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Correspondence

Correspondents are asked to be brief.

Primary Medical Care

SIR,—It is both surprising and disappointing to learn that the B.M.A. Planning Unit is no nearer the truth concerning the nature of general practice under the N.H.S. than the Todd committee whose composition, I believe, contained not a single general practitioner.

I am getting rather tired of the oft-repeated cliché that we are operating a "cottage industry" which is 50 years out of date. This notion has been foisted upon the profession by the hospital doctors who have now decided that we too must specialize in order to qualify as efficient scientists. Let us face the facts and try to be more practical. If some doctors think the general practitioners are lowering their standards because in the 20th century we still practise from our own homes without the benefit of elaborate equipment, let them consider the nature of the service we provide: 75% of our work is concerned with the solution of minor problems, many of which are non-scientific but require a medical background knowledge, plus a little experience of human nature. The other 25% contain some difficult cases which will have to be referred to hospital for investigation however better trained our successors may be.

Under the present system of free-at-the-time medicine we are becoming increasingly overloaded with trivial complaints which should never reach the surgery at all; nor indeed would they if the public was obliged to pay a reasonable consultation fee. As a result we refer too many patients to hospital through lack of time, and the overloading is passed on to the consultants whose waiting lists become longer. Moreover, many of these unnecessary referrals would not occur if general practitioners were paid per item of service. The gradual extinction of local, "cottage" hospitals also reduces the field of operation for general practitioners, who could perfectly well undertake most minor surgery as well as care for minor bed cases. This would relieve the district hospitals, shorten their waiting lists, improve our morale, and please the patients. The B.M.A. Planning Unit has recommended that future general practitioners, or primary physicians, should after five more years of training become specialists in clinical medicine, psychiatry, psychology, and sociology, while giving up entirely their responsibilities in the specialties of eyes, skins, E.N.T., and obstetrics. What an absurd proposal! Just because we cannot at present treat the more serious cases in these specialties we are to be stopped treating the minor cases, which will have to go direct to hospital. If this ever comes about I pity the public and the hospital staffs.

The whole approach to the problem of general practice (primary medicine) seems to me to be misconceived. If the present training of general practitioners is lacking in the knowledge of certain specialties then by all means insist on three to six months post-qualification hospital appointments. We must be trained for the work which we are called upon to do, not prevented from doing it because of some theoretical idea that sociology and psychology are more important, and there is insufficient time for everything.

The fundamental troubles of the N.H.S. are financial. Effective reforms are hampered because they are politically inexpedient. The B.M.A., however, should be above party politics and state clearly what is needed for the good of both the profession and the public.

To sum up : The future general practitioner, whatever he is called, would be more effective if he were paid per item of service.

He would do better quality work if he were not irritated and overburdened with trivial demands from patients who have no consultation-fee deterrent.

Small local general-practitioner hospitals should be encouraged and doctors assisted by generous grants to modernize and regroup their surgeries.

Our clinical scope should not be circumscribed, but more emphasis should be given after qualification to the specialties which we commonly encounter.

Two years of extra hospital experience after qualification should be the maximum compulsory burden imposed on the primary physician of the future.—I am, etc.,

HUGH CANE.

Bungay, Suffolk.

SIR,—The recent report on primary medical care (30 May, p. 535) prompts me to make the following comments on some of the recommendations.

Firstly, one of the strengths of the general practitioner is that he is in many instances a family doctor, someone who has gained the confidence of the whole family by repeated contact. Therefore, the suggestion that he should specialize in only one or two of certain subjects such as paediatrics, geriatrics, medicine, or psychology destroys that position. It also seems to me impractical to the patient to have to seek treatment for his skin, E.N.T., and ophthalmic condition primarily from the already overloaded hospital outpatient departments. Many hospitals already have waiting lists of several months for appointments in the specialties.

The attempt to specialize at this primary level would, in my view, also inevitably result in second-class status of the general practitioner. Both the patient and the consultant would look on him as a second best and certainly the point put forward that specialization would improve the relationship of the primary physician to his consultant colleague is open to some doubt. Surely most consultants soon realize from referrals, admissions, and other contacts the skill and work of any particular family doctor.

As for the report's suggestion that the primary physician should become a glorified social welfare officer, they have already, in an earlier recommendation, by destroying the general practitioner's contact with the whole family, taken away his one qualification to do that—that is his possible close personal contact with the families under his care. Also, the setting up of larger units would interfere with this and tend to institutionalize primary care medicine.

Finally, the report suggests that without implementation of its recommendation general practice will just drift without direction or purpose. Most general practitioners would agree that this is unlikely. Already the general practitioner in partnership or in a health centre is becoming more integrated by attachment of nurses and health visitors and the like, and by his clinical appointments is coming in close contact with the hospital service, and in the future there is the possibility in many communities of the