KING EDWARD'S HOSPITAL FUND FOR LONDON

PRIORITIES IN MEDICAL CARE

SEMINAR AT THE KING'S FUND COLLEGE

9–11 MARCH 1977

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"THE EVOLUTION OF THE CONSULTANT AND THE GENERAL PRACTITIONER"

by Dr I S L Loudon

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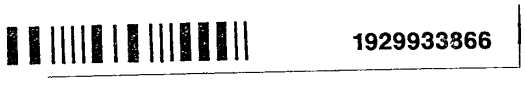
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KING EDWARD'S HOSPITAL FUND FOR LONDON

PRIORITIES IN MEDICAL CARE

"The Evolution of the Consultant and the General Practitioner"

1. The beginning of the 19th century saw the end of nearly 200 years of a stable unchanging system of medical care based on a rigid hierarchy of doctors. This consisted of three distinct ranks:

(a) The Physician - a gentleman and member of a learned profession

(b) The Surgeon - a craftsman belonging to a craft company until the Royal Foundation in 1800

(c) The Apothecary who was a tradesman who prescribed and dispensed. By the Apothecaries Act of 1815 they were given powers to examine and licence and by a legal decision of 1829 they were allowed to charge a fee for prescribing or for giving advice - but not both until another legal decision in 1830.

So rigid was the hierarchy that to ascend from apothecary to surgeon or surgeon to physician it was necessary to renounce your previous association. Everyone knew exactly where they stood on the equivalent of Lord Morau's ladder. (8, 11, 15, 20)

2. The term "general practitioner" came into use at the beginning of the 19th century and signalled the breakdown of this existing organisation of doctors.

3. Reasons for the breakdown are complex, but it did not occur as a result of advances in medical science or of increasing specialisation (Rivington (5) in 1878 enumerated

doctors as "physicians, surgeons, obstetricians, general practitioners and specialists who devote themselves to some special branch of medical practice .... because the inexorable public will not believe in a man who is good all round". Rivington - himself a surgeon - despised specialisation). Reasons for the breakdown and emergence of GP and consultant included:-

(a) Old system unsuited to industrial revolution and increase in urban population.

(b) The emergence of humanitarianism and philanthropy (literally: "love of human beings") as highly valued qualities in the 19th century. (12)

(c) The increasingly chaotic state of the colleges and licensing bodies who, with their spheres of influence and areas of jurisdiction had created a bedlam out of medical qualifications. "The absence of uniformity in training or examination, the need to outlaw rampant quackery, the want of ordinary culture in many who entered the medical profession, the jealousies antipathies and hostilities" (5) led to the Medical Registration Act of 1858 and the General Medical Council.

4. The evolution of the general practitioner was complex, (see Figures 2 and 3) and gradual, and at first the distinction between consultant and general practitioner was blurred. The consultant usually held an honorary appointment at a hospital, but he was not distinguished by virtue of being a hospital doctor, still less a specialist. He was distinguished by three main features.

(a) By being called-in to consult by other doctors to give a second opinion. "Pure" consultants, in the sense of being totally dependent on being called-in for their living, were, even as late as 1870, few and far between ("a mere handful outside London") the rest practising as general practitioners to the rich. (5)

(b) By social class of patient and above all by the size of fee which was, by custom, a matter of great medico-social significance.

(c) The consultant never "dispensed" medicines: to do so would be to act as an apothecary.(2, 5)

19th century novels (eg 1, 2, 3) are the richest sources of information on social distinctions of the various kinds

of doctors and the conflicts between them.

5. The range 9f doctors included in the term general practitioner was at first very wide indeed. (See Fig 4 based on Rivington's own description). At first the majority held the LSA. One view is that the 1815 Act was a far sighted liberalising act making the Society of Apothecaries the pioneers of modern medical education.(8) Another holds that it was a disgraceful example of the snobbish hold exerted by the RCP in maintaining a social distinction. (20) Probably it was a bit of both. Later, when in the 1860s the general practitioner was firmly established as the doctor of the rising influential middle-classes, the general practitioner usually held the MRCS instead of, or as well as, the LSA and thought of himself as a surgeon. Hence country general practitioners were country surgeons, general practitioners still call their consulting rooms and sessions their "surgeries", MPs in their folksy way imitate them and the name is perpetuated in police surgeon and ships' surgeon, although both jobs are general rather than surgical. Faced with the competitive success of the Society of Apothecaries, and the problems of "single" qualifications, the Royal Colleges of Physicians combined together in the conjoint diploma - MRCS LRCP. The physicians promptly recruited an exclusive band by introducing the Membership examination. (8)

6. During the 19th century the hospital assumed increasing importance. But as far as in-patients were concerned they cared almost exclusively for the "labouring and servant classes". The rapidly growing middle classes (and of course the aristocracy) were cared for in their homes. (9) Nevertheless the consultant became to a greater extent not only the doctor who was called-in to give a second opinion; he also became the hospital doctor and the specialist.

7. Events occurring in out-patients in the mid-19th century were to have a profound effect on the GP/consultant relationship. Originating from the out-patient dispensaries for the sick poor, and intended for those unable to afford the cheapest apothecary, out-patients was back door charity stuck away at the side or back of the hospital where, dark and overcrowded, it can often be found to this day. Nevertheless out-patients became astoundingly (and I use that word advisedly) popular and overcrowded both with the

poor and with the middle-classes who could well afford to pay a doctor but preferred not to and adopted many stratagems to look poor and obtain care. (See Rivington for detailed documentation of this invasion of out-patients).

Result : Out-patients became a serious threat to the urban practitioner who insisted on the right to determine who should be allowed to attend with the passport of a doctor's letter.

The principle of referral, central to British Medicine, had its origin in purely mercenary considerations, but it would be wrong to assume that it cannot therefore be a good principle from the point of view of the patient's welfare; in fact it is. But the consequence of referral was that the GP cut himself off from the hospital. "The physician and surgeon retained the hospital, but the general practitioner retained the patient" (Rosemary Stevens, 11) To the GP it was not great loss - after all, hospital work was unpaid. Echos of this battle over out-patients were still discernable in 1938 (BMA - "A General Medical Service for the Nation); it was not won overnight. In direct descent is todays problem of self-referral to Accident and Emergency Departments.

8. By the end of the 19th century sick clubs proliferated. Why? Increasingly effective care became more desirable? Also growing social organisation in industrial society replacing country farm labourers' fatalism? Mining areas frequently retained doctors ("club" doctors) for a fee. Older patients still talk of"going on the club" for being off work with illness.

From sick clubs and revelations of medical examinations of recruits for Boer War came Lloyd George's 1911 National Health Insurance Act, supported by contributions from employers and employees earning not more than £160 a year (£250 in 1919, £420 in 1939). For workers only, not their families.

9. National Health Insurance Act had profound effect on the GP by introducing new concepts that distinguished him more clearly as a separate kind of doctor from the consultant.

(a) By the provision of a secure stable guaranteed state income.

(b) By the principle of payment by capitation fee which gave official sanction to the personal doctor with a personal list of patients. The list of doctors in an area who contracted to provide care for National Health Insurance patients was the "panel" of doctors - hence "panel patients".

(c) By creating the concept of the GP contracting as a personal independent contractor to provide government service - a condition of service greatly prized today by general practitioners.

(d) By the creation of Statutory Committees, Local Medical Committees with power to act through conference and instruct the GMSC which is a sub-committee of the BMA which is not a statutory body at all. (Very confusing and understood by few). (16) But GPs have a long history of considerable political power (much more so than consultants) which they have used almost exclusively to improve their terms of service and hardly at all to improve standards of education.

10. In all four respects the GP was now firmly differentiated from the consultant who remained a privately paid doctor, dependent on referral, with no state income, no personal list of patients and with no political power because he had no need of it (as yet) but equally with no experience of playing the game of medical politics with the State.

11. The writer of a leading article in the British Medical Journal in 1876 remarked that "the country consultant was simply the general practitioner who owes his position to the fact of holding an appointment in connection with a country hospital". To a great extent that remained true in the provinces up to the NHS. Even in Oxford, in the 1930s and 1940s, out of three consultant physicians, two worked mainly as GPs to University staff and to North Oxford with honorary appointments at the Radcliffe Infirmary, while the third was appointed in the 1930s as the first purely consultant physician. In smaller provincial towns the honorary would be even more clearly a GP (usually with a practice of relatively rich patients) who did part-time honorary work at the hospital (in a way not dissimilar from the clinical assistant of today?) Some blurring therefore still remained up to 1948.

12. Between the NHI and the NHS we should note :

(a) The Dawson Report of 1920 (6), if only to wonder why something so sensible fell flat

(b) The BMA publication of 1938 (7), because it prepared the ground for the NHS

(c) The EMS (Emergency Medical Service) of the 1939-45 War because it convinced consultants of the need for a National Hospital Service.(9)

13. The NHS

The organisation of General Medical Services was predetermined by the NHI or "panel system" which was merely extended to cover the whole population. The principles of independent contractor status and payment by capitation fee were retained.

In contrast, the hospital service is a salaried service with the option of part-time or whole-time contracts and merit awards introduced for political reasons concerning private practice.

14. Since the introduction of the NHS the rapid rise in available hospital beds, which was a feature of the period 1800 to 1938, has halted. But the number of hospital staff has more than doubled, the average length of stay has halved and the deaths and discharges per 1000 population has risen by about 70%. During the same period the average number of persons per doctor has fallen from approximately 1200 (similar to the 1851 figure) to 960. This has however, been almost entirely due to extra hospital staff. In contrast, the number of general practitioners has, since the NHS started, remained very much the same. (Figs 5 and 6).

15. Since the NHS began, therefore, the activity of the hospital service has increased continuously and rapidly. For the greater part of this period of time the hospitals have been :

(a) The centres of almost all education - undergraduate and postgraduate.

(b) The centres of almost all research and advances in medicine.

(c) The centres of influence particularly in determining priorities and planning.

The distinction between hospital doctors and general practitioners has steadily hardened since the beginning of the 19th century and the NHS was founded on the basis of there being a hard and fast distinction.

Until very recently, general practitioners were individuals working in isolation, singly or in small groups, with no corporate identity and nothing at all to correspond to the intellectual and academic influence in medicine of the Royal Colleges, the University and the teaching hospitals.

16. Given these circumstances, the disappearance of general practice in the 1950s and early 1960s would not have been surprising. Instead, there is now evidence of a possible reversal of the trends that we have traced since the emergence of general practice in the early part of the 19th century. The evidence consists of :

(a) The growth and success of the RCGP

(b) The introduction and vocational training for general practice

(c) The rapid increase in University Departments of General Practice

(d) The rapid increase in the amount of research carried out in general practice and published in medical journals.

(e) A feeling, not susceptible to accurate measurement, that morale in general practice has improved considerably over the last five years and that the standard of students and young doctors wishing to enter general practice has risen.

(f) Increases in group practices, health centres, group attachment and the concept of the primary health care team (pompous words attached to a successful concept).

As long as medical education was confined entirely to hospitals and hospital doctors, the relationship of GPs to consultants was never likely to change. (b) and (c) above may turn out to be the major factors for a new emerging relationship between general practice and the hospital service. Great credit is due to the RCGP for concentrating on education and research and avoiding the trades-union like activities

and conflicts of the GMSC, the BMA and the Annual Conference of LMCs.

17. All one can say of the next decade as far as the evolution of consultants and GPs is concerned is that it is likely to be lively and interesting.

Postscript

Running parallel to the story outlined in these notes is the fascinating story of the Cottage/General Practitioner/ Community Hospitals dating from Dr Albert Napper's opening of the first Cottage Hospital at Cranleigh in Surrey in 1858 (the year of the Medical Registration Act and of the publication of "Dr Thorne" by Trollope). Either that story is told properly at length or left out as being of minor importance. These notes are too long already, so it must be left out: for the time being anyway.

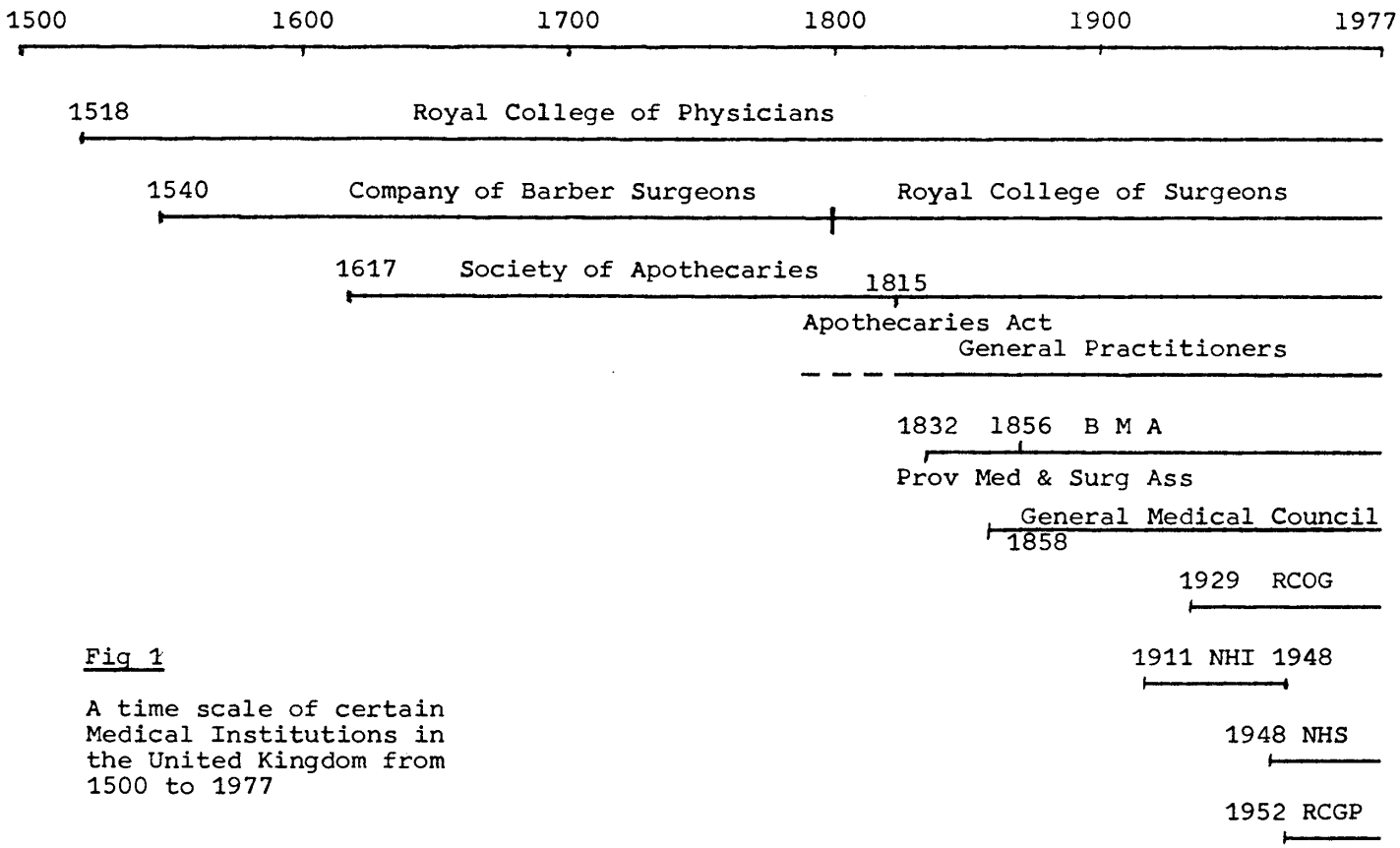

Fig 1

A time scale of certain Medical Institutions in the United Kingdom from 1500 to 1977

Figure 2. The traditional but incorrect picture of the evolution of the general practitioner and consultant

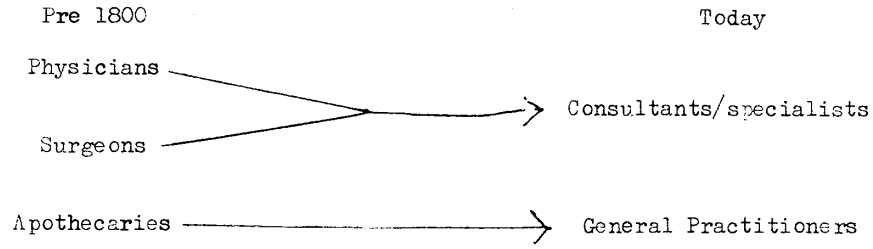

Figure 3. The true picture of the evolution of the general practitioner and the consultant

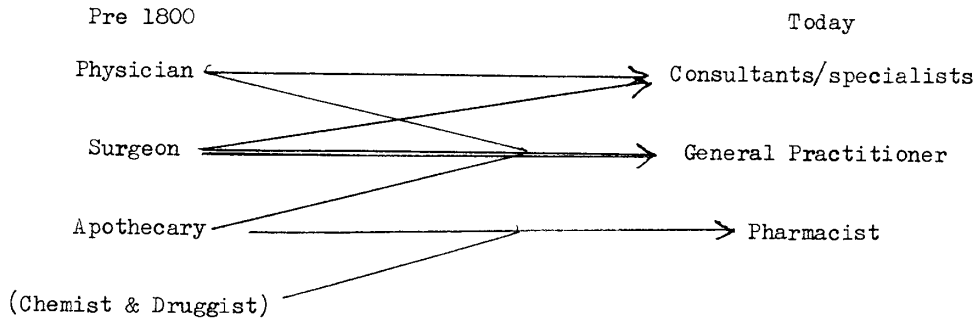

Figure 4. The spectrum of general practice in the first half of the 19th century (Rivington)

1. THE NON-DISPENSING ORDERS

   A. The Regular Consulting Physician

   B. The non-dispensing general practitioner. "Medicine is prescribed and the prescription is made up by the chemist. Patients are seen and visited at a lower fee than that of the regular physician. Half a guinea is often charged."

2. THE DISPENSING ORDERS

   A. The practitioner whose consulting room "is within the interior of his dwelling when it is no longer exposed to the vulgar gaze".

   B. The surgeon-apothecary, "with an open surgery and a red lamp. No retail trade is done but advice and a bottle of physic is given for a moderate sum - a shilling is common charge in the poorer neighbourhoods".

   C. The surgeon chemist "or the red bottle and blue bottle practitioners who kept an open shop and depended greatly on a retail trade in toilet requisites etc:"

Figure 5. Available Hospital Beds (non-psychiatric) England and Wales 1861-1971

	1861	1891	1911	1921	1938	1949	1959	1967	1971
Available beds total x 1000	65	112	197	229	263	262	262	260	258
Available beds per 1000 population	2·69	3·65	5·25	5·77	6·09	5·98	5·77	5·40	5·28
Average length of stay (days)	36·2	28·4	24·5	23·8	18·4		15·6	11·1	10·4

Sources: Pinker 1966. English Hospital Statistics 1861-1938
Tables 9 and 10 showing available beds in hospital for the physically ill.
Health and Personal Social Services Statistics 1975
"Non-psychiatric beds" for data 1949 to 1971 inclusive

Figure 6. Medical Manpower 1851-1871 and 1949-1974

	England and Wales						England	
	1851	1861	1871	1949	1967	1971	1971	1974
Population x 1000	17,928	20,000	22,712	43,785	48,113	48,854	46,131	46,436
1. Hospital Medical Staff W. & E.				11,735	20,395	23,806	22,548	25,618
2. General Practitioners				(22,091) 1959	21,293	21,910	20,597	21,531
3. Community Health Service doctors				(1,365) 1967	1,365	1,333	1,227	(1,332) 1973
Total Doctors 1 & 2 & 3	[illegible]			35,191 Estimate	43,053	47,049	44,372	48,481 Estimate
Average No. of persons per doctor	1,180	1,396	1,552	1,244 Estimate	1,117	1,038	1,040	958

Data for 1851 to 1871 based on Rivingtons (1878) estimates of the number of "medical men"

Data in brackets are the closest available data, with the year on which they are based indicated below them.

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"GP AND SURGICAL TEAM - ASSESSMENT OF OUTCOME"

by Professor Ian McColl

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PRIORITIES IN MEDICAL CARE

"GP and Surgical Team -
Assessment of Outcome"

Stage 1

Presentation of the Problem to the GP and Patient Referral

GP needs to know the following:

(a) Has he correctly identified a surgical problem requiring the attention of the surgical team?

(b) Has he referred the case at the appropriate time?

(c) Has he made the correct diagnosis? (This one is probably the least important but often receives the most emphasis).

Stage 2

Outcome of Surgery

This is largely the concern of the surgical team but information pertaining to the case referred (or which has arrived via Accident and Emergency Department) must be fully, clearly and rapidly returned to the GP.

Essential factor here is communication via

(a) Good records (POMR?);
(b) Telephone (need for recording machine);
(c) Letter;
(d) Discharge summary;
(e) Follow up letters.

Stage 3

Outcome of Follow-up

Responsibility for communication may be with hospital:

(a) Hospital OPD follow up, possibly long term with some problems, eg resection malignant disease, Ca stomach, planned long term follow up for trials, etc.

(b) Hospital OPD follow up short term, eg hernia repair, varicose veins, etc.

Responsibility for communication may be with GP:

(a) Referral back to GP care without visit to surgery, eg letter from OPD referring back to GP after discharge.

(b) Referral back to GP with visits for follow up to be arranged at surgery, eg long term follow up of gastrectomy, FBP regularly, etc.

If the GP is to be able to assess outcome here he must have information on:

(a) What problems he should be looking for.

(b) What follow up investigations (and at what intervals) may be appropriate.

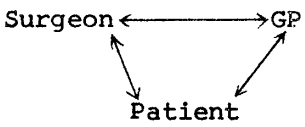
(c) What are the indications for referral back to surgical team.

GP's role is crucial in Stages 1 and 3.

Feedback must be two way - it is not just the surgeon "educating" the GP. Unless he hears from the GP about the long term problems (and successes) of his cases he cannot successfully modify management of these problems,

eg suitable arrangements for terminal care;
appropriateness of early discharge;
day care surgery, etc.

Whole thing will fall down through lack of communication -



Likewise through any failure of co-operation (not forgetting the importance of the patient's co-operation).

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"PSYCHIATRIC EMERGENCIES AND THE TEAM APPROACH"

by Dr Philip Evans

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PRIORITIES IN MEDICAL CARE

"Psychiatric Emergencies and
the Team Approach"

The community-orientated psychiatrist will choose to involve himself in the earliest crisis situation because he knows that psychiatric emergencies are the final expression of social upheaval in a not insignificant proportion of cases. The Camden work illustrates some ways in which a social situation becomes translated into a psychiatric presentation and stresses the importance of the team being in a position to appreciate the most relevant human context. It shows the effect of crisis intervention in reducing the need for acute admission beds and the eventual preventative role of the community approach.

The trend away from the mental hospital to the DGE in the centre of its catchment area highlights the socio-cultural aspects of mental illness, and this is optimistic because it radically removes mental illness from the nihilistic 'endogenous' or 'lesional' perspective of disease. However, to situate psychiatry in the DGH is to declare that psychiatry is also a legitimate part of the practice of medicine - and mental illness not only the product of cultural pressures. The difficulty with the social model is that it does not accommodate well with notions of heredity, constitution and organic pathology. The social model also runs the risk of denying the reality of mental illness which is, of course, what animates the anti-psychiatric movement. When alienation becomes solely the effect of rejection of society, then mental illness becomes an artifact with Szaz, a myth.

There is a form of therapeutic community that exists, fortunately, only in the minds of empassioned idealists for social reform, in which principles of 'decision by consensus' and 'patient self-determination' are logically

extended to become 'abrogation of professional responsibility' and 'abolition of the authority pyramid'. The underlying motive is, of course, to set up an alternative society, political demonstration, the ultimate aim of which is, let us be quite clear, social revolution. The hospital setting is then regarded as an impediment to practice. In my view, the new units are appropriately situated in the DGH because in this setting they force us to examine our individual positions in regard to the various models of madness. An isolationist attitude to mental illness (only the organic, only the psychoanalytic, only the social, model) is outmoded.

Modern Psychiatry, though it reflects the contradiction between social reaction and physical deformation of the mind - a contradiction which is at the very base of its existence - also constantly goes beyond this to seek out a path between the naivety of Anti-psychiatry and the dogmation of archaic doctrines; between the over simplification of psychogenesis and an obsolete 19th Century mechanistic neurology applied to Psychiatry. Psychogenesis and organogenesis of mental illness are now seen to represent a largely false duality because it corresponds to the cartesian duality of mind and body, an obsolete philosophy that stifles the very notion of mental illness because mental illness is situated precisely in the body-mind gap. The problem of today is the articulation of models to arrive at the veritable object of Psychiatry, which can only be a balanced perspective based not on eclecticism, but on a solid, holistic concept of mental disease. Psychiatry is a branch of medicine, but its object is the pathology of relational life.

As the social model of mental illness has in an important measure been opposed to the medical model, so the TC is opposed to medical leadership and decision-making taken on behalf of the patient. Shrodells crystalised out of a primitive soup of energies derived from interests as apparently polarised as psychoanalysis, the Paddington Day Hospital, the National Hospital for Nervous Diseases and the traditional mental hospital. Shrodells was organised out of conflict: the very concept of organisation implies an order; order is established out of disorder; a hierarchy and ideals are implied.

A multidisciplinary system can exist only in so far as the external hierarchies allow it to function; increasingly so as they yield control, but it is also effective only

in so far as its members possess individual autonomy, that is a personal hierarchical organisation; without this self-discipline, individuals have nothing to contribute and the team cannot function as such. Shrodells therefore attempts to live up to Maxwell Jones' concepts of a TC with its emphasis on face-to-face exchange, continual analysis of events, delegated responsibility and parity of esteem - in the final analysis repeating many of the features of the 'moral treatment' of the early 19th Century.

The measure of success of the team approach to Psychiatry is the drastic fall in psychiatric emergencies in the population served. Bed occupancy falls, staff can be redeployed in the field, and the whole emphasis is shifted from a custodial one to a preventative one. But the team approach requires a continual examination of one's basic preconceptions of the nature of mental illness which means moving beyond classical Psychiatry to take a consideration of contributions from other disciplines including politics and even philosophy.

"Domiciliary Work in Psychiatry"

Despite many objections, Psychiatrists are working increasingly in a domiciliary setting and less and less are they seeing their first time referrals in hospital. This is because they recognise certain advantages in the domiciliary situation, in two fields especially: that of family psychopathology and in the management and schizophrenic patients. Speck recognises 13 reasons justifying such an approach.

1. Treatment at home is especially conducive to an understanding of the dynamics of family life and its interaction with the pathology of the patient designate. Inversely, the family has a clearer view of these exchanges in the home setting than it can have in a hospital setting.

2. The social context is of major clinical importance in Psychiatry. The patient's 'presentation' at home is very different from that in the clinical demonstration room*, at a medical consultation, or in an acute admission Unit. The reception given to mentally ill patients in institutions can seriously complicate the symptomatology. What is more, in their own homes,

* Which is why progressive Units have abandoned the scandalous 'presentation' of patients, for teaching purposes.

people can use the structure to suit their advantage: they can come and go as they please, have the choice of room, are able to involve neighbours, etc...

3. The evaluation of acute episodes is much easier to understand at home. Moreover the patients express themselves more clearly in the familiar setting of their possessions and the roles allocated to and assumed by various participants are revealed more clearly than they would be by a retrospective and indirect reconstruction that is inevitably laborious.

4. For schizophrenics in particular, and others in general, admission to hospital is not in itself an advantage in treatment. Often enough, it aggravates the patient's condition and prejudices the after-care. Intensive management on a domiciliary basis will actually obviate admission. When admission becomes inevitable it can be limited in time, programmed for maximum therapeutic effect, and especially, discharge and after-care can be planned from the outset. The progress that a patient may have made in hospital can only be maintained in so far as the family attitudes have changed along is parallel with those of the patient. Many failures of after-care can be explained by the fact that an improved patient returns to a family environment that has remained fixed, hence the 'revolving door' policy.

5. The patient is often the object of 'projections' on the part of the family that scapegoats him. The effect of admission is to sanction, using the weight of medical science, these projective processes which become fixed as a result and no longer available for interpretation. Inversely, treatment at home has the effect of rejecting thos projections and seeks to metabolise the guilt that they engender in the family.

6. Treatment at home allows the active participation in the treatment of certain persons who play a first line role in the patient's destiny and who are all too often excluded from certain institutional treatments This applies especially to people who manage to preserve intact their mental health in a family environment that is highly pathological - fathers, for example, whose importance had perhaps been underestimated with the accent traditionally heavily on the mother/child relationship.

7. After-care is often interrupted by the difficulty some families have in attending out-patient appointments as a result of social isolation. On the other hand,

they will often accept a visiting psychiatric team, that is very quickly accepted as not belonging to the external hostile world.

8. A common practice, whose anti-therapeutic character should be clearly understood, consists of patients forcibly or under false pretences. Not only can this have the effect of rendering hospital treatment totally ineffective, but it also have the inconvenience of seriously altering the subsequent links between the patient and his family. Treatment at home can impose a tactical delay so that when hospital admission becomes indispensable, it occurs only when the patient is prepared to accept it.

9. Pets often have an interesting part to play in the assessment. Not only does their behaviour reflect the general climate of the home but they are sometimes also the object of special preoccupations that can be highly significant, and of course only to be observed at home.

10. All psychotherapeutic processes presupposes a certain symmetry in the relationship between the patient and the doctor, regarded as 'observer/participant': the knowledge and social position of the therapist - and often the total dependence of the patient - make such symmetry more or less impracticable, not only in hospital, where the model dominating the relationship is of an 'asymmetrical or hierarchical type' but also in the out-patient or day hospital setting. Inversely the effect of being 'host' to the patient compensates in part for the asymmetry in the relationship.

11. An important criterion of progress in psychotherapy is the application of progress made in the sessions to daily existence. This application is facilitated by the fact that the sessions are held at home.

12. Though family therapy aims at obtaining the maximum of help on the part of the family for the patient, it is also true that the community in the wider sense constitutes another source of available help that can be tapped more easily from a domiciliary working basis: participation of the neighbours, the family doctor, friends, etc.

13. It is not uncommon that influential people outside the family circle, control the totality of the therapeutic field, acting for or against the current of treatment. Here again domiciliary work provides the opportunity for contact with them.

"Alienation"

As the result of the bombing of some asylums in France in 1940 a number of mental patients were dispersed on the roads. The psychiatrists who eventually received them noted a striking normalisation of behaviour. This was the departure of the movements of community psychotherapy and henceforth it became the first duty of psychiatrists to abolish 'institutional neurosis'. All institutions are by nature 'alienating' and can be diabolically organised to make the patient incurable. All kinds of adverse factors operate in institutions that tend to permit behaviour that is generally regressive; distance from the community of origin, professional ranks (doctors, nursing, administration), monotony (repetative activities, clothing, etc).

To abolish institutional neurosis calls for the participation of all (administrators, doctors, nurses and cooks) in a profound modification of attitudes. The means of achieving this depends much on the method of groups; of all kinds between staff and staff, staff and patients, and outside agencies, for the business of diffusing information and for short and long term treatment aims. Such a transformation requires much time and effort. It calls for a spirit of sustained enthusiasm and open-mindedness which will inevitably fluctuate, vigilance giving way to apathy and enthusiasm to resistance: there are bound to be crises of failure.

In England it had been decided to close all the traditional mental hospitals before 1999 and to replace them with new sectorised structures. In the Netherlands, the United States, Canada and elsewhere, similar efforts are being made. Furthermore, the multiplication of small units amd their diversification (day hospitals, night hospitals, protected workshops, reception centres, etc) enable psychoanalytic and social techniques of treatment to find expression.

None of this would be possible therefore, without a radical change in attitude to the mentally ill on the part of the medical profession, nurses, social workers, etc, and above all from psychiatrists themselves. we are talking about is a continual analysis of people's attitudes, and the obstacles of these are numerous, not least being the career structures themselves of the psychiatric professions.

Community psychiatry has the primary aim of being 'dis-alienating' and this is only possible through people; by the personal reaction of the treaters to the treated so that these can be effected only provisionally and partially by the process of psychiatric alienation. Only this way can a person fall ill and be able to pick himself up again.

'Drugs in Psychiatry'

To meet the medical model, biological treatments in psychiatry should be specific and aetiological, for the pathological basis of mental disease, whatever its cause, is at one level organic. However, all too often in psychiatry, treatment is neither specific nor aetiological for two reasons:-

1. The aetiological point of view is repudiated in the majority of cases.

2. A specific medication acting on a process or organ, is not adequate to cure mental disorders, which are expressed at a much higher level of integration and cannot be reduced to simple organ failure or a localised lesion.

The plethora and effectiveness of chemical treatments should not detract from the value of other biological treatments or the necessity for a concurrent psychotherapeutic approach. This calls for a clear understanding of the reciprocal effect of biological methods on the nervous system and the psycho-social situation on the person. The psychiatrist's efforts, as physician, must be harnessed to those of the patient and his environment, for optimal effect.

KING EDWARD'S HOSPITAL FUND FOR LONDON

PRIORITIES IN MEDICAL CARE

SEMINAR AT THE KING'S FUND COLLEGE

9 - 11 MARCH 1977

"COMMUNITY SERVICES WITH PARTICULAR REFERENCE TO THE COLLECTION OF DATA"

by Dr Mark McCarthy

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THE INTERFACE BETWEEN PRIMARY AND SECONDARY CARE

"Community services with particular reference to the collection of data"

PREAMBLE

By using the words 'community services', are we perpetuating the pre-1974 trichotomy? Can any valuable separation be made between 'primary care' and 'community services', particularly with family planning integrated and hope for child health services?

Nevertheless, do we have, post-1974, a dichotomy of "district services" vs. "primary care" since they have different funding, separate authorities and the FPCs don't have a regional tier? Would it have been better to reorganise hospital vs. non-hospital?

For this paper, let us assume community services approximately equal the former LA services. These are given in Appendix A.

DATA

1. What data do we have?

Traditionally, a large clerical activity in public health departments was collation of routine statistics

(i) to send to DHSS

(ii) to put in MOH's annual report

The basic returns are given in Appendix B. (DHSS 1974, Alderson 1974)

2. What are they used for?

Most of these forms are simply "returned to DHSS" by administrative staff. Little use is made **at** local level to influence management decisions; and no comparative figures for other authorities are published (though they may be available within the Region). They are a very expensive means of producing a few tables in "Health and Personal Social Statistics", "On the State of the Public Health" etc. (An exception might be manpower statistics.)

3. How accurate are they?

There have been no validation studies to my knowledge.. I undertook a small review of cervical cytology statistics for an Area in 1975 and found that two-thirds of the positives reported on statistical returns were due to double-counting, pre-invasive lesions or cancer cells from sites other than the cervix.

4. Morbidity estimates from utilisation data

Compared with HAA, or the first and second National Morbidity Surveys, there is very little routine information on what conditions the community services identify or treat (preventively) - or how well.

The exceptions are:

a) Locally kept handicapped registers. But these have been criticised for excluding many people known to the statutory services (e.g. because of stigma) and including some whose handicap is minimal and don't receive services.

b) Infectious disease notifications - remain useful

(i) to deal with local epidemics (food poisoning, polio)

(ii) to detect underlying trends (meningitis, typhoid, see Appendix C).

c) School health. Several measures of morbidity are made - accidents, dental DMF, infestations, obesity, defects etc found at medical inspection. Sadly these are unsatisfactory measures of population morbidity because there is no standardisation of the number of school inspections that a child will have. The figures relate to events, not to persons.

WHAT COULD WE LIKE?

Ideally, we would like cheap routine measures which relate the services provided to need (perceived by doctors and public) on a population basis. The following are areas of community services provision where data would be helpful.

1. Immunisation and vaccination

This has been the most successful routinely recorded data, particularly as computer recall improves accuracy. It could be related to infectious disease returns as a measure of effectiveness. But we'd also like to know the complications rate.

2. Child surveillance

The Court Report makes important suggestions: but until our system is changed, the overlap between clinics and GPs will bedevil any monitoring system. There is also a need to improve notification of transfers of children from one area to another. Court suggests linking this to family benefit, which now includes all children. It could also be done by HVs and receptionists noting additions and deletions to GPs lists.

3. Handicap register

Eventually, we would hope to measure the effectiveness of the child surveillance programme by comparing the number of handicaps identified in the child population at a given age with the number expected from studies of child cohorts.

4. Other clinic services

a) Dental. We might gain more if we traded the whole of our data system for fluoridated water . . . The DMF index is useful, but now simply continues to tell us what we already know. Information on orthodontics, particularly in the handicapped, would be welcome.

b) Chiropody. The NHS doesn't provide a comprehensive service: need vastly outstrips supply. Although routine statistics of coverage of the population at risk are needed, we also need to undertake research to review their effectiveness, what treatments are given, and to develop priorities and alternative modes of care.

c) Family planning and cervical cytology. Here again, the overlap with GP care makes this monitoring of little value unless clinic and FPC returns are brought together. This could be done, at a local level, given GP co-operation, and then perhaps related to outcomes (babies born? carcinoma of cervix registrations?)

d) Ophthalmology. This is a half-way house between child screening (particularly in schools) and outpatients or ophthalmic opticians. It needs integrating. Measures of pick-up rate should be made.

d) Audiometry. Better child surveillance is needed in school years. The prevalence of auditory defects following infection is changing and unquantified; and treatments are improving.

5. School Health

Court (1976) makes the point that this should be

a) a five-year old medical examination. (This evaluates the pre-school system by the defects found that should have been identified earlier).

b) School nurses should check sight and hearing at least twice between 5 and 10 years.

c) An opportunity for adolescents (13+) to talk to a doctor at length.

6. Child Guidance

The prevalence of emotional and educational disabilities is known for some parts of the country. But child guidance clinics only see a proportion, and there have been few satisfactory evaluations. Much of the money for child guidance is spent by local authorities. Before collecting data, we need to try out various integrated schemes of child psychiatry and guidance between hospital, clinic and school, to understand objectives and effectiveness.

7. Nursing

a) Home nurses. ". . . . were busy with non-nursing tasks and spent deplorably little time in actual patient contact" (Hockey 1966). Probably better management control information is needed, though would this produce better supervision? More difficult, we must also make an assessment of unmet need and try to balance community care against hospital provision (Isaacs & Neville 1976; Opit 1976).

b) Health visitors. We need management objectives to be set, since they have such wide job-descriptions.

At present, there is no routine data to indicate whether all the children in a population are being seen regularly or at all.

Outcome measures for health visitors might include:

Action	(Negative) outcome measure
under fives club attendances	admissions for depression and attempted suicide (women 15-35)
fire guards	child burns (from casualty department)
elderly surveillance	hypothermia admissions or deaths

c) Midwives - should probably be integrated fully by rotation with hospital staff, not a separate community service since many mothers are suitable for discharge within 4 - 5 days post-natal.

THE INTERFACE

The community services, traditionally defined, make little use of secondary care services, since referrals to hospital are undertaken in principle through a general practitioner. In practice child health care has tended to by-pass the GP sometimes - e.g. when a congenital lesion is found needing specialist attention, although the GP is usually informed. In the same way, copies of letters from hospital about children are often sent to both the GP and the child welfare clinic. Professor Court's proposals would go a long way in overcoming this duplication.

Perhaps one theme that will come out of this conference is that the interface between primary and secondary care should not be as rigid as it seems to be. Increasing the community orientation of child health and geriatric services could lessen the hospital load and improve the standards of community care. In the future, the integrated patient record might include details of preventive and therapeutic care, so that evaluation could be patient-based. Then the administrative data - manpower, sessions, time etc. would be seen more clearly as measures of efficiency for management, and not confused with measures of programme effectiveness.

CONCLUSION

Reorganisation could have been a marvellous opportunity to reassess community statistics and surveillance programmes. There could be fewer forms, improved research capability to match the new social service departments, more ad hoc surveys to elucidate local problems. However, the new community physicians seem to be bemused by the complexity of total health services, the power of hospital specialists and the continuing independence of GPs. Ex-MOsH look fondly back to the halcyon days when departments were directly under their control and they could act by command rather than conflict. There is little evidence of new initiatives despite the recurrent emphasis on 'community care' because of low cost. It may be best therefore to develop a new integrated primary care structure and develop new data - collecting methods there, rather than further amend data collection in a declining field of the total health care service.

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February 1977

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APPENDIX A

1. Clinics

Child health (MCW; surveillance)
Ophthalmology
Audiology
Dental
Elderly
Family Planning
Preventive - relaxation, education

2. Schools

Child surveillance
Dental
Special
Guidance

3. Fieldwork

Home nurses
Health visitors
Midwives
Psychiatric nurses

4. Environmental

Infectious disease control
Pollution
Section 47

APPENDIX B

LOCAL HEALTH AUTHORITY RETURNS

The following list identifies the returns completed by the local health authorities, and forwarded to the DHSS. The returns are collated by the local health authority from information provided on an on-going basis by the operational units at local level. The returns are forwarded to the DHSS, where they are processed clerically; analyses are presented in the annual reports. More extensive tabulations than those published may be obtained on special enquiry to the Department, whilst at local level health authorities will have analyses which they may be able to make available to research workers.

Staff

LHS 27/6	Medical and dental staff in post	(at 30 September...)
LHS 27/8	Nursing staff in post	(at 30 September...)
LHS 27/9	Ancillary and nursing staff employed in support of the nursing services	(at 30 September...)
SBL 620	Ambulance staff (all grades) in post	(at 30 September...)
SBL 624	Miscellaneous staff in post	(at 30 September...)
SBL 653	Attachment of health visitors and home nurses	(at 20 September...)
SBL 605	Medically qualified staff in the local authority service	(at 30 September...)

Workload

LHS 27/1	Number of live and stillbirths, premature live and stillbirths by weight and span of life	(annual)
LHS 27/2	Number of ante- and post-natal examinations, number of sessions and clinics	(annual)
LHS 27/3	Number of cases and type of cases visited by health visitor, home nurse, and attended by domiciliary midwife	(annual)
LHS 27/5	Number of beds, cases admitted, and duration of stay in mother and baby homes	(annual)
LHS 27/7	Dental treatment of children, expectant and nursing mothers	(annual)
SBL 603	Return of smallpox vaccination of persons aged under 16	(annual)
SBL 607	Vaccination other than smallpox of persons under age 16 completed during year	(annual)
SBL 611	Visits to recent immigrants during year	(annual)
SBL 618	Chiropody treatments	(annual)
SBL 655	Tuberculin test and BCG vaccinations	(annual)
SBL 667	Family Planning Service; new patients, total attendances, and sessions held	(annual)

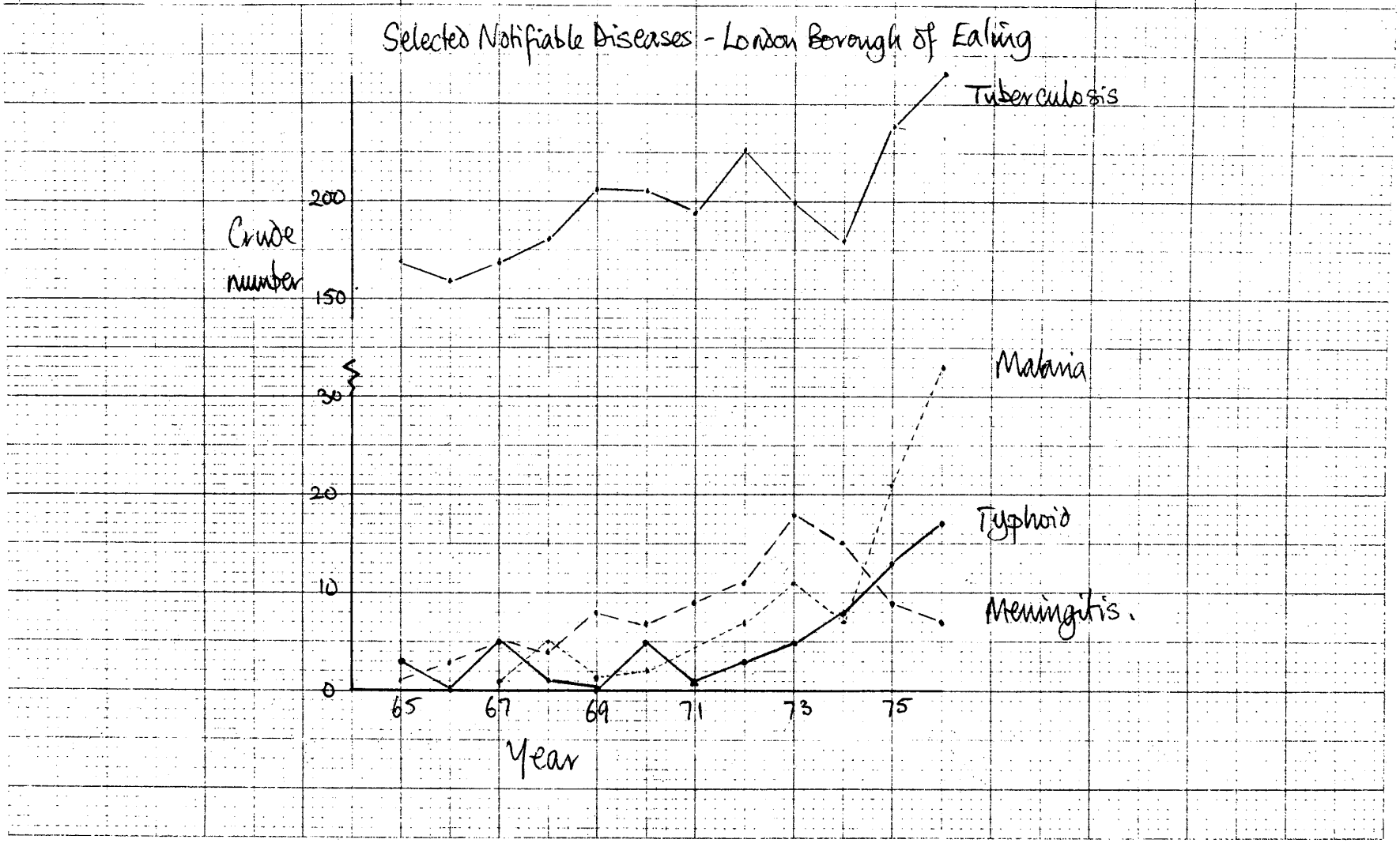
Facilities

LHS 27/4	Number of day nurseries and places; number of registered child-minders and premises	(annual)
SBL 630	Mental nursing homes registered	(at 31 December...)
SBL 631	Mental nursing homes authorized to detain patients	(at 31 December...)

SBL 669	Family Planning Services; facilities provided, scope of services and payments	(annual)
SBL 685	Registered nursing homes	(annual)
Cost		
SBL 637	Ambulance Service, cost statement for financial year	(annual)
AG 213	Return of estimated expenditure	(annual)
RO 3A/3B	Return of actual expenditure for previous financial year	(annual)
PCP 1	Three-year programme of local health authority building projects	(annual)
Other		
SBL 640	Return of food poisoning for year, including all salmonella infections excluding dysentry, paratyphoid, and typhoid	(annual)

Source: Alderson M (1974).

APPENDIX C


Selected Notifiable Diseases - London Borough of Ealing
Tuberculosis
Malaria
Typhoid
Meningitis.
Crude number
200
150
30
20
10
0
65
67
69
71
73
75
Year

KING EDWARD'S HOSPITAL FUND FOR LONDON

PRIORITIES IN MEDICAL CARE

SEMINAR AT THE KING'S FUND COLLEGE

9 - 11 MARCH 1977

"INFLUENCE OF HOSPITAL CONSULTANTS ON PRESCRIBING IN GENERAL PRACTICE (EXCLUDING FORMAL POSTGRADUATE LECTURES)".

by Dr D M Davies

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KING EDWARD'S HOSPITAL FUND FOR LONDON

PRIORITIES IN MEDICAL CARE

"Influence of Hospital Consultants on Prescribing in General Practice (excluding Formal Postgraduate lectures)".

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1. All consultants have some influence on prescribing in general practice because of the drugs they recommend for patients on discharge from hospital, or for out-patients attending their clinics.

2. Consultants with a particular interest in clinical pharmacology and therapeutics can exert an even greater influence by:

(a) encouraging the use of generic names

(b) exphasising the risks of adverse reactions and suggesting measures for their prevention

(c) encouraging "yellow card" reporting to Committee on Safety of Medicines

(d) providing very explicit advice on the total length of suggested treatment, and on the best way of withdrawing particular treatment

(e) encouraging regular interchange of information between general practitioners and hospital follow-up clinics on changes in treatment of patients

(f) involving general practitioners in schemes for monitoring patients under treatment with particular drugs

Cont'd...

(g) involving general practitioners in controlled clinical trials

(h) providing local "bulletins" dealing with therapeutics and/or adverse drug reactions

(i) acting as a local 'information centre' for problems in therapeutics and toxicology

(j) holding special consultative sessions in therapeutics in general practitioner health clinics.

KING EDWARD'S HOSPITAL FUND FOR LONDON

PRIORITIES IN MEDICAL CARE

SEMINAR AT THE KING'S FUND COLLEGE

9 - 11 MARCH 1977

"EDUCATIONAL NEEDS OF GENERAL PRACTITIONERS"

by Dr John D Williamson

--ooOoo--

KING EDWARD'S HOSPITAL FUND FOR LONDON

PRIORITIES IN MEDICAL CARE

"Educational Needs of General Practitioners"

Definitions

Educate : to bring up (a child); to give intellectual and moral training; to provide schooling for; to train (man or animal); to instruct systematically (OED).

Need : circumstance(s) requiring some course; necessity for presence or possession of; thing wanted, respect on which want is felt; etc (OED).

General Practitioner : a licensed medical graduate who gives, personal, primary and continuing care to individuals, families and a practice population, irrespective of age, sex and illness. It is the synthesis of these functions which is unique. He will attend his patients in his consulting room and in their homes and sometimes in a clinic or hospital. His aim is to make early diagnoses. He will include and integrate physical, psychological, and social factors in his considerations about health and illness. This will be expressed in the care of his patients. He will make an initial decision about every problem which is presented to him as a doctor. He will undertake the continuing management of his patients with chronic, recurrent or terminal illness. Prolonged contact means that he can use repeated opportunities to gather information at a pace appropriate to each patient and build up a relationship of trust which he can use professionally. He will practise in co-operation with other colleagues, medical and non-medical. He will know how and when to intervene through treatment, prevention and education to promote the health of his patients and their families. He will recognise that he has a professional responsibility to the community. (Council for Postgraduate Medical Education in England and Wales, 1976).

Assumptions

1. That there are recognisably distinct differences between the functions of the general practitioner and the hospital-based specialist. The main ones are :

(a) Hospital specialists see cases only after referral from a primary care colleague whether the latter be community- or hospital-based (ie GP or Casualty Officer). Access to GPs is unhindered other than by rationing processes artificially introduced into individual practices (eg appointment systems or hostile receptionists).

(b) Since the workload of hospital specialists is pre-selected by professional colleagues his predominant orientation is towards diseases, organs or techniques (eg venereologist, nephrologist, and radiologists respectively). On the other hand the GP has to be symptom orientated (ie he has to make sense of the presented 'complaint chaos' to derive a plan of management).

(c) The basic distinction between hospital specialist and GP then is the degree of specialisation in medical knowledge and technology of the former.

(d) The hospital specialist is therefore predominantly Investigation and Therapy orientated whilst the GP is predominantly Diagnosis, Prevention and Education orientated.

(e) The hospital specialist does not exist in a special relationship to other hospital doctors outside his specialty. The GP exists in a protected relationship with specialists of all varieties.

(f) At the extremes the hospital specialist sees patients for short periods of intensive observation or treatment. The GP sees patients intermittently over a long period of time and for a number of different complaints.

(g) At the extremes the hospital specialist is dealing with an institutionalised and passive patient whilst the GP is dealing with a patient in his or her own familiar surroundings who is much more likely to question the doctor's decision or fail to comply with the doctor's proposed management plan.

(h) A final major difference is the Administrative requirement for absentee workers claiming sickness as a reason for their absence to obtain a doctor's certification of their incapacity for work.

2. That there are basic similarities between the functions of hospital specialists and General Practitioners. The main ones are :

(a) Both have received an adequate basic medical training in the opinion of their certifying University or College and of the General Medical Council.

(b) Both have a responsibility to ration their activities such that patients have done to them only that which needs doing and such that they only do work which requires their particular skills (Cooper 1975; Mahler, 1975).

(c) Both have a responsibility to co-operate with other professional and non-professional workers in the management of the patient's problem.

(d) Both now use a whole-person and problem orientated approach to medical practice.

(e) Both agree the basic need for the distinctions in most functions. Where exceptions occur (eg hospital management of chronic disease on a continuous basis, domiciliary visiting by hospital specialists, open paediatric clinics, general practitioner hospitals and general practitioner surgery) the dispute is usually based on educational and management issues.

3. That in the foreseeable future primary prevention and much of secondary prevention will be undertaken by doctors and other health workers employed specifically for that task. (The abolition of this branch of the NHS would have its own implications for the education of general practitioners who would have to undertake such tasks as immunisation, cervical cytology and developmental assessment in addition to their existing work).

<u>Who Defines Educational Need?</u>

1. National Professional Bodies :

(a) Specialist Organisations (RCP; RCS; RCOG; etc)

(b) General Practitioner Organisations - if so, which?

RCGP, GMSC or other organisations do not have anything like universal membership. It might be assumed that GPs antagonistic to these organisations might have strong views on their own educational needs different to those of one or all of the organisations.

(c) Para-Medical Organisations (RCN; Ass LabTech,etc)

ALL of these organisations will perceive the roles and therefore the education required by the GP in terms of the work of their own membership's attitudes to their own work.

2. Individuals

(a) General Practitioners
(b) Patients

Both of these groups of individuals will have their own individual perceptions of what is needed by the GP and this will depend as much on local characteristics as on professional considerations.

3. International Organisations

Bodies like the World Health Organisation, the World Medical Association, and various international general practitioner associations will help to identify need in one group of doctors by examining what their equivalents in other countries do.

4. Employer

What a GP needs in terms of education will inevitably reflect the job he contracts to do with his employer. In the NHS this inevitably introduces the necessity for consideration of the rationing processes which are delegated to the GP by the State.

Educational Considerations

Three basic considerations exist in any educational programme and these are the content of the programme, the means of its dissemination and the incentives for people to participate in the programme.

1. Content

(a) Knowledge

(i) Appropriate use of alternative manpower (inc the patient)
(ii) Investigation and diagnosis of the presented complaint
(iii) Therapies used by himself autonomously or as delegated by a hospital specialist
(iv) Therapies used by persons as delegated by the GP (inc sub-ordinates, other members of the Team, and the patient)
(v) Methods of health maintenance
(vi) Methods of primary, secondary and tertiary prevention as are appropriate to general practice.

These basic areas are not intended as a complete list of the knowledge that a GP should have but they represent fields in which the GP's knowledge-base is substantially different to that of his colleagues. The same list is applicable to organic, psychological, social or mixed problems and it requires basic consideration of those psychological, sociological and ethical aspects which are so strongly stressed by many GP tutors.

(b) Skills

(i) Educational (by request or by identification of hidden need in the patient)
(ii) Preventive (inc protecting the patient from hospital investigation/therapy, or from involvement with para-medical or non-health-professional workers, or from reliance on GP unless such is both appropriate and necessary)
(iii) Diagnostic (inc investigative)
(iv) Therapeutic (inc physical methods, counselling)
(v) Patient management (inc the effective use of time and social context to produce a management plan that is optimal in terms of professional adequacy and in terms of patient acceptability)
(vi) Business management (inc record-keeping, delegation, personnel management and public relations).

The specific of 'skill education' is that the GP must be able to use his basic resources of social proximity and time (ie recurrent opportunities) in such a way that not only are the patient's recognised problems solved in

as much as that is possible, but also to ensure that his knowledge and skill is used to the benefit of those at risk from unidentified problems.

(c) Attitudes

The only really important thing to say here is that the GP must develop positive attitudes to his role as a responsible and respectable member of the professional health services to the extent that his job satisfaction is enhanced. This means that the GP must recognise and accept both his limitations and his segregation from the wider medical community as potential strengths overcome by a deliberate attempt at co-operation, communication and joint learning.

2. Dissemination

(a) Individual Teaching

(i) Pupil-teacher relationship (formal or informal)
(ii) The commercial representative

(b) Group Learning

(i) Course of systematic instruction
(ii) Ethical lectures on random topics
(iii) Commercial lectures

(c) Solo Learning

(i) Television or radio lectures on medical subjects
(ii) Tape or tape/slide presentation
(iii) Reading

- textbooks
- ethical Journals or Newspapers
- commercial releases

Each of these has advantages and disadvantages. Each can vary in content depending on who designs the teaching experience and why.

3. Incentive

(a) Positive

(i) Cash (direct and indirect)
(ii) Involvement

- group discussion
- self-evaluation
- performance-monitoring (medical audit)

(iii) Interest

- subject
- local interest
- GP orientation
- perceived relevance

(b) Negative

(i) Expense (of attendance or of materials)
(ii) Lack of Time (work-load, distance, duration,etc)
(iii) Low job-satisfaction

- dependent population
- lack of opportunity to practise what he has been taught
- dissatisfaction with administrative responsibilities
- dissatisfaction with convenience consultation
- disinterest in GP as a specialty

The Pupil

The discussion of Education for General Practice tends to assume that the educational needs of all GPs are the same.

There is a clear difference between knowledge or skills - and even on occasion attitudes - which need to be taught to newly qualified doctors and those needed by senior experienced practitioners. The latter need 'new' information and that intended to 'refresh the memory'. The former need to be taught what they need to operate as successful GPs which they have not already been taught in their undergraduate training. Clearly then there are four varieties of pupil:

- trainee
- novice though trained GP
- novice and untrained GP
- experienced GP

The needs of the untrained novice are similar to the trainee though there are financial and emotional barriers to an adequate training programme which have to be taken into account. Despite the insistence that future principals shall be required to be trained there will always be a cadre of people who become GPs late in their professional career for whom training is not appropriate. The novice GP otherwise needs specific information about local problems, resources, policy and practical arrangements.

A final complicating factor is that whilst much of medical education is teaching the middle classes how the working classes live much of GP training is concerned with teaching foreigners how the natives live. This fact complicates the listing given above.

Public Education

Education for General Practice cannot easily be separated from Education of the Public. Appropriate self-care, appropriate consultation, compliance with medical advice, health maintenance and appropriate disease prevention all have a beneficial enhancing effect on the workload and the nature of the task of the general practitioner.

Medical Education

Departments of General Practice in the Medical Schools have a special responsibility which extends beyond merely providing opportunities for students to experience general practice through the traditional attachment scheme. One learns not by experience, but by reflection on experience - the latter is the chief rationale of medical audit. Not only should the DGPs teach students what general practice is from the point of view of the GP, but it should also teach it from the point of view of the consultant. In this way the DGP will not merely be providing career guidance in its teaching but it will be fundamentally affecting the future consultants' perceptions of general practice and its relevance to their own work.

The Educational Needs of General Practitioners

Clearly this is a complex and multi-dimensional subject. In the discussion I hope to synthesise the various strands presented above not merely to emphasise the difficulties

involved but also to suggest strategies to overcome them. Many of the latter will inevitably raise basic questions of the role of the general practitioner in our modern and developing health service.