still young enough to be regarded as being without worldly wisdom. Others avoid giving "non-medical" advice, saying that it is nothing to do with a doctor, that much of it is the job of a lawyer, that doctors have been too dogmatic in the past and have talked and advised upon matters of which they know next to nothing. Others say that they or their patients have found themselves in difficulties as a result of inept advice; now they avoid a repetition.

Special Interests

Inquiries regarding special interests and the possibility of applying them in general practice were not fruitful: 51% of practitioners have some particular bent, sometimes leaning rather definitely towards a specialty; 65% of these find at least some scope for their interest.

One says he has no scope to pursue his interest—blood counts—because he is not paid for it. Those interested in chests and dermatology complained of the difficulty of obtaining radiological diagnosis and treatment. Time was the factor most often mentioned. The interests covered most of the field of medicine and surgery.

The Scope of Practice

Recent Advances in Medicine

Of those who have been in practice long enough to judge, all but 30% say that the scope of practice has been increased by recent advances in medicine. Nearly all mention particularly the treatment of pneumonia with penicillin and the use of the sulphonamide drugs. One practitioner remarks that recurrences and relapses of pneumonia occur more frequently; thus the work is not lessened as much as might be expected.

Approximately 35% contend that the work has increased from this cause, one saying that this is because he prefers to give all injections himself. On the other hand, another doctor observes that he now has fewer visits with oxygen cylinders to pneumonic patients.

Three doctors say that their scope has been diminished by recent advances in medicine. I did not succeed in getting any very satisfactory explanation for this opinion. One said that there is now so much more that can be done for a patient by the general practitioner if only we had fully equipped health centres and beds.

Increasing Specialization

Sixty-six per cent. are unaware of any effect of increasing specialization on the scope and work of practice. The small number (9%) who feel there is an increase in scope due to this cause are of the opinion that more can now be done for patients by referral to consultants whose interests lie in a smaller and more detailed field. I believe that in giving this opinion they really intend the credit to go to the advances in medicine rather than to the fact that medicine is becoming more fragmented.

One-fifth find their scope diminished by an increased demand by patients for reference to specialists and to specialized clinics. There are, they say, so many different consultants nowadays that there is little of interest left for the general practitioner to do. Also, hospital

work has been taken away in many instances and the general practitioner feels that he is not trusted to do things for his patient. He has to think much more carefully when deciding to whom he should refer the patient. Indeed, he is at a loss sometimes to determine who is, in fact, the proper specialist for the particular case.

The most telling cry of those who find the scope of practice lessened by increasing specialization is that of lack of flexibility of hospital beds. Beds in some hospitals are allotted in smaller and smaller batches to an ever-growing list of "ultra-specialists," thus reducing the number of general beds available for "ordinary" cases.

Co-operation of Public Health Services

Only 4% of practitioners have found that the scope of their practices has benefited by changes in or increased co-operation by the public health service since the introduction of the N.H.S. A few mention the better arrangements made by the medical officer of health for obtaining home helps, entry to convalescent homes, or invalid chairs. One speaks of the assistance he has received in mental and nervous cases. There is appreciation where pathological facilities are provided by the public health laboratory.

A few find their scope diminished through the treatment of children by school medical officers without the general practitioners being informed. Others say that mothers are encouraged by the public health clinics to have their babies in hospital rather than at home under the care of the general practitioner. In one area—except in serious emergencies—patients are not admitted to the city maternity hospital unless they have attended the antenatal clinic. The general practitioner is powerless to arrange an admission.

Some clinics are said to have encroached considerably on general practice. Patients are treated partially at clinics, and then, when they have to take to bed, the general practitioner is called in and knows nothing of what has gone before. One practitioner emphatically stated that, whereas he formerly regarded the public health service as an encroachment on his practice, now that it makes no financial difference he is willing for them to share the burden of work. There are others whose remarks suggest a like view.

The points mentioned above are mostly of detail. The overwhelming majority have found no effect on their practices of any changes in the public health service or of increased co-operation.

It seems appropriate here to introduce the subject of relations between the general practitioner and the public health medical officers. There is little sign that the introduction of the N.H.S. has brought about any change in the relationship between the general practitioner and the officers in the public health service. Forty per cent. report little or no contact with the service, and 41% that relations are satisfactory. The word "satisfactory" is not used in the sense that perfect or near-perfect liaison exists between the two branches of the profession. By so describing the situation many of the doctors merely mean that they have no complaint and that on the rare occasions when they have asked something of the medical officer of health they have got it. Of the remainder 9% consider their relations to be unsatisfactory.

On the "satisfactory" side I heard how general practitioners had been actively helped by the medical officer of health in handling dysentery outbreaks. About one-half say the school medical officers now write to general practitioners and give them the opportunity of arranging for consultants' opinions when required, instead of doing it themselves without passing on the information. In a few cases improved relations are attributed to a change of medical officer of health, in one to the fact that he is now full-time instead of one of the local general practitioners. As an example of the other side of the picture, a general practitioner in a large city complained that the medical officer of health had announced in a newspaper that he was in close touch with the general practitioners and that all was prepared in the event of an epidemic breaking out. The general practitioner states that no such contact in fact exists. Then, again, while the general practitioner was strenuously overworking in the influenza epidemic of January, 1951, he was disgusted to read a statement by the medical officer of health that there was no epidemic in the city.

One general practitioner, in the middle-age group, gave me the impression that he knows nothing about the public health service. He reported that the sanitary inspector was good for disinfection, and that was all he knew. One complains that his medical officer of health is interested only in vaccination returns, while another says that the general practitioners in the area have found it necessary, when anything was required of the medical officer of health, to band together and approach him as a deputation.

I heard a good deal of criticism of the clinics and the medical officers working in them. These latter are said to exercise insufficient care when advising patients, and mothers, to go home and call in the general practitioner. Patients having some slight disability or something that calls for no more than an ordinary message to the general practitioner are given the impression that they must ask the doctor "to come at once." It is complained that there is little appreciation by the doctors in the clinics of how disrupting such unnecessarily urgent messages can be to a general practitioner's work.

The explanation may well be that the clinic doctors are unaware of how liable the patient is to be misled by what is said, or to exaggerate the seriousness of a complaint or illness, especially of their children, and do not word their advice accordingly.

Quite often I heard criticism of the work of the clinic doctors. This greatly disturbs the general practitioner, especially when he is unaware that the patient is under treatment at all. Some complain that the clinics treat the patients up to a point and then send them to their own doctor to "clear up the mess." Other general practitioners say that they get many notes such as "Rash: please treat," or "Temp.: please treat." Some feel that the clinic doctors should be allowed to prescribe some of the simpler remedies under the N.H.S. Others resent the fact that another doctor, unknown to them, should be treating their patients. They object to being sent for when the child, who has been for several days under treatment for a running ear at the clinic, has to be kept at home on account of a temperature. The general practitioner knows nothing of what has gone before. Complaints on these lines were

commonly met with. I think they spell only one thing—a deplorable lack of contact between the two branches of the profession.

Some do not mind a certain amount of encroachment by the clinics, because they are only too glad to shed part of the burden on someone else, and they readily admit it. But the majority prefer to treat their patients themselves.

Many feel that the clinics are not necessary. One says that the public health service is redundant so far as individual medicine is concerned. One medical officer of health had told a general practitioner that he was not interested in individuals. Some feel that the medical officers of health overlook the general practitioner's circumstances; for instance, when they send a request to him to vaccinate a child without sending a parallel notification to the parents to instruct them to get in touch with the doctor.

I found some confusion of thought among a few general practitioners about the responsibilities of the public health service. For instance, some seemed still to think that chest physicians were responsible to the medical officer of health and blamed him for situations which were not within his control. A general practitioner sent a case to the chest physician. He heard nothing more until he discovered later that the district nurse was giving streptomycin and P.A.S. He believed that the public health service was at fault in allowing this to happen without his being informed. I had several complaints of the existence of that mystic attribute "the official mind." There were complaints of delay, such as one of 48 hours in seeing a case of pediculosis. The general practitioner finds it difficult to understand such delays.

Undoubtedly the best relations with the public health service are found where the general practitioner himself is doing part-time work in a clinic in that service. It has the double advantage of his getting to know the public health medical officers, and of his being able to make them see his point of view and appreciate some of the important points of general practice.

Elsewhere, and this covers most places, the general-practitioner service and the public health service are miles apart, with the result that both are becoming less effective. General practice is so wide a field that it can get along without the clinic side of the public health service. This is not to say that it would not benefit from closer co-operation.

From my observations I believe that the clinical side of public health work will not reach maximum usefulness unless and until it is brought much more closely into contact with general practice. It should be at least as closely allied to general practice as is the district nursing service.

It has been pointed out that the information required by public health medical officers for the performance of their duties is possessed by the general practitioner. Often there is a barrier between the two branches which can be made less formidable only by the co-operation of the medical officers of health on the one side and, on the other, by the general practitioner overcoming his existing resentment of the public health service, which is largely due to past errors and misunderstanding.

The medical officer of health needs the good will of the general practitioner, and it is necessary for him and his assistants to set out to obtain it. The general

practitioner needs to understand, too, that the public health service can mean co-operation and help instead of duplication and intervention.

During my investigation I found almost no evidence to suggest an enlightened attempt, either by the public health medical officers or by the general practitioners, to co-ordinate the public health service and the general-practitioner service.

Public Education in Health

"Our Medical Correspondent" has done much harm": "Press articles tend to panic patients": "They have too much 'little learning' and get confused"—these are some of the views expressed by 39% of the general practitioners, who find their patients made more sensitive, more "neurotic," by press articles and radio talks on health matters. Some describe it as "public education in disease." Increased surgery attendances, including demands for drugs mentioned, are spoken of as common consequences.

One doctor believes that many patients are discouraged from going to the doctor because they attach to some of the commonest of symptoms the fear of early cancer that has been instilled into them. Another feels that, although patients are more sensitive, further efforts at enlightenment are worth while. Another disapproves because patients' hopes of cure are raised too high. He feels that it is better for patient and doctor that the art of medicine should remain something of a mystery.

Most practitioners agree that this affects patients in different ways according to their type: 35% say it has no effect upon patients; and only 13% feel that as a result of public education in health patients are more sensible in their approach to their illness and to their doctor.

There is considerable divergence of opinion regarding the desirability and the effectiveness of these approaches to the public, which rather suggests a need for examination of some of the methods used. Perhaps also it suggests that there is a line of demarcation between the use of a medical article which does not rise above the suspicion of being a publicity stunt and the genuine attempt to improve the patient's well-being and state of mind by acquainting him with enough knowledge to understand something of disease processes and to achieve a sense of proportion in these matters.

Effect of N.H.S. on Scope of General Practice

Forty-five per cent. of practitioners applaud the fact that their scope in practice has been widened by the introduction of the N.H.S. Not all of these applaud, or even like, the N.H.S. itself; but on one point they are clear—that they can do more for their patients.

They speak with relief of being able to prescribe what the patient needs and to visit him as often as the condition requires, free from the inhibitive consideration of the patient's purse.

The opinion was expressed to me that, because of the costly new drugs and treatment essential to modern practice, the N.H.S. came in the nick of time. Most doctors are, from this point of view, glad of it.

It is doubtless true that, in the past, essential visits were always made and often not charged for, but the patient no longer needs to be anxious about the size of the doctor's bill. The general practitioner welcomes this. He welcomes also the removal of the financial bar to the calling in of a consultant to a consultation in the patient's home.

Other things, such as the stabilizing of a diabetic, can be obtained more easily. There are even a few practitioners who find that the waits for out-patient appointments are shorter.

A considerable number say that the summer and the winter work have evened out more; advances in medicine keep the winter work down while the "free" service keeps

the summer work up. Nearly all say that actual night calls are fewer but that the number of calls received after the practitioner has set out on his round, and also in the evening, is greatly increased.

The small number (15%) who say that the N.H.S. has diminished their scope proved rather a puzzle. For example, there are several who say that their scope is less because "I no longer do minor surgery," or "I send work to hospital now." Although the time factor (or "lack of time" factor) was quoted as the reason, I was unable to discern any marked difference in the demands made upon these practitioners and upon those who customarily undertake minor surgery. Some say their scope is diminished because they will not do minor surgery without special payment beyond the capitation fee, and these are not necessarily always the ones whose income has become smaller under the N.H.S.

Some who formerly did major surgery find their scope diminished by being no longer permitted to do it. Some have had other forms of hospital work taken away from them. The demands of the patient for hospital and specialist treatment are blamed for reducing the scope of practice. One doctor summed up these feelings by remarking that the N.H.S. tends to inhibit the desire to do more for the patient. Significantly the practitioner who made this remark showed no signs of any such inhibition.

About a quarter of the practitioners say that the N.H.S. has made no difference to the scope of their practices.

Midwifery

General practitioners seem to be divided into approximately equal thirds in their attitude to midwifery: one-third dislike midwifery, and have discontinued it entirely or are anxious to cut it down to a minimum; one-third are not very attracted to midwifery, but, feeling that it is a necessary part of the practice, do some; and one-third are keen on midwifery, regarding it as an essential part of general practice and endeavouring to do as much as possible. Attendance at the actual delivery is not, of course, obligatory, and a number of practitioners, even in this last category, do not find it necessary to attend the delivery in all cases.

Most of the doctors said that they see patients far more often than twice before the confinement, as is required by the regulations, many reverting to their pre-Service custom of monthly and, later, fortnightly examinations. Some find that not having to attend the delivery does, at least, enable them to cope with increased demands in other fields.

A vicious circle seems to be operating. There is a danger that the general practitioner will do less and less midwifery. Some fear that the practice of midwifery will be wrested out of his hands altogether. In most areas more mothers are having their babies in hospital. The reasons are economic and domestic as much as clinical. Then there is a tendency for midwives to deliver women at home in the absence of the general practitioner. He is less in demand because of the entry into hospitals, and in some areas because midwives and antenatal clinics encourage patients not to employ the general practitioner. Thus he is getting less and less experience in midwifery, which is building up the argument that he should not undertake it.

At present there is little pulling together in the matter. Misunderstandings occur and jealousies are aroused. The solution would seem to lie in the improvement of the local co-ordination between the general practitioner, the midwife, and the local authority, with the consultant and hospital service behind them ready to assist where necessary.

Relations with Midwives

Though nearly all practitioners are fairly well satisfied with their relations with midwives there are some indications of deterioration. So much seems to depend on the personality of the midwife and of the practitioner himself, but here and there I heard of lack of co-operation.

Suspensions were expressed to me that a B.B.A. ("Born before arrival") is occasionally deliberate; and there were a few complaints of the midwife failing to notify the general practitioner until the day after the labour.

Some midwives appear to resent the general practitioner's having anything to do with midwifery. One says that the midwife takes booked cases from him by persuading the patients not to attend at his surgery for antenatal examination.

A small proportion of general practitioners have expressed a fear that some midwives are anxious to supplant the general practitioner in the midwifery service. The general practitioner knows that he can complain when his instructions to be called to a case are flouted, as happens in some cases and with some midwives. But he is reluctant to do so, for he knows that the midwives are in a strong position; some are even suspected of favouring an opposition doctor.

Some general practitioners are anxious about this situation. They feel that now and again the midwife tries to take on too much clinically in her efforts to draw the practice of midwifery to herself, to the exclusion of the general practitioner.

One practitioner's real anxiety was that the tendency not to send for the doctor was developed to such an extent that he could not give his trainee assistant any experience in midwifery.

(B) PROFESSIONAL RELATIONSHIPS

Relations with Neighbouring General Practitioners

Most practitioners (70%) report that their relations with neighbouring practitioners are good, improved, or satisfactory. The word "satisfactory" is used broadly. It sometimes means no more than a wave of the hand as their cars pass, and an absence of any difference between them. As often as not there is no occasion for anything more than this to develop; or if occasions do present themselves the doctors are too busy or uninterested to turn them to good account.

The question on this aspect was asked largely because of a suggestion that the N.H.S. had encouraged competition for patients by unethical means. Where this was mentioned it was usually related to the period immediately before and after the introduction of the N.H.S., and is reported to have now disappeared. Here and there (about 5%) suggestions were made that unethical practices still continued.

What is more significant is the frequency with which single-handed practitioners, while pointing no finger of accusation, feel so unsure and suspicious of their colleagues that they are reluctant to co-operate with them, for instance, in the working of a rota. It is not a question of bad relations; it is a suspicion of one another hindering the establishment of good relations. Such single-handed doctors are perceptibly more anxious and less contented in their work, especially in the well-doctored areas. Where partnerships exist there is little anxiety on this score.

On the brighter side of the picture are reports of a decreasing tendency to unethical conduct, of the improvement of co-operation by formation of local general-practitioner associations, or regular (bimonthly) drawing-room meetings of groups of doctors, and of the formation of rotas. These are the result of attempts to overcome problems presented by the N.H.S. Improvement in relations has invariably resulted. The practitioners concerned are delighted and find the innovations valuable in every way.

A good example of improved relations exists in a small industrial town where the four doctors were in opposition to each other. The practitioner visited persuaded them all to join in partnership, the better to meet the problems introduced by the N.H.S. A sound and happy partnership had resulted. I saw a similar result where the practitioners had started with a rota system and developed it into a partnership.

The General Practitioner and the Consultants

Sixty-seven per cent. of practitioners declare that their relations with consultants have not altered since the inception of the N.H.S., and a large majority consider them to be fairly good, though often with some reservations.

The sort of reservation frequently made is, "So long as I can select my consultants all is well." Some consultants regard the general practitioner as a nobody; while one young general practitioner finds that the younger consultants are more approachable and more helpful. Many feel that consultants regard themselves as superior beings. One expressed well the feelings of several when he said that the younger consultant is on the defensive in order to conceal an inferiority complex. He does not like to acknowledge that the more experienced general practitioner knows a great deal. It is complained that the younger consultant has no knowledge of the general practitioner, his work, or how to treat him, and that a gap is forming partly because the consultant no longer depends upon the general practitioner for his living.

Many practitioners, while still able to maintain excellent relations with consultants they have known for many years, are frightened by the gap forming between them and the younger consultants. Deterioration is feared when the senior consultants are replaced by younger men who seem to feel superior to the general practitioner.

Some find improvement of relations arising out of the more frequent meetings with consultants on domiciliary visits. From several quarters, though, I heard complaints that consultants were so busy concentrating on other duties that the patients referred to them at hospital were seen, as often as not, by registrars and house officers. General practitioners feel some frustration when they are unable to get the opinion they want.

I tried to find out to what the general practitioners attribute any gap that is forming between these two branches of the profession.

Exclusiveness of Specialties

Only a small number (18%) feel that the increasing exclusiveness of specialties is causing a gap; 45% had no comment to make; while 37% were of the opinion that this was not a cause. One said that the general practitioner has to watch that the specialist does not miss things that are outside his field. For example, he sends a patient who is hoarse to hospital for investigation and learns he is admitted under the E.N.T. surgeon, laryngoscoped, and discharged as fit. On having the chest x-rayed a week later extensive lung disease is shown to be present. Though it may put the general practitioner on his mettle, he finds it more difficult to select his consultant, and feels that the "tingo" attitude is encouraged by over-specialization. A general practitioner, with experience of house-physicians who refused to see surgical cases in the casualty department, was alarmed about future rifts that might appear.

Personal Contact with Consultants

Only eight practitioners feel that the absence of personal contact with consultants is causing a gap to develop. Most meet the consultants from time to time at domiciliary visits or at medical meetings. The frequency of meetings is usually not very great—a few times a year, perhaps. Twenty-three practitioners have little or no contact with consultants. These include four who do not seek it. Another says he hardly knows the consultants, who are 12 miles distant, and feels there is a gap between them and him. Two say they "have no time for consultants."

The very large majority would agree with the practitioner who told me he "likes to travel to a consultation in the consultant's car, for it gives me an opportunity to obtain from the consultant much valuable information." Of those who were in practice before the N.H.S. 90% formerly met the consultant at domiciliary consultations. The proportion

now is 94%. There are probably many more such consultations nowadays. Almost all practitioners are anxious to "be there," but a few definitely place little value upon the meeting. One says he refuses to have the one consultant in the area who insists on the general practitioner being present. Some say the consultants prefer to "drop in in their own time" and not to make an appointment which the general practitioner can keep.

Only 9% of practitioners find it possible to meet consultants in out-patient departments (before the N.H.S. the figure was 12%). In almost all of these cases there are facilitating circumstances, such as a local hospital to which the general practitioner has entry or where he is a co-member of the staff with the visiting consultants. In others the visits are necessarily only occasional. On the whole, general practitioners find that such attendances are quite impracticable because of a clash of times. Some feel that they would not be welcomed if they were able to attend.

Separation of Postgraduate Training

Nowadays a man who wishes to become a specialist is more or less bound to set his course in that direction immediately on qualifying lest he fail to pick up a favourable wind to take him to his goal. He cannot afford, as formerly, to spend time learning something of the hazards of general practice before setting out. He must, in order to be sure of reaching consultant rank, proceed with little or no knowledge of general practice. Forty-one per cent. believe that this plays a part in separating the general practitioner from the consultant. I personally believe that there has not yet been time for this factor radically to affect the relations between them.

It was made clear to me that a large proportion of the practitioners, while quite happy with the consultants they have "used for years and still meet," are fearful of what relations will be like in the years to come, when many consultants will have had no general-practitioner experience. Several remarked upon the lack of understanding of the general practitioner by consultants who have not been in general practice. Others put it the other way round: that one can tell which consultants have done general practice, and that these are the best, at any rate from the point of view of the general practitioner. It is generally also thought by these general practitioners that such are the best from the point of view of the patient as well. Those without general-practice experience have no appreciation of how patients live, so that their approach to the patient suffers, and they make recommendations which are not practicable outside hospital.

One practitioner has the impression that the young consultant is too interested in the scientific side and does not handle patients well. He talks tactlessly in front of them. One feels that their not having had experience of general practice adds to "their feeling of superiority." Another put it this way—that consultants should have occasional courses from general practitioners in the same way as general practitioners do from consultants. Another says that a consultant with no knowledge of general practice is of no use to him.

Twenty-three per cent. said that all consultants should have some general-practice experience as part of their training, and 5% thought that it was unnecessary. Two felt it was necessary only for the general consultant, as opposed to what they were inclined to call the "technician type." One of these thought it was essential for psychiatrists also. I was told that for consultants to have experience in general practice is necessary for the advancement of medicine.

Rather similar arguments and opinions for and against were obtained when discussing the lack of opportunity for the general practitioner of to-day to graduate, in the fullness of time, into consultant status. One said that even if there were opportunities the general practitioner would be up against such specialized competition that it would not be worth it.

Separate Administration

Only about 10% feel that a gap is being caused by the entirely separate, and to the general practitioner remote, administrative arrangements—the executive councils for the general practitioners on the one hand, and the regional hospital boards for the consultants on the other. Some remark that the general practitioner has no channel through which he can make criticisms or suggestions regarding hospital treatment or services. One practitioner feels that the administration is untidy and that there should be one unit of administration for both consultants and general practitioners. In a number of places I was told that no trouble was likely to occur, because some doctors were on both the local executive council and the regional hospital board.

Though perhaps the figures do not underline it, in far too many areas a hedge is growing between the general practitioner and the consultant. The seeds were probably there before the N.H.S. Outside factors, some necessary and some unnecessary, appear to have given a fillip to their development.

The eye of the newly qualified doctor who wants to be a specialist is of necessity, and in the current fashion, fixed upon the material aspect of his career, and sees any chance of experience in general practice only as a likely obstacle to the achievement of his ultimate goal.

This struck me as an unsatisfactory, not to say dangerous, state of affairs, likely in the future to produce frustration in the general practitioner, to diminish the value of the consultant, and thus react unfavourably upon the patient. I liked the plan of one of the general practitioners whom I visited; he makes a practice of asking the house officers in the local hospital to spend a day with him from time to time in his practice. He finds they welcome it and return to their hospitals much enlightened.

Twenty-eight per cent. complain of failure by the consultant to ensure that the general practitioner receives a prompt report on the patient referred. In addition to these an equal number, while not complaining, receive reports only after a long interval. They seem to be satisfied that they receive reports at all. Twelve per cent. say they feel that the younger consultant, particularly, overlooks the interest of the general practitioner in his patient. I heard few complaints of patients being seen by consultants without reference from the general practitioner. There is little increased tendency among patients to approach consultants direct, and usually when it does happen the latter are careful to communicate with the general practitioner. Only in one town did I find any serious complaint, and this from two or three practitioners about more than one consultant. One quoted an instance in which a patient of his was seen by a physician, referred by him to a surgeon, admitted to a nursing-home, and operated upon without the general practitioner knowing anything about it. While being a fairly common occurrence in this one town, it must be emphasized that such things are almost unheard of elsewhere.

The suggestion that consultants and general practitioners should be under the same or a closely integrated administration would no doubt give rise to many objections, and might almost be regarded as revolutionary. Nevertheless, I came away from my investigations with a feeling of which I could not rid myself. This is that the separate administration of the various parts of the medical profession hampers the efficiency of the medical services and detracts from the value of the service to the one for whom it exists, the patient.

Public Health Medical Officers

Relations with public health medical officers have been discussed earlier in this report.

District Nurses

No practitioner has any complaints about the district nurses. Those who commented were full of praise of their efforts. One suggested that they all ought to have the George Cross.

It appears from remarks made by a number of general practitioners that they are using the district nursing service a great deal more than formerly. Much in the way of injections (penicillin, streptomycin) is being done by the district nurses. This is usually because the pressure of work on the general practitioner is so great. In some I detected what I thought was rather too much readiness to delegate these tasks. In most cases it arises from the fact that the nurse is visiting the patient daily, anyway, and it is thus no hardship to ask her to give the daily injection.

Relations with Health Visitors

Seventy-two per cent. of the practitioners whom I asked (I did not introduce this subject until I had seen about 40) have no complaints about health visitors. Neither were there any reports of co-operation worthy of notice. Some of these have no knowledge of health visitors' activities. Twenty-eight per cent. complain bitterly about them. Some regard them as a waste of nursing man-power.

The complaints heard are mostly of interfering with and instituting treatment and of giving advice outside their sphere without consultation with the general practitioner, and of frightening patients. Mothers are advised to stop breast-feeding—one on account of pain in the breast due to engorgement. One health visitor threatens mothers that their children will develop rickets if they do not take cod-liver oil; another tells mothers that their children have some disease or that they need operations.

Then they promise early admission to sanatoria, which the general practitioner knows is next to impossible. The general practitioner probably gets some of the blame for not seeing that the health visitor's promises are carried through. There is criticism sometimes of the general practitioner's treatment, and remarks like, "Your doctor should have prescribed so and so." There is too much prying into how the doctor is treating the patient and too much talk of the illness of neighbours, colourfully expressed, which frightens patients.

These complaints point to an unsatisfactory state of affairs. Better co-operation with the public health services would surely change this situation, to the patient's advantage. I have seen an experimental practice in which health visitor and general practitioner work closely together and have a daily conference. The benefit to the patient inherent in this mutual assistance is at once apparent to anyone who has attended such a conference, as I was privileged to do.

(C) THE GENERAL PRACTITIONER AND HOSPITAL WORK

Since the inception of the N.H.S. there has been a drop in the proportion of general practitioners doing any form of hospital work. Of the practitioners seen, only 28% had done hospital work before the introduction of the N.H.S.; the proportion now is 20%. In the towns 23% did hospital work formerly, now only about 16% do. In the country 38% of the practitioners used to do hospital work, and even now 30% do.

A number, though still doing some work in hospital, resent having had their scope reduced. One says he is restricted to doing four tonsillectomies a week, even in the face of a growing list of patients needing that operation. Others were formerly on the staff as surgeons, whereas now, although they have the use of general-practitioner beds, they are not permitted to do surgery.

Another point of view was expressed by the man who said that the N.H.S. had brought him to the point where he had either to become a specialist or to give up any sort of hospital work. Others feel that they are being steadily pushed out. The stock example of this is the general practitioner who formerly did all the anaesthetics at the local hospital. Now specialist anaesthetists are being appointed.

Most of the hospital work referred to consists of the use of general-practitioner beds in hospitals. Not all practitioners mind not having such beds. Many general practitioners in industrial areas have never been used to

having hospital beds and have hardly considered the matter as a practical proposition. Thus, only one-third of the urban practitioners having no hospital work or beds feel that their practice suffers in any way because of it. Nearly half of the country doctors feel that their practices would be better off for having hospital beds.

The arguments put forward against having beds are that they are unnecessary; that it means "too many cooks"; that a "lot of rubbish" is talked about the need for beds; that there is not time to use them properly in the face of the additional work arising out of the N.H.S. One practitioner says that, while he welcomes the possibility, he feels that the provision of an adequate number of beds in general hospitals is of far greater importance.

A town practitioner says that the taking away of general-practitioner beds is most damaging to general practice. Because of it the general practitioner of the future will be a less good doctor. Another says that the provision of general-practitioner beds would help to overcome his feeling of professional isolation.

To sum up, the urban practitioners do not seem to have any great enthusiasm for beds, except in the smaller towns where beds have been taken away from them. The country doctors are rather more interested so long as they are not placed so far from the hospital that their being on the staff would interfere with their ordinary visiting rounds. In discussing this problem the question of insufficient time kept cropping up. A number feel that the idea is a good one, and to the benefit of general practice, but are doubtful of being able to spare the time for its proper development.

Clinical Assistantships

Four out of every five favour the suggestion that general practitioners should be permitted to do clinical assistantships in hospitals. Most of them stipulate that time should be made to enable them to do it, or that the appointments should be paid. These two provisos are probably closely allied. There were some practitioners who, although interested, stated that the burden of work was such that they might find it difficult to accept such an appointment, even for one session a week, and at the same time continue to give their patients adequate service. The position would obviously be easier in partnerships where the partners were co-operative and would not all wish to undertake clinical assistantships at the same time.

A number expressed the view that it would be economically possible to take up a clinical assistantship only if no diminution of income were involved.

Some expressed the opinion that such appointments would be valuable for younger men only, say up to the age of 40. One says he would like to do it, but feels he would not be made welcome and would be looked down upon by the hospital staff. This mode of expression, which again points to the gap between consultant and general practitioner, kept cropping up in various guises during the whole of the survey.

Another favours clinical assistantships, not mainly because of the clinical value, but more for the advantage it would bring of close contact with the consultant world. Another says it should be compulsory for all practitioners at intervals.

Those unfavourable to the idea think that a general practitioner should stick to general practice, that if he did his work properly he would have no time. Some feel that it would be worthless because clinical responsibility would not be given; that it would not help because it would be specialist cases, not general-practitioner cases, that would be seen; and that what the general practitioner requires much more are general-practitioner beds in a local hospital.

(D) HOSPITAL FACILITIES

Fifty-two per cent. of the practitioners visited feel that practice is obstructed by the inadequacy of hospital services. The inadequacy refers to quantity rather than quality, and is of course closely bound up with staffing and accommodation.

Waits for Out-patient Consultations

According to 60% of doctors the average wait for consultations is two to three weeks; only 10% can expect their patients to be seen in a week or less. Eight per cent. find two months or longer to be the expected wait for an appointment unless the practitioner marks the case urgent. Most practitioners say they do this only in cases in which delay would harm the patient.

Opinions vary on what length of wait constitutes an obstruction or interference with the conduct of the practice. Some regard three weeks as too long, others are content. Just over 20% complain of obstruction.

Some say waits are long only for certain departments. The orthopaedic departments undoubtedly lead the field in occasioning lengthy waits, while usually E.N.T. and psychiatry tie for second place.

With psychiatry, of course, hurry is impossible. Some general practitioners feel that the E.N.T. specialists would be freer to see patients more quickly and to advise and operate on the more complicated cases if general practitioners were once more allowed facilities for operating on tonsils and adenoid cases. The long delay (two years or more) for tonsils and adenoid operations is such a common cry among general practitioners as to provide material for a music-hall joke. Many general practitioners who formerly undertook this work are no longer allowed to. They are not paid, and hospital facilities are denied them.

The long wait in orthopaedic departments was sometimes attributed to the inability of many of the specialists to trust the general practitioner to keep an eye on the patient.

Waits for Admissions

Whereas the greater proportion of doctors visited have constantly with them the boggy of long waits for beds for their patients, only in rare instances did I hear complaint that the admission of a suspected early cancer case was so delayed as to jeopardize the possibility of a cure by early treatment.

The satisfied practitioners are well content if their "cold" surgical cases are admitted within three months of their first being seen by a consultant. All agree on the necessity for maintaining a priority system for admission. For simple hernia, for example, the clerk can wait, while a high degree of priority is given to the collier.

About 70% of the doctors report that the "normal" length of wait for admission for non-urgent cases is six months or more. A few are able to get any type of case into hospital within a week because beds are available and the turnover is rapid. Yet one general practitioner told me that the surgeon to whom he refers his patients has ten patients waiting for each of his hospital beds. General practitioners who are on hospital staffs or in close touch with consultants find things easier.

Several mention that they are driven to using the domiciliary consultation service at times as a method of ensuring that patients are admitted to hospital. This applies rather more to emergency admissions, when it is used as a last resort. Fourteen per cent. of practitioners find serious difficulty in obtaining emergency admissions—12% of country doctors, and more than 14% of town doctors. Considering all that has been heard publicly about this problem, the number of practitioners reporting difficulty seems surprisingly small. The reason almost certainly is that where difficulties do exist they are usually very great.

Where an Emergency Bed Service operates I found a fairly consistent volume of praise for it. Admission is not always obtained by this means, and the service sometimes seems to be awkward. Nevertheless most practitioners find it infinitely preferable to the position of the country doctor who told me he "sometimes has to try four hospitals, each 20 miles away," or of the one who sometimes has to "go on his knees," or of him who has to spend an hour telephoning.

The Emergency Bed Service does not escape criticism. Several practitioners resent being asked to tell a lay clerk the temperature of a patient in whom he has made a diagnosis of acute appendicitis requiring admission to hospital. There are similar objections to "viva voce examinations" by house officers and questions such as, "Have you felt the pulse?" There seems a lot to be said for the principle that if a general practitioner has decided that admission to hospital is urgently necessary then the job of the Emergency Bed Service should be to find a bed and not first to decide whether or not a bed should be found. Presumably the Emergency Bed Service clerks ask certain questions (described as "impertinent" and "silly" by several) because they in their turn are asked these same questions by hospital officers.

Anyone who has had experience as a house officer knows that each area has its small quota of general practitioners who are adept and practised at obtaining urgent admission to hospital for patients whose clinical condition does not warrant it. Nevertheless, only those with experience of general practice can realize what a tremendous relief of anxiety there would be for general practitioner, patient, and relations if hospitals were to agree to see any patient whom the general practitioner regarded as urgently requiring admission. It would be for the hospital to admit him or to arrange his admission to another hospital unless the general practitioner was considered, by a doctor who had *seen* the patient, to be mistaken. The small number of offenders found to send cases frivolously and frequently could surely be dealt with tactfully by a quiet approach from a doctor connected with the hospital.

Admission of Aged and Infirm Sick

Long waiting for admission to hospital for the aged and infirm sick, and for old people, is almost a universal problem. Eighty per cent. of practitioners complain of the difficulties. Country and town are equally bad. Such expressions as "very bad," "hopeless," and "very time-consuming fixing them up" were evoked over and over again. Some describe the position as desperate and frustrating; the relieving officers who used to do such a wonderful job have disappeared. Particularly worrying has it proved where the local Poor Law hospital has been turned into a general hospital. One doctor said it was not surprising there is a problem: there are now 35 beds for chronic sick in his area, where formerly there were hundreds. Several told me that many on the waiting-list die before they are sent for.

I was told of a medical superintendent who visits the home of every patient who is proposed for the waiting-list. He examines the patient and assesses the degree of priority or urgency of the case. The admission list is maintained accordingly. The effect is said to be to make each general practitioner feel that his patient is being given the same chance of admission as the patients of other general practitioners, and that the worst cases stand the best chance. This method is thought to be fair and to deal with the problem on the right lines. The practitioner who told me of this is far less harassed than most others.

Another complaint I heard was of the unwillingness of the young people of to-day to care for their old folk. In several houses I visited this was apparent. I got the impression that some of the young couples, trying to concentrate on making and keeping a pleasant home for their families, are vaguely frightened of the possible effects of the home being centred round a chronic invalid. They are persuading themselves that the old people would be looked after better in hospital. The enormous increase in the numbers of old people has created an immense problem.

Housing conditions do not permit an easy solution, and lack of hospital beds prevents the most obvious solution. The result is that four out of every five general practitioners are daily grappling with this problem and are bearing a very large proportion of the burden of it. Others are

grappling, too, but the general practitioner and the district nurse find themselves in the hottest part of the fight, and with next to no weapons.

Tuberculosis

Another almost constant worry is the long wait for sanatorium beds. Only 23% say that waits are not long; 7% have no experience or make no comment. The remainder are finding that their tuberculous patients have to wait many months for admission to sanatoria. Attention has long ago been called to this situation, but it still persists.

Fifty-seven per cent. of practitioners are satisfied with the arrangements in their neighbourhood for the domiciliary care of tuberculosis cases. Some are satisfied because they supervise the treatment themselves, giving streptomycin and P.A.S., or sharing this duty with the district nurses.

Thirty-three per cent. speak of insufficient visiting and not enough attention to the patients in their homes. Some say they feel that the chest physicians have too much to do and too few chances of getting a sanatorium bed. As a result the care of patients in their homes is inadequate. They complain that all the care many of these patients get is to attend at the clinic about once a month and there be told that they are to come again in another month to have a further x-ray examination.

Three doctors specifically complain of the difficulty in getting patients visited in their homes, even when pressed, of a delay of a week before a visit was paid to a case of haemoptysis, and of six weeks' delay in visiting another case, despite several telephone calls by the general practitioner. A typical instance of the kind of inattention complained of is that of a patient being visited three times in two years by the "tuberculosis nurse" and nothing else.

Minor Operations at Hospitals

Only 14% complain that there are long waits for getting minor operations performed on patients at hospital. The remainder have no complaint. The complaint does not apply to urgent infective conditions, but only to such conditions as sebaceous cysts and ganglia, the majority of which can usually be borne for a few extra weeks without hardship.

Reasons for Inadequacy of Hospital Provision

Practitioners were asked for their opinions about the reasons for the inadequacy of hospital provision. The majority had no theories to offer or drew attention to the building situation and the shortage of nurses. A few mentioned that nursing as a profession was unattractive and underpaid. Others mentioned general practitioners sending cases to hospital unnecessarily, increase in the local population, and the fact that advances in medicine have made it possible to operate upon patients whose condition would formerly have been regarded as hopeless.

Some remarked on the effect of allotting fewer and fewer beds to more and more specialists in smaller and smaller fields. There is less flexibility of beds and fewer are available for general and emergency work. Teaching hospitals are blamed by some for keeping interesting cases too long, for teaching purposes.

Some attribute many of the difficulties to the fact that the introduction of the free service, coupled sometimes with public education in health, and always with official encouragement to use the service, has uncovered many conditions the existence of which the patients formerly kept to themselves. Now patients are enlightened and encouraged and are presenting themselves for treatment, and they need treatment; and until this back-log is dealt with the hospitals will give the appearance of inadequacy.

Appointments Systems for Out-patients

Most practitioners now find an appointments system operating in the hospital out-patient departments to which they refer patients. Twenty per cent. of these comment unfavour-

ably. Most of them say that patients have to wait just as long as ever they did when they reach the hospital. In fact, the appointments are not kept by the hospitals.

A few say that the appointments system acts like a dam, letting a little through while the water accumulates behind it. The consultants now see only a prescribed and appointed number and the delays get longer and longer.

A favourable comment was that the general practitioner may now grade according to urgency the patients he sends.

Some hospitals send for two or three patients for one appointment and are criticized for thus causing delay. The defence may be that patients on occasion fail to keep appointments and that it is necessary to ensure an adequate flow of patients for the consultant to see.

On balance, I find that the appointments system is favourably viewed. Most general practitioners feel that if further study is given to the problem a more satisfactory system could be evolved.

Direct Access to Radiological Departments

Forty-one per cent. of practitioners are able to send their patients direct to the x-ray department. Of those without such access 53% complain that their practices suffer, especially from the consequent delay in coming to a diagnosis. Of those with no complaint about the lack of facilities, a substantial proportion say that the reading of an x-ray film needs a consultant's opinion as well. Fifty-one per cent. report that they discuss the results with the radiologist. One practitioner finds great advantage in being able to go to the hospital, when he has time, and take part in the screening.

An important point made by some is that when a general practitioner refers a patient for an opinion the consultant of to-day "invariably has an x-ray film done." It is argued that most general practitioners are excellent judges of the need for such investigation; they can be, and should be, trusted with direct access. If they were, the amount of radiology would appreciably lessen.

Direct Access to Pathological Departments

Sixty-five per cent. of the general practitioners have direct access to some pathological facilities. This is by no means always the pathological laboratory of the local hospital. In some areas pathology, often limited in scope but more than the bacteriology required solely for purposes of preventive medicine, is done for general practitioners in the laboratories of the public health service. This is warmly welcomed by them. In one large town, where I visited several practitioners, all spoke appreciatively of the service of the borough pathologist, his eagerness to help, and his interest in the correlation between the patient's illness and the pathological findings. He often visits the bedside.

Fifty-two per cent. of those without such access feel that their practice suffers from this lack. About half of the practitioners, on occasion, discuss the results with the pathologist. While two complain that it is difficult to get in touch with the pathologist and another that the pathologist would not welcome it, others say the reports are adequate and they have no need for such discussion.

Very few (10%) do their own blood counts. Some say they used to do them but have given it up owing to pressure of work. A few do estimations of haemoglobin and sedimentation rates. The large majority of general practitioners consider that their results would be of little value, for they have no time to keep their hand in.

Physiotherapy Service

About one general practitioner in five can arrange for physiotherapy to be given to any patient of his requiring it. Some of these have to send to a physical medicine specialist, but reasonable requests are not refused. The remainder must first refer the patient to a consultant, as it is he who can authorize physiotherapy. In 34% this involves long delays, sometimes because the orthopaedic

consultant cannot see the patient for several weeks, sometimes because of inadequate facilities in the physiotherapy department, sometimes both. In acute conditions the symptoms may clear up before treatment can be started.

In a number of towns and in a few country areas the patient may obtain physiotherapy privately. This may be less costly than repeated expenditure on bus fares to the local hospital. Many general practitioners think a domiciliary service would be better, and instance the time spent in draughty buses and out-patient halls as undoing any good done by treatment. One general practitioner is annoyed at having to send patients 17 miles away to obtain a consultant's recommendation for treatment at a clinic just down the road from his own surgery.

Some think the consultants keep the patients under treatment too long, thus lengthening the wait for others. Three practitioners say that too many facilities for physiotherapy tend to stop patients helping themselves. Some like the "screen" and are not anxious for direct reference.

There is not sufficient physiotherapy for all, but, except here and there, I did not get the impression that this is causing serious hardship.

(E) RELATIONS WITH HOSPITALS

Questions were asked concerning how far hospitals were encroaching on general practice. Only a very small percentage thought that this occurred on a serious scale.

Only 3% of practitioners complain that hospitals see patients without a doctor's letter. This, of course, excludes patients presenting themselves "off the streets" as casualty cases. One in four finds that hospitals tend to some extent to retain cases longer than necessary, keeping them for treatment which could be regarded as in the province of the general practitioner. More than half of these general practitioners do not mind, and are perfectly happy for the hospitals to shoulder the burden. The practice is not always frowned upon, for, as some practitioners say, the hospital doctors often feel that, having started the treatment of a case—for example, incision of an infected palmar space—they are shirking their duty if they do not continue to treat the patient until the condition is almost cleared up. They do not consciously or deliberately take work from general practitioners.

Half the practitioners find the position much improved under the N.H.S., though complaints are still heard that the hospitals do not appreciate the distances patients have to travel to attend daily for simple dressings. Some attribute the improvement to the fact that in the past the hospitals were interested to keep up high attendance records in order to qualify for grants from certain voluntary funds, whereas this no longer applies.

One-third of the practitioners feel that the out-patient departments are crowded with minor cases which should not be there. This causes delay in obtaining early treatment or advice for new and more important cases. A considerable number, including some of those who told me that they no longer do any minor surgery because they "do not get paid specially for it," blame other general practitioners for sending such cases to hospital.

There is some suggestion that hospitals encourage chronic invalidism by telling patients unnecessarily to report back, being afraid of the responsibility of discharging them. The hospitals should realize that they can trust the general practitioner to refer the case again if he is not satisfied.

There is a great deal of complaint regarding the crowding of orthopaedic departments. This point stands out in the replies I received on this subject. Many general practitioners feel that those responsible for seeing and following up patients who are being treated for orthopaedic conditions are too reluctant to let go of them. They are unwilling to trust the general practitioner to keep a satisfactory eye on these patients during the more static periods of their treatment; for instance, while a limb is in plaster. It is common experience that such patients are told by orthopaedic departments, in what is no doubt a laudable attempt

to ensure the most perfect supervision of the patient's treatment, to report back week by week. At these attendances all that happens is that the patient is seen, maybe by the house-surgeon or registrar, asked if the plaster is giving any trouble, and then told to report again in another week. The general practitioners contend that they can be trusted to keep an eye on a plaster and refer the case should they suspect that all is not well. At the same time they feel that the cluttering up of the out-patient department by these queues of unnecessary weekly visitors takes away much of the consultants' and registrars' time that should be made available for seeing and treating new patients.

Ten per cent. say that they are not informed when their patient is referred to another department for further opinion. Some of the remaining 90% say that on occasion they do not hear of the reference until the case is "complete." Some feel that, when they are still in attendance on a patient who is attending an out-patient department or undergoing investigation, it is helpful to be kept informed of what is going on. Not to be so informed clouds their relationship with their patient. Others think that it is too much to require of the hospitals and are quite content to wait until the investigations are complete.

In two practices only was there serious complaint that transport was being used like a daily bus service to convey patients to and from the hospital to receive minor treatment which the general practitioner himself could give. In five other practices the view was aired that transport was being rather wastefully used by the hospital.

Lack of understanding of the problems of the general practitioner is almost certainly at the bottom of most of the complaints (from 27% of the practitioners) that when patients visit hospital they are given the impression that better medicine is available there than at the hands of the general practitioner. One practitioner complained of the maternity hospital; others of similar isolated instances.

Some young house officers are said to regard the general practitioner as a low grade of doctor. The fact that a small proportion of general practitioners misuse the hospitals tends to detract from the esteem in which most of them should be held and to promote careless harmful criticism. I heard of a registrar who, lecturing to students by the bedside, held up the general practitioner's letter and said, in the hearing of the patient: "You need take no notice of this." Then, again, a young consultant, thinking aloud, said that the patient's condition might be due to sleeping tablets prescribed by the general practitioner. This patient and his family have now left the general practitioner and will probably influence others of his patients in the village to do the same.

One practitioner, in speaking of such disparaging remarks, said that his knowledge of his colleagues in the neighbourhood suggested that some of the remarks were true—but he did not say he thought their utterance was justified.

Some think sisters and nurses are at fault. Patients ask them, "Should my doctor have sent me to hospital sooner?" and the sister, sometimes, perhaps, but not always correctly, replies, "Yes," forgetting that the delay in admission is more likely to be due to the long waiting-list than to the general practitioner's inefficiency. One said that he felt sure the nursing staff gave the impression that simple dressings and the like are really properly done only at the hospital. They may not think of the general practitioner and his relationship with his patient, but the latter is only too ready to interpret it as a reflection on the general practitioner. I heard no suggestion that patients are deliberately given such impressions.

The occasional absence of any appreciation of conditions in the home was illustrated by the instance of a woman sent home 10 days after delivery and told to apply treatment to her baby's eye every 15 minutes, day and night.

These complaints can be explained by a lack of knowledge of general practice, a lack of awareness of how easily damage can be done, and a strong element of thoughtlessness.

There is also lack of understanding of each others' problems almost everywhere, but it is only fair to mention the many general practitioners—some of whom have minor criticisms—who state that the hospitals serve them well and are very helpful.

One of the potent causes of harm to the doctor-patient relationship is inadequate liaison between the hospital and the general practitioner, particularly at the time the patient is discharged from hospital. It can also interfere with the convalescence and treatment of the patient.

About one-half of the general practitioners do not complain of the poor liaison, and many of these refrain from complaint only because they feel the staffs of hospitals are hard-pressed.

The large majority receive a letter from the hospital telling them about the patient's progress and treatment in hospital some two to three weeks after he has been discharged. Less than one in five hears within a week.

Less harm is done when the patient sends a message for a visit the day after his discharge. Only thus does the doctor know that the patient is once more under his care. But the patient still remains mystified that his doctor has not heard from the hospital. As the days go by he may begin to wonder what there is about his doctor to explain why the hospital has not bothered to write.

The general practitioner's prestige and the confidence of the patient in him are seriously damaged by this prevalent lack of attention on the part of hospital authorities. Incidentally, teaching hospitals are reported to be the worst offenders. In one large teaching hospital the ward sister, on being asked by a patient on his discharge whether he should inform his general practitioner, says: "No, of course not. We shall be writing." The registrar or house officer is unaware of this promise—or one hopes he is—and does not carry it out, at any rate not for a week or two. The patient waits at home confidently expecting his general practitioner to call, while the general practitioner is quite unaware that the patient is once more under his care. After a few days of waiting a message may be sent. By that time the patient is in no mood to believe the general practitioner's side of the story.

A great deal of harm and embarrassment is caused by such thoughtlessness. As regards the sending of information to general practitioners, only in a few cases did I hear such remarks as, "Very good and prompt," "I am telephoned before patient's discharge." Others report that damage is constantly being done. In a case of miscarriage the patient was sent home the day after admission, but the general practitioner was not informed. General practitioners often complain that they are not notified when a patient dies. The cheery inquiry after a patient's health two days after he has died takes some living down. One practitioner told me of being called to a case of diabetic coma the day after the patient's discharge. He was completely in the dark about the insulin arrangements. I witnessed a similar case with another practitioner late at night. In his case it was hypoglycaemic coma. Timely information from the hospital would have greatly simplified the doctor's task.

Practitioners complain that they lose patients by not visiting them after their discharge from hospital. Many patients will not believe that their doctor does not know of their discharge. To a patient his own case is all-important. Surely the doctor must have been told? Some general practitioners say they suppose the trouble is due to the shortage of typists. To excuse it on these grounds is to postulate that a typewritten letter is essential. It is not.

A number of the practitioners I visited felt that if only house officers could be informed of the implications of these problems they would ensure that general practitioners received, within 24 hours of the patient's discharge, at least the information essential for the continuation of treatment. A fuller account, where necessary, could follow when time permitted.

(F) THE DOCTOR-PATIENT RELATIONSHIP

Nine out of every ten practitioners have friendly relations with their patients. Consultations are conducted on a friendly plane. Though the warmth of the friendliness varies, only 6% of the practitioners visited regarded the relationship as a purely matter-of-fact or business-like one. In one-third of the visits a specially high degree of mutual respect and friendliness between the doctor and the patient was apparent.

Ninety-six per cent. of practitioners believe that one doctor for a family is desirable, and find that such a state of affairs largely holds good in their practices. Sixteen per cent. strongly object to sharing a family with another doctor, and some will go to the extent of requesting patients to leave their list in order to avoid it. One said that he would take this action even though he is most anxious to increase his list. Sometimes there is no alternative, as there is no other doctor in the area.

In some cases both partners attend at various times, which represents some departure from the strictly individual family-doctor principle.

Some women doctors find themselves unable to feel strongly about this, as they acknowledge the desire of the man of the house to have a male doctor. One woman doctor told me she takes only women and children as patients. A young couple may on marriage retain two different doctors. Often the arrival of the first child brings the whole family under the care of one practitioner.

While the majority of practitioners are agreed that the attitude towards them of at least some of their patients has deteriorated, I did not find proof of the current statement suggesting a wholesale disappearance of friendly relations. Seven per cent. find that a substantial number of their patients tend to regard them as a servant, and about 3% notice a marked tendency to be regarded merely as an official. Thirty-two per cent. report a definite tendency to be regarded as a supplier of medicines rather than as a medical adviser, while 22% detect this tendency in a small minority only. From my own observations I believe that in nearly all these 54% of practices this tendency is noticeable among only a minority. Some general practitioners are so easily irritated by such an attitude that they are apt to think it more widespread than it actually is. One doctor described the attitude well when he said, "Some of the patients now merely include me with their errands: rations from the grocer, a call at the shoe repairer's, and a bottle of cough mixture at the doctor's." In about half the surgeries I attended I heard the shopping-list technique in action, often one person calling for a list of needs for two or three.

Twenty-seven per cent. declare that their patients regard them as a friend, and 32% as a "professional man." In many cases the relationship is described as "a bit of both." One woman doctor says her patients regard her as "a doctor, woman, and mother."

Mention was often made of the unsatisfactory attitude among the younger adult patients, but it is presumably possible that better relations may develop, perhaps when the patients are up against it and the general practitioner helps them out. It can hardly be expected that the youthful patient and the youthful doctor will achieve a satisfactory relationship straight away. It is therefore not surprising to find the percentage of those general practitioners in the youngest age group whose patients

regard them as friends is smaller (16%) than in the older age groups (31%). There is little doubt that there exists among the older group a proportion of general practitioners unable to adapt themselves easily to the new service, while the tendency among the middle group is to accept it and adapt themselves more readily. This is perhaps in the nature of things, and may well have a bearing on the doctor-patient relationship.

On my mentioning the word "servant" some said, "I would not tolerate such an attitude," which underlines the truism that it takes the doctor and the patient to make the doctor-patient relationship.

Attitude of Ex-private Patients

Two-thirds of the practitioners find no adverse change in the attitude of ex-private patients. There are, of course, more demands by some who formerly could not afford to send for the doctor so often. The general impression is that there is a settling down after a bad start.

Many practitioners have told their private patients that they are perfectly welcome to join the N.H.S. list. In some cases a knowledge of the patients' purse and pride has led the practitioner to encourage them to join the list. At the same time it has been explained to these patients that the call at the house, rather than a consultation at the surgery, would be made on clinical grounds only.

One in four complain that they are beset by increased demands by their ex-private patients. Now that the service is "free" the family medicine chest and the home doctor are set aside and the general practitioner is summoned. Some find that their patients still want to "dodge the column," to have the frills for which they formerly paid, the prolonged visit (instead of the wait in the surgery), and at a time to suit the patient. Most find little trouble in this direction. They say that patients are learning to adjust themselves and are becoming content with the new arrangements. Some have explained to their patients that it is like the theatre: the show is the same, but they are to see it from the pit instead of the stalls. Quite a large number of practitioners find their former private patients are more considerate and indeed hesitate to send as often or as early as they should for fear of imposing on the practitioner.

About four out of every five practitioners report that either none or a very few—for example, 6 to 20—of their private patients have remained as such. Forty-five per cent. of practitioners feel that the refusal to allow private patients to have drugs and dressings free of charge under the N.H.S. has substantially reduced the number of patients remaining private. It has been quite commonly observed to general practitioners, "I wouldn't mind your bill, Doctor, but I cannot afford the chemist's." A number of practitioners are inclined to be bitter about this matter, feeling that there is more behind it than just an interpretation of the Act, that its enforcement is a shaft deliberately aimed at their freedom.

Though, in the nature of things, what little private practice there is flourishes more easily in the towns, I found no marked differences in the proportion remaining in the towns as compared with country practices, nor in the different age groups.

Forty-three per cent. say they do not wish to have private patients now. The advantages of not having to relate medical care to finance are mentioned. Then, some say that private patients are too much bother, they want too many frills, and that much private practice is

too far removed from real medicine. Twenty-two per cent. are indifferent in the matter or are unable to comment, having little or no experience of private practice.

The remaining 35% are anxious to preserve at least some private practice. They agree it may be exacting, but they believe it to be the correct relationship between doctor and patient, and are prepared to give the frills. Some say that private practice must be preserved or the standard of medicine will drop rapidly; that private practice is the challenge to the doctor to give good value; that the capitation fee lacks this challenge; that in private practice good medicine can be done; that the homely chat and the giving of non-medical advice are most useful.

Some like private patients because they pay better. In some practices the retention of a small proportion of private practice has enabled the practitioner to "keep his head above water" financially.

(G) ORGANIZATION OF GENERAL PRACTICE

Premises

In trying to assess the suitability of doctors' premises I had in my mind an idea of average premises, reasonably comfortable for doctor and patient, with no hindrance to the satisfactory conduct of the doctor's work and with reasonable warmth in both waiting-room and consulting-room. The furniture was also considered in the assessment.

Often the type of accommodation varies with the class of practice or the neighbourhood. The more elegant, homely, and comfortable premises are usually associated with the better-class practices. This factor seems usually to be unrelated to the size of the practitioner's income. Some of those with small "good-class" practices often have the best premises. In many cases this is due to the furnishing having been undertaken when the practice was a private and more remunerative one.

I have not taken into account in this assessment those branch surgeries which are but a house of call, usually consisting of a front sitting-room of a cottage or council house, furnished in traditional style, and used only for the simpler clinical work.

The average adequate consulting-room is clean, reasonably bright, and fairly well decorated, with seats for patient and friend as well as for the practitioner, a couch, and a satisfactory method of heating. There is room to manoeuvre, for examining patients, and for the conduct of minor procedures. Lack of space is sometimes compensated for by the existence of a separate room for examinations. Forty-nine per cent. of the practitioners had premises conforming to the above description. The premises are not usually convenient for the performance of more than minor procedures; nor is it necessary that they should be, for most practitioners do not undertake anything beyond minor surgery in their consulting-rooms. They are adequate for maintaining a high clinical standard. In order to be a good doctor it is not essential to be surrounded by cream paint and chromium plate.

About 17% of the premises seen may be described as being well above what may be considered adequate. In these were found separate examination-rooms, fully carpeted, spacious, elegantly furnished rooms, and newly built surgeries with special rooms for treatment and minor operations.

About 24% of the practitioners have premises which are fairly adequate but in which something essential is

lacking or below standard. In these, for example, I noticed the absence of washing facilities, inefficient heating, or a rather dismal and uninspiring appearance.

I regard 10% as unsuitable. Rooms are dismal and bare, dirty and inhospitable, and often totally inadequate for the number of persons attending. One doctor sees patients in a porch. In some poorly housed districts it seems to be difficult to maintain the standard of the premises above that of the neighbourhood. Any feature of comfort or cleanliness is soon defaced. Some general practitioners are evidently discouraged when they see lines round the walls where greasy heads have rested or marks of nailed boots on the floor. In one instance the doctor has had to bolt his waiting-room chairs together to prevent their being taken. One practitioner did not show me his premises.

It is not always the general practitioner's fault when premises are inadequate. There was the doctor who was seeing his patients in a room about 6 by 12 feet. Two-thirds of the way down the room was a screen, beyond which sat six to eight patients. This was his waiting-room, a small corner being set aside for his secretary-receptionist. The remainder of the room was the consulting-room, in which there were a couch, an instrument trolley, and a desk. The doctor complained bitterly of the arrangement. He formerly had a suite of rooms which he rented, but the property had been sold over his head. He declared that the rent had been raised so high that he had had to leave. He had been unable to find better premises anywhere in the area. He understood that his rent had been raised to make way for the followers of a calling less honourable but more lucrative than medicine.

Sometimes poor premises have had to be substituted for better ones that have been bombed. In some cases landlords are unreasonable and are concerned more with raising rents than with effecting repairs and decorations.

Sometimes a surgery is badly decorated or ill-appointed owing to uncertainty of tenure and consequent unwillingness on the part of the general practitioner to spend money on it. A doctor in a provincial town told me that the rent for his small consulting-room and moderate waiting-room was equivalent to that of a medium-sized London flat. There was no other accommodation in the town and the owner took advantage of this fact.

While present housing conditions prevail a knowledge of the facts is necessary before premises are criticized. Nevertheless, there are a few practitioners who do not appear to appreciate the functional value to their patients and themselves of clean, cheerful, and suitable premises, and some who are so poorly paid that they are unable to make the improvements they know to be desirable.

Equipment

It is quite a hardship upon a new entrant into practice to equip himself with the basic range of instruments and equipment. The established practitioners only rarely need to buy new items. I found that 91% of practitioners have what one might call the full range of essential equipment. The instruments about which I inquired were those for the treatment of wounds and accidents and for the simpler minor surgical procedures, syringes, and the diagnostic instruments, auriscope, ophthalmoscope, stethoscope, sphygmomanometer, and urine-testing apparatus.

A number of practitioners do not have a proctoscope or a vaginal speculum. Others say they have them in the cupboard but that they "never use them nowadays." Nine per cent. have not the basic equipment mentioned above. Sixteen per cent. have more elaborate equipment, including ultra-violet and infra-red apparatus, x-ray plant, or special instruments of other kinds. It must be emphasized that such instruments are not essential to the ordinary conduct of general practice. One young town practitioner said that he would not buy instruments, as it does not pay him to do minor operations.

On the whole the standard of equipment is quite adequate as to essentials and in view of the diminishing range of some practices. The instruments are not always kept attractively, and I have seen many lying about dusty and disused. But when needed they can be cleaned. Many practitioners have electric sterilizers, and those that have not usually have available some method of sterilizing instruments.

Co-operative Arrangements with other General Practitioners

Perhaps the most unsatisfactory feature of some of the rota systems is that they are too large. A well-perfected arrangement, from the practitioners' point of view at any rate, that I saw is one in which ten doctors work not in partnership but "in symbiosis" in one building with ten consulting-rooms. Each has his own practice and shares the message-taking clerks with the other nine. After morning surgery is over one doctor takes all the new messages until the following morning, when the next doctor on the list takes over. Midwifery cases are excepted. The practitioner is on duty for the whole area for one day in ten and for one week-end in ten. At busy times there are always two doctors on duty. It is claimed that, with freedom from worry about extra calls, the general practitioner not on duty can proceed unharassed with his routine visiting, do his evening surgery at the right time, and thereafter enjoy his leisure.

Whatever may be the rights and wrongs in this matter I am left in no doubt that the practitioners who have been able to make some sort of co-operative arrangements with neighbouring doctors have much less anxiety about their work and are happier for being able to enjoy a small amount of leisure. Some have only a casual arrangement, some an arrangement for week-ends only, and some for half-days only. The majority have an understanding only with partners and assistants. Some partnerships help out a single-handed neighbour and require nothing in return.

In some areas the introduction of a rota has done more than ease the constancy of the burden on the individual. It has turned the sourness of professional rivalry into the sweetness of co-operation. Yet in other areas the sourness and the doubts remain. Practitioners are suspicious of one another. I noticed particularly that it was some of the younger men who told that they have tried to arrange a system of mutual co-operation with the other doctors around them but that their efforts have been met with refusal and suspicion.

There is of course, here and there, the individualist. He does not wish to leave his practice to others, not because he is suspicious but because he considers his patients are his own business and his own duty, not to be delegated. If his patient is taken suddenly ill, he prefers to be there, to go himself. There is much to

be said for this attitude. I can only remark upon the less worried mien and the more rested look of the man who can get away from time to time and can return to his practice with a freshened outlook. He is happier than the man who snatches a half-day and returns to his home on a cold evening knowing that there will be three or four (or more) messages on the pad in the hall awaiting his attention.

In one or two instances the practitioner declines to join in a rota because he does not want to be involved in emergency calls which might be well outside his own area. In other cases a rota is impossible owing to distance. A number of country doctors live in professional isolation and need to be on call the whole time. The isolated general practitioner who wishes to have a holiday has no chance of arranging for one or two colleagues to look after his practice and to return the compliment when he gets back. He must have a locum if he wants to go away; often he can neither afford nor obtain one. Inquiries show that it is not more easy to obtain a satisfactory locum nowadays. The main difficulty with locums at the time of the survey was finding the money to pay them, for a locum tenet's fees were the same for all practices, whether the principal's remuneration was high or low, whether his list was large or small.

Appointments System in General Practice

Inquiry was made into the practitioners' custom of seeing patients by appointment. Only 2% of practitioners see their patients by appointment only. Of the remainder one-third never see patients by appointment and two-thirds use an appointments system for special examinations, for life assurance work, and for private patients. The figures show that this practice is about the same in town and country, but that doctors in the two youngest age groups are more inclined (70%) to use an appointments system. The system is used by 58% of the oldest age group.

Employment of Non-medical Staff

One-fifth of the practitioners say they are handicapped by the absence of ancillary help, and by this is usually meant clerical or secretarial assistance. The remaining 80% say they are not. About half the practitioners have some form of help, whether part-time or full-time, suited to their needs, sometimes shared with a partner or partners. About 25% of practitioners would like such help but have not got it. Usually it is a question of finance. There may not be full-time employment and there is difficulty in getting someone to take on the job part-time. A further factor is the impossibility of altering the surgery premises to accommodate clerical help.

The help that is most wanted is someone to get out the record cards and put them before the practitioner while he is seeing the patients. Then there is the taking of messages during surgery hours, to enable the practitioner to carry on with his work undisturbed by calls to the telephone. The replacement of the cards after the patient has been seen and the filing of letters and consultants' reports can also be done by a confidential clerk.

Most large practices have such help. In the smaller practices it is not often a problem because the doctor is more likely to be concerned with dealing with distances and access difficulties than with large numbers of letters and cards. These do not often want clerical

help. It is the middle-sized practice that is the problem, where numbers are sufficient to make the clerical work a time-consuming burden and where remuneration is not enough to allow of the employment of a clerk. About 55% of the town practitioners employ some sort of assistance, while only 40% of the country practitioners do.

Record-keeping

Three out of every four general practitioners pay a reasonable amount of attention to record-keeping. The card of each patient is seen in the surgery (and for this a secretary-receptionist is a great asset), but only one in three finds it necessary or convenient to take the cards out with him on visits or to enter details at the end of each day. The type of notes varies from the very full to the very brief with only essential features recorded. A common custom is to take the opportunity of entering on the card a summary of any particular illness when the patient who has been visited subsequently attends at the surgery, for instance, for the final signing-off certificate.

The remainder seem to pay rather scant attention to records. Some regard record-keeping as a sort of "red tape" imposition. Others say that hunting out and replacing, say, 40 record cards during a surgery add so many minutes to the length of the session. They can afford neither the time to do it themselves nor the clerical assistance to do it for them. One finds "it a nuisance"; another "can't be bothered." The cards are sometimes kept well out of reach. Some record "important things only." Another says that to keep his records properly would occupy him till midnight.

I noticed that a good deal of irritation arose when a practitioner was on the list of more than one executive council. I met one who had patients in the areas of four executive councils. There is a separate pad of E.C.10 forms for each area. The searching for the right pad or the altering of the heading in ink is an unnecessary bother to the busy general practitioner. There would not seem to be much interference with the accountancy of prescribing and dispensing if all E.C.10 forms bore no area heading, and were rendered to executive councils according to the address of the chemist dispensing them.

Effect of the N.H.S. on Organization of Practices

The introduction of the N.H.S. seems to have made very little difference to the organization of practices.

Sixty-four per cent. of practitioners say that it has had no effect, and 13% of the remainder were not in practice before July, 1948. Nine per cent. discharged their dispenser, 3% took on a clerk. Many stopped dispensing. Three per cent. opened new branch surgeries and 3% closed them. Twelve per cent. opened new surgery premises or specially altered or improved them. Eight per cent. took on a further partner or engaged an assistant. These are some of the changes that were made to meet the altered circumstances, but in the main the practitioners have just carried on as before.

The Doctor's Wife

The wives of the great majority of the married doctors are involved in duties connected with their husbands' practices. The most usual duties are the taking of messages and answering the telephone and door-bell. Some have a good deal to do in connexion with the practice. They may be concerned with the organization of the practice, with the arrangement of the visiting-list, and

with the filing of correspondence and reports. In short, some wives act as their husbands' secretaries.

A small proportion of wives are almost entirely free from the cares of the practice. This situation is usually found where a caretaker at the surgery takes all the messages and passes them on to the member of the partnership on duty.

Health Centres

Many practitioners are concerned about the way their wives are tied to the home because of the needs of the practice and the patients. A few of them expressed approval of health centres on this account alone. Forty-eight per cent. of practitioners approve of the health-centre idea, and 47% are opposed to it. In some country areas the question hardly applies, as it would be uneconomical to establish health centres in areas with only one or two doctors. A few say it would be good for towns but not for the country. Some favour health centres on account of the provision of diagnostic and ancillary facilities, and one, while not wanting a health centre, would welcome a diagnostic centre to which he could send his cases direct.

The arguments in favour are accentuation of difference between N.H.S. and private practice; development of group practice; better standard of practice; easier relief arrangements; sharing of nursing and clerical assistance; benefits, including improved ethics, from working together, and better accommodation. One practitioner thinks that there would be fewer attendances because it would be more like a hospital and patients are afraid of hospitals.

One doctor, not in favour, gives as his reason that health centres would be too like a hospital out-patient department. One speaks of the disadvantage to general practitioners who are not in the health centre, and another of the untoward effect upon the doctor with the small list when his patients see many more waiting to consult other general practitioners working in neighbouring rooms. Fears are expressed of having to "clock in" or to be controlled in other ways, of patients having to travel farther, and finding themselves beyond "pram-pushing" distance of the health centre. Some concern is expressed lest the practice in a health centre should lose something of its personal touch, that something valuable, yet intangible, would disappear from general practice and never reappear.

Many of the general practitioners are satisfied with their own arrangements, prefer to run their own show, and feel that the institution of health centres would not benefit the patients. One said he would prefer a general-practitioner hospital with consulting-rooms. This would enable close contact with the consultants to be established.

Opinion is almost equally divided on the desirability of health centres. I found no body of opinion which thought that the institution of health centres would be of much positive value to patients unless radiological and pathological facilities were provided. Most practitioners realize that the provision of such facilities, especially radiological, at each health centre housing, say, ten general practitioners would be so costly as to be grossly uneconomical.

(H) GENERAL PRACTICE AND THE N.H.S.

Over the whole range of practitioners visited I found 37% more satisfied and 42% less satisfied since the introduction of the N.H.S. Fifteen per cent. feel neither

one way nor the other, while 6% cannot give an opinion, not having had experience of practice before July, 1948. The percentage of those more satisfied is higher in the youngest age group and lower in the oldest. This finding is hardly in keeping with the inference that might be drawn from the chorus of voices heard and the letters written on the subject.

Those dissatisfied complain of the great pressure of work which prevents them doing all that is necessary for good practice. Two declare that the whole conception is bad; some feel that they would rather be paid for what they do, and object on these grounds. They consider that patients should have a financial interest in the use of the Service. Two or three say they are harassed by patients lodging complaints or by the fear of it. I found this fear cropping up now and again and playing quite a big part in making the general practitioner anxious. There are those who seem unable to put aside the feeling that the complaining patient may well hold in his hand the power of professional life or death for the general practitioner.

Then some, in fact most of those more satisfied, call attention to the fact that there are many things that need improvement or putting right. Some like the N.H.S. better because they can do more for their patients, can prescribe more freely, and can visit as necessary. Also there is no bother with bills now. The frequency with which I heard this matter of bills mentioned with relief suggests that the sending out of accounts was a major anxiety with many practitioners in the old days of private practice. Three express approval on the ground that the N.H.S. is better for the patient. I am satisfied that there are more who feel this too. The reply given by one practitioner is somewhat saddening: he likes the N.H.S. more because he does "not have to bother so much about the patients now."

One young practitioner likes the Service less, but, rather grudgingly, declares that it causes less worry and dissatisfaction than was expected.

Apart from these the remainder of the profession can be described as being receptive towards the N.H.S., ready to like it more and more. They are alert and critical of its shortcomings and often inadequate remuneration, and determined that a good service shall evolve, with full benefit for the patient and contentment for the general practitioner. The two things are not unrelated.

Size of Lists

Only one country doctor visited says he wishes to look after more than 3,000 patients in his practice. Seventy-six per cent. do not want more than 2,000. In the towns the number most popular (27%) is 2,500. Twenty-two per cent. prefer up to 3,000, while 13% are quite happy with 4,000. Some of these latter, apart from a slight concession to the country doctor, genuinely cannot understand how a doctor can be happy with less than 4,000 patients, or how he can find enough to occupy his time. In the practices I visited the distribution of the various sizes of list between practitioners was about the same in the town and the country. In the towns I found that 33% had lists larger than they felt they could deal with satisfactorily, in the country 26%. Forty-two per cent. of the town practitioners and 38% in the country have less than they can manage, while in both town and country about 27% have what they regard as the optimum number of patients.

There are many who are unshakable in their belief that no doctor can look after 4,000 patients in general practice, and 2,500 is the popular figure. I have on several occasions been privileged to witness at work practitioners with 4,000 patients, examining them with care, treating them with skill and enthusiasm, and maintaining friendly relations with them of the kind that is normally regarded as ideal as between doctor and patient. It is pleasant to record that some of these are young men who are doing fine work. They are giving their patients the full range of general-practitioner care, and managing them well. I have seen practitioners who have more patients than they can handle. Some admit it, declaring that they must have them to keep the home fires burning or the youngsters at school. I saw a few who seemed to show no sense of vocation. Their work was hurried and scanty, and there was no attempt to comfort the patient or relieve his anxiety. The concern of these few men seemed to be mainly the size of their lists and the resultant income.

One cannot be dogmatic about the number of patients a general practitioner can care for. Apart from the obvious difference between town and country, I thought I detected that in some areas the work is busier.

Excessive Demands

Nearly all the practitioners visited have among their patients a proportion, usually small, who are constantly at the surgery. Some of these are, of course, the chronic sick—the chronic bronchitics, the dyspeptics, the inadequate personalities, and the like. But there are also those who appear to be attracted to their doctor's surgery as if by a magnet. I saw one or two at least of these patients at nearly every surgery session through which I sat. Sometimes I could spot them myself, and at other times the practitioner would remark, after the patient's departure, "She's up here every week with some little thing or other." They are more commonly women. I was led to wonder, on occasion, what there was behind this urge to be under the doctor, this urge to be slightly ill.

I found very few complaints that could fairly be labelled frivolous. It was exceptional for even the trivial case not to have something wrong. The practitioners themselves are not always agreed on this point; whether, for example, it is unnecessary for the person with a common cold to attend the surgery. Obviously, with certain patients, it is a necessary precaution. The reason for quite a large proportion of "trivial" attendances is to get a prescription so that dressings or medications can be obtained free.*

Opinions on this subject vary widely. There are those practitioners who, sometimes harassed by overwork, seem too ready to find fault. The view was expressed to me that some general practitioners do not realize that there always have been, and always will be, a small proportion of calls that appear unnecessary. The following illustrates how opinions may vary on this matter. I was shown a list of surgery attendances over a period of several weeks, a third of which were marked as being considered unnecessary. But in the fairly lengthy surgery that I witnessed in this practice I felt that only a much smaller proportion could be so designated. Nor did I see such a high proportion as one-third in any other practice.

* The charge for prescriptions was not imposed until after the survey was concluded. It has since been announced that the number of prescriptions issued since the imposition of a charge has not diminished.

Of the truly frivolous I heard little and saw less. Sometimes, of course, although the call itself may be frivolous there is a genuine medical background. A schoolmaster sent for his general practitioner from the school at which he was teaching. On arrival the doctor was told: "I have lumbago and I want an injection so that I can go to the school concert to-night." It takes a good deal of consideration from other patients to counteract the irritation caused by such a call as this one. Almost universal is the experience that actual night (out-of-bed) calls are fewer, but that the number of calls received after the practitioner has set out on his round and also in the evening has substantially increased. Many practitioners, especially those in the fifties, complain that each night call becomes an increasing burden as the years go by.

Just under one-third of the practitioners consider they are subjected to an excessive number of unreasonable demands on their services. The remainder have no such complaint.

Effect of N.H.S. on General Practice

I was asked by the Committee to try to assess whether practitioners were laying the blame for any shortcomings on the N.H.S. when, in fact, the cause was to be found elsewhere. I did expect to find the N.H.S. made into something of a whipping-boy, but I found it so in the case of only about 14% of practitioners.

Lack of time is a frequent cry. It was not always borne out by what I saw of the operation of some practices, but it most definitely was in others. In a substantial number of practices lack of time has reduced the range of the service the practitioner can give to his patients. This is not to say that the patient is not receiving the treatment, for much of this work is now being carried out in hospital out-patient departments.

Of only one in five of the practitioners I saw did I think that their work was so hurried as to interfere at times with its quality. The majority will not allow this to happen. A sense of responsibility seemed to be lacking in only a very few instances. I noticed a tendency to pass cases to hospital which seemed to be excessive in 11% of practitioners. Only in 5% of cases did I find that the practitioner was prevented from indulging in short chats with the patients. Few, however, have much opportunity for more prolonged converse.

Fifty-eight per cent. of the practitioners say that they are working harder than they did before they joined the N.H.S. Thirty-two per cent. say that they are not. Many say that surgery attendances are greatly increased, but not the number of visits they have to pay. Some, having taken a partner, are working about as hard as formerly, which means that much more work is being done in the practice. A typical example is the practitioner who says that he used to have very little work in the summer—say, ten patients in the surgery and three to six visits a day. Now there are always more in the surgery, and he rarely pays fewer than ten visits a day in the summer. Another who says his surgery attendances have increased thinks that the opposite is the case with his visits, because formerly he had a subconscious tendency to overvisit, which the N.H.S. has cured. The amount of work entailed is very difficult to assess. One told me that the day of my visit was exceptionally busy. He saw 12 patients during morning surgery (there was another in the evening), and paid 15

visits. This was in the country, but it struck me as a reasonably comfortable day for any general practitioner. This practitioner, like some others, seems to approach his work in rather a leisurely manner and makes very heavy weather of it. He looked a tired man, and perhaps was. A number of practitioners told me, before I left, that the day of my visit had been "amazingly slack."

Frustration and Loss of Interest

Few human beings are perfectly happy and contented; similarly, few are free from worries and difficulties of some kind or other. Therefore to ask practitioners whether or not they suffered from frustration and loss of interest since the introduction of the N.H.S. was to ask for a gradation of replies.

Some say, "At times I get frustrated." Others mention specific causes of worry and frustration. The commonest is the difficulty in getting patients admitted to hospital. There is an undercurrent of feeling that the organization and administration of the N.H.S. proceed on their majestic way without due regard to the general practitioner or his patient. There is confusion, or there seems to be, regarding who should be blamed for the pin-pricks and the parsimony, for this is how many of them look at it. There is often criticism of their representatives, those who negotiate for them. I have heard more criticism of the profession's leaders than of those with whom they are negotiating.

Wherever the blame should properly lie, the fact that so much criticism abounds indicates that all is not well. Yet the majority (65%) have managed to adjust themselves, at least partially, to things as they are. Buoyed up, as in some cases, by hope of improvements, they have not allowed themselves to suffer from a sense of frustration and loss of interest. Twenty-eight per cent. say they do suffer. The remainder cannot make comparisons with pre-N.H.S. times.

One said talk of frustration was "a lot of rot." Others think general practice is "satisfying," although things are not quite as they would like them. Some bemoan the loss of hospital work, especially major surgery, and of access to pathological and radiological departments. The figures show only slight differences as between the three age groups. I saw one young practitioner who described himself as frustrated because he finds general practice insufficiently interesting academically. Another has lost interest and is thoroughly frustrated. He has been in practice only since July, 1948, but was unlucky in his choice of area, and he is frustrated and lacking in interest because things have not come up to his somewhat rosy expectations.

Questions of finance naturally entered into my conversations with practitioners on some matters, and a section on this aspect of general practice would have appeared in my report. Since the conclusion of the survey, however, the Danckwerts award and the recommendations of the Working Party have been announced. Consequently, to include any account of the views of the practitioners on the distribution of the pool and the methods of payment would now be pointless in the face of the considerable changes that have been effected.

(J) POSTGRADUATE TRAINING OF THE GENERAL PRACTITIONER

Fifty-three per cent. of the practitioners admit to having adequate local facilities for postgraduate training. The percentage in the towns is higher than that

in the country (61 to 34). Thirty-six per cent. say that occasional clinical meetings and lectures are open to them, by which is usually meant four or five a year. Two country doctors do not know what facilities are available to them. Ten per cent. say there are no facilities.

Forty-six per cent. of the practitioners use the facilities occasionally and 38% not at all. The remaining 16% avail themselves to a considerable extent, including attending a postgraduate course, sometimes a set of weekly meetings or lectures, sometimes a fortnight's course away. Some meet regularly with the consultants at the local hospital.

In one or two places I was told that local meetings have been few and far between or have been stopped owing to poor attendance.

There is no great difference in the use of the facilities as between town and country practitioners. The under-40 age group has the highest proportions of those availing themselves of opportunities for instruction. Seventy per cent. of them do so, at least occasionally. In the over-60 age group interest is comparatively poor. Some of them tell me that they are approaching the point when they will retire from practice, and have no enthusiasm for further information.

Many complain that they are too busy to attend, and many that times arranged for meetings are unsuitable. The consultant is said to show preference for the early evening, immediately following an afternoon session, while the general practitioner does not finish until later in the evening. Others say they are too tired in the evening. Evidently there is no ideal time. Then, again, some are unwilling to leave their practice for the time necessary for attendance at a meeting. These include the individualist and the practitioner who cannot come because he is single-handed and has no arrangements with other practitioners for the care of his patients in his absence. Some, of course, live too far away.

There are those who object to going to meetings only to be called away, and complain that this has only to happen once or twice for enthusiasm to be damped. Some are not interested, and others prefer to spend with their families any time they have to spare. Others are just disinclined to join in things, or are shy.

There is some criticism that the subject-matter of the lectures given by the consultants is too academic and too far removed from general practice. Conversely, I was told that the lectures are too simple and not interesting enough. To please more than a small proportion at a time would seem to be difficult. A number of those not interested in lectures say that they believe they can learn all they want from the material they see every day in their practices, and from their contact with the consultants at domiciliary visits. Some declare that they would be best suited by being allowed access to hospitals, where they could see cases under treatment and discuss them with the hospital staff.

Asked whether they would like different facilities for postgraduate training, very few said they would. Most of the requests are for arrangements for time off, especially to travel the longer distances, and for more meetings arranged at more suitable times. Some wish for more clinical meetings, and one suggested lectures by general practitioners on their problems.

Eleven per cent. read a great deal; that is to say, several periodicals and medical textbooks. Seventy per

cent. say they regularly read one or two medical periodicals. This usually includes a weekly and a monthly one. Eighteen per cent. read very little. These figures are fairly constant in the three age groups, with a tendency to rather less reading in the over-60 group. This tendency in this group runs approximately parallel to the interest in postgraduate courses and local clinical meetings and lectures.

A few complain of serious lack of time for reading. Many are pressed at times, but on the whole they are able to do some reading.

(K) A GENERAL IMPRESSION

The Practitioners Seen

The following table presents a picture of the group of practitioners selected, and shows the impression they made as general practitioners.

	Total	%	Class											
			1	2	3	4	5	6	7	8	9	10	11	12
Good . . .	81	44	7	10	4	16	12	3	4	7	—	4	11	3
Adequate . . .	82	44	3	19	2	12	17	5	1	8	2	3	5	5
Inadequate . . .	14	7	1	2	2	2	4	1	—	1	—	—	—	—
No assessment	11	5	1	1	2	2	1	—	2	1	—	—	1	—
	188		12	32	10	32	34	9	7	16	3	7	17	9

		Town	Country	Age Groups		
				25-39	40-59	60+
Good ..	..	52 40%	29 49%	31 53%	40 40%	10 32%
Adequate ..	..	58 45%	24 41%	19 33%	49 50%	14 45%
Inadequate ..	..	12 9%	2 3%	3 5%	6 6%	5 16%
No assessment	..	7 6%	4 7%	5 9%	4 4%	2 6%
		129	59	58	99	31

This is a summing-up of the quality of service that was, in my judgment, available to patients from their general practitioners. Tables which show that no less than 92% of the practitioners whose work was witnessed were adequate or better than adequate may come as a surprise after reading some of the paragraphs of this report. The apparent discrepancy is due to the emphasis necessarily placed upon faults and shortcomings because of the critical approach to the survey.

Perhaps the most difficult and invidious part of an observer's task is to sum up fairly. He must be fair both to those to whom he reports and to those on whom he is reporting. In retrospect I can say that I did not find the assessment as difficult as I expected. The easiest practitioners to assess are the good ones. They nearly always gave an immediately good impression, which remained confirmed at the end of the day. I did not assess any practitioner as inadequate without substantial evidence. Four per cent. of the practitioners declined to allow me to watch them at work, or I was prevented for other reasons. For example, three practitioners with small practices had no patients to see on the day of my visit.

In the category "good" I placed those practitioners whose skill was evident and whom I found exercising a constant care and thoroughness with every patient, a keen appreciation of the whole man in the patient, together with a friendliness and spirit of kindness and helpfulness. This is not to say that these qualities do not exist in those classified as "adequate," but the standard I set was high. In these others, such qualities

are not present to so high a degree. It has been a privilege to watch these men and women at work. It has been an inspiration to witness in a special few the enthusiasm they have for their work and the constant vigilance they exercise to maintain their standard of excellence.

I have, of course, seen a wide range of personalities. At the other end of the scale there is the practitioner whose sole object appears to be to "get through" his patients with as much dispatch as possible, and to limit services given to the bare essentials. He does not, as a rule, appear to give satisfaction to his patients. He supplies them with a bottle of medicine, and that quickly. He is rarely concerned with anything below a full list, and would, I believe, prefer to give the service he is giving to a large number of patients than offer a wider and more thorough range of service to a smaller number for the same remuneration.

Then there is the man who has in him some of the necessary characteristics, but who has allowed increased pressure of work to weigh him down to such an extent that the service he gives is below what would otherwise be, and probably was formerly, his normal standard. He has allowed his conscience to be stilled by "increased demands."

Ninety-two per cent. of practitioners seen at work were adequate or something better. Some were harassed by a considerable amount of overwork and sometimes by financial anxieties. Such men do not readily reduce their standards, and have sought, rather, to limit their responsibilities. They tend to send to hospital cases requiring minor procedures which formerly, having time, they would have undertaken themselves. Within the limited field to which these have withdrawn, their work is adequate.

For every general practitioner that I class as inadequate there are 10 who are, in my view, adequate. Half of these, that is 44% of the general practitioners (46% of those I saw at work), are good.

I came away from the survey with three major adverse impressions, which are summarized below.

Lack of Cohesion

My foremost impression is that of lack of unity in the N.H.S. and lack of unity in the medical profession. Both of these are jeopardizing the status and the effectiveness of general practice.

I became aware, early on, that unless certain gaps are closed the patient will not derive maximum benefit from the Service.

The human gaps must be closed. The general practitioner, the consultant, and the public health medical officer need to get to know each other and then to learn to work in concert. There is growing up a new generation of consultants, and a still newer one of those who will become consultants. These know little of the general practitioner and are unaware of his difficulties. Neither are they aware how easily these difficulties may be increased. Then the public health service and the general-practitioner service seem to be treading different paths. Where their paths meet there is often doubt and misunderstanding.

The other gaps are administrative. Maximum benefit for the patient cannot result from a trisected service. The feeling I derived from the survey was that bridging the gaps with liaison committees seemed less likely to be the cure than local co-operative effort. I cannot rid

myself of the feeling that the gaps must be filled completely. The N.H.S. is crying out for a unified administration.

Inadequacy of Hospital Services

The hospital services are causing considerable anxiety to the general practitioners in their attempts to obtain treatment for their patients. Hospitals are still contending with a back-log of operations and a more health-conscious public, resulting in increased demands. The aged and the chronic sick are poorly provided for.

Steps to enlarge the scope of general practice might well be the means of easing the load on the hospitals. Better access to radiological and pathological facilities, and general-practitioner beds, would encourage and help the majority of general practitioners.

Increased Demand for Services

At the time of the survey some practitioners were faced with so many demands on their services that they were unable to give the time that was necessary or that they would have wished to give to each case, even the trivial ones.

Much has been heard of the need to reduce the demands by patients on their practitioners. Methods of eliminating unnecessary demands are being sought. From my own observations, and in the opinion of the majority of doctors, the number of frivolous calls is small. On the other hand, the number of calls that might be regarded as trivial is much larger.

What is trivial to a doctor is possibly a matter of anxious importance to a patient. Formerly the question of finance overrode much of this anxiety.

Often the trivial call is a means of obtaining a prescription for something which formerly the patient would have bought from the chemist. The idea that the public are entitled to such medicines from the N.H.S. is now deep-rooted. Apart from the possibility that the token charge for prescriptions will alter it, the demand seems likely to continue at approximately its present level.

The extent of this extra demand means a great deal to some practitioners and affects others but little. Some practitioners are harassed by the amount of work, sometimes of an unsatisfying nature.

At the time of the survey there seemed to be room for a review of the quantity of work to be carried out by the general practitioner in the N.H.S. To advocate any further compulsory reduction in lists does not come easily to one who has seen, as I have, a number of practitioners dealing, single-handed, with a full list and giving a thoroughly good service to all patients.

There seem to be two courses for general practice to take. The first is to make such adjustments to meet the new situation as will stimulate clinical interest anew and give scope for its exercise. The other course is towards the impersonal health service. Some fear the evolution of general practice into some sort of a glorified hospital out-patient department where intimate knowledge of the patient, continuity of treatment, and the idea of the doctor as guide, philosopher, and friend are sacrificed to a hurried impersonal machine. It is for this reason that they express disapproval of the idea of health centres.

A number of practitioners expressed their sensation of being dragged down to a lower level, a feeling of being disregarded and in bondage.