THE HISTORY OF GENERAL PRACTICE

DR DUNCAN SHREWSBURY (BRIGHTON & SUSSEX MEDICAL SCHOOL)

INTRODUCTION

“If you know your history, then you will know where you’re coming from then you wouldn’t have to ask me ‘who the hell do I think I am?’”

Marley, B. and Williams, N. (1983)
Buffalo Soldier. Confrontation; Tuff Gong/Island

Exploring the development of general practice can shed light on many of the values that underpin practice today. It can also help understand some of the challenges within the discipline and at its interface with other, healthcare specialties and members of society.

NEED TO KNOW

ASPECTS OF HISTORY & DEVELOPMENT OF GENERAL PRACTICE

1. The origin and education of community physicians
Community-based medicine was practised for centuries by apothecaries with knowledge passing down generations via apprenticeships lasting usually for 5 years. This learning arrangement was formalised in 1563 through legislation (The Statute of Artificers) and was the route through which the vast majority of doctors entered practice. There were no regulatory bodies, final exams, medical schools or hospitals (as we know them) and only 2 religious universities (Oxford and Cambridge who graduated ‘physicians’). It would be another 300 years before the advent of another non-religious university - in London (UCL) - and another 400 years until any other university could grant degrees.

The Rose Case in the 1700s established that members of the Society of Apothecaries could both prescribe and dispense medicines, although this had been challenged by the Royal College of Physicians who wished to restrict prescribing rights to their members.
The nineteenth century saw new technologies such as the stethoscope, microscope and staining techniques that in turn facilitated the connection between medical symptoms and pathological causes of disease, resulting in the development of a clinical method. This involved eliciting symptoms by questioning and examining the patient, testing of specimens and finally, diagnosis and treatment. This diagnostic model of clinical reasoning (the clerking), continues to be taught to medical students today. The introduction of a clinical method, together with technological advances and an increasing population produced a need for larger hospitals staffed by full-time doctors.

The Medical Registration Act of 1858 reflected the increasing influence of hospitals and formally ended the community-based apprenticeship route to medical practice. The Act recommended a hospital-based placement of six to twelve months that replaced apprenticeship. On these placements, groups of medical students were encouraged to attend timetabled ward rounds and clinics and also encouraged to learn 'off-timetabale' by searching for patients to practise the new diagnostic process on.

The Medical Act of 1958 established regulation of the profession by introducing mandatory exams overseen by a new regulatory body - the GMC (Clarke, 1966). This was a big drive in formalising medical education through the University-based degree programme structure we have today. Previously hospitals had carried out medical education themselves with no role being played by universities.

2. General practice as a distinct discipline
With different training and settings of work, also came different challenges: responding to the needs of the community, as well as to individuals, and - significantly - funding. Initially, doctors worked on a private basis in communities would provide care for a fee. Sometimes this fee was covered, or subsidised, by local philanthropic, labour or local government arrangements.

For a fascinating insight into the realities of everyday practice at this time consider reading the fictionalised autobiography - The Citadel by A J Cronin. This book clearly describes the links between social conditions and disease in the South Wales valleys in the years before the introduction of the NHS. It also explains how the original ideas for the NHS evolved (Aneurin Bevan was born and worked in South Wales)

The National Insurance Act came into play in 1911, which afforded provision of primary healthcare to working men within communities, which was expanded by the rollout of the nationalised health service on the 5th July 1948 (Tait, 2002). The leaflet that fell through everyone’s letterboxes states on the first page:
'The arrangements for general medical practice are the most important part of the proposals for a National Health Service. The family doctor is the first line of defence in the fight for good health'. (National Archives)

This placed general practice at the forefront of health promotion, illness prevention, and the first port-of-call for patients seeking help. This would inherently focus the practice of the speciality on undifferentiated illness, whilst simultaneously managing the on-going relationship-based care for chronic conditions for all age groups, from ‘cradle to grave’.

From the outset, this was a speciality that was over-stretched, and standards of practice varied greatly. Influence from dissatisfied clinicians, and international reports (Collings, 1950) eventually led to the formation of what became the Royal College of General Practitioners (RCGP) in 1952, as a body that would set professional standards, influence and improve the quality of patient care, and advocate for the need for patients to have access to well-resourced primary care.

Again, the formation of the RCGP was opposed by some other members of the profession, with the initial meetings being held in secret. The first President of the College - a Yorkshire GP, William Pickles is the subject of a fascinating book about General Practice in the years up to and after the formation of the NHS (Pemberton, 1984).

3. Modern General Practice
Since the inception of the NHS (opposed by almost all doctors), general practice in the UK has remained a comprehensive, free at point of contact service. As we shall see, these two key characteristics underpin some of the efficiency of general practice when compared to the models of primary healthcare that exist in other countries (hyperlink to 3d). A potentially significant change to this arrangement came in 2012 with the Health and Social Care Act. This legislation put GPs at the heart of the NHS, as leaders of Clinical Commissioning Groups (CCGs). These groups are responsible for commissioning (and decommissioning) care contracts from both hospitals and GPs. This is done within tightly regulated budgets, meaning that different CCGs are increasingly making rationing decisions that mean that national coverage of some services is no longer applicable. The Act also makes it easier for other, non-NHS healthcare providers to bid for contracts. This may lead to efficiencies through competition but also risks further fragmentation of the 'National' part of the NHS.

What are your own views on the role of politics within the health system?
4. Evolving issues
Major factors that will underpin the development of the organisation of GP going forward will be: the relationships that different organisations have with each other; the makeup of the teams that work together to provide patient care; and the relationship that patients have with individuals within these teams.

Examples already taking shape include:

- The clustering of practices together to form Primary Care Networks in England (Fisher, Thorlby & Alderwick, 2019).
- Drawing on increasingly diverse skill-mixes of new types of health-providers within GP teams, to manage specific workloads: such as advanced clinical practitioners to manage on-the-day demand (Primary Care Workforce Commission, 2015).
- Increasingly working with hospitals and other healthcare providers to provide more seamless care. For example, some hospitals now own GP premises and GPs (in the form of CCGs) now increasingly influence what happens in hospitals.

These developments will continue to draw on the fundamental ability to adapt, lead and innovate that are so inherent and valued in general practitioners.

SUMMARY

Viewed through an historical lens the role of general practitioners in service provision and education has much changed over time. Initially, almost all doctors were GPs and learned through a community-based apprenticeship. A small number of 'physicians' graduated from just two universities. GPs historically practised individually on a fee-for-service basis, but seismic changes occurred in 1948 with a unified, free at point of contact service responsible for prevention and treatment of disease and maintenance of health. Large changes had by this time occurred in medical education, with most of medical education being carried out in hospitals, under the aegis of universities.

Today GPs practice in increasingly large and diverse teams, often from purpose-built premises using highly sophisticated IT. Individual practices are increasingly amalgamating to form 'federations or networks. Today, the role of GPs in training future doctors is increasingly recognised with medical students again spending time learning medicine in community settings.
Looked at in this way, the roles of both hospitals and primary care in provision of healthcare and education can be seen as arising out of differing traditions and fulfilling differing functions that have changed radically over the years. Inevitably tensions arise through the process of constant and increasing rates of change. However, it is through awareness and acknowledgment of differences and then working through these differences that the NHS benefits from the creative tensions between these two increasingly intertwined sectors.

ACTIVE LEARNING

✓ Ask your GP tutor or discuss in your group the top 3 most impactful changes that have been seen or rolled out in general practice in the last 5-10 years.

✓ Explore with patients their perception of change in general practice - what is the impact on their care and access to healthcare?

✓ Explore with patients what ‘their’ GP means to them - how long have they known their current GP? How did they select them? What qualities does their GP have that makes them return to see them? What sort of problems would they take to their GP?

✓ Consider paintings that represent general practice in history, such as Sir Luke Fildes’ (1891) “The Doctor” (https://www.tate.org.uk/art/artworks/fildes-the-doctor-n01522). Explore how pictures may embody some stereotypes that wider society and the medical profession has moved on from, but also draw on the intimate relationship: a doctor in the very heart of a family's home at a most distressing and vulnerable moment.
The King’s Fund have undertaken a number of enquiries into aspects of general practice, from workforce modelling, to quality of care, and to models of commissioning and funding. The details of these reports are likely to be beyond the scope of undergraduate medical teaching, but offer some useful insights and illustrative figures and examples:


**REFERENCES**


Fisher R, Thorlby R, and Alderwick H. 'Understanding primary care networks: context, benefits and risks.' *The Health Foundation*, 2019. Accessible via: https://www.health.org.uk/publications/reports/understanding-primary-care-networks?gclid=Cj0KCQjwpavpBRDQARIsAPfTwizhPoQ4xHrOEU2_BB4W3TsyuloxG_jXLBLxQt0VgMI1xLoHtByXCvMaAs6kEALw_wcB


Penberton, J. Will Pickles of Wensleydale; the life of a country doctor. RCGP; Exeter. 1984


The following resources have been developed in conjunction with SAPC Heads of GP Teaching. If you have any queries or questions regarding the resources on offer, please contact **Prof. Joe Rosenthal** or **Prof. Alex Harding**, Co-Chairs of SAPC’s Heads of GP Teaching Group.