“The Future Place of the Personal Physician”

By

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THE SPEAKER

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THE SERIES

The Lecture Series was established in the name of Michael M. Davis, medical care pioneer, by his friends and admirers. Mr. Davis opened the series in 1963 with an address entitled “America Challenges Medicine.” Each year a distinguished leader of medicine, the social sciences, hospital care, social welfare, government, labor or management is invited to address persons interested in the improvement of medical services. The intention is to stimulate free and open discussion and to furnish a forum in which medical care programs may be proposed, examined, and presented for public consideration.

THE OCCASION

Dr. Godber delivered this talk at Billings Hospital, the University of Chicago, on May 7, 1969.

THE INVITATION to give this seventh Michael M. Davis Lecture came as a total surprise. It is a privilege that could not have been more welcome to one who has enjoyed the friendship of Dr. Davis and his family for more than twenty years and has admired and received inspiration from his own and his son’s work through that period. This is not the place for a eulogy, but in preparation for this occasion I have re-read “Medical Care for Tomorrow”—with us for fourteen years and still bearing an antithetical title—and read for the first time the first lecture in this series in which Dr. Davis provided what could have been texts for those who were to follow him for many years to come. Most of us spend our time cultivating in depth some small area in fields of personal health services or operate much more superficially, and with understanding which must decline with the passage of years, over a much wider area. Mine has been the second of these functions, and in Britain where the organisation is so different from your own. Perhaps the most striking of those differences is the extent to which we have depended in our National Health Service, and expect to depend, upon the work of the personal physician who undertakes primary medical care and is the means of access to the ever more complex system of specialist service which is complementary to his work.

In his Michael Davis Lecture last year Dr. Arthur Engel described the evolution of a system which has given Sweden one of the best health records in the world. Over more than a century the county councils in Sweden have evolved their
hospital system and they now also administer the district medical service, which is the nearest thing to British general practice they have. Their service is thus administratively unified but, like our own, has serious divisions in function, especially between care in the community and the hospital and specialist services. Elsewhere in Scandinavia the same division occurs and even in Denmark personal physicians work single-handed with even less contact with hospitals than in Britain. Yet the intention in these countries, as in Britain, is that the public will first seek medical care from general practitioners and will only be sent on for specialist help if the general practitioner requires it. This has been the common situation in the past throughout Western Europe, but the growth of specialisation has gradually led patients in most countries to seek specialist help direct where there is no rule to prevent it. In your country that process has gone further and faster. Dr. Davis made the point in the first lecture in this series that four-fifths of your younger graduates were training for specialties, and three years later Dr. Coggeshall said that over 85 per cent of new physicians enter specialised practice. The changing trend is not merely recent; Dr. Davis said that in 1931, three-quarters of all active physicians in the United States were general practitioners, but by 1963 60 per cent limited their practice to a specialty. By comparison, in Britain there are roughly 21 doctors in general practice to 23 in hospital work, including junior staff, and there are two principals in general practice for each established specialist in hospital.

Other Systems

In Eastern Europe planned development has gone much further. In the U.S.S.R. there is one physician for every 450 persons. Each district with a population of about 1,800 adults has a uchastok doctor to provide primary care, but he is not responsible for the care of children. In a city he will work with perhaps 20 others from a poly clinic which also has a full staff of specialists, to whom patients may go direct, and which serves a population of 50,000. Yet other specialists will treat those patients who are admitted to hospital wards, and these patients on discharge may be supervised by different physicians again. As a shift system is worked, it is hardly possible to say that a personal physician exists.

In Yugoslavia the system is nearer that of Britain; the generalists are grouped in medical centres and serve a defined population, but the specialist health centres may receive patients direct and their links with hospitals are less close than they would be in Britain.

In a country such as Brazil the doctors are concentrated in the larger towns and most of them work in a specialty. Many patients go direct to hospital in the event of serious illness, or to ambulatoria staffed by specialists for primary diagnosis and treatment if they are not acutely ill. Continuing care by a personal physician is the privilege of a very few.

In India again it is difficult to get medical care outside the large cities, and only the few have personal physicians; many with acute, possibly communicable diseases seek assistance first, and often at a late stage, from the emergency department of a hospital.

In West Africa, where the proportion of physicians to population is very small, little more than emergency diagnosis and treatment at health centres is practicable outside hospitals, which are few. Separate field programmes with mobile units
for the control of some of the communicable diseases may be used. Specialist services and most of the physicians are concentrated in the largest cities; for example, a fifth of all the active physicians in Ghana work at the teaching hospital in Accra. Detached health centres amongst widely scattered rural populations can only offer straightforward emergency services, and continuing contact with the personal physician of one's own choice is, for the great majority, simply not possible.

Population–Physician Ratios

I have mentioned the developing countries to call attention to the fact that for a very large part of the world's population one of the assumptions under which we live—that the need for medical care will be satisfied in one way or another—is simply not attainable. It requires a ratio of physicians to population which a very large part of the world's population will not have within the lifetimes of most of us here. Most countries with sophisticated health services have a ratio of population to physicians of 1,000 to one or less, but in Asia and Africa the ratio may be anywhere from 10,000 to 60,000 to one. For those latter populations medical service is not even at the point from which the U.S.S.R. had to develop 50 years ago, for their ratio then was 7,000 to one. To achieve the standard that we now enjoy would require a co-ordinated, almost military, type of programme spread over many years, with a defined strategy of approach to limited objectives year by year. The lesson of Eastern Europe is that such a programme can be made to work—not that it is a suitable programme for us.

Dr. Engel last year described the logical step-by-step evolution of the Swedish health services, which had the great advantage that they already possessed a unified administration by the time the real sophistication of medical work began. One hospital system had operated over a period of more than 100 years; it led to the development of hospitals of the right size and in the right place before modern methods made concentration for efficiency essential. Competition between comparable institutions in the same place—with the waste of resources of men, equipment and money, that had bedevilled the situation in Britain and in North America—was thus avoided. No such orderly development could occur in Britain until our National Health Service was initiated almost 21 years ago. Without the radical solution of transferring the hospitals to state ownership we could not have made such progress as we have achieved in the last 20 years. The physical reconstruction has been limited by an inheritance of buildings and competing claims on resources, but at least what we have had has been applied to relief of the greatest need.

The administrative pattern of health services in any country must reflect to some degree its social organisation in other ways. The size of the country, the distribution of the population, and the pattern of central and local government all have a bearing on the way in which health services can and should be organised. The British system has been evolutionary, with occasional mutations of which the transfer of ownership of hospitals in 1948 was one. Since then development has shown interesting parallels with that of Sweden, although the system of financing is more akin to that of Eastern Europe and insurance payments play only a minor part. Its peculiar feature derives from the history and present nature of British general practice, and for a true under-
standing of this one must go a little farther back in history than 1948. The process has been well described by Rosemary Stephens in her book, "Medical Practice in Modern England" and the system itself by Dr. Burnet Davis in Public Health Notes in 1949.

British Development

The registration of doctors in Britain, and therefore the control of standards, goes back a mere 113 years. Before the Medical Act of 1856 there had been confusion as to responsibility, and conflict between the physicians (that is, the specialists in internal medicine) on the one hand and the apothecaries (forerunners of the general practitioners) on the other, with the surgeons falling somewhere in between. In the next half century that conflict ended in a fairly clear division of responsibility between specialists on the one hand and generalists on the other. It was to leave the specialists (and particularly the specialists in internal medicine) with the clearly-defined custom that they only received patients referred to them by general practitioners, and also with an assumption of superiority of which of course they were more conscious than anyone else.

Of course there were some patients who evaded this barrier at either end of the social scale, but it was not normal even for the most eminent and wealthy to consult a specialist direct. At the other end of the social scale some poor patients, especially children, might go direct to the so-called casualty departments of hospitals when acutely ill and so reach specialist care. The development of sick clubs and friendly societies toward the end of the last century, and the introduction in 1911 of a National Health Insurance scheme to provide personal physician services for employed work-
ers, helped to crystallise this situation and also to ensure that there were general practitioners within the reach of everyone—geographically if not always financially. Except in the event of accident or other emergency, this also controlled access to hospital. Even the very poor under the old Poor Law system could go to general practitioners, appointed as district medical officers, who could provide what was called medical out-relief for the destitute.

This position was firmly established even in most of the smaller towns where the limited group of specialists having hospital appointments were also in general practice. The two functions of specialist and generalist practice were sharply distinguished. The profession itself was ambivalent about this, some thinking of rural practice away from town and hospital alike as the ideal practice, others regarding general practice linked with a hospital post as the best; but a large proportion had neither position.

Evolution of Specialties

The evolution of many of the specialties has taken place largely during this century. In addition to the physicians and surgeons there were gynaecologists and obstetricians, paediatricians, ophthalmologists, otologists and pathologists in main centres at the beginning of this century, but over most of Britain these specialties were only slowly being separated between the wars, and differentiation was not complete when the health service was introduced in 1948. The one immediate effect upon medical practice after the change in 1948 was to complete, within a matter of two years throughout the country, not only the separation between specialist and generalist but also the differentiation of the specialties. There had
been many general surgeons who undertook traumatic surgery or gynaecology or even otology; there had been specialists in internal medicine who were also paediatricians or perhaps pathologists or even radiologists. The reason for this was simply financial, because hospital work had been unpaid, and private practice outside hospital or in a few special beds in hospital was the only support of specialists. Hospital patients, who were the majority, did not pay fees themselves. Once work in hospital became remunerative, appropriate staff could be appointed in the numbers required, so far as suitably trained people were available. At the same time the division between specialist and generalist was completed because very few generalists remained with hospital appointments in specialties; most of those who were fully trained in a specialty turned to the specialist side of their practice.

The National Health Service Act transferred all but a very few (mainly denominational) hospitals to state ownership. It provided for their administration through regional boards, which determined planning and policy, and through local management by committees in charge of groups serving substantial districts, instead of leaving management to some thousands of individual units. The first ten years of the hospital service were substantially devoted to organising and developing clinical services within each mixed group of hospitals, and to providing a rapid expansion of staff in the specialties. Despite lack of resources for building, and the gross inadequacies of much of the accommodation that existed, a reorganisation of function within each group and great improvement in quality of work was possible. Moreover, these changes could be brought about without the standard dependence on local resources, since the cost was met by the state. Where the need was greatest most could be done, and what building was possible could be undertaken where the need—rather than local wealth—was most manifest. But this process of change established in each hospital group a specialist team which was divided from the general practitioners in function.

Payment for service made it possible to provide the specialists that the community needed, but it also made it possible for the specialists to segregate themselves sharply from their colleagues outside the hospitals, on whom they no longer had to rely for private patient referrals. There were times when feeling in the profession that there were conflicting interests between the two groups became sharply apparent. There was indeed differentiation between them in the adjustment of their remuneration, which was only put right for the general practitioners by arbitration four years after the beginning of the service. There was, in fact, an administrative structure and a system under which a specialist service could be and was evolved; there was no such system promoting evolution in general practice, and it is most unlikely that it would have been acceptable to our individualist profession if it had been proffered in 1948.

When the Health Service was first mooted, there was much talk of health centres where family physicians could work together with those providing preventive services. It was thought that some specialist service might also have been undertaken making the centres outposts of the hospitals. In fact, when the service was introduced, about half the doctors were in some form of partnership and a few were in well organised groups but the other half, especially the majority
of older doctors, were in single-handed practice. What might be thought the ideal relationship of one doctor always available to one patient was the model at the back of people’s minds.

**System of Payment**

The system of remuneration for general practitioners that was inherited from the old health insurance was one of a capitation payment for each person at risk, with a limit of 4,000 on the individual doctor’s list. Expenses were reimbursed in total, but the pay of the individual doctor was not related to the expenses he himself incurred. It was left the doctor to organise his practice as he chose, to provide himself with adequate assistants or not, and to practice single-handed or in partnership. The only limitation was that he had to have approval for the use of a paid medical assistant.

It was a system economical for government, which knew the cost it faced, but it left the doctor to provide all practice requisites and was not calculated of itself to improve the quality of practice, since a doctor could set his standard of practice facility almost as low as he chose. Because of the remarkable stability of practice populations a large list had formerly been a valuable asset which a doctor could sell on retirement, but this procedure was abolished, with financial compensation, by the National Health Service Act.

Clearly this unorganised pattern of practice could not last when the changes that were taking place in medicine itself so obviously required better organisation, and least of all could it stand comparison with the rapidly improving organisation of hospital medical work.

At the insistence of the profession, safeguards were built into the National Health Service Act against compulsion of doctors to change their methods of practice. This Act was essentially devised to make it possible for all members of the public to use the medical care which practitioners as independent contractors were prepared to provide. The physician had a duty to provide all the services needed or to see that patients were referred to other sources such as the hospital. The underlying assumption was that the doctor himself was the one fixed point of contact, but that he would prescribe drugs, usually dispensed by pharmacists, and that parallel services from dentists and optometrists could be used as required by those who needed them.

Patterns of medical practice change slowly, and the public was already familiar with the service as it was. There was therefore no great pressure for rapid change, but there was an immediate—if modest—increase in demand, because service was now free at the time of use to the women, children, and old people who had not been insured previously. However, the established usage of reference to hospitals only through general practitioners, which continued under the new system, prevented a rapidly increasing demand on specialist services. General practice bore the brunt of the immediate change.

**Years of Slow Change**

There have been 20 years of slow change since then—slow partly because any profession is slow to change, and partly because the financial and administrative basis of the service in its original form was not such as to promote change. General practice was simply accepted as if it were a fact of life, and because it was strong enough to carry the immediate burden the hospital service was re-organised almost under its protection.

Dr. Coggshall three years ago said that mod-
ern medicine was really a development of the last 30 years. I think he was a little unfair to the first 35 years of this century which saw the beginnings of radiology, pathology, and cardio-respiratory physiology, but certainly the pace of the last 30 years has not only been faster than that of any earlier period but has been constantly accelerating and is still accelerating.

Most of the scientific apparatus of medicine is in hospitals. Because of the extraordinary speed and range of the expansion of scientific knowledge applied to medicine, specialisation which permits a man to be informed in depth about at least part of his subject has become accepted, despite the resistance that was still evident 20 years ago to some of the fragmentation which now goes unquestioned.

Resistance continues against the further subdivision which must still occur. There are less than 30 medical specialties in which consultant appointments are made in British hospitals now. There are 64 recognised specialties in the U.S.S.R. The figure accepted here (for instance by the Hospital Insurance Plan of New York) is somewhere in between. Yet within specialties like internal medicine or even cardiology there are sub-specialties in which individuals or individual units achieve pre-eminence. While the argument is still going on in Britain as to whether paediatric surgery or urology, for instance, should be distinguished from general surgery, or whether a consultative neurological service is needed in every hospital centre, specialties like neuroradiology, neuropathology, and clinical cardio-respiratory physiology become established in leading centres. Some techniques like those of organ transplantation are developed by specialist teams who may receive patients from clinical colleagues anywhere in the country, while there remain other fields of medicine where such progress is resisted—for instance, physical medicine, because it is said that all clinical specialists should be rehabilitation-minded, although we know very well that they are not.

In the last 20 years admissions to hospital in England and Wales have increased from 2.9 million a year to well over 5 million, despite great reductions in admissions for tuberculosis and other communicable diseases. But the greatest proportionate increase has been in services for traumatic and orthopaedic surgery, gynaecology, such regional specialties as neurosurgery, plastic surgery, and thoracic surgery, while general surgery and internal medicine show less than the average overall increase. In fact, admissions have increased almost entirely because of shortened stay, and the total of days of care in hospital each year has actually fallen.

It is specialisation which has brought more patients into ward care, and it is in supporting services such as pathology, radiology, and anaesthesiology that the greatest increases in specialist staff have occurred. Anaesthesiology is the largest specialty in Britain today and the next two are pathology and psychiatry. Psychiatry also has made great progress, with more rapid and effective treatment, so that fewer patients are retained for long-term care and there is far more outpatient and day hospital treatment. In 13 years, from 1954 to 1967 inclusive, the proportion of the population in psychiatric hospital units at one time has fallen from 3.4 per thousand to 2.7, and in some regions more than half of those inpatients are first admitted to psychiatric units in general hospitals.

I have said that specialisation will go further
and mentioned some specialities which are established, but in which progress is slow. There are others like the subdivisions of pathology, clinical haematology, clinical physiology, toxicology, clinical pharmacology, and human genetics which are underdeveloped over the country as a whole; there are some special departments, mainly in teaching centres, but they cannot meet the needs of a service which sets out to provide for all what it can provide for any.

Financial Implications

The main problem of a National Health Service is this of generalisation. Once it is established that a new clinical service like cardiac surgery or a change in equipment is beyond the research and development stage—as for instance from a valve to a transistorised hearing aid in the 1950’s, or maintenance haemodialysis or intensive care for acute myocardial infarction in the last five years—we must try and bring it within reach of all who need it. It is always relatively easy to get support for a research programme, but the financial implications to a universal service may be enormous. If these can be met, it can be no part of any medical ethic that a service which can meet an acknowledged need can be rationed by the patient’s income alone.

Last year Dr. Engel described the way Swedish services have been deployed nationally, regionally, and locally to meet much the same demand. In Britain a few national centres exist and some of the highly specialised centres in London draw patients from far outside the metropolitan area at least in the development stage (for instance, centres for cardiac surgery in small infants, or heart valve replacement). Special centres were needed for the provision of powered artificial limbs for children with phocomelia after thalidomide. Some of the work on chemotherapy of certain forms of cancer such as chorion-epithelioma has been or is being concentrated in a few centres. Reference centres for microbiology, for poison control and for cytogenetics, special hospitals for mentally ill or subnormal criminals, centres for grossly disturbed adolescents and for control of radiation safety are other examples. Broadly, each of our 15 hospital regions is organised to provide all specialists services apart from such exceptions. Centres have been established in all regions for such specialised work as neurosurgery, cardiac surgery or radiotherapy, and from these consultative clinics are provided in many of the peripheral hospital groups. Other highly specialised investigative work can be undertaken by one or more laboratories for a whole region serving from 1.5 to 5 million people, or even for several regions in, for instance, chromosomal studies or toxicological tests. Before the precipitin tests for pregnancy we had two large centres for the whole country using the Hogben test with specially imported Xenopus toads. One centre currently produces all sera for tissue typing. Some centres are beginning to develop highly automated chemical pathological services which can serve more than one hospital group. Each hospital group provides services in all the ordinary specialities, and through it—or directly—the regional centres are accessible. Through the regional organisation hospital staff can get specialist support in any field.

Hospital Plan

All this is set out in the Hospital Plan published at the beginning of 1962, which outlined the background and future development of a building programme then already under way. A similar
programme for various health and welfare community services was published a year later. Both plans referred to general practice, but neither attempted to incorporate a plan for its development, since the practitioner's status as independent contractor with the health service remained. Yet the definition that has been given to the hospital programme carries with it the logical certainty of some re-orientation of general practice. The hospital plan proposed a network of district general hospitals in every region, each supported by regional centres for some specialties to provide consultative services throughout the network. The concept of the district general hospital is similar to that of the central hospital in Sweden which Dr. Engel described last year. It incorporates provision for geriatric and psychiatric patients and envisages the disappearance of separate special hospitals, small or large. It should serve a district with a population of 150 to 250 thousand, and it is essentially an exercise in concentration and replacement. So much of our existing building is outdated and worn, and despite all the efforts of the 1950s to provide scientific departments to support the use of these old buildings, they cannot often be made fully efficient, and should not be retained for any longer than we can help. District hospitals need the support of special centres at regional hospitals which are usually larger and may be associated with a medical school. The "teaching hospital" is often now a group of several hospitals, some for special purposes, associated with a university medical school; it is not now seen merely as a district general hospital, but every new teaching hospital we build will be a district general hospital with added educational and regional functions. A third of these district general hospitals are built, building, or in

an advanced stage of planning. Many others will consist of the redevelopment or replacement on the same site of existing hospitals, and often some part of that redevelopment has already occurred. There is of course no end to a hospital building programme, but at least one can foresee the day when we reach the stage of hospital building related to planned obsolescence.

Distances Short

A typical district in Britain is far smaller in area than you would expect here. Our population is so concentrated that it is unlikely that 10 per cent would have to travel more than 10 miles to a district general hospital. Our difficult areas might involve for a few people a journey of 45 miles, and in Scotland the distance might be greater still, but compared with the distances you have to face in, say, North Dakota, that is child's play.

Our distances are so short that much consultative and investigatory work can be undertaken in out-patient departments, and indeed consultative out-patient work is of an importance quite comparable to that of the work in the wards. Roughly 160 out-patient first consultations for every thousand of the population take place in a year, and including accident and emergency departments total attendances of out-patients are of the order of 45 million a year. By comparison, approximately 104 admissions per thousand of the population occur each year. Since patients only reach consultative out-patient departments on reference from general practice, it is apparent that a close partnership between generalist and specialist practice is needed. Indeed these out-patient consultations must be seen as the chief points of contact between specialist and generalist practice, with an important effect on both.
Our hospital plan is essentially a building plan. It is a programme to provide the material resources that the specialists of the country need. Yet the hospital is not primarily a building but a group of people working together on behalf of the population served. One can regard the district general hospital as the group practice centre of the specialists working in it. It is inevitable that the subdivision of hospital medicine has made the specialists more, not less, dependent on each other. If this were not so the decision to concentrate them all at a large district general hospital might well be questioned.

No patients now are the responsibility of one specialist alone. Full investigation calls for assistance from diagnostic departments, which in turn must work with the whole range of clinical specialties if their own expertise is to meet requirements. Surgery is powerless without anaesthesiology; modern therapy, either medical or surgical, involves the use of methods which require far closer observation of patients, often using increasingly complex instrumentation.

This support is only practicable in large general hospitals, and these become powerful centralised units which are in some danger of becoming too introspective. We have called the unit the district general hospital and that puts the emphasis where it should be, in that the district comes first. Hospitals as we all know are for patients, not for doctors. Therefore we must see the function of the district general hospital as that of providing a particular kind of service for the population of the district, not as an end in itself.

**Partners of Medicine**

The modern district general hospital not only requires a specialist medical team but also many others who are partners of medicine. Nurses have been the chief partners of medicine for almost as long as medicine has existed. Their training is more scientific—and their remuneration is higher—than ever before, but there is now a large group of other professions which are also supplementary to medicine. They have a varying degree of organisation and they range from the highest levels of physical and chemical science to electronic engineering and various technologies.

The most highly trained in these professions should clearly rank with the most senior doctors with whom they work, and we must expect that non-medical biochemists, physicists, and the like will increasingly take part in the medically orientated teams which are now responsible for medical care. The same point was made by Dr. Coggshall in his lecture, and it has been made most forcibly in the recent report in Britain of a special committee under Sir Solly Zuckerman. There must still be a doctor responsible for the patient's care, but he commonly shares that responsibility with others. For every 10 consultants in the Health Service—that is, fully trained specialists, in our parlance—there are working in the hospitals 15 other doctors, 100 trained nurses or midwives, 170 other nursing staff, 30 scientists or technologists, and 270 other staff. In the related community services there are 20 general practitioners and 15 nursing staff. This group of professionals of all kinds makes up the Greater Medical Profession, and collectively it serves 430 patients in hospital at any one time and 53,000 people outside who need care.

Altogether the district general hospital is an extremely formidable grouping of people, with a forbidding range of skills to be faced by the prospective patient. The selection of his portal of
entry is no light matter. For reasons I have already given, the patient does not have to make this selection himself; his family doctor does it for him. But that means that the generalist must himself know the citadel well enough to make the right choice. He must know which one or more of the large group of colleagues best meet his patient’s needs, and that colleague or those colleagues must be prepared to help and inform him in return. Just as specialisation has made specialists dependent on one another, so has general practice become the largest specialty of all—dependent upon the hospital specialist group, but also depended upon by them.

General practitioners have direct access to radiological and pathological services in hospital, providing about a third of the loads of these departments, and because in this way the reports of specialists are made direct to them, few attempt such work themselves in their own practice premises. Consultative out-patient services, in which specialists are able to investigate and treat patients referred by general practitioners or refer them back with an opinion and recommendations about further treatment, are among the main activities of all hospital groups; group practices containing both generalists and specialists, such as have developed in the United States, are not needed. A specialist group is a hospital group and general practice is practice mainly outside hospital; the two share responsibility for the district and must combine to do it.

Access to Beds

Some critics of British general practice make much of the fact that few have access to hospital beds for the care of their own patients. In fact, nearly one in five has access to beds in hospital, and about one in four has part-time work for hospital authorities in some non-specialist capacity. 260,000 patients were treated by their own doctors in hospital in 1967—more than 5 per cent of all admissions and about a quarter of maternity cases. Nevertheless it is true that two-thirds of general practitioners do not have such facilities, and some, not all, of this majority do desire them. An enquiry in Wessex showed that one in eight did not. The right answer to this must be that even a service which is deliberately orientated toward home care, where this is possible, cannot always provide suitable support where the home is inadequate. At any one time about 20 patients from an average practice are in hospital. Twelve of them are in beds for the mentally ill, mentally subnormal or chronic sick; less than six are in beds for acute medical or surgical cases; only one or two are in beds for internal medicine, and only occasionally will one of these not need specialist supervision. Nevertheless it is wrong that practitioners who could assume such responsibility for even occasional ward patients cannot do so, and in some district hospitals this is arranged.

There is great rigidity in the allocation of beds to individual specialists, and a spurious prestige often attaches to the number so allocated. What is needed is greater flexibility in use of beds, not yet another allocation.

The Health Service also provides, as part of community care, nurses, midwives, and health visitors. These work with patients in their own homes, and are employed by local authorities, not by the hospitals or by general practitioners. The work of the home nurses has always been closely related to general practice, but has been arranged in the past to cover a district rather than the work of a particular doctor or group of doc-
tors. Midwives formerly dealt independently with home confinements, calling a doctor only in case of need, but under the Health Service, since a quarter of all confinements still occur in the home, midwives now work much more closely with doctors. Here again until recently they dealt with patients from an area, rather than a practice.

Public health nurses in the past also dealt with areas and had little contact with general practice. They were based on the Well Baby Clinics, which are the responsibility of local authorities. Obviously all this work needs co-ordination with general practice and that has developed rapidly in recent years. Single-handed general practice with no co-ordination between practices and no attempt to rationalise geographical distribution is singularly ill-adapted to the needs of a community today.

Promote Group Practice

In a few places groups of general practitioners had been formed before the health service began, working in common premises and sharing ancillary help, usually in partnership. Fifteen years ago central funds to promote the provision of group practice premises were first established, since few doctors then showed any readiness to work from publicly provided health centres. Now the actual number and the proportion of single-handed practitioners is steadily declining, while the proportion of doctors in partnerships of three or more is rapidly increasing and already exceeds half the total. Under a new system of remuneration, introduced three years ago, the expenses of a practice, including ancillary help, are met largely by direct repayment, and a special allowance is paid to doctors in group practice. Almost half of all general practitioners were entitled to receive it by the end of 1968.

Fifteen years ago local authority nursing staff were first attached to two group practices, working with the doctors for their practice population instead of being responsible for an area in which many doctors might work. After 10 years of very slow progress this movement is now developing rapidly. Two years ago one in six of all health visitors was working with a practice, and one in nine of all local authority nursing staff. By now those proportions must at least have doubled, and the principle is accepted by the great majority of local authorities and doctors. In several areas all the nursing staff are now attached to practices. In a few groups also, local authority-employed social workers have been associated with practices, and Forman and Fairbairn last year reported on one such group which included five doctors, two health visitors, and a social worker, as well as a home nurse.

In 1948, 10 premises were taken over as health centres; in the next 16½ years 20 health centres were built; in the last four years 66 have been built. During 1968, 39 were opened in England and Wales, at this moment 90 are being built, and 200 more are in various stages of planning.

The implications of all this are clear. Single-handed general practice is unlikely to continue, although of course a few individualists will remain for a time. The normal pattern within a few years will be that the personal physicians will work in groups, and health visitors, nurses, and midwives will join them in those groups. I have a personal dislike of the description “attachment” normally given to this arrangement. Hospital medicine is largely a doctor/nurse partnership in which now, of course, scientists and technologists
are also partners, and practice in the community ought to be a doctor/nurse partnership too. The fact that at present the nurses are employed by local authorities need be no deterrent.

Most groupings of doctors have been originally a result of personal links rather than a deliberately planned organisation of medical care for a district. In a few places, like Dartford in Kent where the doctors joined together in two sets of premises, and Skipton in Yorkshire where there were two groups, this began before the Health Service came into being. In Swindon there was for many years a large health centre for one particular occupational group. Recently, some health centre developments have deliberately provided for all doctors serving the district, and there have been examples—for instance Hyde or Cheadle Hulme near Manchester—of all the doctors in an area forming groups with the same object. It is easy to see where this trend will take us.

**District Hospital**

Our hospital pattern has already emerged with the District General Hospital designed to provide all specialist services for the population of a much larger district than that served by a health centre. Within this larger district common-sense, public, and professional advantage and economy all point towards planned regrouping for the personal physicians, in centres provided by themselves or by health authorities, so as to provide reasonable access for the public and simplified access for the professional staff to the hospital. With nursing staff working with the groups, preventive work in the community—including well baby clinics, antenatal care, and personal preventive measures like immunisation and special screening procedures—can obviously be best developed in such group centres. Within the groups there may be some development of special medical interests in which, too, part-time work in a specialist group in a hospital may be practicable.

But the personal physician should not need to have such a special interest in order to satisfy himself, since his own specialty of general practice will be as important as any. I do not mean that all doctors will now be arbitrarily directed into practice centres planned for them, but rather that the logic of the situation is apparent to the doctors themselves, and the group practice and health centre developments show that in large numbers they are now actively seeking such a reorganisation. Moreover, the new system of payment for general practitioners has made it possible for them to employ the needed supporting staff in their practices with little cost to themselves.

It is obvious that the progressive rearrangement of all medical practice in the district between the district general hospital on the one hand and group practice centres on the other cannot be the end of the story. General practice has become one of the special fields of medicine, admittedly the largest, but still a field of work requiring special preparation and aptitudes and no less skill. I commented earlier on the way in which specialisation in hospital work makes the specialists more, not less, dependent on each other. It makes them, as a group, even more dependent upon the personal physician working in the community.

If there were no specialists the general practitioners could provide a service for most of the illness in the community, but if there were no general practitioners, or their equivalent, the specialists would be overwhelmed. Since generalists and specialists are dependent on each other, there must be a ready communication between them,
and a meeting place. The practice of using outpatient departments for investigation results, in Britain, in a hospital admission rate which is only about three-quarters of that in the United States or Sweden and only half that of Saskatchewan or the U.S.S.R. This also means that there is less participation by general practitioners in in-patient hospital work. For many years they have been less accustomed to use the hospital premises and, therefore, to meet their specialist colleagues than have their counterparts in the United States.

It is in hospital that advanced resources exist, and the contact specialists have with each other helps to keep all in touch with medical advances. The pace is such now that no one isolated from this sort of exchange can continue to practice modern medicine. But equally scientific, specialised medicine needs to keep contact with real life and human needs in a community; science is not all.

A Meeting Place

The division between specialist and generalist practice necessitates the provision of a meeting place. Moreover, there is another large group of doctors, the junior staff in hospitals, for whose further training an organised programme is essential. To meet this need, medical institutes with library and teaching facilities are now being generally provided. There are 200 such centres in existence in England and Wales, two-fifths already in specially-built premises, and organised programmes of vocational training for the younger doctors and of continuing education for all are provided in them. More academic programmes are organised on a regional basis for those training in specialties, and special refresher courses for general practitioners, which have been provided since the health service began, have been greatly increased. In 1952 one-twentieth of all general practitioners attended at least one postgraduate course, in 1968 about one-half did; altogether, over 18,000 courses were taken. Not only are expenses paid for such courses but there are now incentives in remuneration for those who take them.

There is thus emerging in Britain a functional unit upon which the organisation of health services will be based. It is the district which requires a general hospital and a group of practice centres, with a medical institute at the hospital to serve as an educational centre and meeting place for all the health professions. The public is then served by a complex, at the centre of which is the hospital as the main support of practice centres dispersed through the community. In this way general practice is supported by the specialties, and the service the community requires in any area of medicine is partly provided by each.

The sharp differentiation between practice in hospital and the community should diminish and we are now planning hospital development on the assumption that this will occur. The effect in reducing capital requirements, as well as increasing functional efficiency, can be very large. Last year the detailed plans of two new district hospitals were announced, which are to cost together about as much as one would have cost in the past. Each provides generous diagnostic and treatment facilities with the latest scientific resources for the neighbourhood, but has fewer beds than we have been accustomed to provide for the same population. By the intensive use of out-patient and day care facilities, and shortened stay in the wards for those who must be admitted, followed by care in the community, it is believed that a service of at
least equal efficiency can be given with substantial economy. But this is wholly dependent upon close association between specialists and generalists and the hospital and community nursing staff. We must demonstrate that this can be successfully done, but the intent to do it amounts to no more than the logical application of best current practice where facilities now permit.

Public Health Function

I have deliberately said little about public health or social medicine or whatever name we use next, but there is a crucial function for the community physician—the heir to the Medical Officer of Health—who I think will be the man best able to help both specialists and generalists do the work the community needs—preventive and curative. Individual clinicians do not think first of community needs. Why should they? Their concern must be—as everyone of us, when a patient, hopes—with the individual under care at the moment. But individuals will only get what they need in this complicated world of medical science if competent, understanding men have organised the deployment of mutually supporting services to that end.

If the best results are to be obtained from the district general hospital group practices complex, it will be necessary to improve upon the services now provided in some hospitals in support of general practice. The first of these must be communication, in general on the educational lines already mentioned, and in particular on the prompt provision of information about individual patients. We may one day see a comprehensive individual health record file with automated access, provided it can be kept in confidence.

It will be necessary to make hospital diagnostic facilities more easily available to the general practitioner, and it may be necessary to ensure transport for some patients to group practices, since the isolated doctor in a village is unlikely to remain.

It will no doubt be possible to put some group practice centres actually on hospital sites, but although our Royal Commission on Medical Education has suggested that health centres might be much larger, it is most unlikely that 80 to 100 doctors serving a large area will all be congregated in one place. The largest health centre we are building at the moment is for 17 doctors, but we have several for 10 or more. There is no reason why a group of 10 or more doctors should not be made up of several teams, as Draper has suggested, but, although larger groups may be practicable in thickly populated cities, there will be areas served by a group maybe of six or less.

General Practice Content

So far I have said little about the content of general practice. There are some who would dismiss it as a collection of trivia, grossly overburdened by the unreasonable demands of patients under a free Health Service. Some have lamented an alleged decline in interest or transfer of interest to hospitals. Some have suggested that in modern medicine there is far less that the general practitioner can do. There is in fact far more. It is true that we have far better control of many infections now, but they still have to be controlled, and this is done very largely by new therapies and new prophylaxis which the general practitioner uses. Much of our medicine is now concerned with the management and limitation of chronic and degenerative conditions, and this is an ideal opportunity for joint specialist/generalist work. The
management of hypertension, for instance, has great potential not only for the limitation of cardiac disability but the prevention of stroke.

Medicine of the future will certainly involve more intensive search for inapparent disease. This is not likely to be by wholesale screening campaigns, but rather by selective screening by the personal physician dealing with a practice population—in the main well-known to him—and using specialist diagnostic facilities. We could well devote more effort to providing simple diagnostic apparatus for use in practice. Wonderful new machines that do every conceivable test in a matter of seconds and print out abnormal results in red at a cost of hundreds of thousands of dollars in outlay are not necessarily the most useful.

It is true that the community service could be provided on a clinic basis, with the patient simply seeing the doctor of the day; or general practice might be provided, as McKeeown has suggested, in three or four sub-specialties, rather as the Russians have done. That might happen one day, but it is unlikely in Britain now; it is much more likely that we will go on trying to make general practice in its new form more efficient. Grouping of nursing staff with the practice, and provision of secretarial and other ancillary help, can greatly reduce the personal load on the doctor and give him time for things that require his skills.

I have no doubt that efficient practice organisation could be as important a contribution—as Herman Hilleboe has emphasised—to the improvement of general practice as the other steps I have described.

Better Training

I am not saying that our brand of general practice is right for everyone, only that we can with our system improve it greatly and provide what we want to have. A part of that improvement must be through better professional training for practice, at undergraduate and postgraduate level, such as the Royal Commission recommended, the Royal College of General Practitioners has long advocated, and your own specialty boards will doubtless require here. Several schemes for such training already exist, and I believe they will become general and, in effect, obligatory within the next few years.

We do not want to turn general practice into a faint carbon copy of specialist practice. The progress of specialisation in hospital will continue and the personal physician will soon be the only doctor with a truly comprehensive and continuing view of his patient’s health. Shorter patient stay in hospital inevitably gives him a part in every specialist’s work for his patient before and after—and perhaps during—in- or out-patient care. If there is to be a General Physician in the future—and surely the patient needs some medical guide through the scientific maze—then a general practitioner properly prepared for the role and helped to fulfill it is a possible answer. The patient’s need for the future is not total care by one doctor, but timely use of the skills he needs at the moment, under the guidance of a practitioner who knows when to involve others. The ultimate object is not the organisation of medicine for the doctor’s sake but better patient care.

When we have done all this you may ask whether the effort will have gone into propping up an institution which may be dear to us but can never be as efficient as a group of specialists could be. My answer is that we have indeed looked at the alternatives, and have deliberately chosen what we are now trying to do because we believe it
will be more efficient. We have, in fact, accepted the view that our separation of specialist practice into a service reached only through the personal physician will, in our context, give a more satisfying result to the patient and a more efficient use of technical resources. In fact we can have humanity and science too. It is not a universal panacea, but we believe it will work best for us, so we are setting out to give it the best opportunity we can devise.

I end with a quotation from the New England Journal of Medicine published just eight weeks ago. "Medical care is increasingly fragmented and complex, and the warmth of a long term association with a single physician has become a luxury for a few rather than the customary setting for the delivery of health care." I do not know if that is true here. I do know that it is our wish and intention that it shall not be true in Britain.

REFERENCES


