THE PRACTITIONER AND THE HOSPITAL SERVICE*

BY

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Greek and Roman hospitals were little more than hostels in association with the temples, designed to give rest and shelter to pilgrims visiting the shrine, many of whom were sick men. Constantine, the first Christian emperor, closed the pagan hospitals, and thereafter the care of the sick was undertaken as a Christian duty by the monasteries. The oldest hospital in Britain is St. Bartholomew's of Rochester, which was founded in 1078. St. Bartholomew's, Smithfield, and St. Thomas's, Southwark, followed shortly afterwards. These were religious institutions in which the sick were cared for by the monks and nuns of the Order, and in time similar hospitals grew up in association with all the main Orders.

When Henry VIII suppressed the monasteries between 1536 and 1540, most of the hospitals then in existence closed. In London St. Bartholomew's, St. Thomas's, and Bedlam remained, but it cannot be claimed that the few beds these provided and the kind of treatment they were able to offer did more than segregate a few of those suffering from the more revolting diseases, such as leprosy and syphilis and madness, from the gaze of their fellow citizens. There was no hospital treatment in the sense of a service of advice and treatment available to those who needed it. The sick were looked after at home and they got well or died at home, unless they had no home and no friends, when they died in the streets. There was no doctoring, for such men as had a medical training and had been given a licence to practise plied their trade among the nobility and the wealthy. The great mass of the people turned for advice and treatment to unlettered quacks, men who had acquired a shrewd practical outlook and a little more knowledge than their neighbours of the herbs and manipulations of folklore, and who handed out the traditional concoctions and incantations of the alchemist.

A New Spirit

Quite suddenly, and for reasons that are difficult to assess, a new spirit was born at the beginning of the eighteenth century. Led by Sydenham and Boerhaave, medicine was transformed from an abstract philosophy to a scientific study concerned with the causes and treatment of disease. Doctors left the library and the debating chamber to sit by the bedside, to record what they saw rather than argue what ought to or might happen. Men in all walks of life became concerned with their responsibilities as well as their privileges, and found a new interest in seeking to help those who were poor or in trouble. One expression of this new medical outlook and this new spirit of philanthropy was the founding of secular hospitals. Westminster Hospital was founded in 1719, Guy's Hospital in 1725, and before the end of the century eleven new hospitals had been founded in London, thirty-seven in provincial cities, and nine in Scotland.

The movement continued apace. By 1925 there were 909 voluntary hospitals in Britain providing 60,000 beds.

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In 1870 hospitals of another class, designed not to provide curative treatment but to care for the aged, the helpless, and the chronic sick, were founded by local authorities under the Poor Law, and by 1925 they provided beds greatly in excess of those in the voluntary hospitals and were undertaking all forms of medical and surgical treatment. The first cottage hospital was built in Cranleigh in 1852. Others of the same type—that is, institutions with from five to thirty beds serving the needs of a small area—appeared in rapid succession. Many were founded as memorials after the first world war. By 1925 there were few towns in Britain with a population of 2,000 or over that did not possess such a hospital.

These hospitals were all established and maintained for a similar purpose, to care for those who, because of the nature of their ailment or their own poverty, could not be looked after at home. Those who were wealthy and had comfortable homes never went to hospitals. They retired to their own bed or in some cases to a convenient room specially prepared as a sick-room. Any treatment, such as cupping, bleeding, or leeching, was carried out by their practitioner. If an operation were needed it was performed by him on a wooden table by the light of lamps held by the domestic staff. There was no essential separation between the doctor who looked after the patient at home and the doctor who looked after him in hospital; indeed, the words "consultant" and "specialist" were unused till the present century. There were no special degrees or diplomas. Practitioners were seeing the same cases, using the same methods of investigation, giving the same treatment, doing the same operations, and using the same language as members of the hospital staff.

An appointment to the staff of a teaching hospital brought with it the privilege of teaching students and thereby training a series of practitioners who would usually call on their old chief for help when faced with a difficult case, or when attending a wealthy or exacting patient. An appointment to a provincial hospital brought with it a certain prestige. Many of these men added to the sum of knowledge by their observations and researches on the nature of disease, and established international reputations by their writings, but they differed from their colleagues, the family doctors, in achievement rather than in kind. Right up to the beginning of the first world war the majority of physicians on the staff of the London teaching hospitals were what to-day would be called fashionable West End general practitioners, who, in addition, saw the patients of other doctors in consultation. General practitioners were constantly in touch with their old teaching hospital, or the hospital of the district in which they practised. They called upon their old chiefs, they attended ward rounds and took part in the discussions, they went to lectures, and they watched operations. The suggestion that doctors in hospital and doctors in general practice inhabited separate worlds would then have been unthinkable.

A New Principle in Treatment

The separation of the general practitioner from the hospital began in the closing years of the nineteenth century. With the notification of infectious diseases, and their treatment in isolation hospitals, a new principle was established, that certain illnesses may no longer be treated in the patient's home by his own doctor. About the same time investigation of diseases began to pass from examination by the ordinary clinical methods, amplified by simple chemical

tests and the use of instruments easily mastered. Radiology and bacteriology appeared, and soon became essential to the study of many problems. They demanded apparatus, laboratories, and equipment that could be supplied and applied adequately only in hospital. The bedside tests of the early part of the century rapidly multiplied into the new science of clinical pathology, which in turn became further subdivided into clinical microscopy, biochemistry, and haematology. The optical instruments designed for the indirect inspection of cavities demanded increasing skill and experience. As information accumulated, as disease groups were disentangled into separate entities and new diseases were discovered, a gradual change appeared in the orientation of hospitals, particularly the teaching hospitals. They were no longer places for treating the sick, but places for research into the cause of disease. Rare diseases were given precedence over ailments of economic importance. Groups of patients were segregated for study. Experimental medicine raised its head. Practitioners, on the other hand, became more and more loaded with non-medical tasks, with certificates for the avoidance of duties and the securing of luxuries.

By the end of the 1914-18 war consultants were a race apart, and special degrees and diplomas, specialist associations, and specialist journals appeared to separate them from their fellows and to indicate the particular sect to which they belonged.

We have seen that in the teaching hospitals, which were becoming more concerned with investigating the unusual rather than treating the important, the general practitioner had become virtually excluded. In the council hospitals, which were rapidly assuming responsibility for the routine treatment of disease, the practitioner was able to have his cases admitted more readily without the somewhat humiliating argument with a recently qualified house officer, but he was equally unable to take any part in their subsequent treatment.

It is necessary at this point to refer to another tendency. With the elaboration of methods of treatment, and particularly with the increasing enterprise, safety, and success of surgical operations, it was becoming apparent that no private house, however well appointed, could offer the facilities for sepsis and for nursing that could be given in a specially designed building. First appeared nursing-homes, many of them built by consultants or groups of consultants to offer to their private patients a service approaching that which their hospital patients had enjoyed for some time. Then, as methods grew more elaborate and the standard demanded still higher, it became obvious that only in a hospital with its attached scientific departments and its resident staff could the highest level of treatment be attained. First private rooms intended for patients of moderate means unable to afford nursing-home fees were added to the ward units, and then whole private wings or private blocks were presented by charitable donors. In these blocks there was no means test. The increasing tendency for all but the simplest treatment, including that of such physiological events as normal labour, to be conducted in the precincts of a hospital brought a further separation between the practitioner and the consultant that was not at first appreciated. It removed the practitioner from the interest and the emoluments of caring for his patients when they became seriously ill, and it gave the consultant attached to a hospital equipped with private beds an automatic increase in income that he did not necessarily deserve.

A Disastrous Barrier

As a direct result of the complete separation of the general practitioner from the hospital, there had developed in many cottage hospitals and in some voluntary hospitals in the smaller towns a policy of excluding all but general practitioners. Such a policy, which was quite frankly mercenary, and had for its main object the retention among a local group of the emoluments and benefits of the private beds, was to a large extent responsible for the artificial and,

as it turned out, disastrous barrier erected by the National Health Service Act between the practitioners and the hospitals. I will cite the imaginary town of X, situated in lovely country at a distance of thirty miles from the manufacturing city and university town of Y. With the development of motor transport X had become a dormitory, where all the wealthy men who earn their money in Y had their country houses. The X War Memorial Hospital was their particular pride. Its buildings were the latest thing in hospital architecture; its equipment was the best that money could buy. Two of the hospital rules were significant. First, that no one might be elected to the hospital staff till he had been in practice in the neighbourhood for a minimum of five years; and, second, that no patient might be treated except by a member of the staff. The first rule excluded anyone with higher degrees, or at any rate with adequate postgraduate training, from appointment to the staff; in practice it meant that staff appointments were for sale, since the purchase of a partnership often included a guarantee of such an appointment. The second rule denied to patients treatment by experts of their own choice—indeed, treatment by experts at all if an expert be defined as one who has made a whole-time study of the art that he practises.

The standard of work in hospitals of the type I have mentioned was in some instances quite deplorable, particularly where surgery was concerned. In the view of many at the time the Act was under discussion, the occurrence of disasters amply justified the closing of cottage hospitals. How wrong this opinion was we have since learned to our cost.

The National Health Service

The final and official segregation came with the National Health Service Act. After July, 1948, the medical profession was split into categories, defined with the verbose exactness of the Civil Servant. Each man, after qualification, preregistration employment, and national service, must enter or be herded into one of several pens, and within that pen he must live until he dies or retires. Of these pens, the lowest is that of general practice. General practice was artificially debased. The general practitioner was made a shuffler of patients' cards, a signer of certificates, a distributor of benefits, a treater of minor ailments within strictly defined limits and with strictly specified remedies, a stooge with a twenty-four-hour working day, liable to be victimized by trivial complaints but forbidden to complain himself. The specialist was artificially elevated. All citizens may demand specialist treatment, therefore specialists must be turned out to fill the demand. We are now in a ridiculous position where a well-trained and competent doctor is forced to refer his patient to a man of lesser ability but marked with the correct rubber stamp, in order that he may carry out treatment that he himself could do very much better. Hospitals have accumulated unmanageable waiting-lists because their beds are blocked by patients undergoing treatment that could very well have been carried out at home, by patients admitted for investigations that the practitioner could have conducted himself had he been granted x-ray and laboratory facilities, and by patients retained merely through the fear of litigation bred by a series of legal decisions that seem to have been given on the simple working rule that the doctor is always wrong.

We have now had five years of experience of the National Health Service. Whatever benefits it may have conferred on the health of the nation, on the hospitals, or on the specialists, its effect on the spiritual side of general practice has been disastrous. I cannot express this better than by quoting the *Medical World Newsletter* of August 16, 1951.

"After undergraduate and formative years of intimate and enthusiastic participation in the whole range of hospital work, and of satisfying and stimulating membership of the hospital team, to enter general practice is to have crossed the professional Rubicon. There is no way back. New and compelling forces and alien but seemingly accepted influences gradually exert their deteriorating and irresistible effects. Idealism and enthusiasm wane in the face of expediency. Clinical disciplines and scientific

methods are weakened and worsened by pressure of economic necessity. Many different factors are responsible for the present unhappy mood in the great body of family doctors, but it is probably fair to say that none is more culpable than the gradual and now almost complete exclusion of the general practitioner from the hospital services."

A Short-sighted Policy

At the time that the chasm started to appear between consultant practice and general practice, the consultant was a man whose interests covered the whole of medicine or the whole of surgery and who had earned his position by some special aptitude of knowledge, wisdom, or technical skill. To-day the term "specialist" is usually used in place of "consultant," and the change of title corresponds to a significant change in training and outlook. The specialist knows a great deal about a small aspect of medicine or surgery. In acquiring detailed knowledge he has lost breadth of vision; in fact, he has become a technician to be employed rather than a wise man to be consulted. There is all the greater need to-day for general physicians, men who can survey a clinical problem as a whole and can from that survey decide which of the many brands of technicians shall be employed to confirm the tentative diagnosis or apply the appropriate treatment. General medicine to-day is passing into the hands of the general practitioner, and it is of paramount importance that his training should be as thorough as possible, and that he should be allowed to continue it through life.

In considering the relationship of the general practitioner to the hospital we must bear in mind three separate aspects of the problem—the education of the student, the training of the postgraduate, and the care of the patient.

Education of the Student

The training of the student is, and always must be, the business of the teaching hospitals, but we have every right to ask them in all seriousness if they know their business. Are they teaching their students the broad principles of medicine and surgery, and training them to look after the sick, or are they wasting their time by showing them diseases they will never encounter, discussing theories that may never come to anything, or talking of research projects that may or may not lead to something in the generation after next? It is the working doctors who care for the sick, but it is the professors who plan curricula and who have the ears of the Government. To a professor there is something slightly indecent and degrading about the care of sick men, yet he decides the manner in which those doomed to this menial task shall be educated. The Government, desirous to reform the training of doctors, appointed the Goodenough Committee to study the problem. Sir William Goodenough was a business man. He was helped by ten very eminent gentlemen, all doctors in the sense that they were on the *Medical Register*. Seven were professors of academic subjects who had never attended a patient since they left hospital. Three were consultants. None were practitioners. The Goodenough Report, as might have been expected, reeks of academism, and succeeded in adding still further to the burdens of the student's training while taking it still further from the needs of his future vocation.

There is a great need to-day to remember that we are teaching men to be doctors. They do not need to be, and they should not be, taught physiology and anatomy as scientific subjects, but as the groundwork of their future study of medicine and surgery. If they wish to become physiologists or anatomists rather than doctors, that is a matter for postgraduate study. They do not need to be grounded in research. What should concern them is not what lies beyond the frontiers of knowledge, but what is already known; to that they can later add the results of research when these have passed from the realm of speculation to that of tested knowledge. They do not need to know more of rare diseases than that they exist, their main outlines, and the place where further information may be

found if it is required. They do not need to study operative technique, but they must know all about the diagnosis of the surgical emergencies and they must know what modern surgery has to offer in the treatment of disease. They need not have more than a passing acquaintance with the specialties, except for midwifery, paediatrics, and dermatology. But they must be taught far more than they know now about the psychology of the normal, about the infectious diseases, about the surgery of trauma and infection, about industrial diseases, about minor maladies, about sex relationships, family planning, and the day-to-day adjustments of married life, and about the legal obligations of the practitioner.

An attempt is already being made in some medical schools, notably in the Universities of Edinburgh and in London—at St. Bartholomew's, St. Mary's, and Charing Cross Hospitals—to give the students before qualification an introduction into general practice, the specialty which most of them will follow and with whose main outlines they should all be familiar. Before long a general practitioner, or a group of general practitioners working in relays, will be appointed to the staff of every teaching hospital. The logical delivery from the morass in which medical education is now floundering is that the training and examination of the future doctor should be taken from the colleges, who no longer represent medicine or surgery but rather groups of highly specialized technicians, and from the universities, whose examinations represent a parochial rather than a national standard, and handed over to a board on which general practitioners are largely represented. The curriculum that would be evolved by such a group would be better than the present one, for it would deal with basic sciences and basic principles, rather than with the fads of the moment or the fancies of the future. It would be shorter—five years should be ample—and would therefore leave more time for specialized postgraduate study. It would turn out men trained to use their five senses to examine and their minds to apply the lessons of experience to the series of problems that would confront them through their working lives.

Training of the Postgraduate

The second aspect of the relationship between the hospital and the practitioner concerns postgraduate education, though in this respect what is wanted is co-operation rather than education. The general practitioner is overworked. He has few professional contacts. He has little time to read. For fifty years after qualification he will be practising an art that is constantly changing, and if he is to continue to practise it successfully he must be able to learn of those changes, and to discuss with others the problems that have faced him.

For the newly qualified a further period of hospital work with added freedom and responsibilities is essential. An advantage of the Health Act is that it should make possible an eventual grouping of the hospitals in a region that will benefit both the teachers and the taught. In the past hospitals have fallen into two main categories: those with many students and inadequate clinical material, and those with abundant clinical material and no students. In the future we may hope that the students will spend part of their training in other hospitals than their parent one, where, with plenty of patients to examine and fresh viewpoints to study, they will learn more than they could in surroundings that have become familiar. I foresee a time when a teaching unit will contain 5,000 beds rather than the 500 to 1,000 it does now, when none but the senior physicians and surgeons will be permanently attached to the parent hospital, when students, registrars, and the junior consultants will serve for periods in various hospitals in the group, and when the teaching will be spread over a wide panel and be available to undergraduate and postgraduate alike.

But, apart altogether from formal postgraduate training and periodic refresher courses which practitioners may attend if they wish, it is essential that the sharp cleft that has appeared within our own time between consultant and

general practice should be filled in, and that the practitioners of a district should be made to feel that they belong to the hospitals of their district and that the hospitals belong to them. At present, in many instances, the only contact is a hastily scribbled note asking for information that the doctor could easily obtain if he had the facilities, and a hastily dictated and stereotyped reply received some days later. Many suggestions have been made how this situation might be improved.

Each hospital should keep a record of all the doctors in the district from which it draws its patients. It should treat them as the Royal Society of Medicine treats its Fellows, sending to each a monthly announcement of coming activities, of such fixtures as tumour clinics, cardiac discussions, and clinical lectures, in which he might be interested. It should make it clear to practitioners that they are really welcome, and teach those twin menaces to co-operation—the soured sister and the bumptious houseman—better manners. It should specially welcome them at ward rounds where their own cases are being discussed; indeed, it might well arrange that of the two weekly rounds one should be for students, the other in the first place for postgraduates and visiting practitioners. It should ensure that practitioners are welcome, not alone in the wards but in the departments. A reception once or twice a year at which consultants and practitioners could meet on a social rather than a professional basis, and a practitioners' common room where they could meet each other and where some of the textbooks and journals not usually in the practitioner's own library could be consulted, would go far to encourage the spirit of camaraderie.

A further method of bringing the general practitioner into closer contact with the hospital is by clinical assistantships, a scheme in which the Barnet Group Hospital Management Committee has been a pioneer in the London area. At the Barnet General Hospital six general practitioners are appointed to six clinical assistantships—two in medicine, and one each in surgery, obstetrics and gynaecology, dermatology, and paediatrics. The appointments are for a period of six months, which may be extended to twelve. The grading is registrar (part-time), and the clinical assistant attends two sessions a week. The scheme has proved most satisfactory. The practitioners value the educational and clinical contacts and get a better understanding of the internal workings of the hospital and appreciate its difficulties. This, in turn, brings about a better relationship between the hospital and outside general practitioners. The system of clinical assistantship is being extended to other hospitals in the Barnet Group.

Care of the Patient

The third aspect of the relationship between hospitals and doctors concerns the care of the patient. At the present time much of the educative value of practice is lost to the practitioner because he is unable to pursue his investigations to the point where a firm diagnosis is possible, or to treat his patients when they require nursing. On the other hand, the hospitals are inundated with cases of a comparatively trivial nature that the practitioner should have treated, and in examinations that he could just as well have made himself. The answer lies in the provision of general-practitioner beds.

The ideal arrangement in theory, that the practitioner should continue in charge of his patient after he has entered hospital as he did before, is unfortunately impossible in any large hospital for administrative reasons. The doctor's visit forms quite a small part of the work of a ward. Patients must be wakened, washed, and fed, beds must be made, temperatures and pulses must be taken, medicines must be administered, closed periods for bed-pans and visits to the lavatory must be instituted at frequent intervals. The superintendent, the matron, the honorary, the registrar, and the houseman must all make their rounds. Physiotherapists, occupational therapists, clinical chemists, dietitians, clerks, and photographers all come in to practise their particular

trade. Visitors bring noise, chaos, and mess for a couple of hours a day. In a teaching hospital ward rounds intrude, in a non-teaching hospital the turnover of fresh cases and the number of minor treatments is much greater. It is clear that in such hospitals the nursing staff cannot possibly cope with simultaneous visits by eight or ten different doctors. In such circumstances attendance by the practitioner at a ward round when his patient is being discussed provides the only practicable form of liaison.

It is possible that specific beds may be allotted to general practitioners in a large hospital, or that a ward may be set aside for their use, but the difficulties of blending such a unit with the work of the rest of the hospital are almost insuperable. A preferable solution is the general-practitioner hospital or the cottage hospital.

Cottage hospitals were under a cloud at the time of the passing of the National Health Service Act; but those who decided somewhat hastily to close them forgot that the treatment of illness is often more psychological than physical, that confidence and equanimity are the first stage to recovery, and that sick folk will get well in familiar surroundings, near their homes, in touch with their families, and cared for by doctors and nurses they know, when they would pine in the chill antiseptic surroundings of a large distant hospital subjected to the skilled but impersonal attentions of strangers. Cottage hospitals had suffered in reputation chiefly because of the incompetent surgery that was performed in some of them. Admirable institutions were condemned because of the faults of some men who worked in them. These faults will not be repeated now, and the cottage or district hospital, properly run, should provide in every local community lacking a general hospital the answer to the relationship between practitioner and hospital.

The size of a cottage hospital is open to debate, but thirty beds is about the smallest unit that will justify the addition of an x-ray unit and a clinical laboratory, both of which are essential to efficient work. There should be a consulting staff consisting at any rate of a physician, a surgeon, and a gynaecologist working at a neighbouring general hospital, and each of these should make a regular weekly visit, and attend at other times if required to do so. The x-ray plant and the laboratory should be in charge of whole- or part-time technicians, but a consulting radiologist and pathologist should supervise the work. Whether all the practitioners in the neighbourhood are on the staff or only a limited number is a matter for local arrangement.

On the one hand, a smaller staff make for easier administration. On the other hand, no practitioner should be obliged to hand over his patients to rivals, which means that anyone in single-handed practice must have the right to admit patients. In most cases a rule that doctors become eligible for election only when they have practised in the district for five years will allow each firm to be represented.

In such hospitals practitioners will be able to investigate and to treat their own patients, referring to the central hospitals only those presenting unusual difficulty in diagnosis or calling for unusual skill in treatment. In deciding upon a line of treatment it must not be forgotten that it is a principle of the National Health Service Act that every in-patient or out-patient should have the advantage of the advice of the appropriate consultant. Any practitioner can perform minor operations, or ones of greater scope, but it would be well that he should do so with the knowledge and approval of the consultant surgeon to the hospital, and preferably that he should have held the post of clinical assistant to him. In the case of litigation, a practitioner who had operated on his own responsibility without taking advantage of the advice available to him would probably be held liable for any untoward results.

The health centre is not as yet anything more than a glorious dream in the minds of the planners. It has never been exactly defined, but in essence it is a place where doctors of a neighbourhood, by working in a building specially planned for the purpose, can enjoy the advantage of communal

facilities in waiting-rooms, secretarial assistance, and accessory methods of investigation, can see their patients in consulting-rooms designed as such, and can consult each other or the representatives of the public health services, who work in adjacent premises. In many ways the health centre is to the cottage hospital what the out-patient department is to the general hospital, and there are many advantages in placing the two in proximity, though not in the same building. The secretarial and filing staff, the offices of the local health authorities, and the group premises of several firms of practitioners working in rivalry do not fit in with the conception of a hospital, but the need in the health centre for x-ray and laboratory facilities demands proximity. The ideal arrangement would be a separate building in the same grounds, or at any rate in the same street.

Conclusion

Finally, the domiciliary consultation is one of the beneficent provisions of the Act that cannot be used too often. Better than its sister Mercy, it blesses three people—him that asks, him that gives, and him that takes. It helps the practitioner because it enables him to meet the consultant man to man over a live problem, to put all those small points and difficulties that cannot be put in a letter, to set out the personal as well as the medical aspects, if need be to call his bluff and insist on simple instructions in plain English. It helps the consultant because it gives him the opportunity seldom offered in hospital, to study a patient rather than a case, and to appreciate the difficulties with which the practitioner must contend. It helps the patient because it brings Harley Street to his bedroom, and cuts out the fatiguing journey and the long wait of a visit to hospital.

What, then, is the ideal relationship of the practitioner to the hospital? The ideal relationship is one of the friendliest possible contact, of the closest possible co-operation.

The consultant and the practitioner are both men trained in the same basic sciences and working for the same end. They have been parted by the increasing complexity of modern medicine. They have been forced further apart by some of the unintended and unexpected consequences of the new Act. Both are overworked. Both tend to assume a superior attitude which is really an inferiority complex with the bristles out. But both can work together if they try, and the first thing is that they should come together.

GENERAL PRACTICE AND THE HOSPITAL*

BY

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There seem to be many people who claim—and, for all I know, believe—that all the ills from which British medicine suffers to-day had an acute onset on July 5, 1948. This, however, is to forget that all illness must be examined in the light of the previous history of the patient, predisposing factors, and environment. Changes in social and political climate, medical development, and the accelerated advance of knowledge are all important considerations in the diagnosis and treatment of the ailments of the body and mind of medicine. The chronically precarious financial state of the old voluntary hospitals, the burden on the local rates which the development of the municipal hospitals caused, the rise in the cost to the patient of so many medical services in this

increasingly complex world contributed their important shares to the drastic experiment initiated five years ago. It is not my purpose either to defend or to condemn the experiment, but rather to offer some thoughts on the problem of rehabilitation, with particular reference to the association of general practice with the hospitals.

During the past 30 or more years there has been an obvious change in hospital staffs. Whereas formerly many, perhaps originally all, senior members of hospital staffs worked as general practitioners for much of their time, now almost none do, and I sense a general attitude that this is as it should be.

This development is usually attributed to the increasing specialization which has been so obvious in the same period. There is doubtless substance in this claim, especially in respect of surgeons, but I do not think the advance of specialization is the whole reason in the case of non-surgical staffs. In Scotland the general physician—that is, the consultant who tries to survey the whole field of internal medicine—is still fighting a successful rear-guard action for survival against the forces of narrow specialism which are dominant elsewhere. However, the ever-increasing number and complexity of diagnostic and therapeutic techniques have influenced the pattern of hospital staffing, for the development of these techniques is inevitably a hospital matter, and therefore expertness—that is, specialism in their uses—is first acquired by the hospital staffs, and the hospital physician acquires skill which the doctor working outside hospital has little chance of attaining, or at any rate can do so only much later. More and more, therefore, the hospital physician has devoted his time to applying these special skills and the experience gained in their application even while still trying to maintain a wide general outlook.

Also the financial and social eminence attainable, at any rate in former days, by top-flight consultants has attracted men into purely hospital and consultant work divorced from the rough and tumble of general family practice.

Hospital Staff and Domiciliary Practice

Be the explanations what they may, we were already, long before the last war, faced with the fact that the general hospitals were for the most part staffed by men who were not engaged in general practice, and indeed in many cases, to their detriment, never had been. This trend has continued, and has probably been accelerated by the war and by the introduction of the National Health Service, so that now there are very few G.P.s on general hospital staffs, and the idea is prevalent that none need apply. The almost universal practice of appointing junior staff—that is, registrars, senior registrars, and others—to whole-time appointments, and the difficulties in the way of any two-way traffic between general and hospital practice, are already breeding a race of young consultants who have not only no experience of general family practice but very little of domiciliary practice of any kind. To my mind this is one of the gravest defects of the Service, since, in the future, consultants will lack a vital element in their training—namely, the experience of attending people in their own personal and domestic environments, experience which contributes so much to the making of a good doctor, and lack of which accentuates the danger of the development of an impersonal and mechanistic approach to what are, after all, intensely human problems.

Since the clinical teaching of undergraduates is almost entirely confined to members of hospital staffs, their increasing lack of experience in family and domiciliary practice

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