THE PERSONAL DOCTOR
AND HIS RELATION TO THE HOSPITAL

Observations and Reflections on Some American Experiments in General Practice by Groups

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IN this country we have one big experiment in medical care, and a few little ones. In the United States they have a great many experiments; and I went to see some that bear on the future of general practice.

What I shall describe is not the pattern of American medicine but rather the efforts of people who are trying to improve on that pattern. And obviously my few weeks in the States do not entitle me to say whether, or how far, any of these efforts will succeed. But of one thing I am certain—that an occasional look at what is being attempted in other countries can help us to decide what we really want for ourselves. Or don't want.

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Some forty years ago the Soviet planners, for their part, decided that general practice was already an anachronism: even first-line medical care, they said, should be given by specialists. Hence in the Russian town the patient goes to a policlinic, and in the country he goes to a small hospital staffed by a team consisting perhaps of a surgeon, an internist, a pædiatrician, and an obstetrician. In Russia the equivalent of our general practice is thus provided by low-grade specialists, who are the peripheral and most subordinate officers of a unified medical service.

In Britain since 1948 we have taken quite a different line: we have declared that hospital work is for specialists but general practice is (and ever shall be) for general practitioners. Our practitioner is and remains an independent doctor, whose professional prestige can be as high as that of his hospital colleague. The previously growing tendency for practitioners to become part-time specialists has been checked by putting the two branches of medicine under separate management. Thus general practice as we know it has been preserved for posterity—carefully sheltered from the prevailing wind of specialisation.

In America, where this wind has sometimes been a hurricane, one can study its effects; and they include some alternative ways of doing the work that general practitioners do here. When I have said something about these, I shall return to the question I took across the Atlantic. Is the independent practitioner really out of date? Would his functions in fact be better performed by medical groups based on the hospital? If we continue to preserve him, what exactly are we trying to preserve?

PRACTITIONERS WITH BEDS

General practice in Britain and America differ strikingly, of course, in their relation to the hospital.

In Britain, as I have said, the tendency before 1948 was for practitioners to develop a specialty; and quite a lot of them combined family doctoring with surgery. Unfortunately, in cottage hospitals with small staffs, some of these did far more difficult surgery than was proper: and reaction from this abuse was probably the main reason why, in the new service, the hospital boards deprived so many practitioners of the beds they formerly controlled. The public, it was felt, would be safer if nearly all specialised work were put in the hands of whole-time specialists rigorously selected for the purpose; and the large majority of the 23,000 N.H.S. practitioners cannot now look after their patients in hospital. In England and Wales fewer than 10,000 beds remain in their large.

In the United States, by contrast, the majority have easy access to hospital beds. Most of the community hospitals (which correspond to our former cottage hospitals and other voluntary hospitals) were originally built on the plea of the local doctors; and the classical pattern is that all these doctors are on the staff. What surprised me, however, was to find that the staffs of even large and important hospitals often include people who, if not general practitioners in the more comprehensive sense, are undertaking general medical care. Accustomed to the sharp British division between Specialists and Others, I expressed this astonishment:

> " This may be fine for the doctors," I said: " but if I get as far as a big hospital, I want to be treated by someone who's giving his whole time to hospital medicine. Maybe you don't let a general practitioner operate; but, even so, some medical emergencies are just as tricky as surgical ones. For my full-time illness, I want a full-time specialist, not a part-time one, even if he *has* been looking after my health for years."

But the Americans, naturally, have an answer to this, and a good one. It is that the large American hospital, like the American home, has fewer *doors*—that life inside it is lived more publicly.

INTERNS AND TEACHERS

Dr. A, a youngish internist,[1] is still only a part-time specialist in that he does what we should call general practice at a health centre, visiting patients' homes; but he is also one of the 200 doctors on the staff of the local community hospital and is on the teaching staff of a famous hospital in Boston. " When I send a patient in," he told me, " the intern gets busy, and then the resident, and treatment is started. The intern may ring up to say what he's doing. By the time I visit, all the wheels may be in motion." Though this patient is Dr. A's responsibility, the whole-time staff will do teaching rounds on his cases, and so may members of the visiting staff—a distinguished hæmatologist, for instance, on an occasional pastoral visit.

In a big teaching hospital the chief of the medical service may actually think of his department as a hierarchy in which he has final responsibility for all patients, though he delegates it to some part-timers. In

1. Internists are specialists in internal medicine—i.e., general physicians. Interns are junior housemen, and residents are senior housemen.

smaller hospitals, no doubt, a full-time chief will be more anxious not to seem to interfere with the treatment of cases admitted under their own doctor. But, even so, Dr. A thought it the duty of any chief of service to interfere if a mistake comes to his notice. The other day, for instance, his chief of service had tactfully rung him up to ask whether he knew that one of his patients had lately been on cortisone, which might be an alternative explanation of some of her symptoms. " No offence intended," said Dr. A, " and none taken."

The key to all this is the word *teaching*. At first, in my insular way, I interpreted this as instruction of students; but the Americans very rightly apply the word also to instruction of interns and residents; which means that any round with junior staff, in any hospital, should be a teaching round (though I gathered that it all too often is not). The full-timer who can take his juniors to see and discuss any case in the hospital, in even the most private bed, can be a pretty effective safeguard for the patient against errors arising from insufficient knowledge or attention; and the publicity of practice in a large hospital means that the doctor who admits the patient, though he retains responsibility, will readily get advice if need be, even if he does not seek it.

Admittedly, a great many American hospitals—even quite big ones—have no interns and no full-time specialists: they are staffed entirely by people who are doing general practice as well as hospital work. But the number of such hospitals is likely to diminish. The trend towards specialisation is manifest in efforts to persuade the hospital authorities to appoint a full specialist as chief of each main service—or at the very least a surgeon who does nothing else but surgery. The hospital may then rule that at all operations the full-time surgeon shall be scrubbed up and ready to help; or a plan may be introduced whereby the surgeon assists the practitioner with the easy operations while the practitioner assists the surgeon with the difficult ones.

COLLECTIVE RESPONSIBILITY

The lack of fully specialised staff means that at present one's chances of dying quietly in a hospital bed with the wrong diagnosis are higher in America than in Britain.—Quietly in the sense that nobody knows, except perhaps the nurses; or that if one's colleagues know, they can do nothing about it.

But here again the risks of a libertarian system are being countered by characteristically American devices. Already two years ago some 75% of general hospitals (though only 25% of hospitals with less than fifty beds) were approved by the Joint Commission on Accreditation; which means not only that they reach a tolerable level of facilities for patients and staff but also that the doctors take steps towards collective responsibility for their work. Thus, on the surgical side, records must include a provisional diagnosis, recorded wherever possible before operation: all tissues excised must be reported on by a pathologist; and a " tissue committee " must report periodically on these data. Likewise admissions and discharges (including deaths) may be discussed at one of the monthly meetings, which must be attended by at least half the staff. Some hospitals hold " case conferences " at which one or two doctors are asked to discuss a subject in the light of their (not always very good) results. A neighbouring medical school, invited to provide lecturers, may send one or two senior men to look through the hospital records, in search of subjects on which teaching is specially desirable. And sometimes an attempt is made to assess the quality of the hospital's work by a formal review—a " medical audit "—of its records and the activities of its doctors.

An experienced medical administrator said to me that in a good hospital such formalities as tissue committees and medical audits do more harm than good: what really matters is to have a staff that trust each other and consult each other fully. But they can be, and are, a great help to the reformer who—sometimes against heavy odds—is bent on raising the standards of his hospital. I was assured, moreover, that American doctors generally do not mind their failures being discussed by colleagues—even colleagues with whom they are competing for practice—provided the discussion is private. Like the Russians and the Chinese, they claim to be able to tolerate sessions for self-examination—a moral accomplishment which we British so far show little sign of emulating.

FREEDOM—WITH SAFEGUARDS

But I must not wander too far from my argument. The main point I have made so far is that, whereas in Britain all but a few hospital beds are reserved for full specialists, in the United States a great many such beds are at the disposal of general practitioners and part-time specialists. Hence the profession is not, as in England, sharply divided, at the hospital gate, into specialist sheep and generalist goats.

This American system can work well—for the patient as well as for the doctor—provided the hospital's standards are set, and unobtrusively preserved and promulgated, by full specialists. In the large hospitals these men exert their influence through consulting with the part-time staff and through teaching the interns. In small ones the patient gets increasing protection (though sometimes posthumously) from critical reviews by outsiders and by the staff themselves.

VARIOUS KINDS OF GROUP

In America, as in Britain, a great many practitioners are still in " solo " practice. I met a few of them, including one so oldfashioned as to prefer to practise from his own home (" far more convenient than driving down to an office every time a patient calls "). But I am less concerned here with the ways in which American practice resembles our own than with some of the innovations—the efforts to do something different. My picture is correspondingly distorted; and the reader (like the visitor to the U.S.A.) must everywhere remember that " this, of course, is not America ".

What I was looking at were various forms of group providing first-line medicine; and in its simplest form such a group is the same as an English partnership, except that its office will be equipped for more investigation and may have more ancillary staff—besides being probably a better building with more amenities. Among the people I would gladly have as my family doctor were two partners in a small town in Wisconsin (one of whom, as a university preceptor, always had a student under instruction) and three men working from their own centre in North Carolina but also teaching on outpatients in the university hospital.

Where the American groups diverge from their British counterparts is when they begin to turn into clinics offering *specialised* investigation and care. Sometimes the result is

a modest affair proportionate to local needs, but sometimes it is—well, the Mayo Clinic. The process begins through the drive of some doctor who sees that the requirements of the neighbourhood are not being met; or one who must have a larger supporting structure for his genius; or one who merely wants to expand his business or find scope for his organising talent. But as the group gets going it may develop a life of its own, and new motives. I was fortunate enough to see what seemed to be various stages of this process, as well as several different types.

Natural History of the Private Clinic

The first two were still at the stage of being expressions of a personality.

1. *An Organised Partnership*

One was in a little mountain town. On the best available site within easy reach of the hospital, a well-qualified surgeon was practising with two associates. His long shed-like building was unpretentious; but as an artist he had lined each room with a different wood, and had given the consulting-rooms the friendly look of home. As an organiser, however, he had pursued Modern Efficiency as far as she would go (which is sometimes rather further than she ought), with light signals outside the examining-rooms, internal loud-speaking telephones by which anybody could talk to anybody, and music from the consulting-room ceiling. My guess is that this little mountain practice will soon get bigger and more specialised.

2. *An Enlarging Clinic*

The other had already done so.

Before the war three doctors, with local support, transformed an old school into a small hospital. This they then transferred to the community; but a symbiotic arrangement was made whereby the hospital took part of the private doctors' fees and in return provided them with " offices, nurses, technical staff, equipment, laboratories, medicines, bookkeeping services, and other conveniences ".

A condition of the public grants with which the hospital is being rebuilt to 100 beds is that the private clinic shall no longer be in the same building; but hospital and clinic will continue to be " mutually convenient to each other ". Under the leadership of an able and indefatigable surgeon, aided by an able administrator, the clinic and hospital represent a big addition to the medical resources of the area; but it still seemed to me more of a private enterprise than a public utility.

The doctors in the clinic all work for their own fees: the surgeon thinks that salaries lead to laziness and slow work. Some of them still provide general medical care from their clinic offices, and I asked one of these whether he really *liked* listening to patients with minor ailments. With a wry smile he replied: " It's worth it."

SECOND GENERATION

The two groups I next describe belong to the second generation, having proved viable after their originator had gone. The first is interesting because, though it is a specialist group, general practice in the neighbourhood is still an important part of its activities. The second illustrates the natural fate of general medical care in an increasingly specialised organisation—unless a deliberate effort is made to preserve, develop, or transform it.

3. *A Clinic with Much General Practice*

A quarter of a century ago a doctor working from an A.D. 1750 mansion in a township near Boston decided to give up his lawn and build a medical centre. Much enlarged, this is now owned and run democratically by the Dedham Medical Associates. Specialists of all the main kinds have sessions at the clinic; and both consultations and investigations are easily arranged. But, as I said, the really noteworthy thing is that this medically sophisticated group is still providing personal or family medical care for the local community (as its founder did in his nextdoor mansion); and, stranger still, the five members of the group who do this are paid individual fees and are thus in competition not only with the local practitioners but with each other.

These five doctors are not general practitioners but internists, and they can take their patients into the hospitals where they are on the staff. Normally they see their patients at the clinic, where each has his own room; but they pay home visits, up to 20 miles away—the fee being perhaps 5–7 dollars for an ordinary home visit, mounting to as much as 25 for a long distance. Even though the clinic is now long established, local practitioners never refer cases to it; but neither external competition nor internal competition seems to disturb the group's equanimity. Patients sometimes want to change their doctor, but (said the present chairman) if one joins a group one must be prepared to give and take: what matters is not what is good for the doctor but what is good for the patient. New members are chosen with deliberation, and during the first year they spend some five months deputising for their seniors when these are on holiday. At night the telephone is answered by a lay person who is paid to take and refer the calls: at weekends *three* of the five doctors are on duty, for it is found that if the weekend work is done by only one he is exhausted on Monday.

4. *A Clinic with Little General Practice*

From this relatively small building in a populous area we pass to a remarkably big one in the little Wisconsin town of Marshfield, which has perhaps 10,000 inhabitants. Like the Mayo Clinic in neighbouring Minnesota, the Marshfield Clinic exports medical care, getting patients not only from its own State but also from far away; and that is the reason why the Roman Catholic sisterhood who provide the 280 pay-beds at the local hospital are already finding these too few. Several of the clinic staff of 38 specialists have appointments in universities, and at least one has an international reputation; but for old time's sake the internists among them still accept local people as their personal patients whom they visit if need be.

For all this arose out of a general practice. The founder, Karl W. Doege, " only a small town doctor but full of love for his profession ", believed in better diagnosis and treatment through " intimate association of physicians in their work, constant study and mutual assistance ",[2] and in 1916 he brought five other men into a well-knit clinic group.

The members of this group, joining after three years' probation, are paid on the same scale regardless of specialty or number of patients seen: " our present plan is based on the assumption that each physician is as valuable to the organization as any other ". Related to age, experience, and years of service with the clinic, salaries rise till 60 and then decline till 65, when the member loses his vote.

Providing security and fine facilities for work, the clinic is virtually (though not legally) a non-profit-making organisation. People who regard it (or one of the members) as their own doctor pay lower fees than the far larger number who are referred for consultation; and sometimes a little embarrassment arises over referrals because the clinic is thus in competition with the other 7 practitioners in the town.

Large and specialised though it is, it is still in general practice.

But at Marshfield personal medical care is a merely vestigial function, and we cannot look there for our shape of things to come.

Two Planned Experiments

From these illustrations of the natural process of specialisation I turn to two carefully planned attempts to develop general practice as part of a balanced medical

2. Baldwin, R. S. *Group Practice*, August, 1959.

service. With support from Funds and Foundations, these experiments are being made in rural counties which had previously had hardly any specialists.

The first is based on a hospital, the second on a private clinic.

HUNTERDON

Hunterdon County, in rural New Jersey, with 45,000 people, had about 25 general practitioners and 12 public-health nurses, but no hospital and no specialists. Farsighted citizens decided against having " just another hospital " and have cooperated to create one with teaching-hospital standards and progressive outlook which should be the county centre not only for medical practice but also for public health and teaching.

With 120 beds, the hospital is staffed (a) by permanent specialists, of whom 17 are full-time, and (b) by almost all the local general practitioners. The specialists, as faculty members of New York University, spend one day each week at the Bellevue Medical Center: all their earnings go into a professional group fund from which they are paid (regardless of specialty) what is to all intents and purposes a regular salary. The medical board is composed equally of specialists and practitioners, appointed by the board of trustees. Some of the hospital's interns and residents are particularly attracted to it by the prospect of learning something about general practice, and a few students spend a month or two there " to gain an understanding of community medical practice ".

As a hospital Hunterdon is outstanding: its pædiatric department, where mothers have always been encouraged to come in and help,[3] is only one of many good things. As a public-health centre it has had some successes but also setbacks: it has not become the focus of local welfare services or of a county health department.[4] But here I am concerned only with its effect on general practice.

It has given the local doctors a diagnostic centre to which they can bring their patients: examining and auxiliary rooms are used by all doctors alike (" we purposely want the specialists and general practitioners to be falling over each other "). It thus gives them and their patients the benefit of easy and personal consultation; and they also participate, if they wish, in weekly staff and departmental conferences. In all this Hunterdon avoids " the two medical traps into which so many rural hospitals fall: either they are medically mediocre because they lack specialists; or, if there is a specialist corps, it runs things at the expense of the voice, stature and potentialities of the family doctor ".[5]

The facts of hospital life have to be faced; but all save one or two practitioners seem to be now content that patients admitted under their care are ultimately the responsibility of the full-time specialists, who make daily rounds and can offer suggestions. That in the hospital the practitioner is no longer really in charge is shown by the following interpretation of his duties:

> " He has a continuing obligation to the patient after his admission to the center, and he takes an active part in discussions concerning treatment. He thus maintains his contact with the patient and his family, writes orders, scrubs to assist in surgical procedures, if he so desires, and thus shares responsibility with the specialist on the staff for the selection and application of the best in modern therapy. He attends medical and pediatric patients and makes uncomplicated obstetric deliveries. The responsibility for normal obstetric practice is his, the role of the director being almost entirely advisory and, as the occasion requires, supervisory." [6]

This is a gallant and exciting experiment—at least partially successful. But it leaves me with two doubts.

First, if you have a hospital with not only full-time specialists but also residents and interns, can you continue to say that the patient's own doctor remains in any real sense in charge of him after his admission? Having let the consultant take over his role as arbiter, the practitioner finds that his lesser role as the patient's attendant has to be shared with the intern or resident; and it is hardly surprising that, at Hunterdon and elsewhere, doctors admitting their patients have sometimes felt that, while helpful consultants are one thing, helpful interns are quite another. Yet the intern, who is on the spot, can scarcely be blamed if he talks to patients, and he may easily seem to take too much upon himself. Is the arrangement functionally sound? Or should we not perhaps interpret these difficulties as showing that the bedside team becomes in fact too large and cumbrous if the practitioner is introduced as anything more than a welcome visitor?

Secondly, what effect has this kind of attachment to a fine hospital had on the doctor's professional habits at his own " office " or surgery, five, ten, twenty miles from Hunterdon? May he still, for instance, be seeing far too many patients in an afternoon?

RIP VAN WINKLE

The second experiment—even more gallant actually—is quite different; and whatever shortcomings it may have it cannot at any rate be criticised for leaving the doctor's office unchanged; for it includes a direct attempt to upgrade medical work at the periphery. Instead of leaving personal care to the individual practitioner, it aims at meeting the medical needs of a county through half a dozen widely spaced group clinics working in close relation to the centre.

The story is at first not unlike that of other groups. An able young surgeon was persuaded to come back to his home town of Hudson, in the small farming county of Columbia in New York State. With a partner he started what became a clinic, and (known since 1946 as the Rip Van Winkle Clinic) this has a strong family resemblance to others I have described. Very busy, and attracting some patients even from New York City, it hopes to move from its present cramped building to a site opposite the community hospital to which its members admit their patients. It is a true group in that the members put private fees into the pool from which they draw their salaries; and the salaries have steadily gone up.

What is chiefly remarkable, however, is that this clinic—a piece of private enterprise—is now conceived as the nucleus of comprehensive medical care for its county. Already in three areas which have lost their doctor through death or retirement, the Rip Van Winkle Foundation has set up a small well-equipped clinic—two being in old houses while one is an exemplary new building. The basic team in these clinics (when achieved) is to be two internists, a pædiatrician, and a dentist: thus the doctors in charge are not general practitioners in the usual sense but specialists.[7] They live in or near their clinic but visit Hudson, and they are in turn visited weekly by a surgeon and an obstetrician-gynæcologist. Regular vans take people, equipment, and specimens to and from the centre.

COUNTRY VERSUS TOWN

In the U.S.A., as in many other places, the young doctor does not readily go to work in the country. The Hunterdon Hospital is trying to make rural New Jersey attractive by offering him the kind of diagnostic and therapeutic facilities he learned to use in his medical school, and an academic atmosphere. The Rip Van Winkle Clinic is trying to make rural New York State attractive by likewise offering opportunities for really good work with some academic stimuli. It enables young specialists to take such work without having to " assume responsibility in areas in

3. Hunt, A. D., Trussell, R. E. *Modern Hosp.* September, 1955.
4. Trussell, R. E. Hunterdon Medical Center. Harvard University Press, 1956.
5. *Architectural Forum*, December, 1953.
6. Rannels, H. W. *Postgrad. Med.* 1959, **25**, 180.
7. All the staff are Board-certified or Board-eligible in their specialty.

which they are not comfortable ", and it offers a guaranteed salary and often a house from the start.

To those who really like looking after people in their everyday life, and who like the country, these conditions may well seem almost perfect; and there are youngish doctors in the Rip Van Winkle clinics who seem ready to make general medical care their lifework. On the other hand the scheme has not succeeded in incorporating the general practitioners of the county, and some difficulty arises from the fact that the doctors it has imported are all specialists. The probable reason why the turnover of staff has been disappointingly high is that all these young doctors have been trained as internists and pædiatricians, not as general practitioners; and after a period in rural Arcady the young internist is apt to reflect that elsewhere he could be doing much more specialised work which would interest him more than the endless repetitions of local family care—and could be earning more money. In a large city such as New York the trained internist may be willing to do some general practice—as the price of staying where he wants to be. But, if he goes to the country, he expects to work as a specialist.

Though hindered by the young internist's tendency to move on, genuinely personal care is the aim of the Rip Van Winkle Foundation; and the clinic is unique, among other things, in being the only group under the Health Insurance Scheme of Greater New York (H.I.P.) which offers prepaid medical care to individual families.

Three H.I.P. Groups

Of rather more than 3 million Americans whose general medical care is covered by prepayment schemes, about 550,000 are members of H.I.P. At present, except at the Rip Van Winkle Clinic, these are all enrolled corporately as vocational groups (e.g., all the employees of a firm who wish to join)—an arrangement that removes the risk of selection by " bad risk " individuals or families. Almost all the care is given by 32 medical groups, which make their own arrangements within limits set by a medical control board, and provide (with loans or otherwise) their own premises or equipment. H.I.P. defines group practice as

" provision of preventive, diagnostic, and curative medical services by family physicians, specialists, and other professional and technical staff working as a team in a group center, pooling their knowledge, experience, and equipment, as well as income ".

It gives the group about 32 dollars a year (it hopes to raise this) for each person on their list: and after the group have paid their expenses they distribute the balance among their doctors, as they think best, according to such factors as number of hours worked weekly in the group, number of years of postgraduate study, and length of service with the group.

" The security of an assured income and retirement program, the relief from discussing fees and from sending and collecting medical bills, and the knowledge that costs will not deter patient cooperation permit the H.I.P. physicians to be primarily concerned with the provision of good medical care." [8]

Groups have an average of about 30 doctors, of whom about half are specialists, with regular sessions, and half are family physicians. Even the latter may do private practice, but the only charge they may make to H.I.P. members for normal services is 2 dollars for calls requested and made between 10 P.M. and 7 A.M. On the preventive and welfare side, help is given to groups by headquarters consultants in health education and community resources. The medical control board requires " a base-line history and physical examination for each new adult enrollee as soon as feasible after joining the medical group . . ."

Only well-qualified doctors are appointed to the groups, and some 10 million dollars has been invested in the centres.

As evidence of the advantages of the care it provides, H.I.P. cites an inquiry showing that perinatal mortality (per 1000 live births and fœtal deaths) was 21·3 among its members compared with 30·1 for all private patients in New York City. In another investigation, annual hospital admissions were found to be 77·4 per 1000 among H.I.P. members against 94·8 among people who had similar hospital coverage but got their general medical care differently.

I was able to see something of three of these groups.

A CITY GROUP

The first showed how general practitioners in a group can fulfil their task without overwork, confining it to office hours.

Originally a small specialist clinic, the building was rather shabby and cramped, but the doctors seemed friendly and consulted each other freely even about their private patients whom they saw on the premises. The personal care was given by general practitioners, who had no offices of their own outside; and, though they had sessions at municipal hospitals, they could not take their H.I.P. patients into these.

Their elected chairman does not believe in overwork—" the tired doctor misses important signs "—and the hours are down to 35 a week with none on Saturday or Sunday. From 8 A.M. till 7 P.M. one or other doctor is on duty for " house calls " (summons to the patient's home): after 7 these are taken by two competent and well-qualified outside doctors hired for night duty.

The group preferred more leisure to more money, and did not mind confining their work to their clinic. Boring? No: they had their weekly session or two in hospital, and they met people when off duty. They would be quite happy if the clinic were part of a hospital building. To attach particular patients to particular doctors was unnecessary: the group had been there some time and they were all known and trusted. But they would have liked to be able to give more time to each patient.

A SUBURBAN GROUP

The second group, far from the centre, was very different. Here the general medical work was done by internists.

Serving a scattered population, this group had two clinics. The one I saw had lately been built for 600,000 dollars and was a fine small health centre, with separate rooms for the children, a laboratory, X-rays, a syringe service, a library, and the usual private pharmacy in the hall.

The internists I met were highly qualified; and though they might treat boils, and sew up lacerations if need be, minor surgery was otherwise done by the surgical specialist in the nice little operating-theatre; the children were looked after by the pædiatrician and childbirth by the obstetrician. On the other hand, one of the internists doing family care also did sigmoidoscopies at the clinic. He himself was also on the staff of a good hospital, to which he could admit clinic patients; but the newer physicians had no beds yet. The doctors' homes were not far away and they had a night-duty roster. I got the impression that in general a patient was regarded as the patient of the group rather than of any particular doctor.

The admirable facilities of this medical centre were offset by some environmental disadvantages. It is situated in what was once a village, with a beautiful school; but the area has

8. Daily, E. F. *J. Amer. med. Ass.* 1959, **170**, 272.

been virtually devastated in the process of becoming an inchoate suburb, without the traditions or stability of a community. Already there is a large population, acquiring the "suburban neurosis".[9] Wives are housebound while their husbands have the car at work (they would not think of walking $1^1/_2$ miles to the shops with pram and children). What some of the doctors felt was an abuse of house calls was exacerbated because H.I.P. members are spread over a large area, and the call may be from 20 miles away—the member being determined (some felt) to get her money's worth. One doctor described his difficulty in avoiding the unnecessary use of antibiotics: the patient thought he was being done down if not given them. Whereas the private doctor is suspected of giving unnecessary treatment so as to gain money, the H.I.P. doctor is suspected of withholding necessary treatment so as to save it.

From all its well-qualified young physicians this centre demanded (or had demanded) a difficult adjustment from specialised hospital work to general medical care—in a socially unattractive neighbourhood. But its staff included several of the so-called redundant medical registrars whom H.I.P. has from time to time recruited from Britain, and these required a further adjustment. Every effort had been made to explain to them the disadvantages as well as the advantages of going to America.[10] But the resemblance of the two countries too easily obscures the differences in culture. American observers are astonished—indeed sometimes shocked—to find English patients so ready to accept their doctor and what he says to them: in the United States the patient is far more demanding, and suspicious. A relatively new arrival (much liked, I later heard) felt that in America he was treated less as a professional person: he was called in to treat the body in just the way a garage man is called in to treat the car. An experienced American colleague said: "Perhaps it would be a good thing if the doctor could again talk to the patient with more authority." I noticed that though, in this clinic, the doctor's table was small and round, so that the patient could feel equal, a small arc of the circle had been inconspicuously cut away in front of the doctor's chair.

A HOSPITAL GROUP

But the third H.I.P. group is the most instructive; for it is really a hospital group, and shows how hospitals *could* take over most of the work now done by general practitioners.

The Montefiore Medical Group, in a somewhat antiquated building beside the Montefiore Hospital, seemed to have a high morale: they believed in what they were doing and enjoyed doing it.

The 50 members (16 full-time) all belong to the hospital staff and can take their patients into hospital beds, where they have full responsibility for what is done. Compared with the general practitioners at Hunterdon for example, the Montefiore group are in a far stronger position vis-à-vis interns and residents, because they are all recognised specialists. Family medical care is provided by internists only, and the patient can be looked after by the same doctor in his home, in the clinic, and in the hospital bed. The group's patients in the hospital are visited by group members in a "grand round" once a week.

The group look after about 26,000 H.I.P. patients and make a serious attempt to give them genuinely personal care. The patient selects one of the internists as his family physician (children under 9 are looked after by a pædiatrician) and he does not see any other specialist except on referral from the chosen doctor. The latter works 25 hours a week in his office; but he also has his hospital duties, and each night 3 family doctors, as well as a pædiatrician, and a representative of each specialty, are on call. His income depends partly on the number of patients for whom he is personally responsible; but to all intents and purposes he is on a salary, since his remuneration can be calculated three years in advance. He can see private patients at the clinic out of his office hours.

The demands on this centre are increasing, but no more patients can be taken till it is rebuilt. The new building will be physically part of the hospital.

"The precondition for modern medicine in our group," says Dr. George Silver, chief of the division of social medicine at Montefiore, "is a hospital-based unit, salaried physicians, a central unit record, supervision through meetings, communication between doctors, and some form of replacement for the family physician in the light of modern urban needs."

"We recognize that the changing circumstances which have pretty much pushed the general practitioner out of the scene, at least in urban life, have not changed the situation under which the patient still wants and needs a family advisor, counsellor and guide."[11]

The internist equivalent of the "family physician" in the Montefiore group is unquestionably giving good medical care. But he still cannot be said to meet all the patient's need for support and help outside the clinic. An experiment has therefore been undertaken in which his contribution is supplemented by those of a psychiatric social worker and a public-health nurse—the three forming a "health team" which can offer a "new type of family medical practice".[12] Able to get specialised help alike from physical diagnosticians and from psychiatrist, psychologist, social scientist, or health educator, such a team can give advice, guidance, and support in the ordinary emotional stresses of the family. Dr. Silver is writing a book about this Family Health Maintenance Demonstration. He describes it as *one* way of replacing the general practitioner of yesterday and today—whose demise, he feels sure, is only a matter of time.

Home Care

That the Montefiore Hospital should be the scene of this significant sally into general practice is no mere chance; for the staff of this hospital have already made important excursions into territory outside their walls. Though the institution which first undertook the medical care of patients in their own homes was the Boston Dispensary, which started in 1796, the modern type of home-care programme originated at the Montefiore thirteen years ago under Dr. Bluestone.[13]

Hospital beds are scarce and increasingly expensive; and a great many patients with long or chronic illnesses are happier in the beds they all of them have at home. The object of the fifty-and-more home-care schemes now running in the U.S.A. is to give such patients the essential benefits of hospital care without taking them out of their natural environment—except during acute episodes when this may be essential.

Beth Israel Hospital in Boston, for example, has a team (physicians, nurses, psychiatrist, "physiatrist", occupational

9. Taylor, S. *Lancet*, 1938, i, 759.
10. The commencing salary of a member of a H.I.P. group is in the region of 14,000 dollars; and top incomes for those doing general medical care may reach as many pounds—though this means looking after perhaps 2700 patients, which is considered far too many.
11. Silver, G. A. *Proc. Rip Van Winkle Clin.* 1957, 8, 20.
12. Silver, G. A. *Yale J. Biol. Med.* 1958, **31**, 29. Republished in the *Medical World*, January, 1960, p. 55.
13. Bluestone, E. M. *Lancet*, 1951, ii, 1078; *J. Amer. med. Ass.* **1954, 155**, 1379.

therapist, social workers, and others) who give comprehensive care to people who no longer need be in hospital but are too ill to come as outpatients.[14] Drugs and equipment are provided, and the patients are told to telephone the hospital at any time day or night if they want help.

Though the programme was designed to benefit the patients —teaching and research being secondary objectives—it offers many opportunities for education, not only of medical students but also of nurses and social workers. Participation in the home-care programme is an important part of teaching at the New England Medical Center, and at the Massachusetts Memorial Hospital it is regarded as the main clinical base for the department of preventive medicine.

Home-care programmes are mostly restricted to people who cannot afford to pay a private physician, but some are already being extended to patients under their own doctor.[15] As a Minor (or possibly Major) Prophet, Dr. Bluestone sees this as a means of salvation for the family physician; for it is a way of bringing him into the organisational pattern of the hospital and into the centre of the circle of specialists where he belongs. The hospital wall, Dr. Bluestone says, must not be used as a barrier, or as an excuse for limiting hospital know-how to patients on the right side of it:

"The hospital must help the practitioner to solve the patient's problem in his own home wherever this is possible and desirable. For this purpose, portable hospital equipment and skilled personnel which are now restricted to intramural patients must be made available to extramural patients, under conditions which leave the practitioner free to call on the hospital for either kind of service as required."[16]

The Mine Workers

To these examples of various patterns of medical care I add three from the services created for the United Mine Workers of America. Counting dependants, the Miners' Welfare and Retirement Fund (financed jointly by employers and employees) is concerned with about a million people, and the development of its medical work —largely against opposition—is a phenomenon in American medicine. In the large mining areas both hospital and general practice used often to be very poor: contract practice with the workers at a mine was sometimes at a disgraceful level, and the injured could seldom hope for skilful treatment and reablement. One step towards improvement was the simultaneous building of ten hospitals by the Miners Memorial Hospitals Association, while another is the establishment of specialised clinics and small centres for general medical care.

1. *An Outpatient Department*

At Beckley in West Virginia the Association has an excellent hospital of 200 beds with a very capable full-time staff. Its system of sterilising equipment has been studied by British visitors, and its arrangements for distributing food and stores to the wards also deserve attention. But its interest for me lay chiefly in the fact that it was a hospital trying to provide—mostly for miners and their dependants—much of the kind of care which is given elsewhere by practitioners.

In a sense this was given at a high level, for the patients waiting in the crowded central hall were all seen by senior specialists. Two of these attempted a little sorting, but all comers were then seen by one or other specialist in his own office. On the other hand, though some at least of these physicians strongly believed in personal care, the outpatients' atmosphere seemed less conducive to this than a private doctor's office; and some of the patients, if better known to the doctor, would not have needed more than a glance and a few words. I was not surprised that the medical director said that he would be glad if a couple of his internist residents with a bent towards general practice could be set up in a small nearby clinic where they could spare the hospital by doing some sorting.

2. *General Care from Clinics*

The Bellaire Medical Foundation has a central clinic in an old house in Bellaire, Ohio, and a beautiful new one 12 miles away to which some of the staff go daily by car. At least two of the internists are senior men—one being an authority on pneumoconiosis—but they all do family care. Some of the staff have access to the local hospital, where the trustees are well disposed to the Foundation; and all the group do a grand round on all the group's hospital patients once a week. But, like quite a number of the groups I have described, they work under professional handicaps or medicopolitical difficulties, and their surgeon has had only three patients referred to him by an outside doctor.

They attach some importance to keeping their own patients, and they are ambitious on the social and preventive side of their work, including periodic health examinations and the home service by which the Fund helps "independent living" by the disabled. They hope to have a psychiatrist and a psychiatric social worker someday.

Their morale was high: many of the staff, and a lawyer trustee, gave me a lot of time on a Sunday afternoon and evening.

3. *A Centre with Peripheral Practices*

If Bellaire was particularly interested in general medical care, Centerville in West Virginia was specialist-oriented. Primarily a consultation centre, it was bursting out of its quarters in a converted farmhouse and barn, and an additional large building was in construction. Patients needing admission were sent to one of three small community hospitals in the neighbourhood.

This clinic was a lively professional centre for local practitioners working for the Fund, and it hoped they would come in twice a week for consultation or meetings. I visited two of the peripheral practices. In one a practitioner, who was also a playwright, worked solo from a miners' meeting-hall, which had been turned into an austere but tolerable surgery; while in the other a couple of doctors (both new to the job but perhaps all set for dedicated practice) were installed in a well-equipped centre next door to the mortician—a variant on the more usual plan by which the doctor has a drug-store as his neighbour.

Two Questions

At clinics where general medical care was given by internists I sometimes asked two leading questions.

These men having trained as specialists in internal medicine, I asked them whether they would accept an opportunity of full-time work in that specialty. Their answer usually, though not always, suggested that their heart was still in hospital medicine rather than in personal practice.

Secondly, I asked members of the group whether they would like their clinic to form part of the buildings of the local hospital. Here the reply was, in the words of *My Fair Lady*, "Wouldn't it be loverly?"

SPECIALISATION

Much of modern medicine can be practised only by specialists; and, to complement one another, specialists must work in groups. The farther their specialties

14. Sheps, C. G. Address to A.M.A. Regional Conference on Ageing, Boston, Sept. 17, 1959. Also annual reports of hospital's department of home care.
15. Bluestone, E. M. *in* Long-Term Illness (edited by M. G. Wohl); p. 27. Philadelphia and London, 1959.
16. Bluestone, E. M. Letter to members of Hospital Administrators Correspondence Club, 1955.

diverge, the larger should be their group and the closer its integration.

Nearly always the best place for specialist work is a hospital; and, though some of the American groups I saw were what Dr. Silver calls " rootless ", I am sure the bigger ones will end by moving into hospital premises, where they properly belong. I do not say that a small group of specialists cannot work at a distance from the hospital to which they are attached; but, if they do, they will tend to think of themselves as an outpost, an outpatient department, even a sorting-station.

My own opinion therefore is that if, in any country, the general practitioner is replaced by a group of doctors trained to regard themselves as specialists, the result will eventually be provision of general medical care by and from the hospitals. The experiments I saw in the United States seemed to be leading in that direction; and, though they were atypical, they would probably not have existed if the American public had not accepted medical specialisation more fully than the public here. The more sophisticated and affluent Americans tend to bypass the practitioner, making their own provisional diagnosis and going straight to the appropriate expert:

" I called my group this morning, told them I had a bad rash and asked to see the skin specialist. This girl on the phone tells me I've got to see my family doctor first. What kind of a run-around is that when I need a skin specialist? " [17]

Among the Americans who set fashions, the majority might well think that medical care from the specialists of a hospital clinic would be the best possible.

Would they be right? Certainly the clinic or group can give its patients the benefits of specialist advice and treatment without the risk (and expense) of " shopping around ": and it will often work at a higher technical level than the outside practitioner. The task of sorting patients and giving general medical care is ordinarily entrusted to an internist or general physician—whom Esselstyn [18] describes as " the keystone of group medicine ". Whereas many independent doctors have time only for symptomatic medicine, this group internist is expected to reach a working diagnosis, and has facilities for reaching it.

As I have hinted, there can be certain practical difficulties about this upgrading of general care. Patients who drop in for a few words or a few pills may be none too pleased to find themselves given " the works ", and their request for a check-up may be taken rather more scientifically than they intended. Moreover, extra time, from a specialist with a shorter practising week, has to be paid for. In principle, however, the patient clearly stands to gain a lot from entrusting himself to a specialist physician.

The question is: does he not often lose a lot too? Are a specialist group, or any members of it, going to give him the *personal* care that means so much to so many?

PERSONAL OR IMPERSONAL?

No plans for the future are realistic unless they take full account of people's need for personal as well as specialist care. The two kinds overlap, of course. Some specialists (pædiatricians and geriatricians, for instance) practise personal medicine nearly all the time, while nearly all specialists practise it some of the time: a man does not cease to be a good doctor because he is a urologist or a pathologist. But the specialist is, by definition, called on to solve some particular problem; and he may reasonably be reluctant to cope also with the patient as a person. It is no accident that the man who is " Mr. Jones " to his own doctor should so often become, in hospital, " the hæmatemesis in the end bed ".

Many doctors and nurses spend much of their time in preventing this depersonalisation of hospital patients—especially perhaps in the United States.[19] But in any large institution depersonalisation is a natural process which can be mitigated but can seldom be abolished. It is all too evident, for instance, in most hotels.

I remember that when I paid my first visit (rather shyly) to the most famous of London hotels, I was astonished not by the splendour of the surroundings or the food—each readily equalled elsewhere—but by the natural not-at-all-superior manners of the staff, who gave one unhurried personal care. What the rich were paying for (I suddenly realised) was simply the pleasant easy atmosphere of a private house.

Nowadays most hotel-keepers are well aware that people like to be treated as people not as admissions. But big institutions always develop needs of their own which are apt to take precedence over those of their users; and only the very good hotel or the very good hospital gives its clients the sense of personal attention they would expect in a wayside inn or a doctor's consulting-room, surgery, or office.

If specialist care is the primary task of the specialist and the group, personal care is presumably the primary task of the individual practitioner. In real life, this fundamental distinction is often blurred; for, whereas many specialists give their patients not only specialised but also personal help, some general practitioners do not fulfil their particular function. A London consultant was saying to me the other day that, though in principle he favours consultations at which the practitioner contributes knowledge of the patient's history and background, he finds that many patients have never had a chance to tell their story until they reach the specialist. One explanation is that the practitioner has less time than the specialist; but often he has less inclination or has an impersonal outlook on his work. If he thinks of himself as a sorting agent rather than as his patient's real doctor, he feels his duty fully done when he recognises a possibly significant symptom and hands the case to an expert.

THE FINANCIAL EXPLANATION

In this country failure by a practitioner to provide personal care—to take full responsibility for his patients and form a strong personal relationship with them—is usually put down to circumstances: he is usually looking after too many patients, and, because he is paid by a capitation fee, he has no financial incentive to take trouble over cases that a specialist will accept. Superficial, perfunctory, impersonal practice is attributed to " the system "; and at first sight this convenient explanation gets some support from American experience.

17. Weltner, G. H., Lear, W. J. Subscriber Attitudes in H.I.P. Paper read before American Public Health Association, Oct. 20, 1959.
18. Esselstyn, C. B. *New Engl. J. Med.* 1953, **248**, 488.
19. I found that, as a doctor visiting wards, I was carefully introduced to patients, with names all round. An American doctor told me how horrified he had been in an English hospital when a registrar had taken him to see a patient and without introducing him had unrolled the sheet and shown him her leg. He had been equally shocked by the impersonal character of a ward round by a physician—who happens to be a friend of mine and a most humane man.

Even before I landed I was told that one of the big schemes of prepaid medical care, provided by groups, was progressing relatively slowly—because " people don't like it; they feel that they don't get the care and consideration they have from a private physician ". In this scheme the doctors are paid a kind of capitation fee that amounts to a salary; and, though they are a carefully selected body of men and women, an experienced observer agreed that their attention to patients was in fact less personal. This he explained by the way they are paid:

" It's a sad fact," he said, " that when you remove the direct financial bond with the patient—the fee for each service rendered—many doctors become less interested, kind, and sympathetic. A proportion *need* this financial relationship."

In New York's H.I.P. the most common complaint relates to the physician's " attitude ". (" Dr. —— was very impersonal. Never a hello or goodbye.")[17] Unhappily, in American prepayment schemes as in the N.H.S., the occasional patient wrecks the professional relationship from the start by claiming his " rights ".

On the other hand, the fee-for-service system does not necessarily ensure personal attention: one of my lay informants commented bitterly on the mechanical production-line methods of a doctor whom he was paying. For my part I regard this system as a professional hangover; and I hope that, as an alternative basic source of income, the capitation fee will prove more generally acceptable when it becomes larger and doctors can have fewer patients. But difficulties arise with *any* system of paying doctors; and I believe that, as a source of personal care, the American specialist group has a more fundamental weakness than lack of financial inducements to kindness.

LIMITATIONS OF GROUPS

The truth, I fancy, is that a large group can hardly ever perform a personal function really well.

Even a small group has difficulty in doing so. Thus Nourse,[20] though happy in having joined three specialists to form what he calls a " composite family doctor ", says that " strive as they may, no group of doctors can completely substitute for the personal touch of the old-time family doctor, for the reliance of the patient upon one individual for wisdom, counsel, friendship and help ". He begins his admirable article by quoting an indignant young man whose wife had gone into labour early, when Nourse was away duck-shooting, and had been delivered by a partner:

" What's wrong with you doctors, anyway? You aren't like you used to be. You don't really care what happens to your patients; you charge twice as much as you ought to, but when somebody needs you he can't ever find you! What's become of the kind of family doctor we used to have? "

Nourse thinks that his group is giving far better medical care than " the inadequate, sentimentalized image of yesterday "; but he hopes that we shall not discover too late that part of what we have lost is irreplaceable—" the feeling of warm personal regard and concern of doctor for patient, the feeling that the doctor treats people, not illnesses, and wants to help his patients not because of the interesting medical problems they may present but because they are human beings in need of help ".

What Nourse says about his group of four applies, a fortiori, to a group of thirty. In theory, personal medical care of the highest quality will be given: the internists who give it will perhaps have their own list of patients and may look after them for years. But I am pretty sure that in reality any member of such a group will sooner or later come to think of his patients mostly in relation to the clinic and hospital, not in relation to their work and home.

In retrospect I am impressed by the infrequency with which some of these internist-practitioners made home visits: in one group, for example, the normal number was about 5 a day. The explanation given was significant: the home, I was told, is usually a very bad place for examining anybody—you can't move the bed; the mattress sags; and there's incessant conversation and scuffling around. So the patient had better come to the clinic or hospital where one can really find out what is wrong.

Well, of course, this is the point of view of the doctor who has been trained to think in terms of disease in hospital rather than about people in the middle of their families. Surely, if you really want to get to *know* somebody, there is nothing like visiting his home, where much will always be revealed. If I wanted to discover whether a doctor had a vocation for personal care, I should begin by asking what he thought about house calls. After that I should inquire into his attitude towards the unnecessary, and often maddening, visits by which so many patients seek to form, or keep up, their acquaintance with their doctor.

Though, for myself, I should cheerfully register with the internists of the Montefiore Hospital Group—who were friendly, helpful, and competent—I do not think even they would claim to be able to give me all the kinds of help I might want as personal care. That is why Dr. Silver has undertaken the experiment I mentioned, in which the work of the internist is supplemented by that of a public-health nurse and a psychiatric social worker.[12] This is his way of compensating for the group's natural tendency to look inwards towards the hospital instead of outwards towards the home. And no doubt it will work very well up to a point. But I am not yet persuaded that any amount of compensation or ingenuity is going to make a hospital staff—or any group of specialists—the right people to give the public personal medical care. The public, I fancy, will get it better from doctors who are primarily interested in providing it, and who do most of their work at a distance from the hospital.

Hospitals are the fortresses of medicine, and should be used as the second and third lines of defence. The first line should consist of numerous well-sited posts manned by lightly armed but versatile and mobile troops, trained to use their own judgment.

I know, of course, that personal medicine must be more closely related to specialist medicine than it often is at present; but I am pretty sure that the personal doctor should preserve a measure of geographical and psychological independence from the specialists and their elaborate institutions.

TITLE AND FUNCTIONS

What kind of doctor do we want, and what is he to do? Perhaps we shall know the answer better if we find him the right name.

GENERAL PRACTITIONER?

In thickly populated countries like Britain the truly general practitioner is extinct: indeed, few of us have ever seen one. In relatively inaccessible places elsewhere,

20. Nourse, A. E. *Saturday Evening Post*, Oct. 17, 1959, p. 25.

including parts of the United States, there are doctors who do virtually everything that has to be done for their patients; and some of them would deplore any constriction of their work. (I heard of a hospital in the backwoods where none of the seven local doctors could be dissuaded from doing all his own surgery—because his patients expected him to provide full medical and surgical care and he would lose face if he proved less than omnicompetent.) But all over the world the lights are going out on that kind of general practice. Proper and necessary in an isolated countryside, it is improper and unnecessary where the patient with a difficult disorder can have this treated by a specialist. And even in the United States 57·5% of the population last year were already living in the large towns which are designated standard metropolitan areas.[21]

Because specialisation is an inescapable part of medical progress, the trustees of more and more American hospitals are ruling that only specialists shall operate, or do obstetrics, or even have admission rights; and the result in cities is that the general practitioner's practice grows palpably less general. Against this trend the Academy of General Practice is fighting a rearguard action. Though some of its 25,000 members may be partly interested in preserving lucrative occupation, the Academy has done much to improve morale and raise standards among practitioners; and it believes (as I do) that something very important to the public will be lost if what remains of general practice is taken over by the Man from the Hospital. But has it really chosen the best ground for its stand? Nowadays the argument that a qualifying degree gives the doctor a right to do any kind of medical work is quite out of date: we all know that occasional surgery or midwifery is even more dangerous than occasional motor-driving; and unless people are fully competent to do things, and keep themselves in practice, they have no right to do them at all—whatever degrees or tests they took. The Academy, surely, should recognise that truly general practice, except in remote areas, is already finished, and that most of its members are very sensibly doing something far less ambitious and terrifying.

But perhaps their residue of activities includes something enormously worth doing which no hospital or specialist group can do so well? I believe it does; and I think the Academy should be less interested in its members' questionable right to do obstetrics or omphaloscopy and more interested in their qualifications for giving good personal care.

The point at which to call a halt in the process of erosion of general practice by specialists is the point at which the practitioner would no longer be in a position to do this vital part of his job.

FAMILY DOCTOR?

Now that many so-called general practitioners no longer do obstetrics, advise on babies, set fractures, sew up lacerations, test eyes, or prescribe for diabetics, their title is patently obsolete. Devised for an Act of Parliament, it was always chillily official; and now it is inaccurate. As a designation for what Stevenson called "the flower (such as it is) of our civilisation," G.P. is even worse.

Family doctor or family physician, with its friendly warmth, is much better. It suggests continuous care of parents and children over the generations ("I brought your mother into the world") and the experience of medicine and of life that this can give. But as a description of doctors who seldom look after whole families, and whose patients are always moving to another job in another town, it represents an aspiration rather than a fact. In England, in the three years 1948–50, 13% of the population moved from one local-authority area to another: and, as for the Americans, they are "almost a race of nomads" [22]: one person in five changes not only his home but his State of residence every year.[23] And even when they stay in one place, members of a family often have different doctors.

When an American family has young children, the person who often comes closer than anybody to being the family doctor is the pædiatrician; for in the United States, as in Russia, most pædiatricians do a kind of general practice among children, and relatively few are consultants.

PERSONAL DOCTOR?

The doctor we have in mind, then, is no longer a general practitioner, and by no means always a family practitioner. His essential characteristic, surely, is that he is looking after people as people and not as problems. He is what our grandfathers called "my medical attendant" or "my personal physician"; and his function is to meet what is really the primary medical need. A person in difficulties wants in the first place the help of another person on whom he can rely as a friend—someone with knowledge of what is feasible but also with good judgment on what is desirable in the particular circumstances, and an understanding of what the circumstances are. The more complex medicine becomes, the stronger are the reasons why everyone should have a personal doctor who will take continuous responsibility for him, and, knowing how he lives, will keep things in proportion—protecting him, if need be, from the zealous specialist.

Continuity of personal care is the ideal, though admittedly unrealisable unless both patients and doctors are willing to stay in one place. If there were a really good system of recording and documentation by which essential data were passed from one doctor to another, the fact that the doctor changes would matter less than formerly. Indeed Professor Rutstein points out that the disadvantages of personal discontinuity could be offset to some extent if everybody carried around a Lifetime Health Record [24]—which would undoubtedly be more reliable in some ways than the old doctor's memory.

Of course he is right—though in Britain most of us still think medical notekeeping by patients a morbid pursuit, to be discouraged. I know, too, that we must get used to a world in which ices no longer taste of cream, nor new potatoes of new potatoes; and in New York those ghastly plastic flowers seem to be commoner than real ones. But nobody is going to persuade me that a nice receptionist, some good notes, and an internist keeping office hours add up to a personal doctor who knows me and my home. Even if you throw in a psychiatric social worker, I still feel that I am being put off with a plastic substitute for the real thing. And I am supported in this belief by the knowledge that when personal medical care is abolished it is sooner or later reinvented.

21. Computed from Current Population Reports, series P-20, no. 98. Jan. 25, 1960.
22. Rappleye, W. C. Report on Dec. 1, 1959, as president of the Josiah Macy, Jr., Foundation, New York.
23. Wilson, D. America and the Welfare State. *Planning* (issued by P.E.P.) Jan. 25, 1960.
24. Rutstein, D. D. Lifetime Health Record. Harvard University Press, 1958.

Thus, even under the Soviet system, the Russian leaders have personal physicians.[25] It is the natural and sensible thing to do, and they can afford to do it. So should we.

THE PERSONAL DOCTOR

The personal doctor is of no use unless he is good enough to justify his independent status. If (like many unqualified healers) he has a therapeutic personality, that will be a great help; but in any case he needs to have the knowledge that comes of a continuing interest in medicine, together with trained and critical judgment.

DIAGNOSTICIAN

If he is to take responsibility he must feel that *he* is the patient's doctor: and he will never feel this unless he tries to make his own diagnoses—as fully as his facilities and time allow. Examination of patients is necessary because, as everybody knows, the fatal mistakes are made not through lack of knowledge but through lack of care. But my point is rather different. It is that the doctor who fails to examine and diagnose has lost his right to be an independent personal practitioner. Experience may well have made him skilful and very useful in dividing the serious from the trivial; but, if he does no more than this, he is working as a preliminary sorter or feeder for the hospital, and he may as well do it as a peripheral and junior member of the hospital staff. To be a personal doctor one must remain a real doctor, and not turn into the manager of a practice.

TEACHER

The personal doctor must also be a teacher, not only in showing people how to avoid disease but in showing them how to live with their disabilities—physical or mental. These things are not done at a single interview at a clinic. I was deeply impressed by an experienced pædiatrician in Wisconsin who said that when a mother is troubled about some deviation in her child, she may need reassurance not once but again and again. Nobody, he felt, could give such help as the physician who saw the children, year after year, well and ill, removing or at any rate sharing the parents' anxieties and burdens. And nobody else was so well placed to prevent those recognisable mistakes of upbringing that so often lead to emotional disaster.

PSYCHIATRIST?

On the topical question whether the personal doctor should train himself in psychotherapy, I shall say no more than this—he must allow people to talk. Often a patient and sympathetic hearing is all that is required to give someone insight and a fresh start. Yet doctors everywhere have become so busy that they commonly deny the patient what he wants most.

"No time," of course. To which the obvious retort of the simple-minded public is: "Why, then, do you say you have too many doctors already? Why not have more?"

DIVISION OF LABOUR

The public is right: there are too few doctors for the work to be done. Nevertheless there may sometimes be too many for the money available to pay them. Whereas Russia has met her medical needs by mass-producing doctors who are none too well qualified and worse paid, the profession in Britain intends to keep up its standards.

One alternative to having more doctors is to make better use of those we have—by giving them ancillaries to do everything the doctor need not do himself. The logical development of this is that the practitioner of the future will be the leader of a team in which nurse, receptionist, secretary, health visitor, and social worker relieve him of many things he used to do. Thinking in terms of a *general* practitioner, this solution seems sound; and certainly we want doctors of high quality whose skill is used economically and who make use of other people's skills. But if our object is to provide the right conditions for a *personal* doctor, we must beware of carrying this division of labour too far. If somebody else is to do all the small things for the patient, under the doctor's distant supervision, personal contact will be reduced to a minimum; and if this happens, the patient might just as well go to the hospital. Unquestionably the practitioner needs helpers in his surgery or office, and should be able to call on a wide range of skilled ancillaries outside; but the particular object of his independent existence may be defeated if he leaves all dressings to the nurse, sympathy to the receptionist, messages to the secretary, and the solution of home problems to the social worker. Organisation can be a menace to the personal care we are supposed to be organising.

Again, for personal care to be a reality, free choice is necessary, and there should be quite a few doctors to choose from.

I see that van der Wielen,[26] after a detailed study of practice in Holland, gives 2000 as the maximum number of patients that a doctor should have on his list; and if we are really to aim at good personal care—and stop the drift towards wholly hospital medicine—we shall have to think again about the number of doctors needed to give it. Is our country really incapable of using all the doctors it trains—or even of finding and training and paying more, of the same or a higher standard?

HOME OR HEALTH CENTRE?

Where should the personal doctor work? Ideally, I would say, he ought to work in his home—like his archetype, the genuine family doctor of yore. For establishing a lasting personal relationship there is nothing better than seeing the patient in his home or yours. But doctors, like other people, usually want to retain their wives; and if they are to do this, most of them will nowadays have to have their surgery, consulting-room, or office at a distance. Even so, it should not look like a shop, an office, an outpatient department, or a mortuary: it should look like an extension of the doctor's home. Some doctors could make their patients feel like personal friends if they received them inside a refrigerator, while others can make them feel like personal enemies in the warmest and most cheerful surroundings. But because human qualities can triumph over environment, it does not follow that a place that looks like the bathroom is as good for personal doctoring as one that looks like the master's study.

Agreement that what is wanted today is not a general practitioner but a *personal* practitioner could make a big difference to the kind of buildings from which doctors work. Many of us were reconciled or attracted to the National Health Service chiefly by the promise of a new deal for the practitioner, who was to have all the help he needed to do better work in better quarters—the health

25. Field, M. G. Patient and Doctor in Soviet Russia. Harvard University Press, 1958.

26. van der Wielen, Y. De Huisarts en de Doeltreffendheid van zijn Aandeel in de Gezondheidszorg. (The General Practitioner and the Effectiveness of his Share in the Care of Health.) Gezondheidsorganisatie T.N.O. Assen, 1960.

centre. Personally I thought that the kind of health centres then proposed would be a success, and I still regard the failure to experiment with more of them as inexcusable. But I now suspect that they were wrongly conceived.

There are, I have suggested, only two kinds of care—personal and specialist. The best place for the first is the doctor's home, or some equivalent of it, while the best place for the second is the hospital. For the health centre—a new kind of intermediate institution—I can see no function. If visited by specialists, it could be useful as an extension of the hospital; but as an extension of the doctor's home it is unconvincing. A building which looks like an institution, or is so large that it has to be organised like one, may be a good place for getting the benefits of modern science or civic aid, but it is not the place for finding one's *own doctor*. The skill of interior decorators, though it may make a modern medical centre quite charming, very seldom disguises the fact that the doctor's room is not his own. Three photographs of the children, and some pink-foot geese by Peter Scott, are Not Enough.

SOLO OR GROUP?

The doctor we all want to have looking after our families and ourselves is always at home and always ready to cope: he is never off duty and never on holiday. That is the patient's ideal; and such people do exist. A young practitioner in North Carolina complained that old Dr. J. had spoilt the neighbourhood: he had had no interest whatever outside medicine, and had always been cheerfully on call, day or night.

But, though we should like our doctor to be always on hand, we also want him to be a well-balanced man with a life of his own—not a tired obsessional. He must have leisure and recreation; and the only way in which he can get them and maintain a twenty-four-hour service is to have assistants, or partners, or colleagues who stand in for him. Though there are doctors who still prefer solo practice, the general tendency is towards association. Whereas before the start of the National Health Service, about half the practitioners were working singlehanded, the proportion now is less than a third.[27]

The group thus formed may do one of two things. It may do its utmost to preserve the personal relationship: though the patient may have to see a partner, he belongs very definitely to his own doctor. Or it may try to make him feel that he is the patient of the group rather than of any individual. Thus in an American practice a card for patients said:

> " To render good medical service on a 24-hour a day basis, we three general practitioners operate as a group practice. We would like for you to feel that you are a patient of all three physicians rather than any specific one and to feel free to consult any one of us about your health problems as they arise."

Where there are only three partners and they work together for years, there is admittedly a good chance that patients will establish a pretty strong personal relationship with all of them. But what happens when this group enlarges, or takes in members who do not stay? Wherever a partnership exceeds two or three, or ceases to observe the one-patient one-doctor rule, its feet are set on the slope that leads from personal medicine to group medicine; and the proper place for group medicine is the hospital.

27. Godber, G. E. *Lancet*, 1959, ii, 224.

In countries like England, where specialist services are well developed, all that the patient needs outside them is the care of an individual doctor. Formal or informal association with one or two others of his kind will help the personal doctor—not only because it gives him leisure, and a chance of doing some specialised work on the side, but because he can talk about his cases to his colleagues over coffee. But there is, I suggest, no functional advantage in having any larger or more complex group, which is liable to turn into some sort of "rootless" clinic.

SPECIAL INTERESTS?

An essential feature of the kind of small partnership I am advocating is that all its members shall be primarily personal doctors. It is thus entirely different from the " composite general practitioner " described by Nourse,[20] in which the functions of the old general practitioner are fulfilled jointly by (let us say) an internist, an obstetrician, a surgeon, and a pædiatrician working together. That resembles the Russian model for the countryside (except that the specialists are far better trained); and it is based, in Russia as in America, on the obvious fact that no one man is competent to undertake all kinds of practice at a modern level. But what may still be right for isolated places in the U.S.A. or U.S.S.R. is wrong for Britain, where nobody is very far from hospital. No longer needing truly general practitioners, we do not need their composite modern equivalent either. We need doctors with different, though equally important, terms of reference.

But though I believe that in Britain all specialised work should be done in, or under the auspices of, the hospital, this does not mean that no personal doctor should do any of it. On the contrary, it is necessary that the personal doctor with special interests should be able to follow them —partly because he must not feel unduly restricted in the practice of his profession but also because the two sides of medicine—personal and specialist—need to be linked by people who are engaged in both.

But there is a vital condition on which alone this should be done—namely, that the personal doctor who wants to practise any specialty must join the appropriate specialist team of a hospital. As personal doctor he is an independent practitioner, professionally the monarch of all he surveys; but in so far as he decides to be also a specialist he must accept the leadership of the whole-time specialist at the hospital. Under the National Health Service final responsibility in any specialty must rest on a consultant and not on a part-time specialist.

Taking the largest and fiercest bull by the horns, I say firmly that this rule applies to obstetrics. The delivery of infants is unquestionably part of general practice; but, as I have tried to show, general practice is dead or dying in this country. To my mind at least, obstetrics belongs to specialist medicine rather than personal medicine—to " episodic " medicine (in Dr. Iago Galdston's phrase) rather than " maintenance " medicine. Some might say, of course, that if the practitioner has to act as agent for a specialist when he looks after a woman in labour, he must equally act as agent for other specialists when he looks after a child with asthma or a man with angina. On this argument, if he loses his independent status in obstetrics he loses it in everything. But in real life, surely, there is a substantial difference between the two kinds of work. In his management of asthma or angina the doctor may need specialist advice, and in a crisis he may have to send

the patient to hospital. But nowadays he cannot properly practise obstetrics *at all* without a specialist organisation at his back; and, since it may have to cope with results, that organisation is entitled to lay down rules—e.g., about antenatal care. Hence there are particularly strong reasons, I would say, why the ultimate responsibility for all maternity work in an area should be borne by consultants. Many practitioners who are primarily personal doctors are extremely good at this work, and they should go on doing it; but if they deliver babies—whether at hospital or in the home—they should do so as members of the obstetrician's team.

The obstetric bull being now (I trust) removed from the arena, I come to a more general pronouncement—namely, that when a man in personal practice finds that his mind is really on a specialty, his move into hospital work should be made easy by opportunities to gain the needful qualifications. Though personal and specialist practice should be clearly distinguished, the difficulty that people nowadays have in transferring from one to the other is wrong. Our system is far too rigid.

RELATIONS WITH THE HOSPITAL

Outside the specialist services, the personal doctor is in full charge—responsible and independent. Only when we are sure that this independence will be recognised and safeguarded can we go on to consider the equally important *inter*dependence of the two kinds of medical care. Unless they are hand in glove, the patient must suffer.

COMMUNICATIONS

At the most elementary level is the obvious need for really good communications between personal and hospital doctors.[27 28]

Even in America, hospital reports and letters often come late: there are delays in dictating, and typing, and signing, and posting. One answer to this is that, since we have to live in the modern world, we should make more use of its convenient inventions. A big advance in medical civilisation would be made almost overnight if every hospital in this country followed the example of the Massachusetts General Hospital in urging housemen to use the telephone freely. Without regard to distance, they are encouraged to ring up the doctor if they want more facts when his patient is admitted, and always to inform him fully before the patient is discharged.

Equally, of course, the practitioner has a duty of communication, in which he too often fails—in America as here. Thus in nearly 60% of cases attending a university consultation centre no medical information was sent by the referring doctor.[29]

MEMBERSHIP OF STAFF

Provided they undertake to provide such information, all personal doctors should, I suggest, be made associate members of the staff of the hospitals with which they work. As such, they would have free access to any of their patients who are admitted, and on such visits their help would be regularly invited. They should be welcomed, too, on any ward round; they should have full use of the library; and there should be at least one comfortable room which they could regard as their home in the hospital and where they could meet their specialist colleagues. Already some hospitals try to serve as a kind of club for the doctors of the locality; and the gain, though intangible, is out of all proportion to the cost.

I see the associate members of a hospital staff as comparable to graduates who keep their names on the books of an Oxford or Cambridge college. They are not fellows, and they take no part in college government; but as members of the college they may have the right to dine in hall, and they are always received as people who " belong ".

" DEPARTMENTS " OF GENERAL PRACTICE

The American Academy of General Practice goes much further: it wants all large hospitals to have " departments of general practice " on a par with the departments of medicine or surgery. Except that it may sometimes look after the outpatients, such a department has no clinical service of its own; but it gives general practitioners a voice in hospital administration and opportunities to meet as a group intent on raising standards—by self-criticism and self-discipline.

The Academy is trying to preserve much of the old *general* practice, and the hospital has to allow members of these departments to practise general medicine, pædiatrics, obstetrics (" to include low forceps, episiotomy, cervical and perineal repair "), and surgery (" as it applies to the care of wounds and reduction of simple fractures ").[30] If they wish to go further in a specialty they must satisfy a credentials committee and will then be under the jurisdiction of the chief of the clinical service in which they work.

OFFICE AT THE HOSPITAL ?

A rather different but notable experiment is being made at the New England Medical Center in Boston, where three practitioners have been given an office in the hospital. They still have their private offices outside, but at the hospital they can see cases for which they might like specialist investigations or opinions. The object, Professor Proger [31] explains, is to combine the advantages of individual and group practice: in his own community the practitioner functions as an individual family doctor, while in the Medical Center he functions as a member of a group.

This scheme has much in common with the one at Hunterdon Hospital (see p. 746), to which all the local practitioners can bring their patients for examination and consultation. But in this Boston teaching hospital the purpose is more widely educational. Not only does the practitioner gain, but so do the students and interns. A student working in the family doctor's office " would be getting not outpatient work that imitated office practice, but actual *office practice* " and the scheme gives the hospital a chance to develop a home-care programme for students that " would *be* private practice in the patient's home ". Through the family-doctor unit, Dr. Proger hopes, medical practice in the area will be directly influenced by the standards of the teaching centre.

28. *Lancet*, 1959, ii, 219.
29. Williams, T. F., White, K. L., Andrews, L. P., Diamond, E., Greenberg, B. G., Hamrick, A. A., Hunter, E. A. Paper read at annual meeting of American Public Health Association, Oct. 19, 1959. Other interesting findings in this study were that about half the referrals were initiated by the patient rather than the doctor, and that over half the patients did not go back to see their doctor within the next month or two.
30. General Practice in Hospitals. Prepared by the commission on hospitals of the American Academy of General Practice, Volker Boulevard at Brookside, Kansas City, 12, Missouri, U.S.A. April, 1959.
31. Proger, S. (New England Center Hospital, Boston). Memorandum on the Family Doctor Unit in the Medical Center.

"GENERAL PRACTITIONER BEDS"

Like the American Academy of General Practice, I am sure that the personal doctor, when so inclined, should undertake specialist work—either in hospital or in a specialist service outside it (e.g., maternity). But the kind of associate membership of the staff that I want him to have would not entitle him to do this: he must also hold a specific appointment which attaches him to a hospital department for which a consultant is ultimately responsible.

The rule is plain and we must stick to it. Outside the hospital services the personal doctor is in charge: inside them he is an agent for the specialist.

Thus, if he is to look after patients in any kind of hospital bed, he should be appointed and paid for the purpose by the hospital. But I hope that, so far from being an exceptional arrangement, this will become very common. Hospital boards ought, I believe, to provide many more beds where practitioners can deliver their patients, and treat the less serious illnesses, under the auspices of a consultant. In the countryside these auspices might be rather remote; and usually the practitioner would use his own judgment. But I do not think that this would restore the abuses sometimes seen in cottage hospitals in the old days, and sometimes still seen in America. In doing this hospital work as an appointed member of the consultant's staff, the practitioner would have strong reason to seek advice, instructions, or other help whenever difficulties arose: indeed there would be good hope of the frequent consultation which can be so informative to both sides. Stallworthy [32] has lately made the excellent suggestion that practitioners should, in the same way, staff the hospital annexes to which patients should be transferred as soon as they can safely leave the ordinary wards.

American observers often say that the British practitioner's status as a doctor, and his morale, must have been damaged by depriving him (so often) of his hospital beds. Though the classical study of general practice in North Carolina [33] revealed no difference in the quality of care given by doctors with hospital associations and those without, I suspect that these American observers are right: to maintain their enthusiasm and their interest in medicine, some doctors require the stimulus of looking after illness in hospital, while almost all of them require the stimulus of frequent contact and conversation with colleagues. Though a proportion can get full professional satisfaction from purely personal medicine—and perhaps the proportion will grow—it is very important that anyone who feels the need of hospital work should get it readily.

HOME CARE

If very early discharge from hospital becomes the rule, the practitioner will be taking over some of the hospital's work—for which, indeed, it might properly pay him a fee. Even so, his patient's return home means that he must resume full responsibility, seeking hospital help only when he needs it.

But, though the hospital must be careful not to invade the personal doctor's territory, its special services should always be at his disposal. Where he is working as a peripheral member of a hospital department, as in obstetrics, he can of course command the help of his departmental colleagues, in the form of a flying squad if need be. But there are other aids to home treatment, such as the visiting pædiatric team,[34] which should have further trial, and at all times home consultations with specialists should be encouraged. These arrangements would go a long way to satisfy Dr. Bluestone's plea that the hospital should sustain the practitioner; but in Britain the hospital need not ordinarily supply him also with nurses or equipment or social workers or domestic helps. In this country these come from the health department.

RELATIONS WITH LOCAL AUTHORITIES

In the U.S.A., where private enterprise gets so much honour (and often deserves it), the public-health authorities have been very cautious about taking any part in curative medicine. Their attitude is slowly changing, under the leadership of such men as Dr. Herman E. Hilleboe, health commissioner of New York State, who says [35]:

> ". . . both preventing and ameliorating disease and disability is the business of everyone in medicine. . . . The function of a public health physician is to perform public health services that require organized community action. This may be preventive, diagnostic or therapeutic. . . . The function of a general practitioner is to perform any private health service that his patient needs. This, too, may be preventive, diagnostic or therapeutic. Both the private practitioner and the public health physician may perform these services directly or by referring the patient to another medical specialist.
>
> "All this may seem like a rather simple way of straightening out a fallacious bit of reasoning which had as its faulty premise: Public health equals preventive medicine. The truth is, it has not been easy to clear up this misconception . . . what is emerging is a general recognition that a close partnership between public health physicians and general practitioners is vital to the welfare of the people in every community."

In Britain, happily, many medical officers of health have long cooperated with practitioners in providing personal services. Developments at Bristol under Prof. R. H. Parry were a notable early example.

That the personal doctor in this country can increasingly look to the health department for aid in his work is, I believe, a good thing because it counters any tendency of practitioners to think too much in terms of hospital medicine. On the one hand, because his patients so often need specialist help, and because contact with consultants and other colleagues is the best means of keeping medically alert and well informed, the practitioner should be much more closely associated with hospitals than is usual today. But, on the other hand, this association must not blind him to his own chief task, which is to look after people *outside* hospital—and keep them out of it when he properly can. Those practitioners who like to spend part of their time in hospital work should certainly do so; but it would be a great pity if many others did not prefer the work now done in public-health and school clinics, or take part in industrial medical services (though these, if Lord Taylor [36] has his way, will be under the wing of the hospital boards rather than of the local authorities).

Though, as already explained, I have lost faith in the kind of health centre we used to hope for, it did have the great merit of bringing the personal doctor into daily touch with people from the public-health department. The more closely they work together, the better for his patients.

32. Stallworthy, J. A. *Lancet*, Jan. 9, 1960, p. 103.
33. Peterson, O. L., Andrews, L. P., Spain, R. S., Greenberg, B. G. An Analytical Study of North Carolina General Practice 1953–54. *J. med. Educ.* 1956, **31**, no. 12.
34. Lightwood, R., Brimblecombe, F. S. W., Reinhold, J. D. L., Burnard, E. D., Davis, J. A. *Lancet*, 1957, i, 313.
35. *N.Y. St. gen. Pract. News*, March-April, 1959.
36. *Lancet*, 1959, i, 923.

SELECTION AND CONTINUING EDUCATION

The conclusion that henceforth we shall want personal doctors rather than general practitioners implies that many of our students ought to be selected for qualities other than (as Dr. Lester Evans put it) being good at chemistry at school. And whereas until recently our tendency on graduation day was to select the future specialists and let everybody else go into general practice, we might do better in future to select the future personal doctors and let everybody else be a specialist. Besides techniques, the personal doctor should have character, much knowledge, many interests, and, above all, a capacity for identifying himself with his patient. For, call it what you like, this is no easy role. Silver [12] well summarises its exigent requirements when he asks:

" Who will see the patient in the first instance and determine if the complaint is minor or major? Who will refer cases to the specialists for more complex and precise diagnosis or treatment? Who will collate the reports as they come in? Who will adjust the *precise* ' scientific ' reports or findings to the patient, that imprecise person of infinite variability? Who will be so intimately related to the family as to know the interpersonal problems, assess them in relationship to the complaints or symptoms, and provide the support and guidance that probably does more to determine the duration or severity of an illness than the specific treatment? Who will carry on the day-to-day psychosomatic practice? Who? "

One professor spoke for many when he said: " Our educational system is producing experts, not doctors." But the doctor has to be an expert too.

UNDERGRADUATE EDUCATION

What kind of training is required by the man who wants to be both?

Dr. Proger says that in large towns the good family doctor is coming to be basically a well-trained internist.[31] And this is in line with the North Carolina finding [33] that the longer a man's training in internal medicine, the more likely he was to be a good doctor:

" The importance of training in internal medicine lies not in the name of the discipline or service but rather in the comprehensive viewpoint and emphasis on the basic techniques of diagnosis. These are the core of medical practice."

Comparing performance in the medical school with later performance in practice, the North Carolina investigators found evidence that a longer course in internal medicine makes up for lack of brilliance, turning some of the slower students into good physicians.

Since most of us hold that all doctors—whatever they are to do later—require a sound general training, I let myself in for a snub from a Boston professor when I asked what kind of training he provided for personal care. " Education", he replied, " should not be directed towards any special branch of medicine." But he agreed with me that it should not be directed *against* personal practice, as still too often happens. In point of fact, his school and others in Boston use their home-care programme very skilfully to give students a view of the world outside hospital [37]; and in New York Prof. Duncan Clark [38] and Prof. George Reader [39] told me about the ways in which their students make personal studies of families. Apart from this, in many American medical schools the student is introduced to personal practice by preceptors—practitioners who either take students in the outpatient department or have them in their homes and practices during the vacations for anything up to several months.

On the other hand, opinion is divided on the value of such schemes. Some medical schools do not really want to send so many students to study with practitioners or in peripheral hospitals, but they have to do it because their own hospitals (perhaps in a smallish town) do not yield enough experience. Though some preceptors are very good indeed, others are uninterested. In support of his scheme by which practitioners have offices in the teaching hospital, Dr. Proger's strongest argument, perhaps, is that " the student's familiarity with family medical practice becomes a part of his daily life " [31]: it is an integral part of the curriculum—not something stuck on to it.

POSTGRADUATE EDUCATION

But in medical education, Dr. Hilleboe said, the main problem has now shifted from the student to the intern and resident, and to the practitioner with his need to keep up to date.

Many American teachers feel that their medical schools must accept responsibility for the postgraduate, and they approve the idea by which university influence is supposed to permeate the National Health Service. But attempts by universities to give leadership in their localities encounter obstacles within as well as without: many of the staff, intent on research and teaching in their own departments, do not hold with universities assuming this external, social, role. In the Middle West the valuable work of universities in raising standards of agriculture is said to have made them sometimes too utilitarian: to use an ivory tower for silage can be a mistake in the long run. Nevertheless, for medicine, I am on the side of those who think of the doctor as a perpetual student for whose continuing education the medical school should provide.

The means whereby a university can spread knowledge and raise standards are the same in all countries. It may have a say in the appointment of staff, both senior and junior; it may lay down conditions on which students will be sent to preceptors, or interns to hospitals; it may hold lectures or courses at the periphery; or it may persuade practitioners to come to courses at the centre.

In courses at the periphery, I was told, practitioners are often reluctant to present cases and discuss them freely—fearing to lose face with their juniors or their fellows. (Dr. Rappleye thinks that, for this reason, an impersonal kind of teaching is best on the doctor's home ground.) They are much more forthcoming, however, when brought to the centre.

Wisconsin University has a magnificent new postgraduate teaching centre, used by, among others, the agricultural and medical faculties; and here a recent course for pædiatric practitioners was made successful by splitting them into groups of six or eight, under a " tutor ". Not knowing, or being in competition with, the other members of their group, they felt really free to talk—and did.

Except perhaps in Russia, the difficulty about central postgraduate courses is to get hold of the people who might profit most. Though about 300 of Wisconsin's 3400 doctors attended one or more of the eleven courses last year, 100 were regular attenders and 50 almost addicts.

But courses are not what matter most. The American Academy of General Practice insists on its members attending them. Medical schools do well to spend time and trouble on making them both acceptable and valuable. And no doubt television will increase their range and

37. Hass, G. *Lancet*, 1958, ii, 442.
38. Clark, D. Family Study in a Health Center Clerkship. Address to annual meeting of the Teachers of Preventive Medicine, Nov. 11, 1956.
39. Merton, R. K., Reader, G. G., Kendall, P. L. The Student-Physician. Harvard University Press, 1957.

efficacy. But, for the doctor as for the student, it remains true that the best way of learning is by *doing*.

Dr. Proger is right when he says that the best kind of postgraduate medical education is the kind that is a part of one's daily work. Of the practitioners who have offices in his teaching hospital he wrote: " One would not need to be concerned about courses for the family doctors who were a part of the center. Their daily activities would constitute such a course; a continuing and permanent one." [31]

Though I should like to see his New England Medical Center experiment (and many others) tried in this country, I think it will end by orienting its doctors towards the hospital when they should be oriented towards the home. For my part I believe that if the personal doctor is to exist at all, the centre of his work must be geographically as well as philosophically distant from the hospital. But we cannot get away from the fact that the best—indeed the only—way of maintaining a reliable medical judgment is to be always discussing cases with hospital colleagues as well as fellow practitioners.

Like the young man in *If* who was to walk with kings nor lose the common touch, the personal doctor must talk to specialists while preserving his own holism. He may or not work part-time in the hospital, but he must be in and out of it. Postgraduate courses are no substitute. Even reading the journals, I fear, would not quite make up for lack of daily contact over patients.

Medicine (as someone said to me) should always be practised in a critical environment.

THE FUTURE

Both Dr. Iago Galdston and Dr. Lester Evans wisely tried to divert my thoughts from mechanisms to principles: we should, they said, be worrying less about methods of *organising* care and more about the *kind* of care likely to be wanted in future.

" Episodic " medicine in Galdston's view, is likely to decline (a new method of treating cancer might put most surgeons out of work); but " maintenance " medicine will still be needed. Other authorities pointed out that against the growing complexity and scope of specialist work (e.g., the extension of surgery if organ-grafting becomes feasible) must be set the simplification of many diagnostic and therapeutic tasks. This may make it easy for practitioners to detect and manage diseases now requiring a lot of work in hospital. " The Pap smear ", Professor Rutstein remarked, " is more reliable than physical examination."

Also looking ahead, Dr. Silver quoted A. N. Whitehead on the tendency of professional groups to take on new functions, deputing old ones to the group below. Thus the nurse and social worker, following their upward course, can relieve the practitioner of much of his old work, leaving him free to specialise as an internist in a group.

This is the argument behind Silver's experiments at the Montefiore Hospital, and it has far-reaching implications. If we accept Whitehead's professional upgrading as a law of Nature, we must conclude that in the future very few doctors will want to do anything that could be done by an ancillary, and we must abandon the concept of a personal doctor who likes looking after people and is therefore content to do menial things for them as well as clever ones.

But in a rational society natural processes would not necessarily continue unchecked; and we could decide that specialism in medicine is being carried too far. If we liked, we could now close our ears to what this journal called the siren song of the specialist—*Anything you can do I can do better*. For there is one very important thing that the specialist can seldom do as well—namely, look after people as people. As Prof. Nathan Smith said to me, " bringing specialist services to an area is one thing: taking care of people is quite another ".

Perhaps I am wrong, but I should guess that in the prevailing culture of the United States, the independent personal doctor is going to be specialised out of existence, and that within a few decades medical care will mostly be based on the hospitals. Those who would like to keep the best of the old system cannot hope for much support from a public which has got rid of small shops in favour of supermarkets, and which so often actually prefers the mass-produced substitute to the genuine article. One cannot rely on public instinct to choose the best; for in times of rapid change people often go astray over their real needs. The American suburban woman with her car is probably gratified that she can now do her day's or week's shopping with hardly a human contact, but she was more likely to keep healthy and happy in the old days of walking and gossiping. The up-to-date man or woman getting his medical care from an impersonal group instead of a personal doctor may unbeknown be losing even more.

In the words of Lester Evans, whatever happens in medicine the age-old demand of the person—the patient—for help has to be satisfied, by somebody. Somebody must listen to him: if not the doctor, then the priest, or the social worker, or the osteopath. In medical situations, the doctor is usually the helper to whom the patient turns first, and he therefore starts with a therapeutic advantage. But he loses it if he sees his task as merely the recognition of primarily dangerous disease, if he fails to accept his patient as a person, or even if he asks somebody else to cope with the personal side. In America I was told that people often favour small hospitals because they get T.L.C. This mysterious remedy turned out to be an old one—tender loving care. Very often it is what they chiefly want from their own doctor.

Much personal care can, as Professor Rutstein said, be given by the public-health nurse. Which is true enough. My point is that, unless the doctor gives it himself, no sufficient reason remains for his being an independent practitioner. Sooner or later he must be absorbed by the hospital service.

TWO KINDS OF DOCTOR?

Though I think we should retain and strengthen the personal doctor as residuary legatee of the general practitioner, I know that this belief will seem to some both backward-looking and impracticable. Dr. Hilleboe, for example, found it hard to conceive of two separate kinds of doctor, and he thought that a man concentrating on personal care would inevitably have a lower professional status which would deter able students from such a career.

If he meant that there should be one medical profession, not two, I am with him; and I would agree that in Britain the practitioner is already too far divided in practice from the specialist. Nevertheless I think that a division of some sort is functionally correct because it corresponds to the patient's two needs—a primary need for personal

care and a secondary need for specialist skills. Unless a division is preserved, the first of these needs will more and more go unfulfilled.

As for status, the personal doctor must make it very largely for himself. As the Royal Commission [40] has explained, in our changed society the doctor can very seldom enjoy the prestige that comes of being one of the few educated people in his neighbourhood; and nowadays his patients are less docile. Moreover, though the personal doctor should be paid as much as the average specialist, and exceptional performance (in this work as in the specialties) should be recognised financially and otherwise, he will seldom have a chance of the monetary and professional rewards that go to men who win a national or international reputation. He will have to be content with a small territory—often smaller than it is today—for nobody can give really personal care to a flock which is large or widely scattered. But think of the history of general practice, and its innumerable examples of a kind of prestige that the eminent consultant hardly ever gains. The deep regard of the people of a locality is at least as satisfying as the plaudits of a congress. And it takes at least as much earning.

Personal practice, admittedly, is scarcely worth attempting without a vocation for it. But possibly in future a growing proportion of the newly qualified will say: " I'm going to be—not a radiologist, not a surgeon, not a biochemist—but a *doctor*." That, after all, was the thought with which many of them entered medicine. And a doctor is what 90% of the patients (though they may not know it) really need.

CONDITIONS FOR INDEPENDENT PRACTICE

But if we are making a serious attempt to develop good personal care in this country, good recruits are only a beginning. We must offer them conditions in which the odds are in favour of their improving steadily, as doctors, throughout their years in practice. At present the odds are often, if not usually, against.

To be a good personal doctor, a man must really take care of his patients: he must make diagnoses and take decisions—not merely write little notes to specialists. To shoulder such responsibility safely, he must know both his limitations and a great deal of medicine. And the best way of learning these, and keeping up to date, is frequent conversation with the specially informed.

In the National Health Service the financial incentives are mainly against the doctor who wants to look after a reasonable number of people and do all he can for them. If we mean to encourage such doctors, these incentives should be reviewed and probably revised. But, after my American visit, I have a new consciousness also of the harm done under our system by keeping practitioner and specialist so far apart. I remain convinced of the personal doctor's need for autonomy, but I now think this compatible with the kind of day-to-day contact at hospital which can make his own work so much more interesting and efficient.

The virtue of independence is nullified by isolation. The practitioner's usefulness and professional status depend on his being well informed; and in the modern world close association with the hospital is therefore a condition of his professional survival.

Some ways of strengthening that association have been suggested above, but there are others. Though we may not follow the Americans in everything, let us at least adopt—or rather resume—their excellent habit of wide experiment.

40. Royal Commission on Doctors' and Dentists' Remuneration; p. 106. H.M. Stationery Office, 1960.

SUMMARY AND CONCLUSIONS

Except in isolated places, the general practitioner is already extinct.

In the Russian countryside, and in many American towns and villages, he has been replaced by a small group of doctors trained in different specialties—a " composite general practitioner ".

But in Russian cities, and in some experimental American schemes, general practice as an independent activity disappears altogether. General medical care becomes one of the functions of a group which also gives specialist care.

Both in America and in Russia many such groups (clinics, policlinics, &c.) are still separate from hospitals. But the hospital is the natural centre for specialist work, and the groups will eventually be absorbed into the hospital organisation.

As medical centres for their area, the hospitals will then be offering full medical care. And if they do this satisfactorily there will be no place for the independent practitioner.

From the technical standpoint, this plan has obvious advantages. An internist, in easy consultation with other consultants and with beds at his disposal, can give the patient technically more than any independent practitioner. Hence the American public, already specialist-minded, may soon come to feel that hospital groups can best meet all its medical needs.

In our National Health Service such developments are impeded because the independent practitioner is protected, under an organisation separate from the hospitals. But his independence cannot be preserved indefinitely if his work could evidently be done better in a hospital milieu.

With the advance of specialisation, many of the functions of the independent practitioner have already been taken over by the hospital, and he will eventually be absorbed into the hospital system unless he is seen still to perform some important function for which independence is necessary.

The function which the good practitioner can in fact perform better than the best of hospital groups is personal medical care—looking after people as people. Whereas the specialist is, willy nilly, oriented towards the hospital, the independent doctor is well placed to think of people in their homes and workplaces, in health as well as in illness.

In these islands, with hospital specialists almost everywhere accessible, the general practitioner (composite or otherwise) is dead. But the personal doctor is needed more than ever.

Only if we clearly recognise his role can we set about fortifying him in it. To know what should be done for (and by) the independent practitioner, we must stop thinking about general practice and think instead about personal practice.

The change of name brings out better the importance of this part of medicine; for personal care is the primary medical need. But it also introduces a different criterion which displays different shortcomings and different ways of meeting them.

Looked at as " general ", a practice may pass muster, or even appear good, if it ensures that serious illness is picked

out and sent to hospital; but if we examine its merits as a " personal " practice it may be plainly on quite the wrong lines. Thus in a general practice, as in a hospital, unhurried personal attention may seem no more than an amenity—something extra for which a charge might properly be made. But in a personal practice it is the sine-qua-non.

Similarly some of the ways in which we have sought to improve general practice may be wrong if personal practice becomes our aim.

Personal medicine is practised by individuals, not by groups; so the personal doctor must look after people personally. For treating people at home he should get whatever aid he needs from medical officer of health or hospital; but, though he must use ancillaries, the purpose of his existence may be defeated if he deputes too much work to other people.

Similarly it may be defeated if, inspired by efficiency experts, he seems to put his patient on anything resembling a production line. The hospital must be to some extent a factory, but the personal consulting-room must *not*.

In the patient's eyes, the ideal doctor practises from his own house and is on duty twenty-four hours a day. In real life the outside surgery or office, the partnership, and the duty roster are usually a necessity; but the surgery should be home-like and the partners preferably not more than one or two. The large partnership tends to become a group with a clinic.

The personal doctor who is keen on a specialty, or likes hospital practice, should have every chance to pursue it. But while he is actually engaged in such work—which for him is a sideline—he cannot claim his usual autonomy. He should do specialist work only as a member (internal or external) of a hospital department. If they can accept this condition, a great many practitioners should go on doing obstetrics, both inside and outside hospital, and far more than at present should look after beds—especially in small hospitals and hospital annexes.

Even if he holds no specialist appointment, the personal doctor should work as closely with hospitals and specialists as is possible without imperilling his independent and responsible status. Those who are willing to help hospitals by supplying proper information about patients should be made associate members of the hospital staff, with appropriate privileges.

To take care of patients as their personal doctor demands the continuous exercise of well-informed judgment; and for acquiring and maintaining such judgment no other form of postgraduate education can compare with frequent discussion of cases with colleagues.

Personal medicine is a vocation, and it may or may not still attract enough people capable of taking its responsibilities. But this much is clear. Whether in America or here, the independent practitioner, outside hospital, will survive as a personal doctor—or not at all.

Without specific action, it will be not at all.

In the United States I was the guest of the Milbank Memorial Fund, whose president, Dr. Frank G. Boudreau, is the most perceptive of all hosts. Some of the many other colleagues who helped me have been gratefully mentioned above; but I must particularly thank those who gave up whole days to my visit—notably Dr. George Silver, Dr. C. B. Esselstyn, Dr. Joseph Garland, Dr. Leslie Falk, Dr. Thomas Nichols, Dr. Henry T. Clark, and Dr. Nathan Smith—and also Dr. O. M. Peterson for his advice on where I should go. If those who entertained me should read this article, the thoughts of some of them may turn, I fear, to the Spartan boy who nourished a fox in his bosom. But this fox at least recognises his good fortune.

That I actually saw all the intended people (and one chipmunk) was through blindly following the detailed instructions of Miss Anne Donohue, of the Milbank Memorial Fund.

Special Articles

ROYAL COLLEGE OF SURGEONS OF ENGLAND

THE completion of another stage in the buildings planned for the college in Lincoln's Inn Fields was celebrated on Tuesday when new laboratories were formally opened. Guests were welcomed by the president, Sir James Paterson Ross, and heard about the rebuilding scheme from Sir Eric Riches, chairman of the building committee, and Mr. Alner W. Hall, the architect.

The new floors which were opened this week lie behind the original college and adjoin the premises provided by phase I of the building programme (which included the Great Hall, museums, and laboratories). Phase II was the Nuffield College of Surgical Sciences, which stands on the east side of the college; and the buildings now completed and in use form phase IIIA. The final phase, IIIB, now starting, will, by additions and alterations, accommodate departments of pharmacology and biochemistry and the Hunterian Museum.

Phase IIIa

On the ground floor a skilfully lighted and comfortable lecture-room has been named after Sir Cuthbert Wallace; and next to it there are a committee-room, named after Mr. W. R. Gibson, and a fellows' common-room, named after Sir John Bland-Sutton. Where the new corridor joins that leading to the Great Hall, a rotunda has been created, in which stands Weekes' statue of John Hunter, which when the original college building is restored to normal will be visible from the front door.

The first floor contains the department of dental science and the odontological museum, the only part of the college museum to escape the late war virtually undamaged.

The second floor completes the suite of research laboratories for the department of pathology.

The third floor includes the department of research in ophthalmology, formerly housed in one room in another part of the building. With this department is the Wernher Group for Research in Ophthalmological Genetics (a unit of the Medical Research Council). A demonstration room on this