

Chapter 1 **General practice: past, present and future**

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Early days

The term 'general practitioner' was probably first used shortly after the passage of the Apothecaries Act of 1815. This was a time which marked the end of the Napoleonic Wars at the Battle of Waterloo, the invention of the stethoscope by Rene Laennec in 1816 and the flowering of the geniuses of Constable, Blake, Keats and Turner. It was also a time of unregulated medicine, when body snatching was still rife and when the medical landscape was dominated by the powerful Royal Colleges of Surgeons and Physicians. Over the next two decades, the golden age of medicine, Thomas Hodgkin, Richard Bright and Thomas Addison, all working at Guy's, made their astonishing landmark contributions. By 1844 general practitioners (GPs) had identified themselves as a well-defined section of the medical community, and attempted to form the ill-fated Association of General Practitioners.

The origins of general practice, however, can be traced far further back in medical history. The apothecaries emerged from the pepperers and spicers of the middle ages, and were originally members of the Grocer's Company of London, founded in 1373. The Worshipful Company of Apothecaries received its charter from King James in 1617, and established an apprenticeship system of training. Whilst physicians were university educated and steeped in Hippocrates and Galen, the apothecaries were involved in making and dispensing drugs prescribed by physicians; they were not allowed to diagnose or prescribe treatment.

The medical profession was decimated by the Great Plague in 1665 and the Apothecaries' Hall was destroyed in the Great Fire of London during the following year. Over the next 50 years professional tensions developed between apothecaries and physicians, and patients began to address both of

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them as ‘doctor’, finding it difficult to distinguish between them. The physicians, fearing for the erosion of their professional status and their incomes by these medical upstarts, attempted to introduce legislation to prevent apothecaries from becoming involved in the treatment of patients, but met their own Waterloo in 1701 in the ‘Rose Case’, which changed the course of medical history.

The Rose Case

William Rose was an apothecary and a liveryman, practicing in St Martin’s in the Fields, London. At the turn of the century he treated William Seale, a butcher in Hungerford Market, providing medication for which Seale was charged the enormous sum of £50. Seale commented that he was ‘never the better but much worse’ for his treatment, and complained to the Royal College of Physicians, who undoubtedly regarded this complaint as an opportunity for an important test case. The college’s case against Rose was based on an act passed during the reign of Henry VIII and was brought before the Court of the Queen’s Bench under the Lord Chief Justice and a jury. Rose had administered ‘boluses, electuaries and juleps’ without licence from the college and without direction by a physician. Because apothecaries were not allowed to ‘practice physic’, Rose was found guilty, but the Attorney General advised the Society of Apothecaries that they should bring a Writ of Error to the House of Lords; the case was heard in the Lords in 1704, and the original judgement was quashed. Seale’s counsel, Samuel Dodd, claimed that the judgement would not only ruin Rose but all apothecaries, and that the physicians were making use of an outdated act of Parliament whose application would ‘oppress the poor and be extremely prejudicial to sick persons in the case of sudden accidents or illness’. Their lordships were also aware that many physicians ‘would not attend when at dinner or abed’, and ruled that apothecaries could, in future, treat all illnesses, whether slight or grave.

The apothecaries

Over the next century the apothecaries widened their medical repertoire, dealing with surgical problems including abscesses, ulcers, eye diseases and toothache, and in 1740 became involved in midwifery as well, recognising that if they were able to ‘deliver the babies, you will have the family as patients for life’. The Apothecaries Act of 1815 gave the Society the powers to examine and license apothecaries after serving a 5-year apprenticeship and also to carry out quality-control checks on their premises. Further regulation of prescribing and practice was introduced by the Pharmacy Act of 1852 and the Medical Act

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Table 1.1 Milestones in the development of general practice: the first five hundred years

Period	Milestone
14th century	Grocers, pepperers and spicers
15th–17th century	Unregulated apothecaries, surgeons and physicians
1617	Worshipful Company of Apothecaries established by Royal Charter
1701	The Rose Case
1815	Apothecaries Act
1844	Association of General Practitioners proposed but never established
1852	Pharmacy Act
1858	Medical Act, outlawing quackery and introducing formal training and examinations

of 1858, which outlawed quackery and introduced a formal system of medical education, examination and licensing (see Table 1.1).

In the mid-nineteenth century, the future of general practice, which was by then established as a separate section of the medical profession, might have been altered for ever if the foundation of the Association of General Practitioners had been successful, and had been able to act as a professional base and political lobby for its members. Sensing competition, however, the powerful Royal Colleges, notably the Surgeons, did all they could to suppress the foundation of the Association, and contemporary accounts of the acrimonious debates which ensued make today's jibes about arrogant hospital consultants and golf-playing GPs look distinctly insipid. However, the Surgeons prevailed, and the Association of General Practitioners was stillborn. The future of general practice was further threatened by a change in the public's health care seeking behaviour. There was an extraordinary rise in the number of patients seeking first-contact care in hospital casualty departments. The records of the London Hospital, Whitechapel show that the annual number of new outpatient attendances in the early 1820s was around 5000, rising to 52,000 in the 1870s and, by 1910, had risen to 221,781. The reasons for the popularity of hospital departments as primary care providers are not clear, but this change in patient behaviour resulted in the bankruptcy of many general practitioners, who demanded that in future hospitals would only see patients who had been sent there by general practitioners with an accompanying letter. This episode marked the beginning of the referral system in the United Kingdom, and of the gatekeeper role of the general practitioner in today's National Health Service (NHS).

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The beginnings of the NHS

Another central feature of the NHS, that of registration and capitation, has its roots in the National Health Insurance Act of 1911, which entitled employees earning less than £160 per year to free medical care from general practitioners taking part in the scheme, who were paid on the basis of capitation, i.e. the number of patients on their registered list or 'panel'.

The NHS was created by the National Health Service Act of 1948, a political leap of faith of great imagination and altruism, championed by the 'Welsh Wizard' Aneurin Bevan, and all the more extraordinary for emerging from the years of austerity following the Second World War. The NHS was the first, and for many years the only, health care system for which the State took responsibility, providing care free at the point of delivery irrespective of a patient's ability to pay. It encapsulated the registration system of the entire population with general practitioners and the capitation system of payment. It led to a sharper division than ever between primary care (general practice) and secondary care (hospital medicine) and confirmed the central role of the referral system from GPs to specialists. It also introduced general practitioners' 24-hour responsibility for providing care to their patients and located the responsibilities for medical education and research firmly in the hospital sector.

In a salutary counterweight to the optimism of the NHS Act, Joseph Collings published 'General Practice in England Today: A Reconnaissance' in *The Lancet* of 1950, as a result of visiting many practices around Britain. Collings commented that 'few skilled craftsmen, be they plumbers, butchers or motor mechanics, would be prepared to work under such conditions or with equipment so bad'. Irvine Loudon, our most distinguished chronicler of the history of general practice, commented:

Just at the time when the hospital service was beginning to forge ahead in a state of high optimism as a result of the therapeutic revolution, general practice was stagnant. Post-graduate education was virtually non-existent. All too often general practitioners, who were poorly paid, lacked self-respect and showed little or no ambition to improve either their standards of practice or knowledge.

Loudon describes the change in general practice, accompanied by a rise in standards and morale, 'amounting to a transformation of general practice between 1948 and the mid-1960s', as little less than astonishing. Key factors in bringing about this sea change in professional practice and attitudes included the Family Doctors Charter of 1966 and, perhaps, most important of all, the

Table 1.2 Milestones in the development of general practice: modern times

Period	Milestone
1911	National Health Insurance Act: the origin of the 'list' system
1948	National Health Service Act: registration with GPs, services free at the point of care
1950	Collings Report, critical of infrastructure and professional standing of GPs
1952	College of General Practitioners founded
1966	Family Doctors Charter
1972	RCGP obtains its Royal Charter. Mandatory vocational training requirements for all new GPs
1991–1997	Margaret Thatcher's Internal NHS Market and GP Fundholding
2000	NHS Plan
2005	Our Health, Our Care, Our Say: re-introduction of competition and private service provision in the NHS

foundation of the College of General Practitioners, later the RCGP, at around the same time (see Table 1.2).

Modern general practice

The transformation of general practice has continued, and in many ways accelerated, over the last 40 years. Vocational training for general practice, the 3-year period of hospital and general practice-based education now mandatory for all entrants to general practice, has led the way internationally, and the standards of postgraduate education in general practice were the benchmark for the quality of training in the medical specialities for many years. Group practice, with general practitioners working alongside the other members of the primary healthcare team, has supported a system of primary care which has become the envy of the world. The increasing sophistication and widespread application of computer systems in general practice, coupled with the patient registration system, has supported high-quality clinical record keeping, audit and health promotion, as well as providing an internationally envied resource for clinical and health services research.

The growth of the academic departments of general practice in the universities has been little short of astonishing, with undergraduate teaching in general practice and community settings now accounting for up to 15% of clinical curricula, and the research output of many of these departments now bears comparison with the best primary care, clinical and health services research in the world. Despite repeated NHS reforms, the ability of general practice to provide comprehensive, continuing, personal and coordinated

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care to the population remains unrivalled on the international stage, and the recently introduced contractual arrangements for general practitioners have, at last, linked remuneration to the achievement of specified quality outcomes for the management of a range of important clinical conditions, encapsulated in the Quality Outcomes Framework.

The benign gatekeeper role of general practitioners, enshrined in the referrals system, has contributed significantly to the cost-effectiveness of the NHS, and the crucial importance of extending high-quality community-based care has been a central feature of Government policy, including the concept of the 'primary care-led NHS and the most recent Government White Paper, 'Our Health, Our Care, Our Say', which confirms this policy direction. Practice-Based Commissioning provides further opportunities for practices and clusters of practices to engage meaningfully in the commissioning of services that are most appropriate for particular patient populations and sub-groups.

Current concerns

In many ways general practice has been, and still remains, the jewel in the crown of the NHS, but the future is, as always, uncertain. Improvements in recruitment and retention, and in clinical standards and in the remuneration of general practitioners, have come at a price. The new contractual arrangements have signalled a retreat from 24-hour responsibility for patients, with out-of-hours care being frequently delegated to co-operatives of general practitioners, and the move from a 'small business' model of partnership working to a service in which part-time and salaried doctors play an increasingly important role, has resulted, inevitably, in an erosion of personal continuity of care, although organisational continuity is a reality in well-organised group practices. The numerous government initiatives to increase patient choice and to improve access, including NHS Direct, walk-in centres and the opportunities for non-NHS providers to deliver primary care services, are likely to create new challenges for the provision of personal, comprehensive and continuous care, recognising that ready access and convenience are priorities for many patients in an increasingly consumer-driven environment.

As doctors in primary and secondary care find themselves acting out roles that were written for them almost 700 years ago, there has never been a more exciting time to be involved in the drama of general practice and primary care in the United Kingdom. For many of us what is at stake is nothing less than the future of an extraordinary medical service which sprang from the imagination of a few visionary men in the middle of the twentieth century. For all of us there is the challenge of providing the best possible care to our population in the twenty-first century.

A vision of the future

How might general practice look in 20, 50 and 100 years' time? Whilst much foreseeable change will be driven by technological advances, globalisation and changing demography, the emergency of new infectious diseases and the burden of the chronic, non-communicable disease will all play their part. Much change will be unimaginable at the present time.

We will undoubtedly know much more about our bodies in health and disease in a decade's time, as genomics becomes more sophisticated and more affordable and the sequencing of our genes begins to fulfil the promise of the revolution started by Crick and Watson. Our ability to give accurate prognoses will be severely tested as complex genetic influences on disease development are discovered, but their precise impact on our life cycles will be difficult to measure. There is little doubt, too, that imaging, without the use of invasive procedures, will continue its remarkable evolution, so that early detection of vascular, neoplastic and degenerative diseases can be achieved by direct visualisation rather than by the detection of proxy biological markers – think of colon cancer and faecal occult bloods, coronary heart disease and cholesterol, prostate cancer and prostate specific antigen.

Much of this information will be made available to patients by private organisations that may not be well connected to health services and may not be able to provide adequate interpretation and follow-up of potentially alarming findings.

The use of information communications technology has the potential to change radically the relationships between doctors and patients, at home and in the surgery, by the use of text and picture messaging, of remote biosensors and even remote testing for monitoring chronic disease – a potentially chilling alternative to the warm support provided in the practice's chronic disease management clinics.

And there will, of course, be more unpredictable changes. But at the centre there will always be a patient and a clinician, whose tasks will continue to include coordinating care, providing advice, support and explanation, protecting from harm and encouraging well-being. Roles, responsibilities and medical terminology may all change, but this person looks to me very much like a general practitioner.