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# GENERAL PRACTICE

## Report of a WHO Expert Committee

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WORLD HEALTH ORGANIZATION

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## WHO EXPERT COMMITTEE ON GENERAL PRACTICE

Geneva, 2-8 July 1963

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## GENERAL PRACTICE

### Report of a WHO Expert Committee

The WHO Expert Committee on General Practice met in Geneva from 2 July to 8 July 1963. Dr V. Djukanović was elected Chairman, Dr Eric Martin, Vice-Chairman, and Dr B. L. Taneja, Rapporteur.

Dr F. Grundy, Assistant Director-General, opened the meeting on behalf of the Director-General and welcomed the members. The Expert Committee, he said, had been convened to examine the role and functions of the general practitioner in present-day medical care and to consider what improvements might be effected to keep general practice abreast of modern knowledge in medicine. WHO Expert Committees have studied the role of hospitals and their relations with the community<sup>1</sup> and the training of the physician for family practice;<sup>2</sup> to complete the picture the role of the general practitioner and his relations with the community and other branches of the health services also require study.

#### 1. INTRODUCTION

It is impossible to consider any one branch of medicine in isolation from others, or in isolation from the social, economic, and cultural changes taking place in the community. General practice is inevitably influenced by the vast increase in population in the world, by the processes of industrialization and urbanization, by the rise in living standards and the level of education, and by the breakdown in the isolation of areas and communities in many countries. It is influenced by technological advances in general and particularly by the tremendous advances that have been made in recent years in the understanding and treatment of disease. These advances have been accompanied by the development of a host of diagnostic, therapeutic, curative, and preventive procedures that are beyond the compass of any single medical practitioner. As a result, specialization has come to play an increasing part in medical care, to such an extent that in medical schools in some countries more graduates opt for specialization than for general practice.

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<sup>1</sup> *Wld Hlth Org. techn. Rep. Ser.*, 1957, 122

<sup>2</sup> *Wld Hlth Org. techn. Rep. Ser.*, 1963, 257

Social, economic, and cultural change, the effect of increasing specialization, and the demands of patients and the community for a different approach to problems of health and disease have combined in many parts of the world to render general practitioners unsure about their role. There is controversy about the exact part they should play in the modern world, about their relationships with the community and with the other health and welfare services, about the training they should have both before and after graduation, and even about the image they should present to the public.

## 2. DEFINITIONS

### 2.1 General practice

General practice is the front line of medical care and in some form or other exists in every part of the world. As a rule, it is not limited to patients with specific diseases within specific age-groups. It is the field of medical practice where the patient usually makes his first contact with the doctor, and he has direct access to him. The goal of general practice is to provide continuing and comprehensive medical care for the individual, family and community.

While the Committee considers that primary medical care should always be provided by a qualified general practitioner, it must be realized that at present there is a great shortage of doctors over large areas of the world and that this type of care is being provided by persons with limited medical training or even by persons not employing scientific methods.

### 2.2 General practitioner

A general practitioner is a doctor who works in general practice. He does not usually limit his professional work to certain disease entities or to certain age-groups. Patients have direct access to him, and he assumes responsibility for providing or arranging for the provision of continuing and comprehensive medical care, both preventive and curative.

### 2.3 Specialist

A specialist is a doctor who has received special training and who limits his practice either partially or wholly to particular disease entities or to patients in certain age-groups. He may be consulted directly by patients, but in many countries patients are referred to him from other doctors.

### 3. FUNCTIONS OF THE GENERAL PRACTITIONER

If the general practitioner is to advance with the times, he must be prepared and able to carry out certain special functions. He must be adequately trained for this purpose, and facilities should be made available to enable him to carry out these functions satisfactorily.

#### 3.1 The provision of comprehensive and continuing care

To provide comprehensive and continuing medical care, the general practitioner must be able and ready to act as adviser to the individual and his family. He must also be aware of the possibilities offered by the preventive and curative services, and be prepared to use them for his patient's benefit.

#### 3.2 The provision of front-line medical care

The general practitioner must be prepared to assume responsibility for dealing with a large proportion of the diseases and problems that he encounters. The detailed content and nature of his work must depend on prevailing needs and circumstances, on the customs of the community and his profession, and on the system of medical care.

#### 3.3 Personal care

The general practitioner, like every good physician, must treat patients as individuals rather than as cases. His past knowledge of the patient, his family, and his environment, should enable him to provide personal and individual care.

#### 3.4 Family care

The general practitioner responsible for the care of the individual must have a sound working knowledge of his family background, so as to be able to take into consideration the effect of the family on the individual as well as that of the individual on the family.

#### 3.5 Community care

The general practitioner has certain important responsibilities to the community in which he works. He must be familiar with, and pay due attention to, the social factors affecting the health of the individuals in his care, as well as the influence on the community of the health of the individual and his family.

He must be prepared, by personal action, to influence the living and working conditions of the community with the aim of improving its health.

### **3.6 Educational function**

In all his contacts with his patients, with other medical, health, and social workers, and with representatives of the community, the general practitioner should be alive to any opportunity to teach and guide them in matters relating to the health of the community.

## **4. PRESENT SITUATION**

In the past, general practice played a readily understandable role in medical care. It fitted in with the medical knowledge and outlook of the times, and the general practitioner coped unaided with the great majority of medical, surgical, and obstetrical problems with which he was confronted.

Now the situation is very different. Because of medical and social advances, the role of the general practitioner is no longer so clearly defined, and it has become increasingly difficult for him to discharge effectively the functions expected of him by the community and the medical profession.

### **4.1 Problems facing general practice**

Although, taken as a whole, morale in general practice today is fairly high, the feeling exists in certain quarters that general practice is a dull and uninteresting branch of medicine. The Committee feels that, far from this being so, clinical interest and opportunities for personal satisfaction are as great in general practice as in any other branch of medicine. It also feels that policy with regard to general practice should be based on recognition of these opportunities and the satisfaction to be obtained.

There is also an increasing awareness among general practitioners of their isolation, accompanied by the feeling that this isolation is not attuned to the times.

There are relative and absolute shortages of doctors all over the world, and, in particular, insufficient general practitioners to meet the increasing needs of general practice. These needs are directly related not only to population increases but also to the growing demands of patients and the community.

Attracting young doctors into general practice has become more and more difficult, for many reasons. Students are attracted by the glamour of specialization and research, which tend to receive greater publicity than general practice. They are taught almost entirely by specialists, who have little or no experience of general practice and are inevitably biased in

favour of specialization. In most medical schools, no attempt is made to teach or even inform students about general practice, its role and its ideals, nor are provisions made for graduate training for general practice; the students may indeed form a low opinion of general practice from some of the cases in their teaching hospitals referred by general practitioners. Moreover, specialists as a rule earn more than general practitioners. Finally, work in general practice is seen to be often more arduous, both physically and mentally, and to provide less leisure than work in a specialty or in research.

Certain inherent features of general practice create professional and personal problems for the general practitioner. He works alone and in relative isolation. He lacks continuing friendly professional contacts and surveillance, which do much to raise standards and stimulate effort. He is out of touch with the growing points of medicine, and, lacking time because of pressure of work, he needs to make a strong effort of will to carry out regular reading or undertake courses of postgraduate training. He may be faced with personal problems, such as the difficulty of finding and equipping adequate premises, the inroads made into his private life by having to install his consulting-room in his own home, or the disruption of his family life by his being constantly on call. The education of his children may also present difficulties in rural areas.

The volume of work in general practice can be overwhelming at times, with the result that the general practitioner becomes over-tired and irritable. The nature of the work may also cause him irritation and boredom. Often, too, he lacks incentives; and he receives, for example, no compensation for or recognition of high-quality work.

It is inevitable that much of the time of the general practitioner should be devoted to relatively minor illnesses, and it is small consolation to him that this may represent the true spectrum of disease in the community. His work thus presents him with special problems of its own.

In many places, the general practitioner has not the facilities to enable him to assume to the full his diagnostic, curative, preventive, and public health responsibilities. His equipment is often inadequate and the organization of his work unsuited to the needs of his patients.

Finally, his relations with his fellow-practitioners, with other health services, and with the public frequently leave much to be desired. He often seems to leave the case for scientific medicine and against charlatanism to go by default, to be less vocal than he might be against prejudices and harmful customs and habits, and to put up too little opposition to the dissemination in advertisements, the press, or other commercial media of statements and views that are distinctly injurious to the health and welfare of the community. He feels that he has no control over the effects of radio and television on the mental health of the community, and that these effects may be distinctly harmful.

## 4.2 Premises

Traditionally, the general practitioner receives and treats patients in his own house. Recent surveys have shown that the layout and architectural features of the professional rooms are seldom appropriate to their function. Some general practitioners possess a radiological unit, and protection against radiation is at times insufficient. The problem becomes acute in new districts or new towns where all the buildings are composed of standardized dwellings that do not provide a suitable professional setting.

One solution to this problem adopted in some places is for groups of general practitioners to acquire joint premises and organize a kind of group practice, sharing expenses. Some municipalities, too, have provided special medical premises, separate from the personal dwellings of the doctors. These premises save the time of the patients, improve co-ordination between practitioner and specialists, and avoid duplication of diagnostic procedures. They are rented at a low cost or offered free to the general practitioner.

In some countries, polyclinics offer the same facilities to the general practitioner. These polyclinics may be part of a general hospital, consisting of consultation wings or group practice centres in which physicians receive their patients. In many countries, they are to an increasing extent combined with medico-social facilities and serve as multipurpose centres.

Where medical facilities are inadequate and general practitioners very scarce, it has been found beneficial, from the point of view both of providing basic peripheral comprehensive health units and of relieving the pressure on the out-patient department of the main hospital, to organize a network of polyclinics or dispensaries. In urban as well as in rural areas, these polyclinics or dispensaries are often close to or in the community development block, which is the centre of community life and has its post-office, agricultural advisory office, maternal and child health centre, social work unit, etc. There are still not many of these polyclinics or dispensaries, but the concept is well established and accepted.

The Expert Committee feels that facilities should be provided for ensuring the comprehensive care of the whole population in a way that is suited to local conditions. This comprehensive care can be provided in various ways, and different countries have adopted different approaches. In many countries, however, comprehensive care of the whole population is still far from being achieved. It is the opinion of the Expert Committee that in these countries it is the task of the government to explore ways and means of ensuring that the whole population is given continuing and comprehensive care.

## 5. FORMS OF GENERAL PRACTICE

The form of general practice is determined by many factors. Among them are the way in which the health services grew up in the area concerned ; geographical and demographic factors ; the economic situation and the amount the authorities spend on the health services ; the local health situation and the prevalent diseases ; and political, religious, and educational factors. Broadly, however, the following forms exist :

### 5.1 Individual practice

In individual (or solo, or single-handed) practice, the general practitioner works independently of other practitioners. He may, however, have nurses or other auxiliary workers assisting him. The individual practitioner may work independently because he prefers to do so, because he lives in a geographically isolated area that would not support another doctor, because there is a great shortage of doctors, or because it is the professional custom for general practice to be conducted single-handed.

In some countries where the number of doctors is adequate there appears to be a trend away from this type of individual practice, but it still remains the usual form of general practice in many areas.

### 5.2 Group practice

In group practice two or more medical practitioners work together. There are many types of group practice. Two or more general practitioners may retain their own separate premises and work from these, the main reason for the formation of the group being to enable one partner to replace another when the latter is off duty. Or several practitioners may work from common premises and pool their resources. In some group practices, there may be one or more specialists working with the general practitioners ; in others all the members of the group may be specialists. Group practices may be large enough to have a complete range of diagnostic and therapeutic facilities and even their own hospitals or nursing homes.

### 5.3 Other forms of general practice

Other forms of general practice are less easy to classify. In some countries general practice is conducted from a hospital, health centre, or polyclinic. The general practitioner is a member of the staff of the institution on which he is based, and he makes direct use of hospital facilities for his patients. Or he may work from his own premises but be, at least partly, under the supervision of a hospital or health centre. Or he may work

independently from a building provided by the government and perhaps staffed with auxiliary personnel by the government.

Sufficient information is not available on the organization, operation, efficiency, and acceptability of all these forms of general practice. It is the view of the Expert Committee that they deserve detailed study to enable informed advice to be given on how best to conduct general practice under various conditions. The Committee recommends that WHO carry out a survey of forms of general practice over as wide an area as possible.

## **6. RELATIONS OF THE GENERAL PRACTITIONER WITH OTHERS**

### **6.1 Relations with the family**

For the provision of comprehensive medical care, it is essential that the general practitioner should also function as a family doctor, know the immediate environment of his patient and be able to make contact with all the members of his patient's family whenever necessary. Caring for the whole family helps to develop those intimate doctor-patient relationships that make for the best type of medical care. Moreover, the general practitioner then views the family as a unit. In treating his patient, therefore, the general practitioner considers him not only as an individual but also as a member of a family group with its own environment and its own emotional stresses and strains.

### **6.2 Relations with the community**

Working as he does in the community, the general practitioner must assume certain administrative responsibilities and statutory duties essential to the community, such as certification of births, deaths, and incapacity, and notification of certain communicable diseases.

The Committee stresses that good medical care is vital to economic progress. While endeavouring to provide the best possible type of medical care, the general practitioner should at the same time take into careful consideration the social and economic cost of the care provided, not only to the patient and his family but also to the community.

He should play a greater part in developing preventive care in all its aspects. He must therefore have a knowledge of the epidemiology of common communicable diseases, so that he can pay special attention to their prevention.

He should also be aware of his responsibility for educating his patients and the community in the promotion of health and prevention of disease.

In his work in the community, the general practitioner must co-operate with other members of the health and welfare services, including district nurses, midwives, home helps, and social workers.

### 6.3 Relations with the hospitals

In many countries the general practitioner has little or no access to his local hospital. This has been a subject of increasing dissatisfaction, and it has often led to deterioration of the relations between the general practitioner and the hospital. Closer co-operation is necessary for the following reasons :

1. If there is to be continuity of care for the patient, the general practitioner must be able to follow up his patient in the hospital.
2. If medical care is to be properly carried out, diagnostic and other facilities must be available to the general practitioner from the hospital.
3. Owing to the great developments that are taking place in medicine, there is a need for continuing education of the general practitioner to keep him abreast of current advances. This can best be organized from the hospital.

To provide a high level of medical care for his patients, the general practitioner applies the diagnostic and therapeutic skills that he has acquired during his undergraduate and postgraduate training. In order to achieve this aim he needs help from other medical services, of which the hospital is a most important member.

In most countries it has become or is becoming economically impossible for individual general practitioners, or even groups of general practitioners, to provide the necessary staff and equipment for their own radiological and pathological diagnostic services. Even where they have both staff and equipment, there is the danger that they will not have sufficient use for them, so that standards are liable to be low and results unreliable. The Committee feels that, for standards to be maintained, there must be special diagnostic units provided for general practitioners and staffed by specialists and trained laboratory workers. These might be located in hospitals. The general practitioner would be entitled to refer his patients direct to them and the results of investigations would be sent back direct to him.

Alternatively, if the hospital is remote, there should be local diagnostic units available for general practitioners either affiliated to the hospital or provided by some other agency such as a polyclinic or a group-practice unit.

These diagnostic facilities, the Committee stresses, should not replace the standard diagnostic aids that the general practitioner has on his own premises but should be complementary to them.

The Committee recommends that studies be undertaken of the ways in which general practitioners use diagnostic facilities, so as to determine the need for improvements or assistance. Some of the questions that require answers are : What diagnostic facilities are available to the general practitioner ? How does he use them ? What individual variations are there in their use ? What investigations are requested ? What facilities should be available ? Studies of these questions should be carried out in a comparable manner in various parts of the world as a step towards improving facilities for, and standards in, general practice.

#### **6.4 Specialist facilities for ambulant patients**

With growing specialization in both the diagnostic and therapeutic fields, the general practitioner is often in need of help and advice from the specialists, and, more often still, of special therapeutic or diagnostic assistance.

In some cases, the patient goes on his own initiative to the hospital and asks for consultation with the specialist. In other cases, the patient is referred to the specialist by a general practitioner. The Committee feels that the system of medical care in relation to out-patient facilities requires further study.

#### **6.5 Domiciliary consultation service**

In some countries, the general practitioner is able to call out a specialist to see patients who are too ill to travel to the out-patient department.

#### **6.6 In-patient facilities**

The general practitioner must be able to arrange for the admission to hospital of severely ill patients and those requiring complex diagnostic and therapeutic procedures. These patients may be admitted as emergencies or may have to wait their turn for a bed.

In many countries, once the patient is admitted, his care becomes the full responsibility of the hospital staff, and the general practitioner has no say in his treatment. Even in these circumstances, the Committee feels that the general practitioner should be kept fully informed of the treatment given and that on discharge the patient should be returned to his care. In certain countries the general practitioner continues to treat his own patients in some hospitals.

The Committee recommends that a comparative study be undertaken of hospitals where patients are cared for by their own general practitioners and hospitals where they are cared for by specialists. This should be complemented by a study of the circumstances in which and the extent to which

general practitioners should continue to care for their patients in hospital.

In view of the increasing expense of hospitalization, admissions to hospital should be restricted to patients genuinely in need of hospital beds. To avoid unnecessary admissions and to help early discharges, general practitioners must co-operate to see that this is done.

Local general practitioners occupy certain posts in some hospitals. The Committee considers that this practice is desirable and that its development should be encouraged.

These considerations apply mainly to public or voluntary hospitals. But in many countries there are private hospital clinics, or nursing homes run by doctors or associations, which provide similar services. In most instances, these services cover surgery, obstetrics, or other specialties, and the general practitioner has fewer facilities at his disposal where internal medicine is concerned.

### **6.7 Relations with health services**

The modern concept of public health includes both preventive and curative care.

Some general practitioners work solely in the practice of curative medicine. Others may also carry out some regular specified public health duties, for example, as a part-time school officer, or in a child welfare clinic. Yet others, whilst primarily engaged in clinical practice, also hold the job of part-time medical officers of health with defined public health responsibilities. This combination is usually found in scattered communities in rural areas. Finally, there are public health officers of designated areas who also undertake curative care.

Lack of interest in public health on the part of the general practitioner may be due to defects in his medical training, the feeling that public health work is of low status, or existing patterns of organization.

The Committee recommends that WHO should undertake trials of various combinations of preventive and curative care with the participation of general practitioners.

### **6.8 Relations with occupational health**

Occupational health is of growing importance. General practitioners in many countries are playing a part in this field. In the Committee's view the general practitioner needs special training to enable him to discharge his responsibilities in occupational health.

Where the general practitioner does not participate in occupational health services, it is desirable that a systematic exchange of information

should be established between the industrial physician and the general practitioner, so that the industrial physician is fully aware of the social and family situation of the workers whom he treats and, conversely, the general practitioner is fully aware of the working conditions and circumstances of his patients.

## 7. PREVENTIVE MEDICINE

Attitudes to disease and its prevention are changing. Epidemiological studies have shown that many of the diseases now prominent, especially in the developed countries, are preventable. However, some of these diseases are slow to develop and years may pass before they become clinically manifest. It is therefore necessary that vulnerable groups should be defined, sought out, examined periodically, and, if necessary, protected against known noxious agents.

In this new situation the general practitioner has an important part to play. He must be prepared to go into the community and seek out such vulnerable groups, persuade them to come for regular examination, and actively look after their health. For this purpose, he will need to employ new techniques designed for early and presymptomatic diagnosis of disease.

In preventive care, the general practitioner must fit into a plan which needs to be prepared for each country and each area to meet its own local problems. To play his part in such a plan, the doctor must be educated and trained for preventive work. Unfortunately, as a rule scant attention is paid to the preventive aspects of medicine in the teaching of medical students and graduates.

### 7.1 Types of preventive medical care

Although preventive programmes require central planning, the general practitioner is more concerned with methods and techniques that can be readily used in his own practice. Some of these are listed below.

Routine, well-accepted methods, such as regular immunization of children and adults, antenatal care, supervision of child development and welfare, and routine follow-up of diabetics and tuberculosis patients form part of the everyday techniques of general medical care.

Early and presymptomatic diagnostic techniques are rapidly developing, the aim being to detect diseases in their early and treatable stages. Such techniques are already widely employed, for example, in the detection of cancer of the breast, cervix, and lung, and in the early diagnosis of tuberculosis, diabetes, coronary arteriosclerosis, hypertension, glaucoma, and mental disorder. For early and presymptomatic diagnosis the general practitioner needs to work closely with diagnostic and other clinics.

### 7.2 Periodic medical examinations

The periodic medical examination of patients is common in some countries. The objectives include the early diagnosis of conditions such as cancer of the breast, rectum, cervix, skin, tongue, and lung, the remedying of defects and the treatment of incipient disease.

The periodic medical examination is a relatively expensive method of preventive medical care, in terms both of cost and of the doctor's and patient's time. There is no doubt that it leads to the early diagnosis of many abnormal conditions, and the regular contact between doctor and patient is valuable. However, its application on a wider scale requires careful consideration. The Committee feels that research is required to examine more closely the usefulness of the method in relation to its cost, when and how often the examinations should be done, the specific examinations to be carried out, and the percentage of successful results. It will then be possible to assess the suitability of the method for mass examination of the population or of specific groups in the population.

### 7.3 Vulnerable groups

There are certain vulnerable groups in the community to which special attention must be paid. It is desirable that they should be defined and kept under continuous observation.

## 8. HEALTH EDUCATION

Health education has always been an integral part of the general practitioner's work. Because of the closeness of his contacts with his patients and the good relations that he is able to establish with them, the general practitioner is in an excellent strategic position to inculcate the principles of health into them. In this work of health education, he should co-operate with the school and maternal and child health services, the occupational health service, the local authorities, and the auxiliary workers.

## 9. MENTAL HEALTH

Mental health as a part of the general practitioner's work has been studied by a WHO Expert Committee on Mental Health.<sup>1</sup> The Committee concurs with the views expressed in that report.

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<sup>1</sup> *Wld Hlth Org. techn. Rep. Ser.*, 1962, 235

Estimates of morbidity show that between 5% and 20% of all the work carried out by general practitioners is concerned with mental and emotional disorders. If to these disorders are added the anxiety and misery that accompany most somatic illnesses, the total amount of mental illness and the extent of the problem assume formidable proportions. Indeed, the problems of mental health permeate the greater part of a general practitioner's work, and it is unrealistic to regard them in the same way as, for example, problems of obstetrics or ophthalmology. Often the mental and emotional disorders of the patient are found to be interrelated with disturbances occurring in other members of the family or with environmental factors that could be modified with the help of social workers.

Most of this mental illness consists of minor neurotic and affective disorders closely related to the patient's personality, environment, and family history. The major psychotic illnesses are rare and account for a very small proportion, probably less than 5% of all mental illness seen in general practice.

The general practitioner is generally unable to deal with the problem of mental illness as well as he might, since his training in medical school has, in most instances, been quite unsuitable for the type of problem that faces him in general practice. He usually acquires some competence with practice, but until he does many of his patients suffer. Also, he often has insufficient time to deal properly with his cases of mental illness, which require much more time than cases of somatic illness.

To enable the general practitioner to deal adequately with mental disorders, it is desirable to increase his understanding of himself, of his patients as people, and of their psychiatric and psychosomatic disorders. He needs, therefore, to be trained, and his training should not only give him knowledge about mental health and illness, but also furnish him with the necessary skills and attitudes to recognize and deal with mental disorders and the many ways in which the mind can upset the body and the body the mind.

A constructive attitude to the emotional problems of sick people or to mental disorders must start in the undergraduate period. But for the most part skill can be acquired only when the young practitioner has started in practice. Training in mental health should therefore be both undergraduate and postgraduate.

The general practitioner is only one among many people concerned with mental health and disorder; he must co-operate in a team in which different members may have to assume leadership at different times. Constant co-operation is most necessary with the patient's relatives, since it is they who bear the heaviest share of the burden of mental and emotional disorder. There is a particularly promising field for co-operation between general practitioners and health visitors (public health nurses) in dealing with small children. This is the largest field for preventive psychiatry. Close

co-operation may help parents, for example, to use their authority properly and children to acquire a sense of responsibility. Co-operation with psychiatrists is, of course, imperative, and can be achieved much better than in the past through such modern mental health services as day hospitals and mental health centres.

In recent years, the tendency has been to treat as many psychiatric patients as possible outside hospital and in their homes. This might have been expected to increase the work of the general practitioner, but in fact the increase has been negligible, since he rarely has more than one or two severely disturbed patients at one time in his practice. By far the greatest part of his psychiatric work is still with patients who are never admitted to mental hospitals.

The general practitioner also has a function to fulfil in the prevention of mental illness and in the promotion of mental health. For this purpose, he should work in conjunction with the mental health services.

## 10. AUXILIARY WORKERS

There is a shortage of doctors in most countries, particularly in general practice. If the general practitioner is to be able to carry out his essential functions, he must therefore have assistance from auxiliary services. The fact that the front-line medical workers in some countries are not the general practitioners but the auxiliaries should not be regarded as a matter of regret, but accepted as a positive way of coping with the immense health problems those countries are facing.

There are many types of auxiliary worker, among them social workers, health visitors, home helps, district and home nurses, and psychiatric social workers; and there are, of course, secretaries and nurses, sometimes paid for by the general practitioners themselves. Except in well-integrated health services, however, there is usually poor co-operation between the auxiliary workers employed by local public health authorities and the general practitioners. Co-operation should be encouraged as much as possible, both by impressing upon the general practitioner the value of using the auxiliary services and by impressing upon the public health authorities the need for their auxiliary workers actively to enlist the general practitioner's support and to help him in his work.

In various parts of the world, studies are being made of the best type of auxiliary service for the general practitioner. The Committee feels that the findings of these studies should be collected and disseminated, and that comparable studies should be undertaken to complete the information obtained and to determine the best methods of ensuring full co-operation between general practitioners and the auxiliary services.

## 11. RESEARCH

Without active research, general practice will stagnate. The prestige of general practice, too, will depend to some extent on the quality of the research it carries out and on the contribution it makes to medical knowledge. Research also has valuable effects on the general practitioner carrying it out, opening his mind to wider horizons, furthering his professional education, and making him a more knowledgeable and experienced doctor, able to provide a better service for his patients.

Apart from its effects on the general practitioner, research is needed to supply answers to a large number of questions in medicine. Many clinical problems exist to the solution of which general practice can make a contribution. Research is also needed on the nature of general practice itself, and on the role of general practitioners in the community, in systems of medical care, and in preventive medicine.

### 11.1 General practice as a field for research

Research in general practice has been neglected because it has not appeared an obviously fruitful field of study, because research-minded doctors have not been attracted into general practice, and because, until very recently, research workers outside general practice have not been sufficiently interested to organize or support studies in this field. There has now been a notable change of attitude, and in many countries research of various types is being carried on in general practice. The Committee believes that this trend should be encouraged and supported, and that WHO can play a valuable part in facilitating and co-ordinating research in general practice.

It is now generally accepted within the medical profession that there is great scope in general practice for certain special types of research. Detailed, elaborate research studies are not suitable for general practice; they are best carried out by institutions and hospitals. But careful, well-planned clinical and epidemiological studies can profitably be carried out in general practice by general practitioners in close collaboration with statistical, epidemiological, and clinical colleagues.

### 11.2 Recent studies

Many of the classical research studies of the past were by general practitioners. Since the Second World War, increased interest in research, particularly in epidemiological methods, coupled with the desire to make general practice more effective, has contributed to a virtual renaissance of research studies by general practitioners.

Research studies in general practice have provided information on the incidence and prevalence of diseases and disease syndromes, on the utilization of the doctor and the health services, and on referrals to hospital.<sup>1</sup> Most of this research has been carried out in the Netherlands, the United Kingdom, and the USA, but there appears to be no good reason why similar studies should not be carried out elsewhere.

The Committee recommends that WHO take an active part in supporting research in general practice. One possibility is the establishment of a centre for the collection and dissemination of information on the research being carried out in general practice and the results obtained. Apart from epidemiological and clinical research studies, the Committee feels that emphasis should be placed on co-operation with the social sciences in carrying out studies on the place of general practice in medical care and on how the community uses the general practitioner services. Excellent work could be done by the general practitioner on family studies, in tracing the natural history of disease, or in helping to establish norms of health.

### 11.3 Records

The importance of well-kept medical records as the basis of good medical care is as great in general practice as elsewhere in medicine. Records kept by the general practitioner may be used by hospitals, health services, and other persons, and they may be transferred when the patient moves from his home. They should therefore be legible and clearly understandable, and provide a full history of the patient. Obviously, they must also be adapted to the general practitioner's work. They therefore have to be brief, they should fit into small folders so that they can easily be carried by the general practitioner when he visits his patients at home, and they must be in such a form that the important features relating to the individual patient can be quickly picked out.

The records in use all over the world by general practitioners are of endless variety. The Committee considers it desirable that a study be made of the various types so that a prototype incorporating the best points of each can be prepared. Standardization of the general practitioner's records would greatly help in epidemiological and other studies of disease.

It is part of the general practitioner's duties to complete such records as death certificates, notifications of infectious diseases, immunizations and health inspections. These are used by the authorities to analyse health in the community and the quality of medical care. The general practitioner is not always aware that these records are important both as giving a clear picture of disease in the community and the steps being taken against it

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<sup>1</sup> Fry, J. (1957) Five years of general practice. A study in simple epidemiology. *Brit. med. J.*, **2**, 1453

and as a prerequisite for any consideration of health measures to be taken. Every effort should be made to remedy this situation ; not only during his medical training but also after he has started in practice, the general practitioner should be constantly reminded that prompt and accurate recording is a vital component of the organization of community medical care.

## 12. TRAINING

The Committee fully endorses the recommendations given in the eleventh report<sup>1</sup> of the WHO Expert Committee on Professional and Technical Education of Medical and Auxiliary Personnel (*Training of physicians for family practice*). These recommendations are reproduced here in full:

1. Every medical school should provide opportunities for its undergraduates to receive some of their training in the setting of family practice. This experience should be common to all students and not confined to those who are likely to become family doctors. The methods adopted by a medical school in providing teaching in this extra-mural setting will clearly require to be adapted to the local resources and circumstances.

2. In order to raise the standards of family medicine, all graduates who choose family practice as their future work should undergo a period of postgraduate study and preparation specially designed to meet their needs in this field of medicine. Details must of necessity be left to the countries concerned. A substantial amount of this training should be given in the actual setting of general practice, although hospital experience, public health and preventive medicine and the psychological aspects of medicine should all be represented in this phase of training.

3. Whatever the basis of his undergraduate and postgraduate training, the family doctor ought to be a "perpetual student" throughout his professional life. Every effort should be made to remove such obstacles as may render it difficult for the family doctor to participate fully in continuing training, whatever his financial compensation, the organizational framework of health and welfare services, or other circumstances in which he works.

4. More research should be undertaken in this field of medicine. Morbidity studies in different countries can be of great help to those who have to decide on the priorities of emphasis in undergraduate and postgraduate teaching programmes. There is urgent need for research into the different forms which family practice can assume, not only in various countries, but also in different situations (for example, urban and rural) in the same country. Research should also encompass evaluation of different methods of training, both undergraduate and postgraduate, which are being developed in many countries and in widely differing circumstances.

5. The need for family physicians to participate in the teaching of students has been emphasized. Thus it is necessary to train family doctors in teaching methods in order to render their instruction more effective. One of the means of assisting developing countries is by assignment of teaching staff. In such programmes it is important to bear in mind the advisability of including some physicians who not only have practical experience in family practice but also are acquainted with appropriate teaching methods.

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<sup>1</sup> *Wld Hlth Org. techn. Rep. Ser.*, 1963, 257, 35

6. At all stages in the training of the family doctor increasing attention should be paid to the development of the skill of working with auxiliary and paramedical personnel. This is particularly urgent in rapidly developing countries where, in attempting to meet all the needs of the community which he serves, the doctor faces the problem of how to strike a balance between preventive and community action on the one hand, and the offering of personal curative services on the other. Well-organized co-operation with properly trained paramedical and auxiliary personnel would multiply the effectiveness of the physician's work.

### 13. THE FUTURE OF GENERAL PRACTICE

The Committee is strongly of the opinion that general practitioners fulfil an essential function, and will continue for the foreseeable future to fulfil an essential function, in the medical services of all communities, since the kind of continuing and comprehensive care that they provide meets the basic needs of the individual, the family, and the community. Many systems of medical care can be, and have been, devised, with the emphasis now on this and now on that component, but in all systems a central place must be found for a personal, family doctor who knows his patients, their family, and their social background and approaches their health and welfare problems with understanding and sympathy. Furthermore, the person first consulted by the patient should be sufficiently trained to diagnose his condition or should know how to obtain a diagnosis, and he should be able to deal himself with the less serious conditions (the great majority), thus preventing the specialists and hospitals from being overwhelmed with work. These central and primary roles are both filled by the general practitioner, and it is hard to see who otherwise could fill them without a severe fall in standards of medical care.

From the point of view of the public, the general practitioner is still considered, as in the past, to be someone from whom sound advice can be sought and in whom full confidence can be placed, not least because what passes between patient and doctor remains secret, in accordance with medical ethics.

This is not to say that all is well in general practice today or that it should be left to continue as it now is. Indeed, the Committee's discussions showed that there is a general feeling in most countries that general practice suffers from defects that must be remedied in order to bring medical care up to the standards now required by medical progress and often demanded by the public. It is clear from the preference of many young graduates for specialization and research, from the continuing controversy about general practice today, from the shortage of general practitioners, and from the demands of general practitioners for better facilities or a larger share in hospital work, that the role of general practice is at present in the process of being reinterpreted. The Committee feels that discussion of the role

and functions of general practice is desirable and necessary and can only do good. In most countries, the system of general practice has developed gradually over long periods of time to suit the prevailing conditions. Nowadays the pace of change has immeasurably increased, and adaptations that once took generations must now be made in the shortest of time. Inevitably, this results in local or general dissatisfaction, and, on the part of some general practitioners, a reluctance to abandon past privileges and practices that does more than anything else to encourage the view sometimes held that general practice is outmoded.

While the Committee firmly believes that this view is mistaken, it also believes that general practice in many countries is in need of reassessment and readjustment to bring it into line with modern medical knowledge. Ideally, the general practitioner should have had a sound education in scientific medicine and the social sciences, as well as special preparation to meet the local problems of general practice in whatever part of the world he is going to practise. His contacts with his fellow practitioners and specialist colleagues should be regular and continuing, his relations with local hospitals and the other medical services close. He should have easy access to diagnostic facilities and be able to obtain specialist opinion and the assistance of the social services when he needs them. Because medical knowledge is advancing very rapidly, his education must not stop with what he has learned in his medical school and afterwards in his postgraduate studies; he must keep abreast of new knowledge by attending regular refresher courses, seminars or case conferences, or by any other means available to him. His premises, equipment, and staff must be adequate, and his practice organized to meet the demands placed on it. He should be content in his work, feel that it is appreciated, and consider himself reasonably well compensated for his efforts. His patients should be satisfied with the care they receive. Finally, the system of general practice should form an integral part of the whole system of medical care, function efficiently and economically, cover the entire population — so that no one is deprived of the continuing comprehensive care it provides — and be acceptable to the medical profession as a whole.

The Committee discussed examples of the many forms of general practice at present in existence. All of these strive towards some sort of ideal for general practice, and all in some way or other fall short of the ideal. It is clear that, while the objectives of general practice are much the same the whole world over, differing local conditions must change the emphasis on one or other aspect; thus prevention must inevitably play a more important part in the general practitioner's duties in some countries than in others. With the information at present available on forms of general practice, it is impossible to say that any one system is better than another, and the Committee considers it desirable that an exhaustive study should be made of general practice throughout the world, designed to

reveal the merits of the various systems of medical care. The systems developed in each area doubtless meet local needs in a way that is appropriate to the area and cannot radically be changed without serious disturbance of medical organization and care; but the Committee believes that more knowledge should help bring about adjustments enabling most systems of general practice to advance with the times, and that general practice is bound to benefit from an informed discussion of the advantages and disadvantages of the various systems.

In the meantime, the Committee considers that certain trends in general practice are likely to continue and that some of them should be welcomed. The establishment of colleges and academies of general practice cannot fail to foster a corporate spirit among general practitioners and may raise standards of general practice generally. The increasing tendency towards group practice will help reduce the isolation of the general practitioner, give him the advantage of professional discussions with his fellow-practitioners, enable him to equip himself more completely and economically, and lessen the burden of work he has to do. The closer association of general practitioners with hospitals can hardly fail to be of mutual benefit to both hospitals and general practitioners, and it will also improve the range of diagnostic and therapeutic services available to the general practitioners. Moreover, the refresher courses of various types now being increasingly offered to general practitioners provide them with the necessary opportunity of keeping up to date.

To sum up, the Committee holds that discussion and controversy about general practice are healthy signs. They should have the excellent effect of pruning away much in general practice that has now outlived its usefulness and enabling general practice to meet the requirements of the modern world with confidence.

#### 14. RECOMMENDATIONS

During the course of its discussions, the Committee made certain specific recommendations. These include:

1. A detailed study of the organization, operation, efficiency, and acceptability of general practice in as many forms as possible over a wide area.
2. Studies in various parts of the world of how general practitioners use diagnostic facilities, with a view to improving these facilities or assisting the general practitioners.
3. Studies of systems of medical care in relation to out-patient facilities.

4. A comparative study of hospital services in which the patients are cared for by full-time specialists and hospital services in which they are cared for by general practitioners.

5. A complementary study to the preceding one, to investigate the circumstances in which and the extent to which general practitioners should care for their patients in hospital.

6. The participation of general practitioners in trials of various combinations of preventive and curative care.

7. A study of the usefulness of periodic medical examinations in relation to their cost, when and how often they should be done, the specific examinations to be carried out, and the percentage of examinations revealing dangerous pathological conditions.

8. The collection and dissemination of the results of studies on the auxiliary services most suited to general practitioners and of the best methods of ensuring full co-operation between general practitioners and the auxiliary medical services.

9. Stimulation of research in general practice by facilitating and coordinating it at an international level.

10. Studies of the various types of general practitioner records with a view to preparing a prototype incorporating the best features of each type.

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