General Practice

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'The essence of general practice is an unconditional and open-ended commitment to one's patients. The commitment of a GP is to a person, not to 'a person with a certain disease'.' [i]

General practice or primary care?

General Practice is one of 65 specialties recognised by the General Medical Council. Confusingly, the term is also used for the physical setting where the majority of GPs work. Primary care is not a recognised medical specialty in the UK. It includes general practice but encompasses much more – including other health professionals who often work in and with GPs. Practice reception and administrative staff, practice nurses, district nurses, health visitors and midwives in particular all play a key role in the primary health care team. There was a drive in the mid-1970s onwards to encourage and develop the role of such teams – to the benefit of patients and these health professionals. More recent changes have seen the gradual disintegration of teams with National Health Service managers seeming to prefer geographical allocation of many of these professional resources.

Primary care also covers a wider range of health professionals who have traditionally worked independently of GPs, such as community pharmacists, physiotherapists, dentists, optometrists and podiatrists. All play an important part in the care of the patients we all serve but their roles and contribution are beyond the scope of this historical account.

The early years of the NHS

Prior to the introduction of the NHS in 1948, the majority of care was provided by practitioners working alone, often from their own home, with little day-to-day contact with colleagues. Even in the early part of the period covered by this account, there would have been only a few medical specialties – and these were often defined in general terms (for example, general physician, general surgeon, etc). However, one of the features of medical progress has been the mushrooming of medical specialties from that small handful to the 65 specialties and 31 sub-specialties recognised by the GMC today.

The way in which care was organised before the NHS was vastly different to what we know today. It was not until the National Insurance Act in 1911 that there was any form of national service – and that was initially available only to working men. Under the scheme, GPs were paid for each patient registered with them (this capitation system still forms a significant part of GPs income today). Even with this new source of regular income, it was often a struggle for newly qualified doctors to make a living. Most doctors worked as general practitioners covering a broader range of medical activities than we would see now.

Many towns and villages had a cottage or community hospital where medical emergencies, accidents and midwifery were delivered. Visiting consultants undertook clinics and surgeons performed operations in some units, often supported by GPs with additional skills in anaesthesia. Such hospitals allowed GPs to look after patients with a wide range of conditions and were seen as a valuable local asset. Many of these facilities have closed over the years, not least because of changing views on what could be sustained at a local level.

Delivering care was particularly difficult in remote and rural areas such as North-East Scotland where the population density was low. The situation was most acute in the Highlands and Islands and a commission was set up to look at how best to deliver care to these communities. The resulting Dewar Report[ii] published in 1912, was seen by many as the blueprint for the creation of the NHS ensuring delivery of care throughout the country.

In 1942 the Beveridge Report[iii] formed the basis for widespread welfare reforms after the war, including a national health service. Mary Esslemont, a well-known GP from Aberdeen, was the only woman to be involved in discussions between the Ministry of Health and the British Medical Association to set up a national health service. During these negotiations GPs fought for and got independent contractor status whereas hospital consultants became direct employees. Once the NHS Act was passed, after July 1948, GPs were required to provide primary and personal medical care for every person registered with them. In addition, they became the gateway for patients to specialist hospital care – formalising the process of referral whereby the normal route to a patient seeing a specialist was through their GP.

Given their independent contractor status, many GPs took the opportunity to engage in other activities – partly through personal interest and partly for financial reasons. A number of the GPs in the region took up post as clinical assistants working one or more sessions per week in various hospital departments such as A&E, dermatology, and orthopaedics. Police surgeons carried a substantial out of hours workload. As the oil and gas industries became established, several GPs and practices began to offer occupational health services, including offshore work. Indeed, the initial medical response to the Piper Alpha disaster in 1988 was from a GP, Dr Ronnie Strachan, a director of Aberdeen Industrial Doctors, who flew out to the fire-fighting vessel, Tharos, with his daughter Pauline (also a GP) and other medical colleagues. 167 men from the crew of 228 died.

The evolution of a specialty

In 1950, an Australian academic, Joseph Collings, published results of a survey of general practice in the UK[iv]. It highlighted inconsistent standards of care and, often, poor practice premises and organisation. It acknowledged that low morale amongst GPs was exacerbated by isolation and poor working conditions. The report was one of the catalysts in the formation of the (then) College of General Practitioners. And so began the development of general practice as an independent discipline within medicine.

Up until then, it was not widely accepted that general practice had a unique body of knowledge; all the GP needed had been learned by the time of graduation. That began to change in the early 1950s with the publication of the first textbooks on general practice. The principles which define general practice began to be articulated more clearly, not least the fundamentally different relationship that GPs have with their patients. Clinicians in other fields form relationships with patients based on their disease or condition whereas in general practice the relationship with the patient is open-ended and not disease-specific. It also became increasingly recognised that the underlying roles of the generalist practitioner and the specialist were different – different but complementary.

GENERALIST AND SPECIALIST

DIFFERENT YET COMPLEMENTARY

GENERALIST	SPECIALIST
Exclude serious disease	Confirm serious disease
Accept uncertainty	Reduce uncertainty
Explore probability	Explore possibility
Marginalise danger	Marginalise error

(after Marinker)

Similarly, GPs were not considered to have any role in research. A notable local exception of profound international significance was Leslie Florence. An Aberdeen graduate, he was the successful applicant from a field of 80 when he secured a GP post in Turriff. In 1960, he recognised neurological side effects in patients prescribed a new drug, Distaval (thalidomide). After discussion with the professor of therapeutics at Aberdeen University, he wrote to the British Medical Journal about his observations. In common with most whistleblowers (even today) his claims were dismissed by the pharmaceutical company. This letter, the first published evidence of side effects of thalidomide, was seen by Frances Kelsey from the US Food and Drug Administration, and led her to refuse to authorise the use of thalidomide in the US. Because of this, in 1962, she received the President's Award for Distinguished Federal Civilian Service. Florence received no recognition.

Despite the college's attempts to promote good practice amongst its growing membership, GPs continued to struggle throughout the 1950s and early 1960s. General practice seemed to be little understood by consultant colleagues in hospital, health service administrators and politicians. There was much criticism of GPs capabilities, exacerbated by Lord Moran (who had been Winston Churchill's private physician and was intimately involved in discussions about both consultant and GP pay in setting up the NHS) asserting his view that GPs were doctors who had fallen off the ladder of hospital specialisation. There were widespread feelings of unhappiness and low morale amongst GPs. The flashpoint came in the mid-1960s when the GP committee of the BMA encouraged

GPs to sign but not date resignation letters from the NHS. The message finally struck home and, after much discussion, a new contract was launched in 1966.

The Family Doctor Charter of 1966 introduced major improvements to remuneration and premises which were to have lasting effects on practice organisation and structure. Overall pay was increased and allowances given for forming group practices, employing staff and delivering vaccinations and screening.

The jewel in the crown?

The issue of resources has continued to the present day. For most people, their GP practice is their most common interaction with the NHS. During the latter part of the 20th century, it was generally recognised that general practice dealt with 90% of patient contacts while hospital specialties dealt with 10%. However, resourcing was the reverse of that – with only 10% of NHS funding going to general practice and 90% to hospitals. The situation began to deteriorate even more in the early 2000s so that now less than 7% of the NHS budget goes to general practice, despite numerous UK and Scottish parliamentary and thinktank reports highlighting the key role played by general practice in the NHS – and the need to increase its funding. There is longstanding international evidence that healthcare systems improve in effectivity and efficiency when general practice is better resourced[v].

Change, always change

The 1970s and 80s is sometimes called a 'golden age' for general practice. The number of doctors working singlehandedly declined – there were still some 200 singlehanded GPs in Scotland in 2000, but contractual and other changes have resulted in fewer than a dozen today. The proportion of female GPs increased, reflecting the increase in numbers of female medical graduates. Practices began to employ practice managers, practice nurses and other staff. New health centres began to be built, facilitating the attachment of other health professionals such as district nurses and health visitors. The day-to-day organisation of the practice changed significantly. The time taken on home visiting reduced and appointments at the surgery became the norm.

A reorganisation of the NHS in Scotland in 1974 was focused on service integration. This was intended to bring together regional hospital boards, (GP) executive councils and local authority health departments but it

took many years before its aims were achieved. Even then, general practice and community services were still seen as somewhat separate.

In the late 1970s, Scotland introduced an A4 records system – a significant advance on the Lloyd George envelope system introduced in 1911. The various components were available free, although practices had to complete the not inconsiderable task of converting from one to the other. Computers followed, initially to assist with prescribing and routine screening rather than clinical records, which came somewhat later. Most practices are now 'paperlight' and other helpful advances include electronic outpatient referrals, electronic labelling of blood and other samples and the paperless transfer of results from the laboratory.

Initially there were a variety of different software systems but mention should be made of GPASS (GP Administrative System Scotland). It was developed by David Ferguson, a GP in Glasgow who had gained a degree in electrical engineering before studying medicine. The system was 'adopted' by the Scottish Home and Health Department. By the 1990s, it was used by some 80% of practices in Scotland – offering the potential for new areas of medical research. At one time arguably the leading system in the UK, GPASS is now no more, a victim of under investment and commercial competition. With some £3.4 million funding secured by Professor Lewis (now Sir Lewis) Ritchie and colleagues over its 26-year existence, a small unit at Aberdeen University, led by two local GPs, Bob Milne and Mike Taylor, developed electronic data gathering to allow local and national audits of patient care. Some years later, the methodologies developed by the unit underpinned the internationally significant work of Aberdeen health sciences graduate Colin Simpson and colleagues' vaccine effectiveness and safety studies during the swine flu and Covid-19 pandemics.

Other technological advances were the introduction of answering machines along with pagers and then mobile phones. These revolutionised the day-to-day working of not only the GP but their family as well! Out of hours work also changed. Previously responsible for the care of patients 24 hours per day 7 days a week, GPs began to work together to form co-operatives to provide out of hours care. A subsequent contractual change relinquished GPs of this responsibility and out of hours care became the responsibility of all local health boards and NHS 24 was established. Aberdeen was at the forefront of many of these developments, helped by a health board administration which was open

to broad interpretation of the regulations when it came to improving patient care.

In 1990, another contractual change saw greater emphasis on health checks, minor surgery, cervical cytology and target payments for immunisations. Although the introduction of fundholding and prescribing budgets in 1991 were controversial, the benefits of increased GP involvement in the provision of secondary care was realised in the region. One of the key factors was that the local fundholding association insisted that any improvements in waiting lists etc should apply to all practices, not just those which were fundholders. Further contractual changes in 2004 emphasised quality with the introduction of a quality and outcomes framework.

Advances in the investigation and management of both acute and long-term conditions have resulted in many patients now being treated more appropriately by their GP in the community rather than in hospital. As with other parts of the NHS, patient expectations have increased over time. Further structural change after the demise of fundholding sought to integrate primary care – but the changes failed to align with changes to the GP contract. The workload in general practice became increasingly difficult and yet another new contract came into effect in 2018. This resulted in many responsibilities, including childhood vaccinations, being transferred from the GP to health boards. The net result of these various changes has been that funding has gone increasingly into primary care rather than into general practice.

Compounding the increase in workload has been increased difficulty in attracting younger doctors into general practice, despite repeated promises by government to increase the GP workforce – most of which have failed. Organisationally, the pattern of partner-owned-and-run practices is at risk, many practices now being run by commercial businesses employing salaried GPs.

Arguably, one of the strengths of medicine in North-East Scotland for much of the period covered here was the shared experience that doctors had locally. Until the latter part of the 20th century, the majority of medical students at Aberdeen were from the relatively small local area. Having very often attended the same schools, attended the same medical school, whether intending a career in general practice or hospital medicine, many knew and had strong working relationships with each other. More recently, increased numbers entering medical school,

including from more diverse backgrounds, means this local feature has all but disappeared.

Academic General Practice

In 1963, Edinburgh University appointed the first professor of general practice in the world. Having established a GP Teaching Unit in 1967, Aberdeen University appointed Ian Richardson to be its first professor of general practice in 1970. There then followed a period of rapid development – both nationally and locally. The (by then) Royal College of General Practitioners produced its seminal report 'The Future General Practitioner – Learning and Teaching'[vi] in 1972. This landmark document defined the discipline and laid the groundwork for both undergraduate teaching and postgraduate training. The RCGP lobbied for general practice to be included in every medical school curriculum and for every university to establish a chair in the discipline, this finally being achieved in 1996.

Aberdeen embraced these developments, introducing an undergraduate programme which was dependent on much good will from practices throughout the region and a vocational training scheme offering twelve places each year. Academic research is an essential activity for any clinical discipline – but this was no easy task when general practitioners' workload was heavy and support funding negligible. However, the Aberdeen department secured national grant funding which enabled it to make full-time academic appointments. John Howie, John Berkeley and John Bain were appointed senior lecturers and Ross Taylor as lecturer (later senior lecturer). Six local GPs (Denis Durno, Pierre Fouin, Alec Taylor, Geoffrey Gill, Fraser Richardson and James Shand) were appointed to part-time lecturer posts.

In the pre-NHS era, medical students in Aberdeen received an introduction to general practice as part of their public health teaching. Between 1948 and the creation of the General Practice Teaching Unit there was no formal teaching in general practice. It was not until after Richardson's appointment as director of the GPTU that undergraduate teaching began to develop. Despite considerable financial support of teaching to hospitals little or no such support was available to general practice. So, these developments were substantially dependent on the goodwill of GPs and practices throughout the north-east. Gradually, over the following decades, the general practice contribution to teaching

increased and became better funded. General practice is consistently rated by students as one of the most valuable aspects of their course.

In 1980, Richardson was appointed Dean of the Faculty of Medicine – the first GP in the UK to be appointed to such a post. Unfortunately, this coincided with severe constraints on the university's budget and when in due course each of the 'three Johns' moved on (John Howie and John Bain to chairs in Edinburgh and Southampton and John Berkeley to an NHS administrative post), they were not replaced. Richardson retired in 1984 and the chair was frozen. Prof Roy Weir, professor of community medicine, became acting head and in 1988 Taylor was promoted to be head of department.

The chair was re-established in 1992 and Lewis Ritchie was appointed. Under his leadership the department developed significantly with research themes in cardiovascular disease prevention, computing/telemedicine, oncology, prescribing and rural health. In 1997 Philip Hannaford became the first incumbent of a second (research) chair, funded by NHS Grampian. At the time of his appointment, Hannaford was director of the RCGP Epidemiology Unit in Manchester and relocated the internationally respected RCGP oral contraceptive study to the city. Further chairs were established so that the department became one of the largest in the UK. In the first UK Research Assessment Exercise in 2001, Aberdeen was one of the top five rated departments of general practice in the UK.

Ritchie was knighted in 2011 'for services to the NHS in Scotland'. He held a number of academic and service posts, including chairing several national reviews into aspects of NHS provision in Scotland. He was appointed director of public health in NHS Grampian in 2012, in addition to his academic appointment. Hannaford went on to be a vice principal of Aberdeen University. Another GP, Dr Pauline Strachan, held the post of deputy chief executive of NHS Grampian from 2010 to 2014.

Although the NHS invested considerable resources into training hospital specialists, there was no similar resource to train GPs, so the RCGP developed a model of (postgraduate) vocational training which was rolled out across the UK on a regional basis.

Until the mid-1960s there was no expectation out with general practice that postgraduate training for general practice was necessary – and there was certainly no funding for it. Most GPs went straight into general

practice (after completing their pre-registration year). In 1977, parliament passed vocational training regulations at last. By 1979 the regulations required at least 12 months training in general practice and by 1981 such training became mandatory for appointment as a principal. However, it was not until 1995 that training became mandatory to work in any capacity in general practice. Perhaps even more surprisingly, it was as recently as 1998 before there was any mandatory assessment of knowledge or competence to work in general practice. Although it was first introduced in 1968, the membership examination set by the RCGP did not become the required entry standard for general practice until August 2007.

Competition for places became fierce, helping to ensure a well-trained supply of general practitioners, many of whom settled locally. As well as the formal three-year programme it was possible at that time to complete a 'do-it-yourself' programme and that was popular too. Both the structured and DIY programmes were initially overseen by Denis Durno (1974-86), the first regional adviser in general practice, and subsequently by Bill Reith (1986-96) and Mike Taylor (1996-2008). The GPs and practices approved for postgraduate training had to demonstrate that they met national criteria before appointment and these were assessed every three years to standards set by the Joint Committee on Postgraduate Training for General Practice (JCPTGP). As with other parts of the UK, these peer review visits helped to enhance the quality of general practice as a whole as well as training.

The success of vocational training both locally and nationally was largely due to the dedication and commitment of those GPs who took on the challenge of being GP trainers. They had to undertake additional training in educational theory and practice and undergo a rigorous approval process both for themselves and their practices – and their appointment was subject to regular review. There is little doubt that the way in which they shared good practice at educational workshops and events helped improve standards of care throughout the region.

Under the auspices of the local faculty of the RCGP, a number of local GPs and practice staff sought to improve all aspects of care for patients by developing criteria for Quality Practice Award. This required considerable commitment from the whole practice team and was adopted nationally by the RCGP in 1996.

Over the years, a number of GPs from the north-east took on leadership roles within the RCGP, George Shirriffs as chair of RCGP Scotland 1990-93, to be followed by Colin Hunter 1996-2000, Bill Reith 2000-03 and Ken Lawton 2007-10. Shirriffs went on to become national coordinator for higher professional training and was awarded an OBE. Reith had been honorary secretary of the RCGP 1994-99 and participated in the Shipman Inquiry (2003-24). He went on to be the first chair of the college's Postgraduate Training Board 2005-11. Hunter went on to be honorary treasurer of the RCGP 2003-12 during which time he oversaw the college moving from an annual income of £16m to over £40m. He also led the college in its move to a significant new HQ in London. He went on to chair the trustee board 2012-2018. He was awarded an OBE.

The future

Throughout the 70 or so years covered by this account, general practice has continued to adapt to the changing expectations of patients and society. However, we seem to be approaching another flashpoint. With an inadequate number of doctors coming into the specialty, an increasing workload and diminishing resources the future of general practice is precarious.

We wish to acknowledge the help of Prof Sir Lewis Ritchie, Drs Denis Durno, Ken Lawton, Mike Taylor and Hamish Wilson in reviewing early drafts of this paper.

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[i] McWhinney, I; 'The essence of general practice'; chapter in 'A celebration of General Practice'; ed: Lakhani, M.; Radcliffe Medical Press; Abingdon; 2003

[ii] Report of the Highlands and Islands Medical Service Committee (Dewar Report); 1912; Cmd 6559

[iii] Social Insurance and Allied Services (Beveridge Report); 1942; Cmd 6404

[iv] 'General Practitioners in England Today – a Reconnaissance'; Collings, J; Lancet, Vol 255; Issue 684; P 555

[v] 'Contribution of Primary Care to Health Systems and Health'; Starfield, B; Shi, L; Macinko, J; The Millbank Quarterly; Vol 83, No.3, 2005 (pp 457-502)

[vi] 'The Future General Practitioner – Learning and Teaching'; Report of a working party of the RCGP; British Medical Journal (for) the RCGP; London; 1972

Suggested reading

‘A History of the Royal College of General Practitioners – The First 25 Years’; ed: Fry, J; Hunt, J; Pinsent, R.J.H.; MTP Press Ltd; Lancaster; 1983

‘A Celebration of General Practice’; ed: Lakhani, M; Radcliffe Medical Press; Abingdon; 2003

‘Academic General Practice in the UK Medical Schools 1948-2000’; ed: Howie, J; Whitfield M; Edinburgh University Press; Edinburgh; 2011

‘Single- Handed – General Practitioners in Remote and Rural Areas’; Donovan, R; Bain, J; Whittles Publishing; Latheronwheel; 2000

‘Family Medicine – The Classic Papers’; ed; Kidd, M; Heath, I; Howe, A; CRC Press (Taylor & Francis); London; 2017

‘Scotland’s Health and Health Services’; ed Woods, K; Carter, D; The Nuffield Trust: London; 2003

Keen to ensure that the history of general practice and of general practitioners in the North-East of Scotland was preserved, Dr Peter Duffus embarked on a series of conversations with (mostly) retired GPs to record their stories.

In addition, where he could, he gathered the history of practices across the region, both city and shire.

Both the conversations and histories have been loaded onto the Aberdeen Medico-Chirurgical Society website. For various reasons, not all of these are copyrighted so they have not been published openly to a general audience. However, they are available on request to bona fide researchers and others.