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Physicians and Family Doctors: A New Relationship?

I. J. T. DAVIES, MB, MRCP, FRCP Ed
Physician, Highland Health Board, and Regional Director of Postgraduate Medical Education, Raigmore Hospital, Inverness

When a lecture is reprinted simultaneously in the journals of two Royal Colleges, when its author is influential and an acknowledged leader of his branch of the profession then what he has to say is worthy of careful reading. This is especially so when his contents concern other branches of the profession and when the conclusions may be wrong. Respect for the achievements of the author require that his arguments be listened to with care. Nonetheless, prestige carries with it the burden of influence and this imposes on those who believe the arguments to be contentious a responsibility to state the other case lest silence be taken for consent and the authority of the author carries the day.

John Horder's article, 'Physicians and Family Doctors – a new relationship', analyses some of the attitudes governing the relationship between two groups: consultants and general practitioners (Horder, 1977). He maintains that the attitudes of each group to the other are changing and that these changing attitudes will lead to a changed relationship. As a generalisation this must be true but, unfortunately, he has chosen only those changing attitudes that support his supposition that the relationship will change in a way he would seem to favour. He has assumed that general improvements in the appropriate knowledge and special skills of general practitioners as a group must lead to changes in the attitudes (and so ultimately the relationship) of consultants and general practitioners to each other. This may not be so – the attitudes of one professional group to another, which have developed over many years, are compounded of many, and sometimes complex, factors and involve a relatively slow evolution of opinion (and sometimes prejudice). His case for a different relationship between consultants and general practitioners is based on the undoubted educational achievement of the Royal College of General Practitioners. As he says, 'The Royal College of General Practitioners was a light shining in darkness when it started in the 1950s and today it is the most important single influence for raising the quality in general practice'. To a lesser extent he has invoked the impecunious-emphysematous-syphilitic-Polish Count-argument with its implications that general practitioners (unlike consultants) have to continue to care for incurable patients whose cultural, social and personality backgrounds may fit them poorly to cope with their illnesses. Despite this, he does concede that hospitals are part of the community; he does not, however, consider relevant the proposition that hospital doctors are likely to be just as humane, caring, kind and available as the friendly neighbourhood general practitioner. The hospital doctor has the more

difficult task: he must decide what are correct and orthodox procedures for diagnosis and management for the presumed diseases and then consider how these may have to be modified, given the cultural, social and personality aspects of the patient. Hospital doctors resent the implication that they do not 'know' the patient's background and that they advise investigations and treatment which are, at best, unnecessary and, at worst, unkind. In general, they are as caring as their general practitioner colleagues and they sometimes have to take the unpleasant step of subverting the short-term kindness of doing nothing to the greater kindness of advising uncomfortable procedures that may result in some long-term alleviation or cure.

Many consultants would not agree with Dr Horder's restricted choice of those attitudes consultants have towards general practice, attitudes that will determine the future relationship between consultants and general practitioners. Relationships consultants would include are: their attitudes about the diligence, financial rewards and democracy of general practice, the respect general practice has for the sensibilities of other groups, and their doubts about some of the current educational upheavals of general practice, particularly the implementation of the 1976 Vocational Training Act.

DILIGENCE

1. *Decreased List Sizes*

There are many different ways of measuring the diligence of a group or of individuals. The recent Review Body Report showed that between 1970 and 1975 the average list size per general practitioner had decreased by 4.4 per cent; superficially, at least, it implies that less work is being done (Seventh Review Body Report, 1977).

2. *Growth of Deputising Services*

Between 1971 and 1974-75 there was a 47.3 per cent increase in the number of calls dealt with by a general practitioner deputising service in the 18 towns and cities in England and Wales surveyed by Dixon and Williams (1977). The number of deputising service consultations represented about 2 per cent of all visits made by general practitioners. However, deputising services usually operate only at night and at weekends so that the proportion of calls dealt with by the deputising service during these hours is considerably higher. It was concluded that, as long ago as 1970, around half the night calls in Sheffield were being handled by the deputising service; the subsequent growth of this service and others suggests that the proportion may now be higher. In 1972 it was known that 28 per cent of general practitioners in England and Wales were using deputising services (Williams and Knowelden, 1974). This information does not imply that the service given is any better or worse than that of the patient's own general practitioner but it does indicate that general practitioners in the areas studied were making extensive use of deputising services and it is believed that this tendency is increasing (Buxton *et al.*, 1977).

3. *Minor Casualties in Hospital Casualty Departments*

Dr P. O'Flanagan, who was a general practice vocational trainee in Derby, reported that in a six-month period, when he was working in a major accident centre, 67.9 per cent of patients seen were thought appropriate for management by general practitioners (O'Flanagan, 1976). This figure confirms that of earlier surveys (Morgan *et al.*, 1974; Cliff, 1974). The number of trivial cases attending hospital casualty departments is increasing because of the organisation of general practice or because of the patient's opinion of general practitioners' capabilities or availability. There was an 8.9 per cent increase in new patients attending hospital casualty departments between 1970 and 1975 (Seventh Review Body Report, 1977).

> 'Too often it seems a general practitioner appointment system imposes an inflexible 24 hour delay (except for major emergencies); while at weekends many family doctors use deputising services which again are geared to domiciliary emergencies rather than minor complaints.... Certainly it is unfortunate if the effect of an appointment system should be the diversion of minor emergencies away from the general practitioner into overburdened hospital accident departments – and this has been the trend in recent years. One of the worst features of medicine in many North American cities is the total lack of primary care out of hours: action can now prevent the same thing happening here, and action will be needed if the high reputation doctors enjoy is to be preserved. (*British Medical Journal*, 1974)

FINANCIAL REWARDS

Those consultants who are Clinical Tutors who run postgraduate centres and organise postgraduate teaching programmes in District General Hospitals receive only an honorarium, and they firmly reject moves to be paid more for doing a job which, they argue, should be done for the love of it and not for financial reward. However, general practitioners argue differently and have achieved some notable and worthwhile financial rewards for teaching juniors and organising training programmes which consultants still regard as their duty and therefore do unpaid.

All Regions now have a Regional Adviser in General Practice who is paid at the maximum rate of the consultant salary scale as soon as he takes up his appointment. General practice is the only specialty in which the Regional Specialty Adviser is paid a salary by the State for doing a job which is broadly similar to that carried out by specialty advisers in all the other specialties; it is the only discipline in which the trainers are paid specifically for training their juniors – this is the Vocational Training grant – at present £1,300 a year, with a tax-free allowance of £1,125 per annum for an additional car (Statement of Fees and Allowances payable to General Medical Practitioners, 1976). Furthermore, general practice is the only discipline in which all those who have undertaken some form of specialist training receive an extra salary allowance (vocational training addition).

Questions about relative remuneration do not go unasked. Consultants believe that, on average, general practitioners are better paid than themselves. The average

general practitioner receives from NHS sources an effective taxable income of £12,000 (taking into account tax benefits, car expenses, seniority payments, fees for contraceptive services and hospital work). Bearing in mind that about 40 per cent of consultants are part-time and 20 per cent are not yet on the maximum of the scale, the average gross taxable salary of consultants is £8,850.

Consultants resent the fact that general practitioners have kept their options open and can resign more easily from the NHS. It may be argued that this is not the fault of general practitioners and that they cannot be blamed for the naïvete and political ineptitude of consultants. This is perfectly true, but logic is no match for envy, and consultants *are* envious, so the 'relationship' must take into account envy among other things.

DEMOCRACY WITHIN GENERAL PRACTICE

The Royal College of General Practitioners is one of the newest Royal Colleges, having been founded in 1951. The longer established Colleges and Specialty Faculties welcomed the new Royal College and its enthusiasm in carrying out its self-appointed task of making general practice a specialty to be considered on a par with the other major specialties of medicine and surgery. However, the Royal College of General Practitioners is not yet, and may never be, truly representative of all general practitioners (Breakey, 1976; McKee, 1977; Capstick, 1977; Cargill, 1977). There are, in the UK, approximately 24,000 general practitioners, of whom 8,000 are Members or Fellows of the College; of those, only 2,500 are Members by virtue of having passed the Membership examination of the College.

There is a widespread feeling that the proposed structure of vocational training for general practice may be so contentious that:

1. Those of the Royal College of General Practitioners who have been responsible for its formulation have not obtained the majority consent of all general practitioners.
2. They may have seriously questioned whether such consent would be forthcoming.
3. They have therefore sought the force of law to implement their minority view.

VOCATIONAL TRAINING ACT 1976

The National Health Service (Vocational Training) Act 1976 empowers the Secretary of State to make regulations which—

(*a*) Prescribe the medical experience required of a doctor seeking to enter general practice as an unrestricted principal;
(*b*) Designate a body to issue certificates indicating that the prescribed experience has been acquired;
(*c*) Designate a body to assess experience not identical to that prescribed and, where appropriate, to issue certificates indicating that such experience is equivalent to that prescribed;
(*d*) Set out circumstances in which a doctor is exempt from the need to acquire the prescribed experience;

(*e*) Establish an appeal body;
(*f*) Appoint a day from which the training requirement shall become operative.

The effect of the Act will be that from the appointed day Family Practitioner Committees will be able to make arrangements with doctors wishing to become unrestricted principals for the first time only if those doctors have experience conforming to that required by the regulations.

This Act is now on the statute book and it has been welcomed as

> 'another milestone in the development of General Practice . . . it should go a long way towards showing young doctors, the public at large, and our colleagues in other branches of medicine, that general practice is serious in its determination to improve its own standards. It will lay a more secure foundation of required experience from which to identify those doctors completing training who choose to show that they have achieved the standard of excellence the College seeks to promote in clinical practice.' (*Journal of the Royal College of General Practitioners,* 1976).

One real anxiety sympathetic commentators voice is that this is the first time the Government has had a direct say in prescribing the experience to be required for entry into a chosen discipline. All other specialties rely on the innate professional standards within the specialty for monitoring and maintaining the educational standards of that specialty. Many observers foresee dangers in the statutory imposition of standards and many feel that it is feasible that pressure could be brought to bear by the government of the day to alter the educational standards of vocational training once it feels that the numbers entering general practice need to be increased or decreased. The point is taken that Government itself will not dictate standards and that standards will be laid down by the Joint Committee on Postgraduate Training for General Practice. Nevertheless, there is still a risk that pressure could be brought to bear on this committee to acquiesce in the alteration of educational standards in a politically convenient direction, particularly as all the Higher Specialist Training Committees are financed largely by grants or contributions from the Health Departments. All other disciplines formulate their training standards through Higher Training Committees. These have arisen through Colleges and Faculties with an acknowledged and traditional role in regulating training standards. It has not been necessary for them to resort to law to ensure acceptance by the discipline of the committee regulating the training standards. When the recommendations of the Merrison Committee concerning the General Medical Council's regulatory role are enacted, the Council will be given statutory powers to nominate the most appropriate body to oversee the training requirements of the different disciplines which, when completed, will lead to specialist accreditation registered by the Council. General practice is unique in that the committee concerned with educational standards will itself be recognised by statute.

DISREGARD FOR THE SENSIBILITIES OF OTHER GROUPS

The teaching methodology and the organisation of vocational training for general

practice, which have been espoused by the Royal College of General Practitioners, are controversial. Yet these contentious views have been successfully and completely enshrined in the documents and recommendations of the Joint Committee on Postgraduate Training for General Practice.

This committee is an independent body comprising nominees from the following:

Royal College of General Practitioners (6 plus 1 trainee);
General Medical Services Committee of the British Medical Association (6 plus 1 trainee);
United Kingdom Conference of Regional Advisers in General Practice (3), Conference of Regional Postgraduate Deans (1);
Association of University Teachers of General Practice (1);
Armed Services General Practice Approval Board (1), and observers from the Councils for Postgraduate Medical Education (3), Department of Health and Social Security (1), and Scottish Home and Health Department (1).

Hospital appointments constitute two-thirds of the time of approved Vocational Training schemes (2 years in hospital posts and 1 year in a general practice post) and the educational standards of the whole of the vocational training schemes are overseen by the joint committee. It is therefore illogical and tactless that the committee should be so heavily weighted in its membership by general practitioners and not contain a single clinical consultant. This anomaly must be clearly appreciated and remedied otherwise hospital-based specialists will be increasingly unwilling to participate in vocational training schemes.

The Committee produces a document, 'Criteria for the selection of hospital posts which may be recognised as providing suitable experience for Vocational Training Programmes for General Practice', and its visiting panel, which visits to approve vocational training schemes, does consider and usually comment on the hospital aspects of the training; this, in the complete absence of any clinical consultants on a committee of approximately 25.

More than 1,000 vocational training posts are still required in order that all those entering general practice can have completed approved vocational training schemes or programmes. Vocational training having been statutorily established, and the Joint Committee on Postgraduate Training for General Practice being the body that approves vocational training schemes and programmes, could well mean that consultants might find that their existing SHO posts and some prospective SHO posts would have to be approved by a committee consisting largely of general practitioners and one on which they are not represented at all. Should SHO posts not be approved for vocational training in general practice, the pool from which candidates for SHO posts will be drawn may be seriously reduced if general practice trainees are thus precluded from applying. The Joint Committee on Postgraduate Training for General Practice may well, therefore, have indirect control over many junior hospital posts.

A further indication of failure to take account of consultants' sensibilities is the establishment of this Joint Committee as a Higher Specialist Training Committee, on a par with the Joint Committee on Higher Medical Training and

the Joint Committee on Higher Surgical Training. All the other Higher Specialist Training Committees are dealing with trainees who have completed general professional training and who have therefore been qualified at least 4 years and often as long as 8 years (bearing in mind that 37 is still the average age of appointment to the consultant grade). The Joint Committee on Postgraduate Training for General Practice is dealing with training which may begin immediately after registration (i.e. a period which corresponds to general professional training). One explanation for this difference is that the Higher Specialist Training Committees are supported by grants or contributions from the DHSS, whereas the inspecting committees of the various Colleges and Faculties which inspect the suitability of posts for the appropriate postgraduate diploma and the committees concerned with general professional training in England and Wales are financed from College or Faculty funds. General practice is unique in that the committee that oversees training immediately after registration is supported by Exchequer funds.

It may seem churlish to have raised some of these issues, but relationships depend on many attitudes and some prejudices. Perhaps I am wrong in my impression that the relationship of which Dr Horder speaks will be affected by some of the issues I have raised; maybe the majority of consultants have not thought much about the matter, but then neither have the majority of general practitioners. Nonetheless, I believe that it would be wrong for Dr Horder's views to pass unquestioned, although I hope that he is right and I am wrong.

CONCLUSIONS

The good relationship between individual consultants and general practitioners is not in question. The relationship between groups is dependent on individual attitudes to the other group. The educational achievements of the Royal College of General Practitioners are exemplary and undisputed; that these achievements are leading to changes in attitudes and relationships between the groups is inevitable; that the changed relationships will also depend on opinions about other aspects of general practice must be considered. Some of these other opinions are discussed as well as questions about the advisability of some of the educational developments in general practice which have resulted in the 1976 Vocational Training Act.

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Book Review

A Dictionary of Medical Ethics and Practice by William A. R. Thomson.

John Wright and Sons, Ltd, Bristol 1977. Price £10, 272 pages.

This book, styled a dictionary, contains a great deal of well-presented accurate information on a wide variety of topics. In his preface the author says 'such a book cannot be comprehensive if it is to remain within the limits of reasonable size' and it is indeed eclectic rather than comprehensive. In fact, one does not know what to expect to find in the book and the only thing to do is to look to see if a certain subject is there. Some of the topics dealt with are, of course, treated at considerable length; for instance, Abortion has 10½ columns. Some more strictly medical technical information finds its way in; for instance, Phenyl Ketonuria, Tay Sachs Disease and Albinism. There are useful references for most of the matters that are covered. This is all alongside Battered Wives, Mormons, and the Care of the Dying. In places, opinion, some might say bias, comes through alongside facts; for instance, in Corporal Punishment. There is philosophy and much that is practical, too, about the approach; for instance, under Bereavement. The Doctor-Patient relationship, the Doctor-Dentist relationship, the Doctor-Clergy relationship and the Doctor-Doctor relationship all get discussion and much that is comprised by so called 'medical etiquette' finds inclusion here – that bone of contention that used to and still does arouse such high feeling between the profession and the public. It might have been wise to include a short section on medical etiquette as such, even if only to dismiss it and refer the reader to other sections of the book. Aimed primarily, it seems, at family practitioners, there will nevertheless be a useful place for this book by the lay public despite its sometimes rather technical approach and within the limits of its less than 300 pages, albeit of smallish print.

KENNETH ROBSON