average practitioner has not sufficient capital to undertake major reconstructions and alterations unaided. Consideration must be given to extending the Group Practice Loans Scheme to apply to all types of general practice. In addition the possibility of more generous tax-concessions for rebuilding, alterations, employment of ancillary staff, and provision of equipment must be studied. A ten-year plan for general practice is needed even more than in the hospital field.

With such suitable incentives and aids for general practitioners to help themselves the future of general practice will be assured and rapid improvements should occur.

Summary

The present and future roles of the general practitioner are under much discussion. There is a general desire to help the G.P., but before such help can be usefully given it is necessary to have up-to-date factual information on the subject.

A survey has been carried out on 33 selected general practices, within 50 miles of London, to collect information on their organization and premises, and to obtain the general views from the individual doctors.

The visits were carried out by a general practitioner and an architect, and simple methods were employed. In the space of one hour much detailed information was obtained.

The general practitioners were all "good G.P.s." They were individualists jealous of their independence. Their morale was high but they complained of professional isolation and some dissatisfaction with the present situation. Doctor–patient relations were good and there was no abuse of the N.H.S. by their patients. Relations with hospitals were excellent: those with local health authorities were indifferent. Although all felt that they worked hard, less than half (14) considered that the size of the lists should be reduced. A decline in private practice was evident. Eighteen had no private patients, and the great majority expressed a dislike for private practice.

In contrast to the individuality of the G.P.s there was an extraordinary sameness in the organization of their practices. Premises were arranged in a similar fashion. Even the new purpose-built premises were inflexible with few thoughts for the future. Ancillary staff were not well accommodated. One-third of the doctors lived on the premises. There was only minor interference with home life. Night calls averaged only two a month and 28 of the 33 practices worked some rota scheme. Appointment systems were used in one-third of the practices. Those who did not have appointments considered a 20-minute wait by the patients a reasonable minimum. Half of the practices used an examination-room and two-thirds held special clinics for children, inoculations, and antenatal care.

There was a high standard of cleanliness and interior decoration, and in 26 of the practices there was evidence of recent or contemplated alterations. In spite of this 20 of the premises were regarded as unsuitable, and in 14 there was evidence of poor conversions. There is need for research into the optimum sizes and functions of the various rooms and into cheap and efficient building methods.

Examples are given of two practices that were visited, each of 6,000 patients. The faults in premises are noted and possible suggestions made to improve them.

We recommend that more extensive and detailed studies be carried out, that an advisory service be established to help G.P.s to replan and redevelop their practices, and that financial incentives and assistance be made available for this purpose.

We would like to thank the 33 general practitioners who so kindly and so willingly co-operated with us in this study.

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HOW GENERAL PRACTITIONERS USE OUT-PATIENT SERVICES IN TWO LONDON BOROUGHS

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Advice and care by senior consultant members of the medical profession have always been offered to out-patients by the London teaching hospitals. With the inception of the Health Act, however, institutions which had originated as fever hospitals or as a result of the Poor Laws came under the regional hospital boards, and, as newly constituted general hospitals, also became identified with a statutory obligation to provide consultant services. Thus a trend which had been developing during the pre-war years was officially accepted at a national level. The general practitioners in central London therefore found themselves in a position where they had a very wide choice of hospitals to which they could refer their patients for management as out-patients. It is the purpose of this paper to describe a survey of the use of out-patient facilities by general practitioners in two adjacent Metropolitan boroughs. In the area studied there are three teaching hospitals, and three hospitals under the control of the regional hospital board (R.H.B. hospitals *passim*); two of the latter have well-developed out-patient departments, while in a third only a few specialties are offered.

Method

At the beginning of 1962, when the survey was started, 77 general practitioners were holding more than two surgeries a week in the two boroughs. Over a four-months period 73 of them were interviewed by one of us (D.J.P.B.); four refused to co-operate, but they were all members of partnerships in which other members

had agreed to participate in the survey. Thus we obtained information about every practice in the area. Interviews were to some extent standardized by asking every doctor the same general questions concerning choice of hospital, reasons for using the service, and their attitude towards various aspects of it. Details about the doctors themselves were obtained from the *Medical Register* and the *Medical Directory*. The partnership status of participants is shown in Table I and a summary of their qualifications is given in Table II. The doctors were divided into two groups according to whether they said at interview that they used the R.H.B. hospitals as much or more than the teaching hospitals.

TABLE I.—*Partnership Status of 77 General Practitioners in Two Metropolitan Boroughs*

Single-handed	33
Partnership of two	22
,, ,, three	9
,, ,, four or more	13

TABLE II.—*Some Details of Qualifications of 73 General Practitioners in Two Metropolitan Boroughs who Participated in the Survey*

Licence only		12
University qualifying degree	British Isles	42
	Overseas	9
Higher degree (M.D., F.R.C.S., M.R.C.P.)		4
Postgraduate diploma		9

Findings

Factors Influencing Choice of Hospital.—No doctor sent *all* his patients to a single hospital, but it was possible to divide the referrals according to whether a teaching or an R.H.B. hospital was more often used (see Table III). A careful study, which took distance and public transport into account, showed that the accessibility of the hospitals to the patients was the biggest single factor in determining the out-patient department to which the majority of referrals were made.* Accessibility is not, however, the only factor. As Table IV shows, in 38 of the practices the patients are usually allowed to decide which hospital to visit, and, while in general they choose the most convenient one, they will in some cases avoid the R.H.B. hospitals, which

TABLE III.—*Type of Hospital Most Frequently Used for Out-patient Referrals by 73 General Practitioners*

Teaching hospital	31
R.H.B. ,,	42

TABLE IV.—*Type of Hospital to Which Patients are Usually Referred According to Whether Doctor or Patient Most Commonly Makes Choice*

	Teaching Hospital	R.H.B. Hospital	Total
Doctor's choice	10	25	35
Patient's ,,	22	16	38

still have, among older people, an association with workhouses. It is interesting that only five of the doctors believed that many of their patients objected to the presence of medical students in the out-patient department. In the other 35 practices the doctor usually decides which hospital is to be used, and 25 of these doctors preferred R.H.B. hospitals; of these 25, 20 have come into the area since 1949. The two main reasons they gave for this preference were that in R.H.B. hospitals (1) they found it easier to establish personal relations with the consultant staff, and (2) the hospital staff as a whole were more aware of the needs of the practitioner.

Admission of Acutely Ill Patients.—It was found that doctors differed in the way they went about seeking hospital admission for acutely ill patients. Those who use the out-patient departments of teaching hospitals depend mainly on the Emergency Bed Service, while most of those who use R.H.B. out-patient departments obtain admission for their patients by telephoning the R.H.B. hospital direct (see Table V).

TABLE V.—*Out-patient Referral Pattern According to How Admission for Acute Sick is Sought by Telephone*

Body First Telephoned	Out-patient Department Most Commonly Used				Total
	Teaching Hospital		R.H.B. Hospital		
	No. Observed	No. Expected	No. Observed	No. Expected	
Teaching hospital	4	14·9	2	19·1	6
R.H.B. ,,	5		23		28
Emergency Bed Service	23	17·1	16	21·9	39

Relations with Hospital Staff.—General practitioners were asked several questions which had a bearing on their relationship with individual consultants: 80% never discussed their patients' problems with a consultant—in fact, 5 (7%) stated categorically that they thought it would be unreasonable of them to take up the time of the hospital staff in this way. As Table VI shows, only one-third nominate the consultant they wish the patient to see, and these are mainly users of R.H.B. services ($P<0.05$). Most of those who specify the

TABLE VI.—*Out-patient Referral Pattern According to Whether or Not General Practitioner Specifies Consultant by Name*

	Teaching Hospital	R.H.B. Hospital	Total
Doctor specifies consultant	6	19	25
,, does not specify consultant	26	22	48

consultant do so because they want to establish a personal and professional relationship with him; only a few do so because of the consultant's interest in a particular disease. The commonest reasons given for *not* nominating a consultant were (1) the practitioner thought that all consultants were equally capable of treating any disease within their specialty; (2) the practitioner knew no consultant by name; (3) specifying a consultant involves a longer delay before the patient is granted an appointment. Taking Table VI into account, the third of these reasons may reflect on the appointments systems in the teaching hospitals. All but 10 of the doctors felt that once a patient had been referred to the out-patient department they did not want to be involved in any further decisions about treatment or cross-referral to other specialists within the hospital.

Reason for Referral.—Sixty general practitioners offered the opinion that their primary reason for sending a person to the out-patient department was for the establishment of a diagnosis, but 10 said it was for treatment of conditions which they had themselves diagnosed and three said it was to reassure their patients. Those who gave diagnosis as the chief reason were asked to say whether they thought the specialist's opinion or the investigations he had at his command was the most valuable information obtained from the referral. Table VII shows an interesting difference between teaching

*We studied this aspect of the problem by marking all the practices and all the hospitals on a map, and then analysing the referral patterns. To publish this map as a figure in the present paper would, however, make it possible to identify confidential information with the doctors who co-operated in our survey.

and R.H.B. hospitals in this respect. This difference is probably the result of a number of factors, one of which is the lack of any direct access to pathological laboratories or *x*-ray departments for the practitioners using teaching hospitals.

TABLE VII.—*Referral Pattern of 60 Doctors According to Whether the General Practitioner Considered the Specialists' Opinion or Special Investigations the Most Valuable Information he Obtained from the Out-patient Department*

	Teaching Hospital	R.H.B. Hospital	Total
Consultant opinion	7	27	34
Special investigations	19	7	26

Use of Diagnostic Facilities.—In addition to the R.H.B. hospitals, some diagnostic facilities are available at two other centres within the area, one of which is run by a local authority and the other is independent. Table VIII gives an analysis of the attitude of practitioners towards diagnostic facilities according to the out-patient service most used, and it can be seen that a greater proportion of those who use the R.H.B. hospitals also use the diagnostic services despite the fact that these are not necessarily at an R.H.B. hospital. In addition, it was found (Table IX) that the younger doctors show more interest in the diagnostic services than do their older colleagues ($P<0.05$).

TABLE VIII.—*Out-patient Referral Pattern According to Whether or Not General Practitioner Made Direct Use of Diagnostic Facilities*

Doctor's Use of Diagnostic Facilities	Teaching Hospital	R.H.B. Hospital	Total
Used	14	26	40
Not used	18	15	33

TABLE IX.—*Direct Use of Diagnostic Facilities According to Whether or Not Doctor Qualified Before* 1940

Doctor's Use of Diagnostic Facilities	Date of Doctor's Qualification		Total
	Before 1940	1940 or Later	
Used	19	21	40
Not used	24	9	33

Discussion and Conclusions

It is a matter of considerable interest that, as Table III shows, 57% of the doctors in the area we have studied use out-patient services which have come into existence quite recently in preference to others which have been available for a very long time. Indeed, the teaching hospital out-patient departments are evidently more attractive to the patient than to the doctor, although the reverse is true of the R.H.B. hospitals. By being in a position to exercise a choice the local doctors were able, unconsciously, to give some indication of what a general practitioner requires of an out-patient department, and indeed of the hospital service. Bearing this in mind, we believe that the following conclusions may be applicable outside the London area, where lack of choice of hospitals makes studies such as ours impossible.

1. Most of the general practitioners allowed the patient to choose the hospital, so that "patient satisfaction" (a concept which we will not attempt to analyse here) is evidently of considerable importance to the family doctor.

2. Although in the area studied there is little personal relationship between family doctors and hospital staff, it is clear from the answers given by doctors using the R.H.B. hospitals that there is in many practices a desire to establish such a relationship.

3. The majority of the general practitioners made use of their opportunities to have special investigations carried out without referral of the patient to a consultant. This opens the question of whether further extension of these services throughout the country would relieve the load on out-patient departments.

Summary

A survey is described of the use made of out-patient services by 73 out of 77 general practitioners in two adjacent Metropolitan boroughs in London, with particular reference to the reasons some of them use the relatively newly established departments in R.H.B. hospitals in preference to older ones in the teaching hospitals. Such factors as accessibility to the patient's home, the patient's own preference, the policy of the hospital concerning emergency admissions, the general practitioner's desire to establish personal relations with hospital consultants, and the direct availability of special investigations are considered. The present findings are discussed in the light of possible developments in medical care throughout the country.

Our thanks are due to the general practitioners who kindly provided us with the information we present here, and to our colleagues at Guy's Hospital for their advice and criticism. Our research on out-patient services is supported by King Edward VII Hospital Fund.

ROYAL COLLEGE OF SURGEONS OF ENGLAND

QUEEN OPENS POST-WAR BUILDINGS

H.M. the Queen visited the Royal College of Surgeons of England on November 7 to open the new post-war buildings. She was accompanied by H.R.H. the Duke of Edinburgh. In his address of welcome the President, Sir ARTHUR PORITT, said that their presence set the seal on what was a red-letter day for the College—the transformation of a sadly war-damaged building into an active and full-blooded modern institution, the activities of which were commensurate with the almost incredible advances of surgery in this century and in keeping with the tempo of the times.

Royal Honorary Fellows

Both the Queen and the Duke of Edinburgh were Honorary Fellows, and royal interest, Sir Arthur said, went back to the very beginnings of the College, for it was granted its first Royal Charter in 1800 by King George III, and its mace was a gift from King George IV. King Edward VII, as Prince of Wales, became the first Honorary Fellow in 1900—the College's centenary year; King George V and King Edward VIII, both again while Prince of Wales, were also Honorary Fellows, and King George VI became the first "Visitor" to the College—a title which the Queen had also graciously accepted. This was Her Majesty's first visit to the College in that capacity, but many of those present remembered the previous occasions on which she had been there—first in 1951 to receive the Honorary Fellowship, and then in 1953 when she laid the Memorial Stone for the New College buildings—which stone was now incorporated in the far wall of the Great Hall. On that occasion the Queen used a mallet previously used by Queen Victoria.

One of those present at the ceremony of the laying of the Memorial Stone was the progenitor of the College's