zulke grootheden. Overigens is niet te zeggen wanneer voor het westen de toekomst — toekomst dan verstaan als een essentieel andere fase onzer samenleving dan de huidige — zal aanbreken.

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De arts-lezer zal weinig teleurgesteld zijn door het uitblijven van enig vergezicht op de gezinsfuncties van de toekomst. Per saldo is, professioneel gesproken, een verdieping van zijn inzicht in de levensachtergronden van zijn huidige patiënten een zaak, die reeds genoeg van hem vergt. Als hem een echte teleurstelling heeft bekropen, dan zal dat vooral zijn vanwege het feit, dat de beschouwing hem zo weinig over de huidige gezinsfuncties heeft opgeleverd, waarmee hij in zijn werk iets kan aanvangen. De schrijver kan echter niet worden verweten, dat hij ongerechtvaardigde verwachtingen wekte. Aan het begin van de beschouwing werd uitdrukkelijk gezegd, dat bij de huidige stand der gezinssociologische kennis weinig praktisch nuttigs van een verhandeling over gezinsfuncties mocht worden verwacht. Het moge lezer en schrijver beide tot troost zijn, dat op dit artikel over het gezin nog een aantal andere zal volgen. Alle artikelen tezamen bewerkstelligen misschien dat vanuit de gezinssociologie iets noemenswaardigs wordt bijgedragen tot de verdere vooruitgang van het medisch kunnen. In elk geval, alleen op basis van de mechanistische hypothese kan de medische wetenschap haar ambitieuze doeleinden niet bereiken. De psychiater Erik Erikson is in zijn uitspraak, als motto boven deze beschouwing geplaatst, doorgestoten tot een voor de medicus belangrijk inzicht. Was nu de gezinssociologie maar wat verder in haar mogelijkheden de arts inzichten te bieden van medisch-functionele bruikbaarheid.

*Evolution of General Practice in Great Britain**

BY PROF. R. SCOTT, M.D., D.P.H., EDINBURGH

I am deeply honoured by your invitation to take part in this symposium to mark the 10th anniversary of the foundation of the Dutch College of General Practitioners, and bring your greetings from your sister-college in Britain. I am delighted that on this occasion you are also celebrating the establishment of your first University Chair of General Practice and bring good wishes from the University of Edinburgh and, in particular, from colleagues in my own department, to Professor Van Es and to those who will work with him, in your institute and elsewhere, and so crown with success your efforts and his, to secure the academic basis on which general practice wil flourish, in both our countries. I assure you that I feel just as involved as you do in this exciting adventure in Utrecht.

The practice of medicine does not recognise National boundaries. We may not yet be members of the European common market in the political or economic sense, but in the field of medicine Scottish graduates, in general, and those from the University of Edinburgh, in particular, have for centuries passed come to Europe and especially to Holland to share in the common market of ideas. Indeed the institution in which I now work was established in the eighteenth century as the immediate result of a visit of one of our professors to the University of Leiden whence he brought back to Scotland the philosophy, the teaching and the inspiration of Boerhaave.

* Voordracht, gehouden ter gelegenheid van het elfde N.H.G.-congres, 18-19 november 1966 te Amsterdam.

The patterns of medical care in my country have thus evolved over a considerable period of time. The introduction of a National Health Service in 1948 was not a single act of revolution but rather a major step in the evolution of a plan to provide medical care for a whole nation. The introduction of our National Health Service had three immediate results:

1 It rationalised our hospital and specialist services and reorganised them, on a regional basis, throughout the country;

2 It defined more sharply the personal and preventive services provided by local public health authorities and at the same time it removed the hospital and curative services from these authorities thus forcing them to concentrate on disease prevention and health promotion, and

3 It ensured that every citizen, irrespective of age, sex, social class or socio-economic circumstance, had direct access to a personal doctor, i.e. a general practitioner. Thus every individual now has free and unhampered access, and continuity of access, to a personal doctor. For a substantial sector of our population this was in 1948 a novel experience.

The Health Service Act unfortunately did little to promote the integration of the three parts of the service, the hospital and specialist sector, preventive medicine, and the general practitioner sector. Indeed its first effect was to create a sharp

distinction between the doctor who works inside the hospital and the doctor who works in the community and in the homes of his patients.

It widened the gulf between the specialist and the generalist. Academic teaching and research were almost exclusively centred on the hospital, and the gulf, which was at first an administrative one, began to assume academic, professional and economic features which tended to intensify the problems of communication and understanding between these two major branches of the profession. I repeat that this differentiation between the specialist and the generalist was not created but rather accelerated, and put into sharper focus, by the introduction of our National Health Service. It is my view that this sharpening of focus can do one of two things — either it results in a complete fragmentation of medicine and of our profession, or it is the necessary first step in order to synthesise and integrate the generalist and the specialist in a common professional purpose, viz. providing optimum and comprehensive care for our patients. If I did not think that it was possible to achieve the latter alternative, I would not be here to-day.

I would now like to comment very briefly on one or two major features in the evolution of general practice in Britain in recent years.

A striking feature and one which is in sharp contrast with your experience in Holland has been the trend towards partnership and grouping in general practice. Before 1940 nearly three-quarters of our practitioners were in single-handed practice. Now the figures are completely reversed. Over 70% of our doctors are in partnership and the trend towards larger partnerships or groups is increasing in momentum.

There has also occurred a redistribution of our medical manpower. Almost half of our doctors work in the hospital the other half as general practitioners in the community.

This distribution of medical manpower is, however, not constant and the trend is for the ratio of hospital to community doctors to increase. Thus the ratio of doctors to patients in the hospital is increasing, while the ratio of general practitioners per thousand of the general population is decreasing. The specialist is personally responsible for fewer and fewer patients. The number of patients for whom the general practitioner is responsible is increasing and this at a time when the general practitioner of to-day is much better trained and has more skills and better tools at his disposal. The individual general practitioner can to-day do very much more for the individual patient. Paradoxically, he now has to spread his skills and knowledge over a larger number of patients.

On the purely clinical side it is possible to identify certain broad patterns in considering the changing relationship between the general practitioner and the hospital. On the one hand, certain sectors of medical care which were a substantial feature of the work of the general practitioner a generation ago now almost the exclusive concern of the hospital. This particularly applies to the whole field of surgery which is no longer regarded as anything other than a hospital service. To a large extent this has already happened or is certainly happening in the case of obstetrics, that is to say, the actual delivery of the woman is becoming more and more a hospital phenomenon although her prenatal and post-natal supervision is still regarded by many as a major function of the family doctor.

Many illnesses and particularly those of an infective nature, which a generation ago were regarded as urgent cause for having the patient admitted to hospital are now dealt with in general practice. This is perhaps particularly striking in the case of children, so that patterns of illness in an acute paediatric teaching hospital have completely changed in the past twenty years or so and the medical student can never see the whole range of acute infective episodes and exanthemata, if he spends all his student days within the confines of the hospital. Advances in chemotherapy, metabolic disease and biochemistry, have all resulted in a tendency for the hospital to push into the field of domiciliary medical care much of what was its exclusive concern only a short time ago. Indeed specialisation can only advance when this is possible. On the other hand, many of the clinical problems dealt with by the general practitioner a short time ago are now referred to hospital.

There is thus a constant two-way traffic between the spheres of interest and clinical activity of the hospital and the community sector of medical care. This has come about partly by modern advances in knowledge and technique and partly because of the way we organise our resources and administer our medical services. Finally, we have to recognise that Medicine itself, the medical profession, our universities and our medical services are themselves social institutions. We are all influenced, to some extent, in our daily work by the social, economic, political and cultural features of the society which we serve.

In the long run it may well be that these social factors or characteristics of a society are at least as important as the contribution of medical science as such, in determining the future role of the general practitioner.

The extent to which we as doctors are concerned with the incidence of juvenile delinquency or of illegitimacy, with the provision of better amenities for the aged in a society in which their numbers are increasing both actually and relatively, our changing social values in respect of religious beliefs and practices, new knowledge and understanding which comes from advances in the behavioural sciences, raising of standards of education in the general population — all these factors and many others determine, to some extent, how patients present themselves to their family doctor. The doctor may not be very happy about the pressures put

upon him by society, he may feel ill-equipped with the time, the tools and the training to deal with them, but the mere fact that we grant ever individual direct access to a doctor means, among other things, that society now has an eloquent means of expressing the problems which arise from faulty interpersonal relationships, from failure of society to meet these problems and evolve effective means of dealing with them or at least mitigating their effects.

These are some of the features influencing the changing role of general practice. Some of them are echoed in the new provisions for general practice embodied in our recent legislation which seeks, by financial inducement and changes in administration, to encourage among other things : 1) vocational training for general practice in the early postgraduate years; 2) in-service training for the doctor already established in practice; 3) improvement in organisation at practice level by the employment of ancillary workers (nurses, secretaries and technicians); 4) the setting up of appointment systems; 5) inducements favouring group practice; 6) financial recognition of seniority; and 7) increased payments for the care of vulnerable groups, e.g. the aged.

Looking further ahead one sees a great extension of direct access of the general practitioner to the diagnostic and therapeutic services of the hospital. A re-integration of hospital and community services and a blurring of the artificial boundaries between preventive and curative medicine. The extension of health overhauls, pre-symptomatic screening of vulnerable groups and the appropriate use of automation, will ensure that the future general practitioner cannot be exclusively concerned with curative medicine. The quality of the personal service which he can give to his patients will be enhanced rather than diminished by such developments.

The future of general practice is bound up with its integration on the one hand, with the hospital and, on the other hand, with the preventive and social services of the community. This highlights the need for planning and reorganisation not only nationally but particularly at the regional and local level.

Thus many of us see the approaching end of the truly independent contractor — working in isolation, unrelated to his colleagues, unchallenged in respect of his professional skills and practice, unwilling to engage in experiment and trial of different methods of working and unwilling to have new methods assessed by objective evaluation. The main problem then is to determine the extent to which we erode the principle of the independent contractor while retaining and preserving the doctor's personal professional integrity and the highest ideals of the doctor-patient relationship.

I have attempted to give a very brief outline of the salient features of the evolution of general practice in my own country. I have tried to do this as objectively as possible but I must point out that I have been expressing my own personal views and opinions which are not necessarily those of all my colleagues. I have done so because when you invited me to address you I was asked to do just that and also to indicate, against this background, my own views concerning the function of an academic Department of General Practice. Here, of necessity, I must be even more brief and again I hope you will forgive me if I draw on my own limited experience. Nothing that I say should be interpreted as being a prototype or a model for academic departments since it is obvious there are great varieties of ways in which such a department can come into being and function effectively. I see my own department as having six major and inter-related functions.

1 The actual provision of medical care in the day to day setting of general practice for a permanent practice population;

2 The teaching of medical students in the setting of general practice;

3 The in-post training of the staff of the department;

4 The prosecution of research in the setting of general practice and the extension of knowledge relevant to the academic and professional problems confronting the general practitioner;

5 The integration of the activities of the department, particularly in relation to the medical care, teaching and research, with clinical and para-clinical departments in the medical school and, finally,

6 The provision of specific vocational training for postgraduates preparing themselves for a career in general practice and for doctors already established in this field of medicine.

In considering the personnel required to staff such a department and to develop its teaching and research programme, I would consider it highly desirable that the department should be headed by a clinician who is still actively engaged in practice or who has at least had a substantial experience in this field. One individual however cannot adequately embrace all the skills and disciplines required by such a department. He and his supporting staff should be chosen with this in mind. There are three groups of disciplines which are basic to such a department and which require freedom to develop independently where necessary but in such a way that all three are seen to contribute to every major departmental activity. These are:

1 medicine itself and especially internal medicine and its supporting laboratory disciplines;

2 the group of skills and knowledge concerned with epidemiology including biometrics and