THE FAMILY DOCTOR IN BRITAIN

BY JOHN FRY, GENERAL PRACTITIONER, BECKENHAM, KENT

The evolution of the family doctor in Great Britain has taken more than four centuries. From the early days of specialisation, with the first foundation of the Royal College of Physicians and Surgeons, in the 16th century, to the present day of the Welfare State and the National Health Service, the family doctor has maintained his characteristic place in the British system of medical practice.

Following critical periods during the last war and just after the war British general practice remains the largest branch of the medical profession. There are now nearly 23,000 family doctors serving a population of 50 million.

The significant events in the evolution of British general practice was the introduction of a comprehensive National Health Service (N.H.S.) in 1948. More than 95 percent of general practice is now carried out under the N.H.S. (the remainder prefers to have private treatment, often from doctors who are also practising in N.H.S.). Under the National Health Service all treatment is free both in the homes and in the hospitals; all drugs are free; all prophylactic measures are carried out free of charge and so are all investigations; there is a comprehensive sick-insurance scheme; and local authorities arrange for social and nursing benefits in the home. The family doctor is paid by a capitation fee of almost one pound for each patient (adults and children) per year and he also has extra payments for maternity work, immunisations and for patients who only stay temporarily in his area.

Until the introduction of the National Health Service there was a danger that falling standards might lead to a collapse of the system of general practice. Since then there has been a renaissance in this field and the outlook for the future of general practice in Britain is now very bright. It is now up to the general practitioner to provide as good a service as he wishes. He has facilities for investigating his own patients at the local hospital laboratory or x-ray department and he can call out specialists to visit his patients in their own homes to give him their opinions in consultation. There is nothing to prevent the British general practitioner from providing a complete personal medical service for his patients outside the hospitals.

A further sign of this renaissance has been the formation of the College of General Practitioners, a body with over five thousand members, whose aims are to develop the academic side of general practice. To elaborate the situation it is useful to consider a number of aspects.

The place of the general practitioner in the medical system. Each person in Britain, under the National Health Service, is entitled to receive medical care at home from the general practitioner of his or her choice. As a rule all the members of a family are under the care of a single doctor. The process of „registration" is very simple and involves the patient giving the doctor a medical card which he then sends to an Executive Council Office, who then send to him the patient's complete medical records which are held by the doctor providing the medical care.

The general practitioner works in his own premises and gives the necessary care he is able to provide. It is he who decides when the patient requires specialist treatment. When this is necessary he refers the patient, with a letter of introduction, to the specialist at a hospital out-patient department. When the specialist has seen the patient he then sends the patient back to the general practitioner with a letter giving his opinion and advice as to future management.

In this way, with the aid of free facilities for investigating his patients at the laboratory and x-ray department, the general practitioner is able to look after most cases of rheumatoid arthritis, anaemia, coronary artery disease, anceemia, peptic ulcer, infections of the chest, asthma, hypertension and so on at home without hospitalisation.

Home nursing care and provision of domestic help in the home are provided by „home nurses" and „home helps".

Under the British National Health Service the general practitioner is in complete charge of his patients at home and it is he who plans their medical care and it is he who decides when the assistance of the specialist is necessary. The relations between the patients and the general practitioner are invariably good, as they are between the general practitioner and his specialist colleagues.

Entry into general practice. In order to provide an adequate and uniform distribution of doctors in all areas of the country, entry of new doctors into general practice is controlled by the local Executive Councils, who are the bodies administering general practice. Areas are divided into those with too many general practitioners in the district (compared with the average for the area), an average number and too few. Young doctors are discouraged from starting up in the areas where there are too many doctors and are encouraged to go to the places where more general practitioners are needed.

This system, although it may seem rather dictatorial in theory, works very well in actual practice and young doctors are saved from losing much money and prevented from many anxieties.

There are three ways in which a young doctor may enter general practice.

1 In Britain over half the general practitioners work in partnerships of two or more (the usual number is two or three). The fashion is growing and more doctors are forming such groups and thereby work in teams sharing premises, staff and expenses. When a new partner is required the doctor take into their practice an „assistant-with-a-view" (to partnership), and providing that they get on well with each other the young doctor becomes a partner after the six or twelve months' trial period. He has his share of the income and he has financial security until he retires.

2 There are still nearly 10.000 general practitioners who practice alone and independently. When they retire, or die, the vacancy is filled by the Executive Council advertising the vacancy and appointing the most suitable candidate. As a rule there are about 20-50 applicants from which a choice has to be made. The new doctor does not have to pay for the goodwill of the practice but he does have to buy or rent premises from which he will work.

3 A third way of entering general practice is for the young doctor to „put his plate up" outside his home and to wait for patients to arrive! This only occurs in areas with much new building. It is almost impossible for a doctor to build up a practice in this way in an area with old-established general practitioners because it is not the custom for the British public readily to change doctors.

Training for general practice. Before becoming a principal in general practice it is usual for the doctor to have had considerable experience and training in this branch of medicine. We realise that general practice is as much a speciality as say ophthalmology, dermatology, internal medicine or orthopaedics, and the young doctor must have some training and teaching before he is ready to practice on his own.

There is an extensive system of „trainee assistants" where young doctors work with experienced general practitioners for at least a year — and during this time it is the duty of the older doctor to train his young colleague. It is the custom for young doctors to act as assistant to a number of doctors in different areas, over a period of two or three years, to obtain experience in different types of general practice.

The National Health Service pays the salary of the „trainee" in his first year. In addition to this work in general practice two years' work in hospitals are usual. This work is carried

out in the internal medical, obstetric, paediatric, dermatological and otorhinolaryngological departments.
Before a young doctor settles in his own practice therefore he has usually done two years' work in a hospital and two or three years as an assistant in general practice.

Postgraduate training. To maintain high standards doctors must be „perpetual students" and some postgraduate training is essential.
A great number of possible methods exist in Britain. There are many postgraduate courses organised by university departments at places like London, Cambridge, Edinburgh, Manchester and Bristol where the general practitioners can go and stay for one or two weeks attending series of lectures and demonstrations. Similar residential courses are also arranged by hospital departments other than universities. Another type of course is the non-residential extended course where the doctor attends once a week for ten to twelve weeks for lectures, discussions and demonstrations. Courses such as these are recognised by the National Health Service and the doctor attends them free of charge and he also gets an allowance for a locum whilst he is away.
In addition to these formal courses there are many meetings arranged by local medical societies and symposia organised by the College of General Practitioners. In Britain we have the same problems of attracting doctors to such courses as elsewhere. We find that it is the same group of 20-30 percent of doctors who regularly attend and much thought is being given to new ways of encouraging the others to attend.

Undergraduate education. All medical schools in Britain are now teaching their students something about general practice. The methods vary from place to place but the most common are as follows.
Students in their last year of training are sent to general practitioners for a week or more. They live with the doctor for that time and go about with him to see what general practice is all about. The students love this for it gives them their first real insight into the practice of medicine outside the hospital. It also does the practitioner good to have a young colleague watching him and questioning him on his work.
Lectures are given by general practitioners to students a few times a year on various aspects of general practice and many medical schools have a general practitioner who regularly attends teaching sessions to give his views on the management of patients.
There are a few special units where much more elaborate teaching of general practice is carried out as at Edinburgh and Manchester. In Edinburgh the university runs an actual general practice to which students are permanently attached and in Manchester there is the Darbishire House Health Centre which is administered by the university where students attend for teaching and training.
Plans are being discussed for departments of general practice to be formed in university medical schools to organize teaching of general practice to undergraduates and postgraduates.

Research in general practice. One of the most interesting developments in general practice in the past ten years has been the growth of research in this field. Many general practitioners are now carrying out research studies in their practices and the journals regularly contain papers from general practitioners reporting completed studies.
The scope of research in general practice is enormous. The general practitioner has the advantages of being able to follow-up his patients for many years and he is thus in the best position to study the long-term natural history of disease. He sees conditions which are never seen by any other medical men, i.e. the common respiratory infections and many cases of anaemia, migraine, hypertension, measles, mumps, influenza, etc. which never reach the specialist. These are just a few of the possibilities. We have only to sit back and think for a few moments to see many other subjects that could be studied.
General practice research requires no special training and no large amounts of money but merely an inquisitive and searching mind and an ability to record information and analyse the results by a simple process of organization. In Britain research in general practice has so far been carried out by individuals working independently, by groups of practitioners organized by the College of General Practitioners, by university departments and by the Medical Research Council. Published studies include work on acute otitis media, asthma, peptic ulcer, hypertension, chronic bronchitis, psychosomatic disorders, anaemia, measles, use of antibiotics, clinical trials and many others.
In research there is a need for more international collaboration and it is here that more contacts are needed with our colleagues all over the world.

College of General Practitioners. In stimulating academic interest in general practice and in organizing research and training for general practice this College has played a very important role.
Founded in 1952 it now has more than five thousand members and has affiliation with sister colleges in the commonwealth.

Problems. We still have many problems to solve but awareness of them is the first step to their solution. For example, we realise that isolation is a feature of general practice. The doctor working alone is apt to become too rigid and fixed in his work and he needs the occasional stimulus of close contact with his colleagues. We realise that under the National Health Service there is too much security for the general practitioner and a lack of incentives to bring out the very best in the doctors.

Solutions. After a critical period in the first five years of the National Health Service we feel that standards in general practice are rising and that many of the problems are being solved. More and more doctors are forming partnerships and work together in groups in a team. More and more doctors are attending postgraduate courses and taking part in the training of students. Others are being stimulated by participating in research studies. The problem of incentives, which must be financial to be effective, is being considered by a Committee.

The Future. General practice in Britain now is a virile and flourishing branch of medicine. It has grown out of a period of self-inferiority and it has a new confidence developed out of the realisation that it is the largest branch in the medical system, that it is essential for the patient to have his or her own personal family doctor in health and in illness, that the work is as interesting as the doctor wants it to be and that the opportunities in variety and interest are immense.
Living in a world where co-operation and exhange of views is the custom there is a need for more of this in the field of general practice. More visits by individual general practitioners to visit and study the work of their colleagues in other countries are needed. Such visits are stimulating both to the guest and to the host.

BASISCURSUS SOCIALE GENEESKUNDE EN GEZONDHEIDSLEER

Uitgaande van het Dr Veeger Instituut te Nijmegen zal een basiscursus sociale geneeskunde en gezondheidsleer worden gehouden met het doel artsen, die een sociaal-geneeskundige functie vervullen of ambiëren, uitbreiding te bieden van feitelijke kennis, inzicht in de problemen en methoden van basiswetenschappen als epidemiologie, sociologie en statistica, alsmede gelegenheid tot het zelf bestuderen, vooral met behulp van literatuur, en in discussie brengen van bepaalde onderwerpen.
De cursus wordt gegeven in het Dr Veeger Instituut te Nijmegen van 4 tot 15 september aanstaande, vervolgens op 35 dinsdagen en tenslotte van 2 tot 6 juli 1962. Het cursusgeld bedraagt *f* 150,—. Aanmeldingen kunnen geschieden bij Dr E. van der Werf, Griftdijk Z. 119, Lent (0 88 00/2 05 64) onder vermelding van datum van geboorte en van artsexamen en van huidige en eventueel vroegere werkkring.