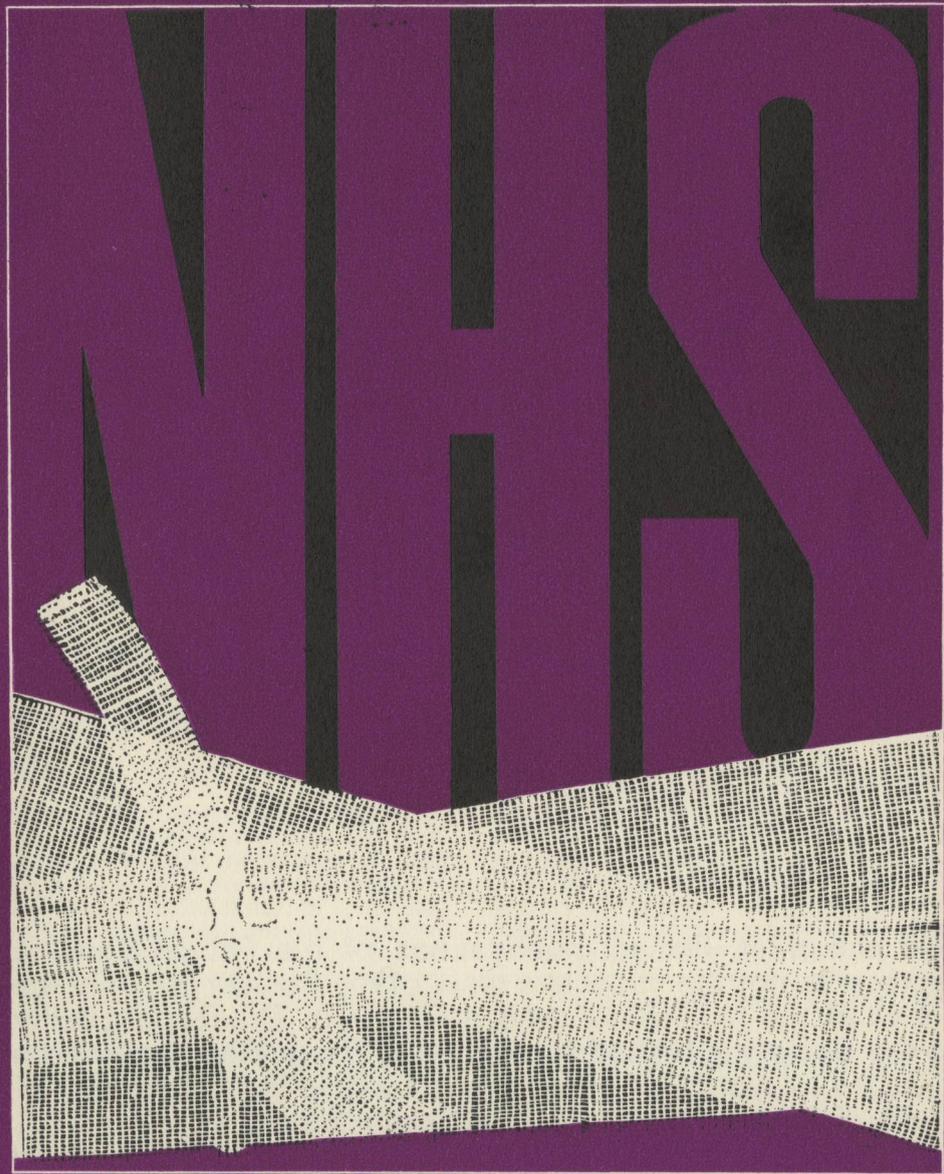


general practice

a study group

young fabian pamphlet 9 3s



young fabian pamphlet 9

general practice

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this pamphlet, like all publications of the Fabian Society, represents not the collective view of the Society but only the views of the individuals who prepared it. The responsibility of the Society is limited to approving the publications which it issues as worthy of consideration within the Labour movement. Fabian Society, 11 Dartmouth Street, London SW1
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1. introduction

Signed letters of resignation from 18,000 general practitioners needing only three months to take effect, lie in the chambers of the BMA. This is a situation which almost justifies the newspaper headlines declaring crisis and sensation, which suddenly appeared before a largely unsuspecting public one morning in February 1965.

Much has been achieved by Kenneth Robinson in his negotiations with the GPs' representatives since that time and the expected crisis has been largely averted. However, the recent situation has made it obvious that the majority of general practitioners are extremely dissatisfied and are determined to secure better terms and conditions of service. It is broadly true that the background to the dispute has been poorly understood, although prospects of a short term solution are good, the long term wishes and aspirations of the GP has seldom achieved any special study or even recognition. The NHS has suffered since its inception from an intellectual sterility with regard to planned growth. The structure and scope of the solutions to the recent crisis are in danger of being limited by the usual triad of conservatism, ignorance and penury. The NHS, "An act of faith in man's wish to help his fellows in times of misfortune" (*Members one of another* Labour Party, 1959) has many times taken second place in the priorities of a nation all too often prepared to pay only lip service to its financial and physical needs.

This pamphlet is written in the belief that any short term settlement can only succeed if it takes cognisance of long term aims, and that decisions formed now must herald the evolution of a service, recast to accommodate the many reforms which have become apparent over the last 15 years. The NHS has remained tragically stagnant for too long. The new disciplines and techniques which have been applied in the field of social medicine have demonstrated both the deficiencies and the possible improvements in the structure of a service that is still firmly entrenched in the 19th century. Nowhere is this more evident than in general practice.

"The industrial revolution has passed general practice by; it remains a cottage industry, under organised, under capitalised, and overworked." (Professor J. H. F. Brotherton, 70th Congress of the Royal Society of Health, 1963.)

THE RECENT CRISIS

This owes as much to past frustrations as to present irritations. The NHS was, in respect of GPs, imposed on a profession often reluctant and sometimes openly antagonistic. The BMA, as usual in medical politics an outpost of reaction, fought the conception and implementation with a fervour that owed much to the personality of its then general secretary, Dr Charles Hill. Through the years that have elapsed the feelings then evoked have receded but they still lurk in the background of many BMA pronouncements (and often find expression in the regular column by Pertinax in the *British Medical Journal* somewhat cynically titled "Without Prejudice"). General practitioners have long felt with, it must be admitted, considerable justification that it was the hospital consultants who managed to achieve the best terms at the inception of the NHS.

Inevitably, the complicated negotiations which established the form of our present service, made the final settlement a disappointing compromise. Aneurin Bevan realised that without the support of the consultants and particularly those from the teaching hospitals there was little hope of achieving a truly universal health service. Their prestige and influence was essential. Consequently he felt forced to make his major concessions to the consultants, and allowed them generous fixed remuneration on a sessional basis with no real curtailment of their freedom. The GPs, through the negotiating body of the BMA, firmly opposed both a salaried service and health centres and insisted on their traditional role as private contractors. This action ensured the divisive structure of the NHS which has dogged its progress ever since. The demarcation between hospital and other medical practice, which existed even before the NHS,

has emerged as one of the major factors in the loss of prestige that is so often complained of by GPs. Furthermore, it is largely responsible for the increasing tendency for the GP to become a kind of medical sieve, left to cope with a residue of what many feel is only trivial illness.

the review body

The method of payment devised for GPs was also the direct result of their peculiar position as private contractors to the newly formed executive councils. Over the years the GPs have tended to channel their frustration with the increasing discrepancies between their status and that of hospital consultants into claims for increased remuneration. But perhaps this is only because the other more intangible factors are difficult to change, without conceding part of their doctrinaire belief in independence as the essential ingredient to good general practice. The succeeding years produced a series of conflicts—progressive pay claims and awards, including the adjudication by Mr Joseph Dankwerts which did reduce the financial differential between consultants and GPs, and the crisis in 1956, which resulted in the first threat of planned withdrawal from the NHS. The GPs retained throughout the suspicion that the differential was being perpetuated both in terms of pay and conditions of service. The Royal Commission's recommendations were also seen as tending to maintain the status quo. It produced one significant advance however, the establishment of a Review Body, aimed at "The settlement of remuneration without public dispute, the provision of some assurance for the professions that their remuneration is not determined by considerations of political convenience". (*Royal Commission on Doctors and Dentists Remuneration, 1957-60. HMSO 939.*)

This was unanimously welcomed by the profession in the hope that the constant bitterness over remuneration would at last cease. Those who wished to reform the NHS felt that now the profession would be able to concentrate on a rather more positive approach, though the BMJ

warned, in an editorial "General Practice Outmoded?" that "time is not on the side of those many who believe a radical reform of general practice is urgently required". (*British Medical Journal, 1963, Vol 1.*)

the pool

The first award of the Review Body, announced in 1963, was for a 14 per cent increase generally acknowledged to be fair and reasonable. Consultants, paid on a sessional basis, received the full award as did the junior medical staff. The GPs, paid by a pool system which had been resented for many years, suffered severely by comparison. The pool is calculated by a complicated mathematical system which involves multiplying the agreed average pay, at present £2,765, by the total number of GPs. This sum is then divided and paid out, with respect to agreed rates, for certain services carried out by individual doctors. Something approaching £13 millions a year is distributed for maternity care, hospital work and other special demands such as immunisations. Only after this has been paid is the remainder, admittedly the larger amount, distributed in capitation fees for the general medical services. Since some GPs carry out many such additional services and others few, there is a wide discrepancy between the claims of individual doctors. In effect some GPs take money not only from their colleagues but from themselves in reduced capitation fees. While the pool operated on a surplus it was a tolerable though unsatisfactory method of payment. However, unprecedented demands in fees for special services were made on the pool during 1963. In consequence the pay rise represented only a 9 per cent increase to the average GP. When this was realised resentment overflowed.

The GPs immediately demanded a further increase limited to those doctors whose payment came from the pool, that is excluding hospital doctors. The Review Body, though not due to report again until 1966, was asked to make an interim award. Lord Kindersley, the Chairman, agreed to do this since the claim was

supported by the Joint Consultants Committee and thus seemed to represent the wishes of the whole profession.

The Review Body now faced a claim for an additional £18 millions. The GPs suggested that all payments for maternity work, local authorities and government work should be paid for separately, and that the pool should be maintained only for the general medical services, which are paid through the capitation fees. They also demanded a system of seniority and experience payments since the profession had failed to agree on a scheme to reward merit in general practice, although this was favoured by the Royal Commission.

resignations

In February 1965, the Review Body, which had considered these claims, reported to the prime minister and its recommendations were accepted. It advocated that a further £5½ millions be made available, but made it a condition of payment that approximately £4 millions should be used to reimburse GPs directly for auxiliary help and other expenditure designed to improve premises. The responsibility for these conditions was solely that of the Review Body, although these were the very ideas that the Minister of Health had previously suggested to the profession, in the attempt to give some inducement to provide a better service. The Review Body also made proposals for reforming the pool that went some way to meeting the profession's objections but flatly rejected seniority payments. The BMA argued that the imposition of conditions was not within the remit of the Review Body, but even the BMA did not appear to have realised the strength of feeling that had been slowly building up amongst GPs over the years, or to have expected the outburst of indignation which met these proposals. The Minister by asking this body to clarify certain points, ensured that the conditions were dropped—a significant concession.

Nevertheless the General Medical Services Committee advised the Council of BMA,

through its front organisation the British Medical Guild, to call on GPs to exercise their prerogative to terminate their contract of service with the NHS after the statutory period of three months notice had elapsed. Resignations were to be sent in, signed but undated, to be used at the appropriate time.

Throughout the crisis the BMJ increasingly represented militant opinion and it was left to the *Lancet*, so often the profession's conscience, to present a reasoned case, pointing out that it was an interim award, and that the next triennial review was due in only twelve months. It welcomed the positive proposals earmarking money for auxiliary help and other expenses, and in an editorial entitled "No Withdrawal" (January 1965) appealed for reason. "The government has accepted this independent body's recommendations without reserve and has imposed no conditions of its own. The profession's negotiators have not, and they now seek to further the profession's claim directly with the government 'in a state of threat.' Why? Has the body which in January was 'composed of men of eminence and authority and acceptable to the medical and dental professions' become so quickly a tool of the Treasury or the Ministry of Health?" (*Lancet*, 1965, Vol. 1.) It described the method of approaching the Minister while at the same time asking for resignations, as negotiating "with a claim in one hand and a pistol in the other".

The profession's negotiators claimed all along to have wide public support, but there was little evidence for this assumption. *The Observer* on 14 February, said "By threatening to withdraw from the health service because of dissatisfaction over the Review Body's findings, the general practitioners are resisting an attempt to improve standards". Many people began to question the profession's attitude, comparing their actions with those of a trade union refusing the award of an independent tribunal. By concentrating their frustrations once more on remuneration, the GPs lost support from a section of public opinion that would have been fully prepared to support them

on grounds of overwork, long hours or conditions of service. The Minister repeatedly expressed his readiness to negotiate, stipulating only that the quantum of remuneration must still be fixed by the Review Body, and refusing to go back to the old system of direct negotiation between the profession and the Ministry of Health.

not merely pay

In an editorial, *The Practitioner* accused the BMA of giving a false image of the GPs by "harping on problems of pay" and stated that "The sooner the Ministry of Health and the British Medical Association realise that what the vast majority of general practitioners is interested in is service, and the means whereby they can give this service to their patients, the sooner will the citizens of this country receive the medical care to which they are entitled". (*The Practitioner*, 1965, Vol. 194.) This was also the theme of an excellent editorial in the *BMJ* entitled "Towards a better Family Doctor Service" which put the emphasis in the right place by stressing that there had been little incitement for the recent outburst, and went on to say, "The public at large and the Minister of Health should therefore realise that the discontent lies deep. The medical profession too should realise, in fact does realise, that this discontent is only in part due to the mechanics of the health service. It is caused as much by the rapidly changing position that the general practitioner faces today with medical science far outstripping in its discoveries and application what he was taught at his medical school ten or even five years ago. . . . The general practitioner has to get back into the main stream of applied clinical science." (*British Medical Journal*, 1965, Vol. 1.)

the joint report

There must of course be some short term *ad hoc* solutions. The current negotiations are only the start of a long period of discussion, but already there has been a remarkable degree of agreement and it

looks as if the crisis is at least averted. The joint report shows that the Government has agreed to abolish the pool but still insists that the Review Body price the contract. The Minister has accepted the establishment of a general practice finance corporation, payments towards practice expenses, direct repayment for the cost of ancillary help and has instituted reforms to reduce certification. (Joint report of discussion with the Minister of Health upon the charter for the family doctor service, BMA, June 1965.) The Council of the BMA at this stage feel that the progress fully justifies their belief that eventually satisfactory agreement will be reached on all the points in their "Charter for the Family Doctor Service".

There are, however, signs that the profession is already balking at any governmental control over the general practice finance corporation. The *BMJ* in an editorial "Time for Decision" implying acceptance of the negotiations, argues "The statement that 'the Health Ministers would need to have powers to issue directions to the corporation' requires further explanation before it can be accepted as innocuous. Again, the Health Ministers are to decide whether practice premises are suitably sited and of a suitable standard before the Corporation provides money for their development. The Health Minister would give 'directions on priorities', and, through a central committee, advise on policy. These things have in them the seeds from which can grow too much central direction of developments in general practice." (*British Medical Journal*, 1965, Vol. 1.) It is to be hoped that this attitude will not solidify into opposition to the rationalisation of general practice that must form a central part of the negotiations to come.

As yet there is no official statement on the proposals contained in the "Charter" concerning the general practitioner's readiness to provide a 24 hour a day, seven day a week cover for his patients. This represents a far more difficult administrative problem and it is hard to see how it can be arranged, given the present structure of general practice. It is when GPs are determined to negotiate for limi-

tations on the working day that the question of their continued status as private contractors is most forcibly brought into question. At present the illusion is maintained that the GP, as a private contractor, is a pillar of private enterprise, whereas he has possibly less freedom in many respects than the hospital consultant, who is salaried and employed by the regional hospital board. The local executive councils and the ministry's regional medical officers already impose quite severe conditions of service. The GP agrees to give complete medical cover to all patients on his list throughout the year day in, day out, and to keep adequate surgeries and medical cards. The list is not allowed to be in excess of three and a half, or four thousand if in partnership, but in emergencies he must treat all comers. He has to provide locums for illness or holidays, to arrange his own time off, and in fact accept a considerable limitation of his freedom by his very determination to remain independent.

a long term plan

This pamphlet argues that we should utilise the present crisis to review the position of the GP within the context of the whole framework of the NHS. Many features of general practice as it is at present conceived in this country do not work satisfactorily to the benefit of the consumer or the doctor. At the same time there are other aspects of the NHS which are just as unsatisfactory and also in urgent need of reform. We suggest that the answer to the GPs' problems lie ultimately in radical administrative changes which would allow the evolution of a more cohesive and efficient service. If the executive councils were disbanded and the GP appointed by the regional hospital board within whose catchment area he wished to practice, he would then be in exactly the same contractual position as the hospital consultant. We shall argue that there are many additional advantages to integrating the hospital and domiciliary services in this way, not only for the GP, but also for the hospital and the community. This solution might eradicate many of the GP's grievances, make

possible the fundamental changes that have long been needed, and allow the introduction of a salaried service without loss of freedom. Hospital consultants have never seriously complained of being hampered in their work by too much executive control. They have retained their clinical freedom and maintained their independence, while gaining a significant place on all decision making bodies regarding the NHS.

We are well aware that the majority of GPs have worked conscientiously to promote the NHS, often under exceedingly difficult conditions, despite their original distrust of "socialised medicine". There is evidence that the public is generally sympathetic to their problems and that there is a fund of good will, built up over the years, which is a direct result of the devoted service to his patients, which the GP has consistently provided. Our proposals are not primarily destructive, although they would involve relinquishing the present concept of domiciliary care. We wish rather to reinstate the front-line doctor as a specialist in primary diagnosis and domiciliary care, which is his right and proper function in any effective health service. The deficiencies in the present GP service which we will pinpoint cannot be attributed to individual negligence so much as to the system in which he is forced to work. It is our contention that only by cardinal reforms can we really help the GP to achieve the higher standard of medical care which he, himself, wishes to provide, and the GP should realise that a stubborn refusal to change his position will only result in furthering the divisive structure of the NHS and impeding progress towards higher standards.

Now is the time for the Minister of Health to grasp the opportunity not for a patching up operation but for a radical re-orientation in terms of payment, contract and conditions of service. We do not wish to imply that reorganisation of the health service is an easy matter or that it would solve all problems. But it could be a valuable and important aid to developing better medicine. As an American admirer of the Health Service has said, "In 1948 the financing of medical care in

Great Britain was revolutionised, and the result has been a boon to the British people. The time has now come to change the organisation of care, and with it the structure of medical practice." (Steven Jones "Why do they emigrate?" *The Lancet*, 1965, Vol. 1.) The present GP crisis could be used as an opportunity to reconsider many unsatisfactory aspects of the health service. Not only general practice is in need of reform.

2. how good is the GP?

Before we consider the various solutions to the present crisis which have been suggested, we should re-examine the role of the GP as it now exists within the NHS. We should also see how far it is possible for doctors to fulfil the demands of this role, for in this and other countries which have GPs there is an uneasy feeling that we are expecting these doctors to master too many skills and to keep abreast of too wide an area of knowledge. The WHO Expert Committee on general practice which reported in 1964, after asserting the vital importance of general practice went on "This is not to say that all is well in general practice today or that it should be left to continue as it now is . . . general practice suffers from defects that must be remedied in order to bring medical care up to the standards now required by medical progress and often demanded by the public".

What about the patient's view? Perhaps the best consumer study in print is the one by PEP. (*Family needs and the Social Services*, 1961.) The survey dealt with a representative sample of urban families with children under 16 and their usage of, and attitudes to the various social services. Like less ambitious studies, this work confirmed the view that in general practice "the customer is happy". 86 per cent of families were satisfied with the kind of attention given by their GP and 72 per cent of families had not changed and did not wish to change their GP. But before we sigh with relief we should remember that the patient is clearly in no position to judge the technical proficiency of his doctor. This obvious point was confirmed by a very detailed study of general practice, carried out in the USA (O. L. Peterson, *Journal of Medicinal Education*, 1956, pt 2), where income is a reflection of popularity with patients. The doctors judged best by the investigators were not those with the largest incomes.

perinatal mortality survey

We are only just beginning to study ways of measuring the quality of medical care, whether inside or outside the hospital.

The problem is to determine how many people are ill, whether their illnesses might have been prevented and how good their treatment has been. These things are notoriously difficult to measure. The numbers of deaths from particular causes in specified groups of the population provide some evidence, although, of course, mortality rates measure only a small part of illness in an era of successful control of many previously fatal diseases. The picture that we get of GP efficiency from mortality studies is fair but not flattering. A useful index, with relevance to general practice, is perinatal mortality, that is still births and deaths in the first week of life. During one week of 1958 there was a national study of all the births which occurred in Britain (perinatal mortality survey). (N. R. Butler and D. G. Bonham, *Perinatal Mortality*, 1963, Livingstone.) A great deal of information was collected about these births, about the prenatal care that had been given and about the deaths which occurred in the subsequent three months. This allowed comparisons between the standards of hospital and GP care.

The perinatal mortality for the babies of mothers, booked and delivered in hospital, was no more than the national average, although these cases were selected for hospital care because they presented real or potential high risk. Perinatal mortality was higher in the group delivered at home, which suggests either that care outside hospital or the selection of cases was deficient. The key position of the GP in selecting these mothers should be remembered. Some hint at the underlying reasons for this surprising finding was given by the study of anaesthetic methods used. At home and in GP units, local or regional anaesthesia was rarely used for forceps deliveries (about ten per cent) compared with general anaesthesia (85 per cent), which is less safe but in some ways easier to employ. In hospital 43 per cent of patients had local or regional methods of anaesthesia. Similar differences were found in the anaesthesia for breech delivery.

The perinatal mortality survey also revealed some disturbing information about

the quality of prenatal care given by GPs. To quote from the report itself "One third of all women had no haemoglobin test in pregnancy. One woman in six did not have her blood pressure taken at each prenatal visit. In 5.5 per cent of women the blood Rh type was not known and not tested during pregnancy. Only in those women having hospital care throughout were these tests done almost invariably." The perinatal mortality survey was carried out seven years ago, and many GPs now have better access to hospital laboratories, but anxieties inevitably remain as to how far standards have improved and kept pace with subsequent advances.

further studies

When we turn to other studies of how GPs work and the quality of the equipment that they use, again the picture is far from rosy. This is not something that is recent or the result of the NHS. In 1950, a New Zealand GP, Joseph Collings, published in *The Lancet* a survey of British general practice which revealed widespread deficiencies. (J. Collings, *Lancet*, 25 March 1950.) This caused quite an uproar at the time, and stimulated further studies, notably by a staff member of the BMA (S. Hadfield, *British Medical Journal*, 1953), and one by Lord Taylor (*Good General Practice*, 1954, OUP.) Although the later studies were aimed to stress the good features of British general practice, their authors had to admit that all was not well with the British GP and his ways of working. In the Taylor study, a quarter of the observed doctors were deemed to be unsatisfactory, despite the fact that the doctors studied had been selected on the basis of their colleagues' esteem.

Subsequent studies, whether of the ways GPs use drugs or diagnostic services such as X-rays or pathological tests, or the ways they call on domiciliary nursing services, reveal wide variations between practices, variations that do not fit at all well with patterns of illness and disability. (S. L. Morrison, M. M. Riley, *Medical Care*, July 1963; J. A. H. Lee, M. Wea-

therall, P. Draper, *Proceedings of the Royal Society of Medicine*, November 1964; J. Fry, J. B. Dillane, A. C. Glendinning, J. Keall, *Medical World*, July 1964.)

domiciliary leadership

It is often claimed that the GP plays a vital part in the organisation of the health services, because he is in a unique, front-line position. He is the first person to whom the sick patient turns, and it is his decision that determines whether the patient is referred to hospital or is recommended for some other form of care. As such, the GP is often portrayed as the leader in a domiciliary team of specialists and ancillaries. How well does he, in fact, fit this dynamic role?

Relations between the GP, nurses and social workers are far from satisfactory. Until very recently collaboration between doctor and public health nurses was almost non-existent. It is now improving, partly as a result of the policy of attaching these nurses, particularly health visitors, to general practices rather than having the nurse work from the public health department. However, such schemes at present affect less than five per cent of health visitors and there are still strong antipathies between many doctors and these nurses. Relationships with home nurses are usually said to be excellent, but when the extent of communication is analysed, it transpires that in towns, nurses work for several doctors and do not always seem to discuss patients regularly each week, let alone each day. Indeed, a standard method of communication is still by notes left in the patient's home.

There is ample evidence that social workers could give valuable assistance with many of the problems presented to the GP. One study showed that a considerable number of patients needed, in fact, the help of a skilled case-worker. (J. Collins, *Social casework in general medical practice*, Pitman Medical, 1965.) In practice, social workers, such as child care officers, often complain that communication between themselves and the GPs is often

defective. Sometimes this is simply because doctors are busy, but in addition doctors do not seem to understand the work and the skills of social workers. Indeed, why should they? Doctors are taught little about social casework or the social services. Professional social work is changing rapidly and without constant information about these developments, GPs cannot be expected to understand modern practice. How then can the GP collaborate effectively, let alone lead?

GPs and hospitals

We should now examine the GPs' relationships with hospitals and hospital specialists. Again this is not encouraging. In the recent official report on general practice, the Gillie Report, reference was made to home visits by specialists (*Report on the field of work of the family doctor*, HMSO, 1963.) The number of these domiciliary consultations is rising in the NHS, but it is estimated that "consultation with both doctors present at the patient's home, takes place today at less than half of the visits, and this proportion is probably falling". Furthermore, a study of out-patients who attended Guy's Hospital showed that in 40 per cent of cases, it was the patient, not the GP who chose his hospital. (R. M. Acheson, D. J. P. Baker, W. J. H. Butterfield, *British Medical Journal*, November 1962.) This suggests that the GP is not selecting for his patients the particular consultant by whom he will be treated. A study of GPs' letters to hospitals also reveals inadequacies, for instance, the reasons for consultation and the social background of the patient are often insufficiently described. (J. J. McMullen, A. Barr, *Journal of the College of General Practitioners*, January 1964.) Some hospital doctors complain that patients have not even been examined before referral. When the patient actually arrives at the hospital there are big differences in what happens to patients from different practices. For some practices many patients are usually admitted directly for treatment, but from others the patients are frequently transferred to other hospital departments, suggesting incorrect initial referral (*Hospital Out-*

patient Services, Oxford Regional Hospital Board, 1963.) Consequently the hospital rather than the GP plays the major role in selecting the correct service and controlling the patients' treatment.

There are many barriers to competence in general practice, which account in part for these facts. GPs are overworked, not necessarily with legitimate medical affairs, but with administrative duties which should be handled by secretarial assistants. The GP often does not have the time to make the necessary preliminary examinations. Only 30 per cent of GPs have effective secretarial help, and without this, adequate note-taking is hardly feasible. (A. Cartwright, R. Marshall, *Medical Care*, April 1965.)

GPs and psychiatry

A special problem in general practice is the number of patients whose complaints are largely emotional or psychological in origin. Very few GPs have been trained to cope with the task of detecting these. Medical students are taught comparatively little psychiatry and much of what is taught concerns only the severe psychotic forms of illness. This may well explain the readiness of many GPs to label apparently unnecessary calls from patients as trivial. Some of these patients could probably be treated adequately by a suitably trained GP, but successful psychotherapy requires a great deal of time; more than the patient can expect from doctors under the present system.

continuity of care

The image of the GP as the personal doctor providing continuity of care throughout the patient's life, is also one which is not always supported by the facts. One important function of the GP in this role is to ensure that the patient he has referred to hospital receives adequate care and is satisfied with his treatment . . . to act as a kind of hospital ombudsman. Few GPs, in fact, manage to see their patients while in hospital, and they are all too frequently made to feel unwelcome by

the hospital staff. After discharge, hospitals often supervise the follow-up of patients. This is sometimes criticised by GPs as being unnecessary, but often it is to the patient's benefit, because he needs both specialist skills and hospital equipment. The GP has a justifiable grievance, however, in that the hospital does not always provide him with sufficient information about his patient's condition or progress. ("*What do they really want?*" Wessex Regional Hospital Board, 1964.) This is absolutely essential for continuity as well as courtesy, but it by no means always happens.

The myth of continuity of care is most apparent for those patients who require repeated periods of hospital treatment. With the present tripartite system, the GP, the hospital, and the local authority are each responsible for providing separate segments of a service that ought rationally to be a whole. Communication between these three sectors are minimal, and indeed there are no organised channels of communication. Forsyth and Logan in their study entitled, "*The Demand for Medical Care*" (OUP, 1960), state that it is at the point of integration between the hospital and the domiciliary services where the NHS is most unsuccessful. The GP is just not in the position, with the present administrative set-up, to provide continuous personal supervision of his patients during periods of sickness.

NHS reform

The description of these darker features of general practice confirms the view that the most serious problems are not those related to remuneration, but to the conditions of service and demands of the role itself. Only by the most earnest endeavours can the conscientious doctor overcome the obstacles to good medical practice which are features of the present organisation of medical care. The good GP, and there are many of these, is well aware of the deficiencies in the care which he can at present provide in Britain. It must be emphasised, of course, there are shortcomings in other parts of the health service too. Not only general

practice is in need of a thorough reorganisation. We must now consider whether the orthodox solutions to these problems are sufficient and can furnish the reforms which will assist the GP to function effectively.

3. orthodox solutions and their inadequacies

The GP's problems have been pithily summarised by Dr Richard Scott, the first British professor of general practice, as problems of time, tools and training. It is said, therefore, that the way to improve general practice is to provide the doctor with efficient and pleasant premises, with access to modern diagnostic and therapeutic equipment, and to save the GP's time by using non-medical colleagues for non-medical jobs. In addition, it is proposed to alter medical education, so as to train doctors specifically for general practice, rather than to half train him in a number of specialities, as at present.

the conventional proposals

The problem of premises is now being tackled by granting loans to groups of doctors, by building health centres and by allowing the GPs to use local authority clinic buildings. The proposed increased expense allowance for secretarial help and the development of training courses for secretary-receptionists, should improve the administration of practices. Attachment or alternative schemes of liaison with community nurses should provide more nursing help for the doctor, more satisfying work for the nurse and a better service to the patient. Attachment schemes for health visitors, would provide for the GP, a close link with workers who have training in both health education and social work.

An important aspect of current planning for general practice is to reduce, if not abolish, isolated practice. The doctor, like other professionals, needs the stimulation of his colleagues to encourage him to maintain high standards of work. Grouping of practitioners also makes it much easier to arrange cover for holidays and study. In addition, since group practices usually serve larger populations than the single GP, the work can be shared more easily with paramedical workers such as nurses, social workers, technicians, receptionists and secretaries. In some places there are plans to bring the GP into closer contact with the hospitals, partly by giving him sessions of hospital employment and partly by encouraging him to visit

hospitals to see patients and attend meetings.

training

Various suggestions have been made about ways to improve the initial training and postgraduate education of the GP. Medical education is at present confined largely to hospital experience, and this is now recognised as being a serious imbalance. In addition there is little opportunity or incentive for GPs to continue their education so that they keep up with advances in medical techniques and treatment. Schemes have been suggested for redesigning undergraduate and post-graduate training for those who will go into general practice and for paid leave or other incentives to encourage doctors to attend refresher courses regularly.

These changes would undoubtedly improve matters. The question is whether they would be sufficient, and whether they make sense in relation to the planning of other parts of the health service. We also need to consider whether there have been advances in medical technology and general social changes which explain why other industrial countries, as politically different as the USA, the USSR and the Scandinavian countries, have sharply reduced or abolished general practice in urban areas.

INADEQUACIES OF CURRENT PLANS

The essence of present day thinking, such as that in the Gillie Report, is that we must and can have family doctors who are competent to practice as primary diagnosticians for all age groups and conditions, and who will work from independent centres, largely separate from the other health services. These assumptions can be called in question and there are many points at which any such a plan must inevitably falter.

In the first place, all are agreed that the GP must be allowed increased access to diagnostic facilities and that it is essential that he learns to make greater use of

these. Basic radiological and pathological tests should be readily available, and he should be able to refer, with ease, patients who require more specialised tests to the appropriate consultant. Modern diagnostic equipment is usually both expensive and unsuitable for transport, and only a very small proportion could be widely dispersed to GP surgeries or health centres. The GP will have to make use of hospital facilities, and therefore in this context it is necessary to examine the implications of the hospital plan for domiciliary medical practice. (*A Hospital Plan for England and Wales, 1962, HMSO.*)

The district general hospitals, of the hospital plan, were originally intended to have six to eight hundred beds and to serve a population of a hundred to a hundred and fifty thousand. Subsequent statements have suggested that the size will increase rather than decrease. Even in an area of fairly high population density of four thousands per square mile, this could mean that one hospital would have to cover an area up to about three miles in radius. The larger the population that we make our hospitals cover, therefore, the harder we make it for domiciliary doctors and their patients to reach diagnostic equipment. There is evidence that distance plays an important part in determining how much use GPs are likely to make of open access to hospital facilities. (S. L. Morrison, M. M. Riley, *Medical Care*, July 1963.) There is no cognizance of this problem in the hospital plan, no intention to build diagnostic centres which would bridge the gap, and insufficient capital laid aside for the expansion of diagnostic aids, which such open access would entail.

This is hardly surprising. The hospital plan was not drawn up with the primary aim of integrating the three arms of the health service. Considerations of size of hospital and the physical extent of its catchment area were not viewed from the standpoint of the GP, or projected improvements in domiciliary care largely, again, because of the strict division of responsibility between the regional board and the executive council, even at minis-

try planning level. Consequently, the conventional solutions to the GP's problem, which consist simply of grafting additions on to the existing hospital plan, are unlikely to be adequate. The GP is justifiably dissatisfied with this kind of piecemeal solution, where his particular needs have not been fully considered. The GP deals with over 90 per cent of all illnesses which are treated by doctors (D. L. Crombie, K. W. Cross, *Medical Care*, 1963), and his position deserves more careful attention when new services are planned.

competence and generalism

As medical knowledge and skills have become more complex, there has been a steady separation of specialist groups from the generalist types of doctor. Indeed medicine is a good illustration of the economic theory that increasing complexity necessitates a division of labour. The general practitioner in Britain had his role institutionalised by the NHS Act, and consequently Britain has seen less change in the organisation of medical practice than countries which do not have this kind of artificial stability. A generalist was retained in the front-line of the service and although in theory it is attractive to have a doctor who combines competence in several specialities, we have seen that for one reason or another this concept does not seem to be working well. It is quite unrealistic to demand from one man a high level of skill in recognising illness and in the knowledge of an intricate array of diagnostic aids and therapy for the full spectrum of disease. This is an important reason why other countries have organised primary medical care around teams of specialists, although not always with complete success. In particular, if we are to develop the front line doctor as the king-pin in preventive medicine, which requires the early recognition of symptoms that are slight or indefinite, one must somehow allow the doctor to deepen his knowledge, without losing the advantage of the whole-body, whole-person approach, which the narrow organ-specialist finds difficult.

Most orthodox solutions including the BMA charter, contain within them the inference that to improve GP competence, it is necessary to reduce the size of his list. While it may be true that a case load of three thousand and more is too great a burden for one man to carry, if the present system is maintained there could be grave consequences for the doctor's competence in reducing the size of population for which he is responsible. For many serious conditions, the incidence is low, and to reduce the size of the GP's list will lessen still further his experience in meeting these conditions and hence his ability to recognise them. For example bronchiolitis in young children is not very common, but it can be fatal if it is not treated correctly. It is dangerous therefore if GPs do not encounter it sufficiently often to be able to diagnose it in the early stages. Dugald Baird has pointed out that in large towns, GPs are responsible for only about half the deliveries in their practices, and that these deliveries are selected for their expected normality. "He has therefore little experience of abnormal midwifery, and so cannot help the experienced midwife when she is in difficulties." (D. Baird, Paper given at Royal Society of Health Congress, 1965.)

the family doctor

The term "family doctor" has become very popular with general practitioners. Some go so far as to describe the GP as a "specialist in family medicine". When, however, these doctors describe the work and training of the family doctor, it is clear that they are describing doctors who are partially trained in a number of specialities. Fox (T. Fox, *Lancet*, April 1960) in suggesting an alternative to the term for GPs, namely "Personal doctor", drew attention to the fact that not all members of families wish to have the same doctor. Two recent studies of urban practice showed that no less than 20 per cent of the members of families chose to register with different doctors. (J. M. Akester, A. W. MacPhail, *Lancet*, August 1964; *Family needs and the Social Services*, PEP, 1961.) Adolescents, for

example, frequently prefer not to use the family practitioner. Then, too, we should remember the large portion of the population that does not conform to the pattern of the nuclear family, single people and the widowed, for example.

It may not be necessary to maintain the present concept of the family doctor, in order to ensure that all patients have a personal doctor. We have already cited instances to illustrate that one of the most important functions of a personal doctor, to provide continuity of care, is often impossible in any case with the present system. There are many other areas where fragmentation of services exist—for example, maternity care, now split between the GP, the hospital and the local authority clinic, and the health of school children which is catered for in part by the GP, with assistance from the hospital specialists, and in part by the school health services of the local authority. If the child suffers from an emotional disorder, yet another individual, the education authority's education psychologist will be called upon. Again, simply tinkering with the present services, without a radical plan to integrate the various segments, cannot be expected to provide a satisfactory solution to this state of affairs.

Surely the value of the concept of a family doctor lies particularly in the understanding of the interactions of mothers and young children and in seeing the need for continuity of medical care.

Co-operation between doctors could cover the former problem, while continuity of care must be achieved by far-reaching changes in the administrative organisation and the siting of services. In an industrial society which is increasingly mobile, we surely have to plan for continuity of care to be incorporated into the health service by means other than relying on the memory and resources of one doctor. Even under ideal conditions none of us can expect more than 40 years' care from an individual doctor, and it is usually considerably less.

Adequate medical records and modern

data processing could give us good family and personal medical histories as they have been doing in Denmark for a number of years. The advantages offered by the automation of medical records, and the changes which such methods are likely to necessitate in the development and organisation of the health services, have clearly not been considered so far in the plans to extend the Service. These methods need not be regarded as something which will materialise only in the distant future. In America much research has been devoted to their development, and in our own country some progress has been made already in the application of the computer to medical problems. West Sussex, for example, has been operating a highly successful computer control of immunisation for over two years.

we not consider rationalising our various administrative boundaries for health, so as to facilitate this kind of development? In this field, yet again, we see the benefits of a fully integrated service. Resolution of the tripartite system would allow such rationalisation.

data processing

Data processing equipment, whether punched cards or computers, needs larger numbers for efficient use than could be provided by the patients of a few GPs' lists. By dealing with large groups of patients we could, however, easily provide doctors with many statistical analyses which would aid them in their work, and incidentally remove much of the tedium associated with good record keeping, as well as improving efficiency. In addition an important new development in medical care is the extension of the use of screening tests for signs of early illness. Cervical smear examinations are a well-known example. These tests are most effectively used if they are carried out on the groups most at risk. Again, the organisation of such programmes will be greatly helped if records are handled by machine. As screening tests develop, we can therefore expect to see the administration of such programmes being conducted on large rather than small groups of the population. In this case they are unlikely to be examinations that the individual GP can organise.

Data processing could be a responsibility of the present or enlarged executive councils, if suitably equipped. But should

4. the virtues of general practice

At this stage perhaps we should consider which aspects of the GP service we wish to retain, and which aspects we need to change or improve. We can then proceed to consider another plan which will go a long way towards achieving these objects.

TO BE RETAINED

Domiciliary care, including domiciliary visits by consultants. For mental illness in particular it is necessary to increase domiciliary services in order to give reality to the modern philosophy that the community should accept responsibility for its sick members and receive them as part of the normal spectrum, rather than shut them away in institutions. Also much physical illness can be competently treated in the home, and it is often unnecessary for patients to stay for long periods in hospitals, provided that hospital facilities can be easily provided on an out-patient basis. No-one wants to see develop here the system that prevails in the USA where doctors rarely visit the patient in his own home.

The Personal Doctor, the continuous supervision of one's health over a period of years by a single person. One who sees the patient as an individual, not as a collection of organs, and who knows something of his background and home circumstances, through contact with other members of the patient's family. This ensures that the patient is treated as a whole person, and protects him from the narrowness of the super-specialist, whose knowledge is restricted to one field. We wish to preserve the front line doctor as an expert in primary diagnosis.

The 24 hour cover. The British system of a 24 hour domiciliary service is not unique but it is the envy of many countries which have abandoned this principle. It is not a feature that we should jeopardise in any future plans for GP reorganisation. But the present operation of this service imposes a severe strain on the GP, and he is now suggesting that this duty be drastically curtailed, if not abolished. We must consider alternative methods to ensure that this can be continued without

making excessive demands on individual doctors.

TO BE IMPROVED

GP competence and status. We have discussed, in some detail, the evidence that many GPs do not achieve a high standard of medical competence, at the present time, nor are their needs fully appreciated or catered for in the health service plans for the future. The NHS will undoubtedly have failed if it develops in such a way that the front-line, or personal doctor, is seen to be inferior to the specialist or hospital doctor. It is quite pointless to castigate the GP for his deficiencies. The basic faults of general practice which form the basis of his discontent are endemic in the present organisation of the health service and in the concept of the GP as the complete, all purpose doctor.

Integration of community or domiciliary care and hospital care. This means that a reorganisation of services must be considered which substitutes for the present tripartite arrangement, a single cohesive medical service, that will achieve a more rational and patient orientated system.

Collaboration between the GP and the other domiciliary workers. Home nurses, social workers, health visitors, etc., do not now function efficiently because of the fragmentation involved in the tripartite system.

GP diagnostic aids. We have shown that the GP must be allowed easier access to and greater knowledge of these important tools especially in the developing field of preventive medicine. Better education for the primary diagnostician, both during his initial training and throughout his career, so that he can keep pace with advances in medical science.

Automation of records and medical procedures. Automation has not as yet touched the general practitioner, but must be considered as a necessary tool for medical services in the very near future. This requires specific planning.

More humane hospitals, more patient-orientated, than they are at present. These would provide a pleasanter environment for both patients and staff. Attempts to make in-patient treatment more informal, particularly for children and maternity cases, are making some progress, but more determined efforts are needed to break down the hierarchical traditions, which are a barrier to the introduction of less autocratic methods of care. We shall suggest that the domiciliary workers, both medical and non-medical, may be able to make important contributions to the solution of this problem.

5. a new plan for health

The solution which this pamphlet advocates is very largely an extension of the plan outlined by Laurie Pavitt in his pamphlet entitled *The Health of the Nation*. (Fabian Research Series, 236, 1963.) He attacked the present tripartite system, with its three separate administrative organisations; the regional hospital boards, 15 throughout the country, responsible for the development of the hospital service, and acting as employer to the hospital doctor, with day to day administration in the hands of a series of hospital management committees, each of which controls a group of hospitals; the local health authorities, numbering 148, which are responsible for sanitation and the control of infectious diseases as well as a growing series of welfare functions, these include the school health services, the care of young infants and their mothers, home helps, home nurses and health visitors and the mental health community services and care of the aged and physically handicapped, and the local executive council, 138 of these, roughly co-terminous with the local authorities, which appoint GPs, dentists and pharmacists and are responsible for what are called the general medical services. This segmentation and the developments within each grew up largely for historical reasons, and the many disadvantages of this divisive organisation are becoming increasingly apparent.

Pavitt argued, and we whole-heartedly support this, that these services should be amalgamated on a regional basis, so that one authority is responsible for all these services within a given area. The regional hospital board should be integrated with the other branches of the service now administered by the LHA and the executive councils, and integration should be carried down to smaller units such as the area health boards, outlined in the Porritt Report. (*Review of Medical Services in Great Britain*, Social Essay, 1962.) Each area health board would control a group of hospitals, including general, specialist and chronic hospitals providing all the in-patient requirements for the population of the area, and around which the community and domiciliary services could centre. Pavitt suggested that the adapted

regional board in this scheme should be re-named the Regional Health Services Centre, and the general hospital, with its domiciliary staff, be called the Health Services Centre. This terminology will be used throughout the remainder of this chapter.

the McKeown Plan

Where our argument differs somewhat, or rather extends those outlined in *The Health of the Nation*, is in the position of the GP within this frame-work. In 1962, Professor McKeown (*Lancet*, May 1962) the Professor of Social Medicine at Birmingham, suggested that we need to re-examine the whole concept of the GP as the all purpose doctor. He recommended that we should consider, in place of the GP, four types of front-line personal doctor who would work both inside and outside the hospital.

McKeown's four types of personal doctor were paediatrician, obstetrician, general physician and geriatrician, one doctor for pregnancy and childbirth and one each for the young, the adult and the old. The value of this concept is that the front line doctor could narrow his field in a way which would be understood by his patient and which fits the existing division of medical labour. By this system we could retain the concept of the front line primary diagnostician, who is not an organ specialist, and at the same time limit the range of conditions with which he must be competent to deal. The patient would not have to decide for himself whether he needed a neurologist or a liver specialist; he would go to his personal doctor who would be backed up, where necessary, by the super specialists.

Not surprisingly, these suggestions were received coldly by GPs, but the actual criticisms of the plan were superficial and easy to answer—for instance, whether four different doctors would be needed for a family with gastro-enteritis. In fact, the logic of McKeown's suggestions has not been seriously challenged and indeed other countries have demonstrated that co-operation between doctors can replace

the attempt to combine superhuman skills in a single man. The family health maintenance demonstration at the Montefiore Hospital in New York is a particular example of a successful organisation of domiciliary teams which combine doctors, nurses and social workers. (Gordon Rose, *Medical Care*, October 1963.)

community surgeries

This arrangement would allow the continuation of domiciliary care, for each team of doctors would be responsible for the care of patients in a flexibly defined portion of the hospital catchment area, and would work both from community surgeries and also from clinics within the adapted general hospital now called the health services centre. These doctors would make domiciliary visits, like GPs, but would work with the other domiciliary workers who are at present attached to the local authority. Night care could be organised by a mobile squad from the centre casualty department.

We are avoiding the term health centre because this usually implies characteristics different from those that we envisage for community surgeries. Health centres are the base from which GPs and paramedical workers practice, but the centres are not normally planned to house diagnostic equipment such as X-ray apparatus nor do centres employ laboratory technicians. Health centres are also planned to house GP records. They are normally run by the LHA and many doctors object to the idea of being dependent for the day to day organisation of his working premises on a body which is controlled ultimately by a non-medical legislature. They are quite separate from hospitals with which they have no administrative and slight functional links and so do not help to increase the domiciliary doctors' contact with advanced medical techniques and knowledge. Many of these criticisms, particularly the last, apply equally to the new group practice premises to be set up through the Finance Corporation. The community surgeries would house only examination and waiting rooms, at least in most urban areas,

but having strong links with the hospital could use the hospital diagnostic and teaching facilities including libraries and lectures as well as ready consultant advice. They would be the outpost of the combined health services in the community and bring together hospital and domiciliary services on the patient's doorstep, so to speak. Duplicate medical records would be kept at both the health services centre and the community surgery and would include details of in-patient treatment which nowadays (and in the health centres) domiciliary doctors do not see.

General physicians and indeed all the four members of the community team would be trained to undertake some psychiatric treatment or at least be better equipped to recognise mental illness than GPs are at present. A psychiatrist would, of course, be available for out-patient treatment at the health services centre, which might also run a small in-patient unit or day hospital for psychiatric patients. Under this integrated service it would probably be possible to place more care in the hands of mental welfare officers and psychiatric social workers than is usual at present. This would make their work more satisfying and also relieve the doctor's work load.

the personal doctor

The personal doctor element would be preserved, with the reservation that this doctor would change at appropriate stages throughout the individual's life. This is not such a radical departure from the present system as might at first appear. The principle that a child receives treatment from a doctor who does not attend its mother has already been accepted through the operation of the school health service and the child welfare clinics. In many ways this would be an improvement on the present system, because the child would be attended throughout his childhood by only one doctor, who would be a close colleague of the one attended by the mother and be readily accessible to her. A mother and her young child might sometimes be

treated by the same doctor, for instance, if both were suffering from the same minor complaint. The system should be sufficiently adaptable to allow for this kind of overlap. Similarly the age at which the individual transferred from one doctor to another should be fairly flexible, so that it coincides with the normal changes in his life. In particular the transition from the general physician to the geriatrician should not be forced if the patient did not wish to change and remained in the same area and the physician who had attended him during his adult life was still available. In fact, the Montefiore demonstration has shown that a team of doctors, nurses and social workers, working from a hospital, can successfully look after its own group of patients, without loss of personal care.

The patient's personal doctor could, indeed, be more intimately involved than at present in decisions about the pattern of care provided for his patients throughout the course of an illness, especially the crucial transition between residential care and the home. The personal doctor would be actually on the staff of the health service centre and could therefore participate closely in the decision to admit or discharge his own patients. He would also have the close contact with the community services, which he now lacks, and which would enable him to mobilise these whenever appropriate.

This kind of specialisation, plus the complete integration of all doctors into the health services centre would allow for the improvements in competence and use of technical aids to diagnosis that are essential. For urban areas it is no longer sensible to think of front line doctors working mainly from what amount to slightly modified private homes. The conventional solution, heavily equipped hospitals surrounded by health centres which have neither X-ray facilities nor pathological and biochemical laboratories, will only perpetuate the split between hospital doctors and those who are working in domiciliary care. The latter would still be divorced from the stimulation of the hospital, and the most recent advances in knowledge and technique.

Hospitals have been strongly criticised for being inhuman institutions, but this is no argument for segregation. We need to change the institution, not to segregate some doctors. We are only just beginning to study the sociology of hospitals, but early results are encouraging, and these have definite implications for domiciliary care. Revans' team in the Manchester area has shown that hospitals which have a rigid authoritarian structure not only lose more nurses during training but discharge patients more slowly than hospitals with a more flexible democratic organisation. (*Standards for Morale*, OUP, 1964.) It is very likely that to have more members of the hospital staff working out in the community will have beneficial effects on the institution. We need to study more closely rather than opine about the social or institutional aspects of the hospital, and experiment to find out how these aspects can be improved.

HOSPITAL AND DOMICILIARY LINKS

If doctors doing home visits are to be based on adapted general hospitals, this raises the question of whether the arbitrary size of the district general hospital, laid down in the hospital plan, is too large. In an area of very high density, such as Greater London, with 9,000 or more per square mile, this would mean that each hospital served a catchment area of about ten square miles, with no-one living more than one to two miles away from the nearest hospital or health services centre. At present there is roughly one GP for every 2,300 of the population, and assuming the same number of doctors, and adding in those who now serve in the local authority services, this would allow each hospital to have about 50 attached community doctors.

It is possible to make some estimate of the ratio of the McKeown front line specialists required by the proposed plan, although clearly research would be required to establish the optimum pattern. At present the GP spends between five per cent and ten per cent of his time on obstetrics, 20 per cent on children, ten per cent on the over 65s, and 60 per cent

on the 15 to 65 age group. (D. L. Crombie, *Lancet* letter, 1962.) On this basis the ratio of community doctors specialising in the four age groups would be six general physicians to two paediatricians to one obstetrician to one geriatrician. In fact, this does not accurately reflect all the work now being done in the community, because it does not take account of the contribution made by the local authority doctor and clearly studies are required to establish the appropriate case loads or grouping for particular communities. Also with the complete reorganisation envisaged, these doctors might undertake many duties which they will not at present, and relinquish others. With these qualifications in mind, however, the above figures suggest that the community health team could conveniently work in groups of six, consisting of three general physicians, one paediatrician and two part-time doctors dealing with obstetrics and geriatrics. The latter might spend the remainder of their time in hospital posts or a neighbouring community health team. Each team would serve a catchment population of about 10,000 patients, covering an area of just over one square mile, with no-one more than half a mile away from the community surgery.

Where densities are lower than this, the services would be spread more thinly, but since 80 per cent of the population live in densities of over four and a half thousand per square mile (Registrar General, mid-1962 Census Estimation), most people would live within three and a half miles of their local health services centre and three quarters of a mile from their community surgery. This would not make the scheme impossible to operate, but in fact there seems to be no evidence that 600 beds is necessarily the optimum size for a general hospital. Were we to plan for hospitals or health services centres of about 300 beds, which would serve populations of about 50,000, we could give relatively easy access to modern medicine for about three quarters of the population, all of whom would live within one to two miles of their health services centre. Much of the care of the patient, who is up and about could be

carried out from the modified out-patient department, largely staffed by the community health teams who would undertake the domiciliary care.

low density areas

As an alternative to reducing the size of the hospital or health services centre we could consider the building of diagnostic and treatment centres which would be closely linked branches. The six to eight hundred bedded health services centre could therefore have one or two peripheral centres which would house diagnostic equipment and teams of medical and para-medical staff. Some adaptation on these lines would be necessary for the areas of very low density. It would be necessary to plan specifically according to the distribution of population in these areas, and for example the most appropriate solution for a scattered agricultural population would not necessarily be suitable also for the nucleated mining village.

Whichever plan were adopted, we should clearly have to alter, fundamentally, the administration and design of the present hospital out-patient department, and adapt it to the needs of the health services centre. The vast, unfriendly waiting halls would have to go, as indeed would the delays before patients were seen. Fortunately, some work has already begun on these aspects of out-patient care, which indicate that such features can be modified.

hospital grouping

Hospitals would be grouped in such a way that, within each area board, or its subdivisions, the full range of residential services required by the catchment population could be provided. One hospital management committee or its equivalent would then consist of a number of health services centres, equivalent to the present general hospitals, and in addition whatever special hospitals were required together with units for the chronic sick, the chronic mentally ill and the subnormal.

This would facilitate a ready interchange of staff and of ideas between hospitals for the acute and the chronic sick, and allow the latter easy access to the diagnostic and pathological investigations which could be provided by the health services centre. This solution would provide all the technical advantages of the McKeown balanced hospital community (*Lancet*, 1960) without the necessity of housing all acute patients under one roof in a large institution, or severing staff and patients in the chronic units from contact with others. The chronic units could be served, in part, by staff who worked for periods in the acute units also, and this would improve the recruitment of staff and the physical care available to the chronic sick.

area integration

This kind of organisation would also unify the tripartite structure of the NHS. The health services centres would become responsible for all aspects of health for their defined populations, and the public health staff would also be based there. The welfare functions of the local authorities would also be transferred to and based on the centres, which would be grouped under the area health boards in such a way as to give sufficiently large populations for these activities to be efficiently undertaken. It follows, of course, that the administration of the general medical services now carried out by the executive councils would also be shifted to the centre.

One of the main advantages of the reorganisation of services which we have proposed, would be the proper integration of all the residential and domiciliary services now existing for the sick. There are a number of areas where such integration would greatly improve the operation of services, save time and valuable manpower, and most important of all, provide a more flexible service which could be tailored to the needs of the individual. The advantages of the integration of hospital and community services with regard to the field of maternity and child care have already been mentioned. It is per-

haps easiest to illustrate this point, however, from the field of mental health, where over the past few years great emphasis has come to be placed on community care. Here the split between GP, hospital and local authority greatly impedes the satisfactory resolution of the patient's problems.

present problems

At present the hospital doctor, who often has little knowledge of the inadequacies of facilities available for patients in the community, is responsible for the discharge of many patients who are suitable for life in the community, but only with a battery of supporting services. Even when the doctor knows that discharge under these circumstances is not appropriate, there may be irresistible pressure to discharge from the hospital administration or from the patient himself. The solution to this problem, more hostels, sheltered workshops, domiciliary social work, etc, does not lie within the compass of the hospital, but is regarded as the function of the local authority. If the local authority is not willing or cannot afford to provide these services it is the patient who suffers and the taxpayer who pays, since these patients often remain on National Assistance indefinitely, or until they are eventually returned to hospital. Because of the inevitable demarcation disputes, local authorities are unwilling to provide some services, for example, hostels for long-term care, because they regard these as the responsibility of the hospital, while hospitals cannot raise the capital to do this because they are told that this is the duty of the LHA.

Very many local authorities are so small that they simply do not have a catchment area large enough to support the variety of services required. For example, a rural authority with a population of a few hundred thousand, containing only a few hundred mentally subnormal patients, cannot be expected to provide a junior and a variety of senior training centres, a hostel for subnormal adolescents, a long stay hostel for older people whose parents have died, and a weekly residential unit

for those children living too far away from the training centre to travel daily. Yet there would be some patients in the area needing each of these services. Because of the great discrepancies in size and wealth between LHAS and their ability to provide community services, Dr Kathleen Jones has suggested that we have created instead of a welfare state a series of welfare areas. (Annual Conference, British Sociological Association, 1965.)

a single service

The rational solution to these inequalities surely lies in the integrated service we have suggested, one based on a defined catchment area, within which a single authority is responsible for organising both the residential and the community health services. A range of services can then be provided which link up the patient who has to spend long periods of time in a residential unit, with other services which are shared with patients living at home. Thus the same training centre, rehabilitation unit or physiotherapist would serve both those in hospital and those at home. We must bear this long term aim in mind when we consider any changes in the position of the GP, whose co-operation would be vital in this integrated service.

THE GP'S ATTITUDE TO THESE CHANGES

There are so many conflicting attitudes expressed by the medical profession in this context that it is very hard to assess precisely what their reaction would be to such a scheme. However, there is some evidence that the younger doctor at any rate would welcome many of the features of this plan, and would be prepared to accept others.

A survey carried out by the Wessex Regional Hospital Board, showed that two thirds of all doctors in the region wanted an attached nurse or midwife to help in their practice. 76 per cent of doctors in the age group 25-34 wanted more responsibility in the fields of school health, infant welfare, mental health and

care of the aged and handicapped. About 40 per cent showed a desire to obtain more out-patient hospital work on a part-time basis, and this was so in 63 per cent of the age group 25-34. 82 per cent wanted closer integration of the three arms of the service with some interchange of medical and nursing staff. (Wessex Regional Hospital Board, *What do they really want?*, 1964.) In Abel-Smith and Gales' study of the reasons why doctors had emigrated only nine per cent gave socialised medicine as their reason for going abroad. The majority cited the wider field of work which they could undertake in other countries and criticised the limited role of general practice in Britain. (B. Abel-Smith, K. Gales, *British Doctors at home and abroad*, 1964.)

Although there does not seem to be much support for remuneration by salary this might well be improved if the employer were to be the regional hospital board, and the doctor given the same status and comparable conditions of service to consultants. This would not necessarily involve equal rates of pay, unless the community doctors were as well qualified, and with as much post-graduate training as his consultant colleagues.

No doubt conservative medical opinion would not support the more radical aspects of this solution. However, we are not suggesting that all these could or should necessarily be introduced immediately. It is important, however, that the Minister does not allow the more irresponsible members of the profession to force him into short term solutions which might prevent or hinder the type of comprehensive planning we suggest.

6. towards health services centres

Clearly a network of new hospitals cannot be built overnight, nor can staff who have been used to isolated work suddenly be asked to work in these centres. Having defined the long term aims in the reorganising of the health services we can, however, assist the changes that are already occurring, and which will lead in the right direction.

grouping

The plans announced in the Joint Report of the Minister of Health and the BMA on 2 June, 1965 included the granting loans to GPs to enable them to build and staff group practices. This is obviously a very necessary step, but it is important not to spend money in this way, without regard to the local plans for future hospital and LHA provision. Here we have an excellent opportunity to initiate joint discussions between regional boards, the local authorities and the executive councils. The three arms of the health service could then co-ordinate plans for developments and decide, according to the particular conditions of the area, what is required in the way of new premises and staff for GPs. Only on the basis of such information can the Minister judge when called upon to authorise grants through the proposed GP Finance Corporation. There seems no reason why the Minister should not take direct action to encourage such discussions.

clinical assistantships

In order to improve collaboration between the primary diagnostician and the hospital services, GPs should be encouraged to take up paid clinical assistantships in hospitals, or where this is not possible, at least be invited to take part in clinical meetings for his own patients. Birmingham RHB is already well advanced with the policy of appointing GPs to hospital posts and the Wessex Region has been operating such a scheme with great success for several years. The initiative here lies largely with the RHBs but the Ministry could circulate information on those schemes already in existence, point-

ing out the advantages for the hospital and the patient as well as the general practitioner. It is preferable, however to restrict the GP's hospital work to a specialty relevant to domiciliary work. The specialties open to him, therefore, would be paediatrics, general medicine, gynaecology, obstetrics, psychiatry and surgical diagnosis (not theatre work).

specialisation

The combination of domiciliary and hospital work on the lines suggested by McKeown is already being quietly carried out in some fields. The most striking example is in geriatrics, where it is now customary for geriatricians to do a large number of home visits. In paediatrics too there is a small but successful experiment in hospital-based domiciliary care run by St. Mary's Hospital, London. The obstetric flying squads are another variation in the same trend. The primary diagnostician should be encouraged to co-operate in this process and be allowed to specialise in the way suggested through clinical assistantships, and relevant post-graduate training courses. The advantages of doing so and the benefit to the patient should be discussed if possible with doctors who are applying for group practice loans.

hospital interest in domiciliary care

Similarly we should welcome the interest of some hospitals and specialties in community care. Although the general pattern of epidemiology is changing from isolated episodes of acute illness to frequent spells of chronic illness, the effective control of chronic illness needs hospital facilities. We should therefore welcome the tendency of hospitals to follow-up their patients for prolonged periods. The follow-up, however, should be carried out by the relevant member of the domiciliary team in fact the patient's personal doctor, in his capacity as clinical assistant.

Another short term measure towards this general aim would be to build more maternity units in general hospitals and to encourage more mothers to have their

children in these units. There is no medical justification for childbirth at home. Acute emergencies cannot be predicted with sufficient reliability to justify the risks of deliveries outside hospital.

obstetrics

The benefits of integrating obstetric care around a hospital as the centre is excellently demonstrated by Aberdeen. Indeed, in Scotland since 1948 the teaching hospitals as well as other hospitals have become an integral part of the hospital service. The perinatal mortality in the city of Aberdeen (all parities) in the years 1953-62 was 27 per 1,000 compared with 37 per 1,000 in the urban areas of the north in the 1958 Perinatal Mortality Survey. This is despite the fact that Aberdeen women are much shorter on average than other northern women and they would therefore be expected to have poorer obstetric experience. All Aberdeen women having their first babies are delivered in one teaching hospital.

In reporting the Aberdeen experience at the Royal Society of Health Congress in 1965 Professor Sir Dugald Baird closed his paper with these three paragraphs: "My experience in obstetric practice in Aberdeen is that the team approach backed by careful analysis of the problems, careful checking of the results of treatment and when indicated, the practical application of the results of research, can lower perinatal mortality more quickly and to a lower level than is possible by more haphazard and more individualistic methods.

"Maternity hospitals have been criticised because the patient may be examined by a different doctor each time she visits an antenatal clinic and that the midwife or obstetrician in attendance at the birth may be a total stranger to her. In the best hospitals every effort is made to minimise such undoubted disadvantages, although the organisation necessary to supply a complete service of the highest standard day and night, year in and year out, makes organisation on a team rather than an individual basis essential. In my exper-

iences most women, if treated with skill and kindness by midwives and doctors who obviously know their job, find the system not unattractive psychologically and they also feel safe and secure.

"The virtual disappearance of domiciliary midwifery in Aberdeen—which is primarily a decision of the patients themselves, since we have seldom refused a patient nor have we campaigned in favour of hospital delivery—is possibly some indication that a well planned regional maternity service, based on a central hospital, can be attractive as well as efficient."

Resistance to hospital care does seem primarily to be because many hospital maternity services have earned a reputation for being singularly inhuman. An important step in overcoming this could be integration between hospital and domiciliary services on the lines we have suggested. The obstetrician and nursing staff working in the hospital would then also run some pre- and post-natal sessions at the group practice or community surgery, and be in close contact with the other domiciliary staff working there.

One major cause of the institutionalisation now present in hospitals, is the simple fact that many hospital staff rarely have experience of conditions or relationships outside the hospital, and therefore tend to acquire a rather distorted view of their patients.

build up the domiciliary services

We must extend the domiciliary paramedical services. Efforts should be made, in particular, to recruit the trained married women who no longer work, but who might be brought back into this field on a part-time basis, and these should be encouraged to collaborate closely with the GP. It is estimated, for example, that in every general practice there are between three and four trained SRNs, who could do part-time work. Advertisements in GPs' waiting rooms, for part-time nursing or home help attachments to the practice, might well have the effect of tapping

sources untouched by less direct appeals.

hospitals

We need to review the size of the district general hospital, according to the density of population in the area that it serves. In fact, it appears that proposed plans are often designed to increase hospitals above the six to eight hundred beds suggested by the Ministry. (Peter Cowan "The size of the hospital", *Medical Care*, January 1963.) It is important to establish whether this is compatible with the aim of integrating residential and domiciliary services.

Hospitals should be re-grouped so that each HMC contains all the residential services necessary for its catchment area. (Brian Abel-Smith, "Hospital planning and the structure of the hospital services", *Medical Care*, January 1964.) In this context greater use could be made of the smaller hospitals scheduled to close down in the Hospital Plan, which might be suitable for the chronic sick, the mentally ill, or the subnormal, so that these patients would not have to be housed in large institutions situated outside their own catchment areas, as so many do at present. Hospitals cannot co-operate in planned community care if the patients' homes are not within reasonable distance. Staffing of hospitals might also be easier with these smaller units.

LHA welfare function

Local authorities should be encouraged to experiment in schemes for collaboration with HMCs, if necessary the Ministry of Health compensating the authorities financially if they voluntarily give up control of hostel and special centres. This would also have the added advantage of removing some of the burden on the rates.

pay

Negotiations for changes in the method of payment for GPs are to proceed

throughout the coming year. The Minister should press for the acceptance of a salaried service, if not immediately, at least within some stipulated time period. Without this it is hard to envisage the development of a proper career structure for the primary diagnostician, so that doctors who continue their education and attend post-graduate training courses can be paid according to their improved qualifications. Payment by salary would also facilitate the flexibility of sessions necessary to allow doctors to take part in clinical work or case conferences in the hospital.

experimental schemes

Hospitals, and in particular teaching hospitals, which are at present in a unique position outside the jurisdiction of the boards, should be encouraged to experiment in setting up schemes modelled on the McKeown approach. GPs working in the catchment area of the hospital could be invited to accept appointments on the hospital staff, to group and specialise and to combine domiciliary and hospital work in the way we have suggested. If doctors could be shown that such co-operation need not interfere with clinical freedom but indeed extend the practitioner's field of responsibility, the initial anxieties about the plan would more readily be overcome.

education

There has been much complaint over the years about the lack of adequate training or post-graduate education for GPs, and there has been some headway in improving this. It is essential, however to take more concerted action to improve the training of the domiciliary doctor, and to recognise that his education needs to be planned as carefully as that of the hospital consultant. At present most doctors do not receive any special training for work in the community, apart from a few short periods of attachment to a general practice. All doctors are trained as if they are going to be hospital doctors or organ specialists, and not enough attention is

given to the needs of the student who intends to work as a primary diagnostician, the front line doctor in the community. At present there is no proper career structure to general practice and this is undoubtedly one of the factors which contributes to the feeling that general practice is inferior to hospital medicine, and the sense that many GPs have that they are regarded as failed consultants. Undergraduate teaching is almost entirely in the hands of the hospital doctors, and few courses of instruction or tuition are given by good general practitioners.

A BMA report, as long ago as 1950, proposed a special three year training for the general practitioner, the first year of which would consist of supervised work under selected GPs. During the second year the student would return to the hospital and work in specially designed appointments, largely connected with those specialties related to general practice, while in the third year, the student could spend some time specialising further in the subjects of his choice, serve limited periods as clinical assistant in the hospital, or obtain short locum appointments in approved general practices. (*General Practice and the Training of the GP*, BMA report, 1950.) The Wessex Regional Hospital Board has been operating an in-service scheme on these lines for some years. (J. Revens, "Integration of the GP with the Hospital", *Medical Care*, 1964.)

Perhaps more important is the necessity to improve post-graduate training courses and refresher courses for the front line doctor, so that he can improve his knowledge in his chosen specialty, and keep up to date with recent advances in medicine. At present there are few such courses, specifically for GPs, and little financial incentive to acquire higher degrees, like, for example, Membership of the Royal College of Physicians. Medical schools and teaching hospitals should be encouraged to develop such courses. This would obviously presuppose the introduction of a salaried service, scaled in accordance with qualification, and with paid secondment for further education courses. Doc-

tors chosen to participate in the preliminary service training schemes could also be paid additionally for their teaching responsibilities.

regional administration

We do not wish to underestimate the problems involved in the administrative changes required to complete the full integration of the three arms of the health service. Similar problems will arise with many other aspects of local government when Labour Party plans for the extension of regional administration are implemented. It would be sensible to consider the particular problems of the regional planning and organisation of the health services whenever the reform of regional administration is discussed. In the meanwhile, collaboration between the three administrative divisions of the health service should be encouraged and developed in such a way as to facilitate their eventual amalgamation on a regional basis.

THE REAL PROBLEMS

There is an urgent need for research into the siting of medical and nursing services. How far can patients and relatives reasonably travel? What is important, the time for the journey or the convenience of the transport used? How many community surgeries would we need around the health services centres, particularly for the care of infants, mothers and the old? We also need to understand much more about why patients consult doctors. Many people dose themselves for illnesses for which others consult doctors. Which pattern of behaviour should we encourage?

Modern medical care needs team work. What changes in medical education will enable us to train doctors both to carry responsibilities and to be able to collaborate easily with other workers? On the patients' side, how can we help patients to identify with their health team rather than search for a single father figure? (There are suggestions from the States that patients can place their confidence with a group rather than with an indi-

vidual.) How can we make our hospitals more humane, so that patients would feel happier at the prospect of residential care? Would the integration of domiciliary and hospital services and the sharing of staff break down the rigid hierarchies at present so typical of hospitals?

If health services centres are to be the future pattern, what size and density of population can they cater for most efficiently? What special adaptations are required for different types of rural area?

operational research

We have suggested the lines along which experimental schemes could be set up, which would provide the facts necessary to answer these questions. Britain has an unenviable record for devising expensive social services based on inadequately tested theories. Too often far reaching changes have been implemented, without first undertaking research or experiment to establish that the changes are in fact an improvement or do produce the intended progress.

We are all agreed that the NHS does not function as efficiently as it might, but before we initiate widespread changes, let us develop experimental schemes to test out our proposals and develop medical statistics so that we can ascertain what are the present needs and deficiencies and evaluate the effect of intended reforms. We need more operational research on health services, more epidemiology and more sociological studies. To do this we must attract more statisticians, social scientists and doctors into this field. It seems that the medical schools have failed to encourage sufficient expansion of these disciplines. The Ministry of Health and the regional boards must assume more responsibility for producing the basic information necessary to run the service. The more enterprising boards, such as Wessex, have shown that they are in an ideal position to obtain information about services and to initiate reforms. Laurie Pavitt suggested that a central planning department be set up within the

Ministry, responsible for all sectors and utilising research projects and promoting others. It is most important that this proposal be implemented rapidly, so that we can begin to collect the relevant information to develop a more rational and integrated health service.

yfg

the authors

The Young Fabian Group exists to give socialists not over 30 years of age an opportunity to carry out research, discussion and propaganda. It aims to help its members publish the results of their research, and so make a more effective contribution to the work of the Labour movement. It therefore welcomes all those who have a thoughtful and radical approach to political matters.

The group is autonomous, electing its own committee. It co-operates closely with the Fabian Society which gives financial and clerical help. But the group is responsible for its own policy and activity, subject to the constitutional rule that it can have no declared political policy beyond that implied by its commitment to democratic socialism.

The group publishes pamphlets written by its members, arranges fortnightly meetings in London, and holds day and weekend schools.

Enquiries about membership should be sent to the secretary, Young Fabian Group, 11 Dartmouth Street, London, SW1; telephone Whitehall 3077.

This pamphlet was written by a group of three Young Fabians, two of them medical practitioners and one a psychologist, and all three with both research and clinical experience. The idea of this pamphlet was originally inspired by a weekend seminar on the health service organised by the Young Fabian Group in Spring 1965.

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